First Illinois Speaks
hfma healthcare financial management association
HFMA's First Illinois Chapter Newsletter
January 2013

LEADERSHIP MATTERS

Highlights and Recap First Illinois Chapter Events begin on page 17

Captured News, Events & Updates

In This Issue

Transformations in the Illinois Health Care Landscape

DANIEL T. YUNKER, MBA – SENIOR VICE PRESIDENT, MCHC AND FIRST ILLINOIS HFMA'S PRESIDENT ELECT

The implementation of the Affordable Care Act has already had a significant impact on improving access to care in Illinois. Many of us went through stages of uncertainty, which began with "will reform ever happen?" Then the President's ink dried on the ACA on March 23, 2010. Next, we all waited for the Supreme Court decision about the individual mandates and they were upheld by the court. The next uncertainty that delayed the reality of reform was whether or not President Obama would be elected to serve a second term. He was. So finally we find ourselves at the beginning of 2013 and IT IS REALLY HAPPENING.

In 2012, despite the natural or even defensive progression above, we saw a growing acceptance of the need to transform our fragmented health care delivery system, a renewed commitment to creating patient-centered integrated care, intense leveraging of health information technology and the highly-anticipated expansion of health insurance benefits for previously underserved demographics.

2013 is sure to bring about even more transformation in the health care market, especially in regard to health insurance. On December 21, 2012, the Land of Lincoln Health, Inc., a consumer oriented and operated plan, received approval and $160 million in federal funding from the U.S. Department of Health and Human Services to apply for licensure to offer high-quality, affordable health insurance to individuals and small businesses in Illinois.

Land of Lincoln Health is the first federally approved consumer oriented and operated plan in Illinois. As a member-run organization, Land of Lincoln Health is positioned to obtain licensure to offer all Illinoisans an insurance option designed to meet their health needs and family budgets, all in the communities in which they seek care.

Land of Lincoln Health, which was sponsored by the Metropolitan Chicago Healthcare Council, has the opportunity to innovate the design of insurance products available to consumers, paving the way for

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Transformations in the Illinois Health Care Landscape (continued from page 1)

pioneering new collaborations to enhance quality of care, reduce cost and embrace health care connectivity for the benefit of the people of Illinois.

When licensed, Land of Lincoln Health plans will be available on state health insurance exchanges, another transformative component of the ACA, which are being developed for launch in 2013. Akin to a Travelocity™ for health insurance, health insurance exchanges will provide consumers with an opportunity to compare and purchase health insurance coverage that best suits their needs. Enrollment via exchanges will begin October 2013 and coverage through exchanges is planned to begin in every state in January 2014.

Health insurance exchanges will make purchasing insurance more approachable for the more than one million people who are uninsured in Illinois, as well as those who are self-employed or who manage small businesses. And it is options like Land of Lincoln Health, providing affordable, member-centric plans, that will ensure that people who seek coverage through the exchanges have options that fit their health needs.

While 2013 still holds many unknowns for the health care industry, we can look forward to the implementation of groundbreaking innovations like Land of Lincoln Health and health insurance exchanges, which will reduce the number of uninsured in our communities and greatly enhance access to care for all communities.

Dan Yunker

Senior Vice President, Metropolitan Chicago Healthcare Council and First Illinois HFMA's President Elect

Legislation Connection

BY ANDREW DIGATE, MBA

Down to the Wire in DC

While most everyone knew the Mayan catastrophe slated for December 21 would not ring true, it is not so clear for another potential catastrophe, the oft mentioned and described financial cliff. Even at press time and only two days away from the proverbial date, there is no more clarity today than last month as to the ramifications of a deal or of no deal. The only clarity that came out of DC over the past month or so is that the President got re-elected, the House remained in the hands of the Republicans, and the Senate's still under the control of the Democrats.

While kicking the can down the road continues not to be an option, politicians on both sides of the aisle are looking to be a game changer in the quest to ultimately bend the cost curve. While we in healthcare and others wait, there are some things that will be inevitable over the next few years, regardless if the cliff is averted or not:

- The President's initiatives toward healthcare reform will continue.
- More and more patients will seek out pricing of their care, question tests and associated costs, and contend with high deductible health plans. Similarly, transparency is not going away.
- Technology will push even more to the fore, whether such things as new uses/wider use for telemedicine, more integration of smart phone apps into patient care, or better/cheaper diagnostic tests. While new gadgets are great, there still needs to be an economic and care argument, which will require astute leaders to ascertain and convey to organizational leadership.
- The era of "Big Data" is well upon us and we will continue to be in a data driven world, especially as we contend with ICD-10 and Meaningful Use. While technology will make it easier to store and help crunch the numbers, proactive leaders will seek to understand how all of the data impacts their organization.

The Same in Springfield?

While talk of the financial cliff garners significant talk right now on the Sunday morning news shows, Springfield is contending with their own financial cliff, largely in the form of unfunded pensions. Gov. Pat Quinn says he was "put on earth" to solve the problem and that the upcoming session offers the best opportunity in his lifetime to do so. He gave lawmakers a deadline of January 9, the end of a one-week legislative session when several dozen lame-duck lawmakers can vote without worrying about facing voters again.

What is certain out of Springfield are the 150 or so new laws that will go into effect on January 1, 2013. Further, with many lawmakers leaving office after the veto session and many new ones getting sworn in with the new session in March 2013, proposed legislation should be forthcoming at a breakneck pace. Listed below are some of the new laws that have an implication for healthcare. Additional information on these laws can be obtained from www.ilga.gov.

Debt Buyer Regulation (HB 5016/PA 97-1070): Clarifies the definition of debt buyers to assure that they are subject to appropriate provisions of the Collection Agency Act. Requires debt buyers to comply with any applicable statute of limitations time period. Also allows the Attorney General to enforce violations as an unlawful practice under the Consumer Fraud and Deceptive Business Practices Act.

Group Healthcare Purchasing (SB 2885/PA 97-715): Changes the law under which Health Insurance Co-ops may be formed, including defining an employer as an individual, sole proprietorship, partnership, firm, corporation, association, or any other legal entity that has one or more employees and is legally doing business in Illinois, and includes employer under the HIPPA definition. Increases the maximum number of employees that a participating employer can have from 500 to 2,500 and adds language that states health purchasing groups "shall utilize a licensed insurance producer" to obtain insurance for the group.

Facebook/Social Media Privacy (HB 3782/PA 97-875): Prohibits employers from requesting or requiring any current or prospective employee to provide any account information, including passwords, in order to gain access to the employee's social networking Web site.

Injury Settlement (HB 5823/PA 97-1042): Matches an injury settlement or verdict's payout with the amount that would have been paid under the reduced rates of the injured person's health care insurance and/or health plans. Unless otherwise agreed by the parties, the amount of comparative fault and the full value of the claim will be determined by the court having jurisdiction over the matter. Initiated by the Illinois Trial Lawyers Association, which believes that providers have an inequitable opportunity to collect more than they otherwise would if the claimant didn't receive medical care as a result of an incident that led to a claim for personal injuries or wrongful death.

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Legislation Connection (continued from page 3)

Medical Bill Sharing (HB 3443/PA 97-705): Adds new regulations to govern "medical bill sharing ministries," which are religiously-affiliated organizations that offer their members a medical bill-sharing plan as an alternative to health insurance. Under such bill-sharing arrangements, members contribute into a fund that is used to cover medical expenses when needed. **(SB 2876/PA 97-707):** Prohibits medical bill sharing ministries from having off-shore trusts or bank accounts to pay medical expenses. It also requires the organization to provide a monthly statement of its financial status to its members.

Postsurgical Recovery (HB 5050/PA 97-987): Defines "ambulatory surgical treatment center" or "ASTC." Allows patients to be discharged from a postsurgical recovery care center in less than 24 hours if the attending physician or the facility's medical director believes the patient has recovered enough. Provides that blood products may be administered in the postsurgical recovery care center model. Allows a postsurgical recovery care center model to provide sleep laboratory or similar sleep studies.

Andrew Digate, MBA

President's Message

On behalf of the officers and the Board of Directors of our First Illinois Chapter, I would like to wish you and your families a happy, healthy and prosperous new year!

This time of the year we usually look fondly at our accomplishments and blessings in the past year and make resolutions for the new year in areas where we would like to increase our focus. In addition to getting to the gym more frequently this year, I would like to ask each of you to make a resolution to become more active in our First Illinois HFMA Chapter.

From the bottom up, here are the top 13 reasons why you should become more active in First Illinois in 2013:

13 Local seminars with great agendas and Chicago area, health care leading-industry speakers

12 For those CPA's among us - all of our First Illinois seminars and webinars are now eligible for NASBA CPE credit

11 Two golf outings throughout the year: a chapter-wide golf outing in the fall and a CFO golf outing in the spring

10 National HFMA's Virtual Conference that is free to HFMA members beginning with live sessions on February 6, April 11, July 17, and October 16 - to register go to http://www.hfma.org/virtualconference

9 18 First Illinois webinars offered throughout the year by Chicago area health care leading-industry speakers

8 Our First Illinois certification program and study group to become a certified Healthcare Financial Management Professional - if interested in joining please sign-up with Tim Stadelmann at tim.stadelmann@advocatehealth.com

7 The HFMA National Institute at the Orange County Convention Center in Orlando, Florida, on June 16-19, 2013 - see details at http://www.hfma.org/Templates/InteriorMaster.aspx?id=843

6 Two new First Illinois seminars for professionals new to health care – Revenomics 101 and Reimbursement 101

5 National HFMA's new Career Center – check it out for yourself at http://www.hfma.org/Content.aspx?id=63

4 The chance to get a tour of the new Rush University Medical Center

3 The chance to watch the White Sox send home the Yankees and break Derek Jeter's winning stretch

2 The chance to see if you are "Smarter than a 5th Grader" at our chapter golf outing

1 To quote our past president, Pat Moran, "HFMA membership is like a gym membership - if you don't go you won't get anything out of it."

I hope that you enjoy this issue of First Illinois Speaks and that you are making the most of your membership in HFMA. We have many great events planned for the second half of our chapter year, and I look forward to the opportunity to meet you at one of our events.

Tracey Coyne
2012 – 2013 First Illinois, HFMA Chapter President

Proposed Regulations Issued for IRC Section 501(r) Impact Tax-Exempt Hospitals

BY SUE MIENCIER, HEALTHCARE SENIOR TAX MANAGER, PLANTE MORAN

The Patient Protection and Affordable Care Act (PPACA) established new requirements that a §501(c)(3) tax-exempt hospital must meet to maintain exempt status. The community benefit standard that has been the basis for exempt status for hospitals since the 1960s has not been changed; instead, the PPACA added the following provisions that must be met for each hospital facility operated by a hospital organization:

- A community health needs assessment (CHNA) must be conducted at least every three years.
- Both a written financial assistance policy (FAP) that is publicized to the community, and an emergency medical care policy that provides for emergency medical care without regard to eligibility under the FAP must be established.
- Amounts charged under the FAP are limited to not more than the amounts generally charged to individuals who have insurance, and the use of gross charges are prohibited.
- Prohibits against taking extraordinary collection actions prior to making reasonable efforts to determine if patients are eligible under the FAP.

The PPACA also requires a review of each hospital's community benefit activities at least once every three years by the Secretary of the Treasury (or delegate). This is being accomplished through a behind-the-scenes review process of each hospital's Schedule H by the IRS, which is being done in waves over the three-year period. Hospitals will not be notified of this review or its results. Although the IRS has said that these reviews are not intended to lead to an audit of a hospital, it has not ruled out that the findings could trigger an audit of a specific hospital organization.

These provisions were effective for tax years beginning after the date of the PPACA (March 23, 2010), except for the CHNA requirement – the latter is effective for tax years beginning after March 23, 2012, which is generally the fiscal year ending in 2013. Although the CHNA is not yet effective, in 2011 the IRS issued Notice 2011-52 to provide guidance to hospitals for the CHNA pending the issuance of regulations. This notice may be relied upon up until six months after final regulations or other guidance is issued.

Except for the CHNA, the provisions of §501(r) are currently effective for all tax-exempt hospital facilities, but hospitals have been challenged by the lack of official guidance on what they need to do to be compliant with the new law. Guidance was finally issued this summer in the form of proposed regulations for §501(r) (excluding the CHNA). Proposed regulations are not effective until the year beginning after final or temporary regulations are issued. Despite this, they do show what the final regulations are expected to look like and allow a hospital facility to review its policies and practices to determine what steps it needs to take to prepare for the final rules.

The proposed regulations as they relate to the specific provisions are summarized below. A hospital facility is defined in these regulations as a facility that is required by a state to be licensed, registered, or similarly recognized as a hospital. A hospital organization may treat multiple buildings operated under a single state license as a single hospital facility. The definition also includes hospital facilities operated through a disregarded entity. (Note – A hospital facility for CHNA purposes also includes a facility operated through a partnership entity, while the proposed regulations. do not include entities treated as partnerships. The IRS expects to address this issue in separate future guidance.)

Financial Assistance Policy and Emergency Medical Care Policy (§1.501(r)-4)

A hospital facility's FAP must include:

1. Eligibility criteria for financial assistance, and whether such assistance includes free or discounted care. The proposed regulations. do not mandate any particular eligibility criteria – instead, they require that the FAP specify the financial assistance available under the FAP and all of the specific eligibility criteria that an individual must satisfy to receive assistance.
2. The basis for calculating amounts charged to patients. The FAP must state that FAP-eligible individuals will not be charged more than the

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Proposed Regulations Issued for IRC Section 501(r) Impact Tax-Exempt Hospitals (continued from page 6)

amounts generally billed (AGB) for emergency or other medically necessary care. It also must state which of the permitted methods (described later under Limitation on Charges) the facility uses to determine AGB.

3. The method for applying for financial assistance. The FAP or FAP application form must describe the information or documentation the facility may require an individual to submit as part of the application. The facility may not deny assistance based on the omission of any information or documentation not specifically required by the FAP.

4. The actions the organization may take in the event of nonpayment (unless it has a separate billing and collections policy), including any extraordinary collection actions described in §501(r)(6). Either the FAP or the separate policy must describe the process and time frames the facility (or other authorized party) will use in taking these actions, including any reasonable efforts to determine FAP-eligibility.

5. Measures to widely publicize the FAP within the community served by the hospital facility. The FAP is required to include four types of measures the facility will take to publicize the FAP. Specifically, the FAP must include measures the facility will take to:

   - Make paper copies of the FAP, FAP application form, and a plain language summary available upon request and without charge. Each document must be made available in English and in the primary language of populations that constitute more that 10 percent of residents in the community.
   - Inform and notify visitors about the FAP through a conspicuous public display or other attention-attracting measures.
   - Inform and notify members of the community about the FAP in a manner reasonably calculated to reach those most likely to require financial assistance.
   - Make the FAP, FAP application form, and a plain language summary widely available on the hospital's website, in English and in the primary language of populations that constitute more than 10 percent of residents in the community.

The proposed regulations also require a written policy that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals, regardless of whether they are FAP-eligible. The policy must prohibit debt collection activities in the emergency room or similar venues.

The FAP and other policies above will be considered established only when they are both adopted by an authorized body of the hospital organization and implemented by the facility. The facility is considered as having implemented the policy if it has consistently carried out the policy.

Limitation on Charges (§1.501(r)-5)

Each hospital facility must limit the amount charged for any emergency or other medically necessary care provided to a FAP-eligible individual to not more than amounts generally billed (AGB) to individuals with insurance

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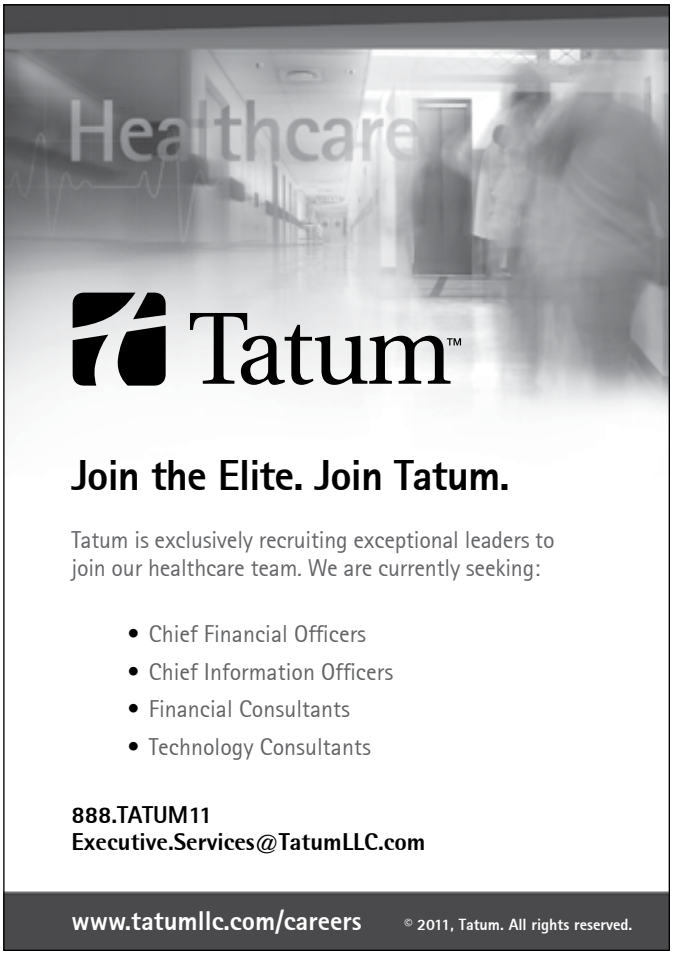

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covering that care. Also, the amount charged for any medical care provided to an FAP-eligible individual is limited to an amount that is less than the gross charges for that care.

Amounts Generally Billed

The proposed regulations provide two methods for calculating AGB:

1. A "look-back" method based on actual past claims paid to the facility by either Medicare fee-for-service only, or Medicare fee-for-service together with all private health insurers paying claims to the facility (including portions paid by Medicare beneficiaries or insured individuals).

2. A "prospective" method based on the facility's estimate of the amount it would be paid by Medicare and a Medicare beneficiary for emergency or other medically necessary care if the FAP-eligible individual were a Medicare fee-for-service beneficiary.

These two methods are mutually exclusive, and a facility may only use one method to determine AGB – once chosen, the facility must continue to use that method.

Gross Charges

A gross charge (or chargemaster rate) is defined as a hospital facility's full established price for medical care that the hospital facility consistently and uniformly charges all patients before applying any contractual allowances, discounts, or deductions. A facility is prohibited from charging FAP-eligible individuals gross charges for any medical care. The gross charge amount is permitted to be the starting point to which contractual allowances, etc., are applied, as long as the gross charge is not the amount an FAP-eligible individual is required to pay.

Billing and Collection (§1.501(r)-6)

A hospital is prohibited from engaging in extraordinary collection actions (ECAs) before making reasonable efforts to determine whether the individual is FAP-eligible.

Extraordinary Collection Actions

ECAs include any actions taken by a hospital against an FAP-eligible individual to obtain payment for a patient care bill that requires a legal or judicial process. These include, but are not limited to, actions to:

- Place a lien on an individual's property
- Foreclose on an individual's real property
- Attach or seize an individual's bank account or other personal property
- Commence a civil action against an individual
- Cause an individual's arrest
- Cause an individual to be subject to a writ of body attachment; and
- Garnish an individual's wages

ECAs also include reporting to credit agencies and the sale of an individual's debt to another party. However, a facility is permitted to refer an individual's debt to a debt-collection agent or other party without selling the debt.

Reasonable Efforts

The proposed regulations provide that a hospital facility will have made reasonable efforts to determine if the individual is FAP-eligible if it:

1. Notifies the individual about the FAP
2. Provides an individual who submits an incomplete FAP application with information relevant to completing the application
3. Makes and documents a determination as to whether an individual is FAP-eligible for an individual who submits a complete FAP application

The proposed regulations provide both a "notification period" and an "application period" for purposes of meeting the above requirements.

- The notification period is the period during which the facility must notify an individual about the FAP. This period begins on the date care is provided and ends on the 120th day after the facility provides the first billing statement to the individual. At the end of the notification period, the facility may engage in ECAs if all notification requirements have been met and the individual has failed to submit an FAP application.

- The application period is the period during which the facility must accept and process FAP applications submitted by an individual. This period ends on the 240th day after the facility provides the first billing statement to the individual.

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The notification component of the "reasonable efforts" requirement is met if the hospital:

1. Distributes a plain language summary of the FAP, and offers a FAP application form to the individual before discharge from the facility
2. Includes a plain language summary of the FAP with all (and at least three) billing statements and all other written communications regarding the bill during the notification period
3. Informs the individual about the FAP in all oral communications regarding the amount due that occur during the notification period
4. Provides the individual with at least one written notice that informs the individual of the ECAs the facility (or other authorized party) may take if the individual does not submit a FAP application or pay the amount due by a date that is not earlier than the last day of the notification period. This written notice must be provided at least 30 days before the deadline specified in the notice.

If an individual submits an incomplete FAP application during the application period, the facility will be considered to have made reasonable efforts only if it: (1) suspends any ECAs against the individual; (2) provides the individual with written notice describing the additional information and/or documentation that must be submitted (including the plain language summary of the FAP); and (3) provides the individual with at least one written notice about the ECAs it may take if the application is not completed or the amount due is not paid by a completion deadline that is no earlier than the later of 30 days from date of the written notice or the last day of the application period.

Once the complete application is received, the hospital facility must make and document the determination of eligibility in a timely manner, and notify the individual in writing of the determination and basis for determination. If the individual is FAP-eligible, the facility must take three additional steps:

1. Provide a billing statement indicating the amount owed as an FAP-eligible individual
2. Refund any excess payments made by the individual
3. Take all reasonable available measures to reverse any ECAs (with the exception of a sale of debt) taken against the individual

The hospital facility will not have made reasonable efforts to determine FAP eligibility if it simply obtains a signed waiver from an individual.

The provisions summarized above (and detailed in the proposed regulations will not be effective until they are issued as final or temporary regulations. However, hospital facilities may rely on these proposed regulations until final or temporary regulations are issued. Although this summary of the proposed regulations includes as much information as space allows, hospitals are encouraged to review the proposed regulations to ensure that all applicable requirements have been addressed.

Hospital organizations are advised to review their policies and practices to assess compliance with these proposed rules, and to plan what new policies, or revisions to current policies, will be needed to be compliant with the regulations once they are finalized.

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What's "New" in the OIG Work Plan

BY KATHY RUGGIERI, SENIOR DIRECTOR, REVENUE CYCLE SERVICES

The U.S. Department of Health and Human Services, Office of Inspector General (OIG) has recently issued the Fiscal Year (FY) 2013 OIG Work Plan. This is an annual Work Plan that addresses the current focus areas of the OIG, including projects still in process from prior FYs in addition to new focus areas for the upcoming year.

Although the Work Plan addresses initiatives for all types of providers, this article will focus on some of the new hospital audits. Some of these audits may or may not be indicative of future Medicare payment reductions. It is recommended that hospitals stay abreast on these focus areas throughout the year to best anticipate future revenue reduction initiatives.

1. Diagnosis Related Group (DRG) Window

The DRG Payment Window Policy has been a component of the Inpatient Prospective Payment System (PPS) regulations since 1983. There have been changes to this policy over the years, and in 2012, the DRG Payment Window was expanded to include wholly owned physician practices. The OIG focus for 2013 will be to analyze claims data to determine how much CMS could save if it bundled outpatient services delivered up to 14 days prior to an inpatient hospital admission into the DRG payment. The current DRG Payment Window Policy bundles all outpatient services delivered three days prior to an inpatient admission. The OIG anticipates that significant savings could be realized if the DRG window was expanded from three to 14 days. Hospitals should pay close attention to these audits as an expansion to this program will have significant financial implications to hospital outpatient service revenue.

2. Compliance with Medicare's Transfer Policy

The Medicare Post Acute Transfer Rule was implemented in FY 1998 and has been expanded in FYs 2005, 2006, 2007, 2008 and 2012. Pursuant to federal regulations, a hospital discharging a beneficiary is paid the full DRG amount. In contrast, a hospital that transfers a beneficiary to another facility is paid a graduated per diem rate for shorter lengths of stay. The OIG has performed significant audits of claims that were reimbursed the full DRG rate and has provided guidance to CMS on claims processing edits that would concurrently identify claims that were actually transferred to another facility and would result in the lesser per diem rate. Based on these recommendations, the Medicare Administrative Contractors (MACs) have implemented claim edits to identify these situations to prevent overpayment situations. Historical OIG audits identified the effectiveness of these edits. OIG audit results have revealed an 85% effective rate with the claims processing edits. The MACs were charged with making additional changes to these edits to further improve the effectiveness. In 2013, additional audits will occur to evaluate the effectiveness of these claim edits to determine if the edits have improved.

3. Payments for Discharges to Swing Beds in Other Hospitals

The OIG will review Medicare payments made to hospitals for discharges that were coded as discharges to a swing bed in another hospital. Swing beds are inpatient beds that can be used interchangeably for acute care or skilled nursing care. Currently, federal regulations allow for a full DRG payment for discharges coded as "Swing Bed" (patient discharge status code of "61"). However, Medicare pays hospitals a reduced payment for shorter lengths of stay when beneficiaries are transferred to another PPS hospital. This is based on the assumption that acute care hospitals should not receive full DRG payments for beneficiaries discharged "early" and then admitted to another post acute provider post discharge. Since Medicare does not pay a reduced payment for discharges to a swing bed the OIG will evaluate these situations and, if appropriate, recommend that CMS evaluate their policy related to payment for hospital discharges to swing beds in other hospitals. In the event this change is implemented, hospitals who discharge patients to swing beds and utilize patient discharge status code of "61" will experience further claim reductions as additional claims will be impacted by the Medicare Post Acute Transfer Rule.

4. Non–Hospital Owned Physician Practices Using Provider Based Status

The OIG will assess the impact of non-hospital owned physician practices billing Medicare as provider based physician practices. A determination will also be made with regard to whether provider based status meets CMS billing requirements. Since provider based status can result in additional Medicare payments, it also increases a Medicare beneficiaries' coinsurance liabilities. Hospitals that bill with a provider based status should evaluate whether the Medicare criteria specific to provider based physician status is met.

It is clear that the OIG is looking for opportunities to further reduce Medicare reimbursement. It is important for hospitals to keep current on these potential revenue reductions. It is recommended that hospitals continue to take full advantage of comment periods to communicate concerns with regard to payment reduction initiatives.

BESLER Consulting can help your organization recover otherwise lost revenue, maximize reimbursement, increase compliance, improve efficiencies and reduce costs. For more information, please contact Kathy Ruggieri at 732-392-8227 or kruggieri@besler.com.

Time to Audit Energy, Critical Systems is Now

BY STEVE BLAU, PE, LEED AP ILLINOIS TRANE

Energy and critical system audits can add dramatic new drive to efforts to improve the energy efficiency and shrink the environmental footprint of your facility. Such audits provide facilities teams with vital information about their building's performance, uncover energy conservation opportunities, and make sure critical building systems are operating up to their design specifications.

The good news is that an audit is time well spent in terms of return on investment. In fact, energy audits typically identify conservation measures that reduce energy use by 30 percent or more, according to the American Society of Heating, Refrigerating and Air Conditioning Engineers (ASHRAE). Critical systems audits make sure heating, ventilating and air conditioning (HVAC) and other building systems are working efficiently and identify potential problems so they can be addressed before they can cause unscheduled downtime and impact the organization and its operations.

Many organizations partner with an energy services company (ESCO) or other qualified third-party to conduct building audits, which usually pay for themselves many times over in energy and operating cost savings.

Tackle easy, quick-payback opportunities first

An energy audit will most likely yield a long list of conservation opportunities, which can then be prioritized based on ease of implementation, return on investment and impact on the organization. Many energy-saving measures cost little or nothing to implement. Others pay back their implementation costs in just a few years. More extensive initiatives take longer to pay for themselves, but may still make sense when the total lifecycle savings and net present value (NPV) of the upgrades are taken into account.

Low or no-cost actions that can yield significant energy savings include fixing air leaks around windows and doors, making lighting retrofits, adjusting building automation system settings, exploring different utility rate options and undertaking retro- or re-commissioning programs.

Installing new building automation systems, retrofitting plumbing for water conservation or making incremental HVAC system improvements may take three or more years to pay for themselves.

Retrofitting buildings with high-efficiency HVAC systems, making building envelope improvements or adopting renewable technologies are longer-term investments that almost always pay for themselves over a building's decades-long occupied life.

Adopt smarter service and maintenance strategies

For decades, maintenance strategies have centered on the goal of restoring or maintaining building systems' original design performance levels. Advances in technology and the availability of real-time system performance data now give facilities teams the tools to adopt a

building performance model, in which the building is managed to deliver specific outcomes.

Today's most advanced intelligent services strategies enable a building to be managed to perform within acceptable tolerances of set performance standards. In hospitals, standards could be set for unit-specific air quality, temperature and humidity levels in support of a comprehensive infection-control initiative. In medical offices, they might include standards for reliability and system uptime, energy use or environmental compliance.

Intelligent services technologies continuously monitor, collect, analyze and act on information from HVAC and other building systems. If building performance varies from the set standards, the system automatically makes adjustments or alerts operators that there is a problem. In many cases, problems can be solved remotely from a central technical services location without dispatching a service vehicle.

Align building and organization performance

Hospital facilities directors are under a lot of pressure these days to reduce operating costs and make sure that every dollar spent results in several dollars of benefit to their boards, organization, and stakeholders.

With energy costs continuing to rise, environmental expectations getting tougher, and capital and operating budgets being squeezed, more institutions are embracing high performance buildings concepts than ever before. High performance facilities can help improve energy, operating and environmental efficiency, and contribute to productivity and efficiency — all while creating a better environment for patients to heal.

For more information, contact: Kristin Kubicki, Marketing and Communications Manager, at TRANE New York – New Jersey at 718-269-3600 or KKubicki@trane.com.

Or, contact: Stephen Blau, TRANE, at 630-734-6083 or sblau@trane.com.

Dedicated Observation Units: The Clinical and Financial Implications

BY CYNDY KOWALSKI, RN, MPA, C-CDIS

Current healthcare reform efforts have identified inefficiencies in access, cost, and quality of care within acute care hospitals. The Affordable Care Act is strengthening the case for dedicated observation units. Medicare's payment penalties for excess 30-day readmissions will place more pressure on hospitals to decrease inpatient readmissions. In this environment of increased scrutiny, few opportunities exist with the potential to reduce cost, enhance patient satisfaction, and improve the quality of care. Although hospitals have explored the concept of observation, many have not developed such units for reasons that include limited space, resources, or an understanding of the clinical and financial implications.

Visits to Emergency Departments (ED) exceed 120 million each year[1], inpatient beds are scarce and expected to become more so, Medicare payments are becoming less, and audits and denials are becoming greater. The decision to develop any type of observation service begins with a solid commitment from senior leadership and strong physician and nurse leadership.

The Centers for Medicare and Medicaid Services (CMS) define observation care as "ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital." Observation care is intended to be a time-limited outpatient service. According to CMS, "the decision whether to discharge a patient from the hospital or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours."

It is our experience that patients placed in dedicated observation units are more accurately diagnosed, discharged to home faster, payers avoid costly admission charges, and scarce inpatient bed capacity is more appropriately utilized. More frequent use of observation can reduce unnecessary admissions and improve fiscal performance for the hospital while increasing patient satisfaction.

Patients who are managed in dedicated (versus virtual) observation units are more likely to receive necessary testing, have shorter lengths of stay and lower overall care costs, in addition to having enhanced patient satisfaction. Providing an alternative to avoidable admissions, observation units allow the hospital to reserve inpatient beds for those patients that need it and relieve ED overcrowding.

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Dedicated Observation Units: The Clinical and Financial Implications (continued from page 12)

The virtual model is certainly inexpensive, presents as easy to implement, and uses beds located throughout the hospital and existing staff. However, it does contain potentially significant drawbacks, including inconsistent care and delays. It can be a "culture shock" for inpatient clinical staff to care for observation patients whose care requires timely and more frequent assessments and testing. It is unfortunate to lose sight of managing these patients within the 12- to 24-hour window.

Understanding the profitability of a dedicated observation unit starts with the basic hospital profit equation in which profit equals revenue minus costs. Observation units can convert previously unprofitable inpatient admissions into profitable observation stays. Hospitals must be careful about shifting too many cases into observation units.

To finish the profit equation and assist in determining the profit potential of an observation unit, costs must be considered. There are fixed costs, which will include start up and maintenance of the unit and staffing costs. The number of observation patients that one nurse must manage is often higher than inpatient ratios. Variable costs, such as linen and paper charting supplies, are relatively insignificant.

For every patient treated in an observation unit and discharged who would have otherwise been admitted, an inpatient bed could be occupied by a patient with the intensity of service that necessitates the acute level of care. Chest pain is one of the more common observation diagnoses. A patient admitted vs. placed in observation may result in a denial due to lack of medical necessity and recoupment of the MS-DRG. If the patient is most appropriate for observation, the facility has the opportunity to bill outpatient charges such as observation hours and infusion services. An efficient observation unit provides opportunity to manage patients as outpatients and determine the most appropriate plan of care.

Observation units can convert previously unprofitable hospital admissions into profitable observation stays while still providing appropriate evaluation, treatment, and risk stratification.

BESLER Consulting provides a variety of observation and case management services. For more information, please contact Cyndy Kowalski, RN, MPA, C-CDIS at 609-514-1400 or ckowalski@besler.com.

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[1] Centers for Disease Control and Prevention, National Center for Health Statistics. (2010) Selected patient and provider characteristics for ambulatory care visits to physician offices and hospital outpatient and emergency departments. United States, 2008.

"You Inc." The Power of a Strategic Career Plan

BY VICKIE AXFORD AUSTIN

If you're over 40, you may remember a song by Paul Simon, "50 Ways to Leave Your Lover." One recommendation in the song is to "Make a new plan, Stan…" That's great advice, not only in the realm of romance. Having a plan is imperative when it comes to managing your career. No one would ever launch a business without having a solid plan, yet the majority of people approach their careers without having a long-range plan.

I fell for strategic planning back in the 1980s when I worked at Scottsdale Memorial Health Systems, Inc. Prior to coming to the healthcare business world, I'd never been exposed to the power and structure of a business plan. So when John Nimsky, our vice president of marketing and planning, stood up at a flip chart in the executive boardroom and created a plan for our emergency department expansion, I was smitten. I thought, "If this works for a hospital, I bet it would work for me."

At the time I was making a career change from working at the hospital to working for an advertising and PR agency, but I wasn't sure how to get there. After the meeting, I went back to my office, shut the door, pulled out a yellow legal pad and put at the top of the page, "Vickie, Inc." After all, I knew I was the business or product I would have to market. Using the same format I had just learned in that board room, I created my first strategic career plan. The plan worked—within six months, I was hired at a local agency.

As professionals in healthcare financial management, you've probably been exposed to strategic planning. Have you ever thought of using the same process to plan your career for the next three-to-five years? Here's a rough outline to help get you started.

First, think of your goal. Your goal needs to be big—and it's usually about making a difference with others. Your goal could be "Provide financial expertise to a world-class healthcare organization, making a difference in the lives of patients, providers and the organization's associates." Whatever your goal, it should inspire you and others. Don't worry just yet about *how* you'll accomplish this goal—just capture the essence of your purpose.

Next define your objective. This objective (or set of objectives) is specific and measurable. It could be your desired salary, a new title or even your personal net assets. You may want to increase your salary by 50% in five years, reach the status of vice president or save for a home or for your children's education. Whatever those metrics are, it's important to state it as a declaration. An example: "Generate $_____ in annual salary by 2015." [Fill in the blank—what would *you* like to be making in three years?]

The next level of your plan is where "the rubber meets the road." Once you've articulated your goal, and you've defined your objectives, it's time to start creating some strategies. Strategies answer the question "How?" How will you generate that salary (your objective) so that you can make a difference in the world (your goal)? Think of strategies like laying railroad tracks… you're laying the tracks to move your career forward toward that goal. Here's an example of a great strategy: **Elevate your visibility as a**

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"You, Inc." The Power of a Strategic Career Plan

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healthcare financial management professional. Unless you're in the witness protection program, when would you not want to elevate your visibility? Another strategy could be **Develop as a leader.** *Shameless plug for your association: strategies like elevating your visibility or developing as a leader can be accomplished by getting involved in HFMA. And visit the association's website (www.hfma.org) to learn about new, exciting resources planned for the Career Center in 2013.*

The last and most easily understood components of your plan are tactics. Tactics are the action steps we take to support our strategies that support the objectives which, of course, support the goal. Most of us *love* tactics. We write endless to-do lists and cram our calendars full of activities. But are those activities strategic? Are the tactics going to move our careers, and our organizations, forward? Only by having a plan in place can we measure the opportunity cost of our day-to-day activities.

This new year, think about where you want your career to be in three to five years. Put your name at the top of a sheet of yellow legal paper, "[You], Inc." Think about your goal, objectives, strategies and tactics. Write them down. Review and revise it every month, every six months, every year. You'll be amazed at the results.

Vicki Austin

Vickie Austin is a business and career coach and founder of CHOICES Worldwide. She helps individuals and organizations with strategic planning and she's a frequent speaker at HFMA chapters around the country. You can connect with her at vaustin@choicesworldwide.com, 312-213-1795, or follow her on Twitter @Vickie_Austin and LinkedIn, www.linkedin.com/in/vickieaustin.

First Illinois HFMA Scholarship Winners: Where are they now?

BY SYLVIA SORGEL, SORGEL CONSULTING, LLC

Here's one WONDERFUL update on Lauren Marshall, daughter of Steve Marshall, First Illinois HFMA member:

Lauren graduated in four years with a psychology degree from Iowa. Her GPA was around 3.8. She was an intern for Campus Crusade for two years at Florida International University in Miami and this year is her first year on staff at FIU. They've built the campus ministry from fewer than 20 students to over 200 during this time. She has traveled to Turkey and Brazil via Campus Crusade and has received additional training in Orlando, Atlanta and San Antonio. She has started her graduate work.

She has to do fund raising every summer to raise support for her work. She raised her complete support in a little over two months when the average for staff is 5-6 months.

Lauren Marshall

Here's another WONDERFUL update from Allison Perlin, daughter of Steve Perlin, HFMA Member as well:

"This year I have begun creating my own major at the University of Wisconsin- Madison in international human rights in addition to my political science major and dance minor. I am currently researching with a Law professor combining his expertise in international treaty law and my interest in human rights into a project, which will be presented at the end of the year. I am serving as president of the Madison chapter of NAMI (National Alliance on Mental Illness) student organization in addition to my active participation in various other clubs such as Model United Nations. I am enthralled with classes and can't wait for the next semester to start."

Allison Perlin

2013 First Illinois HFMA Scholarship Opportunity

The First Illinois Chapter of HFMA ("the chapter") is proud to announce its 7th annual scholarship program for its members and their children seeking higher education.

Scholarship recipients are chosen by the Scholarship Selection Committee made up of representatives from the chapter.

The chapter is pleased to award five scholarships – one for $5,000, one for $4,000 and three for $2,000. The First Illinois HFMA application cycle is as follows:

- First Illinois HFMA applications can be downloaded from the First Illinois Chapter website – www.firstillinoishfma.org.
- All applications must be **postmarked by February 15, 2013.**
- **All applications should be mailed to:** Vincent Pryor, Edward Hospital, 801 South Washington, Naperville, IL 60540.
- All scholarships will be awarded no later than May 1, 2013.

The eligibility requirements for applicants for the 2013-2014 academic year are as follows:

- Applicants must attend or plan to attend an accredited college, university or proprietary/trade school.
- High school seniors and undergraduate students are eligible to apply.
- Only one scholarship per student will be awarded during their lifetime.
- First Illinois Chapter HFMA members and their children are eligible for scholarships.
- Applicants must be U.S. citizens.

Click Here to access the application. The application consists of six parts: the application, a letter of recommendation from a faculty member, two letters of reference, an essay/testimonial, academic transcripts and an interview with the selection committee.

Please note: Scholarship recipients and their parents will be recognized at the annual installation dinner and awards ceremony in July (date TBD).

Please direct any questions to Vince Pryor at vpryor@edward.org or 630-527-3035.

HFMA Treasury Program: December 6, 2012

First Illinois HFMA's much anticipated Treasury Education Program was held on December 6, 2012, at the Metropolitan Chicago Healthcare Council, 222 South Riverside Plaza Suite 1900, Chicago, IL. The program, which was developed for senior healthcare financial executives, chief financial officers and treasurers, covered a full range of treasury topics relevant in these fluid and challenging times and included dynamic presentations on taxation of hospitals, merger, consolidation and affiliation of providers, investment and capital market updates, capital structure considerations, reimbursement in the world of insurance exchanges and rating agency panel discussions (Fitch, Moody's and S&P). Thank you to all who participated and, and a special thank you again to those who sponsored the event.

Treasury Program: Jim Lebuhn, Pat Moran, Suzie Desai and Mark Pascaris

Treasury Program: Laura Minzer, Grace Daigel and Bill Wachs

Treasury Program: Eric Jordahl and Jeff Friant

Treasury Program: Laurie Warner and Adam Lynch

Treasury Program: Carol Lind, Sandy Kraiss and Francis Fraher

Treasury Program: Brett Tande, Michael Hood, Paul Kenney

HFMA Events

Save the Dates and Updates

ANI 2013 Save the Date

Mark your calendars for this year's ANI event, which will be held June 16-19, 2013, in Orlando, Florida.

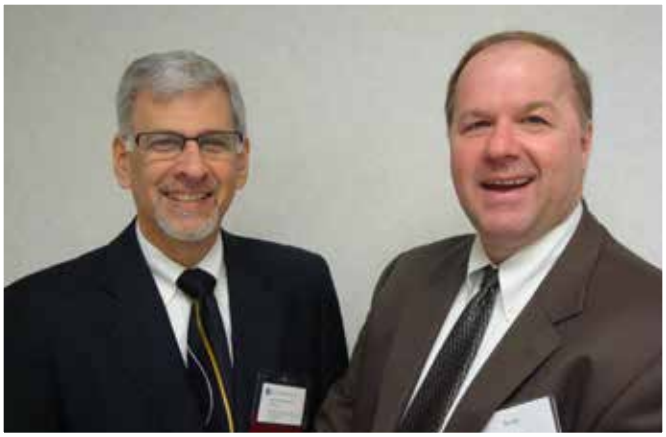
Spring Seminars 2013

San Francisco, CA: April 8–10, 2013

Memphis, TN: May 7–9, 2013

Supply Chain and Operations Improvement Seminar:

November 30, 2012



Steven Berger and Kevin McCole

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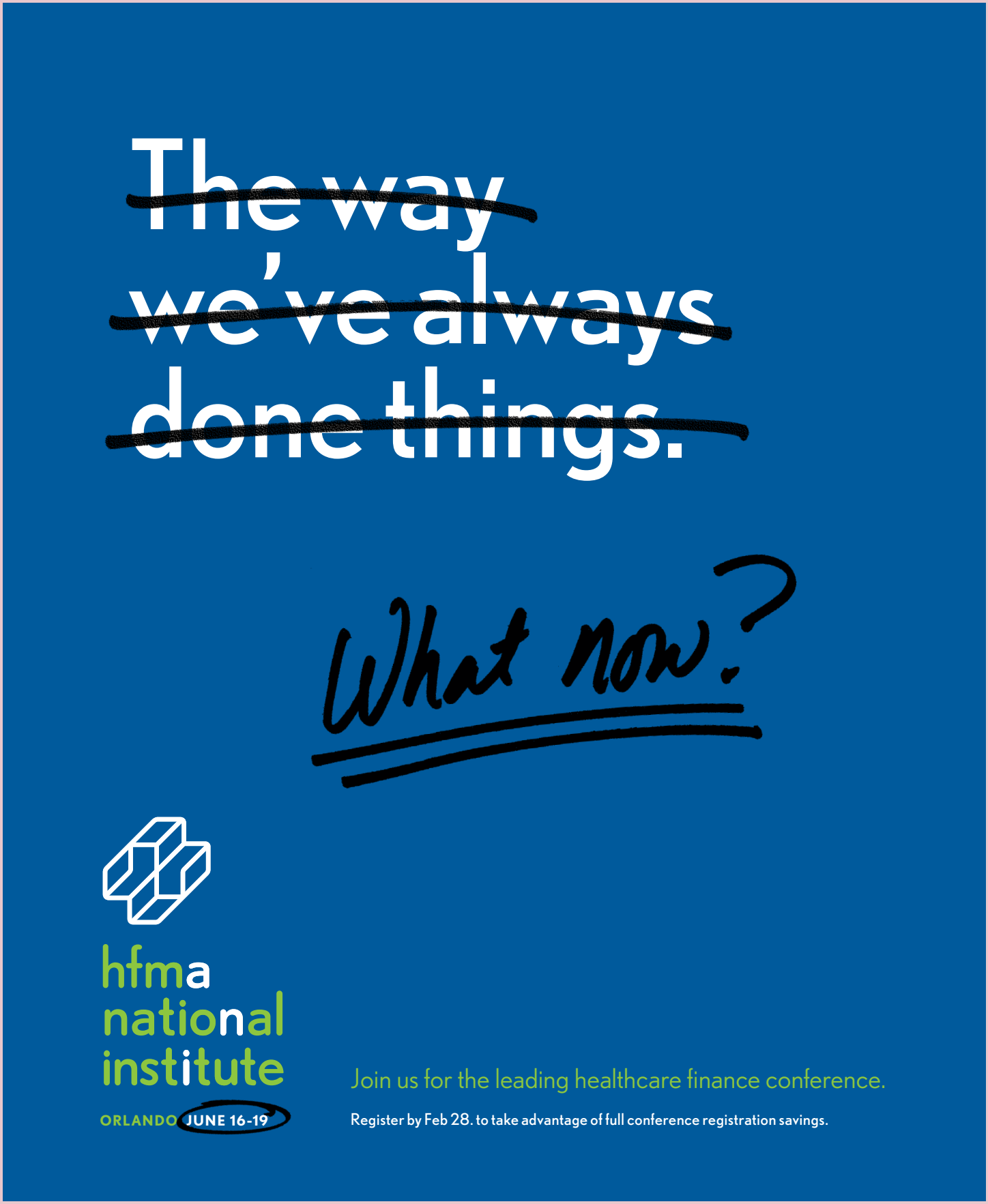
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Member Opportunity to Contribute

Are you new to First Illinois HFMA? A student member? Are you looking for an opportunity to contribute to the chapter and learn? We are looking for members to attend our seminars **– free of charge –** in exchange for providing "recaps" of the events for our newsletter. If you are interested, please contact Tim Manning via email at Newsletter@hfma.com.

First Illinois *Speaks*
HFMA's First Illinois Chapter Newsletter

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HFMA Editorial Guidelines

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

The statements and opinions appearing in articles are those of the authors and not necessarily those of the First Illinois Chapter HFMA. The staff believes that the contents of *First Illinois Speaks* are interesting and thought-provoking but the staff has no authority to speak for the Officers or Board of Directors of the First Illinois Chapter HFMA. Readers are invited to comment on the opinions the authors express. Letters to the editor are invited, subject to condensation and editing. All rights reserved. *First Illinois Speaks* does not promote commercial services, products, or organizations in its editorial content. Materials submitted for consideration should not mention or promote specific commercial services, proprietary products or organizations.

Style

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

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

Founders Points

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

Publication Scheduling

Publication Date	Articles Received By
April 2013	March 10, 2013
July 2013	June 10, 2013
October 2013	September 10, 2013
January 2014	December 10, 2014

First Illinois Speaks
HFMA's First Illinois Chapter Newsletter

event-filhfmaorg@comcast.net

Chapter Educational and Events Calendar 2013

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

Tuesday, January 22, 2013
Webinar: "Model for Commercial Value Based Purchasing with Quantifiable Results and Optimal Gain Sharing Potential" - Accountable Care Solutions Group

Thursday, January 24, 2013
Region 7 Facilities Program

Friday, January 25, 2013
CFO Breakfast

Thursday, February 7, 2013
Revenue Cycle Education Program

Tuesday, February 12, 2013
Webinar: "Hospital Alignment and Integration Strategies" - Grant Thornton LLP

Thursday, February 21, 2013
Reimbursement 101

Friday, February 22, 2013
CFO Breakfast

Saturday, February 23, 2013
Social Event - TBD

Tuesday, February 26, 2013
Webinar: "Lien on Me - Understanding the Illinois Health Care Services Lien Act and Maximizing Recoveries for Providers" - Powers & Moon

Thursday, March 7, 2013
Managed Care Education Program

Tuesday, March 12, 2013
Webinar: "Accounting Issues/Financial Reporting" - TBD

Thursday, March 14, 2013
Compliance Education Program

Friday, March 22, 2013
Leadership Strategic Planning Session

Friday, March 22, 2013
March Board Meeting - In person at location of Strategic Planning

Friday, March 29, 2013
CFO Breakfast

Tuesday, April 9, 2013
Webinar: "ICD-10 Transition Countdown: Ready, Set, Code - Your Complete Strategic Readiness Guide" - McGladrey

Thursday, April 18, 2013
IT Education Program

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