First Illinois Speaks
HFMA's First Illinois Chapter Newsletter
hfma healthcare financial management association
April 2014

WHATEVER IT TAKES

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News, Events & Updates

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How Does Tea Relate to How the Health Care Industry Needs to Evolve in a Meaningful Way to Serve the Consumer?

BY DANIEL T. YUNKER, SVP, MCHC / CEO LAND OF LINCOLN HEALTH AND FIRST ILLINOIS HFMA'S PRESIDENT

Leaders today should not get through a day without pondering this question – Will the health care industry evolve in a meaningful way to serve the consumer? As I think about my last couple of months as the chapter president, I reflect on the extreme transformation health care leaders have been facing over the past year. The answer on whether or not we will evolve is yet to be determined, but it is clear that we will need to lead change and drive innovations that are visible to the consumer. It can be argued that there is a great amount of focus on the pieces of change taking place: Obamacare, health care exchanges, Medicaid expansion, mergers, closures, increased regulations, integrations and expected declining reimbursements to name a few. However, many of these items are being addressed as parts, instead of as an opportunity to redesign a new delivery system, new relationships with customers that address what our organizations need to look like, how to behave and understand what the consumer will demand.

The same old way is not going to get us there. Recently, I was on a flight and met a woman who has been in Corporate America for years. She has had a successful career in the supply chain and logistics vertical, but like many of us, Nancy has grown frustrated with the same old way of doing business. We can all quickly recognize the traditional layers that are required by organizations to make a decision. There are the committees; leaders not willing to take some risk to advance the organization; lack of reliance on those maybe less senior putting their all into an idea; projects or new ways to improve a service; and that effort being stalled, so a leader who has not been involved can think about it. Our layers create decision paralysis. All in all, it was a fascinating conversation

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between two executives from totally different industries, but there were so many similarities.

As the flight continued, I learned that Nancy had a plan. She was pursuing a passion that could reshape how consumers embrace a new way to get value from something that is hundreds of years old – how to brew tea, an item that originated in China as a medicinal drink. It was first introduced to Portuguese priests and merchants in China during the 16th century. What Nancy is chasing is a new way for consumers to brew and consume tea. The idea was a simple one. In addition to the caffeine Nancy craved to get her through her corporate days, she started enjoying tea for some of its health benefits. She quickly realized that others around her enjoyed it the same, but it was so routine that nobody stopped for a minute to think about a new way to get value from tea. After a couple of years of development and numerous hours of video conferencing with manufacturers in China, Nancy launched a business called the TEA TOTALER (www.tea-totaler.com) – coming to a store near you, a consumer-friendly way to brew and enjoy tea.

You might be asking yourself, what in the world does tea have

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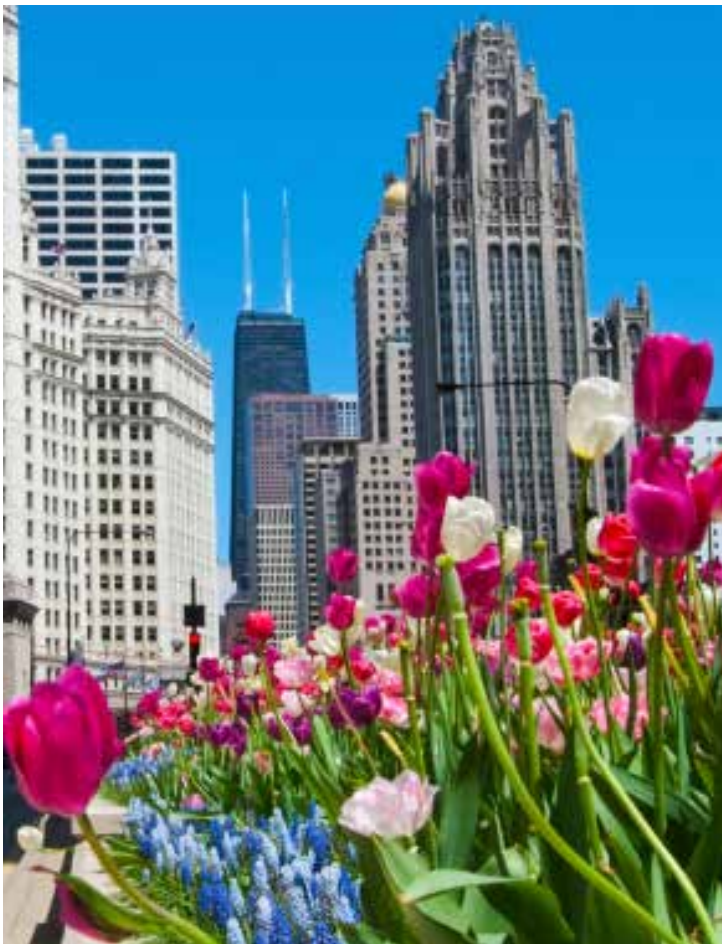
to do with what we are dealing with in health care? No, it is not the connection to potential benefits of health, the point is that we as health care leaders need to get out of our routines and think about how we change how consumers value and utilize health care. Like tea, health care has been around a long time, and we need to capture the essence of how we can change the way consumers value what we do, and not just when they have an emergency or an illness, but really value their relationship with our businesses. We need to make health care easy to understand, easy to navigate and easy to use when it becomes personal in a time of need. This is no simple task. We have very complicated layers within our organizations and industry. How Americans are procuring coverage is changing; as individuals, they are shopping on exchanges, both public and private. It is obvious that the start of this evolution has been a rocky one, but the train has left the station. These individuals who are purchasing on an exchange with subsidies or employer contributions are predicted to rapidly be in the position to determine how the health care dollar will be spent. Leaders need to pause and think about what a disruption this is to the routine that has been in place since World War II, when employers started offering one-size-fits-all benefits to its employees as a way to compete for labor. Today, increasingly, consumers are selecting benefits that they feel have value to them and their families. They will determine what provider relationships they desire when they purchase their plans, how much risk they want to take and will expect a consumer-friendly relationship with those who they choose to do business with.

The talent exists in our organizations to rethink, execute and deliver consumer-centric offerings that will reshape the relationships with those in the communities served. Nancy's employer is going to lose the type of talent that would contribute to the ongoing success of her current company. Fostering an environment that allows team members to contribute to the evolution of your organization is critical to success; and by doing so, you retain the Nancys of the world and find new ways to brew your tea.

Dan Yunker

SVP, MCHC / CEO Land of Lincoln Health and First Illinois HFMA's President



Recruit Me! How to Include Executive Recruiters in Your Strategic Career Plan

BY VICKIE AUSTIN

You're a successful healthcare financial management professional working for the same organization for, let's say, ten years. Suddenly, the ground shifts beneath your feet. Maybe you have a new boss and the chemistry isn't right. Or perhaps your organization just merged with another company, so the landscape has changed completely—and not necessarily in your best interest. For whatever reason, you think it's time for a change. What's your first move?

Many people turn to executive recruiters when they're contemplating a career transition. And that's a great strategy. Executive recruiters are a valuable resource in the work world, especially the higher your role in an organization. Hospitals and other healthcare companies turn to executive recruiters to help them fill positions, often working in tandem with the board of directors, executives and the human resources department to find just the right person for the job. However, knowing how recruiters work—and *for whom* they work—is critical to making this strategy successful.

According to a report by TheLadders (www.theladders.com), a comprehensive career information and job-matching service, nothing is quite so potentially rocky as the relationship between recruiters and candidates. In their report "How to Work with Executive Recruiters," reporter Elizabeth Bennett writes that working with a recruiter can lead to a win-win as long as job seekers understand the appropriate role of a recruiter and what's expected of them as candidates.

First, it's important to know that recruiters ***do not*** work for you, the job-seeker. Executive recruiters are hired, either within a contingency agreement (based upon results) or on a retainer by the organization that has a hiring need. Thinking that a recruiter is an "agent" working on your behalf is not only erroneous but can lead to upset when that recruiter doesn't jump to answer your phone calls or e-mails.

Why do companies work with recruiters in the first place? According to the Overture Group, an executive recruiting firm based in Lisle, Illinois, companies hire recruiters for some of the following reasons:

- The job is critical to the company and the hiring executive understands that recruiters have extensive networks and resources to expand the scope of the search.
- Candidates may feel more comfortable talking to a recruiter and asking questions about the company than they would to an internal recruiter.
- Recruiters can determine behavioral traits that others might not see.
- As specialists, recruiters have the time and the skills to devote to the task.
- Recruiters complement the core human resources department, freeing them up to focus on other primary duties.
- Executive search consultants are objective and have no bias.

The executive search firm does the detailed work of sourcing appropriate candidates, and when they find that "right fit," they also can help sell the company to the candidate.

The best case scenario is when a candidate's experience and expertise are *exactly* what the company is looking for. A recruiter's compensation depends on a perfect (or at least ideal) fit. If you're making a 180° career transition, leveraging your transferable skills into another industry or wanting to reinvent yourself, don't turn to recruiters. They have no incentive to take a risk on a dark horse candidate.

If you do work with a recruiter, please know that they will have a high expectation of professionalism in order to present you to their client, the hiring firm. Your résumé must be tight, truthful, and typo-free. Your cover letter needs to be specific and tailored to the opportunity—and to the recruiter. Listen very carefully to what the recruiter says. This is no time for a dog-and-pony show: stop talking and take the time to hear what the recruiter is telling you about the job and the company. While the recruiter may not be your "agent," he or she is certainly in a position to help you get in the door. Also, know that LinkedIn is now a powerful tool for recruiters, so make sure your LinkedIn profile is up-to-date with highlights of your achievements and a great professional head shot.

Like any form of networking, it's best to build connections with recruiters **before** you need them. If you get a call from a recruiter and you're not in the job market or the job isn't the right fit for you, don't ignore them. Call the recruiter back and have a conversation. Then, put some time and effort into thinking about the job requirements and your own network of colleagues and friends. Contact the recruiter again and recommend some potential candidates who might be the right fit. Invest in a relationship with one or more recruiters and then, when you need one, you'll have a resource you can trust.

Vickie Austin

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Legislation Connection

BY CHERYL A. WESOLOWSKI, CHAIR

State of Illinois Update from the IL-MGMA Legislative Committee

The 98th General Assembly started off 2014 very quiet; the March primary election had a lot to do with that. On the federal level, the year started with healthcare exchanges, which continue to be a major concern for healthcare providers. We have just finished the first quarter of 2014; the issues are just beginning to emerge. The sustainable growth rate formula for Medicare (SGR) has been on the main stage at the federal level for 2014. On March 27, the House of Representatives passed HR 4302. Included in the bill is delaying SGR for one year, which averted a 24 percent decrease in physician fee schedule that would have started on April 1. Also included in the bill postponing ICD10 implementation to October 2015 and the controversial two midnights rule. The two midnights rule is the new federal rule that cuts the Medicare payment rate for most patient stays that span less than two midnights. This bill moves to the Senate for consideration, and hopefully passage. Multiple healthcare organizations are continuing to fight for a permanent SGR fix; this will be the 17th patch to the SGR.

Il-MGMA Legislative Committee was watching the following bills as they made their way through the state legislation last session:

SB 1630: ANATOMIC PATHOLOGY BILLING

This amends the Medical Practice Act of 1987 and the Illinois Clinical Laboratory and Blood Bank Act. It mandates that only the entity personally rendering the service or supervising the service can directly bill the patient.

We have been watching this bill since February of 2013. The major change to this bill has just occurred with the addition of amendment 4, which does not prohibit a referring physician from charging a specimen acquisition or processing charge under certain circumstances. This is significant because the initial bill prohibited any pass through billing.

Status: This bill was scheduled for a third reading on April 1. At that reading there should have been a vote, if it fails the bill is dead, if it passes it moves to the House.

HB 3638 AND SB 2585: DHFS-INS-RX DRUGS-FORMS

This would amend the Illinois Public Aid Code and the Illinois Insurance Code and require the Department of Healthcare and Family Services and the Department of Insurance to jointly develop a uniform prior authorization form for prescription drug benefits on or before July 1, 2014.

At the present time each insurance company and Pharmacy Benefit Managers (PBMs) have their own preauthorization requirements before a physician is able to obtain pharmaceuticals for a patient. It's one of

the many roadblocks to care patients face and it results in hours of administrative time for physicians and their staff. The American Medical Association took a survey in 2010, the results being physicians spend 20 hours per week on average just dealing with preauthorizations, and navigating the managed care maze costs physicians $23.2 to $31 billion a year.

Status: This bill was scheduled for a hearing in the Senate on April 1 and still waiting to get a third reading in the House.

SB 3409 AND HB 5574: DENTIST ADMINISTER VACCINES

This amends the Illinois Dental Practice Act. It adds a provision that allows dentists with the appropriate training to administer vaccinations to patients 10 years of age and older pursuant to a valid prescription or standing order of a physician. It provides that vaccinations may only be administered for influenza, hepatitis B, HPV, and shingles.

There was an amendment added to the bill that was passed by the Senate on March 25. This includes the provision that dentists, after receiving the proper training, can administer only influenza vaccinations to patients 18 years of age and older, with valid prescription of a physician.

Status: This bill has more traction in the Senate, and is waiting for a second hearing. In the House it has been assigned to the Health Care License committee.

Back to Basics: Mitigating Risks and Rediscovering Opportunities

BY STEVE FEHLINGER, FHFMA, SR. CONSULTANT, LUBAWAY, MASTEN AND CO., LTD.

In the course of assisting clients during their budget process, serving in interim roles or in the course of certain focused projects, we uncover issues and opportunities that when acted upon add significant value. These finding, often manifest themselves in lean working environments, over-tasked staff under difficult situations, but can also occur from complacency or lack of attention to details. What follows is a sample of some of the financial issues we identified during a recent engagement to shore up a budget shortfall in a health care facility and a few other common findings recently uncovered. Many of these observations may seem trite by today's expectations, but surprisingly they arise time-and-time again.

Bad debt reserves are understated. Yes, this is a common occurrence in many of our engagements. The financial staffs do not timely update the bad debt model inputs or the model is ineffective. In this changing landscape of increasing patient deductibles, it is essential to keep estimates current and to maintain a skeptical perspective. Not all health care facilities do, but we recommend that they segregate the look-back write offs experience between physician practice, hospital and long-term care or other significant business lines. In addition, a separate write-off estimate between patients without insurance and patients with insurance is preferred to improve and better manage bad debt exposure.

The Patient Financial Services (PFS) staff is too lean for the number of receivable accounts under their control. During the course of a recent interim position assignment, we noticed that due to the conversion of several physician practices to provider-based, the number of accounts grew significantly and were aging without adequate follow-up. The days in receivables were not alarmingly high so the problem was under the radar, but without prompt attention, significant too late to bill write-offs were on the horizon. Following a quick assessment of the makeup of the aged receivables, we turned over all account balances over 90 days to an outside receivable management vendor. The parent health system identified a vendor with an established record, so we outsourced the target accounts quickly unhindered by the customary vetting process. We insisted on weekly progress reports from the vendor and took necessary actions as needed to manage the progress and manage the outcome. Similarly, problems with the number and/or training of registration personnel can also occur. This, too, can overload the billing and follow-up personnel, which can lead to an abundance of receivable accounts to manage as well.

The point of service collection process was not operational. Poor planning resulted in this process being placed on hold. To put this initiative back on track quickly, the responsibility for the registration department was placed where it should have been and assigned to the PFS director to better align responsibility and accountability for upfront collection. While this may seem like an obviously simple solution, organizational structures are often the result of political criteria as opposed to a structure that maximizes efficiency.

The hospital's patient observation percentage was above industry norms. This problem occurred in part because the monthly financial statement package reported the number of patient observation cases without reference to a meaningful standard. Without a ratio to show whether the metric's performance is in control there is no opportunity to take corrective action.

Unfortunately, once identified, moving the metric to an acceptable level is often not an easy task and in this instance, no one was responsible for ensuring the metric was meeting standards. The accountability for achieving an acceptable metric should be with the executive responsible for case management and utilization review. In this case, we assigned it to the Chief Nursing Officer (CNO).

We also found the case management team challenged to assess patient admission criteria timely. This became acute whenever a case manager took any paid time off (PTO). It contributed to a backlog of cases under review and untimely follow-up. To address this problem, we increased the casual hours in the budget for the case management staff. More importantly, we discovered a cultural deficiency among the case managers and their willingness to assist physicians with admission criteria timely. The case managers were clearly dedicated to their work, but their priorities were not in alignment. This required a paradigm shift from a batch processing mind-set to a real-time 24/7 mindset. We also instilled in the case managers a mantra that ***they*** are the hospital's experts in inpatient admission criteria. Their ***primary*** purpose is to help physicians understand admission criteria and ensure physicians document the patient assessment appropriately. There are various ways to accomplish this, which depend on the situation, the size of the organization, and the nature and size of the hospital's parent organization or affiliation. At the end of our relatively short engagement, the observation percentage had been *reduced ten percentage points,* effectively increasing inpatient admission by placing the patient in the correct care level more effectively and timely.

Eliminate unprofitable business lines and sacred cows. All service lines have to make a financial contribution to an organization, otherwise other services have to carry more weight. Often the cost accounting systems at health care facilities are not "reconcilable" to the financial statements or finance has fallen behind in properly maintaining the system. Regardless, a financial assessment of service line performance has to be part of the annual financial planning process even with other pressing demands and with proper planning even in the absence of a reliable cost accounting system.

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Back to Basics: Mitigating Risks and Rediscovering Opportunities

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We also found incorrect assumptions in the assignment of governmental indigent care payments such as the various Medicaid payment pools to their respective areas. Service lines reported in the financial statements in the category *Other Revenue* may hold opportunities for improvement. For example, we discovered a non-hospital service line important to the community, but unable to cover its direct cost. After highlighting this problem and after initial consternation, management successfully negotiated with a competitor to manage the facility under contract with an option to purchase. Through integration and the scale of a larger specialty facility, a less costly management and wage structure allowed the service to continue without financial assistance.

Outsourcing the management of certain services can reduce costs and improve the overall management of the activity. Through consolidation, many health systems already consolidate or outsource services through the effective deployment of skill and scale. For this client, the parent organization had the necessary depth and skill to assume the management responsibility of a key service line. While challenging, the facility was able to affect this change in short order during the budget development process. It is important to note that a corporate-wide centralized activity is not always the best outsource solution or alternative. For example, our firm insources reimbursement analysis as well as other financial services routinely during peak activity levels or even on a long-term basis. Similar firms do as well.

It is always a challenge to implement necessary productivity improvements and align volume level changes to staffing levels changes. The client effectively and aggressively reduced staffing levels in recent years, which resulted in a lean organization. Unfortunately, management did not always have appropriate benchmark analytics available when making these staffing changes quickly. This resulted in areas that were perhaps too lean, such as Financial Services, PFS and Case Management. We all realize that oftentimes, lean resources and short time-lines work against us, which is why benchmark-staffing levels are an important tool in this process. Management, as a proxy, may also use peer comparisons or comparisons across an organization in the absence of a purchased service.

As a budget initiative, the facility targeted staffing levels in patient care areas to accommodate lower than expected patient volume levels. In other words, staffing levels were budgeted at "the cyclical trough" so departments could flex upward when higher volumes occur. Doing the heavy lifting during the budget development process mitigates the challenge of having to flex down to lower staffing levels during the fiscal year should lower volumes than planned occur.

Operational efficiencies and revenue capture were improved through better alignment between the professional component service and the technical billing component of the service. It is important to note that when segregating accountability within a single service line, inefficiencies often occur. For example, this might

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Back to Basics: Mitigating Risks and Rediscovering Opportunities (continued from page 7)

occur in a service like wound care services; the physician practice manages the professional component of the service and the technical component is managed by the hospital. This misalignment is ripe for lost revenue and operational inefficiency.

Complex and multiple pay practices hinder efficiencies and incur unnecessary cost. The situation is most common with the management of union contracts or health systems with disparate pay practices. A myriad of different pay practices hinder standardization and become an undue burden to administer. Oftentimes, pay practices are negotiated without consideration to how the practice will be effectively measured, monitored and managed. The consequence of this is unnecessary hidden labor costs to administer the payroll and benefit costs. Several years ago, a facility was unable to automate their payroll time cards *even with the assistance of a large national vendor* because their pay practices were so complex and convoluted. Programmers could not correctly program the payroll rules. A longer-term solution to such problems is intermittent milestones. This way, significant improvements are possible over time. Similarly, many manual processes for the convenience of employees are difficult to justify in an economically challenging environment. An example of this is an on-campus coffee shop that does not handle a card swipe feature for payroll deductions.

The instillment of an effective cost conscious culture takes diligence and planning. Recently, a client wished to conduct a return on investment analysis of inpatient readmissions to determine whether the cost for corrective action was justified. This is an example of decisions that are counterproductive and can waste limited resources. Another example included the failed assessment of a new service line. In this case, the organization took the time to develop unnecessary detailed expense assumptions, but relied upon revenue assumptions that were too simplistic. In addition, there was no adjustment for the investment in receivables and respective disconnect between cash flows and revenues. Where this culture manifests itself is in a facility with a history of weak financial leadership. It is incumbent on the CFO to set the tone, educate, train, and instill a business mindset that is compassionate, business savvy and can hold people accountable.

In conclusion, it is hopeful that at least one of the areas listed can minimize an unexpected budget hit or help uncover an opportunity for financial improvement. The days of fixing a bottom line with anticipated volume or a price increase for most organizations have long since left the station. The changing landscape requires greater creativity, boldness, and the ability to separate the chaff from the grain in a financial assessment quickly, while using analytical resources wisely and effectively.

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Ratings Expert Highlights Emerging Trends in the Move Toward Value

BY LISA GOLDSTEIN, MOODY'S INVESTORS SERVICE

Moody's Investors Service is seeing 5 to 10 percent declines in volumes in various markets in the country, with some areas experiencing 12 percent declines—unlike anything Moody's has seen before. In a fee-for-service world, the downward trend is putting increased pressure on hospitals and health systems, which are already investing resources in the transition to a more value-based payment system.

Moody's has added new indicators looking at how hospitals are being paid (e.g., capitation, per diem, risk-based) as well as number of covered lives, readmission rates, physician employment—indicators that will help track the transition to value-based payment. Creating value—the focus of a new report from Moody's—outlines four management objectives that Moody's is seeing emerge in hospitals around the country as hospitals work to create value and prepare for the new healthcare environment.

Achieve breakeven performance with Medicare rates.

Action steps include the following:

- Compute the financial "gap" that would exist if all patients were paid on Medicare rates.
- Develop multi-year cost reduction strategies that go beyond low-hanging fruit and challenge historical business models based on volume.
- Open lower-cost clinical decision units for observation-stay patients.
- Coordinate better discharge planning with patient and family members.

Build scale through nontraditional methods.

Considerations include the following:

- Optimal size can be different depending on location, services and mission.
- The rating impact of nontraditional consolidations will vary based on capital needs and impact on performance.
- What efficiencies and economies of scale can be gained through nontraditional methods?

Initiative examples of nontraditional methods highlighted included Walmart's designation of six centers of excellence for associates; the BJC Collaborative, which brings together four sizable healthcare systems for shared savings through group purchasing and shared best practices; Aspen Valley Hospital's participation in the Western Health Alliance, a network of rural hospitals to achieve savings (again, through group purchasing); and Novant Health's shared savings and services model with community hospitals.

Improve the patient experience.

Action steps include the following:

- Expand the care team with physicians, physician assistants, and nurses, especially for chronic condition patients.
- Open urgent care access points and expand hours.
- Establish "care navigators" to ensure patients get post-acute care.
- Execute service contracts with physicians to ensure service standards are met.
- Partner with local employers to manage utilization in lower-cost settings (sometimes in the plant or on the corporate campus). Today, the corner drug store down the street is the new competition.

Cultivate informed leadership.

This indicator is harder to measure, but perhaps the most important to consider, Goldstein says. Five factors looked at in all cases are the following:

- Market position (45 percent)
- Legal security and debt structure
- Operating performance/P&L performance (30 percent)
- Balance sheet and capital management (25 percent)
- Management and governance

The three factors above with percentages make a balanced scorecard, as they total 100 percent; the two other factors are hard to measure when they come into play, and they can drive a rating higher or lower. In terms of governance, it's a whole new day for hospitals and health systems: Individuals with process engineering, manufacturing, and consolidation experience are now being added to hospital boards of trustees. Moody's also looks at the extent to which leaders are evaluating all services and facilities for repurposing, the extent to which they are considering potential partners, and the degree to which they are assessing the business model for the organization.

Hospitals–Tax Exempt Status:
From Charitable Care to Community Benefit

BY GERALD M. SWIACKI, SENIOR VICE PRESIDENT, LANCASTER POLLARD

Nonprofit hospitals are in a new era of compliance, with reporting obligations now inextricably tied to an organization's tax-exempt status. Two recent notices from the IRS attempt to provide more clarity for hospital leadership.

Internal Revenue Code (IRC) Sec. 501(r), which sets forth requirements nonprofit hospitals must meet in order to maintain federal tax-exemption under IRC Sec. 501(c)(3), was created with passage of the Affordable Care Act (ACA) in 2010. More than half of all hospitals in the United States are nonprofit. Thus, IRC 501(r) will have a significant impact on the manner in which health care will be provided in the local community and across the country.

Charitable Care, Community Benefit

In 1956, the IRS standard for tax exemption required hospitals to provide charity care to the extent of their financial ability. "Community benefit" was first articulated by the IRS in 1969. While charity care remained an important component, hospitals were required to expand efforts and promote health to a class of persons broad enough to benefit the community. The standard remained essentially unchanged until 2009 when the IRS introduced a new Schedule H to supplement financial data collected from all tax-exempt organizations. Enactment of the ACA presented another opportunity to expand and clarify federal community benefit requirements, establishing criteria related to the assessment of community health needs; financial assistance policies; and hospital charges, billing and collection practices.

501(r) provides that a hospital organization will not be afforded tax-exempt treatment under 501(c)(3) unless the hospital meets requirements of 501(r)(3) through (r)(6):

- 501(r)(3) requires a hospital organization to conduct a community health needs assessment (CHNA) every three years and implement a strategy to meet those needs.
- 501(r)(4) requires a hospital organization to establish a financial assistance policy (FAP) and a policy related to emergency medical care.
- 501(r)(5) limits amounts charged for emergency or other medically necessary care that is provided to individuals under the hospital's FAP to not more than the amounts generally billed to insured individuals.
- 501(r)(6) requires reasonable efforts to be made to determine whether an individual is FAP-eligible before engaging in extraordinary collection actions.

There is considerable guidance from tax and legal professionals regarding the nuances and best practices for complying with the requirements of 501(r), including the dynamic nature of the CHNA process and the need for its conclusions and responses to be thoroughly documented.

Notices, Proposed Regulations and Procedures

Implementation of 501(r) has not been without challenges and the IRS has attempted to resolve a wide variety of issues through notices and publication of proposed and temporary regulations. It is in the absence of statutory guidance that proposed regulations offer organizations the best instruction on compliance. Most recently (i.e., on Dec. 30, 2013), two more notices provided guidelines for affected organizations. Notice 2014-2 confirmed that tax-exempt hospital organizations may rely on proposed regulations under 501(r) before final regulations are published. Notice 2014-3 provided correction and disclosure procedures for certain failures to meet the requirements under 501(r).

With the issuance of Notice 2014-2, nonprofit hospitals are provided a clear methodology for compliance with 501(r) based on the proposed regulations dated June 26, 2012 and April 5, 2013. For the earlier guidance, information was provided on the requirements for charitable hospitals relating to financial assistance and emergency medical care policies, charges for emergency or medically necessary care provided to individuals eligible for financial assistance, and billing and collections. CHNA requirements were covered in April 2013 along with a discussion on the related excise tax and reporting requirements for charitable hospitals as well as consequences for failure to satisfy 501(r). The 2013 proposed regulations also specified that failure would be excused (i.e., no loss of tax-exempt status), if a hospital corrected and disclosed errors and omissions promptly after discovery.

Most tax-exempt hospitals were required to meet the CHNA requirement set forth in 501(r)(3) by the end of 2013. As for those organizations that made a good faith effort to comply by the deadline, issuance of Notice 2014-2 on Dec. 30 might be considered anything but timely. Fortunately, Notice 2014-3 includes a proposed revenue procedure allowing nonprofit hospitals to maintain favorable tax treatment when failure is neither willful nor egregious.

A Road Map for Hospitals

The proposed correction and disclosure procedures of Notice 2014-3 provide a road map for organizations seeking to excuse one or more failures as long as action begins before the hospital is contacted by the IRS concerning an examination. Correction includes the following four principles:

- Attempt to restore affected persons to the position they would have occupied had the failure not occurred.
- Take action reasonable and appropriate to the failure.
- Make the correction as quickly as possible after discovery.

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Hospitals–Tax Exempt Status:
From Charitable Care to Community Benefit

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- Establish or modify policies and procedures to prevent similar failures from recurring.

Disclosure on Schedule H of Form 990 for the tax year in which the failure is discovered requires:

- A description of the failure, including its type, location, date, number of occurrences, number of persons affected and dollars involved, along with the cause of the failure and practice and procedures in place prior to the occurrence.
- A description of the discovery, including how it was made and timing.
- A description of the correction made, including the method and date of corrections and whether affected persons were restored.
- A description of the practices and procedures, if any, that were established or modified or an explanation as to why no changes were needed.

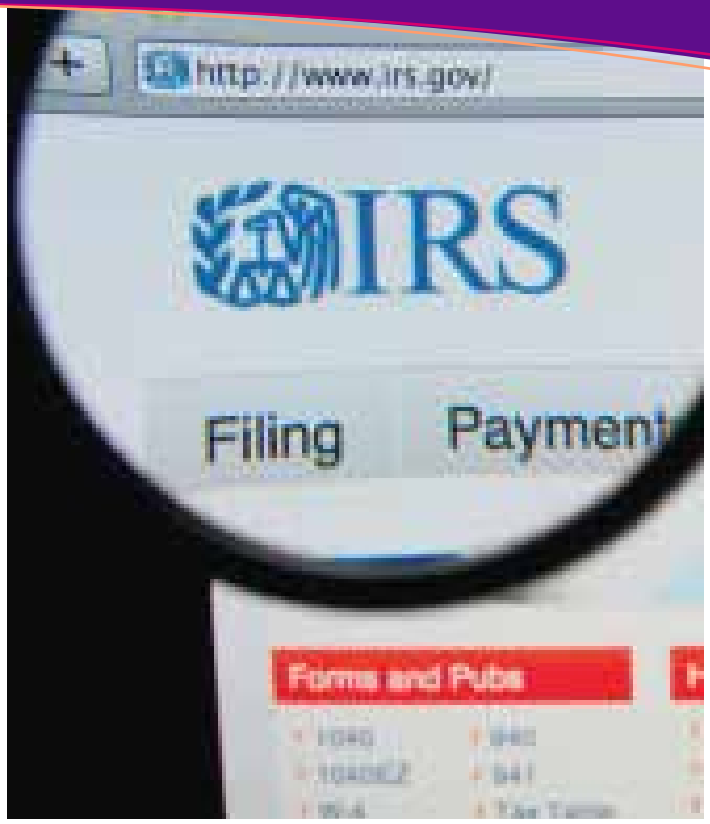
The IRS states that correction and disclosure does not create a presumption that failure was not willful or egregious. However, correction and disclosure in accordance with the proposed revenue procedure will be considered as a factor and may serve as an indication that failure was not egregious or willful.

It is important to note that minor and inadvertent omissions and errors due to reasonable cause will not be considered a failure to meet a requirement of 501(r), if corrective action is taken promptly after discovery. By contrast, a failure to meet the CHNA requirements of 501(r)(3) subsequently excused as a result of appropriate correction and disclosure actions may still result in the imposition of an excise tax.

501(r): A Shift in Emphasis

The IRS continues to focus on activities and policies of nonprofit hospitals while capturing information to ensure compliance with the ACA. However, many of the provisions of 501(r) were effective for tax years beginning after the date of enactment. As such, and without final rules and regulations, the challenge for affected organizations has been to avoid failure. A recent notice confirms certain proposed regulations can be relied upon for compliance pending the publication of final regulations or other applicable guidance. Another new notice proposes procedures to correct and disclose failures to comply with the requirements of 501(r).

Policy analysts predict less demand by uninsured patients for free and discounted hospital care as the ACA is implemented. The anticipated result is greater resources at nonprofit hospitals to focus on community benefits. The entire industry is shifting from managing illness to promoting wellness. Nonprofit hospitals, in return for retaining favorable tax treatment, are expected to contribute



by creating and expanding public and community health initiatives throughout the communities they serve. 501(r) appears to be the tool by which the shift from an emphasis on charitable care to community benefit will be accomplished.

What's New Under 501(r)?

The passage of the Affordable Care Act established four new federal requirements for tax-exempt hospitals under section 501(r) of the Internal Revenue Code. They include:

- Conduct a community health needs assessment (CHNA) every three years and adopt an implementation strategy to meet needs identified in the assessment.
- Adopt a written financial assistance policy that includes eligibility criteria, methods used to calculate charges, applications for assistance, and actions associated with billing and collections.
- Limit charges for services to FAP-eligible patients to levels equivalent to amounts generally billed for insured patients.
- Make reasonable efforts to determine an individual's eligibility for financial assistance prior to extraordinary collection actions.

Gerald M. Swiacki

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Medicare Wage Index: Past, Present and Future

BY PAUL SOPER, PARTNER, IMA CONSULTING

To Our Healthcare Clients and Friends:

Preparing and compiling the annual Medicare cost report is a long and arduous process for most hospitals. One extremely important part of the cost report preparation process is the wage index schedules (Worksheets S-3, Parts II – V). However, these schedules are often pulled together during the final stages of the cost report process without the proper level of attention. The reason the wage index schedules are often an "after thought" is mainly due to the fact that they can be reviewed and adjusted at a later date and also because these schedules do not result in an immediate impact on Medicare reimbursement. However, the importance of completing this section of the cost report accurately and completely must be considered a high priority for most hospitals. Simply stated, millions of dollars of Medicare reimbursement can be at stake if the wage index schedules are not filed correctly. In this article, we will discuss the background of wage index, the challenges hospitals face with the wage index schedules and our insights regarding preparing the current wage index schedules and also on the future of Medicare wage index.

Background

The Medicare wage index calculation is an essential part of the Medicare Inpatient Prospective Payment System (IPPS). Recently, however, due to declining Medicare reimbursement, a hospital's wage index plays an even more significant role in the calculation of Medicare payments made to providers. This means that a hospital's wage index change from the previous year can sometimes determine whether Medicare reimbursement will increase or decrease for an individual hospital, and sometimes to the tune of millions of dollars.

Medicare IPPS is designed to pay hospitals for services provided to Medicare beneficiaries based on a national standard payment amount broken down between a labor and non-labor component. One of the significant adjustments to the standard payment amount is an adjustment for market conditions or the Area Wage Index (AWI). According to CMS website, the definition of AWI is as follows:

Section 1886(d)(3)(E) of the Social Security Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. We currently define hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas (CBSAs) established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act.

The Act further requires that we update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, we derive an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts.

In short, the AWI for acute care hospitals in each CBSA is updated annually and the results are applied to the labor portion of the standardized IPPS payment amounts. Along with the AWI, every three years an occupational mix survey is also submitted to CMS for review.

Challenges

For providers, there are many challenges when it comes to AWI reporting and then complying with the annual audits performed by the Medicare Administrative Contractors (MAC). First and foremost, many providers simply lack the proper staffing to complete the AWI schedules accurately and completely. Numerous nuances exist to gathering, interpreting and compiling the schedules that require a

(continued on page 13)

 (continued from page 12)

certain level of technical knowledge related to the intricacies of AWI.

Second, although an individual provider may file their own AWI schedules correctly, this may not be the case for the other providers in their CBSA. This unfortunate situation may well be a detriment to the whole CBSA as all the providers' data is used in the CBSA's AWI calculation.

Also, it is important to understand that AWI is a "zero sum game" and the national AWI will always equal 1.00. Therefore, even if all the hospitals in a CBSA filed their wage index schedules accurately resulting in an increase to their average hourly wage, if the increase in the average hourly wage for the hospitals in the rest of the country was higher, then the AWI for that CBSA will decrease.

Next, one of the leading challenges faced by providers is that the MAC may not conduct the AWI audits consistently leaving the providers in the CBSA with a lower AWI. A few common areas treated differently by MACs are the wage related costs (specifically pension and health insurance), Physician Part A time, paid hours and contract labor.

Lastly, certain exceptions to the normal AWI guidelines exist, such as geographic reclasses, rural floor adjustments, rural floor budget neutrality factor and Frontier states. Each of these exceptions has a separate set of regulations that can represent both a challenge and a potential opportunity for providers.

Insights

Adjustments are allowed to the "as-filed" amounts on the AWI schedules on the Medicare cost report generally until the end of November prior to the annual MAC audit of these schedules. While many providers take advantage of this additional time, we believe that ultimately it is less time consuming and, quite frankly, less nerve wracking to file the AWI schedules correctly at the time of filing the cost report.

To ensure that key components of AWI data are reported correctly, here are a number of key areas that should be addressed and reviewed:

Paid Hours

- Payroll data should be used to file all paid hours as they do not include accrued hours as typical FTE reports or labor distribution reports do.
- A thorough understanding of the pay codes in the payroll system is crucial in determining which pay codes are to be included.

Contract Labor

- For direct patient care and Administration & General expenses, the dollars and hours need to be supported with invoices that include dollars and hours.
- If hours are not included on the invoice, a provider may use a contract or correspondence from the vendor with an average hourly wage to impute the hours.
- If hours are not included for direct patient care services, such as perfusionists, MRI's, etc., these hours can be imputed using time per procedure or other similar calculations.

Physician Part A

- Be sure to correctly capture all of the physician Part A time with time studies. Many hospitals lose significant reimbursement by not capturing this time correctly.

Wage Related Costs

- If there is a defined benefit plan, or pension plan, be sure to document cash funding on an annual basis. Also, be prepared to provide the annual tax forms as well as actuary reports.
- Be prepared to allocate benefits on a mixed allocation basis, FTE vs. salaries. This is normally an adjustment with a positive impact.

Along with the challenges that providers face with the current AWI regulations, the future of AWI could well entail significant changes being implemented. Section 3137(b) of the Affordable Care Act requires the Secretary of Health and Human Services submit to Congress a report that includes a plan to comprehensively reform AWI under section 1886(d) of the Act relating to IPPS. In developing the plan, the Secretary was directed to take into consideration the goals for reforming AWI that were set forth by MedPAC in its June 2007 report entitled "Report to Congress: Promoting Greater Efficiency in Medicare". A "Report to Congress: Plan to Reform the Medicare Wage Index" was submitted by the Secretary on April 11, 2012.

Although the report was sent to Congress in 2012, no current plans are in place for Congress to take immediate action. However, the report recommended a commuter-based wage index (CBWI). The CBWI attempts to improve upon AWI by using commuting data to define hospital labor market areas. In other words, the CBWI uses data on the number of hospital workers commuting from home to work to define a hospital's labor market. Further, to define benchmark area wages, the CBWI uses geographic units (such as ZIP codes or Census Tracts) that are smaller than the CBSAs used in the current wage index system. In doing so, the CBWI can more precisely reflect wage differences within and across CBSA boundaries. With CBWI, each hospital will be held accountable for their own wage index data and not be a part of a CBSA, so it will be even more imperative that providers report this data accurately. Although it isn't certain if CBWI will be part of AWI reform, it appears to be a clear front runner.

Summary

Correctly completing the wage index schedules on the Medicare cost report is critically important in order for a hospital to receive proper Medicare reimbursement. While not always a "top priority" when completing the initial cost report, as these AWI schedules do not result in an immediate impact on reimbursement, they ultimately may impact significant amounts of Medicare reimbursement for both the individual hospital and also for the other hospitals in that CBSA.

We are pleased to have the opportunity to present this information to you. If you have any questions or need assistance, please do not hesitate to contact me at 484-840-1984.

IOM Releases EHR Cost/Benefit Calculation Framework and Tool

A new model aims to help hospitals determine the ROI of their electronic health record (EHR) systems and best configure these systems to achieve optimal value.

The model, which was developed by participants in the Institute of Medicine's (IOM's) Digital Learning Collaborative and members of HFMA, includes a standard approach for calculating the financial costs, benefits, and implications of implementing and optimizing EHRs and related technologies.

The model comes several years into the federal meaningful use program, which sought to provide about $27 billion in incentive payments to providers that adopt and implement qualifying EHRs. The model will help hospitals at various stages of implementation assess their financial benefits to-date and adjust the ongoing implementation and use accordingly.

"It's a standard framework of the ways that organizations are thinking about the return from their EHR investments," said Chad Mulvany, director of healthcare finance policy, strategy, and development for HFMA. "The first part is to measure where we are with EHRs, and if we are not seeing the returns we thought we should see at this point, then it supports looking for the most leveraged places where we could possibly improve it."

The tool also will enable interorganizational comparisons and identification of best-in-class implementation approaches.

Overcoming EHR Obstacles

The development of the new model followed reports that providers have struggled to clearly identify the costs and benefits from EHRs, which can vary widely. Common logistical and conceptual challenges have hindered the adoption and implementation of EHRs, according to the authors of a discussion paper on the model, *Return on Information: A Standard Model for Assessing Institutional Return on Electronic Health Record,* released on Jan. 6. (Read the report and download the tool at hfma.org/ehr.)

The model includes a catalog of categorized benefits, expenses, and potential revenue impacts and identifies the areas where each may exist. Also included is an alignment of benefits with the stated goals of the Office of the National Coordinator for Health IT's meaningful use standards, assessments of whether benefits are expected to accrue to the provider based on various payment methods, and designation of whether revenue impacts are expected to be negative or positive. Both benefits and revenue impacts are prioritized by their ability to quantify financial impact and the relative scale of financial impact.

"A standard model would provide credibility in discussion with other executives, board members, and even in negotiations with EHR vendors," Jonathan Perlin, MD, chief medical officer, HCA, Inc., and co-chair of IOM's Digital Learning Collaborative, wrote in a *Health Affairs* blog post. "Second, the comparability the model provides would help identify more efficient approaches to implementation, based

on differences in experiences between provider sites, and would accelerate learning about best practices."

Previous research has identified net EHR financial benefits for provider organizations. However, much of the data came from highly capitated systems, the experiences of which may not clearly translate to most other types of hospitals and health systems, according to healthcare finance experts.

The IOM panel agreed that it is difficult to compare studies and determine which differences arise because of the technology itself and the manner of its deployment and which differences are related to the methods used to assess costs and benefits.

The hope is that the model will "[accelerate] improving the business case for EHR implantation and advanced information technologies that improve the safety, quality and efficiency of health care and foster a learning health system," the report's authors wrote.

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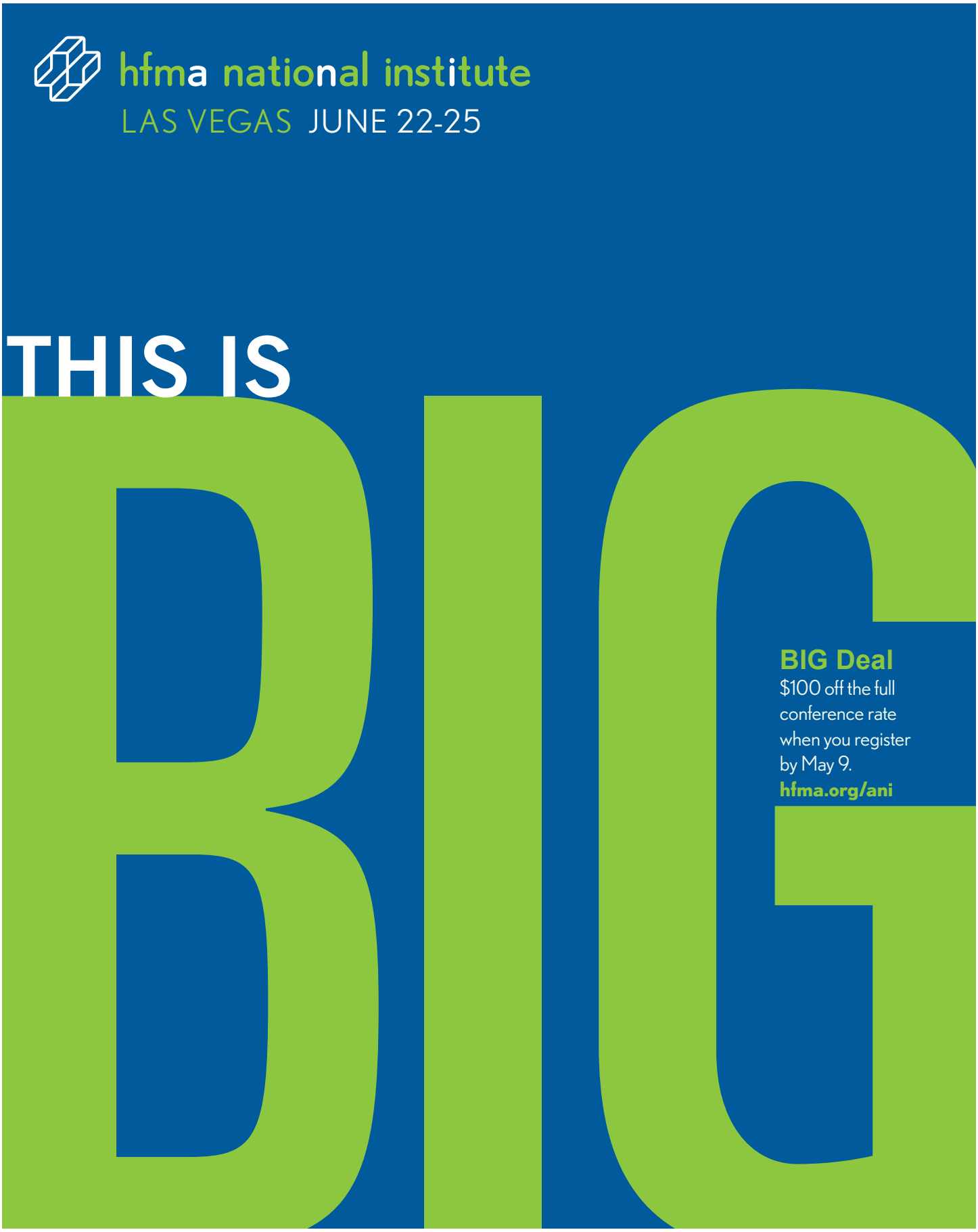
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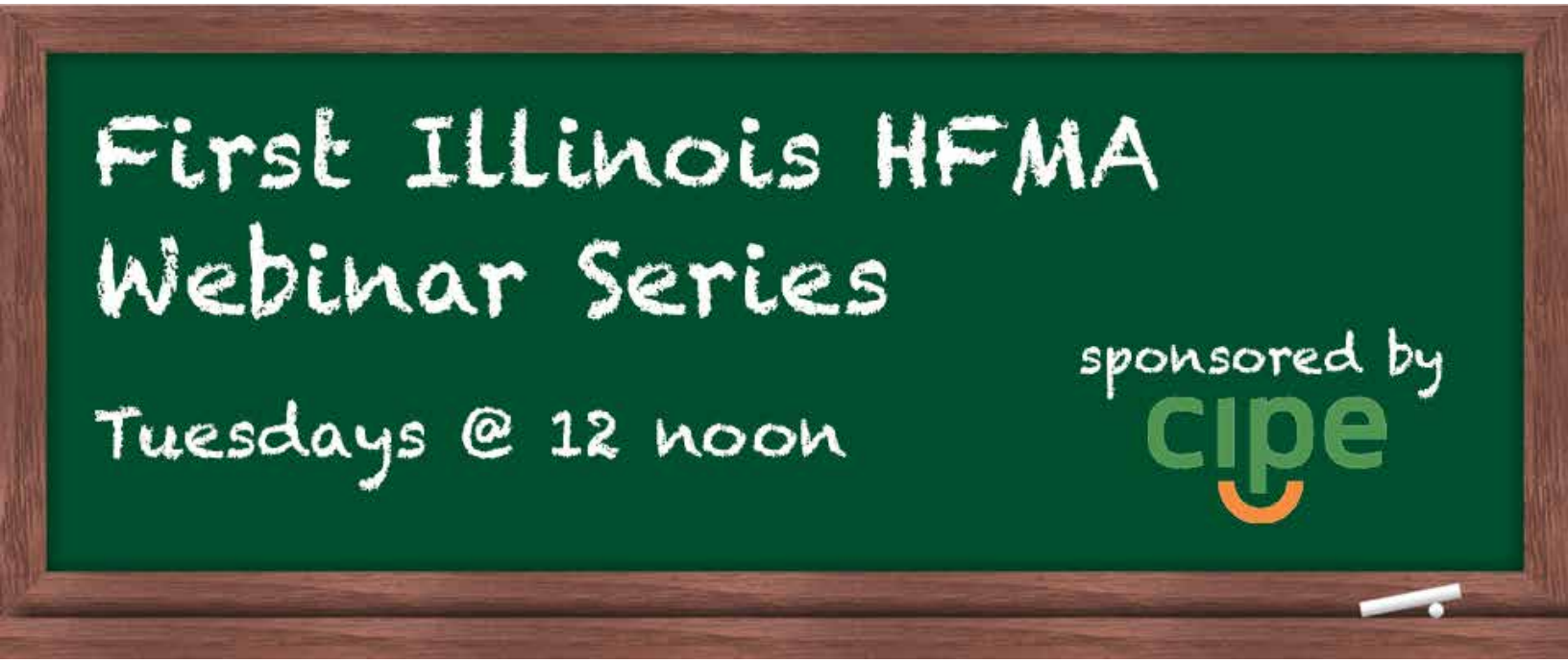

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HFMA's First Illinois Chapter Newsletter

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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.

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October 2014	September 10, 2014
January 2015	December 10, 2015
April 2015	March 10, 2015

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For a current listing of all upcoming First Illinois HFMA Chapter events, please visit: http://firstillinoishfma.org/events/calendar-of-events/

Tuesday, May 6, 2014
Webinar: OS Inc. – Model for Business Office

Tuesday, May 13, 2014
Webinar: Advanced Patient Advocacy – Healthcare Reform Readiness: Patient Enrollment & Navigator Strategies

Tuesday, May 20, 2014
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