hfma healthcare financial management association

first illinois speaks

A Newsletter from HFMA's First Illinois Chapter

January 2004

The Case to Re-Base

Healthy Prescription or Recipe for Disaster?

By Mike Nichols

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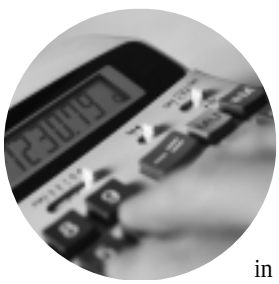
INSIDE:

A popular late-night television show uses a nightly "Top Ten" list to highlight current events in an entertaining manner. This format is widely copied in a variety of settings. This article will use that same format to stimulate a discussion about whether the Medicare program should consider re-basing as a viable option to address a myriad of issues related to its various prospective payment systems. While this article focuses on the Medicare program, many of the ideas can be applied to other payors.



The inpatient prospective payment system has been in place for over twenty years. Outpatient services have been reimbursed under PPS since August 2000 and other services within the continuum of care including skilled nursing, inpatient rehabilitation and home health services are also reimbursed according to their own unique prospective payment systems. CMS has announced a proposed per-diem based PPS for inpatient psychiatric services. While each of these systems has unique features, they share the commonality of the Medicare cost report. Although more complex in many ways, the Medicare cost report has been a relatively static document over the last two decades. Information used in determining the "base amounts" for the various payment mechanisms is influenced by updates for wage index, and other minor adjustments, but overall CMS has not done a comprehensive job of capturing the true nature of provider operations. This could be accomplished through a re-basing initiative. This initiative would provide a more accurate and certainly more current snapshot of the state of the industry. This would also provide other payors with some additional relevant information that could potentially contribute to a more equitable distribution of provider payments.

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Inside This Issue

President's Message

Membership Participation; The challenge of a volunteer organization

Happy New Year! When each New Year starts, it is natural to reflect back upon the past year and think about our accomplishments as well as the things that didn't go as planned or simply went undone. As President of First Illinois, my reflections uncovered some questions that I have for you and I hope that some of you will respond. I have written what HFMA membership has meant to me - career development, networking, available and reliable resources, education opportunities and friendships. For all of these experiences, I am very satisfied with my membership. I have experienced these benefits because I am involved, volunteering for committees, attending educational events, recruiting new members, and serving as a Director or Officer for the past five years. But what would encourage more of you to get involved with the Chapter? All past leaders of this organization have struggled with this question and none of us have found the answer. Your organization has put on five excellent educational events since September, and with the exception of the Accounting and Reimbursement Meeting in January, member attendance has been less than satisfactory. When the Nominating Committee met this month to identify new Directors for the Chapter, we were perplexed at the short list of active volunteers to choose from. We are a Chapter that is more than 1,000 numbers strong, one of the biggest in HFMA, but yet, only a few members step up to volunteer their time and talent. What could we do to change this situation?

Sometimes I wonder if the lack of participation is because many of our members do not know how to get involved. Perhaps our structure for recruiting volunteers is too restrictive. Once a year, usually in April or May, we send out a volunteer recruitment letter asking for volunteers for various committees. The committees are formed and work primarily on organizing an educational event surrounding their area of interest (Revenue Cycle, Managed Care, Reimbursement, etc). Through these committees you can meet others in your field and develop key contacts. If you have volunteered for one of these committees in the past, what was your experience like? Did it meet your expectations? How could we improve?

Why is attendance at the educational events so low? Are the topics incorrectly focused? What would you like to see more of? How do we improve the value of our educational events?

Some of you will have a chance to answer these questions through a short survey that is due out in January. I encourage you to answer the survey. We really do want your feedback because without it, we are not able to know how we need to change to serve our membership better. I also would encourage you to email your thoughts to the leadership of First Illinois. Our email address is firstillinois@firstillinoishfma.org. Whatever ideas we can gather from you will be discussed at the Strategic Planning Committee as we make plans for next year. Please share your experience so that we can continue to build the chapter and the services we offer.

Thank you!

Paula Wilke, President
HFMA First Illinois Chapter

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First Illinois Chapter News, Upcoming Events & Committee Updates

■ Managed Care Committee

(Paula Dillon and Jim Watson)

The ANNUAL HFMA MANAGED CARE PROGRAM will be on Thursday 3/25/04 at the Carlisle in Lombard. The theme of this year's program is *Innovations*, and we have lined up a exciting day of discussion and interaction. This year's speakers and topics include:

- We are pleased to announce that Jeanne Scott, Editor of *Health Politics* will be our keynote speaker. Jeanne is a nationally renowned speaker and we look forward to her insights and perspectives to kick-off our day.
- David Grant from the Illinois Department of Insurance will give us an update on what's happening in Springfield as it relates to healthcare and insurance legislation and proposals.
- Jeff Rooney, CFO at Rush North Shore Medical Center, will present a case study presentation on how his hospital integrated managed care contracting into revenue cycle management.
- We will have 2 panel discussions (one in the morning and one in the afternoon), with expert panels to discuss two cutting edge topics of today. Our morning panel discussion will be about "Technology and its Impact on the Healthcare Delivery System", and will feature perspectives from hospitals, physicians, and health plans. Our afternoon panel discussion will address the move toward "Pay for Performance", which will include Phil Lumpkin who will discuss BCBS' approach, and will also include a couple of provider systems who will share their experiences in performance-based contracting.

This year's program promises to be one of our best ever, and we hope to see you there! Call Jim Watson at 630-571-6770 with any questions or to find out more.

■ Medical Groups & Physicians Committee

(Elaine Scheye)

The MEDICAL GROUPS & PHYSICIANS COMMITTEE ALL DAY EDUCATIONAL PROGRAM on FEB.19 will be a day filled with updates of the significant issues facing healthcare organizations and physicians that include:

- a report of the findings in the HFMA/PWC study How are Hospitals Financing the Future? Access to Capital in Healthcare Today
- Leveraging your Medical Office Buildings for Strategic and Financial Benefit
- a panel discussion about Specialty Care Hospitals and the threats they pose to full service community hospitals from investment banking, rating agency, physician and provider perspective;
- Competition in Healthcare and Developments at the Federal Trade Commission discussed by the head of the Healthcare Division in Washington, D.C.;
- the Conduit Issues Authority effective Jan.1,2004 and how it will affect your access to the tax exempt capital market in Illinois;

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Founders Merit Awards for 2003

By Brian Sinclair, Senior Vice President, Financial Resources Initiatives, Inc. and Chairperson, Awards Committee

Congratulations are in order for the recipients of the 2003 Founders Merit Awards. National HFMA recognizes that its strength lies in the volunteers who contribute their time, ideas and energy to serve the healthcare industry and their local chapter. The Founders Merit Award program was established to acknowledge the contributions made by individual HFMA members.

These awards are part of a merit plan, which assigns a range of point values to specific chapter activities, such as meeting attendance, committee participation, educational presentations, and serving as a chapter officer. A maximum of 40 points can be earned per year with no carry-over. The Follmer Bronze Award is awarded when a member has accrued 100 points, the Reeves Silver Award is earned after an additional 100 points are accumulated, and the Muncie Gold Award is presented after a final 100 points are earned. A fourth award, the Founders Medal of Honor, may be conferred by nomination of the Chapter Board of Directors. This award recognizes significant continuous service after completing the medal program.

The 2003 award recipients are:

Follmer Bronze Award

John V. Burke, CPA
Michael F. Doody
Karen K. Gagnon
Richard A. Hamilton
Michael J. Hedderman
James A. Knepper
Terence M. Mieling, CPA
Peter Morales
Rex L. Pipher
Elizabeth M. Simpkin
Stephen B. Smith
Andrew J. Stefo, CPA
Gregory C. Wimbrow
James F. Wuellner, CPA

Reeves Silver Award

Linda K. Burt, CPA
Teresa Y. Chan, FHFMA
Anthony J. Kazwell
Andrew F. Knauf, CPA
Karen C. Krug, FHFMA, CPA
Alan H. Staidl

Muncie Gold Award

Charles A. Barth, FHFMA, CPA
Harry L. Jones Jr., FHFMA, CPA
Frank J. McHugh
Elaine S. Scheye
Gregory E. Yore, FHFMA, CPA

Each of these award recipients will receive a personalized inscribed plaque from HFMA to officially recognize their achievements. The First Illinois Chapter officers and directors also extend their congratulations and appreciation for the support and participation of the award recipients.

Please refer to your chapter membership directory for more information regarding the awards series, scoring details and a listing of all former recipients. If you have any questions regarding the awards or your current point status, please call Brian Sinclair, Chairperson, Awards Committee, at 630 307-9138.

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First Illinois Chapter News, Upcoming Events & Committee Updates *continued from page 1*

- legal issues update of merger and acquisition and valuation issues and corporate governance issues that affect financial managers;
- update and impact analysis of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003
- an update of medical malpractice issues, nationally and locally (Illinois is a "crisis" state) and strategic use of captives and Hospital Sponsored Physician Program
- how to structure physician practice acquisitions that include divestiture terms that allow for accommodation of changing market conditions and help minimize divisiveness and preserve good will between your organization and physicians.

This year's meeting will be centrally located in downtown Chicago at the Law Firm office of Gardner Carton & Douglas at 191 N. Wacker Drive. And yes, good food with choices for lunch!

HFMA Events

IT Program – November 2003

On Nov. 20, 2003 the chapter conducted a half day program entitled "What's Happening in IT? Industry Update." Mike Cohen from MRC Consulting Group and Cardinal Consulting, Inc, developed the program with assistance from Margret Amatayakul, of Margret\A Consulting.

The program began with an overview of IT happenings and trends by Mike Cohen. This was followed by a HIPAA update presented by Len Pishko, CIO at Alpha Thought, Inc. A lively panel discussion by six local CFO's and CIO's discussing their approaches to getting value and benefits from IT followed. There were lots of good, often conflicting approaches discussed, keeping the age old debate alive and well. Panelists were Andy Stefo CFO from Palos Community Hospital, Bruce Smith CIO from Advocate Health Care, Stan Kroc CIO from Children's Memorial and the CFO/CIO tag team of Jim Doyle and Frank Scafidi from Elmhurst Memorial Hospital. Margret A wrapped up the session with her ideas about a new approach to conducting IT planning.

Based on strong positive feedback from the sessions, it is likely that our chapter will establish an IT Committee to conduct educational programs on a regular basis. If you are interested in participating in such a committee, please contact Mike Cohen at (630) 653-9242.

Mike Cohen is president of MRC Consulting Group. He can be reached at (630) 653-9242 or via email at Mike@mrccg.com.

Len Pishko

Margaret Amatayakul

Panelists: Jim Doyle, Bruce Smith, Andy Stefo, Stan Kroc and Frank Scafidi

Mike Cohen

Katherine Lenhart and Andy Stefo.

HFMA Events

Revenue Cycle Impacts Under HIPAA, December 2003

On December 16th at the Carlisle, our chapter held an educational seminar covering the topic of HIPAA. Our presenter was Day Egusquiza, the president of A/R Systems from Twin Falls, Idaho. The seminar covered the following topics: Revenue cycle impacts under HIPAA; effective denial management through the use of HIPAA transaction and code sets, and privacy issues in A/R.

Our 50 plus attendees received information concerning the impact of HIPAA on the revenue cycle. Items which Day presented gave us the tools to eliminate or reduce denials, move receivables more rapidly, increase the productivity of staff, and even help redesign business processes not only in the business office but in other related areas of a health care facility.

Over half of Day's presentation covered the HIPAA transaction sets. **For Eligibility**, the 270/271 transaction set will help automatically increase clean claim submissions. Health Plans (payers) cite ineligibility and a lack of match between name and health plan number as the primary reasons they deny claims. By making the eligibility request a part of the daily batch routine or real-time processes for all payers (except for worker's compensation and liability payers, which are not considered "*Health Plans*"), we can be able to resolve eligibility issues before submitting any of our claims. We probably should consider hiring an eligibility specialist to focus on implementing an action matrix for all standard 271 payer responses.

For Referral and Authorization under the traditional manual process, revenue-cycle and utilization management staff spend considerable time pursuing authorizations and managed care referrals. The 278 referral transaction set standardizes this function, enabling us to supply required data automatically to our "Health Plans". Day said some manual follow-up may still be necessary, but it would be considerably reduced under the new automatic processes.

Attendees at presentation

Claim Submission, the 837P (old 1500 formats) and the 837I (old UB-92) transaction set are intended to standardize the claim submission process for all payers. A compliant claim may pass the "format" test, but payers have more flexibility in determining the "content" required to adjudicate the claim. Day suggested working closely with payers to determine situational requirements and, to the extent possible, help improve the payers internal processing of claims.

Claim Status, the 276 (provider asking) and 277 (payer responding) have been standardized to allow providers to more easily check claim status throughout the payment pending cycle. As result, we can become aware of pending issues earlier in the process and alert the payer, thereby ensuring that the issues are resolved more rapidly.

For Electronic Remittances, payers are now required to submit an 835 (electronic remittance) with a single, standard set of payment and adjustment codes. However, as Day pointed out, many payer-specific codes are not included in the 835 transaction format so we need to develop a crosswalk between existing remittance codes and the new standardized format codes.

Day's final presentation covered the privacy issues under HIPAA. She pointed out how and where patients have more control of their data. Providers must safeguard the privacy of the patient's health information not only in our own facility, but with outside associates. We must have agreements in place to hold our outside business associates accountable for our patients' data.

Day Egusquiza may be reached at;

Day Egusquiza
Daylee1@mindspring.com
208-423-9036

Al Staidl is Regional VP-Healthcare Services with OSI, and Membership Chair for First Illinois HFMA. He can be reached at 630-724-1197 or maris65@earthlink.net or al.staidl@osioutsourcing.com.

New Members

The Chapter welcomes the following new and transferred members:

Brian T. Anderson
Operations Analyst

Bonnita Boone
Executive Vice President
Capital Risk, LLC

Myrna Climaco
Manager, Home Health Services
Evanston Northwestern Healthcare

Tracee L. Coyle
Contract Specialist
ENH Medical Group

Lillian M. Cuevas
Account Manager
MedAssist Inc.

Bernie Encarnacion
Director, Patient Registration
Provena St. Joseph Medical Center

Kathryn Farley-Agee
Director, Provider Networks
First Health Group Corp.

Cindy Ferrari-Smith
Supervisor Physician Billing
Marianjoy Rehab Hospital

Teresa Dummer Gallo
Supervisor of Cash Application
Lake Forest Hospital

Christopher T. Gena
Student

Pamela Gozo
Vice President
LaSalle National Bank

Michael J. Hallahan
Contract Coordinator
University of Illinois at Chicago

Julie Haluska
Sales Consultant
Argent Healthcare Financial Services

Jean M. Hasse
Senior Financial Analyst
Advocate Trinity Hospital

Shawn H. Heming
Vice President

Susan M. Hull
Coding Practice Manager
AHIMA

Jeffrey A. Jopes
Administrative Director
University of Illinois at Chicago

Henri J. Kinson
Corporate Director, Internal Audit
Rockford Health Systems

June Korbas
Customer Service Manager
Lake Forest Hospital

Leslie M. Krasne
Contracting Specialist
Evanston Northwestern Healthcare

Andrew Limouris
Executive Director
Medix Staffing Solutions

Cheryl J. Lulias
Regional Director Managed Care
Community Foundation of Northwest Indiana, Inc.

Peter T. Lynch
Senior Managing Consultant
Navigant Consulting, Inc.

Samara L. Lyon
Client Liaison
Great Lakes Medicaid

Tim Powell
President
Tim Powell and Associates

Meg S. Neely
Treasury Management Sales Officer
LaSalle National Bank

Kenneth J. Pringle
Regional Finance Manager
Siemens Medical Solutions Financial Services

Brad A. Schlichting
Senior Reimbursement Specialist
Blue Cross Blue Shield of Illinois

Nathaniel Edward Sher
Vice President
Fifth Third Bank

Chris Sioulias
Executive Director
Medix Staffing Solutions

Linda Stevenson
Director, Accounts Receivable
Gateway Foundation

Elizabeth Stuller
Product Leader-Revenue Enhancement
GE Medical Systems

Lyndon D. Taylor, M.D.
President
Healthcare for Women

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The Case to Re-base (continued from page 1)

If CMS were to contemplate the re-basing initiative, the items listed below represent some of the areas where both CMS and the provider community would have to agree that there have been significant changes with tremendous financial implications. The list also can be used to chronicle the history of hospital financial operations over the last two decades. In considering the list we are reminded that history repeats itself.

1.Technology

There is absolutely no question that the use of technology has had a profound impact on the delivery of health care services. Advances in all types of technology including pharmaceuticals, computers, diagnostic imaging and communications have enabled health care organizations to do unimaginable things. While most advances in technology have had the effect of reducing costs and increasing efficiency, they have also had the effect of increasing workloads and increasing health care costs to recover the investments in technology. The existing payment systems have neither adequately rewarded providers who are able to optimize their operations, nor have they provided sufficient resources to continue investment in technologies.

2. Age of Plant

There are two types of hospitals. Hospitals that have been fortunate enough to not rely on Medicare as their primary benefactor, and those without that good fortune. In many cases, the first group have been able to continue to meet the needs of their communities by investing not only in the latest technology, but also maintaining modern state of the art physical plants. These hospitals need to be concerned, however, that as demographics change, they may need to place greater reliance on Medicare. As this occurs, the existing reimbursement levels may not be adequate to cover their investment in modern physical plants. On the other hand, hospitals that historically have been very dependent on Medicare may lack the resources to maintain an efficient physical plant. There are two adverse impacts related to this scenario. First, they may face extinction as consumers with a choice may opt to use more modern facilities. Secondly, the inefficient physical plants result in increased costs, primarily in the area of utilities. The first type of hospital may benefit from re-basing because the costs it is presently incurring would be reflected in the rate setting process. The second type of facility may benefit because the revised rates may contribute to the facilities ability to make necessary modernization improvements to improve its overall efficiency and maintain its market share.

3. Labor Resource Management

As noted above, providers do benefit from changes in the area wage index. In fact, in every one of the existing prospective payment systems, over two-thirds of the payment is adjusted for differences in area wage index. While this is a step in the

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right direction, it is still insufficient. Any changes to the wage index are applied prospectively and based on historical data. The wage data does not capture all the true costs of employee recruiting and retention. Even the proposed occupational mix adjustment is only a partial solution to the variety of labor resource management issues that challenge providers ability to succeed. Re-basing represents an opportunity to potentially "true-up" the current state of provider labor costs.

4. Malpractice Costs

Providers, particularly hospitals, are fighting an extreme uphill battle to obtain and fund necessary malpractice insurance coverage. Jury awards are increasing and providers' rate of return on malpractice investment funds are at historically low levels. Accordingly, hospitals have to pay significantly more to obtain the coverage. In order to reduce the potential for plaintiffs' successful malpractice claims, providers are incurring staggering costs in terms of risk management and litigation. These costs are not adequately reimbursed through the existing payment levels. While the actual loss experience between years may change, some of the other on-going costs would be captured.

5. Regulatory Costs

Since the inception of the inpatient PPS, providers have incurred significant costs relative to a variety of regulatory initiatives. Two notable examples include the costs associated with implementing an effective corporate compliance program and costs associated with HIPAA. A similar situation arose with "Y2K". In these examples, providers embraced the necessity and propriety of these initiatives, but have not been compensated for their participation.

6. Delivery Mechanisms

There used to be two types of patients: Inpatients and Outpatients. Presently, there is a wide spectrum within those categories. These additional categories are made necessary by the way health care services are delivered. Technology, labor resource management, and regulatory costs have been listed as reasons in support of a re-basing initiative. These factors also define how health care is presently delivered. However, the delivery mechanism is also a unique consideration in terms of the need for re-basing. There are a number of procedures that were only considered safely provided in the inpatient setting. Alternatively, due to infection control issues, a popular notion is that the less time patients actually spend in the hospital,

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Vision & Commitment:

Two Keys to True Leadership

By Tim Wright

Vision and commitment stand as two of the fundamental requisites for true leadership. The first, vision, the leader possesses and shares with members of her team. The second, commitment, the leader generates among those members. Let's explore each and then see how together they strengthen anyone's leadership abilities.

True leaders have vision. I do not mean the leaders' optical ability to see the noses in front of their faces. I mean the foresight and the drive to see what the organization can achieve for the good of its customers, its employers, and its stockholders.

As a leader with vision for the future you set the course, inspire members of your team, acquire and allocate resources, and maintain direction toward vision fulfillment.

The leader's vision—your vision— allows the organization to share four distinct strengths.

Destination. A good vision clarifies desired results. If you do not know where you are going, you cannot arrive there. A vision denotes the desired final results—final, from the current perspective. In effect, it puts the end in sight.

Direction. In laying down the destination, a vision encourages clarity of direction, of how to get there. Well stated, the vision enables—encourages—everyone involved to select methods to reach the destination. That, then, supports the entire team's determining and following common direction more readily.

Unity. All of the players involved—whether members of a unit, participants in a department, or employees of an entire organization—look, work, and move in a single direction thanks to a well-founded vision. That unity expresses complementary, focused decisions and actions.

Motivation. Destination, direction, and unity promote motivation among individuals to seek and to achieve the vision. By clearly indicating where a person, team, or entire company wants to be, how it will get there, and the ways it will work (as a whole) to journey successfully, the vision motivates the "let's get it done!" mindset.

To be truly effective the vision must be expressed in words that every person in the organization can understand, remember and implement. In effect, your vision is only as powerful as your ultimate "vision statement."

The vision statement asserts where an organization, association, department, team or individual will be in the future. The future is usually three to five years out. Still, your vision statement should be worded in present tense. Statements of "will be" or "will have" or "will do" place the vision always ahead (and just out of reach in the present sense), as the proverbial carrot in front of the donkey. To be believed as possible by all involved, your vision should be stated in the present tense.

A successfully strong vision statement blends the general and the dynamic. Broad enough to entice interest, spark attention, and motivate actions. Dynamic enough to be believable, meaningful, and specifically valuable for all who pursue it.

For a vision statement to have full potency, it must remain in the heads (memory) and hearts (inspiration) of your team members. That means express it concisely. Use active verbs. Select words that deliver punch or pizzazz and make the vision come alive.

To shape and formalize your vision statement, you may want to follow six integrated steps. Each step contributes unique value to the statement. Each step is simple—even enjoyable!—to complete.

Step 1. Encourage input. No matter how large your team or organization, invite every member who will be expected to strive for the vision to provide thoughts, opinions, data, and responses to the development of the vision statement.

Step 2. Ask questions. As thoughts, opinions, data, and responses come in, seek clarification and explanation and elaboration. As you encourage individuals to share more, they will add more value to what they say.

Step 3. Draft. Simplify. Redraft. Revise. Redraft. Vision statements start off too wordy. Cut back to essential, power-packed words. Imagine that you are sharpening a knife or polishing silver or sanding fine woodwork.

Step 4. Share it. Speak it. Show it. Sign it. Shout it. Sing it. The best test for your vision statement is to show it to the public. You will recognize your statement's strengths and weaknesses by how it feels to express it and by how others receive it. Use every format for expressing it; give your public a chance to receive it from every format.

Step 5. Invite feedback. Obviously.

Step 6. Print it. Distribute it. Believe it. Practice it. For your vision statement to make its desired impact, it cannot just be on your wall or in your annual report. It must serve as launch pad, sounding board, and filter for decisions and actions throughout your organization.

A Bonus Step. Change your vision statement if it does not work. Changes in the marketplace, your structure, the economy, your services, the regulatory environment, or your leadership/management teams may throw your vision right out the window. When that happens, throw your vision statement out also. Start over.

Tim Wright, President
Wright Results
www.WrightResults.com
512-733-6453 or
tim@WrightResults.com

New Members (continued)

Jill Terborg
Director of Admissions and Records
Oak Park Hospital

Edwina R. Vass
Cash Management Specialist
Harris Trust & Savings Bank

Paresh Vipani
Chief Finance Officer
Platinum Health Care

Deborah A. Wasurick
Manager Patient Accounts
Lake Forest Hospital

Sheila Westphal
Business Office Director
Dreyer HMO

Elvylene Yap
Cost Accountant
Rush Oak Park Hospital

Debbie Zolnierowicz
Manager of Payor Relations
Accelerated Health Systems

Six Steps to Commitment

Vision and vision statement may be the first step to generating commitment among the members of the organization, the department, the unit or the team. However, there is much more required to truly generate full-force commitment among the members.

Whether you are hospital CFO, department senior manager, or head of a specific project within your group, your leadership only works to the degree of your team's commitment. To be an effective leader, you must generate true commitment throughout your team.

Let's distinguish between compliance and commitment. We are not speaking of "compliance" in its healthcare usage: Medicare compliance, HIPAA compliance, billing & reimbursement compliance, and such. We are referring to an individual's compliance with a team's, department's, or organization's goals, objectives, direction, and motivation. In this context, "compliance" means doing what is expected, going along with the requirements. A compliant team member obediently cooperates. A compliant person may not do more than that.

Commitment means a good deal more. The team member who demonstrates commitment actively pledges or engages herself to the objectives. Rather than going along, this player "goes ahead." The committed team member channels her time, energy, efforts, and creativity—in full force—to achieve those goals and objectives.

Your objective is to can move individuals on your team from mere compliance to true commitment. Below are six actions that, taken with care and attention, heighten commitment within your team. Such commitment produces efficient and effective results, thanks to your leadership.

Educate about goals and objectives. You should provide information—in an educational format—to everyone who in anyway can impact your team's progress. The player who understands the expected results and the reasons for targeting is much more ready to commit his skills and motivations to working toward those results.

Delegate possession. Do not simply delegate the assignment; delegate ownership of the assignment. Merely handing out task responsibility only tells someone what to do. If you help a person understand what is to be done, what it will lead to, and why that is beneficial, you help her accept full ownership of her assignment.

Appreciate process and progress. By consistently observing and discussing an ongoing project, you preserve momentum toward the desired ends. No need to micro-manage. By demonstrating your active care about what is being done, you contribute to your team's commitment to succeed.

Evaluate the work being performed. Here you want to appraise the quality of the work being performed and the qualities of the work. The difference? Qualities are the separate but related steps that make up the work. Quality is the value, the worth, and the success measure of that work. Both formal and informal evaluation tools help you know degree of progress toward goal attainment.

Elaborate changes as necessary. When changes in the plan, the project, the process, the strategy, or the players occur, be certain you provide sufficient detail of the changes. You also want to provide the reasons for the changes. Review "Educate" and "Delegate" above to reinforce that respect for the "why" contributes to full ownership of responsibility.

Celebrate success. But do not wait to celebrate only the ultimate success. Give affirmative recognition to actions that lead to achievement and then the final achievement itself. Both types of recognition (and it need not be in the form of money!) cement commitment for this and subsequent projects.

Your success in generating true commitment among those on your team will go well beyond six ordinary verbs. Such success will be determined by your putting those verbs' actions to work.

The Challenge of Delivering the Elusive IT ROI

By Michael Cook

CFOs are in a unique position to help solve the elusive ROI problem with costly IT investments. This article offers strategies, processes and tools to help CFOs succeed.

Senior executives continue to be frustrated over the lack of measurable return-on-investment (ROI) on costly information technology investments. The healthcare industry is no exception - according to the 2003 HIMSS survey of provider CEOs, their number one frustration with IT was not being able to measure business value. Gartner, a respected IT research firm, goes a step further and suggests that many executives are not convinced the appropriate mechanisms for translating IT investments into business value exist. Bottom line, IT struggles with credibility problems in the executive suite and at the board level.

While there is no lack of explanations for this troubling ROI trend, many experts point to IT's transitioning to a more complex strategic role as a root cause. This advanced "change enabler" role offers great promise of ROI – allowing organizations to redesign complex business processes, facilitating major business innovations and transforming how businesses are run. But the new role also offers greater risks of failure as the business value of larger, more complex IT investments is dependent on the difficult restructuring of key business processes and governance processes not designed for these complex projects. A final by-product of this new role is the many difficulties of directly linking ROI back to the IT investment. Some high profile "poster children" of this new IT change enabler role are Enterprise Resource Planning (ERP) and Customer Relationship Management (CRM) solutions, with Computerized Physician Order Entry (CPOE) an obvious candidate.

Delivering ROI will never again be as easy as the "good old days" where information technology was primarily a substitute for labor-intensive back office tasks like payroll. The more complex change enabler role requires a modified strategy for organizations to consistently deliver ROI. The strategy needs to successfully tackle three related problems: implementing complex IT solutions; restructuring business processes to deliver the IT enabled business value and developing more effective governance processes to manage these difficult activities. CFOs are in a unique position to collaborate with their peers to develop the new strategy that delivers measurable ROI for high profile, costly IT investments.

The strategy starts by converting potential change enabler IT investment to a larger blended investment opportunity that includes all the non-IT pieces needed to deliver the ROI. In addition to highlighting all necessary restructured business processes that will deliver the ROI, the advantage of this approach includes a more comprehensive view of decision-making factors such as scope, costs, risks and value.

The next steps in the strategy include: creating a value map to identify and integrate the IT and non-IT pieces needed to deliver ROI; performing a readiness assessment to evaluate the integrated projects developed from the map for risks and corrective actions to deliver ROI; and reviewing the current governance process, since change enabler IT investments often require governance changes. The following briefly explains these steps in more detail:

1. Create a Business Value Realization Map… which provides a collaborative process and tool to identify and organize the relevant IT and non-IT elements into a series of integrated initiatives and associated outcomes to deliver ROI for proposed investment opportunities. The initiatives include the necessary business process changes, organizational changes, IT solutions support, human resource requirements, training and other needed business changes to deliver the expected outcomes. Outcomes, either economic or strategic (i.e. patient safety) should be measurable and quantified. And relevant business assumptions supporting the initiatives and their associated outcomes should also be included. The importance of this map is the linking of IT capabilities to the restructured business processes and detailed quantified outcomes that provide the basis for ROI.
2. Perform a readiness assessment for the integrated projects… that allows the organization to perform a "gap" analysis of needs against current resources and capabilities to successfully deliver the projects. This step is performed after a set of integrated, detailed projects is created from the above map, researched and approved as potential solutions. The assessment should address at least the following five areas: business processes changes required; people/skills availability; management support processes i.e. change management; organizational support for the projects; and IT capabilities or options, including how the projects will fit into the current IT Architecture.

   This readiness assessment provides an ideal checkpoint to identify risks and corrective actions needed to successfully deliver the investment. It's also a good point to risk adjust the ROI if appropriate.
3. Evaluate current governance support for change enabler IT investments… candidate processes to start with include: (a) Accountability for the ROI; (b) ROI Measurement System to support Accountability; (c) Change Management Skills to facilitate the delivery and acceptance of complex busi-

 (continued from page 10)

ness changes; and (d) Project Management Skills to manage the integration and delivery of multiple complex projects:

- *Accountability…* a single senior executive should sponsor the set of integrated projects (IT and non-IT) of the blended investment opportunity. The sponsor should be willing to be held accountable for approved ROI, including any budget implications. For this process to be effective, the sponsor must be senior enough to have the power and authority to remove barriers and hold staff accountable for results. Accountability should be tied to annual goals, compensation and bonuses for all key staff involved in delivering the ROI. Without this accountability, expecting ROI to be delivered is unrealistic.
- *ROI Measurement System…"* if it's not measured it's not managed". The system needs three components to be effective: (1) ROI outcomes that are specific, measurable and quantified (this also applies to strategic value such as patient safety); (2) a baseline measurement for the ROI outcome targets prior to starting the projects; (3) and a process to measure and collect the ROI outcomes. The measuring, tracking and reporting should be on going to insure the value continues to be delivered. Please note that reporting systems are not easily implemented because the required information is not generally a by-product of existing systems. However, effective ROI accountability without measuring systems is not possible.
- *Change Management Skills...* resistance to change is fairly common and since change enabler IT investments are dependent on restructured business processes for ROI, proactive management of change is important. Superior change management skills to engage staff in understanding, incorporating and accepting business changes are needed for success. If your organization does not have a solid track record of change management success then improving these processes should be high priority before undertaking such projects.
- *Project Management Skills…* the skills, processes and tools needed for complex change enabler IT investments are greater than those needed for typical IT projects. Skills for review include: coordinating multiple integrated projects with major business pieces vs single IT projects, project scope that includes complex business process changes vs. IT functional capabilities, ROI focus vs IT project time and cost focus, and ROI accountability vs IT project accountability. Adding these advanced project management skills is necessary to manage the delivery of ROI.

In summary, IT is transitioning to a more strategic business "change enabler" role. This new role requires revised strategies, processes and tools to deliver ROI. And this article introduces CFOs to many of the important changes needed and provides a "starter kit" to help champion the necessary changes – ideally in time for CPOE decisions.

Michael Cook is a Principal of Cardinal Consulting Inc. (CCI). He can be reached at: mikecook@cardinalconsulting.org or 630.832.8206

the better it may be for all parties involved. The existing payment methodologies may not adequately address the most appropriate point of service for various types of procedures.

Another aspect of the delivery system relates to the variety of physical settings that presently exist. Now patients can choose specialty hospitals, ambulatory surgery facilities, oncology centers, even physician offices for certain services. Although some of these settings may have their own unique payment system, hospitals need to be cognizant of their existence. Hospitals must package their offerings to remain competitive with these alternative sites. In addition, from a policy prospective, CMS may look to equalize payments across these settings, which could be detrimental to hospitals.

7. Acute Hospital Closures and CAH Conversion

In a pure market based environment fewer competitors would generally be regarded as a "good thing". This may not be the case with the provider community, particularly among acute hospitals. The positive attributes of fewer hospitals are less competition for admitting physicians, patients and talented labor. Alternatively, this situation means that the remaining hospitals get more of the sicker patients and may have to pay more for other goods and services, as suppliers may not need to compete as aggressively to get and maintain business from the remaining hospitals. From the perspective of rate setting fewer hospitals means each hospital contributes more to the overall rate base. This also means that errors (i.e. fringe benefits omitted from the wage index calculation) can have a more detrimental effect. In addition, fewer hospitals mean fewer members to support beneficial advocacy initiatives.

Small hospitals (less than 25 acute beds) located in primarily rural areas may be able to convert to Critical Access Hospital (CAH) status. Hospitals satisfying certain conditions may be eligible to receive full cost reimbursement (101% of cost under MPDIMA, 2003). Historically, these facilities tended to be located in more remote areas. This may be changing due to changes in the regulations. Hospitals should consider how CAHs might impact the re-basing discussion. Like closed hospitals, CAH facilities are excluded from all the rate base calculations. Although these facilities are smaller, they tend to have higher cost per day or discharge due to significant standby costs associated with low patient volumes. Similarly, due to length of stay requirements under the CAH rules, these hospitals will need to transfer their sickest patients as early as possible to nearby acute facilities. Although CAHs often lack the resources to do so, theoretically they could adversely impact the labor situation since the full cost reimbursement would enable them to pay at sufficient levels to attract labor away from "traditional" hospital settings.

8. Impact of Other PPS Systems

As noted above Medicare first implemented a prospective payment system for inpatient acute services. This was followed by PPS for inpatient capital costs, home health services, skilled nursing facilities, outpatient services and inpatient rehabilitation facilities. Now there is a proposal for inpatient psychiatric services. With each additional prospective payment system there are two consequences that are not mitigated through the rate setting process for either the existing PPS services or the newly implemented PPS.

The most obvious consequence is the provider's inability to treat patients in the appropriate setting in a cost effective manner. For example, when hospitals received cost reimbursement for skilled nursing facility services it was often appropriate to discharge the patient from the acute setting to the skilled nursing facility with the confidence that the reimbursement would compensate the facility for the cost of providing the necessary care. When the SNF PPS was implemented, the question became where would the hospital lose less money. As a result many hospitals have closed their skilled nursing units.

The second consequence is that the costs associated with implementing the new PPS mechanisms are not built into the existing systems or the new system. This is caused by the fact that since the rates are based on historical cost data, implementation costs will come after the base period and continue well through the "phase-in period". These costs "fall through the cracks". Now that virtually every type of service has a prospective payment system, all the implementation costs should be incurred. Re-basing provides the opportunity to identify these costs with a view towards their inclusion in the payment rate base.

9.Impact of Managed Care

In addition to costs associated with regulatory initiatives and the impact of other prospective payment systems, the explosion of managed care arrangements has had a tremendous impact on rate setting issues. Managed care represents a combination of regulatory and other PPS costs. In that each managed care contract is different in some way or another, hospitals have been forced to tailor their operations to these contracts. This creates additional cost that is neither reimbursed through the contract itself or through the Medicare program. The reimbursement under the contractual arrangements may be related to costs, but are more likely correlated to the existing Medicare payment formulas or some market based data. Conversely, the Medicare program may be looking to create program savings by looking more closely at private contractual arrangements. There is already some evidence of this pattern with respect to discount pricing for reference laboratory services. It is possible that success in the laboratory arena could be attempted for other payment systems. Hospitals should monitor developments in this area closely due to the potential long-term implications.

10. Demographics

Just as hospitals are aging, so are their patients. One aspect of technology is that patients are living longer. This also means that by the time patients are getting to the hospital they are more likely

sicker than previously thought. Rebasing would provide the opportunity to identify and quantify the true additional costs associated with treating this aging basis. Providers would have some confidence that the base rates would reasonably reflect their current cost structure.

Healthy Prescription

This article has demonstrated many ways in which a rebasing initiative could be "just what the doctor ordered." Providers would have an opportunity to state their case for increased payment levels. Similarly, CMS (and other payors) would have the opportunity to demonstrate the inherent reasonableness of their existing payment levels. In either case the argument would be based on current data, prepared in a consistent manner.

Recipe for Disaster

There are also many significant challenges to a re-basing initiative. There are all the implementation issues. These include establishing an appropriate time frame, defining audit objectives, communicating the results, defining a potential appeal process and finally using the results. Since any changes would have to be budget neutral, there may be significant disparity from the present "winners" and the ultimate "winners." Those changes may be difficult to accept. The result of the audit process on individual facilities may be a harsh wake up call as auditors may make significant adverse determinations regarding the reasonableness and allowable nature of certain categories of cost.

Conclusion

It may be time for CMS to consider rebasing its existing payment systems to reflect the current realities of provider facilities. There are many benefits to this concept, although not without potential risks. Presently, this is just a "water cooler" topic, but it may be worthwhile to consider the factors outlined above in discussions about the adequacy of payment levels both in the context of provider advocacy as well as negotiations with payors other than Medicare.

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Mike Nichols is a Director, Health Care Consulting, RSM McGladrey. He can be reached at (630) 588 0450 (email: mike.nichols@rsmi.com)

Highlights:

Medicare Prescription Drug, Improvement, and Modernization Act (DIMA)

Overview

In late November 2003, Congress approved the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003," which President Bush signed on December 8. The $395 billion measure adds a new prescription drug benefit for Medicare beneficiaries, starting in 2006, and, starting in 2010, a demonstration program to encourage private health plans to compete with traditional Medicare to offer coverage to beneficiaries. The legislation also:

- Increases Medicare payments to rural hospitals and physicians;
- Includes an incentive for employers to keep their insurance coverage for retirees;
- Establishes a program to issue Medicare-endorsed prescription drug discount cards starting in April 2004;
- Allows taxpayers to set aside tax-free funds in health savings accounts (HSAs) for healthcare expenses; and
- Provides qualified low-income beneficiaries with cost-sharing support and premium assistance.

Reimbursement Changes

The bill proposes $25 billion in payment improvements for providers. Key provisions include:

Hospitals:

- Permanent uniform hospital standardized payment amounts
- Full market basket increases to hospitals that submit quality data for 2005 through 2007; hospitals that do not participate will receive market basket minus 0.4 percent
- Indirect medical education payments of 6 percent for the last half of FY04, 5.8 percent for FY05, 5.55 percent for FY06, 5.35 percent for FY07
- Changes to the labor share of the wage index, from 71 percent down to 62 percent for low-wage areas, with all other areas held harmless
- A 12 percent increase in the cap for Medicare disproportionate share (DSH) payments for small rural and urban hospitals (up from the current 5.7 percent)
- A 16 percent Medicaid DSH increase in 2004; low-DSH states will get 16 percent annually for five years
- Increased payments to critical access hospitals (CAHs) to costs plus 1 percent
- Hospitals that would otherwise qualify to become a CAH except for their having a psychiatric or rehabilitation unit may qualify if such units are not more than 10 beds
- Continuation of the outpatient PPS hold harmless provision for two years for rural hospitals with fewer than 100 beds and sole community hospitals (SCHs)

Physicians and others paid under the Medicare physician fee schedule:

- Replacement of the November 1, 2003, physician fee schedule reduction of 4.5 percent with a 1.5 percent increase for 2004, and provision of another 1.5 percent increase in 2005
- Changes to the physician payment formula will be based on a 10-year rolling average of the gross domestic product (GDP), instead of the current single year measure
- Areas with the geographic payment adjustment below 1.0 will be increased to 1.0 from 2004 through 2006
- Bonus payments of 5 percent for three years to physicians delivering care in areas with few physicians (both primary care physicians and specialists)
- A moratorium on therapy caps for 2004 while Congress and CMS work on an alternative to the caps

Home health:

- Elimination of the proposed co-payment provision
- A payment update of market basket minus 0.8 percent for the last three quarters of 2004 through 2006
- Bonus payments for rural providers, amounting to 5 percent for one year beginning April 1, 2004

Ambulances:

- Payments will be based on regional

floors, with adjustments for low-population rural areas
- Across-the-board adjustments for two and a half years of 1 percent for urban areas and 2 percent for rural areas

Durable medical equipment:
- Rates are frozen from 2004 through 2006, with rates for the top 5 services adjusted to reflect prices paid in the Federal Employees Health Benefit Program
- Competitive bidding for the largest metropolitan statistical areas (MSAs), to begin in 2007, expanding to 80 MSAs in 2009

Specialty Hospitals

For new specialty hospitals, the legislation imposes an 18-month moratorium on the current regulation that permits physicians to have an ownership interest in a "whole hospital." The definition of "new" excluding those under construction or in operation before November 18, 2003. Existing specialty hospitals are permitted to add the greater of 5 beds or 50 percent of the beds on their current campus. During the moratorium, the Medicare Payment Advisory Commission (MedPAC) will conduct an analysis of specialty hospitals' costs and whether the payment system should be refined, and the Secretary will examine referral patterns and quality of care issues. The mortorium goes into effect for referrals on or after January 1, 2004.

Medicare Advantage

The legislation establishes a new Medicare managed care program, called "Medicare Advantage." Between 2004 and 2010, the current Medicare+Choice program will be replaced by Medicare Advantage. Starting in 2004, all plans will be reimbursed at a rate at least as high as the rate for traditional fee-for-service (FFS) Medicare. The legislation also encourages health plans to offer coverage not just in one state or one part of a state, but in multi-state regions.

Starting in 2010, CMS will establish up to six demonstration sites for a "comparative cost adjustment program." Health plans will bid to offer coverage to beneficiaries at these sites. All plans, including the traditional Medicare FFS plan offered in that area, will be paid based on the demographic and health risks of enrollees. If the traditional FFS plan disproportionately enrolls high-risk beneficiaries, beneficiary premiums will be adjusted to compensate.

Health Savings Accounts (HSAs)

Under Title XII, the bill allows people with high-deductible health insurance policies — at least $1,000 a year for individuals and $2,000 for couples — to shelter some income from taxes. Individuals less than 65 years old, employers, or family members could make pretax contributions equal to the deductible, up to a maximum of $2,250 a year for individuals and $4,500 for families. After age 65, earnings and distribution also would be tax-free. In addition, the bill provides a 28 percent excludable subsidy for employers that maintain retiree prescription drug coverage once the new drug benefit starts in 2006.

Drug Reimportation

The legislation allows drug reimportation from Canada if the drugs are certified as safe. The reimportation provision also requires HHS to study the major safety and trade issues regarding reimportation. The legislation modifies rules relating to a pharmaceutical company's 180-day exclusivity period for generic drugs. Specifically, it enables multiple companies to qualify for the 180-day exclusivity if they all file their application on their first day of eligibility. Additionally, the legislation contains provisions relating to declaratory judgments, which are designed to accelerate a generic company's ability to enter the marketplace.

Publication Information

Editors 2003-2004

Jim Watson.....630/571-6770 jim_watson@pbcgroup.com
Elizabeth Simpkin.....773/736-5146 elizabethsimpkin@msn.com
Mike Nichols.....630/588-0450 michael.nichols@rsmi.com

Advertising
Jim Ventrone.....847/550-9814 jmv@ventroneltd.com

Design
Jody Simons.....312/226-2227 jody@pubsol.net

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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 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.

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A Newsletter from HFMA's First Illinois Chapter

Healthcare Financial Management Association First Illinois Chapter

2003-2004 Calendar

Month	Responsible Committee	Format	Date	Location
February	Medical Group Practice	Full day	Thursday, 2/19/04	Gardner, Carton & Douglas Chicago, IL
March	Managed Care	Full day	Thursday, 3/25/04	The Carlisle Lombard, IL
April	Continuum of Care	Half day	Thursday, 4/15/04	IHA Naperville, IL
May	CFO	Full day	Friday, 5/7/04	TBD
May	Annual Golf Outing	Full day	Friday, 5/28/04	TBD

www.FirstIllinoisHFMA.org

Have you checked the website lately? This is your one-stop source for all kinds of chapter news and information. Features include:

- Committee chairs and officers directory – who to call, how to get involved
- Calendar of Events and upcoming program announcements – see the hot new topics and speakers
- Online registration – save time and register by email (sorry, no credit card processing yet)
- Newsletter archives – find that great article from a past issue

The Website Committee is working hard to provide more features and functions all the time. Frank McHugh (chair), Morley Kerschner and Athena Peterson have volunteered to help bring our Chapter communications into the 21st century. To learn more, or join the committee, please go to the website and choose "Contact Us" to send an email.

The First Illinois Chapter

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