hfma healthcare financial management association

first illinois speaks

A Newsletter from HFMA's First Illinois Chapter

April/May 2007

Courage IN LEADERSHIP

Transparent Pricing – Are you ready?

BY MARILYN HART NIEDZWIECKI, RN, CNOR, CPC, CPC-H, CPA

INSIDE:
Highlights and Recap
First Illinois Chapter Events

January 2007
Healthcare Finance:
Paint it (in the) Black

February 2007
Your Strategic Competitive Advantage: What It Takes to Obtain and Maintain It
February Social Event: Casino!

March
The Chicago Area's Healthcare Agenda

Founders Merit Awards

Inside This Issue

Transparent Pricing 1
First Illinois Chapter News: Golf Outing! 2
Outpatient Prospective Payment System's Inpatient Market Basket Update for Fiscal 2008 Linked to HCAHPS 3
HFMA Events:
January 2007 – Healthcare Finance: Paint it (in the) Black 5
Founders Merit Award Winners 7
February 2007 – Social Event Harrah's Casino 9
February 2007 – Your Strategic Competitive Advantage: What It Takes to Obtain and Maintain It 10
March 2007 – The Chicago Area's Healthcare Agenda 11
Part Two: Performance Based Contracting 12
Turning Uninsured Accident Victims Away 17
Calendar 2007 20

Transparent pricing of healthcare services is becoming a frequent topic of discussion for healthcare leaders. Some states are requiring the chargemaster to be publicly posted as this will allow consumers to "shop" for services. And all hospitals are seeing an increased volume of phone calls due to consumer inquiry as to costs. Price shopping will become more common due to consumer-directed healthcare and the increased cost-sharing and higher deductibles that consumers are paying. As costs of healthcare continue to escalate this issue is escalating. Healthcare spending has increased dramatically over the years and currently constitutes 16% of the gross domestic product. Thankfully, we must also remember that most healthcare is obtained when it is urgent and consumers will not have time to shop for prices. This article will discuss considerations and possible solutions to prepare your organization to better provide information on prices to customers.

Understanding the complexity of hospital charging

Hospitals charge by using a "chargemaster". A chargemaster is a complex file that comprises all the charges used by everyone. These are built based on using Uniform Billing Revenue Codes, CPT/HCPCS codes, and charges. These revenue codes assist in defining charges to insurance companies and to The Centers for Medicare and Medicaid (CMS). There are many rules associated with using CPT codes to remain compliant with coding rules. However, there are no specific rules as to how to charge when it comes to billing for that CPT code. Take a procedure done in surgery. Some hospitals may charge supplies, some will include all supplies in a timed charge, some may charge based on a 'case-rate" or flat rate for the service, while still others will use a combination of these. These types of variations may be present throughout the organization and vary by department. Imagine how complex this would be for a consumer or average employee to attempt to calculate a charge for a surgery! In addition, there are usually numerous levels in the operating room which may be charged based on individual specifications as defined by the organization. These levels may be charged based on the "actual" procedure done and not the "scheduled" procedure; or on staff present in the room.. Quoting a price on a scheduled procedure can be very different from the final bill based on the actual procedure done. Nothing in

continued on page 14

HFMA Event

Golf Committe Update

31st ANNIVERSARY!!!
FIRST ILLINOIS CHAPTER – HFMA GOLF OUTING MAY 25, 2007

The 31st First Illinois Chapter HFMA Golf Outing will be held on Friday, May 25, 2007, with the primary scramble location at St. Andrews Golf and Country Club and Klein Creek Golf Club for regulation play.

- All participants in our outing receive our golf gift - a North End Lightweight Hybrid Jacket – great for all weather occasions!!
- For early bird golfers, an early barbeque will be held from 11:00 AM to 1:00 PM – outdoors, weather permitting.
- Our regular networking barbeque will be held after golf – the BBQ opens at 3:00 PM and runs until 7:00 PM.

Sponsorship opportunities for this fun and well attended event are still available! For more information, contact either Dan Cook or Ron Hennings, Golf Committee Co-Chairs for more information. Get your tee times booked!!!

Register Now for HFMA's 2007 Annual National Institute (ANI)

ANI - The Healthcare Finance Conference

HFMA's annual conference will take place on June 24-27 in San Diego. Keynote speakers for this year's conference include Colin Powell, former US Secretary of State; James Gilmore, founder of Strategic Horizons, LLP and Quint Studer, renowned healthcare expert.

This year's program offers members 81 tool-driven sessions covering topics such as:

- Auditing, accounting and tax-exempt priorities
- Pricing, consumerism and CDHPs
- Medicare, managed care and revenue strategies
- Pricing, revenue cycle and business benchmarks
- Pay-for-performance and quality.

You'll participate in classroom sessions that cover the hottest issues you're handling on the job – whether your specialty is financial management; the revenue cycle; payment, reimbursement or managed care; or compliance. More than 300 top industry suppliers will be on-hand during the Idea Exchange Exhibit to answer your questions and demonstrate the latest products designed to help your organization perform better.

Come find the the practical ideas and tools you need to achieve results in your career and organization! More information, including conference details and registration information, can be found at www.hfma.org

Outpatient Prospective Payment System's Inpatient Market Basket: Update for Fiscal 2008 Linked to HCAHPS

BY JOHN BISAHA

The Centers for Medicare and Medicaid Services (CMS) has issued a final rule regarding the Outpatient Prospective Payment System and estimates the Fiscal 2008 increase to be approximately three percent.

But it specifically links the submission of HCAHPS data (beginning with discharges in July 2007) and two other measures: 1. Submission of mortality rates for Medicare patients within 30 days of hospitalization for heart attack, heart failure, or pneumonia, and 2. Submission of specified measures from the Surgical Care Improvement Project to acquire this money. Although the submissions are purely voluntary a hospital will not get their increase unless they submit the required information.

Financial Officers should be particularly aware of HCAHPS because the survey might require cooperation with an outside vendor and specific time frames must be met. HCAHPS was developed to ultimately be part of a pay for performance and transparency initiative, so that submission of accurate and timely information is important.

HCAHPS is not a satisfaction measure, and is unique in that it does not measure a process but measures a patient's perception of care based on what the consumers thought was important for hospital care. The results of this survey will compare your hospital with others in your state and across the nation starting fall of 2007. Managing and improving a healthcare provider's HCAHPS scores will be an ongoing process rather than a single event.

What is HCAHPS?

The HCAHPS survey, an acronym for "Hospital-Consumer Assessment of Health Care Providers and Systems." provides a standardized instrument and data collection methodology for measuring patients' perspectives of hospital care. As consumers become more informed about their healthcare options, HCAHPS is intended to provide a standardized tool with which consumers can compare hospitals so they can make health care choices.

The HCAHPS survey was built on the landmark health plan patient perspective on care survey, known as the Consumer Assessment of Health Plans Survey (CAHPS). CAHPS is recognized as the national standard and is used to assess the care provided by health plans covering over 130 million patient. The H is for Hospital so that is survey is called Hospitals –CAHPS or simply HCAHPS. (In the future there could be other surveys such as Behavioral Health- CAHPS, Dialysis- CAHPS, and Nursing Home-CAHPS etc.)

The HCAHPS initiative is part of a strategy set forth by the President and The Department of Health and Human Services (HHS) who has a goal to increase and maintain quality in healthcare. Three goals of HHS are to support consumer choice by making available comparable data on care that allows comparisons about hospitals on subjects that are important to consumers, to create hospital incentives to improve quality of care through patient-driven performance measures, and to encourage accountability in healthcare through public reporting of results. HCAHPS was designed with all three of these goals in mind.

In an effort to achieve this goal of improved quality in healthcare through transparent, patient driven performance metrics, The Centers for Medicare and Medicaid Services (CMS) partnered with the Agency for Healthcare Research and Quality (AHRQ) to develop a survey that could produce credible and useful information for the consumer. In doing this, HCAHPS has become one of the most broadly backed healthcare projects ever developed; it is supported by and is in partnership with the members of the Hospital Quality Alliance (HQA).

The HQA is public-private collaborative with members including the American Hospital Association (AHA), Federation of American Hospitals (FHA), Association of American Medical Colleges (AAMC), Joint Commission of Accreditation of Healthcare Organizations (JCAHO), American Medical Association (AMA), American Nurses Association, (ANA), Consumer-Purchaser Disclosure project (CPDP), AFL-CIO, and AARP.

Developed through a collaborative process open to the public and a product of scientific research, consumer field-testing, and numerous opportunities for public comments, HCAHPS collects uniform patient feedback on hospital care and enables a comparison between hospitals.

The present survey applies to all

continued on page 4

Outpatient Prospective Payment System's Inpatient Market Basket Update for Fiscal 2008 Linked to HCAHPS (continued from page 3)

acute care and critical access hospitals, and contains twenty-seven items, consisting of eighteen items that encompass seven domains of patient perspectives on care, four screener questions designed to enable only appropriate response to certain questions, and five items used for comparability of scores across hospitals. The seven domains are:

- Care from nurses
- Care from physicians
- Cleanliness and quiet of the hospital environment
- Responsiveness of hospital staff
- Pain control
- Communication about medicines
- Discharge information

Currently, the survey is a voluntary with the scores of individual hospitals ranked with other hospitals in their market. These scores will be presented by CMS and possibly JCAHO on their hospital comparison websites the end of 2007.

For hospitals that participated in the dry run initiative, the first official data collection for comparisons between hospitals started October 2006. With data being released the end of 2007. If a hospital is not currently voluntarily participating in the national implementation of HCAHPS which started with the OCTOBER 2006 discharges they will have to complete another Dry Run March 2007 to be eligible to submit data to CMS for July 2007. Hospitals that have not participated in any Dry Run will also have to complete this DRY Run to be able to participate. This is the last Dry Run. If a hospital does not participate they cannot submit data and will not be able to receive full payment.

To complicate the process further a dual submission process for the data is necessary if a hospital wants to maximize the comparison of their hospital with others. The dual process is important for the following, very different, reasons:

The CMS submission through QNET is the present submission. This data will be compiled for the hospital comparisons on the seven domains. Mode adjustments via, still to be developed algorithms, will be applied to this data. This is the data which will be posted on the CMS website and will compare your hospital results with others in your state. This is what you are technically being paid to submit.

The CAHPS submission will have a different purpose and is purely voluntary. It will not have any mode adjustments or identify the name of your hospital. It will use the questions of the seven domains and categorize the results on specified benchmarks. Some of these benchmarks are: Geographic region of the country, bed size, teaching status, ownership and control). This data is to be used by policy makers for decision making purposes. It is hoped that this representative comparative data will make it possible for hospital to identify areas for quality improvement.

Because the HCAHPS data reporting process is so important over 96% of hospitals are working with vendors to handle the survey and submit the data to the proper organizations. When choosing a vendor please choose carefully. Vendor selection is critical and must be done carefully. Make sure you choose a vendor which has a large data base of hospitals, can submit data to both CMS and HCAHPS, and can assist you with reporting, benchmarking, and statistical analysis. Of primary importance is the ability of the vendor to work with you in educating your staff , providing" best practice" initiatives, and training your organization to increase quality in the HCAHP domains.

John Bisaha is a Partner in the Healthcare Group for the Gallup Organization and is a member of the First Illinois HFMA Chapter. He can be reached at john_bisaha@gallup.com

Healthcare Finance: Paint it (in the) Black

Thursday, January 18, 2007 Program

The First Illinois HFMA Chapter presented the second of two programs that were jointly produced by both the Revenue Cycle and Accounting and Reimbursement Committees – approximately 100 attendees participated in the day-long session that featured a two-part structure. The morning's session featured general healthcare finance topics including the following:

Program Introductions –Brian Katz, Patrick Moran, and Michelle Holtzman; Program Co-Chairs

IHA Updates – Current Issues and Agendas – John Bomher

Preparing for Revocation of Tax Exempt Status – Mary Rauschenberg

Union Organization Activity in Chicago Thomas Luetkemeyer

Health Plan Designs and the Bottom Line Impact – James Watson

Program participants had the option of attending afternoon tracks focused around Revenue Cycle or Accounting/Reimbursement topics, including the following:

*Revenue Capture and the Chargemaste*r – Marilyn Niedzwiecki

Front End Technology – Bruce Nelson and George Sakelaris

*Workflow Strategies for Dealing with the Un(der)insure*d – Patti Denham

DSH/Title 21 Updates – Christopher Keough

Transmittal 16 Cost Report – Peter Harmon
Cost Saving Techniques for Self-Funded Hospital Plans – Alicia Faust

Both groups recovened at the end of the day's program to hear the latest on the Medicare Advantage Plan and its current impact, presented by Ray Swisher.

A more detailed program summary will be presenting in the mid-May issue of First Illinois Speaks.

George Sakelaris & Bruce Nelson

James Watson

Katz, Holtzman, & Moran

Thomas Luetkemeyer

Marilyn Niedzwiecki

Mary Rauschenberg-1

Patti Denham

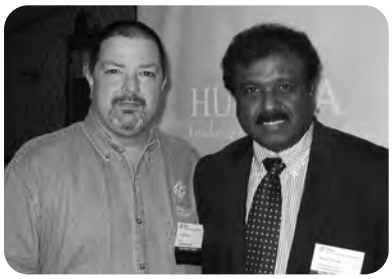
Raymond Swisher-1

HFMA Awards and Certifications

Founders Merit Awards for 2006

BY PAULA DILLON

Vince Pryor & Jerry Jawed
(Gold Award)



Vince Pryor & Martin D'Cruz
(Gold Award)

Vince Pryor & Jim Heinking
(Gold Award)

Vince Pryor & Mike Nichols
(Silver Award)

Vince Pryor & Jim Watson
(Bronze Award)

Vince Pryor & Paula Dillon
(Bronze Award)

Vince Pryor & Thomas Jendro
(Gold Award))

Vince Pryor and Sylvia Sorgel
(Bronze Award)

The 2006 award recipients are:

Follmer Bronze Award

William J. DeMarco

Paula Dillon

Dennis Gooche

John Roquena

Jeffery Rooney

Sylvia Sorgel

James Watson

Pamela M. Waymack, FHFMA

Reeves Silver Award

Michael Nichols, CPA,

FHFMA

Alexis Washa, CPA, CHFP

Munice Gold Award

Guy Alton, CPA, FHFMA

Martin D'Cruz, FHFMA

James Heinking, FHFMA

Shana Jacobs Jones, FHFMA

Jerry Jawed, FHFMA

Thomas Jendro, FHFMA

HFMA Events

Winter Social Event – Harrah's Casino

Thursday, February 8, 2007

The First Illinois HFMA Chapter presented their annual winter Social Event on February 8th, 2007 at Harrah's Casino – attended by more than 40 participants, including several new members, the evening featured both the opportunity to network with fellow HFMA members and glean some insight into other healthcare topics.

Vince Pryor, President of the First Illinois Chapter HFMA welcome the attendees and had the opportunity to provide updates on a number of chapter initiatives, including upcoming chapter educational programs in March and April and the variety of webinars that will presented in April and May, with support from several chapter sponsors.

Highlighting the evening was a special presentation by Richard L. Clarke, DHA, FHMA, President of HFMA National on "Healthcare in the 21st Century. Dr. Clarke's talk covered a variety of key topics that are prevalent in today's healthcare industry:

- Impact of HSAs on the community
- Patient Friendly Billing Initiatives
- Consumerism and what it means for healthcare professionals
- Community benefits provided by hospitals
- Use of technology in facilitating higher quality care
- Pricing and service transparency
- Impact of changing payment methodologies
- Potential for a singular payer system in America and what that structure might look like
- The need for performing the everyday "blocking and tackling" to handle operational issues but continuing to focus around a common strategy

The evening's presentation also generated a lively question and answer session between Dr. Clarke and the program attendees and was well received by the participants.

The First Illinois Chapter HFMA would like to extend it thanks to Dr. Clarke for contributing his time and expertise to the evening's event.

Program Attendees

Brian Sinclair, David Golom & Jerry Jawed

Lee Remen, Rick Roos, & Chris Hoffman

VincePryor, Richard Clarke & JimWatson

Richard Clarke, Vince Pryor & JanetBlue

HFMA National Founders Points

Do you know your Founders Points? Founders Points are awarded to members for service to their Chapter and National HFMA, and are the basis for the Founders Merit Awards: The Follmer Bronze award, Reeves Silver award, and the Muncie Gold award. For more information on the awards and their history, please refer to the Awards and Recognition section of your member directory, or call the First Illinois Chapter Award Committee chair, Brian Sinclair at (630) 307-9138. Members can check their current point totals at any time by reviewing your profile in the Member Directory section of the National HFMA website, www.hfma.org.

In 2004-2005, HFMA revised the Founders Award point system. In keeping with the core purpose of the recognition program, the Founders program will only record points for volunteer effort, and no longer include points for attendance at HFMA educational events. (Attendance for CPE credit is tracked separately).

Additionally, Founders Points are no longer a requirement for maintaining certification. That requirement was replaced with a 90-contact hour requirement over three years. More recent changes: in April 2005, the Regional Executive Council of HFMA voted to re-align the Founders Muncie Gold award level from 100 to 75 points, effective for the 2004-05 year.This change only affected members with a total of 201 Founders points or above. The converted "old" totals through May 31, 2004 were amended accordingly. The change does not affect certification maintenance since Founders Award points are no longer used for certification maintenance. Nor does the change affect any of the awards already distributed for the 2004 year. The Regional Executive Council also approved the following changes to the Founders Program:

1. Point allocations adjusted as follows, effective for the 2004-05 year:
   – Newsletter Article- raised from 1 point to 2 points per article published (National and Chapter)
   – Committee Co-Chair - reduced from 4 to 3 points per co-chairPosition
2. Approved language to more clearly define significant service for the Medal of Honor award criteria, effective for the 04-05 year.

If you have questions, please contact Award Committee chairperson Brian Sinclair at 847-227-2268

HFMA Events

Your Strategic Competitive Advantage: What it Takes To Obtain and Maintain It

Thursday, February 15, 2007

This year's physician educational program opened with a capital markets update from Moody's rating agency that included an analysis of the potential effects of the challenges to for profit tax status of healthcare entities. It is anticipated that more challenges around the country will occur. In this connection we had yet another update from the Office of the Illinois Attorney General as to the status of bills pending before the Illinois Legislature which again, resulted in much discussion centering around why and how the Ill AG arrived at calling for an 8% charity care contribution from hospitals in Illinois. This issue remains unresolved.

This years program, in addition to the legal issues update provided by Ed Bryant, J..D., well known by our Chapter, included a discussion with Tim Schier from Cain Brothers about joint ventures between hospitals and physicians and the changing motivations between the two parties and changing models of J-Vs.

New this year was a panel discussion on technology as a strategic advantage. The panel included discussions about Proton Therapy, gamma knives, and the Cleveland Clinic provided us with their ranking of what they think are the top medical issues, cancer being ranked number one priority and a discussion of some of the key financial issues associated with financing newer technologies.

Physician compensation issues, always a throne in both physicians and hospitals sides was discussed by Dr. Jim Foody, Vice Chair of Medicine for Clinical Affairs, at Northwestern University Feinberg School of Medicine who provided a thought provoking discussion of his views as to how and what for doctors should be paid He avoided the usual formulaic kind of presentations we usually hear about physician compensation models.

David Buysse & Anne Murphy

Edward Bryant & Tim Schier

Elaine Scheye & Edward Bryant

We thank DrinkerBiddleGardnerCarton for the use of their superlative conference room and the generous partial underwriting by AstraZeneca of our program.

HFMA Events

Chicago Area's Healthcare Agenda

Thursday, March 15, 2007

This years managed care program held March 15th was a huge success! With neat 110 people in attendance the speakers and topics covered many of todays hot managed care topics. The speakers and their topics were as follows:

Jill Foucré Regional Vice President of UnitedHealthcare Network reviewed some of United's strategies for 2007 including Consumerism & Transparency. United is leading the way in this market with Consumer Driven Health Plans. The environment is changing … again, and there is concern that individuals are not prepared for their role in health decisions.

Steve Hamman, Jill Foucre, & Bill Berenson

Steve Hamman, Divisional Vice President of Blue Cross Blue shield of Illinois focused on one of BCBS's strategies —engaging providers through performance based recognition, their Blue Star Hospital Report Card, report Cards for doctors and other e-commerce initiatives.

Bill Berenson, Senior Vice President of sales of Aetna gave an overview of Aetna's strategic focus, products & initiatives including programs/tools to help consumers make more informed and cost-effective healthcare decisions, performance networks & pay for performance initiatives.

Elena Butkus

Elena Butkus, Vice President of Illinois Hospital Association in charge of public policy issues related to hospital finance and the private market reviewed all of the recent health care legislative initiatives going on in Springfield including insurance reform, workers' compensation, and the uninsured. It is a busy time for our State government.

Denise Meredith & Ross Westreich

Ross Westreich, CFO, Humana's North Region Medicare Operations and Denise Meredith, Provider Relations Manager, North Region focused their discussions on the aging population in the US and Humana's Medicare Advantage Plans, Private Fee-for-Service (PFFS) – plans and Preferred Provider Organization (PPO) – plans. They outlined how payment is derived from CMS to Humana.

Ray Swisher, Branch Manager of Managed care Services, CMS Region 5 provided a thorough overview of CMS's Medicare Advantage and Prescription Drug Programs.

Ray Swisher

Keith Kudla

Keith Kudla, President of Harmony / WellCare has been busy this year with the State's Medicaid initiatives. First, he covered a brief history of Medicaid Managed Care in Illinois. Then, Keith provided an overview of the State's PCCM program, which is the next chapter in Medicaid Managed Care. He concluded with an overview of the Governor's proposed Universal Health Coverage plan and its financing mechanisms.

Dr. Kaveh Safavi, Chief Medical Officer of Solucient and a well-known futurist provided an overview of where managed care is headed. Examples of his slides included information

Dr. Kaveh Safavi

such as "medical patients account for over ? of all inpatient stays." "Orthopedics is the only growing inpatient surgical line." "Cardiovascular services decline has had the greatest impact on the decline of hospital admissions. CV surgery is down 34 %." "Hospital acuity has increased, mortality has decreased but there is stillroom for improvement." "Patients are using quality measures to make their decisions but the reputation of the physician still dominates the hospital selection factors."

Dr. Mark Shields

Dr. Mark Shields, Vice President of Medical Management for Advocate Health Partners shared some of Advocates strategies for clinical integration and the importance of infrastructure and pay for performance initiatives. Advocate is focusing their improvement efforts on patient registries, clinical protocols, patient education tools, patient reminders, and mandatory provider education/CME.

Brent Estes

Brent Estes, President of Rush Health Associates spoke to the value of physician-hospital ventures & the importance of infrastructure. Brent outlined important assets of infrastructure, People in analytical/technical, clinical & service positions, data and the ability to invest in scalable technology solutions. Business goals and the ability to make the "tough decisions" funding foster success.

There was a generous number of write in comments on the evaluation forms. The overall program score was 1.7 on a scale where 1.0 equals very good and 2.0 equals excellent. The Managed Care Committee wants to thank all of our Speakers and all of those who attended the event. We also would like to thank MultiPlan once again for their generous support of this year's social/networking reception after the program. It was a good networking event!

Part Two of a Two-Part Series

Performance Based Contracting

Its time has come, are you ready?

BY WILLIAM DEMARCO

What are some of the things you must do now?

So this is a future vision here in Chicago while other markets like Seattle, Philadelphia , Minneapolis and Kansas City are already in the midst of these changes with alliances of employers and providers finally sitting down to talk out their concerns about progress in the direction of a better health care system.

Although these seem like distant drum beats, remember none of the HMOs in Chicago are owned by Chicago companies any more. In fact many are national in scope operating in the cities I have mentioned.

Also remember that the employers who have patiently waited for a one step simple solution to all this are watching Milwaukee and all its problems and starting to regain momentum in solving these issues in smaller coalitions using smaller networks and defining a need for more sophisticated data to build their clout.

A payer driven system may be what happens in Chicago unless a couple of large and forward thinking institutions form an enterprise to begin benchmarking both quality and cost locally. We are not advocating fixing charges because this continues to be illegal, but we are saying that right now 10 HMOs are creating 20 indexes for 30 different product lines and the contract you have in your hands right now can be amended to either follow all these guidelines or can be amended to represent a solid counterproposal to follow a limited set of well published guidelines.

To do this, even as a single facility, means one needs to start thinking about performance first, money second. That is, if you do the service and do it better than anyone else, you have a great argument to state that savings should be shared between payer and provider.

But to do this requires a tracking system and definitions.

All Health plans and most employers are familiar with the HEDIS indicators. They were developed by HMOs and Employers years ago to underscore value and quality, which eventually formed the NCQA organization as the evaluator of HMO quality. Some of these same indicators are being used in the Pay for Performance demo project.

This is lingo health plans and most large employers understand and if you are comparing your organization to others using these measures you just gave the health plans a reason to pay you a little more than the guy down the street.

Are you NCQA certified as a hospital or medical group? If you need to be to bid on a performance contract, would you be able to take your measures and compare them?

Other groupers like Episode Treatment Groupings, Ambulatory Visit Groups, are ways to package services and price services on a global basis. The ultimate, Diagnostic Cost Groups, DCG, are algorithms of risk adjusted care that is a next level up for payers and represents the future. The present is to begin looking at the quality initiaves your organization already has in place, what are the leading quality services that your QA department would say are superior to other competitors in your area? Oh yes, and where are the weaknesses?

The urgency here is that others will grow while others are left behind. The hospital you work for may be great at Oncology and hearts, but in terms of maternity and ortho may be a notch or 2 down from the rest. This is a financial

dilemma because your CFO will say that one hand washes the other and cross subsidies of departments and systems keeps everyone up and above the red line.

Well if we are now competing on department quality we surely have no more subsidy and projecting expenses just got tougher, especially if those lock-in contracts now go to the top tier, not the bottom tier, hospital.

The beauty of this discussion is that part of being high quality should translate to lower cost and that means we get away from price discounts. In other words system redesign has barriers but also benefits. Several papers published by Agency for Healthcare Research and Quality (AHRQ) address areas of redesign. *Leading practices in system redesign* Harrelson *and Transforming health systems through leadership, design and Incentives* are both papers that convinced Medicare it was going in the right direction in implementing pay for performance back in 2004 2005. These are excellent starting points to understand the vision of where Medicare is going and what your organization may want to consider in its action plan.

The arduous journey is when the employer or health plan says lets share savings because now you're right back in the risk business. What a hospital finds over time is that as expenses due to efficiency and effectiveness of care are reduced so is revenue. That's why hospital based plans had a hard time operating long term and why integration took a back seat to building capacity for more and more specialized illnesses. This is complex business but is a necessary part of where the future is going. Smaller more specialized networks of top performing doctors and hospitals holding themselves accountable to payers and consumers.

Future of performance based contracting.

The good news is no one is ahead or behind you. We are all learning this together and getting all the parts of the puzzle together in one room to discuss this is a vital first step. But also having some goal in mind will help this agenda to become clear.

continued on page 13

Performance Based Contracting: Are you ready? Part Two (continued from page 12)

The goal of creating your own "attachment A" with provisions for quality measurement against a baseline you start with is a big vision but makes sense when you consider the alternative.

Start small with easily measured areas that you can get off the Premier Hospital website. They are running classes on pay for performance, but will tell you it was much more that P4P that had to be instilled in the minds of staff. From medical records to the medical director, there needs to be a focus on quality measures and performance in its broadest definition.

Have you ever asked why Managed care offers employers medical management services but hospital does not? Have you ever wondered why disease management companies for Arizona and Florida are hired to do case management your hospital could do? Have you ever wondered why you give these managed care companies all your billing data regularly and they charge employers to see it and then use it against you in negotiations?

If you had that data on an employer specific basis you could go right out to the employer and show their risk management folks where they could get more value for their dollar, where they could rearrange benefits, alter the future with wellness and health promotion plans.

To have your own "attachment A" would allow you to monitor what you are paid and what is denied so you can at least judge your companies success with PBC.

This entire move from wholesale selling to large payers and now moving to selling services to consumers who really want to make their deductible go further is a new approach.

7 years after the Institute of Medicine Quality Chasm report, most hospitals have not read it but every employer coalition has. They were shocked with the number of lives lost to simple mistakes of poor safety habits in the hospital. The 8th annual Health Grades report published two weeks ago states that if every hospital operated as a 5 star quality facility over 302,403 lives could have been saved. Half of those lives lost fell into 4 categories of disease: Heart Failure, Sepsis, Community Acquired Pneumonia and Respiratory Failure. The report also observed that the gap between best hospitals and worst hospitals became wider.

This differentiation will not be done with slick brochures, TV campaigns and radio spots. It's a very carefully thought out positioning campaign that keeps you in the eye of the employer as a leader in quality and the source of benchmarking data for his or her company.

Most people who have never sold to employers do not understand that employers are incredibly loyal to things that work. If your health system is doing the work and trying to make improvements and being accountable to the employer's decision makers, then you have no fear of being displaced by an insurance company's change or a published guideline comparison between your hospital and the competition.

The employer will tell the insurer yes you can sell your insurance but you must use our favorite providers or there is not deal.

That's a powerful sell and right now employers are gearing up for 2007 and want managed care to give them a good reason why this provider is better than another provider. Entering this change in its early development is a tremendous advantage to the early adopter. Waiting for guidelines to be set in stone and even risk loosing one or two big contracts is expensive to fix. The payers will continue to add more and more measurable services. It makes sense to build form a small set of datasets and then add to it then trying to build everything at once. The environment will force you to choose sides. We hope you choose your own.

Bill DeMarco is President and CEO of DeMarco and Associates and an active member of the First Illinois HFMA chapter. He can be reached at bill.demarco@demarcohealth.com

Transparent Pricing (continued from page 1)

healthcare can be predicted with 100% accuracy. Healthcare is a "practice" and not a "science".

Healthcare procedures are defined by CPT codes (current procedural terminology) which are published and updated annually by the AMA. The complexity of coding also makes price shopping difficult. Looking at something as simple as a biopsy in radiology, there are many variations in coding and charging. The charging would normally be dependant of the number of lesions, the number of biopsies, where they are, and the type of radiological supervision that would be required. This would depend on the modality used such as fluoroscopy or ultrasound. Many interventional procedures have specific CPT codes that are very specific to the intervention itself. Ninety-nine percent of hospital employees are not adequately trained to understand this complexity; nor would consumers be able to obtain an accurate price by looking at the chargemaster. In addition, hospitals may choose to charge for supplies, local anesthetic, etc. or they may bundle any combination of these. To add to this complexity; hospitals may "hard-code" the CPT in the chargemaster or "soft-code" it which means HIM will place the code on the bill to an "open" charge.

Another example relates to "Emergency Room Evaluation and Management" codes. The Federal Register has not yet defined specifics on how to use levels and have instructed hospitals to create their own criteria. This criterion must be fairly based on the use of facility resources and be followed consistently. This criterion is created internally and varies from organization to organization. In addition, some hospitals are still charging for "procedures" in their leveling system; while others charge separately using many different methods.

Complexities of Price Quotes and Price Transparency

As demonstrated by the complexities noted above, it is very difficult to quote an accurate price to a consumer. Intimate knowledge of coding, finance, and clinical operations is necessary to give an accurate estimate. In addition, caveats must play a part as healthcare is not a specific science. Even the best estimate can change based on clinical events and individual medical needs.

Price transparency will lead consumers to "compare". This will be a difficult for the consumer to actually compare "apples-to-apples" logic. A good example relates to an IV infusion in an outpatient or ambulatory setting. CMS has written guidelines for correct coding of these infusions and have come up with instructions on charging the "routine supplies" associated with this procedure. In a physicians office setting, tubings and other routine supplies can not be charged. However, hospitals may or may not charge for these supplies; however if they do they must place them under a revenue code that is "bundled" such as 270 (supplies). So the consumer may obtain prices from an office, or two differerent hospitals using different methodology leading the consumer to 3 very different price structures.

This example alone represents one of the complexities of transparent pricing. If hospitals "benchmark" on average pricing information; this detail is given based on the CPT code itself and not incorporating what is considered "additional". Understanding that this information is not an "apples-to-apples" comparison is essential when developing prices. People responsible for quoting prices must also be aware of what "extras" there are when quoting prices.

continued on page 15

 (continued from page 14)

Providing Price Quotes to Consumers

The demand is increasing daily for a consumer to be able to place a phone call and obtain a price for a procedure. Hospitals have some processes in place; however consumers will begin to hold us responsible for these quotes. There needs to be a formal process in place and the development of scripts to use when quoting prices. Listed below are ideas you might consider when formalizing this process at your organization.

Determine if you will have a centralized area that will be responsible for this function. Some organizations are developing the concept of a "Revenue Cycle Department" which may be a perfect place to put this function. This department could be an entire topic itself; but for this article it is important to mention that some clinical expertise is an essential component. If there is no department like this; a team that includes HIM, clinical staff, and patient financial services personnel is essential.

Some organizations are placing this function with central registration and this provides convenience as the consumer can ask the price during the registration process; and will reduce calls. If this is the case, much education is necessary so personnel know exactly what is expected of them as far as scripting; in addition to a solid understanding of what the test actually entails. Information must be organized in a way that is complete and easy to access. Information management can assist with this process.

When deciding the best place to put this function; you may also want to consider customer questions after the bill has been sent when they call to question some charges. Centralizing this entire process in the patient financial services areas has some benefits in reconciling quotes to bills and fielding questions later.

Determine how the organization will be accountable for the price quoted. One possibility is to develop a script for a verbal quote that states that the hospital cannot be completely accurate for what a consumer thinks they need. If they want to be sure the consumer needs to fax you an order for the exam. Consumers often use "lay" terms and leave out important information. Past experience with price quotes is that often a consumer will say they need an x-ray of the head; when in reality they need a CT of the head with and without contrast. If the consumer wants to fax in an order then the hospital can be more accurate and provide a quote in writing.

Work with the clinical areas on understanding how they charge. In the above example you need to be aware of what else may be charged with the CT scan. Examples are oral or intravenous contrast agents and any additional supplies that may be charged for the intravenous start.

Work with the legal department for assistance in developing letters and any other correspondence that is given to consumers.

Invasive and surgical procedures may best be quoted by providing averages for that case; possibly to the level of the physician as many charges are based on time. Physicians perform services at different speeds and if you charge

continued on page 18

Turning Uninsured Accident Victims Away... or into Profitable Patients?

BY TONY VIGNALI

The numbers of uninsured Americans continue to grow. The US Census Bureau reported that 47 million Americans were without health insurance in 2005 (16% of the population). Sixty-seven per cent of those 47 million were in families where at least one person worked full time. Other sobering statistics: 41% of Americans with moderate incomes had no health care coverage for at least part of 2005 and 53% with annual incomes under $20,000 are without insurance.

Every medical provider expects to give a certain amount of uncompensated care to patients in need who have no means of payment. A major challenge facing almost every medical provider is to find ways to treat as many uninsured patients as possible without jeopardizing the solvency of the practice. One solution is to identify segments of the uninsured population with alternative means of payment that are large enough to create revenue streams that make them worth pursuing.

One such segment is the population of uninsured accident victims who have legitimate, third party liability claims that should provide financial settlements at a future date.

According to the National Highway Traffic Safety Administration, there were 6.3 million motor vehicle accidents in 2005, in which approximately 3.2 million people received non-fatal injuries. Assuming this group matches the national uninsured average of 16 per cent, this segment would number about 512,000.

Some medical providers currently treat uninsured accident victims in exchange for contractual or statutory liens and receive payment from the proceeds of the patient's settlement or award.

Other medical providers who previously provided care to these patients have stopped treating this group because they lack on-staff underwriting expertise to determine which cases will settle for amounts sufficient to reimburse them at acceptable rates.

Many other providers have avoided treating these patients because of the perceived risk of non-payment, associated staffing and administrative expense and the unwillingness to wait as long as 2 years or more to receive payment from settlement proceeds.

Fortunately, medical providers now have options that will allow them to tap the revenue potential of this patient population without the associated expense, risk of non-payment or excessive length of time for reimbursement.

Several companies have been created with the following business model.

- Hire people with the highly specialized experience and underwriting expertise to evaluate the merit of patients' cases and value of potential settlements.
- Provide prompt payment to medical providers for approved patients' treatment.
- Handle all facets of filing and administering liens, collection activity and payment negotiation with attorneys and insurance companies.

Most of these companies are small, operating within a single metropolitan area, state or region. At least one company provides this service nationally to a broad range of medical providers and practice types. Some of the companies pay in 30 days, while others may take 90 days to pay. All of the companies factor their reimbursements to account for the high risk and time value of money. The majority are payer-finance company hybrids who assume 100 per cent of the risk of non-payment by the patient.

Providers who have become part of these accident care networks of treating and referring physicians, attorneys and hospital case workers often find that these network referral sources also become a source of insured patients as well. Additionally, they find that grateful patients who are given quality treatment at their time of need often refer significant numbers of family, friends and co-workers to their practice.

There is no single solution to the problem presented by America's uninsured or the numerous other factors that threaten the financial health of many medical practices. However, solutions are available that allow medical providers to stop turning away uninsured accident victims and start turning them into profitable patients with greatly increased chance of full recovery. What better win-win propositions exist presently?

Tony Vignali is Vice President of Sales and Marketing for MedFinance. He can be reached at 612-746-1927 or at avignali@medfinance.us

Transparent Pricing (continued from page 15)

based on time it is important to incorporate differences.

Long-Term Solutions

As price transparency becomes more common; with expectations that eventually the hospital chargemaster will have to publically displayed, hospitals can begin to find ways to make charges more "black-and-white". Hospitals may want to start bundling "routine" supplies into procedures and "room and bed". Then when a customer calls and asks what a room rate is; you can feel confident that this room will include all routine supplies such as dressings; air mattresses; disposable linen protectors; positioning devices,etc. However to do this a detailed analysis must be performed as most hospitals want projects such as these to be revenue neutral. In addition you should include finance; clinical and managed care so all understand what will be happening. You need to consider any contract clauses that relate to chargemaster increases and any revenue shifts that may occur.

Other areas that may need review include the operating room. You may want to review how "levels" are charged so that you will be able to better answer consumer questions on how you charge. This should be done by defining what is routine and what is not; and determine what constitutes a specific level. Bundling items in the operating room such as gloves, gowns, marking pens, etc will generally eliminate many phone calls relating to customer dissatisfaction. Many of these charges are what give us the negative public opinions related to stories of the "$10 aspirin".

What are you waiting for?

Hospitals need to take action on the demands for price transparency. If you have not made this a formal function in your organization you need to start. There are short term solutions for the immediate needs and longer term solutions for satisfying future price transparency laws and demands.

Marilyn Marilyn Hart Niedzwiecki RN, CNOR, CPC, CPC-H, CPA is Manager, Revenue Integrity for Children's Memorial Hospital and a member of the First Illinois Chapter HFMA. She can be reached at mniedzwi@childrensmemorial.org

Coming in the May issue of *First Illinois Speaks*

Financing Hospital Energy Service Projects

Joint programming efforts

Program recaps of April and May Education events

CFO Outing Recap

Recaps of educational webinars

Information on upcoming summer chapter events

Member Profiles

New Member Listing

Publication Information

Editor 2006-2007
Paula Dillon.....(630) 627-4549 pauladillon@sbcglobal.net
Official Chapter photographer
Al Staidl
Advertising
Jim Ventrone .....(847) 550-9814 jmv@ventroneltd.com
Design
Jody Simons.....(312) 226-2227 jody@pubsol.net

HFMA Editorial Guidelines

First Illinois Speaks is the newsletter of the First Illinois Chapter of HFMA. *First Illinois Speaks* is published 4 times per year. Newsletter articles are written by professionals in the healthcare industry, typically Chapter members, for professionals in the healthcare industry. We encourage members and other interested parties to submit materials for publication. The Editor reserves the right to edit material for content and length and also reserves the right to reject any contribution. Articles published elsewhere may on occasion be reprinted, with permission, in First Illinois Speaks. Requests for permission to reprint an article in another publication should be directed to Editor. Please send all correspondence and material to either of the editors listed above.

The statements and opinions appearing in articles are those of the authors and not necessarily those of the First Illinois Chapter HFMA. The staff believes that the contents of First Illinois Speaks are interesting and thought-provoking, but the staff has no authority to speak for the Officers or Board of Directors of the First Illinois Chapter HFMA. Readers are invited to comment on the opinions the authors express. Letters to the editors are invited, subject to condensation and editing. First Illinois Speaks does not promote commercial services, products, or organizations in its editorial content. Materials submitted for consideration should not mention nor promote specific commercial services, proprietary products or organizations.

Style

Articles for *First Illinois Speaks* should be written in a clear, concise style. Scholarly formats and styles should be avoided. Footnotes may be used when appropriate, but should be used sparingly. Preferred articles present strong examples, case studies, current facts and figures, and problem-solving or "how-to" approaches to issues in healthcare finance. The primary audience is First Illinois HFMA membership: chief financial officers, vice presidents of finance, controllers, patient financial services managers, business office managers, and other individuals responsible for all facets of the financial management of healthcare organizations in the Greater Chicago and Northern Illinois area.

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.

Founders Points

In recognition of your efforts, HFMA members who have articles published will receive 2 points toward earning the HFMA Founders Merit Award.

Publication Scheduling

Publication Date	Articles Received By
December 2006	November 24, 2006
January 2007	December 22, 2006
April 2007	March 5, 2007

first illinois speaks
hfma healthcare financial management association
A Newsletter from HFMA's First Illinois Chapter

Healthcare Financial Management Association First Illinois Chapter

Education Calendar 2007-08

Wednesday, May 9th, 2007

3rd International Healthcare Symposium – International Perspectives on Healthcare: Lessons for the United States. Featuring Richard L. Clarke, President of HFMA

Thursday, May 10th, 2007

7:00 AM CFO Education Program and Golf Outing
"Executive Leadership and Mentoring: Fulfilling Personal and Professional Missions
Medinah Country Club

Tuesday, May 15th, 2007

12:00 Noon Webinar
"How much will this cost me" – A Price transparency and Patient Responsibility Estimation. Sponsored by NEBO Systems

Thursday, May 24th, 2007

12:00 Noon Webinar
"Debt Capacity and Feasibility. Sponsored by Plante & Moran, LLC

Friday, May 25th, 2007

First Illinois Chapter Annual Golf Outing
St. Andrews Golf Club and Klein Creek Golf Club

FIRST ILLINOIS HFMA and UNIVERSITY OF ST. FRANCIS
IN EDUCATION PARTNERSHIP!
For information call: Tom Jendro at (815) 740-3534,
or email tjendro@stfrancis.edu

The First Illinois Chapter

The First Illinois Chapter wishes to recognize and thank our sponsors for the 2006-2007 Chapter year.
Thank you all for your generous support of the Chapter and its activities.

Platinum Sponsors

Grant Thornton
Plante & Moran, PLCC

Gold Sponsors

Capital Source • Charter One/Royal Bank of Scotland • Crowe Chizek & Co LLP • Healthcare Financial Resources, Inc. • JP Morgan Chase Bank • National City

Silver Sponsors

Claimquest Corp • Cleverly & Associates • DST Systems, Inc. • Harris & Harris, LTD • MAILCO, Inc. • NCO Financial Systems, Inc. • Pellettieri & Associates, P.C. • Powers & Moon, LLC • Virtual Recovery, Inc.

Bronze Sponsors

Chamberlin Edmonds • CMD Outsourcing Solutions, Inc. • Cymetrix • Gustafson & Associates, Inc. • Healthcare Outsourcing Network, LLC • IMaCS, Ltd. • MedAssist, Incorporated • MEDCLR • MedFinance • Medical Recovery Specialists • On Target Staff • Physicians' Service Center, Inc. • R & B Solutions • Revenue Cycle Solutions • Revenue Production Management, Inc. • Senex Services • Strategic Reimbursement Inc. • United Collection Bureau, Inc. • Wellspring Valuation, Ltd.