hfma healthcare financial management association

first illinois speaks

A Newsletter from HFMA's First Illinois Chapter

April, 2006

the Business of Caring

Avoid Unnecessary Whistleblowers: Prepare for New Compliance Legislation

BY BOBETTE M. GUSTAFSON

INSIDE:

Highlights and Recap First Illinois Chapter Events

January 2006 Accounting and Reimbursement Program

February 2006 Medical Groups Practice Program

March 2006 Managed Care Program

As if the federal qui tam law wasn't enough to worry about, now states have incentive to encourage would-be whistleblowers. To minimize unnecessary whistleblower activity, a review of and update to organizational policies, as well as mandatory employee training is the best bet.

The Deficit Reduction Act, signed into law this past February, contains two sections which pose challenges to and require the attention of providers. Section 6032 provides substantial incentives encouraging states to enact vigorous false claims legislation. Section 6033 mandates employee education regarding the laws governing false claims recovery. Although not effective until January 1, 2007, the laws' ramifications will become apparent soon. Providers should begin preparations immediately.

Encouraging State False Claims Laws

The Deficit Reduction Act rewards states by permitting them to retain an additional ten percent bonus on federal Medicaid payments recovered in suits brought under their state false claims laws. This "bonus" incentive means that states likely will pass new whistleblower legislation, or enhance their current laws, to closely emulate the federal False Claims Act (FCA). To qualify for the bonus, the state's legislation must be approved by the Department of Health and Human Services' Inspector General and must meet Deficit Reduction Act requirements. Currently only twelve states have broad false claims laws that contain qui tam enforcement: California, Delaware, Florida, Hawaii, Illinois, Indiana, Massachusetts, Michigan, New Hampshire, New Mexico, Nevada and Virginia. Similar laws in Louisiana, Tennessee and Texas apply to Medicaid only.

Under the federal FCA, anyone who knowingly (directly or indirectly) submits a false claim to the federal government is liable for up to three times the amount of the government's damages, plus mandatory per claim penalties from $5,500 to $11,000. What makes this especially effective – and troublesome - is that qui tam provisions allow private citizens with knowledge of potential violations to file suit on behalf of the government for a share of the settlement proceeds.

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Inside This Issue

President's Message

April Showers . . . Bring May Flowers . . .

In January the Accounting and Reimbursement Committee program "Winning Strategies 2006… Will Your Team be There?" had an attendance of 107. A special thank you goes out to Susan Hull who agreed to be a last minute replacement speaker – Sue did a GREAT JOB!

On February 16th the Medical Groups and Physicians Committee program "Regulations, Competition and Entrepreneurism in Healthcare: The Challenge of Providing Quality Medicine in Today's Milieu of Competing and Conflicting Players" had an attendance of 125; although the weather on this morning was a challenge – once arriving at our meeting location of Gardner, Carton & Douglas they were a perfect host – even providing much needed umbrellas for our members at the end of the session – THANK YOU!

On February 24 the Certification Committee conducted a full day certification coaching course. Lead by committee chairs Suzanne Lestina and Mike Nichols, 26 members were prepped, prodded, and prepared for the HFMA certification Core exam as well as the Specialty exams. Good Luck to each our members as you continue to pursue certification (see the February 2006 First Illinois Speaks for the background story).

On March 3rd our Chapter Officers program "HFMA 201 – We Need You!" drew 41 members. During this program we outlined member opportunities to volunteer within our chapter as well as rewards for membership recruitment.

Coming up next is the Managed Care Committees program "Managed care 2006 – Send Lawyers, New Computers, and Money! Emerging Managed Care Issues and Trends Facing Providers". This program is co-sponsored with the Association of Illinois Patient Access Managers. As of this writing nearly 90 members have signed up for the event.

Please watch your mail for information about our last event of the year on May 26th – the First Illinois Chapter Golf Outing. We will be retuning to St Andrews Country Club and Klein Creek Golf Course. I am looking forward to seeing all of you there for this years fun filled day.

The "April Showers" song about bringing May flowers is really about change. Change is also underway in all of our chapter activities. The election process for next years Directors and Officers is currently out to membership for the vote. We know however that Vince Pryor will succeed to President on June 1, 2006 according to our chapter by-laws. During March and April we will also put a call out to every member giving you the opportunity to volunteer for committee work in the 2006 – 2007 year. In early May our Officers and certain Committee Chairpersons will travel to Southern California to participate in National HFMA's Leadership Training Conference. Finally, in June we will be going to the National HFMA Annual National Institute in Orlando Florida to wrap up the 2005 – 2006 year and to officially "kick-off" the 2006 – 2007 year. Busy, busy times filled with many changes!

King Whitney, Jr. sums up change this way:

Change has considerable psychological impact on the human mind. To the fearful, change is threatening because it means that things may get worse. To the hopeful, change is encouraging because things may get better. To the confident, change is inspiring because the challenge exists to make things better.

For me change is good and inspiring. Thank you all for giving me the opportunity to lead the First Illinois Chapter this past year – and to Vince – I wish you all the best.

Sincerely,
Jim Heinking, FHFMA
President
First Illinois Chapter HFMA

the Business of Caring

First Illinois Chapter News, Upcoming Chapter Events & Committee Updates

Upcoming Chapter Events –

CFO Meeting/Golf Outing

Just a reminder – The Chapter's annual CFO committee will be holding its 2006 meeting and golf outing on May 5th, 2006. The day's event will be held at the Calumet County Club.

Golf Committee

Plans are moving along for this year's 1st Illinois Golf Outing which will be held on Friday, May 26th, 2006. Continuing the tradition, scrambles will be held at St. Andrews in West Chicago, and regulation play at Klein Creek. This is a milestone event – 2006 represents the 30th anniversary of the event and will feature food, fun and lots of good raffle prizes. Not a regular golfer – no problem! Both novice and veteran golfers are warmly invited to attend!!

Call for Sponsors – Requests for event sponsorship have recently been mailed to chapter members on behalf of their organizations – multiple opportunities exist to support this year's outing, either in the form of raffle prizes, general sponsorship or hole sponsorship on any one or all of this year's courses. Costs for general or hole sponsorship range from $100 to $400 – members of the outing committee will be touch with you organization shortly regarding this opportunities. If you are interested in becoming a sponsor, you may also contact Al Staidl, Golf Committee Co-Chair at 630-724-1197.

First Illinois Chapter Elections New Officers and Board Members

Congratulations to the First Illinois Chapter officers and board members for 2006-07

Officers:

Vince Pryor
President

James Watson
President Elect

Guy Alton
Secretary

Mike Nichols
Treasurer

New board members for the coming year

Carl Pelletierre
Eleanor Michalek
Elizabeth Hills

They will join the existing board members

Liz Simpkin
Larry Connell
Sylvia Sorgel

Get to Know Your Members!

Suzanne Lestina, CHPF, CPC

Suzanne Lestina is the Technical Manager of Patient Financial Services/ Revenue Cycle for HFMA. In this role, Suzanne will help revenue cycle professionals meet today's healthcare challenges by providing education, analysis, and guidance. She will accomplish this by supporting coalitions with other healthcare associations to ensure accurate representation of the healthcare finance professional. She will work with and educate a broad spectrum of key industry decision makers on the intricacies and realities of revenue cycle operations. Ms. Lestina will be working with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices, and standards.

Suzanne joins HFMA with over 20 years of healthcare experience, including 10 years as a revenue cycle consultant. Her consulting experience includes education, revenue cycle operations assessments, work redesign, and compliance audit/reviews. Prior to her consulting work, Ms. Lestina held revenue cycle leadership roles for two Chicago area hospitals. She is a past president of the 1st Illinois chapter of HFMA and remains actively involved with her chapter. She speaks frequently to HFMA chapters across the country; healthcare providers; state hospital associations; and other professional associations.

Suzanne can be reached by phone at HFMA headquarters or by email at slestina@hfma.org

In Memoriam

Honoring Susan Hull

With great sadness, the First Illinois Chapter of HMFA reports that long-time member Susan Hull, MPH, RHIA, CCS, CCS-P passed away Friday, April 7th. Susan was a dedicated member of our chapter and a valued associate at American Health Information Management Association. An independent, spirited individual, Susan kept very private just how sick she was. In January Susan graciously stepped in for a speaker and facilitated a presentation at the Accounting and Reimbursement Committee's program. As late as mid-March she was taking on – and completing – new tasks, even though, as is now clear, she knew the end was near.

Please take a moment to think of our lost colleague and the professionalism and passion that Susan contributed to our chapter and our profession.

*Susan was a strong individual - I knew she had cancer but she gave us the impression she was over the worst- not terminal. She never asked for special consideration and talked as if she was going to make it. Right up to the end she continued to take on tasks at work and with HFMA. I will miss her and her spirit – what an example she set as a professiona*l.

– Gail Walker, Co-Chair, Registration Committee

Susan always had a friendly welcome and was the positive face greeting chapter members when registering at programs. She was always willing to contribute and pinch hit at a moment's notice to further member's educational experiences. Above all, she was always reliable and extremely knowledgeable on subject matter. Her expertise in the industry will be missed.

-Al Staidl, Membership Chair

HFMA Events

Winning Strategies 2006 . . . Will Your Team Be There?

Accounting and Reimbursement Program – January 19, 2006

The Accounting and Reimbursement Committee's annual education program "Winning Strategies 2006…Will your team be there?" was held at the William Tell Holiday Inn in Countryside on January 19, 2006. This year's seminar was again a great professional development opportunity.

Jo Ellen Helmer and Tadd Ingles of Ernst & Young LLP provided an update on accounting and financial reporting matters that included variable rate bonds, interest rate swaps, malpractice reserves, defined benefit plans and asset retirement obligations. Unfortunately, Larry Manson was not able to speak due to a very bad cold/flu. The Committee especially thanks Susan Hull of AHIMA for stepping-up at the 11th hour to discuss the OIG 2006 Work Plan. Her presentation was very interesting and insightful. Great job preparing a presentation and preparing to speak on very short notice! Thanks again Susan! David Warren of the Healthcare Finance Group, Inc. provided an update on the capital markets, including a discussion on the types of debt financing and asset based/cash flow based senior debt. Vicki Austin of CHOICES Worldwide provided a very dynamic discussion on networking.

The Committee's own Mike Nichols of RSM McGladrey and Tracey Coyne of Ernst & Young LLP provided a reimbursement update. Tracey provided a comprehensive Federal SSI update. Mike discussed Medicare bad debts and a model to compare Medicare reimbursement vs. cost. Unfortunately, Tom Hubner of Ernst & Young LLP was not able to speak due to a very bad cold/flu, but he did provide the attendees with discussion materials related to current issues in Graduate Medical Education.

Finally, Stephanie Gilman and Greg Brock of Deloitte & Touche LLP discussed the structure of reimbursement departments in the current healthcare environment and potential structure changes in the future. Steve Perlin of Health Management Associates provided a State of Illinois update. Zack Fortsch of McGladrey & Pullen LLP provided another comprehensive and insightful tax update.

HFMA First Illinois Chapter was able to provide a very condusive environment to learn, exchange ideas and network with peers. A special thanks to the speakers who made this another successful program! You can reach committee chairs Patt Marlinghaus at patt_marlinghaus@rsh.net or Brian Katz at brkatz@deloitte.com.

Registration Committee members Ross Stebbins and Susan Hull

Speakers Todd Ingles, JoAnn Helmer and Tracey Coyne

Brian Katz, Vicki Austin and James Heinking

David Warren

Steve Perlin and Zack Fortsch

Stephanie Gilman and Greg Brock

Mike Nichols and Tracey Coyne

HFMA Events

Regulation, Competition and Entrepreneurship in Healthcare:

The Challenge of Providing Quality Medicine in Today's Milieu of Competing and Conflicting Payors

Medical Groups and Physicians Program – February 16th, 2006

David Buysse, Ann Murphy and Jim Unland

Elaine Scheye

Frank McHugh

Rick Stock

The Medical Groups and Physicians Committee's annual education program "Regulation, Competition and Entrepreneurs in Healthcare" was held at the law firm of Gardner, Carton and Douglas on February 16th, 2006. As in past year's, this program provided an opportunity to hear insight into key topics and represented a diverse speaker group.

Frank McHugh of Provider Health and Dan Cain of Cain Brothers provided a joint discussion regarding capital markets and its impact on the healthcare marketplace. Following a brief Q & A Session, Chairperson Elaine Scheye moderated a panel discussion that included John Schneider – Chair of the AMA Council on Science and Public Health and Leonard Kranzler, M.D., Neurosurgeon at Illinois Masonic Hospital. The discussion centered on the latest in Pay for Performance methodologies and whether or not they represent a long-term solution.

L. Edward Bryant, Sr. Partner at Gardner Carton Douglas provided HFMA members with a timely update on pressing legal issues and their short and long term financial impact for healthcare executives. Pharmacy issues were also part of the day's discussion, with Marilyn Daley of Edward Hospital providing an overview on current drug reimbursements.

A second panel discussion followed – facilitated by Jim Unland of The Health Capital Group, John Cusack of Gardner Carton and Douglas's antitrust section and John Marren of Hogan Marren discussed implications of the antitrust issues involving the FTC, Evanston Healthcare, Advocate, and United Healthcare.

The day concluded with representatives of the office of Lisa Madigan, Attorney General providing participants with updates on key legislative issues.

HFMA First Illinois Chapter was able to provide a very condusive environment to learn, exchange ideas and network with peers. A special thanks to a number of individuals: Chairperson Elaine Scheye for facilitation of a well-rounded program; the speakers who contributed to the success of the program; and our hosts at Gardner, Carton & Douglas, who provided a setting conducive to learning and networking with fellow HFMA members.!

John Schneider, M.D. and Leonard Kranzler, M.D.

HFMA 201 – "We Need You"

As follow-up to a very successful HFMA 101 program presented in August, the First Illinois Chapter conducted a secondary program – HFMA 201 "We Need You" at Aramark Headquarters on March 3, 2006. Over 40 individuals attended, including chapter officers in additional to other chapter leaders and committee chairs. Designed as a tandem program to the August HFMA 101 program, HFMA 201 focused not only on the structure and role of the 1st Illinois Chapter overall, but also on the wide variety of volunteer opportunities fand contributions available through the chapter.

Current leadership, including Jim Heinking, current 1st Illinois Chapter President and Vince Pryor, 1st Illinois Chapter Incoming President, spoke to the audience regarding the roles of leadership, officers, and strategic planning for the chapter. Other chapter leadership participating in the day included Jim Watson, current Chapter Secretary; Guy Alton, Chapter Treasurer; Brian Sinclair, Chapter Education Co-Chair and Awards Chairperson; Al Staidl, Membership and Golf Chair; and Suzanne Lestina, Certification Chair.

Participants also received in-depth information regarding the roles of each of the respective chapter committees and their contributions to the chapter on an annual basis. Amongst the opportunities identified included various committee opportunities, chapter certification efforts and future leadership development. An interactive Q & A session followed each of the presentations, along with recognition that efforts from the initial HFMA 101 program generated not only an increase in new members but committee participation as well!

A warm thanks to all attendees for participating and to chapter leadership for a well organized and information program!! Look for additional chapter opportunities such as this in the future!!

New members. Back row, left to right : Richard Lanis, Michel Agriopoulos,Brian Sauvageau, Bob Dubow, Robert Clements. Front row, left to right : Gina Kociuba, Shayda Samarghandi, Mark Friedman, Keith Kellog

HFMA Events

Managed Care 2006 – Send Lawyers, New Computers and Money!
Emerging Managed Care Issues and Trends Facing Providers

Managed Care Program – March 16th, 2006

The Managed Care Commitee's annual education program "Managed Care 2006 – Send Lawyers, New Computers and Money!! Emerging Managed Care Issues and Trends Facing Providers was held at the William Tell Holiday Inn on March 16th, 2006. Over 100 participants were in attendance to hear a diverse speaker group representing a broad scope of managed care topics.

Frequent managed care presenter Dave Grant from the Illinois Division of Insurance kicked off the morning's discussion with an overview of various pieces of legislation in Springfield – amendments to the consumer fraud act, clean claim definitions, and the impact of High Deductible Health Plan products (or as Mr. Grant referred to as "Chase the Dollar Plans) were amongst the bills discussed. Following Mr. Grant's presentation, Managed Care Committee Co-Chair John Wyrostek provided the audience with an updated summary of the newly proposed AllKids program and its operational and financial implications for providers and healthcare organizations.

Jim Heinking and Katherine Murphy

Carl Pellettieri

1st Illinois Chapter member Carl Pellettieri focused his segment of the program on worker's compensation – specifically reforms to the Workers Compensation Act. Among the different segments identified were issues regarding claims filing, hold harmless provisions, fee schedules changes, utilization review programs, and pertinent outliers.

Neil Greene of the law offices of Neal Greene provided terrific insight into the complexities of the ERISA Act – reminding participants of the original intent of the 1974 Employee Retiree Income Security Act. At a basic level, this act encouraged employers to give benefits to employees and also set a series of minimum standards of how responsibilities are enforced for each party, fiduciary liabilities, and how plans are funded to comply with plan rules.

Neil Greene

Following a lunch break, Mike Nichols of RSM McGladrey and a member of the Accounting and Reimbursement Committee presented highlights of the Medicare reimbursement model – this was a topic of interest for program participants, as Mike's presentation focused on the applicability of using Medicare data as a benchmarking tool for managed care negotiations. Some of the advantages identified of comparing costs versus reimbursement included easily understandable summary information, as well applicability for operational and strategic discussions.

Mike Nichols

Katherine Murphy, Janet Blue, L. Kascher, L. O'Roth, E. Michalek, L. Remen, R. Hickok

Following Mike's presentation, The 1st Illinois Chapter once again was pleased to present a joint panel discussion with aIPAM – the association of Illinois Patient Access Management. Panel members included the following: Katherine Murphy, Nebo Systems; Bernie Encarnacion, Advocate Christ Hospital; Janet Blue, OnTarget Staff; Eleanor Michalek, Provena St. Joseph Hospital – Elgin; Lee Remen, HeathWare Systems; Joe Hickey, Nebo Systems; Vicki Mueller, Delnor Hospital; and Lori Shibbona, Advocate Good Shephard Hospital. The group focused on a variety of challenges and opportunities that providers have faced in confronting access issues – a key part of the discussion focused around how the definition of access has evolved and how the role of access specialists has become critical to ensuring operational efficiencies and improved bottom line results.

The day's program concluded with a presentation on the emerging trends of Pay for Performance methodologies by John Marren, Partner with Hogan Marren, Ltd. As a follow up to his presentation at the February program on this topics, audience members had the opportunity to hear a overview about the success of current Pay 4 Performance programs to date ranging from targeted audiences and necessary expansion to support more managed care and consumer directed programs. Among the key elements for successful P4P programs are incentives and rewards (both financial and non-financial), clinical integration, reporting quality and price considerations and identifying what are the ultimate benefits of the program.

Once again, the Managed Care Committee planned an innovative and thought provoking program that providing a great educational opportunity for chapter members. A special thanks to a number of individuals who contributed to the success of the day – committee members who helped develop topics and speakers as well as Co-Chairs Brian Washa and John Wyrostek for facilitating a diverse and beneficial program. Congratulations on a job well done!

Managed Care Co-chairs, Brian Washa & John Wyrostek

Work Smarter, Not Harder: Portfolio Modeling in Revenue Cycle Workflow

BY BRUCE NELSON

At double the pace initially projected, consumer-driven health plans are growing in prevalence. As a provider, are you ready for the implication that every patient is likely to have significant liability as soon as they walk in? The question is: How has your facility changed revenue cycle workflow in anticipation of the potential "new crisis?"

Perhaps that is the problem. The many cries of a "new crisis" might have desensitized some of us. After ten to twenty years of issues that had potential to upend the industry, it may be hard to believe that consumer-driven healthcare is going to "change everything".

Taking healthy skepticism into account, still it is hard to avoid the implications of consumer-driven healthcare. The nation's consumers (your patients) remain ambivalent and uncommitted to paying your bills. Consider how consumer-driven healthcare will impact you and your facility. The following numbers show the extent to which patient self pay responsibilities are increasing. And there is no end in sight:

- "Traditional" PPO: $500 deductible, 80/20 coverage
- High Deductible Plan: $2,000 deductible, 80/20 coverage
- Out of pocket maximums: $5,100 single, $10,200 family

As a result its likely that debt is going to pile up at a rapid pace. Other industries dealing with consumer collections universally rely on predictive modeling and risk scoring to manage work. Now in the same boat; healthcare is rapidly moving towards portfolio modeling to reduce bad debt and better recognize charity accounts.

Does portfolio modeling work in healthcare? Absolutely, both at the front and back end. It is possible to predict, in advance, who is going to pay. It is also possible to predict, in advance, what collection workflow is most effective.

Case-in-point:
One large integrated healthcare system employed risk assessment modeling as "the brain" of workflow redesign. The system expected to lessen the pace of rising bad debt and better identify charity cases all while moderating collection costs. No small challenge.

The risk model focused on:

- Generating early payments (at time of service as well as at point of billing)
- Improving recovery rates across all categories of account age
- Recognizing early all charity care and uninsured discounts
- Factoring in how account balance correlates to payment likelihood and calls for different collection workflows
- Acknowledging non-traditional factors that can help prioritize collections (on the front-end as well as the back-end)

To start the modeling process, retrospective data was analyzed to see which factors best indicated when and how a patient would pay their bill. Generally patients were placed into high, medium or low payment probability categories. Charity/Medicaid qualification probability was assigned as well. These probability quotients became the drivers of workflow redesign.

However, this was only the starting point. An initial model is just that; it must "evolve" as patient collection data continues to be gathered and results outcomes are continually updated.

Assessing current workflows and planning appropriate changes became a part of management's regular tasks. Focused on getting the best return for the least collection expense, changes affected the timing of collection letters, how each group was approached and which patient groups were given extra attention. The same ROI perspective was used to determine when to outsource collection efforts and what course of action to take regarding upfront collections. Essentially, the model allowed this healthcare system to "work smarter, not harder."

"It is possible to predict, in advance, who is going to pay. It is also possible to predict, in advance, what collection workflow is most effective."

Another way of looking at this approach is to consider that each patient segment has a specific ROI relating to a cash gain and/or an expense reduction. For example, some patients are a "known ROI" and the best collection approach is easy to implement. Another group could best be classified as a "known ROI given proper payment incentives." A third payment group might actually produce the best ROI when collection expenses are minimized, rather than pursued for the sake of a cash improvement goal. In each case, it is important to design workflow based on the known ROI for each payment group.

Validate the ROI of Portfolio Modeling

Since payment prediction technology carries an up-front cost, users must

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Financing Options for Nonprofit Rural and Community Hospitals

BY THOMAS R. GREEN

Strong finances as well as up-to-date facilities and equipment mean better physician attraction and retention, improved community
perception and assurance that a hospital will serve its region for the long term. Many smaller hospitals, however, often cannot access the capital to make the investments critical to their survival. Although profitable, many do not meet the high benchmarks required to earn investment-grade ratings and cannot raise the funds on their own.

With the right guidance, however, most rural and community hospitals can efficiently access capital. Many can fund their growth and renovations with conventional revenue bonds, either credit-enhanced or unenhanced. In addition, the federal government recognizes small hospitals' financial challenges and has established programs to enhance community and rural hospital credit so they can borrow at lower interest rates.

PART I

Integrating Strategic Plans and Capital Financing

Whether a hospital chooses to build new, renovate or refinance, its plans and its credit strength will determine eligibility for funding options. Hospitals must evaluate their strategic plans and their funding needs in tandem to determine their best financial options. The first steps toward acquiring funding are performing a needs assessment and evaluating credit strength.

Strategic plans outlining long-term missions and anticipated changes to infrastructure and services should be reviewed and updated regularly. A well-crafted financial plan matches a hospital's financial resources to the strategic plan, quantifying and allocating available capital. The capital allocation plan should be integrated into a strategy to manage assets and liabilities so the hospital not only accomplishes its strategic objectives, but improves its capital structure — and hence its credit strength.

When borrowing, hospitals and their advisers must consider their needs and objectives in the context of creating a capital structure that improves or maintains the credit profile. The ultimate goal is a finance strategy that maximizes access to the capital markets and minimizes the cost of capital, without damaging liquidity by contributing too much cash to a project and, conversely, without relying extensively on debt.

Recognizing Strengths and Weaknesses: The Credit Profile

A hospital's credit strength or financial health is the most important factor in determining its cost of capital. Organizations with strong financial health have more ability to repay debt and tend to be more appealing to investors and lenders, who balance their risk with interest rates. The better the credit profile, the lower the interest rate on the financing, and the less capital costs over time. Investors and credit enhancement providers will review both quantitative and qualitative factors to measure an organization's credit strength.

Ratios that demonstrate financial performance are used in quantitative analyses. These ratios can be generally grouped into three categories: capital structure; cash flow; and liquidity, profitability and operations. The following ratios are relied upon most frequently when assessing creditworthiness:

- Debt Service Coverage
- Days Cash on Hand
- Operating Margin
- Debt to Capitalization

Qualitative factors such as management, demographic changes, technological capabilities and medical staff characteristics affect hospital credit profiles. Ignoring these factors can give a hospital and the credit markets an incomplete picture of the hospital's credit profile and its financial options. For example, a hospital with strong financial ratios located far from a major bank may find accessing capital more difficult than its ratios suggest. Conversely, a well-articulated qualitative analysis of a hospital's long-term viability could help it secure bond insurance even if its credit profile is slightly below the usual credit profile required for such enhancement.

After completing the credit profile, a hospital can work with its financial professional to determine the best way to leverage its strengths and/or use strategic enhancements to achieve lower interest rates and less expensive capital.

PART II

Financing Options for Rural and Community Hospitals

More detailed information on financing options is available in the unabridged "Financing Options for Nonprofit Rural and Community Hospitals."

Long-term debt, usually tax-exempt bonds or taxable notes, is a popular choice for hospitals needing capital. Bonds and notes represent a borrower's obligation to pay interest to the investor in return for the lending of money over a given period of time.

Bonds can be rated or unrated. The ratings range from AAA down to C or D, with AAA to BBB considered "investment-grade." Unrated or low-rated bonds are often referred to as "speculative-grade," "junk " or "high-yield." The higher the rating, the lower the interest rate the borrower pays to offset investor risk.

Bonds generally can be sold either (1) without additional enhancement and marketed based on the borrowing hospital's strength or (2) credit-enhanced using vehicles such as bond insurance, mortgage insurance and letters of credit. Credit enhancements make mortgage notes and bonds less risky to the investor and more affordable to the hospital. They can be provided either by commercial institutions, such as banks and bond insurers, or a public entity such as the federal government.

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Financing Options for Nonprofit Rural and Community Hospitals

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A) Unenhanced Bonds

Hospitals with excellent credit strength may choose to issue bonds without additional credit enhancement. These rated or unrated revenue bonds will tend to trade at a broader range of interest rates depending on the market's perception of risk at the time of the sale. Borrowers who issue bonds and notes on their own merit do not have to pay fees for credit enhancement, but they may find capital more expensive over time or be subject to longer lock-out periods, more restrictive covenants or other investor requirements.

B) Bank Loans and Private Placements

Another source of borrowed funds is traditional commercial bank loans in the form of real estate or equipment term loans. In small communities with smaller local banks, the loan size often is restricted by the bank's lending limits and the types of credit risk a bank is willing to accept.

Tax-exempt bonds also can be privately placed, often with the local bank. This structure can allow a local bank to stay involved with the hospital, and those bonds that cannot be placed locally can be sold outside the community.

C) Commercial Enhancements

Hospitals also have the option of using commercial enhancements to obtain better interest rates on their bonds. These include letters of credit and bond insurance.

A letter of credit issued by a commercial bank is an irrevocable obligation to make bond payments if a borrower cannot. Borrowers pay banks for this option. A hospital with a letter of credit can issue tax-exempt bonds that carry the same rating as the letter of credit provider. The primary benefits are lower costs of issuance and somewhat lower annual debt service when compared to some structures. The process for obtaining a letter of credit generally is shorter than that of other enhancement options, and up-front closing costs are relatively low. Hospitals also may have the opportunity to leverage existing local bank relationships and can issue supplemental or additional debt.

Letter of credit structures can provide more flexibility than other options, but banks can be hesitant to extend credit. The project and the obligor's credit profile must fit into the conservative underwriting requirements of a commercial bank.

Bond insurance, like a letter of credit, guarantees that investors will be paid even if the hospital cannot make its scheduled payments. It generally is available to hospitals that independently can achieve a rating of BBB or better. Generally bond insurance is less expensive annually than the letter of credit option. The cost, however, must be paid up front, and bond insurance may not be the most cost-effective option for hospitals expecting to pre-pay their bonds or restructure the debt before the final scheduled maturity. Bond insurers tend to be more receptive to longer amortizations (20 to 30 years) than banks providing letters of credit.

D) Government Enhancements

The Federal Housing Administration (FHA) and the U.S. Department of Agriculture (USDA) have special enhancement programs that feature longer amortizations and lower interest rates. Government enhancements put the full support of federal organizations behind these hospital loans and bonds, making them much more attractive (less risky) to potential investors.

The USDA offers three funding options under its Community Facilities program: guaranteed loans, direct loans and grants. All three are designated for nonprofit rural organizations that serve communities of less than 20,000. The funds can be used to build, enlarge or improve essential facilities including hospitals and clinics and to buy new equipment. Applicants must be unable to obtain funds from commercial sources at reasonable rates and terms.

The guaranteed loan program has several

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advantages not shared by either traditional bond issuances or other federal programs:
The loan can be for up to 100 percent of the cost of the project, and 90 percent of that loan is guaranteed. While the loan is designed for building new and improving existing facilities, it can be used toward refinances under certain conditions.

Federal loans come with federal oversight. Borrowers generally are required to contribute to an escrow account for real estate taxes (if applicable), insurance and replacement reserves. The USDA also requires annual audited financial statements.

The Federal Housing Administration's Sec. 242 program generally is available to fund new facilities, acquisitions or the substantial renovation and modernization of existing projects. Hospitals may refinance debt through the 242 program with certain caveats. The program offers borrowers the opportunity to issue bonds at an "AAA"-equivalent rating. Interest rates are fixed, and no financial guarantees are required by parent or affiliated entities. Subject to certain debt-service coverage and liquidity levels, hospitals utilizing the program may transfer excess cash flow to parent organizations.

Issuing debt through the FHA Sec. 242 program can save hospitals money, but initial costs and the time necessary to apply for the program should be taken into consideration. Hospitals must pay a one-time fee of 0.8% of the loan amount in addition to an annual premium and must make monthly payments to a mortgage reserve fund.

The government streamlines the FHA Sec. 242 application process for Critical Access Hospitals, offering slightly different underwriting criteria to speed up consideration and make it easier for these small hospitals to qualify. Critical Access Hospitals still, however, must meet operating margin and debt-service coverage ratio requirements. This is where the special provisions make a significant difference: Hospitals that only recently received their Critical Access Hospital designations and cost-based Medicare reimbursement are allowed under the program to calculate their historical pro forma debt service coverage ratio as if they had been receiving the full cost-based reimbursement for the last three years. Not every Critical Access Hospital will qualify; even with the special provisions, careful evaluation of finances is essential when applying.

Conclusion

The financing options for nonprofit rural and community hospitals can be complex and confusing. Each financing structure has a unique set of characteristics that will likely be perceived to have both desirable and undesirable qualities. Each option must be evaluated with input from a knowledgeable investment banker/financial adviser and in concert with the unique credit profile of the hospital and its long-term strategic plans.

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(This article is abridged from "Financing Options for Nonprofit Rural and Community Hospitals."

Prepare for New Compliance Legislation (continued from page 1)

Under the DRA, state false and fraudulent claims laws must: meet the following requirements:

1. Establish liability to the state for false or fraudulent claims described in the Federal False Claims Act with respect to Medicaid expenditures
2. Contain provisions that are at least as effective in rewarding and facilitating qui tam actions as those included in the federal False Claims Act
3. Contain a requirement for filing an action under seal for 60 days with review by a state Attorney General
4. Contain a civil penalty that is not less than the amount authorized in the federal False Claim Act

Medicaid Fraud and Control Units (MCFUs) will become even more aggressive and sophisticated in their efforts. Laws already require MCFUs to investigate every whistleblower inquiry filed – even before potential merits are evaluated. It is likely that additional MCFU funding will be made available this year and it is predicted that states will hire more investigators and invest in new and more sophisticated fraud detection technology.

Employee Education Requirements

The Act requires that effective January 1, 2007 any entity that receives or makes at least $5 million in annual Medicaid payments to provide mandatory employee education including:

1. Written policies, procedures and training protocols with detailed information related to:
   - The federal False Claims Act
   - State false claims laws
   - Federal administrative remedies for false claims and statements
   - Whistleblower protections with respect to the role of such laws in prevention and detection of fraud, waste and abuse in federal healthcare programs
2. Written materials with detailed provisions and training regarding the entity or provider's policies for preventing waste, fraud and abuse
3. Information in the Employee Handbook regarding the law and rights of employees to be protected as whistleblowers along with the provider/entities policies and procedures for detecting and preventing fraud, waste and abuse

PREPARE EARLY for the Deficit Reduction Act of 2005… A Provider Checklist

- Stay abreast of revised or new State False Claim legislation – Assume there will be activity!
- Evaluate and monitor current and/or pending State False Claim legislation
- Monitor progress of whistleblower advocacy groups and their impact on False Claim legislation models which heavily favor qui tam whistleblowers and their lawyers
- Stay focused on new or enhanced Medicaid Fraud and Control Unit initiatives
- Review and revise policies and procedures in light of the Act and State laws that are in effect, being revised and/or implemented – Make sure they:
- Fully comply with the Federal False Claims Act
- Fully comply with State False Claims laws
- Address detection and prevention of fraud, waste and abuse
- Clearly state employee rights and protections as whistleblowers
- Review and update employee handbook in light of the Act – Make sure it:
- Clearly defines compliance program including the law and rights of employees to be protected as whistleblowers
- Completely defines policies and procedures for detecting and

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Prepare for New Compliance Legislation

(continued from page 11)

preventing fraud, waste and abuse

- Educate employees and ensure that business partners and agents are doing the same
- Develop and implement a formal education plan for employees and leadership teams. The plan should address all aspects of the Federal and State laws, as well as internal compliance policies and methods for detecting and preventing fraud, waste and abuse
- Develop and administer post-training competency assessments; provide additional training as necessary
- Approach contractors, agents and other external parties and review their education plans, tools and competency assessments
- Eliminate the potential for whistleblower situations! – Create a "Compliant Culture!"
- Review the organization's Compliance Plan, ensure that it meets the Federal Guidelines published in January 2005
- Make sure to conduct annual Compliance Plan evaluations, make the necessary changes to be consistent with the January 2005 Federal recommendations
- Evaluate efforts to ensure compliance with the 2006 OIG Work Plan and special advisory bulletins and special fraud alerts
- Ask employees to help build the tools and to assist in conducting audits to identify compliance
- Solicit employee assistance in conducting "root cause" analysis of all potential problems and ask for their input in building and implementing the necessary new and procedures and controls
- Make a "big, positive deal" out of employees who participate in any way with the compaliance process and openly celebrate these activities

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Portfolio Modeling in Revenue Cycle Workflow (continued from page 7)

have confidence that their investment will result in an appropriate ROI. As previously mentioned the ROI can be related to improved cash flow and/or it can be related to reducing collection costs. Demonstrating that the model forecasted accurately and more importantly delivered measurable results is the key to proving the methodology's worth and the ROI of its supporting tools.

Compare the results of a control group against an experimental group. To achieve about 95% accuracy, the control group must be of statistically significant size, include a random distribution across patent segments, and be worked by the organization's traditional collection methods. Accounts in the experimental group should be segmented by payment probability, or predictive modeling, and then each account pursued according to the workflows appropriate for its respective segment. After a pre-established time period, compare the control with the experimental populations in terms of collection results, collection expenses, aging, public relations, and write off allocations. For example measurable collection expenses may include:

- Amounts collected upfront
- Average cost per collection letter
- Average cost per collection attempt
- Percent of accounts closed
- Average age of at account closure

Documented improvements in overall collection percentages can add millions of dollars to a healthcare provider's bottom line.

Conclusion:

Healthcare providers must be prepared to meet the demands of sharply-rising, self-pay liabilities Hospitals that are currently challenged by bad debt and self-pay collections will suffer as CDHP plans grow in number nationwide. Risk assessment modeling is increasing across the nation's healthcare systems. ROI results show that modeling works. Many more providers are currently evaluating this new technology as solution for their way of working smarter, not harder in the future.

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A broad topical article may be 1000-1500 words in length. Shorter, "how-to" or single subject articles of 500-800 words are also welcome. Authors should suggest titles for their articles. Graphs, charts, and tables **(PDF or JPG only)** should be provided when appropriate. Footnotes should be placed at the end of the article. Authors should provide their full names, academic or professional titles, academic degrees, professional credentials, complete addresses, telephone and fax numbers, and e-mail addresses. Manuscripts should be submitted electronically, on computer disk or by e-mail as a Microsoft Word or ASCII document.

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2006 Calendar

May 5, 2006

CFO Meeting and Golf Outing, Full Day, Calumet Country Club

May 26, 2006

Annual Golf Outing, Full Day, St. Andrews & Klein Creek

Tony Kazwell (Silver Award)

Michelle Holtzman (Bronze Award)

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