hfma healthcare financial management association

first illinois speaks

A Newsletter from HFMA's First Illinois Chapter

July 2010

STEP Up

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CFO Golf Outing

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The Impact of Health Reform:
Prepare Now for Three Distinct Phases

BY NAV RANAJEE, REGIONAL DIRECTOR, Sg2

The Patient Protection and Affordable Care Act of 2010 (PL 111–148) is a hybrid: part tax legislation, part entitlement expansion, part regulatory reform. It is primarily designed to expand insurance coverage

to an additional 32 million people; what it does not do is reform the organization and delivery of health care.

However, shifts in payment incentives designed to reward performance will challenge providers to change the way they deliver care. The call for accountable care organization (ACO) demonstration projects in the reform bill has many providers scrambling to understand what this means for them. A recent Sg2 Web seminar on ACOs that offered strategies for improving clinical performance across the care continuum attracted a record 700 attendees. To succeed in the next 5 to 10 years, providers must manage performance across inpatient and outpatient care sites, foster hospital/physician integration and control their cost structures.

Understanding the timing of key legislative elements is important. The most condensed sequence: taxes, followed by coverage expansion, followed by more taxes. Budget math largely drove this staging,

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The Impact of Health Reform: Prepare now for Three Distinct Phases

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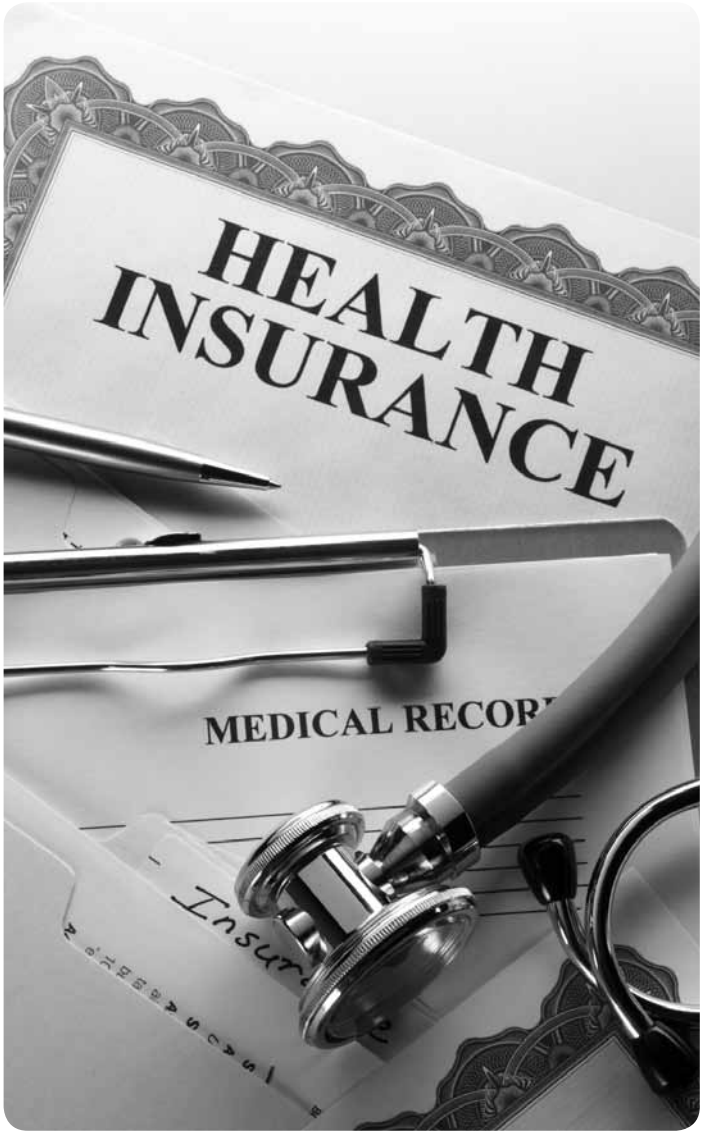
in order to create a law that the Congressional Budget Office (CBO) would score as budget neutral (though eventual budget neutrality seems doubtful). Nevertheless, the sequencing of revenue measures, insurance market reforms, coverage expansion and other elements will shape the future health care market in important ways. Reform's staging can be divided into three time periods:

- 2010–2013: The Prelude
- 2014–2017: Market Expansion
- 2018–2020: Regulation and Restructuring

After a few lean, unsettled years of prelude, most health systems stand to benefit from a rapid expansion of insurance coverage beginning in 2014. To be sure, there will be both winners and losers as disproportionate share (DSH) payments are traded off against broader coverage. However, this is not to imply that the legislation invites complacency.



Later in the decade, we will have something much closer to universal health insurance coverage, a fresh federal budget crisis and a more regulated health care market. Price transparency, rate regulation, bundled incentives and capacity constraints will likely become a reality for most health systems. Scrutiny of costs and value will jump-start focus on accountability and productivity. Smart organizations will develop skill sets that enable them to thrive in a more regulated, budget-driven market.

2010–2013: The Prelude

Reform provisions during this period make minor adjustments to the insurance markets, raise new revenues and set the stage for the big changes beginning in 2014. The U.S. Department of Health and Human Services (HHS) also will be working out the logistics of the new subsidies, insurance exchanges and regulatory structures to follow. The major provisions during this time are:

Hospital payment cuts and incentives for Medicare

- Medicare market basket cuts
- Financial penalties imposed on providers with "excess" readmissions
- Incentives for primary care services

New insurance market rules

- Lifetime benefit caps banned
- Most retroactive rescissions banned
- Coverage of preventive services mandated

New taxes (starting in 2013)

- 0.9% increase in Medicare payroll tax >$200,000 (individuals) or >$250,000 (married couples)
- 3.8% tax on interest and dividends for high-income taxpayers
- 2.3% tax on sale of medical devices

Medicare/Medicaid demonstration projects

- Funding of various demonstration pilots including ACOs, bundled payments and value-based purchasing

Expect a period of slow growth, deteriorating payer mix and a battle for market share. Insurance coverage will continue to erode, mitigated somewhat by the improving economy and new health plan innovations. Securing a permanent sustainable growth rate (SGR) fix will remain the focus for physicians as multiple forces increase the drive toward employment. Primary care physicians will see incremental economic improvement due to increased payment incentives.

This will be a lean, transitional period for hospitals. The winners will employ aggressive channel management to grow market share while readying for the market expansion to follow in 2014. Weaker players will be consolidated. Systems with strong clinical programs, balance

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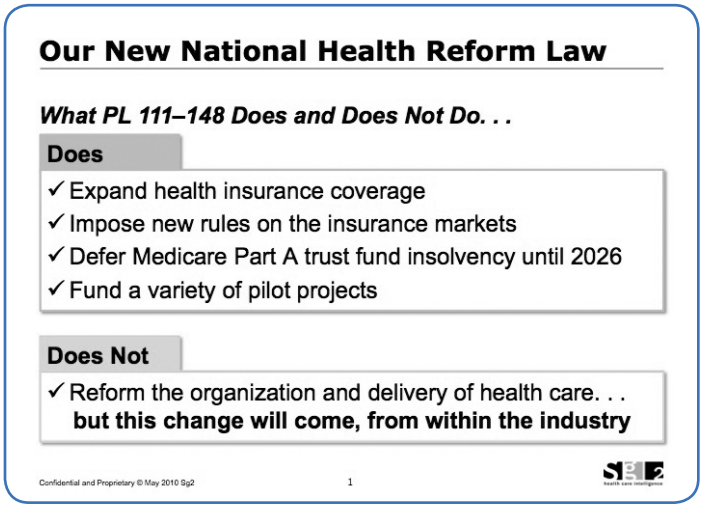
sheets and referral channels will use this transition period to grow market share and gain competitive advantage.

2014–2017: Market Expansion

In 2014 alone, the CBO estimates 19 million uninsured individuals will obtain coverage. The influx of revenue and millions of people into the health system will alleviate many of today's most intractable problems related to the insurance system…and create new problems related to administrative complexity and access to care. These challenges will intensify in some markets as coverage expands to the 92% level. Major provisions include:



Mandatory insurance

- Require most U.S. citizens to have qualifying health insurance; tax individuals without coverage
- Expand Medicaid to all individuals with incomes up to 133% of the federal poverty level (FPL)

New insurance exchanges

- Create state-based American Health Benefit Exchanges for individuals and exchanges for small groups

Employer requirements

- Assess penalty on employers with more than 50 employees that do not offer coverage
- Require employers with more than 200 employees to automatically provide coverage

Reductions in DSH payments

- Cut Medicare DSH payments by 75% initially and then adjust based on percent of population insured

Successful expansion of coverage will hinge on the interplay between individuals, states, health plans, public and private exchanges, and the tax code. Providers should benefit from less bad debt and more paying patients, but the calculus behind reduced DSH payments will challenge states and hospitals. In 2015, a new administration and Congress may be pressured to provide more support to states, regulatory relief to insurers, provider subsidies and tax code tweaks to keep reform on track.

In some markets, newly insured individuals will cause surges in emergency department, primary care and specialist utilization. Hospitals will tap more mature information technology (IT) to improve access and comply with complex quality reporting requirements. Some health systems will pursue targeted or broad risk-contracting models. More states will explore and adopt this mechanism of cost control.

2018+: Regulation and Restructuring

The excise tax on high-cost health plans is the only major provision taking effect during this period. Given political difficulty in enacting the so-called "Cadillac" tax, Congress may never allow this provision to take effect.

The biggest changes will be felt in this period as budget pressures mount and the government moves to increase regulatory scrutiny and contain costs. The true industry impact during this time will result not from the law itself but from forces put in motion by reform.

There will be few truly independent players (hospitals or physicians) remaining. Systems will fight harder for year-over-year performance-based rate increases. They'll also develop mechanisms to weather unpredictable Medicaid payment challenges and value-driven reductions to Medicare reimbursement. The ACO as currently envisioned will work in a handful of markets, but most providers will absorb risk and reward through a radically transformed fee-for-service system. Concierge/tiered access plans will be common in affluent markets. Traditional debt vehicles, philanthropy and new sources of capital will enable ambulatory expansion and selective inpatient projects.

Positioning for the Post-Reform Market

Despite the broad reach of national reform, the law will not disrupt the powerful forces that make health care delivery a local phenomenon. If universal coverage in Massachusetts can be used as an example, providers will be challenged by capacity constraints, budget shortfalls and regulatory scrutiny. Strategies will vary by type of health care system:

Academic Medical Centers (AMCs)

AMCs must find ways to leverage their brands, scale and scope and at the same time address their untenable cost structures. It is time for many AMCs to expand their regional footprints and to organize a full continuum of care through affiliation agreements, expanded physician networks and IT integration. AMCs must become catalysts for workforce innovation that extends diagnostic expertise and collaborative care delivery models over larger populations.

Concentrated Local Systems

These systems may have the most to gain from reform. While focusing on improving their cost and quality positions, they should

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pursue physician alignment models and clinical integration contracting vehicles. They then will be positioned to selectively migrate toward emerging care delivery pilots. These systems can strike agreements with commercial payers that deliver favored rates in exchange for meaningful performance improvements.

Independent Community Hospitals

The decade ahead will force many independent hospitals to seek partners with strong balance sheets, robust IT and favored contracting relationships. Those that currently possess strong cash flow and physician loyalty can outflank larger systems, leveraging their strong performance and service in what will become grueling fights for market share.

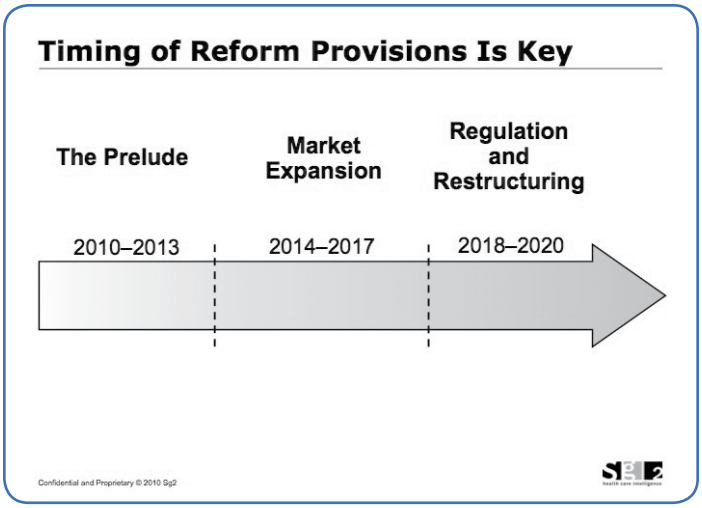
Sole Community Providers

Reform seems to preserve a tenuous protected status for critical access hospitals and other rural providers. Nevertheless, these providers increasingly must seek stronger partnerships with regional health systems that can provide capital, contracts, IT, physician recruitment expertise and clinical leadership.

Conclusion

Health and payment reform will challenge traditional models for managing health care. Over the next 5 to 10 years, a higher percentage of operating revenue will be linked to how well providers coordinate and manage patient care seamlessly across multiple sites of care. Providers need to begin today to understand how they can best structure their organizations to withstand the regulatory and competitive pressures of the next decade.

Nav Ranajee is a regional director with Sg2. He can be contacted at nranajee@sg2.com. Headquartered in Skokie, Illinois, Sg2 provides expert-led, future-focused solutions for growth and clinical performance across the full continuum of health care services. Learn more at www.sg2.com. This article is adapted from an Sg2 special report, The Impact of Reform. Please contact Sg2 to receive a copy of the complete report.



Letter from the President

The year 2010 is going to be a year of transition as healthcare reform begins to unfold. The upcoming changes will shape our industry for years to come – just as prospective pay set the course for healthcare in the past. It is said that the future is what you make of it. In 2010, healthcare will experience significant challenges, and HFMA is ready to assist our members to meet those challenges.

The National HFMA theme this year is "Step Up," and the First Illinois chapter will Stepping Up to assist our members in embracing the new healthcare environment. This chapter year, our focus will go back to the fundamentals of membership, certification and education.

The strengths of our organization reside in our membership and our quality education programs. Member participation in these education programs will provide the core knowledge to ensure members are able to Step Up to the coming challenges. To leverage additional educational opportunities this year, we will be offering more free webinars, and we will not only be partnering with other chapters within Region 7, but also nationwide as well.

Our efforts will also be focused on member certification. Achieving this designation demonstrates a wide-ranging understanding of the healthcare finance environment. We will be exploring the opportunity of both an online and an in-person study group to assist members in preparing for the examination.

Continue to visit our website www.firstillinoishfma.org to keep up to date on these changes and to keep your calendar current. Watch for changes as we begin to transform our website to a more useful tool for our membership.

I am looking forward to "stepping up" to the challenges in the year ahead. With your involvement, we can make 2010 a great year!

Best Regards,

Patricia K. Marlinghaus, CPA, MBA
2010 – 2011
Chapter President,
First Illinois, HFMA

Investment Management and Role of Hospital CFO

BY DAN YUNKER, VP & CFO, METROPOLITAN CHICAGO HEALTHCARE COUNCIL

Old habits die hard. In the 1970s, 1980s, and early 1990s, it was not uncommon for the CFO of a hospital or hospital system to manage the hospital's investment portfolio by buying high quality government and corporate bonds. The CFO would utilize the services of a broker to execute the trades (and perhaps make some recommendations along the way), but ultimate (i.e., fiduciary) responsibility for the portfolio sat squarely on the shoulders of the CFO. This approach was consistent with then existing guidelines and statutes. The Uniform Code of Fiduciary Conduct contained what had become known as the Prudent Man Rule. This section of the code required that only prudent investments be made by trustees and other fiduciaries. The key here is that each investment was looked at independently to determine whether or not it was prudent.

Then in the early/mid 1990s, due to the increasing acceptance of Modern Portfolio Theory (which stipulates that investments should be looked at as part of a portfolio and not in isolation), the Prudent Man Rule was changed to the Prudent Investor Rule. It was during this time that some very large, sophisticated, and successful endowments (Yale, Harvard) were being recognized for the great portfolio management work they were doing. This, combined with the increasing sophistication and ease of access to a variety of investment products, led many hospitals to aspire to a more sophisticated portfolio structure.

This was, and remains, a laudable goal. But with the ever so high demands on many fronts, are hospital CFOs and investment committees well positioned to do this? To be clear, I am not saying that CFOs and committee members are not bright, hard-working and well educated; in my experience, they are. But for most, their investment committee responsibility is not their full-time job. It would be unreasonable to expect them to do the type of analysis, investment selection, monitoring, and risk management required on a day-to-day basis with today's more sophisticated portfolios. Especially in a time when our healthcare finance world as we know it today may be going through a major transformation.

So what's a hospital CFO to do? You can't go back to the simpler portfolios of yesteryear. And would you really want to if you could? Would that be the best way to ensure future assets are available for financial needs faced by the organization?

The CFO/committee structure is well suited to establishing the policy and objectives for the funds and providing a certain level of oversight function. However, most hospital CFOs and investment committees do not have the time, resources or experience to identify, analyze, and monitor these more sophisticated investments and portfolio structures and to do so on a daily basis. Remember, the organizations that legitimized these approaches (such as Harvard and Yale) have full-time, professional investment staffs.

To bridge this gap, an effective CFO and/or investment committee needs to identify the tasks that need to be done and how those responsibilities should break down between committee and staff functions. Here is a list of some of the key responsibilities:

- Investment Policy Statement and Spending Policy
- Portfolio Structure
- Asset Allocation and Risk Management
- Manager/Product Selection and Monitoring
- Account Reconciliation
- Cash/Liquidity Management (receipts/disbursements)
- Committee/Board Communications

Then, the CFO/investment committee determines if its organization is appropriately positioned to handle these responsibilities with the time, experience, expertise, and infrastructure required. If so, then you are in a rare and fortunate situation. But if you are like most hospital CFOs that I'm familiar with, you are not so fortunate. You need to consider alternative structures for these functions that cannot properly be done inhouse.

I have engaged in multiple dialogues with the investment management industry and my sense is that they have recognized this complexity that CFOs face and have begun to respond with a variety of outsourced fiduciary services. And if you are doing this already, remember, just because you are outsourcing certain tasks associated with fiduciary responsibility doesn't mean you've been able to remove that responsibility from yourself. Still, for alternative approaches like these to be effective, you need to know the organization you are working with will put the interests of the hospital ahead of its own interests. That means outsourcing to a fiduciary – i.e., an advisor rather than a broker who, in most cases, will be unwilling to assume such responsibility.

In preparing for this article, I reflected on dialogue I have had with several firms over the past year including our own relationship with Blue Prairie Group. As co-fiduciaries on a number of our portfolios, including our Employee Benefit Trust, 401k and pension plan assets, they have helped our investment committee discharge its fiduciary duty in a sound, procedurally prudent way. And we think the results have been outstanding. Others in the strategic investment space of note are Ziegler Capital Management, an institutional money manager, and Stratford Advisory Group, an institutional investment consulting firm. Similar to Blue Prairie Group, the services from firms like

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Investment Management and Role of Hospital CFO

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these can include investment policy development, asset allocation strategy, investment manager structure, manager selection, performance measurement, and manager evaluation and oversight. Another alternative approach that came to mind was The Endowment Office (TEO). This model is structured as a cooperatively shared office model, which means that a number of groups can share co-op services or an extension of the financial staff in a co-op model which saves your organization FTE's. To be effective the number of organizations participating in this model should be limited because of the time-intensive work required in meeting with the board and committees to plan and execute uniquely designed portfolios.

All of these firms, and there are many others, can offer what I have found to be a successful relationship: working with an organization like Blue Prairie Group, we have been able to save time and money. And, as co-fiduciaries, they have an obligation to put our interests ahead of their own, allowing us to confidently outsource these important staff functions.

I have also found that by using this approach, our internal committees and the Audit and Finance Committee of my board are better able to ask probing, critical questions about the portfolio. Without a separation of functions, it's hard for the committee (or anyone) to sit in objective judgment of their own work. By embracing an outsourcing type of structure, the committee is evaluating the work of the advisor in a more dispassionate and, I would say, "a more reasoned" way.

If your organization does not have a full-time internal investment staff, you may want to seek alternative ways to get the best competency with a firm that will sign-on as a co-fiduciary. This simple step frees the committee (and yourself) to focus on those activities with the biggest payback for your organization and keeps everyone's skills and responsibilities focused on their highest and best use. And in times like these, the need to focus on tomorrow is greater than ever.

Letter from the Editor

"Everything rises and falls with leadership..."

That's how Pat Williams, General Manager for the Orlando Magic and motivational speaker, opened the keynote address at HFMA's 2010 Leadership Training Conference in Phoenix, Arizona. And, given the current state of healthcare, there is no doubt that leadership will play a critical role in navigating the impending reform, separating those institutions that meet the challenges that lie ahead from those that succumb to them.

In an effort to lead the First Illinois membership through these evolutionary times, our goal as the 2010/2011 Newsletter Co-Chairs/Editors is to facilitate the development of a quarterly newsletter that provides timely, relevant and actionable information to its members; to meet this goal, however, we will need your help. As Patricia stated in her President's Message, the strength of our organization resides in our membership – "quiet leaders" in the field of Healthcare Finance who represent the foundation of our chapter.

Over the course of the next year, we encourage you to contribute to the chapter's newsletter. Anyone who has opened our Membership Directory knows that the depth of our membership is remarkable; all facets of healthcare finance are represented, and the Employer Directory reflects a cluster of nationally, if not world renown, institutions.

With that said, our chapter is in an extraordinary position to not only share information, but, more importantly, knowledge! Subsequently, we invite all members who are genuinely interested in helping each other navigate the challenges ahead to Step Up, speak up and write an article!

Tim Manning
Jim Watson
2010/2011 Newsletter Co-Chairs

First Illinois Chapter News, Upcoming Chapter Events and Committee Updates

FI HFMA General Announcement

Member Communication

First Illinois HFMA's primary method of communicating with its members, in keeping with our "green" movement, is electronically / e-mail. If you have "opted out" of receiving the electronic communications we send to you through Cvent, you need to send an e-mail to event-filhfmaorg@comcast.net or call Sylvia Sorgel, Cvent Administrator, at 773-467-4386 in order to continue to receive program information and other updates from your chapter.

HFMA Events

Accounting/Reimbursement and Revenue Cycle Educational Program

BY PATRICK MORAN, BRIAN KATZ, FRED HATCHER

First Illinois HFMA held its 10th combined Accounting/Reimbursement and Revenue Cycle Educational Program entitled, "One Thing Leads to Another," on Thursday, March 18 at the Embassy Suites in Lombard, Illinois. This program had over 160 registrants who participated in this one-day event. The morning session consisted of four presentations on general healthcare topics. It started off with Harry Greenspun, MD, Chief Medical Officer for Dell Perot Systems, who regaled us with the "latest and greatest" update on Healthcare Reform. He was followed by Keith Anderson, Partner with the Law Firm of Drinker, Biddle & Reith, who examined the "sticky issues" around physician employment with hospitals and healthcare systems. At the morning break, Brian Sinclair, First Illinois Award's Committee Chair, recognized two chapter members with their Founder's Merit Awards: Julie Haluska, with the William G. Follmer Bronze Award, and Robert Kuhel, with a Robert H. Reeves Silver Award. We then had a presentation by Brian Reilly, Director from Crowe Horwath, LLP, on the challenging issues that healthcare providers face on the issues of forensic accounting – everyone should be sensitive to e-mail and on-line issues from work! Finally, Terri Jacobson, Director, Mary Anne Kelly, Vice President and Dan Yunker, CFO from MCHC, updated us on the Healthcare Information Exchange, which will affect all healthcare providers in the First Illinois HFMA service area for some time in the future.

HFMA Roundtable Panel

In the afternoon Accounting and Reimbursement track, we heard very dynamic presentations regarding significant regulatory, reimbursement and tax matters. Zack Fortsch, Managing Director with RSM McGladrey, Inc., began the afternoon with an outstanding and comprehensive discussion of changes that will impact the 990 tax form. Zack provided attendees with an example and very insightful suggestions. Tom Jendro, Senior Director of Finance at the Illinois Hospital Association, provided a very timely RAC update; the Illinois Hospital Association is working closely with the hospital community, CMS, MACs and the RAC to communicate new issues and to identify problems. Afterwards, David Reitzel, Senior Manager of Deloitte Consulting LLP, provided a very thorough and timely discussion on the HITECH component of healthcare reform. His presentation included the mechanics and timeline for meaningful use regulations, as well as a discussion of eligibility for Medicare and Medicaid incentives. Finally, Tracey Coyne, Senior Manager, Chris Adams, Manager and Lou Lopez, Manager of Ernst & Young, LLP, provided a dynamic presentation on key reimbursement takeaways; they provided a sample of key changes to the new Medicare cost report form 2552-10.

In the afternoon Revenue Cycle track, we heard from three excellent presenters who focused on key areas which drive the revenue cycle process. The first speaker was Jeff Morgan, representing Revenue Cycle Partners. Jeff delivered a comprehensive overview of how to achieve healthcare best practices for world class customer service, as well as improving performance and patient relations utilizing a call center and customer service focused training; Jeff emphasized the fact that healthcare executives need to recognize the financial importance of customer service in order to increase patient satisfaction and loyalty, as well as understanding that patients are becoming savvy consumers and will demand an even higher level of customer service.

The second speaker was Lisa Walter, AVP Consulting Services, Revenue Cycle Solutions, Dell Perot Systems, who educated our audience with an update of the impact of ICD-10 on revenue and reimbursement. The key take-aways that Lisa put the spotlight on were: there will be decreased revenue initially during the implementation phase; revenue payment will be altered due to the mapping of ICD-9-CM codes to ICD-10-CM and ICD-10-PCS for DRG and payment classification; and there will be increased payment error rate post go-live. Lisa also pointed out the potential impacts and risks during the mapping process from the old system to the new system, which will require a substantial amount of planning and preparation.

The final speaker on the agenda was Chuck Behl, Vice President of Revenue Cycle, Rush University Medical Center. Chuck presented the results of a clinical follow-up study/analysis of SSI/SSDI approvals, during a five-year period. Chuck discussed how the analysis captured the benefits of these federal programs to their organization as a healthcare provider, as well as how they were able to achieve their goal of expanding and enhancing the eligibility assistance for their patient community.

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HFMA Events

Accounting/Reimbursement and Revenue Cycle Educational Program

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Lou Lopez, Tracey Coyne and Chris Adams

Mary Anne Kelly, Terri Jacobson and Dan Yunker

The Revenue Cycle track concluded the afternoon session with a round table discussion, led by Dan Yunker-CFO, Metropolitan Chicago Healthcare Council. The panel consisted of a blend of hospital and physician leadership, focusing on how hospitals and physicians can participate jointly in the revenue cycle process. The dialogue resulting from questions that the panel responded to from the moderator, as well as from the audience, was both stimulating and thought-provoking for all who attended this session.

The Accounting/Reimbursement and Revenue Cycle chairs and committees would like to offer a special thanks to our meeting sponsors:

PNC Bank	Luncheon Sponsor
RSM McGladrey	Breakfast Sponsor
Revenue Cycle Partners	Morning Break Sponsor
Emdeon	Afternoon Break Sponsor

The Accounting/Reimbursement & Revenue Cycle chairs and committees would also like to thank our exhibitors – PNC Bank, RSM McGladrey, Revenue Cycle Partners, Emdeon, ClaimAssist, On Target Staff and Gustafson & Associates, Inc.

CFO Golf Outing

This year's CFO Golf Outing was held at Eagle Brook Country Club on May 10, 2010, and over 70 people participated.

Golf Results:

- First Place team (Ted Newton, Todd Anderson, Matt Rice)
  10 under
- Longest Drive: Ted Newton
- Longest Putt: Todd Anderson
- Three Closest to the Pins: Matt Rice, Patt Marlinghaus, Earl Thomas

Dan Yunker
VP & CFO, Metropolitan Chicago Healthcare Council

Eleven Key Principles of Labor Management

BY ERIC KAMMER, NATIONAL DIRECTOR, LABOR MANAGEMENT PROGRAM, PREMIER HEALTHCARE ALLIANCE

Hospital executives are facing unprecedented economic and environmental issues that add to the already difficult challenges of optimizing quality, managing costs and strategically managing their organizations. Healthcare providers are experiencing volume shifts, state and federal funding cutbacks, reduced access to capital funding, increased bad debt, and more. Many organizations are forced to respond by delaying capital projects, implementing hiring freezes and salary cuts, and additional cost-saving efforts.

On top of these tremendous challenges, the healthcare industry confronts the most sweeping reform in its history. The provisions included within the law will make it necessary for hospitals to transform the way they deliver care to reduce costs, enhance efficiency, improve coordination among disparate providers, and deliver high quality care. Further, adding millions of newly covered individuals will put a strain on certain resources while fundamentally changing how hospitals are paid for services provided to these individuals.

Today's major healthcare constituencies – patients, physicians, employees, various government entities and payers – are demanding higher quality and greater fiscal transparency from healthcare providers. This challenging landscape provokes critical questions that healthcare executives need to confront; namely, how to:

- Manage labor costs
- Manage supply costs
- Improve patient outcomes and the reliable delivery of care
- Engage physicians in improvement initiatives
- Maximize margin and revenues

It is no secret within the healthcare industry that employee compensation is the most significant factor behind hospital costs. In 2008, hospitals employed more than 5.3 million people and spent approximately $322 billion on employee compensation[1]. The American Hospital Association found that approximately two-thirds of every dollar spent by hospitals goes to the wages and benefits of caregivers and other staff. Not surprisingly, the increase in labor costs is the most important single driver of spending growth for hospitals, accounting for about 41 percent of overall growth and almost three-quarters of the growth in the costs of purchased goods and services[2].

Given these facts, it is clear that effectively managing labor costs is a critical strategy for achieving high-order operational efficiency. Effective labor management is a discipline, not an initiative or project. It is a discipline defined as a process that must be continuously refined within an organization and "hardwired" into its culture. The ultimate goal of an effective labor management strategy is to be both fiscally responsible and ensure that the right amount of staff is in the right place at the right time to provide high quality services and patient experiences.

"Hardwiring" an effective labor management process requires attaining a cultural shift that, by default, supports a new paradigm for conducting business. This shift must be then followed by a timely deployment and execution of the required management practices (such as the key principles identified below), combined with personal accountability for performance. Only with these components in place can an organization sustain the success offered by this process.

The identification of improvement opportunities and use of measurement tools alone does not create an effective program or sustained savings. Premier's research has demonstrated that organizations that have deployed focused resources and installed consistent processes related to labor management, in addition to the right measurement tools, have sustained substantial savings over time. These savings can then be applied to other strategic priorities within the organization.

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Eleven Key Principles of Labor Management

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To assist in hardwiring an organization's labor management process, Premier has established the following **Eleven Key Principles of Labor Management**, based on extensive experience and research of best practices in labor management. These practices consistently produce greater staff productivity, transparent performance monitoring, effective accountability mechanisms, standardized position control processes, streamlined budget processes, and increased operating margin:

1. Lead With Quality

It is imperative to identify and measure quality outcome indicators before, during and after change implementation. Better performing organizations focus on results, not just measurement.

2. Understand: This is a Journey

Leadership must drive a consistent awareness within the organization concerning effective management of labor resources. This attitude must pervade the entire organization.

3. Be Objective

Fact-based decision making requires measurement and ideally, multiple measures for opportunity that capture the full spectrum of service. An objective, consistent, institution-wide philosophy is required.

4. Rapidly Design and Implement

Best-practice organizations use effective planning processes and tools, and are adept at rapid deployment of action plans with timelines of six months or less via clear communication and accountability.

5. Achieve Leadership Resolve

Leadership must set the strategic direction and put in place the organizational road map for managing labor. This requires establishing and sustaining a commitment and accountability within the organization.

6. Standardize Processes and Tools

Install standardized processes for establishing, reviewing and updating labor standards. Consistently deploy standardized tools (e.g., productivity reporting) throughout the organization.

7. Use Benchmark and Comparative Information

Identify internal and external best performance practices and sustain continuous improvement via the process of benchmarking.

8. Coaching Support

A "coaching" model is a key component of an effective labor management program. The role of the "coach" is for education, mentoring and facilitation. Ideally, this coach is experienced in principles of effective labor management and an active participant in organizational leadership.

9. Set Aggressive Targets

Set aggressive yet attainable goals. Do not settle for average performance.

10. Translate to Daily Operations

A fair and methodical process combined with regular productivity reporting is needed to assist line managers in translating expectations to daily operations. Leadership must work with line managers to establish expectations and assist in evaluating the best methods to implement changes within departments.

11. "Variabilize" Fixed Costs

Best-practice organizations identify an expectation to flex staffing in support and back office departments on a quarterly basis. It is possible to effectively "flex" labor across all traditional "fixed" departments to an indicator of patient revenue (e.g., global indicators are adjusted patient days or adjusted discharges).

In closing, creating a sustainable labor management program requires both superior data and superior support. Quality must be a priority, and preferred outcomes need to be clearly established in preparation for achieving effective labor management. An organization's leadership must have the will and discipline to move to a different paradigm and put in place a sustainable culture – one where high quality is coupled with low cost, and data is used to improve processes.

Notes:

[1] Analysis of AHA Annual Survey data for 2008. TRENDS: Even as Health Reform Takes Center Stage, Economic Challenges Remain

[2] The Cost of Caring, AHA

Eric Kammer is National Director, Labor Management Program, for the Premier healthcare alliance. For more information please call 773-665-2032 or e-mail: eric_kammer@premierinc.com.

Observe vs. Admit?

With Medical Necessity, Hospitals Pay the Price When Emergency Physicians Get it Wrong

BY JEFF WAJDA, DO, MS, F.A.C.E.P., VICE PRESIDENT OF CLINICAL SERVICES, LYNX MEDICAL SYSTEMS, A PICIS COMPANY

A growing problem for hospitals is not getting paid for the complex medical care they provide. This is happening at an increasing and alarming degree as a result of insurance auditors determining that "medical necessity was not met" when a patient was admitted to the hospital from the emergency department (ED). In other words, the patient should have been treated under "observation," but was instead admitted.

Federal Regulations

Federal regulations driving these audits speak to the growing need for proper medical necessity documentation at the time of "patient disposition," the point when a physician decides whether a patient should go home, be admitted or held in observation. As a result, emergency doctor admissions are now closely scrutinized.

The Medicare Modernization Act of 2003, which established the Recovery Audit Contractors (RAC) program to identify improper Medicare overpayments and underpayments, is responsible for this increasing incidence of post-payment audits and physician scrutiny. RACs are paid on a contingency fee, receiving a percentage of the improper payments collected from providers. From March 2005 to March 2008, a government demonstration project in several states found $993 million in overpayments. Hospitals were liable for 94 percent of the total overpayments. Of the inpatient admissions, 40 percent were deemed medically unnecessary and 35 percent were targeted due to incorrect coding. What does this mean for hospitals and physicians? Medical necessity is completely determined by physician documentation.

OPPS vs. RAC

CMS and the Outpatient Prospective Payment System (OPPS) guidelines have taught us that the best defense against improper patient assignment and compliance concerns is to have a service valuation methodology that is consistently applied across all ED and hospital-owned clinic visits.

Similarly, when preparing for RAC Medical Necessity audits, hospitals need a policy clearly showing that either observation or inpatient resources were properly chosen. Just as the OPPS general guidelines guided hospitals to develop a consistent valuation method for outpatient visits, three CMS documents provide guidance in developing medical necessity policies. These documents are:

- The Medicare Conditions of Participation
- The Medicare Beneficiary Manual – part A
- The Quality Improvement Organization (QIO) manual

CMS Direction

CMS guides hospitals to have admission policies that are part of their hospital bylaws. These policies should reflect best practices based on evidence-based medicine and also mirror the community standard for how a patient-specific diagnosis is managed.

Just as in the OPPS rules, the CMS documents direct hospitals to have their own policies for determining observation or admission status. Developing these policies for the most common cases admitted to each hospital will provide a framework for physicians' decisions. Consistent policy adherence and complete physician documentation at the time of disposition will then allow a hospital to defend decisions successfully and be best protected against retrospective audit takebacks. The policies individualized by hospitals are not only encouraged by CMS, but will also better protect a hospital than Interqual or other payer-developed strategies.

Document to Defend Against RAC Audits

Physicians are often unaware of how their documentation can threaten the financial viability of hospitals. The payment differential between observation and admission status is usually thousands of dollars, but physicians looking to improve medical necessity documentation often find the Medicare regulations difficult to apply to their medical practice. So how can they improve?

Ways to Improve

The following guidelines will help create a viable medical necessity program in any hospital:

- Medicare dictates that hospitals have admission policies specifying how a patient is to be cared for once they are placed in

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Observe vs. Admit: With Medical Necessity, Hospitals Pay the Price When Emergency Physicians get it Wrong

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admission status. All emergency and hospitalist physicians should have evidence-based rules guiding disposition and subsequent treatment of patients not discharged to home. These rules and the specific community standard for how a patient is cared for with a specific diagnosis are part of the hospital's admission policies discussed above.

- Very specific regulations addressing time, patient acuity, expectations of adverse outcomes and patient risk are published by Medicare and meant to guide physicians in their use of observation or admission status. Emergency physician and hospitalist documentation consistent with these rules helps protect hospitals against financial take-backs.
- Documentation of co-existing disease processes or co-morbidities often help make the case for inpatient status. Emergency physicians should know and document all necessary co-morbid conditions.
- Ancillary tests such as CT scans are frequently not paid because of insufficient documentation. Emergency physicians should be familiar with documentation items that justify the need for costly exams.

Emergency physicians are truly expert at deciding which patients should stay and which can be safely discharged. However, a lack of familiarity amongst this group can lead to penalties for hospitals when faced with RAC audits. Arming these individuals with the documentation they need to defend their expert decision is necessary for the success of hospitals.

Dr. Wajda serves as Vice President of Clinical Services at LYNX Medical Systems where he is responsible for clinical software products and coding services development and represents the company with clients and government agencies. With more than 18 years of emergency medical experience and more than 10 years of group/hospital management experience, Dr. Wajda's career has focused on implementation of clinical and business initiatives through physician alignment and IT implementation.

Can Healthcare Reform Impact Your Tax-Exempt Status?

BY STEPHEN M. CHRAPLA, REVENUE CYCLE PARTNERS

Public Law 111-148, Patient Protection and Affordable Care Act (PPACA) will establish compliance requirements relating to billing practices and financial assistance that must be satisfied in order for a hospital to retain its tax-exempt status. In addition to provisions calling for periodic assessments of community health needs, hospital executives also need to be concerned about the detailed operational processes and procedures for patient billing that will be required to be implemented on the front lines. This article addresses the implications for hospitals of the patient billing requirements of PPACA.

Section 9007 of PPACA establishes a new Internal Revenue Code Section 501(r) which imposes the following new operational requirements on the billing practices of tax-exempt hospitals:

- Development, implementation and communication of a Financial Assistance Policy
- Limitations on charges for services
- Billing and collection requirements related to patients

Hospitals will need to comply with these requirements by the start of their next fiscal year after March 23, 2010. This may create some challenges, since regulations governing this legislation have not yet been developed by the Secretary of Treasury and may not be finalized prior to the required implementation date.

Here are the specific requirements that will need to be met:

Financial Assistance Policy that must include:

- Eligibility criteria to qualify for assistance
- The basis for calculating amounts to charge patients
- The method for applying for financial assistance
- Measures established to widely publicize the policy within the hospital's service area

Limitations on Charges:

- Cap on amounts charged for emergency or medically necessary care to patients eligible for financial assistance to no more than the amounts generally billed to individuals with insurance coverage
- Prohibition on the use of gross charges, regardless of a patient's eligibility for financial assistance

Billings and Collection Requirements:

- Prohibition against extraordinary collection efforts until reasonable efforts have been made to determine if a patient is eligible for financial assistance

The legislation constitutes an amendment to the Internal Revenue Code and will be administered by the Department of Treasury. Reviews are required to be conducted not less frequently than once every third year.

The Secretary of Treasury is authorized to issue regulations and guidance as may be necessary to carry out the provisions of the legislation. The Secretary is specifically directed to provide guidance as to what constitutes "reasonable efforts" for a hospital in determining the eligibility of a patient under a financial assistance policy. The timing of any such regulations and guidance, however, remains uncertain. Typically the Secretary of Treasury issues regulations in preliminary form, followed by a comment period in which interested parties have an opportunity to provide written submissions raising issues, concerns or questions about the proposed language, after which final regulations are promulgated. This process can sometimes take many years. Nonetheless Congress specified that new Code Section 501(r) applies starting with a hospital's next fiscal year following the enactment date, regardless of whether definitive regulations and guidance have been issued by such date.

What does new IRC Section 501(r) mean to hospitals?

Hospitals must meet the requirements of new IRC Section 501(r) in order to maintain 501(c)(3) tax-exempt status. While many hospitals may already operate in a manner largely consistent with the intent of this new legislation, it is critical that the detailed operational aspects of the legislation as well as the related regulations are met. Compliance will be ruled on very specific criteria that differ from previous tax-exemption criteria and state chartered charity designations.

Financial Assistance Policies. Financial Assistance Policies will need to be reviewed and revised as appropriate to include specific criteria for eligibility as well as how amounts will be calculated and the method for a patient to apply for financial assistance. Hospitals will also need to specify, either in the Financial Assistance Policy or in a separate billing and collections policy, the actions they may take in the event of non-payment, including collections action and reporting to credit agencies. The method for communication will also be more extensive than what was customary in the past for many hospitals, in order to satisfy the requirement to "widely publicize" the Financial Assistance Policy within the community.

Limitations on Charges. Gross Charges. Any hospital whose current practice is to impose "gross charges" for services rendered to patients who are not otherwise entitled to a contractual

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Can Healthcare Reform Impact Your Tax-Exempt Status

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allowance with an insurance company or other third-party payer will need to adopt a new pricing approach in order to take into consideration the blanket prohibition on that practice. Since the legislation is silent as to the amount of allowance necessary to satisfy the new requirement, it will be important to monitor guidance from the Secretary of Treasury regarding acceptable levels. Irrespective of whether any such guidance is provided, hospitals must eliminate "gross charges" before the start of their next fiscal year.

Patients Eligible for Financial Assistance. A second limitation relates to amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the hospital's Financial Assistance Policy. In these cases, the hospital may charge only "amounts generally billed to individuals with insurance coverage." The determination of "amounts generally billed" is not further clarified in the legislation. Presumably a charge for any given medical procedure that reflects roughly the mid-point of the range of prices agreed to between a hospital and the insurance companies with whom it has contractual arrangements would satisfy this test. Whether amounts that are higher than the mid-point but still reasonably within the range of contractual pricing would also satisfy the test remains unclear. The Secretary of Treasury may (but is not required to) provide further guidance on this calculation.

In order to comply with this additional rule affecting eligible patients, a hospital must either (1) unilaterally adjust all patient bills receiving emergency or medically necessary care to reflect amounts which satisfy the "generally billed" test, regardless of financial need, or (2) affirmatively determine patient eligibility for financial assistance and adjust the bills only of those patients. If the latter, an open question remains as to the actual mechanism for making the adjustments. For example, must a hospital contact all patients prior to sending out any statements in order to ensure that no eligible patient receives a bill showing more than the "generally billed" amount? Or is it sufficient to include a blanket disclaimer in all patient statements advising them of their right to a further discount if they meet eligibility requirements for financial assistance, and to then make adjustments only on those statements where eligibility has been determined by subsequent communications initiated by the patient? While the latter interpretation might seem reasonable, the legislation is not clear on this point. Again, the Secretary of Treasury may (but is not required to) provide further guidance.

Extraordinary Collection Efforts. A hospital must make "reasonable efforts" to determine whether a patient is eligible for financial assistance before it engages in "extraordinary collection actions." Once again the language of the statute alone leaves room for interpretation, although the Secretary of Treasury is specifically mandated to define the phrase "reasonable efforts." "Extraordinary collection efforts" almost certainly is intended to preclude lawsuits, arrests, liens, or similar actions prior to satisfaction of the "reasonable efforts" standard, but it may well encompass other collection practices as well, such as reporting to consumer credit agencies, threats of legal action or credit reporting, or referring delinquent accounts to an outside collection agency. What is clear is that traditional billing and collection protocols that place the burden on the patient to request or avail themselves of financial assistance will no longer be allowed. Simply sending a patient a series of statements and thereafter commencing aggressive collection efforts is likely to violate the statute. Instead hospitals will need to demonstrate that they have tried in good faith to make a determination of financial assistance eligibility prior to resorting to extraordinary collection efforts. Satisfactory documentation of these efforts will also be well-advised, if not required.

What steps do hospitals need to take?

1. Review current policies for financial assistance, billing and collection and make necessary revisions to comply with the new regulations.
2. Establish Financial Assistance Policy communication protocols for wide publication.
3. If gross charges are currently used, establish a discount policy applicable to patients without insurance or other third-party coverage.
4. Determine what amounts will be charged to patients qualifying for financial assistance.
5. Establish protocols and procedures for screening patients for eligibility for financial assistance, including a documented process meeting the "reasonable efforts" test.
6. Review staffing levels and quality metrics in patient billing area, adding internal or external resources as necessary to ensure compliance.

For further information regarding the billing and collection implications of new IRC Section 501(r) for your institution, please contact Stephen M. Chrapla (phone number: 847-395-7655. E-mail: schrapla@revenuecyclepartners.com).

About Revenue Cycle Partners

Revenue Cycle Partners LLC (www.revenuecyclepartners.com) provides a comprehensive suite of account resolution management services to hospital clients throughout the United States, focusing particularly on non-delinquent patient accounts and third-party follow-up.

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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.

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
October 2010	September 10, 2010
January 2011	December 10, 2010

Healthcare Financial Management Association First Illinois Chapter

Chapter Educational and Events Calendar 2010/2011

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

Wednesday, August 11, 2010
Social Event with CHEF - Sox Game
Chicago, IL

Friday, August 20, 2010
HFMA 101
Morton Arboretum

Tuesday, August 31, 2010
Webinar
Online

Wednesday, September 8, 2010
Social Event - Cubs Game
Chicago, IL

Friday, September 24, 2010
CFO Breakfast
Elmhurst Center for Health, Elmhurst, IL

Tuesday, September 28, 2010
Webinar
Online

Thursday, September 30, 2010
aIPAM
Location TBD

Thursday, October 21, 2010
Accounting/Reimbursement Education Program
Location TBD

Friday, October 22, 2010
CFO Breakfast
Elmhurst Center for Health, Elmhurst, IL

Tuesday, October 26, 2010
Webinar
Online

Thursday, November 18, 2010
Compliance Education Program
Location TBD

Friday, November 19, 2010
CFO Breakfast
Elmhurst Center for Health, Elmhurst, IL

Tuesday, November 30, 2010
Webinar
Online

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