

## **Costing for Managed Care Contracting**

May 6, 2003

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### Introduction

American medical care providers are in the process of agreeing to provide care under special pricing arrangements. These arrangements include global pricing that packages assessment, surgery and follow on care, per diems that include all services, and capitation agreements to provide services as required for a covered population. In many provider organizations, these contracts are being let by managed care or contract management staff without profitability analysis, because cost information is not available or is unreliable. As contract rates cut closer to the margin, this practice will become intolerably risky.

### Contracting on Marginal Revenue

By examining current contracts for a similar set of encounters and patients a baseline of revenue is obtained. By applying the proposed contract terms and reimbursement rules to the same data set, the new revenue can be modeled. The difference between the baseline and model is the marginal revenue. Assuming the activities were profitable to begin with, and if the modeled terms are at least as favorable, the organization will continue to make money.

Unfortunately,

few purchasers of care are likely to be so charitable. As rates deteriorate, the marginal revenue method is unable to detect the true breakeven point for a contract. Moreover, once the first unprofitable contract is set, it often becomes the benchmark for subsequent contracts.

### Using Elementary Costing Methods

In an effort to obtain cost of these activities, some providers are dusting off old costing methods like ratios of cost to charges (RCCs) from the Medicare cost report. These methods have the lure of being extremely easy to implement, however they are extremely risky. Here are some of the inherent flaws:

- 1) The single lump of cost calculated by RCC contains both direct and indirect costs, as well as fixed and indirect costs, labor, supplies, depreciation and so on. It is thus impossible to judge how much and what costs will increase if clinical activity increases.
- 2) The Medicare RCC is based on an indirect allocation process that has been gamed to increase reimbursement, not accurately allocate costs for management purposes. The Medicare cost report uses a single pass allocation that is generally considered inappropriate for management purposes. The more commonly used management method is the reciprocal or simultaneous allocation method which distributes overhead among all centers more accurately.
- 3) The RCC is derived from history, then applied to new charges to derive costs. The RCC calculated costs are often at significant variance with actual costs. The only way to ensure a match is to recalibrate the RCCs, with a new set of values for each month.
- 4) In some providers, the charge value at the charge item level has been set in an arbitrary fashion to maximize reimbursements, in other providers rate controls have prevented adjustments that would bring charges in line with costs. These problems lead to significant distortion of costs allocated within the department's activities, and thus between patients.

As a result of these limitations, managers and clinicians in the organization often express little confidence in cost figures derived in this manner. Care givers are uncomfortable with these calculations for judging true clinical

resource consumption. This lack of knowledge makes them less than full partners in the effort to reengineer health care and reduce costs to live within contractual constraints.

Do these problems mean that each provider needs to make a huge investment in detailed standard cost systems? Failures of large hospital "standard cost accounting" systems over the last decade have created a stampede away from such high cost, high risk projects. While some still see the issue as only black and white, RCC versus standard cost, many providers have quietly developed a reasonable approach combining the best of both solutions.

#### A Better, Hybrid Cost Accounting Approach

The hybrid approach must combine several major characteristics:

- 1) Tie in to the general ledger and financial statements, updating monthly.
- 2) Retain the identity of costs by direct and indirect, labor and non-labor, fixed and variable.
- 3) Provide rapid, global fixed/variable assignments, and allow for easy refinement.
- 4) Offer rapid, global indirect allocations, and allow for easy refinement.
- 5) Allow use of charges in any departments whose charges are less distorted, and estimated workload measures in other departments, with easy migration to better standards.
- 6) Allow easy import of pharmaceutical costs, prosthetic costs and other supply costs.
- 7) Allow use of the cost data combined with contract revenue data on both historical and modeled contract activity.

This approach allows surprisingly rapid implementation using available data, and allows the provider to build upon the foundation data as needed. For example, some cost centers may never need detailed standards, because they are relatively insignificant or have a simple set of patient activities. Other cost centers can be moved forward to improved standards in priority order at a pace determined by the provider.

#### Reengineering Patient Care: Closing The Loop With Clinicians

With a reasonable cost accounting approach, we can see if our proposed contracts are profitable. When a proposal appears to be unprofitable, care givers need to take a hard look at the requirements of the contract in an attempt to live within its constraints. They need to understand the costs of similar cases that have been handled previously to identify where and how to reengineer the care process. As they consider alternative clinical choices, they need to determine the costs of eliminating some activities or replacing them with less costly alternatives. This process crosses disciplines and is iterative.

The process results in creation of expected use rates and pathways. Once use rates and pathways are set, actual activity must be monitored against these targets continuously to identify variances and take corrective action. The ideal way to perform this monitoring is through on-line real-time systems that permit corrective action to change the outcome. For example, patient registration and scheduling to validate appropriateness before the event occurs. Another example is patient management systems that integrate care plans and cost accounting information with order management, to inform caregivers of the pathway plan and the cost of alternative diagnostic and therapeutic choices as the choices are being made.

Cost is clearly a key to managing care successfully. The real cost of using easy but inaccurate cost data is likely to be much higher than the cost of implementing a reasonable cost accounting approach.