hfma healthcare financial management association

first illinois speaks

A Newsletter from HFMA's First Illinois Chapter

January 2008

2008 Form 990 – "Warning Will Robinson"

MAKE A DIFFERENCE

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Highlights and Recap
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For our readers over the age of 40, you may remember a television show from the 1960's – "Lost in Space". One of the duties of the family's robot was to protect them as well as alert them as danger approached. You would often hear the robot exclaim "Warning Will Robinson", arms flailing and taking a defensive position as his sixth sense was triggered.

The following summary will provide an "early warning" to those in the hospital industry regarding changes that the Internal Revenue Service is contemplating with respect to Form 990 and related schedules.

Background

The redesign of the Form 990 is the first major revision since 1979 and is based on three guiding principles:

- Enhancing transparency to provide the IRS and the public with a realistic picture of the organization, along with the basis for comparison to other organizations.
- Promoting compliance by accurately reflecting the organization's operations so the IRS may efficiently assess the risk of noncompliance.
- Minimizing the burden on filing organizations.

The redesigned Form 990 consists of a 10-page core form to be completed by each Form 990 filer. In addition, the redesigned form's 15 schedules are designed to require reporting of information only from those organizations that conduct particular activities.

It is estimated that hospitals will be required to complete 10 of the 15 add on schedules. The Internal Revenue Service issued the draft forms and schedules on June 14, 2007 for public comment, with the comment period ending on September 14, 2007. As of

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Inside This Issue

Letter from the President

Happy New Year!

So the holidays are over, and we begin a new year. I hope your holidays were full of fun, family and friends. The holidays are always a good time to reflect on the many blessings we have and give thanks. I don't know about you, but after the holidays there's a certain "come down" for me after all the hustle, bustle and excitement of that great stretch from Thanksgiving to New Year. (At least last year we had the Bears run to the Super Bowl to keep us entertained; as of press time that didn't look too hopeful this year).

We all start the New Year with goals and objectives in mind; personally and professionally. 2008 is shaping up to be an interesting year in healthcare, and history may look back on 2008 as a turning point in healthcare. We enter the year with CMS proposing to cut physician reimbursement by 10%, and proposing to move to "value based purchasing" which means hospitals' Annual Payment Update will be tied to certain performance measures. There is a laundry list of other regulations proposed (i.e. hospital tax-exemption status), prior regulations being re-tooled (i.e. Stark), and moreover, a general sense that healthcare tomorrow will be much different than healthcare today. We will end the year with a new U.S. President, capable of dramatically changing the current healthcare landscape.

But we can't worry about what could come, we can only try to influence it and prepare for it, with an open mind and a positive attitude. While the U.S. healthcare system is among the finest in the world, it is also fraught with problems. If we as healthcare professionals don't drive the effort to fix it, someone else will do it for us. So these regulations we speak of, the payors that want to determine our reimbursement and reimbursement policies, are already in motion with considerable momentum. Our industry needs to change its paradigm and grab the reins.

It's becoming clear that the days of the independent, stand-alone hospital and medical practice are ill-equipped for the new era of healthcare. It is not a level playing field. We've seen rapid consolidation of the commercial payors in the industry, and CMS is beginning to act more like them than the traditional government agency it has always been. For us to position ourselves successfully, we can take a cue from what we see happening on "the other side". Specifically, aggregation of resources to create efficiencies to improve the end product; much like we've seen in the U.S. auto industry, hotel industry, and banking industry. As someone pointed out to me at a recent HFMA event, referring to the healthcare industry, "your costs are killing my profits".

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First Illinois Chapter News, Upcoming Chapter Events & Committee Updates

■ Certification Committee

"HFMA Certification: Some Journeys are Best Shared with Others

Oftentimes, when someone sets out to reach a personal goal, success is not always predicated on that individual's commitment and effort towards that achievement. Whether the goal is to climb a mountain, run a marathon, or lose weight, the likelihood of success can be helped immensely by the support of others, including those who wish to achieve the same goals.

The same can be said when one makes the decision to go through the HFMA certification process. Whether an individual seeks to enhance their own education about the healthcare industry, improve their chances to be promoted or earn a higher salary versus one's peers, or simply desires the opportunity to face and overcome a difficult challenge; the choice to become certified demonstrates a commitment to personal growth and development. Sometimes, however, once an individual has chosen to pursue the path towards certification, it helps to have the company of others on the journey. And for the organizations that encourage and support their employees along the way, the reward can be even greater than merely a more skilled and knowledgeable workforce.

An example of one organization that has reaped the benefits of the HFMA certification program is the University of Illinois Medical Center. In late 2005, two members of the Finance and Business Planning & Decision Support staff, both of whom were members of the First Illinois Chapter of HFMA, met with their Director, also a HFMA member, about their interest in going through the certification process. After attending a chapter-sponsored education session about the program, the three individuals decided to form a study group to review the materials associated with the HFMA exams. Since the Director was aware that there were no certified employees within the Medical Center at the time, he decided to send an invitation to the other members of his staff along with the Directors of several other Medical Center departments, including Patient Accounting and Managed Care as well as the Physician billing unit associated with the University of Illinois at Chicago College of Medicine. To his great surprise and delight, the Directors of the three departments and eight other individuals accepted the invitation to join the group.

After acquiring the HFMA study guides for the core course and all four specialties, the fourteen members of the study group met for the first time in January 2006 to review the materials for the core exam. Together, the group developed a

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Certification Committee *continued from page 2*

14-week study plan in which they would cover one or two chapters from the study guide each week. Each individual was assigned one week where they would be the group leader and responsible for preparing study summaries and leading the study discussion with the other members. In many instances, the weekly group leader was the recognized "expert" for a given set of materials such as Accounting, Patient Billing, or Managed Care. For sections where no expert existed, some members volunteered to do additional research in a particular area to share that knowledge with the rest of the group.

Over the course of the fourteen weeks, the group met during a designated lunch hour each week to review the assigned materials for the core exam. Upon the completion of the review course in April 2006, most members of the study group began sitting for the core and specialty exams. Since that time, six individuals have passed both exams to become eligible for certification and five others have passed either the core or a specialty exam. Along the way, the members provided support to one another which helped many in the group stay on track with their studies and offered encouragement to those who were not initially successful in passing an exam to ensure that those individuals would try again and be successful in their next attempt. Additional study groups have since been formed by some of the original members for other Medical Center staff not involved in the first group in an effort to continue the commitment to this important development program.

HFMA
CERTIFICATION

Committment to personal growth.

While the primary goal of the study group program is to support each individual in his or her attempt to successfully complete the HFMA certification process, there have been even greater benefits to the Medical Center organization than simply an HFMA certified staff. Some of the biggest benefits of the program have been a greater camaraderie developed amongst the different group members and an increased awareness on the part of each participant of the healthcare finance issues in areas outside their own specialty.

For example, while much of the conversation covered during the weekly sessions focused on the study guide materials, many of the meetings evolved into discussions about how those topical areas worked within our own organization. All of the group participants soon discovered that, with their better understanding of areas that they might not have been exposed to during the course of their day-to-day work, there were opportunities to improve some practices and better coordinate efforts between departments for other processes. Some of the opportunities identified during these meetings ultimately led to several new revenue cycle and process improvement projects that subsequently resulted in several millions of dollars in improved financial performance and cash flow for the organization.

In the end, the investment of time and energy by those individuals who successfully complete the HFMA certification process can result in tremendous returns in terms of their personal and professional growth. And for those organizations that support and encourage this personal development, the return on their investment can sometimes mean a real impact to the bottom line. That positive impact makes the certification process a journey worth taking together.

Robb Micek, CHFP
Chair, Certification Committee
First Illinois Chapter, HFMA

President's Message

CONTINUED FROM PAGE 2

So as we enter 2008, let's embrace this new era of healthcare and help influence where our industry goes. HFMA's goal for 2008 is to be there for you, providing training and educational forums through which we can share ideas on how to do that. Both locally with our First Illinois Chapter HFMA programs and through HFMA national programs,

HFMA delivers knowledge that is national in scope but local in application. Thanks for being part of this movement, part of this "think tank", and may 2008 be a great year for you personally and professionally. Each of us has an opportunity to make a difference.

Letter from the Editor

Happy New Year! It's time to start setting a few New Year's resolutions that 90% of us will probably break by February 15, including myself. One resolution that I will try my hardest to keep, is to stay on schedule with the release of the newsletter.

I have really enjoyed editing the newsletter and would not be able to do it without the help from others. I want to acknowledge Carol Pistorio and Susan Melczer for helping edit all of the articles that I receive from our members. I don't think I could meet the deadlines without them. I would also like to thank all of the committee chairs for submitting the promotions and recaps of their committee events on time. Without everyone's support, it would simply be a newsletter that changed colors each quarter.

Speaking of color, I have chosen to print this newsletter in green for the new craze of "going green", the approaching spring season with the leaves coming back, and last but not least, tax season that is right around the corner. If you have an idea or recommendation for the color of our next newsletter in April, please contact me.

I will be the first to admit, I am not perfect and everyone makes mistakes. Believe it or not, there have been a few minor mistakes in the August/September and October newsletters. I apologize to the authors whose articles were misprinted. The electronic files of the updated newsletters for August/September and October have been corrected and re-posted on our website at www.firstillinoishfma.org/newsletter.htm

To make sure you don't miss any of the information in this newsletter, here's a summary:

Articles

As always, if you have an article for future newsletters, please forward them to my attention.

Amanda Springborn
amanda.springborn@rsmi.com

Founders Merit Awards for 2007

BY BRIAN SINCLAIR, VICE PRESIDENT, DNL HEALTH CARE SERVICES, INC. AND CHAIRPERSON, AWARDS COMMITTEE

Congratulations are in order for the recipients of the 2007 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.

The awards program is a merit plan, which assigns a range of point values to specific chapter activities, such as committee participation, educational presentations, and serving as a chapter officer. The Follmer Bronze Award is awarded when a member has accrued 25 points, the Reeves Silver Award is earned after an additional 25 points are accumulated, and the Munice Gold Award is presented after a final 50 points are earned. A fourth award, the Founders Medal of Honor, may be conferred by nomination of the Chapter Board of Directors to qualifying members. This award recognizes significant continuous service after completing the medal program.

The 2007 award recipients are:

Follmer Bronze Award

Janet E. Blue
Susanna E. Krentz
Gregg A. Mylin

Reeves Silver Award

Catherine Jacobson, FHFMA, CPA
Carl A. Pellettieri, Jr.
Elizabeth M. Simpkin
James L. Watson
Pamela M. Waymack, FHFMA

Muncie Gold Award

Gail A. Walker

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 847-227-2268.

CHAPTER UPDATE

On-Line Registration Updates Coming Soon

First Illinois has contracted with a company called CVENT to help manage the registration process. Beginning with our February program, on-line registrations will be handled via CVENT. This change will be totally transparent to our membership; the program announcements will still come from FI HFMA, and on-line credit card payment security will be managed by our existing FI HFMA secure website. CVENT will create better efficiencies for us and our membership, reducing the workload for our volunteers and also providing value-added data information on registrations. We encourage you to utilize the on-line registration capability whenever possible, which will also help reduce our administrative expense and provide better educational program capabilities.

Editor's Corrections to the August/September Issue

- Page 1: The Uninsured Population and the Rise of Bad Debt is continued on page 12, not page 11
- Page 13: The Differences in Automated Medicaid and Charity Applications was written by Ryan Brebner and Chris Thunder, not Robert Jacobs

Editor's Corrections to the October Issue

- The article "Improve Healthcare Building Environments to Improve Staff Satisfaction" was not in the October issue, but is included in the January issue.
- Bronze Sponsor : Zeigler Capital Markets was spelled incorrectly on the back page.

Illinois Patient Access Management

October 9, 2007 at Medieval Times

BY KATHERINE MURPHY

On October 9, 2007, First Illinois HFMA co-sponsored a Fall Conference and Vendor Faire with aIPAM (association of Illinois Patient Access Management) at Medieval Times, a Renaissance themed entertainment and dining establishment in Schaumburg, IL. "Knights of Shining Access" attendees were greeted by aIPAM associates in colorful medieval costumes and were treated to a lunchtime equestrian show complete with jousts and swordplay.

The nearly 200 attendees listened to presentations about consumer-driven healthcare, automated workflow and regulatory compliance. Also presented was an emotional first-person description by a former Patient Access Director at a New Jersey Hospital which was a major receiving center for the victims of the September 11, 2001 tragedy. Overall a grand olde time was had by all as they feasted on hot pretzels and cotton candy and we expect another popular mix of information and entertainment at the spring aIPAM conference: Access Takes Center Court, Thursday, March 6, 2008 at the Oak Brook Bath and Tennis Club.

NAHAM & HFMA, Bobette Gustafson

NAHAM & HFMA, Bruce Nelson & Julie Haluska

NAHAM & HFMA, Rob Jacobs, Attendee

NAHAM & HFMA, Uday Ali Pabral

NAHAM & HFMA, Steve Gruner, Suzanne Williamson, Dan Western, & Lee Remen

CAVEAT EMPTOR:
The Savvy Healthcare IT Decisionmaker
November 15, 2007 at Aramark in Downers Grove

BY JOHN BRUGIONI

The specific focus of this conference was to enable each attendee to rationally and creatively address the following five questions:

- Are you truly wired or only heavily invested?
- Do vendor relations provide valuable IT benefits or do they leave you burned and bloodied?
- Do you know how to earn more and keep what you earn through innovative payment and banking relationships?
- Can you protect hard-won IT initiatives from corruption and compromise by cyber-villainy?
- What technologies are payers and employers using to manage chronic diseases and control case costs?

The framework for logically answering each of these questions was constructed by the initial keynote speaker, Steven Berger, FHFMA, CPA, President of Healthcare Insights, LLC. His 10 Tools and Techniques Required for Effective Financial Outcomes highlighted the essential elements and objectives of IT applications which are absolutely necessary, not discretionary, for financially responsible and effective health care executive leadership. The executive information arsenal he described included; Daily Dashboard, Balanced Scorecard, Benchmarks, Flexible Budgeting, Labor Management, Non-Labor Management, Service Line/Physician/Patient Level Reporting, Cost Accounting and Denials Management. A prevalent theme in Mr. Berger's presentation was mandatory accountability and stewardship in carrying out our health care missions.

Steven Berger's compelling argument was carried over into 3 Best Practice Case Studies. These studies were carefully crafted by the speakers to emphasize specifically what to do and what not to do when fashioning a solution by the attendees to their own similar organizational problems. The presentations enabled the audience to look over their shoulder and go to school on the enlightened efforts of their respected colleagues in realizing optimal IT solutions to create financial performance breakthroughs. Thomas Smith, CIO of Evanston Northwestern Healthcare (ENH) discussed the collaboration between Epic and ENH in EMR implementation, with a positive outcome assessment 4 years after going live. Kevin Goodwin, Executive Director of Radiology Associates of Milwaukee, SC and Robert Kebbekus, President and CEO of Dominion Medical Management illustrated a technology driven, highly automated revenue cycle management solution for a radiology group practice which is a matter of paramount importance to First Illinois members with physician organization mandates. Seth Avery, JD, CPA Partner of Applied Revenue Analytics described guiding principles and practical methods to determine and communicate a myriad of prices transparently to stakeholders to optimize enterprise financial and marketing strategies in an era of increasing public scrutiny and consumerism.

After lunch, conference attendees were immersed in thorough examinations of three important hot button issues. David Kanzler, Tatum Partners, CFO LifeMasters Supported Self Care described the deft application of information technology within the framework of chronic disease management to enable practitioners, payers and employers to preserve and direct finite resources towards the focused application of evidenced-based practice guidelines, with engaged patients empowered to affect an active role in the management of their conditions. The financial and ethical ramifications of effective chronic disease management were obvious. Aimee Trepiccione, Vice President of Health Care

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IT Chairman, John Brugioni

IT Seminar, Aimee Trepiccione

IT Seminar, David Kanzler

HFMA Events

HFMA 101

"It's About You"

September 20, 2007 at Aramark in Downers Grove

BY GUY ALTON

HFMA 101 - Guy Alton

Over forty HFMA members, some veteran and many new members, attended the 3rd annual HFMA 101 program on September 20th, 2007 at the Aramark Corporate Headquarters in Downers Grove. The day's activities were meant to acquaint new members with First Illinois Chapter HFMA leaders, become familiar with HFMA National and the First Illinois Chapter as well as volunteer and personal growth opportunities.

Jim Watson led the program with an overview of what HFMA and the First Illinois Chapter are all about, sharing our mission, vision and strategic plans and opportunities.

Jim Heinking, former Chapter President and Regional Executive-Elect, shared his experiences and gave ideas to all on how to maximize their HFMA membership.

Brian Sinclair and Janet Blue did a wonderful job of explaining what volunteer opportunities are available to members. Everyone reiterated the theme that the best way to learn, make new friends, and network is to get involved with a committee.

Robert Micek did a great job of explaining the certification program and process. Certification is a great way to help further your career and should definitely be a part of your career plan.

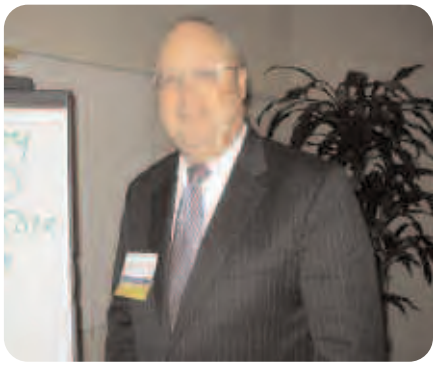
The entire half day program stressed what HFMA is all about – education and networking. If you missed this year's program, watch for the 2008 program in September. We hope to see many of you there!

HFMA Events

The Savvy Healthcare IT Decisionmaker (continued from page 7)

Strategy, JP Morgan Chase Bank, discussed one of the hottest of the hot button issues, Healthcare Banking. Ms. Trepiccione described cutting-edge bank technologies to support providers, payers and patients with integrated healthcare claim and payment solutions. The rapidly approaching pervasive application of health care banking presents distinct challenges to be faced and opportunities to be embraced by IT decisionmakers in enhancing provider revenue cycle management. Finally, Michael DeGraff, of HIPAA Academy described the state of IT security, or perhaps lack thereof, in health care institutions. He described an integrated framework to critically assess and fortify provider defenses against hackers and physical security risks to comply both with legal and regulatory requirements and also to observe the fiduciary responsibility of health care executives in protecting financial and clinical information from corruption, destruction or compromise. Mr. DeGraff's insights were both eminently practical and valuable.

During the day each of the faculty proved themselves expert in their subject knowledge and competent as engaging platform speakers. However more importantly, as genuinely likable colleagues, they personally engaged the audience in numerous dialogues which produced a synergistic and spirited exchange of views and professional experiences. And after all that truly is the purpose of this and every conference, to confer, i.e. to create a genuine conversation among all those present, to share and learn from each other. The formal program was followed by an Ice Cream Social sponsored by ISI Telemanagement Solutions, Inc. through the involvement of Kenneth Rothacker, a member of that firm and the IT Committee.



IT Seminar, Tom Smith

IT Seminar, Seth Avery

UPCOMING EVENTS

FEBRUARY 9, 2008

Winter Social at the Drury Lane Dinner Theater in Oak Brook.

"The Goodbye Girl" Dinner Theater

Directed By: Gary Griffin

This light-hearted romantic, musical comedy is the story of, a single mom and an opinionated actor, with a lease to sublet her apartment that she has no intention of giving up.

Save the Date!!!

UPCOMING EVENTS

HFMA Managed Care Program Preview

Every year the HFMA Managed Care Committee hosts a day-long program designed to inform, excite, and motivate attendees to be on the cutting edge for their respective organizations. Our 2008 program is shaping up to be one of our best yet! Please join your colleagues on Thursday March 20, 2008 to hear insights and share ideas on:

Hot issues and strategic trends in healthcare and why they are important to all of us .....(Kaveh Safavi, MD, JD)

IPA/PHO trends – what can physicians expect?..... (John Marren - Hogan Marren, Ltd)

Key healthcare legislative initiatives under consideration.....(Elena Butkus - Illinois Hospital Association)

Wellness: Learn how one managed care company is differentiating itself .....(Sherry Husa, Dr. Terry Fouts - Great West Healthcare)

What are the key drivers of federal Medicare managed care programs and state Medicaid managed care programs.....(Keith Kudla - Wellcare)

Dissecting the complicated Medicare payment system: A good review for all managed care executives.....(Jin Li MD, HSM International)

New tips for managing behavioral health care ..... (James Costibilo - Ressurection Healthcare)

And back by popular demand: An interactive discussion with The Payer Panel!
Listen to key executives from the top Chicago-area managed care companies discuss their priorities and strategies and how they will affect our organizations.

Meeting Specifics

Date:	Thursday, March 20, 2008
Location:	University Club 76 E Monroe St Chicago, IL 60603 (312) 726-2840
Presented By:	The Managed Care Committee First Illinois Chapter HFMA

This year's social hour will be sponsored by: Great-West Healthcare

CMS Releases Plan for Medicare Hospital Value Based Purchasing

BY MICHAEL APOLSKIS

In November 2007, the Centers for Medicare & Medicaid Services (CMS) presented Congress with a long-awaited report (Report) on options for implementing a Medicare Hospital Value-Based Purchasing (VBP) program in federal fiscal year 2009.

The options in the Report would build on the pay for reporting components of the current Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. However, the VBP program would phase out the RHQDAPU program and make a portion of a hospital's Medicare payments contingent on its actual performance on specified quality measures.

The Report is a product of the Deficit Reduction Act of 2005, which directed the Department of Health and Human Services (HHS) to develop a VBP plan for hospitals subject to the inpatient prospective payment system (IPPS). However, the actual implementation of a VBP program will require additional statutory authority from Congress.

Performance Assessment Model

In the Report, CMS proposes a Performance Assessment Model (Model), under which the Model, a hospital's performance on each measure would be evaluated annually based on the higher of an "attainment score" in the measure period or an "improvement score" determined by comparing the hospital's current measure score with its prior period baseline performance.

For each measure tied to an incentive payment, a hospital would receive 0-10 points for attainment based on where its score falls relative to the attainment threshold (i.e., minimum level of performance to receive attainment points) and a benchmark (i.e., point used to define a high level of performance). Similarly, a hospital would earn 0-9 points based on how much its performance on a measure has improved since the previous period.

The measures would be grouped into domains (e.g., clinical processes of care), and combined to calculate a score for each domain. The scores of the domains would be aggregated to arrive at a hospital's Total Performance Score. In turn, a hospital's Total Performance Score would be translated into the percentage of incentive payment earned by a hospital using an "exchange function." Using this Model, a hospital's performance would be assessed annually.

Incentive Payments

One of the most controversial aspects of the

(continued on page 14)

Warning Will Robinson (continued from page 1)

September 28, 2007, the IRS has received 650 separate comment letters of which 225 came from hospitals. We believe that the complexity of the new "core form" plus schedules will add at least 25% more time in completing and reviewing the tax return. Schedule H will present a challenge to hospitals in terms of gathering data from general ledgers, billing systems, cost reports, financial statements, and community benefits reports. The focus of this article will be devoted to Schedule H - Hospitals.

Schedule H - Hospitals

Schedule H - Hospitals is required to be completed by any organization that operates or maintains a facility that provides hospital or medical care. The form is broken down into the following parts:

- Part I - Community Benefit Report
- Part II - Billings and Collections
- Part III - Management Companies and Joint Ventures
- Part IV - General Information
- Part V - Facility Information

Part I - Community Benefit Report - has generated a significant amount of controversy since it excludes bad debts and Medicare shortfalls as part of the community benefit that is calculated. This part also asks for information regarding the organization's charity care policy and has eight supplemental worksheets which first must be completed to arrive at the figures for this part. These supplemental worksheets compute charity care according to the IRS definition, community health improvement services and community benefit operations, health professions education, subsidized health services, research along with cash and in kind contributions to community groups.

Part II, Section A - Billing Information - asks for gross charges, discounts, net expected and fees billed to Medicare, Medicaid, other government programs, insured and uninsured patients. Many hospital billing systems classify patients as "self-pay" not insured and uninsured. Identifying the payer mix according to the IRS chart could add a substantial amount of time to completing the form. Commentators have suggested that the data in this section may be competitively sensitive with respect to discounts provided to insured patients. This section also asks for the method in which the organization calculates bad debt expense. Section B - Collection Practices - asks whether the organization has a written debt collection policy and if yes, please describe the policy.

Part III - Management Companies and Joint Ventures. The purpose of this section is to allow the IRS to understand the organization's structure and to assess whether any private inurement issues exist. Some of this information is also disclosed in Schedule R - Related Parties.

Part IV - General Information - asks for written information about how the hospital benefits the community it serves. There are four questions in this section dealing with how the organization assesses the needs of the community, communication of financial assistance and charity care, emergency room policies and procedures, as well as, the manner in which hospital facilities further their exempt purpose.

(continued on page 14)

Report is CMS's proposal that the incentive payment be based on 2-5 percent of the base operating diagnosis related group (DRG) payment.

This approach would make a percentage of a hospital's base DRG payment contingent on its actual performance on specified measures, and mean that some hospitals may not "earn back" the full incentive payment will. However, CMS believes that this approach would most directly link the incentive payment to clinical services during a patient stay.

In the Report, CMS indicates that this approach could also create a pool of unallocated funds, which could be distributed as an additional quality incentive. CMS also suggests that the percentage of the base DRG payment could be established annually, so that no additional funding would be needed (i.e., incentive payments would remain budget neutral).

CMS also considers whether the incentive payment could be based on other IPPS payment components, including capital costs, disproportionate share hospital payments, indirect medical education payments, and cost outliers. CMS points out, however, that such an approach may not be directly related to the VBP policy objectives.

Quality Measures

According to CMS, the initial VBP measures could include a subset of the RHQDAPU clinical process of care measures, the HCAHPS patient perspectives of care survey, and two 30- day mortality measures. Further, CMS suggests that all new performance measures should have a preliminary data submission period (with no public reporting), and that new measures should be publicly reported for a period of time prior to being included in the incentive payment.

To qualify for the incentive payment, CMS would require that a hospital report on all measures relevant to its patient population and service mix, including new measures in the testing stage and measures being publicly reported but not used for the incentive payment.

Phased-In Transition

CMS proposes to phase-in the VBP program over a three year period. According to CMS, one option would be to have the incentive payment based 100 percent on pay for reporting VBP measures and the 2-5 percent of the base DRG payment during the first year.

During the second year of this option, CMS proposes that the incentive payment be based on 50 percent reporting and 50 percent performance on VBP measures, using the Model to calculate a hospital's Total Performance Score and translate it into the incentive payment. By the third year of the VBP program, the incentive would be based 100 percent on performance.

Data Transmission and Validation

CMS suggests that the RHQDAPU data infrastructure needs to be modified and strengthened for the VBP program. This could be accomplished by shortening the data submission period to 60 days following the close of the reporting period, but allowing hospitals to resubmit data up to 30 days after the close of each data submission period.

CMS also proposes revising the existing RHQDAPU validation methods to focus on assessing the accuracy of performance measure rates. Beginning in the second year of the VBP program, CMS would select hospitals for validation on a random and targeted basis. Specifically, CMS would select about 600 hospitals for a random audit and about 200 hospitals for a targeted audit. For each hospital selected, CMS would review about approximately 50 charts per year.

Public Reporting

According to the Report, CMS believes that public reporting is an essential tool for motivating hospitals to improve quality of care and for helping Medicare beneficiaries choose quality providers, and it would use the existing Hospital Compare website as the platform for displaying performance results. CMS also believes that measures that contribute to informed consumer decision-making should be publicly reported on the Hospital Compare website, even if they are not considered in the incentive payments. CMS would work to modify the Hospital Compare data displays so that Medicare beneficiaries could more easily interpret performance results.

Monitoring Impacts

CMS recommends that ongoing monitoring and evaluation efforts are part of the VBP program. In addition to examining whether the VBP program improves the quality and efficiency of the Medicare program, CMS reports that it is interested in monitoring whether the VBP program is budget neutral, produces unintended consequences (e.g., hospitals dropping or avoiding sicker patients) or results in hospital gaming data to secure incentives.

Conclusion

Implications for Hospitals

Consumers are demanding greater transparency and information about the care that they receive.

Financial pressures are also driving various initiatives that increasingly link payment to the quality of care. At the same time, health care quality is becoming an emerging enforcement priority for health care regulators.

Government authorities are closely evaluating quality reporting data and increasing their scrutiny of providers that deliver substandard care. HHS's Office of Inspector General has publicly stated that substandard care could not only result in sanctions for providers, but even sanctions for individuals who are not direct care providers if they cause others to furnish substandard care. As a result, all levels of a hospital, including a hospital's governing body, could theoretically have exposure when it comes to the delivery of substandard care.

Consequently, when preparing for pay for performance programs, such as the VBP program, hospitals should not only evaluate the financial implications of such programs, but should also include a board level quality initiative to establish and maintain structures and processes that ensure the accuracy of quality reporting data, effectively address potential quality of care issues, and provide for adequate Board oversight of such issues.

Will Robinson (continued from page 13)

Part V - Facility Information - asks for physical location of each facility and a description of the activities and programs at each facility.

As we go to press, the IRS has issued the updated Schedule H which can be viewed at http://www.irs.ustreas.gov/charities/index.html Due to the complexity of the form, many parts of the revised schedule are optional for 2008. Once the form and instructions become final in 2008, we will issue a follow up article in a future newsletter.

Zack Fortsch is a Managing Director and oversees the tax exempt practice at RSM McGladrey, Inc. Chicagoland offices. He can be reached at zack.fortsch@rsmi.com

Self Pay Balances by the Millions ... Are We Ready?

BY ARNIE HARRIS, ESQ., HARRIS & HARRIS, LTD

Here We Go

The controversial and complicated path of the collection of self pay balances continues to be a major challenge faced by hospital patient account directors, managers and CFO's. Hospitals are now challenged with dramatic growth of their AR related to patients who are uninsured and under-insured. To aggravate the issue, recent popularity of Consumer Directed Health Plans brings high deductibles and limited coverage. Now more than ever, the path to collection of these self-pay balances has become a critical issue faced by managers of self pay accounts.

Point A to Point B

As a collection attorney focused on the collection of healthcare debt, I often observe the conflicting goals of my hospital clients, relative to their desire to collect self pay accounts while balancing that desire with the hospital's mission. The hospital struggles with its role of a community based, not-for-profit hospital, needing to serve the charitable aspect of its mission while being fiscally responsible to carry out that mission. Typically in collections we teach our staff to politely and diplomatically move from Point A in the collection process to Point B with as little deviation as necessary. Point A is defined as talking with the patient or responsible party. It is no easy task to get to Point A which requires multiple attempts by phone, numerous letters, the assistance of technology such as predictive dialers, the struggles around caller ID, answering machines and the like. When we finally reach point A, our goal is to proficiently move to Point B, resolution of the account through payment in full. Even with the challenges of contacting someone regarding their delinquent account, the even greater challenge is assisting them with options in resolving the debt. By examining these challenges the hope is that we can resolve a larger percentage of self pay accounts.

Is it a Debt?

Some of the questions that we need to ask ourselves are as follows:.

Is a self pay balance a debt due a creditor that must be paid based on certain terms and by a certain time? Instead, do we allow the patient the ability to set their own terms of repayment, both in terms of dollar amount and time of payment?

Should we incorporate the payment of interest and collection fees in the patient's consent form?

Should the hospital business office continue to help the patient avoid payment of the debt by finding either alternate payers of the debt or allowing the debt to be written off as charity?

Healthcare is a unique breed unlike any other creditor. The path to payment (Point B) is certainly a winding road with many obstacles.

Some other considerations are the following. Should a full credit application be completed prior to discharge? In addition to discussing charity applications should we also focus on gathering critical information for payment follow up?

As accounts grow stagnant and delinquencies move to our patient accounts department, at what point do we tighten up and require repayment from those who have the means to do so? Let's look and decide. Most industries have a set time period during which they attempt to collect internally and then a policy as to how to treat the matter as a bad debt. At times we let the debts age as we search for alternate payers and do little to attempt collection. Our focus is clearly to find alternate payers and if not found, to write off the debt to charity. We rarely turn our sights on the patient or responsible party for payment of the debt.

Debt Collection for Smarties

As the self pay balance ages, we eventually place the debt to a professional collection firm. We negotiate as low a contingent fee as possible; however our real concern should be fees that we pay net of collections. The dollars collected less the fees paid is the key to recoveries. Instead of looking only at the fee paid, consider the fact that a low contingent fee may result in fewer dollars collected. I would rather have $150,000 dollars collected at a 25% fee then $100,000 collected at a 20% fee. At the higher fee my net back return was $112,500, however, at the lower fee my net back return was just $80,000. Paying the lower contingent fee would have cost the hospital an extra $32,500!

Healthcare should consider alternate collection strategies enjoyed by other industries. The healthcare collection arena has been slow to adopt debt sale strategies as a viable option to raise money from bad debt. Healthcare has also been unable to support profitable healthcare financing strategies. This is where a lender promotes the creation of turning the self pay balance into an actual debt with repayment terms, interest, and penalties for non-payment. Another penalty that may be considered is enforcement of collection of the self pay balance through litigation. Obtaining a judgment and garnishing wages continues to be one of the most common methods of enforcement of collection of a debt.

With the explosion of large self pay balances, some of the options noted above may need to be utilized. There are currently many self imposed obstacles that prevent hospitals from quickly and efficiently reaching what we call point B. As the industry has instituted these obstacles, case law and legislation has followed their lead. Long existing legislation under the Fair Credit Reporting Act and the Fair Debt Collection Practices Act favors the classification of balances due as debt with expectations of payment under a certain time frame.

Here Comes the Judge

A recent Federal appeals court has examined the classification of debt under the Fair Credit Reporting Act. In Pintos v. Pacific Creditors 2007 WL 2743502 (9th Circuit September 21, 2007), the court held that a debt must arise from a voluntary credit transaction to allow certain creditors the rights to access a consumer's credit bureau report. Would a medical debt be considered a voluntary credit

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Self Pay Balances by the Millions ... Are We Ready? (continued from page 15)

transaction? We should begin to set standards in hospital business offices to ensure that self pay debt is viewed as a voluntary credit transaction while at the same time we examine our charity care standards.

Murky Waters…

As the industry continues to face mounting self pay balances, the murky waters that exist between point A (talking with the patient) and point B (obtaining payment) must be examined. Hospitals may turn to their debt collection professionals for assistance in developing a proper road to follow from registration through collection. That road includes expectation of payment from the patient and/or the responsible party. However, the road also includes a sound method of determining everything from those that qualify for charity care, to those that need their third party payer to pay the proper contractual amount, to those that will require enforcement of a newly drafted consent form… now referred to as a credit agreement.

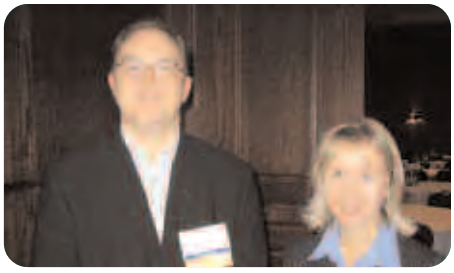
Collection of self pay balances has always been a challenge. As the amounts and numbers continue to grow, they will also grow into more collectable accounts. Most self pay balances are owed by individuals gainfully employed and willing to enter into payment terms. We are even seeing more pure self pay balances owed by those who are gainfully employed yet have chosen to be uninsured due to the cost. Methods exist to properly identify, early in the process, those that should fall within charity care guidelines, those that have the ability to pay voluntarily, and those that may need that extra push. Implementation of these identification methods to re-classify debt appropriately will be critical to success of collection in the self pay arena.

Arnie Harris is an attorney focused on Healthcare debt collection issues. He is President and CEO of Harris & Harris, Ltd., a nationally licensed debt collection firm representing hospitals and hospital systems throughout the United States.

HFMA Events

Accounting and Reimbursement/Revenue Cycle Dual Track Program

October 18, 2007



Tadd Ingles & Maria Stephan

Dr. Richard Kunnes

Rev Cycle Chairs, M. Holtzman & E. Lauer

Pamela Hess & Maureen Drach Murphy

How to Achieve Value from a Telecommunications Service Audit

BY KEN ROTHACKER, ISI TELEMANAGEMENT SOLUTIONS, INC.

Cost containment is one of the top challenges facing healthcare financial managers. In an ideal world, telecommunications services bills would be easily understood, user friendly, and always accurate.

In the real world, those bills are challenging to decipher, frequently incorrect, and growing in number.

You may have been solicited by a firm offering to audit your telephone bills, promising to provide "substantial savings." You may have wondered, "Is there anything to this?"

The answer is a qualified "Yes."

Let's consider a few questions, and then decide whether these claims of savings have merit.

Who Are Telecommunications Consultants?

Consultants who provide knowledge on technical or legal issues often have advanced degrees and certifications. However, there is not yet a certification for telecom consultants analogous to CPA, MCSE, or CCNE. So, how do you evaluate a company that wants to look at your phone bills?

Ask the company how long its consultants have been in the business of telecommunications consulting. You do not want to be someone's test case. Ask for a list of clients that you can call regarding their experience and results with the company. Ask the company for its staff's resumes, background, and actual experience.

How Are They Paid?

There are several different ways that telecommunications consultants can be paid. Some firms offer a contingency fee program, in which the consultants are paid a percentage of the savings they uncover. Ideally, the consultant will schedule invoicing to coincide with the implemented savings, so that you pay the fee out of actual savings.

Ask the company:

- How are these "cost savings" going to be defined?
- Are fees payable for cost savings achieved in one year, two years, or more?
- What about refunds that they obtain for you from your carriers?

As with any good business relationship, make sure that the terms for telecommunications consulting services are defined and agreed upon in writing. Some firms may charge a flat fee per engagement, while others may charge on an hourly basis.

If you are speaking with a consultant who will recommend different carriers or service providers, ask if the consultant is receiving a commission from the carrier. In this case, a consultant may be similar to a financial planner who makes recommendations regarding insurance or investments, charges a fee to the client, and is also paid commission on the products sold.

A key question to ask is, "If I hire you, how much better off will I be over 12, 24, or 36 months?" You should require the consultant to implement any recommendations that you have approved. Otherwise, you may end up paying for recommendations that have not been implemented due to lack of time or understanding internally.

What Will the Consultant Do?

Before beginning a project, your consultant should provide you with a written scope of work, a timeline, and a schedule of deliverables. Scope of work defines what services will be examined in an engagement. These services can include (but are not limited to) local and long distance phone service, facilities analysis (meaning circuits or lines), data (meaning internet connectivity or data networking services), pagers, and wireless/cellular phones.

Has your consultant documented how much of your time or your staff's time will be required to complete the project? Other than during the initial information-gathering period, the consultant should require very few hours of your staff's time to perform an analysis. The best consultants will have you approve a letter of agency (LOA), which allows them to contact your current carriers for information regarding your services. While an LOA may allow the consultant to make changes to your services, make sure that you maintain the right to approve in writing any changes to be made. The consultant can then work directly with your carriers to gather information. As the engagement comes to completion, you should be presented with documentation of the savings, refunds, etc., that have been uncovered and how they were uncovered.

Why Can't My People Do This?

In many organizations, headcount has decreased while responsibilities have increased. In addition to the fact that everybody is busy, the specific tasks involved in conducting telecom-spending analyses are time-consuming. Many telecom and accounting staffs have more work to do than they have time available. Technical personnel who keep equipment running, or accounting staff who do not have specific telecom expertise, cannot reasonably be held accountable for mastering the ever-changing intricacies of telecom contracts and billing. Adding the task of performing an in-depth telecom study to their duties can be a recipe for frustration.

What's the Bottom Line?

Telecom billing is complex. A fresh set of eyes from a consultant who works with telecom billing issues every day can be key to finding errors made by your service providers or to uncovering ways to make your telecom processes more efficient. Using a consultant to discover areas for telecom savings and enhanced value will not reflect poorly on you or your staff. Funds that are not spent on telecom services are funds that can be better deployed elsewhere in your organization.

Ken Rothacker is a healthcare industry specialist with ISI Telemanagement Solutions, Schaumburg, IL. (krothacker@isi-info.com)

Improve Healthcare Building Environments to Improve Staff Satisfaction

BY STEPHEN BLAU

In healthcare settings, staff satisfaction and retention are critical to patient care and hospital outcomes. In fact, the continuing shortage of qualified nurses has been found to play a role in the commission of medical errors, according to a recent Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) study(1). Therefore, maintaining job satisfaction rates to retain healthcare personnel is a continuing, important goal of healthcare organizations.

Given that working conditions comprise a major factor in job satisfaction among RNs(2) as well as all healthcare providers, a positive building environment can play an important role in how healthcare delivery personnel feel about their jobs. Providing supportive positive working conditions, including building layout, temperature, lighting, noise, and Indoor Air Quality (IAQ) can therefore contribute to the ability of medical personnel to perform their work well and maintain high morale.

To create and maintain building environments that support the highest possible levels of healthcare delivery – as well as overall professional staff satisfaction –focus on efficiently providing indoor comfort and proper Indoor Air Quality (IAQ).

IAQ affects healthcare staff satisfaction in several ways. Improving IAQ, including proper air exchange, air flow and filtration, can contribute to lower rates of nosocomial infections that can result in longer patient stays and higher work loads for already stressed staff. Better IAQ also benefits hospital personnel by helping to reduce their risk of contracting infections such as tuberculosis.

For proper IAQ, hospital ventilation and filtration systems must meet strict standards. Look to guidelines set out by The Centers for Disease Control (CDC), the American Institute of Architects (AIA), and the Joint Commission on Accreditation for Healthcare (JCAHO).

Temperature and Humidity

When regulating temperature and humidity, priorities must address patient health and healing as well as staff working conditions. For example, in the operating room, set temperatures to suit the procedure being performed and materials used – as well as the personnel involved. Surgeons and support staff often need to concentrate for long hours wearing layers of protective clothing and sub-optimal temperatures can lead to significant discomfort and sweating.

Consider that different spaces may also warrant specific requirements. Patient rooms will generally require warmer temperatures than surgical suites. Ensure that the design – and control of – healthcare HVAC systems will allow both the precise, and customized, temperature control throughout the facility.

Franklin Memorial Hospital (FMH) in Farmington, Maine wanted the latest in HVAC technology when it undertook renovation of its operating suites in order to "satisfy the surgeons, who wanted the temperature at 62-65 degrees, while the anesthesiologists and other staff wanted higher temperatures." Moreover, excessive humidity can require resterilizing surgical kits, adding thousands of dollars of expense.

For the solution, FMH worked with Trane and Harriman Associates consulting engineers of Auburn, Maine, to design and build a new packaged HVAC system combining an IntelliPak™ air-cooled chiller with a Custom Climate Changer™ air handler and a CDQ™ (Cool, Dry, Quiet) desiccant wheel to provide superior temperature and humidity control. The system included water pumps, piping, Tracer Summit™ automation system and controls. The result: O-R doctors love the new system because it keeps them so comfortable.

Noise and Light

In addition to air quality, temperature and humidity, noise can also directly affect the hospital atmosphere, impacting both workers and patients. High noise levels can add to stress. Building equipment, including HVAC systems, should be selected and designed for minimal noise output.

Poor lighting has been linked to patient depression and medication errors (Designing, 2004). Hospitals can incorporate technologies, such as highly efficient fluorescent lighting, to achieve proper conditions for staff while saving energy. Lighting systems can be integrated in overall building automation environmental management solutions to provide centralized control as well as improve energy management and efficiency.

Centralized Monitoring and Reporting

In launching the industry's Critical Hospital Systems Dashboard, Trane has provided hospital administrators and engineers with a tool that will not only save time and money by providing detailed environment of care documentation for Joint Commission reporting, but also allows hospital staff to continuously view, monitor, track, trend and report environmental conditions in all critical areas from a single location. The Dashboard provides an immediate alarm signal if any critical parameter is exceeded so that staff may take immediate action to correct the situation.

Quality Staff and Environment

Improving patient outcomes can be a direct benefit of raising job satisfaction and lowering turnover among healthcare professionals. Creating healthy, efficient, and comfortable hospital buildings is an integral element of achieving staff satisfaction and retention – worthy of ongoing attention, investment, and improvement.

For more information, contact: Stephen Blau, Illinois TRANE, by Phone: 630-734-6083 or Email: sblau@trane.com.

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(1) Tarkan, Laurie. "Nursing Shortage Forces Hospitals to Cope Creatively". The New York Times, January 6, 2004.
(2) "Designing the 21st Century Hospital: Serving Patients and Staff." Summary based on a conference convened by the Robert Wood Johnson Foundation (RWJF) and The Center for Health Design, June 3, 2004, in Washington, D.C.

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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 **(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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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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Publication Date	Articles Received By
January 2008	December 3, 2007
April 2008	March 13, 2008

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Healthcare Financial Management Association First Illinois Chapter

Chapter Education Calendar 2007-08

Saturday, February 9, 2008
Winter Social
Drury Lane Dinner Theater, Oakbrook

Wednesday, February 20, 2008
Pricing Strategies during Transparent Times
Webinar presented by Cleverley + Associates
12-1pm

Thursday, February 21, 2008
Medical Groups & Physicians Committee-Emerging Issues
Law Offices of Biddle, Drinker, Gardner & Carton
191 N. Wacker Drive, Chicago

Thursday, March 6, 2008
Joint Educational Program-Access Takes Center Court
Oakbrook Bath & Tennis Club
Oakbrook

Thursday, March 20, 2008
Managed Care Educational Program
University Club, Chicago

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