hfma healthcare financial management association

first illinois speaks

A Newsletter from HFMA's First Illinois Chapter

March/April 2007

Part One of a Two-Part Series

Performance Based Contracting

Its time has come, are you ready?

BY WILLIAM DEMARCO

Courage IN LEADERSHIP

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PPC is coming to the hospital managed care desk and we see many institutions wrestling with billing and collecting from current agreements and walking right into the jaws of insurers who now have more data on the provider's performance than many hospitals do.

Hospitals who think they have all the data are falling short because they are missing essential primary care and specialty care claims data and cannot break down even admissions data by employer name, only payer category.

As we move from discussion about wholesale contracts with buyers like managed care to a retail environment of consumers with big deductibles the market for hospital and physicians services changes.

Employers and the government are demanding price and quality transparency as they have concluded that the value of services continues to vary from city to city and from hospital to hospital. With more information now being released from private and public

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Inside This Issue

President's Message

Courage
IN LEADERSHIP

As President of the First Illinois Chapter of HFMA, it is important to me that during my tenure we focus on giving back to our membership. To that end, our chapter leadership has made a concerted effort to provide more opportunities for networking and education to demonstrate value to the membership.

During this year we have initiated social events that have been successful in both providing networking opportunities and enjoyment to the attendees. Our Chicago White Sox outing was well attended, as was our most recent Casino Night. Both events provided an opportunity for new and veteran members to network in a fun environment free from the grind of the work day.

On the education front we have started monthly webinars on relevant healthcare topics that are free to our membership. These webinars commenced in January with the first two programs being put on by RSM McGladrey. Future webinars are being provided by chapter sponsors, Plante Moran and NEBO systems.

Finally, continuing with the theme of returning value to our membership we have initiated a Scholarship Program for members and their children. This year we plan to recognize three individuals with scholarships to continue their education. We are viewing this as an investment into the future. Scholarship recipients will be recognized at a chapter event in the future.

Whether you look at HFMA from a local chapter perspective or at a National level or both, there are many opportunities available to our membership to take advantage of on a daily basis. Our objective this year has been to be front and center with opportunities, with the hope that everyone of our over 1,200 members will be positively impacted by what we can offer. Hopefully, you have experienced this to date or if not will take advantage of one of our offerings in the near future.

Sincerely,
Vince Pryor
President
First Illinois Chapter HFMA

First Illinois Chapter News, Upcoming Chapter Events & Committee Updates

CFO Committee

The CFO Committee will present their 12th Annual Education Session on Thursday, May 10th, 2007 at Medinah Country Club. The theme of the ? day program is "Executive Leadership and Mentoring: Fulfilling Personal and Professional Missions". Co-chaired by Guy Alton and Jeff Rooney, the program features a variety of topics highlighting leadership development and skills, the importance of being effective leaders, and the significance of being strong mentors and coaches. A group of nationally known speakers will have the opportunity to share their insights with attendees, followed by a panel discussion/ Question & Answer Session. Registration information can be found on the First Illinois website at www.firstillinoishfma.org.

Additional questions can be directed to either Co-Chair Guy Alton at: 630-962-4073 or Co-Chair Jeff Rooney at 312-233-2443.

Golf Committee

31st ANNIVERSARY! First Illinois Chapter HFMA GOLF OUTING MAY 25, 2007

The 31st First Illinois Chapter HFMA Golf Outing will be held on Friday, May 25, 2007, with the primary scramble location at St. Andrews Golf and Country Club and Klein Creek Golf Club for regulation play.

- All participants in our outing receive our golf gift - a North End Lightweight Hybrid Jacket – great for all weather occasions!!
- For early bird golfers, an early barbeque will be held from 11:00 AM to 1:00 PM – outdoors, weather permitting.
- Our regular networking barbeque will be held after golf – the BBQ opens at 3:00 PM and runs until 7:00 PM.

Look for your invitation and tee time reservation form in the mail!

HFMA Event

HFMA 101– It's About You – 2006!

Thursday, September 21, 2006

The First Illinois Chapter had the opportunity to present "HFMA 101 – It's About You" to over 45 attendees. This program, which was presented in its second year, was aimed at helping HFMA members maximize their HFMA membership and included a wide variety of topics, ranging from learning about educational offerings to better understanding the volunteer committee opportunities available at the local chapter level.

After a welcome and introduction from Jim Watson, President-Elect of the First Illinois Chapter, the opening HFMA overview was conducted by current First Illinois President Vince Pryor. Amongst the highlights noted in the overview were a review of HFMA's mission, vision and strategy followed by comments addressing First Illinois Chapter strengths and areas of opportunities. Some of the chapter strengths cited included the size and diversity of the chapter, ongoing volunteer committee opportunities, depth of educational program, use of technology resources to deliver information, and ongoing forums for members to interact with fellow healthcare professionals.

Areas of opportunity that were cited included potential collaborations with other organizations, improving the availability of "just in time training" to respond to key industry issues, encouraging additional membership participation in committees and leadership development opportunities, and identifying opportunities with local universities to further develop student membership opportunities. Those opportunities have been incorporated as part of the long-term planning process and strategic plan for First Illinois

Jim Heinking, Immediate Past President of the First Illinois Chapter spoke about the structure of the organization, including officer and board member roles, highlighted the broad scope of events planned for the chapter, and presented more in-depth information about the variety of services available through the national HFMA organization. Those services include various programs to assist with compliance and training, training tapes, and comprehensive subscriptions with quarterly updates.

Various committee chairs were also present during the day's program to speak about their specific area of contributions to the chapter.

- **Brian Sinclair** - Education Committee Chair and **Janet Blue** – Membership Committee Chair - addressed the significance of committee and programs in serving as the underlying basis for chapter events. Highlighted in their presentation were the variety of committee's availability and the diversity of activities that are encompassed by committee membership.

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L to R – Mike Nichols, Pat Moran, Dan Cook, Paula Dillon, Guy Alton, Brian Sinclair, Janet Blue, Jim Heinking

WANTED!

Local healthcare organization seeking motivated and enthusiastic editors and writers with sharp eye for detail, knowledge of the healthcare marketplace, and a desire to become more involved with HFMA's 1st Illinois Chapter. If you fit any of those criteria, we have the opportunity for you – a leadership role on the *First Illinois Speaks* newsletter team!

Published quarterly, *First Illinois Speaks* is one of the primary communication vehicles to our chapter membership and has received previous national recognition for its efforts. The chapter will be planning for its 2007-08 activities and as the current editorial staff will transitioning to other roles, the newsletter will be in need of individuals interested in becoming more involved with *First Illinois Speaks*. We would like to invite any and all comers to become involved with the production of this publication.

Benefits include a flexible work schedule, flexible job responsibilities and a supportive team environment, on-the-job-training and resource materials and guides. Peer recognition recognition for a job well done is an additional bonus!

Please contact Paula Dillon, the 2006-07 Newsletter Co-Chair, to learn more about this great volunteer opportunity!!

HFMA Events *HFMA 101* *continued from page 3*

- **Jim Ventrone** – Sponsorship Committee Chair - spoke to participants about the importance of sponsors for the Illinois Chapter, including helping members understand who current sponsors are and their specific roles: proving financial resources for program funding, technical expertise for chapter activities and proving other services and resources in general to members.
- **Paula Dillon** – Newsletter Committee Chair – provided an overview on the structure of First Illinois Speaks, the newsletter for the First Illinois Chapter, including best practices and improvements in availability of editor resources.
- **Guy Alton** – Secretary – presented members with a virtual tour of the national and local HFMA websites. This live demo allowed members to see in person the ease of navigation through the various websites as well as the wide scope of information available through both national HFMA as well as at the chapter level.
- **Mike Nichols** – Treasurer – spoke to members about the availability of HFMA certification and the importance and relevance that certification has in today's healthcare environment.

Speakers during the day's program also emphasized the ongoing value that HFMA brings to its membership through 1) educational program offerings; 2) ongoing publications with pertinent industry news; 3) availability of committees to foster collegial discussions and program planning; 4) updated websites and web tools to make information more accessible; 5) leadership development opportunities; and 6) ability to network with industry peers.

L to R: Thomas Jendro, Ms Seals, Farana Ahmed

Access Gone Wild!

Thursday, September 28, 2006

In conjunction with the Association of Illinois Patient Access Management (aIPAM), the First Illinois Chapter hosted "Access Gone Wild" at the Brookfield Zoo in September. Over 130 healthcare access professionals were in attendance for a uniquely designed program that featured topics ranging from "Understanding Privacy Requirements", "Navigating the Maze of Technology Options", and "Improvements in Quality Monitoring".

Numerous vendors were also on hand to facilitate discussions with attendees and offer a variety of solutions to the complexity of healthcare issues facing the participants. Seminar attendees were also treated to motorized tour of Brookfield Zoo before returning for lunch and afternoon presentations.

The keynote speaker was none other than Bill Rancic, the original "Apprentice". Mr. Rancic, the successful author of a book entitled "Beyond the Lemonade Stand", spoke about the multitude of skills necessary in life, and offering highlights of his entrepenurial past (audience members found the tale of making pancakes at his grandmother's house highly entertaining). After a brief presentation, Mr. Rancic took questions from the audience, addressing such topics as setting one's self apart from the pack, qualities of effective leaders, getting started in business, and making your "5 minutes" count.

Access Gone Wild Tour Bus

Barb Disher and Lee Remen

Bill Rancic

Jim Watson and Bill Rancic

Linda Martin-Schumacher, Bill Rancic and Debbie Valek

John Dunegan and Vicki Judd

Michael Friedberg

Katherine Murphy

Dr. Matthew Lambert

HFMA Awards and Certifications

Founders Merit Awards for 2006

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

Mary Anne Klis and Vince Pryor

Charles Barth and Brian Sinclair

President Vince Pryor congratulates Treasurer Mike Nichols for achieving the CHFP designation.

The Healthcare Financial Management Association (HFMA) recognizes that its strength lies in volunteers who contribute their time, ideas, and energy to serving the healthcare industry, their profession and fellow colleagues. Established in 1960, the Founders Merit Award series provides a formal acknowledgement knowledges The First Illinois Chapter continued to honor several chapter members during the 2006-07 chapter year for their long term contributions to the First Illinois Chapter. The newest recipients of the Founders Merit Awards are Charles Barth, Fullmer Bronze Award and Mary Ann Klis, Fullmer Bronze Award.

Congratulations are in order for the recipients of the 2006 Founders Merit Awards. National HFMA recognizes that its strength lies in the volunteers who contribute their time, ideas and energy to serve the healthcare industry and their local chapter. The Founders Merit Award program was established to acknowledge the contributions made by individual HFMA members.

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

The 2006 award recipients are:

Follmer Bronze Award

William J. DeMarco
Paula Dillon
Dennis Gooche
John Roquena
Jeffery Rooney
Sylvia Sorgel
James Watson
Pamela M. Waymack, FHFMA

Reeves Silver Award

Michael Nichols, CPA, FHFMA
Alexis Washa, CPA, CHFP

Munice Gold Award

Guy Alton, CPA, FHFMA
Martin D'Cruz, FHFMA
James Heinking, FHFMA
Shana Jacobs Jones, FHFMA
Jerry Jawed, FHFMA
Thomas Jendro, FHFMA

Certification Status

Mike Nichols becomes the newest Certified Healthcare Financial Professional (CHFP). Congratulations to First Illinois HFMA Chapter Treasurer Mike Nichols on achieving the Certified Healthcare Professional designation!! Certification required not only ongoing HFMA membership and professional experience but successful completion of both the Core and Specialty certification examinations.

Please refer to your chapter membership directory for more information regarding the awards series, scoring details and a listing of all former recipients. If you have any questions regarding the awards or your current point status, please call Brian Sinclair, Chairperson, Awards Committee, at 847-227-2268.

Jane Bachmann receives HFMA's highest honor

Jane Bachmann was presented with the Medal of Honor by current First Illinois Secretary Guy Alton on October 19th, 2006. The Medal of Honor is awarded to those members who, after achieving all three Founders Awards – Follmer Bronze, Reeves Silver, and Muncie Gold – continue to significantly contribute their time and talents to HFMA. Ms. Bachmann is President of Bachmann Associates and is an outstanding and long-time contributor to the First Illinois Chapter. Jane has been a member of First Illinois since 1981. She has been extremely active and has served as Directory Chair since 1998. She has also served on the Board of Directors (1990-1992) and chaired numerous committees over the years, including Registration, Newsletter, Membership, GLD, and Classroom Education. Jane was the recipient of the Follmer Bronze Award in 1989; the Reeves Silver in 1997; and the Muncie Gold in 2002.

Medal of Honor Presentation
Jane Bachmann and Guy Alton

HFMA National Founders Points

Do you know your Founders Points? Founders Points are awarded to members for service to their Chapter and National HFMA, and are the basis for the Founders Merit Awards: The Follmer Bronze award, Reeves Silver award, and the Muncie Gold award. For more information on the awards and their history, please refer to the Awards and Recognition section of your member directory, or call the First Illinois Chapter Award Committee chair, Brian Sinclair at (630) 307-9138. Members can check their current point totals at any time by reviewing your profile in the Member Directory section of the National HFMA website, www.hfma.org.

In 2004-2005, HFMA revised the Founders Award point system. In keeping with the core purpose of the recognition program, the Founders program will only record points for volunteer effort, and no longer include points for attendance at HFMA educational events. (Attendance for CPE credit is tracked separately).

Additionally, Founders Points are no longer a requirement for maintaining certification. That requirement was replaced with a 90-contact hour requirement over three years. More recent changes: in April 2005, the Regional Executive Council of HFMA voted to re-align the Founders Muncie Gold award level from 100 to 75 points, effective for the 2004-05 year.This change only affected members with a total of 201 Founders points or above. The converted "old" totals through May 31, 2004 were amended accordingly. The change does not affect certification maintenance since Founders Award points are no longer used for certification maintenance. Nor does the change affect any of the awards already distributed for the 2004 year. The Regional Executive Council also approved the following changes to the Founders Program:

1. Point allocations adjusted as follows, effective for the 2004-05 year:
   – Newsletter Article- raised from 1 point to 2 points per article published (National and Chapter)
   – Committee Co-Chair - reduced from 4 to 3 points per co-chairPosition
2. Approved language to more clearly define significant service for the Medal of Honor award criteria, effective for the 04-05 year.

If you have questions, please contact Award Committee chairperson Brian Sinclair at 847-227-2268

HFMA Events

Healthcare Finance: A Magical Mystery Tour

Thursday, October 19, 2006

BY PAULA DILLON, FIRST ILLINOIS SPEAKS EDITOR, 2006-07

The First Illinois Chapter Revenue Cycle and Accounting and Reimbursement educational committees joined efforts this past year in presenting a day-long program focused around topics applicable across both functional areas – approximately 150 members were in attendance at the day's general event. The combination of the committees was intended to provide a better sense of community amongst topics and participants, as well as foster more collaborative efforts. One additional new offering for this program featured breakout sessions in the afternoon – one specific session focused around revenue cycle and the UB04 education component; the secondary breakout session featured topics pertinent to accounting and reimbursement issues, including pay for performance and tax updates.

Featured topics for the overall program were wide ranging. The kickoff speaker, John Bohmer of the Illinois Hospital Association, focused around the current state of issues in the hospital community, with some discussion around the impact that politics is having on the current healthcare landscape. Additional discussion points in Mr. Bohmer's presentation focused around the impact of the Provena decision as well as potentially how organized labor while serving a catalyst for action, does not necessarily solve all healthcare problems.

David Warren, Regional VP of Healthcare for Textron Financial Corporation, provided a capital markets update – a wide scope of points were covered in his presentation, including an overview of healthcare marketplace demographics and equity market caps in various health care sectors.

Anthony Colarossi and Dawn Dietrich of Plante Moran provided a updated perspective on pricing transparency – in particular, their comments centered around the target audience, how competition creates an impact on overall volumes, effective means to communicate pricing transparency and what pricing transparency may look like in the future and how healthcare professionals will be impacted and involved.

Anita Grivins and Chad Schafer

Anthony Colarossi and Dawn Dietrich

Carl Amour

David Warren

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HFMA Events

Interoperability: Vision, Execution and Funding of One of the Political Season's Hottest Topics

Thursday, November 16, 2006

BY EDWARD CAMPBELL

The IT committee presented its fall educational event on November, 16, 2006 at Aramark Headquarters with a central theme of interoperability – the overall goal of the program was designed to explore ways to connect data and people with the intention of improving health as well as examining during the half-day session national, state and regional initiatives as well as funding and infrastructure issues.

A number of attendees were on hand to explore the impact of an Executive Order by President George W. Bush on August 22 calling for increased interoperability as one step toward high-quality health care.

Gary Katz

The first speaker, Gary Kaatz, President and CEO of Rockford Health System, spoke about challenges faced in his role as Chair the Illinois Regional Health Information Organizations (RHIO) committee. His committee is tasked with establishing principles for the development of RHIO in Illinois.

June Horowitz, Vice President & Chief Marketing Officer of the National Alliance for Health Information Technology gave an informative of view of what is taking place in Louisiana in the aftermath of the Katrina Hurricane. The devastation particularly in New Orleans provided an opportunity to examine the then two tier health system and recommend its replacement. The Louisiana Redesign Collaborative, sanctioned by the Louisiana governor, was created to provide direction. A redesign plan was a condition of federal funding. The building blocks of the plan were quality definitions and expectations, care delivery and reimbursement systems, and consumer understanding. The second phase of the collaborative will address reimbursement and payment issues. Ms. Horowitz stressed the need for healthcare professional to get involved in this effort.

Lydon Newmann

The next presenter, Lydon Newmann, Partner, Accenture Health & Life Sciences says that momentum for interoperability is building. Accenture is one of four consortiums charged to develop national health information network (NHIN) prototype architecture. The working prototype supports biosurvelliance, EHRs, and consumer empowerment. The demonstration site is the Appalachian Region. Major challenges to the development of NHINs, included the lack of standards and the development of trust between providers.

Uday Ali Pabrai

Uday Ali Pabrai, CEO of ecfirst.com, spoke on security issues confronting NHINs. He challenged the audience to think how confident we are of our organization's security posture. In doing so it became clear how susceptible the healthcare industry is to large multipurpose computer network attacks and the rising threat of at attacks on patient information. In this environment NHINs must employ state of the art and stringent security features if privacy is going to be preserved. Mr. Pabrai outlined enterprise security prioritieas and emerging trends. He also stressed the need for good governance.

Michael Lincoln

The final speaker was Michael O. Lincoln, Managing Director, GE Healthcare Financial Services, Inc. In his presentation, "The Funding and Bond Rating Impact of Interoperability", Mr. Lincoln pointed out that information technology is fast becoming an important factor in bond ratings. Bond rating agencies are questioning and evaluating how IT is being used, how much is been spent and noting IT management capability. Mr. Lincoln reinforced that as funding becomes limited, organizations will have to assess what assets need to be owned vs. what assets need to be controlled. A panel discussion composed of the presenters addressed questions from the audience.

Discussion continued over lunch. The open ended topics addressed the IT challenges including electronic medical records and other digital enhancements for providing healthcare. The following speakers participated in the roundtable discussion that was moderated by Mr. Pabrai.

Rockford Memorial Hospital
Joe Graneman, Director of Technical Services

Northwest Community Hospital
Suresh Kirshnan, Chief Technical Officer
Current & future challenges related to IT and their future impact on healthcare delivery in acute care facilities.

Savvis, Inc.
Stephan A. Ward, Industry Solutions Manager - Healthcare and Retail
The value of healthcare hosting vendors to help meet IT requirements for Disaster Recovery, Managed Services, Bulk Storage and external cost effective Hosting.

IBA Health Limited
Farhad Adam Abar, Ph.D, Chief Architect
Transforming healthcare delivery across the globe.

SP Services Inc.
Arindam Chatterjee, Managing Partner
IT impact on Business Solutions for Healthcare.

– Edward Campbell is Vice President of Pridevel Consulting and a member of the First Illinois HFMA Chapter. Mr. Campbell can be reached at ed.campbell@pridevel.com

HFMA Events

Thursday, October 19, 2006

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Patrick Finnegan of the Metropolitan Chicago Healthcare Council concluded the morning session with a detailed presentation on the lessons learned in healthcare from Hurricanes Katrina and Rita – Mr. Finnegan's presentation spoke at length to the concept of emergency preparedness, MCHC's specific role and recent disaster preparedness activities understaken

Participants regrouped in the afternoon to attend one of two breakout sessions: "UB04 Education – the Latest and Greatest", presented by Suzanne Lestina of the national HFMA office and Accounting and Reimbursement Issues – featuring discussions on "Pay for Performance", Howard Underwood, M.D. of Deloitte Consulting; "Tax Updates" by Zachary Fortsch of RSM McGladrey; "FASB Guidelines Update" by Chad Schafer of Plante and Moran; and "Medicare IPPA Final 2007 Rules" by Carl St. Amour of Ernst and Young.

Howard Underwood, MD

John Bohmer

The Case of DRG 243: A Practical Approach to Utilizing PEPPER Reports

BY LISA L. CAMPBELL, MHA, CCS, CCS-P, CPC, CPC-H, CMA

I. Introduction

The Payment Error Prevention Program Electronic Report (PEPPER), developed in 1999, is an initiative established by the Centers for Medicare and Medicaid Services (CMS) in response to a Medicare payment audit conducted by the Office of Inspector General (OIG). The goal of this initiative is to protect the Medicare Trust Fund by reducing the payment error rate for Medicare acute care Prospective Payment System (PPS) hospitals.

PEPPER has been available to providers since September 2004. It is provided quarterly and based on the federal fiscal year. Under contract with CMS, each quarter, the Iowa Foundation for Medical Care, the Quality Improvement Organization (QIO) for Illinois, provides each acute care hospital (except critical access hospitals) with a PEPPER report. This data is intended to assist QIOs and hospitals with their efforts to identify and prevent payment errors. PEPPER is an electronic data report containing hospital-specific Medicare claims data statistics for target areas that have been identified by the CMS as at high risk for payment errors. During each Scope of Work (SOW), CMS identifies target areas that will be the focus of attention. On August 1, 2005, the 8th SOW identified the following target areas:

- Readmissions with seven days of discharge to the same or another acute care hospital.
- One-day stays including transfers
- DRG 127 One-Day Stays
- DRG 143 One-Day Stays
- DRG (s) 182 & 183 One-Days stays
- DRG (s) 296 & 297
- DRG 243
- DRG 014
- DRG 089
- DRG 416
- Proportion of discharges billed to the higher weighted DRG in a complication or comorbidity pair to all discharges in the complication or comorbidity pair
- Three day qualifying skilled nursing facility admissions

The data in the PEPPER report identifies where a hospital falls on a percentile basis compared to other PPS hospitals in the State. Hospitals that fall into the 75th and 10th percentiles for an identified DRG should be concerned with overcoding and undercoding respectively. If a DRG is listed on a hospital's PEPPER report two consecutive quarters in the 75th or 10th percentile, it should be evaluated by the facility immediately. Hospitals should incorporate evaluations of PEPPER data into their proactive compliance efforts and attempt to identify and take corrective actions. To date, most QIOs have taken an educational approach with providers in cases where PEPPER reports show outliers in the 75th or 10th percentiles. However, it is believed that at some point in the near future, QIOs will have to consider that hospitals that continuously fall in the high or low range, have not taken proactive steps to address potential payment issues. QIOs will most certainly be obligated to begin more focused reviews, some of which may lead to the need to inform CMS and possibly the OIG or other enforcement agencies of the high incidence of overpayments.

Although, the information in PEPPER may identify problematic DRGs, it cannot identify the root cause of the problem. In order to ascertain the cause and effect associated with those problems, hospitals should evaluate relevant data and then examine prior and current medical records where those DRGs were assigned as dictated by the data analysis. The following case study demonstrates how this could be effective for a hospital's compliance efforts.

II. Case Study Background

This case study demonstrates how the PEPPER report was utilized to help evaluate why DRG 243 (Medical back problems) was identified as being above the 75th percentile for two consecutive quarters for a specific hospital. The PEPPER report identified that the incidence of this DRG assignment had an actual ALOS of 1 day compared to the industry average ALOS of 4.5 days is a concern (e.g. if a large percentage of the hospital's DRG 243 cases were of shorter duration than the ALOS, the hypothesis is that the patient most likely could have been treated more efficiently in the outpatient setting. Simply stated, the inpatient admission was not medically necessary.). Another concern with the use of DRG 243 was whether or not the back problem was truly the principal diagnosis based on the procedures that were performed during a hospital stay. The Uniform Hospital Discharge Data Set (UHDDS) defines the principal diagnosis as "the condition that was established after study to be chiefly responsible for occasioning the admission of the patient to the hospital." Furthermore, UHDDS defines a principal procedure as "that which was performed for definitive treatment rather than for diagnostic or exploratory purposes." By applying the use of the definition of principal diagnosis and principal procedure, it can be inferred that the two should match. For example, a patient with a principal diagnosis of pathologic fracture of the humerus should have a principal procedure that corresponds accordingly, such as, a closed reduction of the humerus.

III. Objective

The objective of the analysis was to determine whether or not the medical record documentation substantiated the principal diagnosis as the reason for the admission and treatment for DRG 243. The goal of this review was to discern whether there were any abnormalities with regard to the primary diagnosis, primary procedure, Length of Stay (LOS), discharge status and primary payer.

IV. Methodology

In order to validate the use of DRG 243, a download of data for all cases (not just Medicare), over a five quarter period associated with this DRG were obtained and analyzed. Several queries were performed to look for patterns that might be considered problematic. For instance, queries were performed to group the universe into several categories such as admission source, discharge status, nursing unit placement, attending physician, length of stay, procedures performed, length of stay by payer, etc.

V. Results

The review revealed a high incidence of one day stays, especially Medicare one day stays, placement in units unrelated to Orthopedic/Neurology problems and, that in some cases, the procedures performed during the hospital stay might be considered to be outside of the scope of "normal" care for a "medical back" diagnosis that lead to the assignment of DRG 243.

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Financial Intelligence Creates Financial Clearance

BY BRUCE NELSON

If a scientific solution or system can accurately predict, in advance, who is going to pay your bill a high percent of the time, would this be of use to you? If so, how would this affect time of service collections and financial clearance?

Scientific algorithms used to "model" patients for collection activity have been in widespread healthcare use for only the last two years or so. This process finally came to healthcare for three reasons. First health plan design "tilted" the balance of self-pay out-of-pocket balances leading to increased bad debt write offs. Secondly, healthcare providers do not have money to "waste" on collection resources. Third, lawsuits forced revised policies for processing patients for charity qualification.

The industry has now rejected a collection approach best be characterized as "let the collection agencies do the real collection work." This is not to say the agencies have done poor work on behalf of healthcare providers, but it can be argued that this approach has not been optimal for healthcare providers. This is because write offs have skyrocketed and patient public relations have been poor. Waiting for collection agencies to do the "real collection work" cannot be the solution, no matter how good a job your collection agencies might be doing. The back end focus cannot be continued.

If you look at the information disseminated on the Scruggs lawsuits www.nfplitigation.com, you will find considerable advise to consumers (your patients). The questions are designed to put hospitals on the defensive over their collection practices. While uninsured collection policy is certainly a major focus, billing and collection practices receive considerable attention as well. Essentially many are asking hospitals, "Why are you trying to collect from people who have no ability to pay you back." This is no longer done by best practice revenue cycle operations.

So maybe hospitals cannot afford not to implement new technology into revenue cycle operations regarding prediction of payment. Maybe hospitals must take into account payment prediction when deciding what collection approach to use on an account. Maybe it makes sense to use a different approach to a patient with a high probability of payment vs. a patient with a low probability of payment. After all this is what is done in the commercial business world outside of healthcare. By the way, whether you are a for-profit business or a not-for-profit healthcare provider, you still have to "run like a business." Who can effectively argue against that point?

Healthcare providers are now implementing state-of-the art prediction of payment technology into the front end of revenue cycle operations. While these providers are NEVER using this technology to decide who gets treatment, it is being used in a variety of ways at point of registration or via financial counseling:

- Determining the best method to collect at POS based on probability of payment—adjusting collection efforts based on the patient financial situation
- Achieving 100 percent financial clearance at POS. some patients are 'financially cleared" based on their financial circumstances. Others require personalized collection efforts.
- Offering charity to those patients who qualify at the front end, this avoids unnecessary collection activity. For everyone's benefit, those patients who qualify for charity discount programs are "slotted" into them right away, on the front-end. This saves time and money for everyone.
- Obtaining payment at POS based on credit card outstanding balance availability

Most interestingly, many times sophisticated financial information is best used to assist patients and help them understand how they can pay your bills. This is a huge public relations advantage for healthcare providers.

Best practice revenue cycle operations now routinely use technology for prediction of payment, address verification and automated charity processing. This new solution has produced incredible results for healthcare providers: lower bad debts, better reporting of charity and improved patient public relations- beginning at the front end.

Bruce Nelson is Vice President of Sales for Search America and a member of HFMA's Minnesota Chapter. Mr. Nelson can be reached at bruce.nelson@searchamerica.com

Performance Based Contracting: Are you ready? (continued from page 1)

sources the more employers realize they, and now their employees, may be paying for substandard care. This area of performance based contracting changes is what everyone needs to be thinking in terms of managed care agreements but, more importantly, what managed care departments must do to win the best contracts.

What is it?

PBC actually incorporates some of the aspects of managed care such as reimbursement management, contract terms for care definition and some typical legal standards but it goes much further in adding the work comp claims, CDHP claims and other groupings of claims into population based measurement standards.

That requires disease management, some incorporation of safety standards (leapfrog) and some sophisticated data analysis and tracking tools to actually verify that you are actually doing what you said you would do in your contract.

We have worked with PHOs and others who actually purchased the actuarial software to begin identifying good employer groups from bad in terms of expenses.

These clients recognized the advantage of groupers like DRGs to be a basis for negotiation but also realized there were factors of multiple diagnosis and or injuries that fell into work comp categories that allowed them to build in new definitions/rules for extenuating circumstances. This series of risk and non risk corridors allowed these managed care departments to model each detail of their agreement in such a way that they had as much, if not more data, than the insurer or the employer.

For these groups the move to pay for performance will be a natural evolution. For managed care directors who are still fussing about price detail and clerical issues of the contract language, they have a long way to go to actually start looking at a performance driven contracting methods.

Why it's happening now?

The Pay for Performance movement is upon us in the form of Medicare Advantage Plans. However, most of these plans are also operating a commercial population, so as they see the chance to modify reimbursement and use standards that have been protected by AHQR and others as part of the move to quality health plans, they see no reason not to incorporate these measures for Medicare and non-medicare populations.

Even large selfunded employers are demanding quality accountability from their insurers and the White House's recent executive order on price transparency and quality measure for all contractors dealing with federal employees and Medicare did not fall on deaf ears. State employers and the Fortune 500 will be incorporating these demands in this coming year's negotiation with insurers. These insurers have started incorporating performance criteria in their agreements to try to tier physician and hospital services just like they did pharmacy services when their costs went out of control several years ago.

Make no mistake employers are being told by their insured that rising inpatient costs are the key area to focus on, so expect more discussion of how to shorten length of stay and how to reduce hospital daily costs.

More importantly we are seeing another round of discussions on how to avoid admissions altogether using interim measures of case management and homecare along with employers renewed interest in wellness and illness avoidance.

In short, the employer's role as a benefits purchaser has shifted to that of risk manager recognizing that coordinating care from all claims bases and

continued on page 13

getting at actual employer costs of productivity requires they follow the dollar right to which provider did what to what employee and what was the outcome. Centers of excellence have been discussed by health plans and employers for years. As these payers continue to solve cost overruns by getting at the next level of data payers, they will see a means to tier their medical benefits just like they did their pharmacy benefit.

What payers hope to gain?

Payers see the opportunity to make distinct factual decisions about elect providers as a means to lower cost by matching the right patient with the right caregiver. This requires risk managers at the employer and health plan level to design benefits using best of class providers as the rationale to cover these providers at 100%, just like employers and health plans have covered best of class generic pharmaceuticals with minimum or no co pays. Patients who want to use the no generics and brand name drugs may do so, but any cost beyond the generic is paid by the patient. This applies to second tier physician or hospital services that may be good hospitals /doctors but are not meeting the consistent goals of treatment as the top tier of physician/hospitals departments are. The lower tier of pharmacy is not covered either because it is experimental or sub-standard to the norm that has been

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Condition	Coronary Artery Disease	Congestive Heart Failure	Acute Low Back Pain	Diabetes with Cardiovascular Disease or Nephropathy
Improved Compliance	Statin Medication	Beta-Blocker Treatment	Lumbo-Sacral Imaging	ACE Inhibitor or ARB
Potential Per Member Per Month Savings	$0.39	$0.03 Commercially insured $0.57 Medicare risk	$0.14	$0.36
Potential Annual Savings per 100,000 Members	$468,500	$30,650 Commercially insured $690,000 Medicare risk	$172,000	$436,000

Source, ingenix marketing literature to employers

Performance Based Contracting: Are you ready? (continued from page 13)

researched as a standard or at least evidence based guideline.

In effect all top tiers of providers are seen by the majority of patients as the benefits are designed to create an incentive of no financial or capacity barriers to see these top performers. The second tier may have copays and our out-of-network type 80-20 coverages, while the lowest tier has either no coverage or have a 60-40 out-of-area coverage that creates barriers to physicians and hospitals that are offering inconsistent or substandard coverage.

The savings are now able to be documented and several large insurers and employers are taking heed to the fact that there are dollars and LIVES at risk if we continue on the current path of discounts and benefits cuts which merely shift costs but do nothing to take costs out of the system.

Some payers expect to be able to lay off some risk to providers.

In Medicare's case by laying off risk to contracting MA plans, Medicare has a fixed budget that contractors bid on regularly. If the MA contractor is high and over the bid, they may be forced to resubmit or pass along their inefficiencies to the patient marketplace in the form of higher out-of-pocket costs.

Could Medicare create a tiered system? The answer is yes. This is the 5th year of data collection and we are seeing plans move to risk adjusters. MA plans are looking for hospitals and physicians who will share this risk.

Taking this same concept to employers and some insurers, the ability to set guidelines in advance of service and reward top performers is part of the promise of pay for performance but, with PBC, it goes further.

The requirement is not to just discount fees for health plans and employers, but rather reconstruct the delivery system so that fewer dollars go further. This means reduction of expense and improvement of outcome but also speaks to employers' frustration with bad communication between patients, doctors, hospitals, labs and the billing department. These PBC contracts usually contain customer service requirements, call backs, "go to" persons and some assurance that a satisfaction survey conducted regularly will show your hospital has superior outcomes AND superior customer service.

Employers have been supporting value based agreements with Bridges and Leapfrog but now see a great opportunity to fulfill the promise that managed care made and that is to improve quality in a meaningful and measurable way. This is critical for employers to get at what we call the RCA or root cause analysis of their particular problem areas.

As employers put employees at risk for larger and larger out-of-pocket costs for medical care through HRA and HSA, the employees are suddenly motivated by their pocketbook to seek the right care with the preferred physicians and will go to the employer to get that recommendation. Right now patients are asking this question of employers, insurers and coalitions, but the answers are difficult to find because data on performance is lacking.

Why what you are doing in current managed care negotiations cannot work?

One of the things the Health Plan business has taught large payers is that they have clout in both the type of care and the cost of that care.

Discounts are a dead issue as employers move to redesign benefits and reward top performers AND STILL KEEP SOME SAVINGS. The idea that the network you joined will bring you profitable market share when every other hospital is on the same network makes no sense. Offering discounts to PPOs who have no lock-in a manner similar to the HMO product that does have lock-in is a wasted effort. Employers have noticed that PHCS and Beech Street as national networks are not able to get the same discounts local payers get.

An employer creating their own lock-in performance network offers market share gain but the expectations of pricing are getting very sophisticated.

Unlike HMO and PPO contracts that can reduce payments based upon volume or price, PBC also can delay or deny payment based upon quality of diagnosis and treatment, patient satisfaction surveys and, in some cases, outcomes in terms of patients returning to work or other performance points the employer has established to measure productivity improvements.

In short there are 5 ways to get payments delayed and or denied which leads us to say these contracts need to be more sophisticated in terms of what is good medicine and what is not. The first question is the same as the last "can we actually administrate this or not?" This is going to require case managers, disease management specialists, physicians' documentation and the ability to truly operate as an integrated system versus the loosely configured network of services.

Bill DeMarco is President and CEO of DeMarco and Associates and an active member of the First Illinois HFMA chapter. He can be reached at bill.demarco@demarcohealth.com

Below are some examples of the findings obtained.

Case #1

A patient with a disc degeneration of the lumbar spine (principal diagnosis) had a vascular access device (principal procedure) inserted.

Case #2

A patient with a cervical fracture of the neck of the femur (principal diagnosis) had a percutaneous endoscopic gastrotomy tube (principal procedure) performed.

Case #3

One day stay where the Principal Procedure was a cardiac catheterization.

After analyzing the data, it was determined that it was necessary to review records in a collaborative way, including review by physicians (led by the VP of Medical Affairs), Health Information Management (from a coding perspective), and case management (from a medical necessity perspective utilizing Milliman criteria).

There were several categories of record review including:

- All one day stays
- Cases with exceptionally long LOS (6 days or more)
- Cases with Principal Procedures that did not match the diagnosis
- Medicare 3 day stays where the discharge disposition was to a SNF

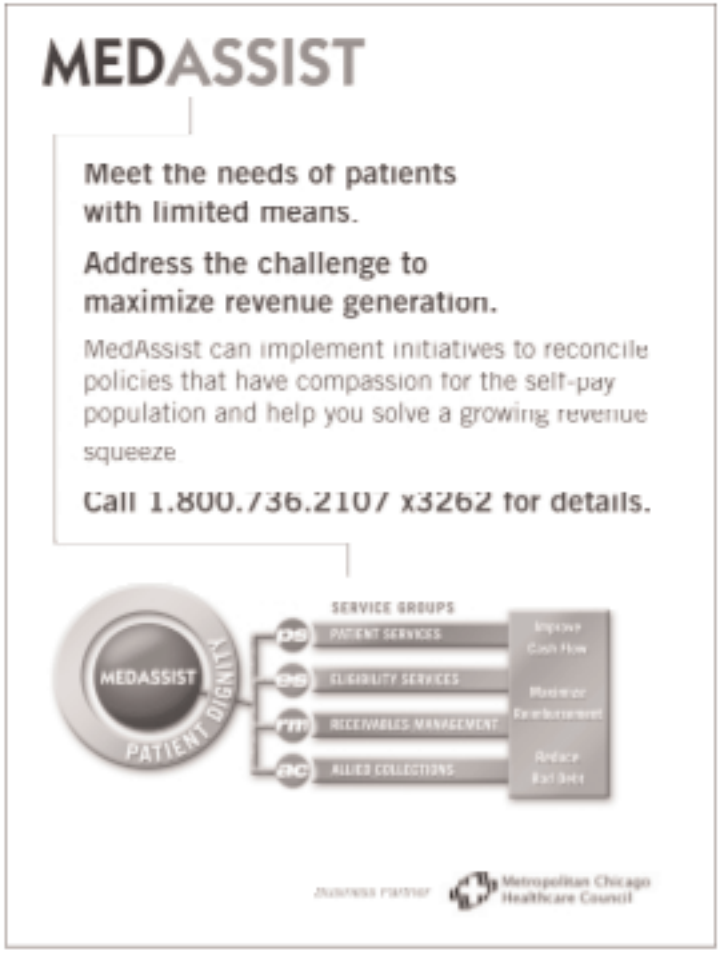
VI. Conclusion

Based on the findings in the study, the sample review of these cases could offer the opportunity to be proactive in ensuring that false or improper claims are not being submitted by the facility. In a compliance driven industry, a proactive approach can lessen the chance of the following occurring:

- Unwanted Investigations
- Corporate Integrity Agreements
- Exclusion from participating in Federal Health Care Programs
- Fines
- And possibly even jail sentences if intentional misconduct can be proven

Although, this case study demonstrates how to examine DRG 243, it provides information on how to explore any other relevant target areas identified on your PEPPER reports.

— Lisa L. Campbell is a BlickenWolf Manager. She has more than 10 years experience in management, training, consulting, chart auditing, medical billing, CPT, ICD-9-CM coding, and medical assisting. She holds a Master of Health Administration and is earning a Ph.D. in Health Care Administration. She is also a Certified Coding Specialist-Physician Based (CCS-P), Certified Professional Coder-Hospital (CPC), Certified Coding Specialist (CCS), Certified Professional Coder-Hospital (CPC-H) and Certified Medical Assistant (CMA). Ms. Campbell is a current member of the First Illinois HFMA chapter and can be reached at lisa@blickenwolf.com



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First Illinois would like to extend a welcome to the new HFMA members who have joined the organization between June 1st and October 31, 2006!

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New Members L to R: Back row: Tino Aurigemma, Jim Marinis, Mark Pawlicki, Nate Bihlmaier, Marta Corral. Front row: Luis Pesantez, Barbara Graf, Linda Stimart, Layne Parrott, Carol Miner, Sarah Escaremo

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

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

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Publication Scheduling

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December 2006	November 24, 2006
January 2007	December 22, 2006
April 2007	March 5, 2007

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A Newsletter from HFMA's First Illinois Chapter

Healthcare Financial Management Association First Illinois Chapter

Education Calendar 2007-08

Wednesday, May 9th, 2007

3rd International Healthcare Symposium – International Perspectives on Healthcare: Lessons for the United States. Featuring Richard L. Clarke, President of HFMA

Thursday, May 10th, 2007

7:00 AM CFO Education Program and Golf Outing
"Executive Leadership and Mentoring: Fulfilling Personal and Professional Missions
Medinah Country Club

Tuesday, May 15th, 2007

12:00 Noon Webinar
"How much will this cost me" – A Price transparency and Patient Responsibility Estimation. Sponsored by NEBO Systems

Thursday, May 24th, 2007

12:00 Noon Webinar
"Debt Capacity and Feasibility. Sponsored by Plante & Moran, LLC

Friday, May 25th, 2007

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