hfma healthcare financial management association

first illinois speaks

A Newsletter from HFMA's First Illinois Chapter

April, 2005

beyond the numbers

The Tradeoffs of Simplifying Your Managed Care Contracts

BY CATHY A. PETERSON

INSIDE:

Highlights and Recap
First Illinois Chapter Events

A review of the
Accounting & Reimbursement Program – Who Moved My Cheese? January 13, 2005
and the
Managed Care Program – Managed Care Innovations: The New Era in Healthcare
March 24, 2005

Hospital management is increasingly frustrated with difficulties of administering managed care contracts. The contracts often include terms that neither the hospital nor the insurer can readily administer which:

- increase administrative expenses;
- increase claim payment errors; and
- delay payments.

This article highlights contract terms that often cause challenges, and reviews pros and cons of the alternatives.

Reasons for Increased Complexity

Contracts have become increasingly more complex over the last five years for a variety of reasons:

1. Providers added "carve-outs" (e.g., special reimbursement for select DRGs, additional reimbursement for implantables) as a way to obtain increased reimbursement from insurers and assure that payment for all product lines is at least at variable cost;
2. Hospitals wanted to be assured that the reimbursement from insurers covered all variable costs for high cost product lines and high cost short stays (e.g., cardiovascular surgery, orthopedics, and neurosurgery);
3. Insurers are trying to reduce and fix their costs for outpatient services by paying groupers for surgeries and developing complex formulas for outpatient services;
4. Several large insurers are moving toward DRG contracting, but using methodologies quite different from those used by Medicare;
5. Insurers are implementing contract methodologies that allow them to determine payment by service type. Specifically, they want to eliminate all contract terms that pay a percentage of charges without a payment cap; and
6. The major national insurers are increasingly taking a "corporate" approach to their contracts. They come to the negotiating table with fixed methodologies (regardless of location), and local contractors have less flexibility than previously. Ironically, the "corporate" approaches vary significantly between insurers.

The Hospital's Role

The *benefits* to the hospital of carving out categories of reimbursement (reasons 1 and 2 above) have been to increase reimbursement and decrease risk. This has been accomplished by the following types of contract carve-outs:

- **High cost per day stays.** With high dollar stop losses usually above $75,000 for most insurers, a large percentage of rapidly growing product lines which have high costs per day will never hit the stop

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Inside This Issue

President's Message

As the third largest HFMA chapter (1200 members) in the nation after Northern and Southern California, the quality of First Illinois' educational programs has been well received. This is made possible through the participation of our Education and Committee Chairs. These individuals have a good grasp of current healthcare issues and, with input from their respective committee members, have played a pivotal role in identifying the best topics and speakers for our programs.

The topics presented at these programs are current and practical for our members. The "value-added" for members attending the programs is the opportunity to network and share ideas of mutual interest. We appreciate the amount of time that is devoted to these programs.

Our 2004-2005 educational programs — Information Technology, Revenue Cycle, the Region 7 Symposium, Accounting & Reimbursement, Medical Groups and Physicians, and Managed Care — were well attended. Two upcoming programs in May are: CFO program and golf outing, and our annual First Illinois Chapter golf outing. We encourage your participation.

The Chapter's ongoing objective is to continue to get more members involved with chapter growth. As we move into the new term, I am confident that the programs we offer make participating in the Chapter a good investment.

I want to thank our past presidents and senior members for their input and guidance. I also want to acknowledge our sponsors and the volunteers who assist in putting these educational programs together. I thank the officers, the board of directors and chairs of our committees for their support and doing an excellent job during my tenure as Chapter President.

Martin D'Cruz, FHFMA
President
First Illinois Chapter HFMA

beyond the numbers

First Illinois Chapter News, Upcoming Events & Committee Updates

First Illinois Chapter Elections

The results of the elections for 2005-2006 are in, with more than 200 members responding. The officers and board members for the coming year are:

Officers

President:	James Heinking, CHFP Executive Vice President, Healthcare Financial Resources
President-Elect:	Vince Pryor, FHFMA, CPA CFO, Ingalls Health System
Secretary:	Jim Watson Director of Managed Care, Rush North Shore Medical Center
Treasurer:	Guy Alton, FHFMA, CPA CFO, St. Bernard Hospital

Board of Directors

Term Expires May, 2006

Martin D'Cruz, FHFMA
Vice President, Managed Care, St. Vincent Health

Richard Stewart
CFO, American Academy of Orthopedic Surgeons

Jim Ventrone, CHFP, CPA
President, Ventrone Ltd.

Alexis Washa, CPA
Senior Director, Evanston Northwestern

Term Expires May, 2007

Larry Connell, CHFP
Director of PFS, Swedish Covenant Hospital

Elizabeth Simpkin
President, The Lowell Group, Inc. Healthcare Consulting

Sylvia Sorgel
Vice President Sales, CMD Outsourcing Solutions, Inc.

CFO Committee

The CFO Committee has a busy spring planned. The annual Education Session/ Golf Outing will be held on Friday May 6th at the Calumet Country Club. Save that date!

In keeping with our commitment to add value to members' participation the April 8th meeting will feature Mike Miller from LT Annum Appraisal Services. Mike's topic will be "Do you know the average age of your assets?" Our June 10th meeting will include a presentation and discussion by Hugh Donovan of Siemens on Clinical Trials. This program has been presented to the Boston chapter of HFMA and was well received.

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First Illinois Chapter News, Upcoming Events & Committee Updates *continued from page 2*

Meetings are held the 2nd Friday of every month at HFMA national headquarters in Westchester. If you would like to get on the CFO Committee mailing list send an email to Guy Alton at guyalton@stbh.org.

Committee Leadership 2005 – 2006

February and March are busy months developing the First Illinois HFMA leadership. In February the chapter president, president elect, and the four immediate past presidents came together to select the candidates for the rotating chapter director positions and to nominate an incoming treasurer officer. After this process the candidates are contacted and they decide to join the First Illinois slate of candidates for the open directors and officer positions. Once this process is complete, the slate of candidates is sent to the general membership for a vote. After the voting process is complete, the new leadership is announced. For more information on this process you should review the chapter's by-laws published in your First Illinois Chapter membership directory.

March is another busy month developing the leadership for the chapter committees. First Illinois has established twenty-one committees for 2005-2006 and may add one additional committee pursuant to the March 11, 2005 strategic planning session. Six of the committees (possibly seven) have a primary goal to provide education to the membership. Fifteen of the committees have the primary goal to provide networking and operations support to the membership. If you are interested in volunteering for a committee leadership position, or would like more information on what is required to become a committee chairperson please contact Jim Heinking at 847-273-2270 or jheinking@hfri.net. Currently the chapter still has opportunities for committee leadership in the following areas:

- Davis Management Committee Chair
- Newsletter Committee Chair

Congratulations and thank you to all of the officers and committee leadership for your support in the upcoming year!

Jim Heinking
President Elect
First Illinois HFMA

First Illinois HFMA's
29TH ANNUAL
Golf Outing

Watch your mail for Golf Outing registration – this is the event not to miss!

CONTACT KEVIN ELLIS AT 312-738-4099 FOR MORE INFORMATION

May 27, 2005 marks the 29th Anniversary for the First Illinois Chapter golf outing.

ST. ANDREW'S GOLF & COUNTRY CLUB will be our primary golf location. Klein Creek will once again be our Premium Course for those who choose to play regulation instead of scramble format.

Once again there will be a barbeque as our afternoon meal running from 3 pm to 7pm at St. Andrew's. We will also have a late morning barbeque for those who may not be able to stay for the entire day's activities, recognizing that it is the beginning of Memorial Day weekend.

Don't miss your chance to kick off the summer with friends and colleagues at the First Illinois Annual Golf Outing. We look forward to seeing you there!

Sole Community and Medicare Dependent Hospitals Eligible for Additional Reimbursement

BY LISA BALLARD, CPA AND RON RYBAR, FHFMA, CMPA

BACKGROUND

A hospital qualifying as a Sole Community Hospital (SCH) or Medicare Dependent Hospital (MDH) for Medicare purposes which experiences a minimum 5% decrease in total discharges may be eligible for a payment adjustment. This article focuses on SCH payment, but the same opportunity exists for MDHs as well.

To qualify for SCH status under the prospective payment system, a hospital must be the sole source of inpatient hospital services reasonably available to Medicare Part A beneficiaries in the geographic area. The factors that are considered in making this determination are isolated locations, weather and travel conditions, and the absence or inaccessibility of other hospitals in the area.

Sec. 6003(e) of 1989 OBRA revised the payment methodology for SCHs effective with cost reporting periods beginning after March 1990. SCHs are paid whichever of the following rates yields the greatest aggregate payment for the cost reporting period: (1) the federal national rate applicable to the hospital, (2) the updated hospital-specific rate based upon fiscal year 1982 cost per discharge, or (3) the updated hospital-specific rate based upon FY 1987 cost per discharge.

Section 405 of Public Law 106-113, which amended section 1886(b)(3) of the Act, provided that an SCH that was paid for its cost reporting period beginning during 1999 on the basis of either its updated FY 1982 or FY 1987 cost per discharge (the hospital-specific rate as opposed to the Federal rate) could elect to receive payment under a methodology using a third hospital-specific rate, based on the hospital's FY 1996 costs per discharge. This amendment to the statute meant that, for cost reporting periods beginning on or after October 1, 2000, eligible SCHs could elect to use the allowable FY 1996 operating costs for inpatient hospital services as the basis for their target amount, rather than either their FY 1982 or FY 1987 costs.

Section 213 of Public Law 106-554, extended to all SCHs the option to rebase using their FY 1996 operating costs. That is, in order to rebase using its allowable FY 1996 operating costs, it was not necessary that the SCH was paid for its cost reporting period beginning during 1999 on the basis of either its FY 1982 or FY 1987 costs. The provision was effective as if it were included in the enactment of section 405 of Public Law 106-113. Therefore, it applied to all SCHs for cost reporting periods beginning on or after October 1, 2000. This option was phased in over four years.

Congress is directed by law to provide for an exception and adjustment for the prospective payment system (PPS) when events beyond a hospital's control or extraordinary circumstances create a distortion in the increase in costs for a cost reporting period. Congress may also provide other appropriate exceptions and adjustments to PPS, including those necessary to take into account a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals that results in a significant distortion in the operating costs of inpatient hospital services.

PAYMENT ADJUSTMENT

For any cost reporting period beginning after September 30, 1983, a payment adjustment will be provided for an SCH in any cost reporting period during which the hospital can demonstrate that the decrease in volume resulted from an unusual situation or occurrence externally imposed upon the hospital and beyond its control. The same opportunity exists for an MDH in any year that it holds this classification.

There are two basic criteria that qualify an SCH or MDH for the payment adjustment. The first criterion involves the decrease in discharges. The hospital must experience a decrease of greater than five percent when comparing a cost reporting period to the immediately proceeding cost reporting period. The second criterion is that the decrease in volume must be due to circumstances beyond the hospital's control. This could include unusual situations or occurrences such as strikes, inability to recruit essential physician staff, floods, unusual prolonged severe weather conditions, or other similar occurrences.

The maximum amount of payment adjustment possible is the difference between Medicare inpatient operating costs excluding passthrough amounts and the DRG amount including outliers. The inpatient operating costs used in the comparison are subject to the limitation equal to the prior year operating costs and updated by the PPS update factor.

A payment adjustment will be made for the fixed costs a hospital incurs in the period in providing inpatient services including the cost of maintaining core staff and services, but not to exceed the difference between Medicare inpatient operating cost and total DRG related payments. Many costs in a hospital are neither specifically fixed nor variable, but are semi-fixed; that is, there are costs that are necessary to maintain operations but also may vary somewhat with volume.

Whether costs are considered fixed or variable will depend to a large extent upon the length of time that a hospital has experienced a decrease in utilization. For a short period of decreased utilization, semi-fixed and variable costs may be considered fixed as the hospital has not yet had time to respond to the decrease in utilization. However, as the period of decreased utilization continues, it is expected that a cost-effective hospital would take measures to decrease unnecessary operating costs. It is for this reason that costs are limited to updated prior period costs.

To qualify, an adjustment request must be filed with Medicare within 180 days following the Notice of Program Reimbursement (NPR) date. A request may also be filed for a cost report that has not yet been finalized to allow the request to be incorporated into the audit cycle.

The number of Hospitals qualifying for this adjustment has been reduced in recent years because many SCH and MDH facilities have converted to Critical Access Hospital status and full cost reimbursement. However, the size of the potential adjustments have increased because most of the remaining SCHs and MDHs are of a larger size.

REQUIRED DOCUMENTATION

The required items in the adjustment request include:

1. General Information. Information including hospital name, address, provider number, and date of classification as an SCH or MDH.
2. Discharge Data. Data must be submitted on the number of discharges in the cost reporting period for which the payment adjustment is requested and the number of discharges in the cost reporting period immediately preceding the period in question. Discharges may be annualized for cost reporting periods of less than 12 months.
3. Circumstances. The request must include a narrative outlining the circumstances that resulted in the decrease in discharges, including description of occurrence, date of onset, and how number of discharges was affected.
4. Cost Data. The request must demonstrate that the total program

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Medical Groups and Physicians Program – February 17, 2005

L. Edward Bryant, Jr., JD, of Gardner Carton and Douglas presented a legal issues update.

Don Carlson, Ziegler Capital Markets; Martin Arrick, Standard & Poors; and Ann Filiaut, Pricewaterhousecoopers; presented issues in capital financing and findings from HFMA's Financing the Future study

Alexander Hantel, MD and Marilyn Daly, RN of the Edward Cancer Center discussed financial impact of changes in Medicare reimbursement for oncology drugs.

Elaine Scheye, Committee Chair

A panel of experts representing a wide array of viewpoints spoke on the timely and controversial topic of charity care and tax exempt status for hospitals. Shown left to right are: John Bohmer, Neville Bilimoria, Stan Jenkins, Jim Unland, Charles Mackelvie, Claudia Lenhoff, and David Buysse.

Tom Curtis, JD, of the law firm of CurtisBond LLP, Pasadena, CA, presented a case study in hospital/medical conflicts from Ventura, California.

HFMA Events

Accounting and Reimbursement Program

Who Moved My Cheese?

January 13, 2005

Zach Fortsch

The Accounting and Reimbursement Committee's annual education program, "Who Moved my Cheese" was held at the William Tell Holiday Inn in Countryside on January 13th, 2005.

This year's session was once again an unparalleled professional development opportunity. Attendees had the chance to expand their interaction with the best and brightest healthcare leaders, while thinking outside organizational limitations. They heard from distinguished speakers on topics ranging from treating the uninsured and underinsured to the impact of Sarbanes-Oxley on not-for-profit health care organizations, along with a wide array of regulatory and government programs updates.

Rick Hamilton

Congratulations to the committee for developing another great program! You can reach committee chairs Patt Marlinghaus at patt_marlinghaus@rsh.net or Brian Katz at brkatz@deloitte.com

Committee Co-Chairs Brian Katz (left) and Patt Marlinghaus (right), with Mike Nichols (center).

Left to right: Patrick Coffey; Greg Pagliuzza, Mike Kittoe, Odin Berg, and Ned Budd.

Nancy Guhman and Tracey Porter Coyne

Managed Care Program

Managed Care Innovations: The New Era in Healthcare

March 24, 2005

This year's Managed Care program was held Thursday, March 24, at the William Tell Inn in Countryside. Committee Chair Todd Anderson introduced the keynote speaker, Dr. Dennis Richling, President of the Midwest Business Group on Health, who opened the day with a discussion of employers' perspective on healthcare trends.

Keith Kudla, CEO of Wellcare Illinois, discussed his organization's plans for Medicare Advantage in the Chicago market. Dr. Christine Stoll of Wellpoint provided insight on new product development trends and network considerations for the commercial market.

Raymond Swisher, Director of Managed Care Services for the Centers for Medicare and Medicaid Services, Region V, described the many new benefit changes ahead for Medicare beneficiaries in 2005 and 2006, including the Part D Prescription Drug benefit, the most significant change in the Medicare program since its inception.

Patricia Ruff, Executive Director of Waukesha Elmbrook Health Care, S.C., a 400-physician IPA in suburban Milwaukee, described her organization's experience with employer coalitions in the Milwaukee area, as well as some innovative means for providers to collaborate with employers in assisting employees to become better consumers of health care.

Last, Dr Robert Zeck, Chief Medical Officer of Adventist Midwest Health and Todd Stockard of Valence Health, spoke about the challenges and importance of data collection and analysis to support clinical integration of a large independent physician organization.

Dennis Richling, MD, President of Midwest Business Group on Health

Raymond Swisher, CMS

Patricia Ruff of Waukesha Elmbrook Health Care with committee member Liz Simpkin.

Robert Zeck, MD, Adventist Midwest Health; Todd Stockard of Valence Health; and committee member Pete Melcher

Todd Anderson, Managed Care Committee Chair

Committee member Jim Watson, with Christine Stoll, MD of WellPoint, and Keith Kudla of WellCare

Understanding the Aetna and Cigna Agreements:

What This Means for the Future of Health Care Payments

BY KAREN HARRIS, J.D.

Background

In late 1999, after winning large settlements against the tobacco companies, plaintiffs' attorneys sought a new target: the health care industry. In particular, these attorneys filed class action lawsuits across the country against the nation's major health care companies. Representing physicians, state medical associations, managed care organizations' members and subscribers, and states attorney generals, plaintiffs' attorneys filed suit against Aetna U.S. Healthcare, Inc., Anthem, Inc., CIGNA, Prudential Insurance Company of America, United HealthCare, and Humana Health Plan, among others (collectively, "MCOs").

Although these insurance companies are sued frequently, these cases were different for a number of reasons. First, these cases attacked the premise of managed care (i.e., the application of cost containment methods requiring coverage justification for proposed health care services) and sought not only monetary damages, but also sweeping policy and operational changes and relief. Even more unusual was the fact that although the plaintiffs sought national class action certification, none of the suits alleged any actual patient injury.

Since most of these lawsuits generally included the same, or similar, types of plaintiffs, against the same, or similar, defendants and contained nearly identical factual allegations and claims, they were consolidated by the Judicial Panel on Multi-District Litigation before Judge Federico A. Moreno in the United States District Court for the Southern District of Florida in 2001. Once consolidated, the cases were divided into two distinct tracks: (i) the provider track, and (ii) the subscriber track. In this article, we focus on the provider track.

Allegations of Lawsuits

Generally, the plaintiffs claim that, between 1990 and 2002, the defendants engaged in a conspiracy to improperly deny, delay and/or reduce payment to physicians by engaging in several types of allegedly improper conduct, including:

(i) misrepresenting and/or failing to disclose the use of edits to unilaterally "bundle," "down-code" and/or reject claims for medically necessary covered services;
(ii) failing and/or refusing to recognize CPT modifiers;
(iii) concealing and/or misrepresenting the use of improper guidelines and criteria to deny, delay and/or reduce payment for medically necessary covered services;
(iv) misrepresenting and/or refusing to disclose applicable fee schedules;
(v) failing to pay claims for medically necessary covered services within the required statutory and/or contractual time periods; and
(vi) misrepresenting and/or failing to disclose the use of inappropriate or unsound criteria to calculate payments due to physicians compensated under a "capitation" system.

The provider track plaintiffs alleged that the insurance companies breached their fiduciary duties under ERISA. Specifically, the MCOs' methods of cost controls and benefits management, such as access to specialist and employing financial incentives to providers to discourage the use of inpatient procedures, were claimed to adversely affect the quality of medical care received by subscribers. Additionally, the failure to provide plan participants and beneficiaries with adequate information about these cost-saving mechanisms employed in managed care was also alleged to be a breach of fiduciary duties.

Under the provider track cases, the plaintiffs also alleged that mail and wire services were used to market health care policies which were intended to defraud and mislead providers about the reimbursement they will receive, in violation of ERISA. These cases also alleged that these insurers consistently and purposefully failed to provide timely reimbursement to providers through practices such as "down-coding" and "bundling" and that these MCOs failed to disclose financial incentives used to deter medical care and/or influence providers' medical judgment.

In terms of damages and relief sought, the provider track cases requested compensation for services the MCOs should have covered and for improperly delayed claim payments. Additionally, and perhaps more importantly, these suits also sought policy and operational changes that would make providers/physicians the arbitrators of benefit coverage determinations.

Aetna Settlement Agreement

Although there was (and still is) great debate as to whether the plaintiffs in these cases would even qualify for national class certification, let alone prevail in the lawsuits, both Aetna and CIGNA opted to settle, rather litigate, these suits.

Under its settlement agreement Aetna agreed to: (i) reform its business practices; (ii) establish a charitable foundation; and (iii) establish a settlement fund for providers.

With respect to its business practices Aetna agreed to:

1. Include in its contracts with providers a definition of medical necessity that bases medical necessity determinations on generally accepted standards of medical practice;
2. Use clinical guidelines based on credible scientific evidence published in peer reviewed medical literature when making medical necessity determinations;
3. Provide physicians access to Aetna's medical necessity external review process;
4. Establish an independent external review board for resolving disputes with physicians concerning many common billing disputes;
5. Facilitate the automated adjudication of claims and thereby reduce the average time taken by Aetna to pay valid claims;
6. Fund initiatives to increase the percentage of claims issues resolved on initial review and thereby reduce the percentage of resubmitted claims;
7. Not automatically reduce the intensity coding of evaluation and management codes billed for covered services;
8. Disclose payment rules and conform its bundling and other computerized editing rules as specified in the agreement;
9. Confirm the elimination of "all product" and "gag clauses";
10. Improve accuracy of information about eligibility of plan members;
11. Ensure the payment of valid clean claims within 15 days for electronically submitted claims and 30 days for paper claims;
12. Provide physicians with the ability to view a complete fee schedule and agree to maintain and update such fees on an annual basis; and
13. Establish a compliance dispute resolution mechanism to address disputes regarding Aetna's compliance with the Settlement Agreement.

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Understanding the Aetna and Cigna Agreements... (continued from page 8)

In addition to reforming its business policies, Aetna also agreed to provide $20 million in initial funding to establish a charitable foundation dedicated to promoting high quality healthcare, with particular attention to initiatives that assist physicians, and improve the quality of care received by patients.

Finally, Aetna established a settlement fund for providers in the amount of $100 million, to be shared among members of the class based upon their practice status and volume of covered services provided to Aetna members. Aetna also agreed to pay up to $50 million of attorney fees in addition to, and not in lieu of, the settlement fund amount.

CIGNA Settlement Agreement with Non-Specialist Physicians

Nearly one year after Aetna first announced its settlement agreement, CIGNA also reached a settlement with non-specialist physicians. The settlement was approved on April 22, 2004 Similar to the Aetna settlement, CIGNA agreed to (i) change its business practices; (ii) fund a charitable foundation; and (iii) establish a settlement fund.

With respect to its business practices Cigna agreed to:

1. Provide members of class access to Cigna HealthCare's medical necessity external review process;
2. Establish an independent, external billing dispute review process for resolving disputes concerning claim coding and bundling edits;
3. Facilitate the automated adjudication of claims and thereby shorten the average time taken to pay valid claims;
4. Fund initiatives to reduce the percentage of resubmitted claims;
5. Disclose payment rules and conform its bundling and other electronic editing rules;
6. Improve accuracy of information about eligibility of plan members;
7. Enable members of the class to obtain applicable fee schedule amounts;
8. Pay interest on valid claims within 15 business days for electronically submitted claims and 30 calendar days for paper claims

Additionally, Cigna gave $15 million to the Physicians' Foundation for Health Systems Innovations, Inc., a not-for-profit medical foundation, established by representatives of medical societies that signed or joined the settlement agreement.

Finally, CIGNA agreed to provide monetary compensation to class members from either one of two funds: the Category A settlement fund, a $30 million fund for all class members; or the Claim Distribution fund, an uncapped fund established to pay three categories of compensation to class members who submitted claims to Cigna during the class period and were affected by claim coding and bundling edits and/or medical necessity denials. Cigna also agreed to pay plaintiffs' attorney fees in the amount of $55 million which is separate from the settlement fund.

CIGNA Settlement Agreement with Specialty Physicians

On December 13, 2004, CIGNA announced it had reached a settlement with more than 210,000 specialty health care providers. This settlement arose nearly a year after CIGNA's settlement with the approximately 700,000 non-specialty physicians described above. The health care providers covered by the settlement include chiropractors, psychologists, counselors, podiatrists, acupuncturists, optometrists, physical and occupational therapists, nurse midwives, nurse practitioners, nurse anesthetists, nutritionists, orthotists, prosthetists, audologists, speech and hearing therapists and others.

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Founders Merit Awards Winners for 2004

BY BRIAN SINCLAIR, AWARDS COMMITTEE CHAIR

The following Chapter Members were presented with plaques to recognize their achievements and service to HFMA. Congratulations to all Merit Award Winners!

Muncie Gold Award

David Golom
Frank McHugh

Reeves Silver Award

John Brugioni
Sandra Beimfohr

Follmer Bronze Award

Greg Pagliuzza
James Heinking
Mike Nichols
Odin Berg
Patt Marlinghaus

For information about the Founders Merit Award program, pleas contact Awards Committee Chairperson Brian Sinclair, at (630)307-9138.

David Golom
Muncie Gold Award

Frank McHugh
Muncie Gold Award

John Brugioni
Reeves Silver Award

Sandra Beimfohr
Reeves Silver Award

Greg Pagliuzza
Follmer Bronze Award

James Heinking
Follmer Bronze Award

Mike Nichols
Follmer Bronze Award

Odin Berg
Follmer Bronze Award

Patt Marlinghaus
Follmer Bronze Award

First Illinois HFMA Chapter Strategic Planning 2005-2006

BY JIM HEINKING, PRESIDENT-ELECT

On March 11, 2005 the strategic planning committee, chapter directors and officers met to review and develop the First Illinois HFMA Strategic Plan. Providing additional leadership and support was Rebecca "Becky" T. Black, FHFMA, CPA; a HFMA National CAT (chapter advancement team) consultant from the Georgia Chapter. The meeting was held at the ARAMARK headquarters in Downers Grove, Illinois.

The chapter strategic plan is reviewed annually to establish a vision, assess the chapter's current situation and list strategic goals and plans for achieving the goals. This is an important step for providing a clear direction to guide chapter activities and committees. By having a clear and up-to-date strategic plan we have systematically developed a review process to improve the chapter operation, set clear working goals, and ensure consistency in all of our chapter activities.

The strategic plan is currently available upon request from any board member or chapter officer. In the next chapter year, the plan will be published in both the First Illinois HFMA membership directory and also on the First Illinois web-site.

This year the strategic planning process included a thorough review of the chapter's Mission and Vision statements. In addition, an environmental assessment of our region was completed and the document included in the strategic plan was updated. As a pre-goal setting exercise the group reviewed the chapter's strengths, weaknesses, opportunities and threats. Finally the group identified three opportunities:

1. Professional Organization Joint Venturing Opportunities
2. Programs to identify new chapter leadership and expand membership
3. Program to collect and share Hospital Chief Financial Officer best practices

The above three bullet items are the general ideas to form the operational goals for the chapter. The final strategic plan document will include a clearly defined goal, implementation strategy, implementation procedure and measurement guidelines. The board and officers are tasked with the responsibility to check and monitor the plan throughout the year. Updates in achieving our goals will be periodically reported in the *First Illinois Speaks* newsletter.

A big round of applause and thanks goes to Becky Black for her time and talents that she shared with our team on the 11th – THANK YOU.

The ARAMARK was a beautiful location to conduct our business meeting. The boardroom suited our purposes perfectly. Our host was a delight and catering was delicious.

And to Martin D'Cruz, Jim Watson, Mike Nichols, Mary Ann Klis, Jim Ventrone, Morley Kerschner, Brian Sinclair, Lee Remen, Alexis Washa, Rich Stewart, Mike Cohen, and Jerry Jawed – this process could not have been a success without you and your input. THANK YOU all for making the process interesting and thoughtful, it is because of individuals like you that First Illinois continues to grow and prosper.

Have you ever wondered about the roles of local HFMA Chapters and National HFMA officers? Sarah Hull, Regional Executive for our own Region 7 answers questions from members around the Region about the Regional Executive role.

Just What is a Regional Executive?

BY SARAH G. HULL

I have been serving as Region 7 of HFMA's Regional Executive (RE) since April of 2004. I have had the opportunity to visit three of the five chapters, and have enjoyed meeting members from diverse locations, jobs, experience levels and finance backgrounds. Throughout my travels I have also found a diverse understanding of the role and responsibility of this position, and why it is beneficial to chapters as well as HFMA National. The following is an excerpt of questions I have been asked, with answers.

How did you get the RE position?

Each year, chapter presidents-elect from each of HFMA's 11 regions elect regional executives to serve as their chapters' primary volunteer and policy link to HFMA National. I was nominated by the Wisconsin chapter, and elected by the region in 2002. I served as the Regional Executive Elect in the 2003-2004 chapter year, observing and learning.

What does a RE do?

Regional executives are involved with:

- Assisting chapter leaders in serving members
- Convening and organizing meetings of the regional leadership
- Fostering effective communication between HFMA National and the chapters
- Expressing the needs and interests of the region's chapter leaders on the Regional Executive Council to the National Board and staff
- Assisting the National Board with policymaking
- Maintaining compliance authority over the Davis Chapter Management System (DCMS) and the Founders Merit Award Program
- Monitoring the performance of chapters within the region

How does my chapter benefit from this position?

- Link to National HFMA: The RE serves as the primary volunteer and policy link between your chapter and HFMA National
- The RE assists chapter leaders in serving members
- Communication link: The RE fosters a dialogue between the national and chapter levels of HFMA
- The RE represents the needs and interests of chapter leaders to the HFMA Board and management
- The RE encourages chapters to collaborate and help other chapters.

The Regional Executive achieves these activities by working with chapter leaders and participating on the Regional Executive Council. This Council serves as the primary volunteer and policy link between the chapters and HFMA National. The 11 Regional Executives advise the HFMA National Board of Directors on requested matters/issues, as well as, work on initiatives initiated by the National Board.

On a local level, communication, collaboration and chapter assistance is provided in the form of regional meetings, conference calls, chapter visits and general email and phone contact. One of the biggest events for this year was the coordination of the Regional Symposium held last October.

The Regional Executive position is a rotating role, providing representation from each of the five chapters once every five years. Candidates must be an advanced member, and have served as a chapter officer for a minimum of two years.

I have enjoyed serving the region, and will transition the duties to Tim Herberts, Southern Illinois, at the Leadership Training Conference in April. He will be followed by Pam Burns, Indiana in the 2006-2007 chapter year. If you have any questions, or if I can be of any assistance, please do not hesitate to contact me.

Sarah Hull is Chief Financial Officer of Ministry Medical Group in Wausau, Wisconsin, and is the 2004-2005 Regional Executive for Region 7 of HFMA. She can be reached at hulls@ministryhealth.org.

loss threshold. This is particularly true for neurosurgery, orthopedics, cardiovascular and trauma surgeries. Obtaining carve-out protection is particularly important given that the costs of these services have been growing significantly due to the population aging, technological advances, and the increasing use of implants.

- **High cost short stays.** With improvements in medical care, average lengths of stay for surgeries continue to decrease. The challenge for hospitals is that over 50% of the cost of the surgical stay is usually incurred the first day. Thus, for surgical cases of less than 3 days, absent a carve-out or case rate payment, it is unlikely the hospital will be paid enough to cover variable cost. The number of these cases is increasing significantly.
- **Implantables.** These are devices implanted into a patient during surgery. The number and cost of implantables has risen dramatically over the last five years. These devices can easily cost over $20,000 for one surgery. Additionally, the cost of the implantables per DRG cannot be easily predicted. We have seen that the range of cost per DRG can vary by over $23,000. Thus, it is very important that, if a hospital does many spine or cardiovascular surgeries, the implantables be paid in addition to the other services. To decrease the administrative burden, contracts should be negotiated so that the insurer pays a percentage of charges. Most insurers will agree to this approach if the hospital can guarantee it has mechanisms in place to mark-up the cost of the implantables by an identical percentage. That allows the insurer to pay the hospital a predetermined percent above cost. The administrative changes required to accomplish this yields a beneficial result.
- **High cost drugs.** Some patients receive drugs that cost several thousand dollars per day. A hospital must determine if the number and/or cost for these high cost drugs is likely to increase. If so, building in a financial protection for the hospital is important. Unfortunately, being paid accurately for drug carve-outs is challenging because many insurers have claims processing limitations and often cannot administer the contract terms.
- **High cost unique technology.** If a hospital has invested in technology that is unique to the area and can significantly enhance treatment or lessen the length of stay, the hospital can usually get additional payment for the technology. The payment can be additional payment for specific DRGs, or direct payment for the technology if there is are specific procedure codes associated with it.

Costs associated with increased contract complexity are:

- Many hospitals' systems cannot calculate expected payment given the complexity of the contracts. Without the systems capability to calculate expected payment, it is more difficult to identify underpayments;
- Insurers make more errors in programming carve-outs;
- Insurers may agree to terms that require manual processing, leading to significant claim errors and payment delay; and
- Hospitals incur additional patient account expenses to resubmit and track claim errors.

The Insurer's Role

Insurers have also played an active part in increasing the contracts' complexity. Over the last decade, they are increasingly trying to negotiate terms that pass more risk to the hospital while limiting the insurer's financial exposure.

- **Increase the high dollar stop loss threshold.** It is not uncommon for insurers to ask community hospitals to accept stop losses of $100,000 or higher. The hospital is likely to be receiving reimbursement below the threshold of a per diem rate per day. With the high costs of care typically in the first two days of a stay, a hospital is likely not to meet even its direct costs. Additionally some insurers' formula for calculating this stop loss is based on the day that the stop loss is hit. Thus, the stop loss is actually set at a higher level and it is more complicated to program expected payment.
- **Change to second dollar payment for the high dollar stop loss threshold.** This is the insurer's methodology of choice for transferring financial risk to hospitals.
- **Pay DRG rates for most of the hospital services, medical/surgical rate for the remainder, and eliminate outlier payments for high dollar cases.** There are two challenges for providers.

First, most hospitals' costs are far more likely to unexpectedly increase due to advancing technologies, new or higher cost drugs, or case intensity.

A DRG approach places the financial risk disproportionately on the provider. Secondly, there are huge variations between patients. We have seen that within DRGs, costs can vary by a factor of at least 6. Thus, outlier payment is critical.

- **Reimburse outpatient surgeries with a grouper and set a low dollar cap.** The percentage of cases that can be performed on an outpatient basis has grown steadily

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every year. The complexity of cases has also increased. If payment changes to a grouper with a low cap, this is a major financial win for the insurer. However, this change can be a challenge both financially and administratively for the hospital because:

1. Most insurers do not follow the same grouper rules as Medicare and usually have language that allows them to change the CPTs which fall within each group. Thus, to program expected payment, a hospital must first get their groupings of CPTs, and then keep on top of whether the insurer changes them (which they usually do yearly and often with no notification).
2. The payment rules get complicated when there are multiple surgical procedures. Some require that the hospital set prices for each of the surgical procedures. If it does not, the hospital will be underpaid. If the hospital has multiple contracts with groupers with different limits, then it requires modeling to best determine how to price the multiple procedures.

- **Limit reimbursement of imaging services.** Historically, imaging was paid as a percent of charges. With the use of imaging increasing dramatically, insurers have negotiated case rates for MRIs and CTs significantly below traditional reimbursement.
- **Contracting for outpatient services on a per visit rather than per test basis.** One large insurer is actively trying to negotiate a corporate contract where they pay a case rate for a visit. If in that visit a patient has an ER visit and gets one or more MRIs or CTs, the insurer would only reimburse the ER rate. If the patient has no ER visits but gets an MRI of several parts of the body, the hospital still receives one case rate (which is dramatically below the market rate paid by other insurers). This type of contract is challenging because in addition to low reimbursement, programming expected payment accurately is difficult.

Alternative Strategies

Developing reimbursement methodologies which are fair to both insurers and providers is always challenging. One method that has been used in the last few years by a large insurer is to pay a percentage of charges (albeit a low percentage), and tie it to the hospital's current charge master. That accomplishes many goals:

1. Provides the insurer with protection from any price increase from the hospital
2. Reimburses the hospitals more when their costs are higher; and
3. Decreases administrative costs for both parties.

However, if the percentage paid is tied to the charge master, then the contract should also have rate increases. This could be accomplished by allowing the hospital to adjust its charge master by an agreed upon cap or even better, by increasing the percent paid. This type of contract would not prevent the hospital from changing its charge master. The insurer with this type of contract would have loaded the charge master into their system when the contract was executed and be using it like a fee schedule.

Another approach is to set a minimum and maximum reimbursement percentage and tie it to the hospital's current charge master. As discussed above, price adjustments would need to be built into the contract. This protects the provider and insurer from inappropriately large or small payments.

Unfortunately, these are approaches that insurers are not willing to consider unless the hospital has significant market leverage.

Summary

If a hospital has limited market leverage with insurers, but provides a significant number of services where the total cost per day is over $5,000 per day, then the only way to get appropriate payment is carve-outs. Without them, the hospital is not optimizing its payment or is assuming significant risk.

It is critical that the hospital have the ability to administer a broad range of contract terms on an automated basis. Every hospital should invest in a contract management and modeling software tool if they do not have a good one. Don't limit your hospital's ability to get payment increases because of the limits of the software. Invest in software and personnel resources that allow the hospital to accurately program expected payment, identify underpayments, and collect them. Our experience has found that the dollar value of underpaid claims versus overpaid claims usually averages at least 5 to 1. If the hospital does not have the ability to identify them, they will lose a lot of income.

While simplifying contracts sounds appealing, most hospitals will be better served by continuing to insist on specific carve-outs, and investing in the necessary tools to administer them effectively.

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Understanding the Aetna and Cigna Agreements...

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According to the settlement, which is the first settlement by any of the companies which have been sued by specialty physicians, CIGNA will establish a fund of $11.55 million, and institute a series of changes in its claims processing procedures.

Under the settlement, CIGNA has agreed to

1. refrain from reducing its specialty health care provider fee schedules for participating providers more than once in a calendar year;
2. further enhance its specialty health care provider claims processing and adjudication system; and
3. continue to expand and improve its online referral, certification and claims management capabilities.
4. provide detailed information regarding its claims-coding policies, fee schedules, and related payment guidelines on its website.

The settlement, which still must be approved by the court, also requires CIGNA to implement and independent external review process to resolve billing disputes and to establish a specialty health care provider advisory committee.

Conclusion

In sum, the Aetna and CIGNA settlement agreements offer much relief to health care providers. Not only in terms of financial compensation, but also in terms of changes in business practices that may help to ensure that physicians are paid in a more timely and appropriate manner. Moreover, assuming that the other insurance companies follow suit and also settle these lawsuits, with a promise to both compensate and change payment practices, the future of health care financial payments may be greatly improved.

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Sole Community and Medicare Dependent Hospitals ...

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inpatient operating cost, excluding passthrough costs, exceeds DRG payments, including outlier payments. If DRG payments exceed program operating cost, no payment will be allowed. Copies of applicable cost reports must be submitted.

5. Semi-fixed costs. The request must include a narrative of actions that are taken by the hospital to reduce semi-fixed costs.
6. Core Staff and Services. The requesting hospital must submit a comparison, by cost center, of full time equivalent (FTE) employees and salaries in both cost reporting periods. The hospital must identify its core staff and services in each cost center and justification of the selection of core staff and services. Minimum staffing requirements imposed by an external source must be used in justifying the minimum staffing requirements.

Core nursing staff is determined by comparing FTE staffing to FTE staffing in the prior year and FTE staffing in peer hospitals. Peer hospital information can be obtained from Hospital Administrative Statistics (HAS) Monitrend Data Books for hospitals of the same size, geographic area (Census Division), and period of time. The American Hospital Association (AHA) Hospital Statistics is also a source for peer hospital had a volume decline is the lesser of actual staffing in that year, actual staffing in the prior fiscal year or core staff for the prior fiscal year as determined for HAS data from peer hospitals.

If the nursing FTEs for the year in which the volume decline occurred are greater than the calculated acceptable nursing staff, an adjustment will be made to reduce the costs in excess of the core nursing staff. The cost report will then be rerun using the lesser costs and the payment adjustment will be calculated using these revised costs.

PAYMENT ADJUSTMENT ISSUES AND STRAGTEGIES

An issue has arisen when intermediaries are reviewing these adjustment requests and in PRRB hearings as to the use of Monitrend Data. After 1990, Monitrend discontinued publishing the data specified in the regulation for the core nursing staffing comparison. Since 1990, the hours per patient day utilized by SCHs and MDHs has generally increased due to smaller inpatient volumes and fixed staffing. This fact has tended to decrease the amount of allowable FTE for the calculation and therefore reduce the ultimate payment adjustment. At this point, there is no substitute for the Monitrend Data. Additionally MDHs are being held to similar standards even though the regulations do not call for application of this payment limiter specifically.

A further issue, which has arisen, relates to defining "circumstances beyond the Hospital's control." It is fairly clear that the circumstances detailed in the regulation are clearly beyond the control of the hospital. There are numerous other circumstances beyond the Hospital's control which are not detailed in the regulation. They include:

1.) Loss of OB Services
2.) Change in technology
3.) Movement of services to outpatient
4.) Issues and circumstances related to Emergency Room staffing and admissions
5.) CRNA recruitment and retention
6.) Other physician related issues
7.) Changes in travel patterns

Proving that these circumstances existed and the impact on admissions is sometimes difficult.

It is also important to make sure that all cost related issues, allocation methodologies offsets and audit adjustments are handled effectively for both the year of the request and the year immediately proceeding the request. Our review with numerous of these payment situations indicates that the prior year Medicare inpatient operating cost increased by the PPS update factor is the limiter to the current year payment amount.

SUMMARY

The two criteria necessary in filing for a payment adjustment are as follows:

1. The decrease in total discharges must be greater than five percent; and,
2. The decrease must be due to circumstances beyond the hospital's control.

In addition, to receive a payment adjustment, the Medicare cost for the period, excluding passthrough amounts must be greater than the Medicare revenue received.

For a more in-depth analysis of the payment adjustment methodology, please see Provider Reimbursement Manual, Part 1, Section 2810.1.

Lisa Ballard, CPA and Ron Rybar, FHFMA, CMPA of The Rybar Group, Inc. are members of the Great Lakes Chapter of HFMA. They may be reached at 810-750-6822 or www.therybargroup.com .

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2005 Calendar

5/06	CFO Classroom and Golf Outing	Full Day	Calumet Country Club
5/27	Annual Golf Outing	Full Day	St. Andrews Country Club

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