hfma
healthcare financial management association

First Illinois Speaks

A Newsletter from HFMA's First Illinois Chapter

May 2003

From the President

create the future

Never Through, Saying,

"Thank you"!

The First Illinois chapter year 2002-2003 is fast coming to a close. It seems like it took forever to prepare for this year and then the year just flew by. So many accomplishments this year! So many changes embraced by chapter members and leaders! These forces have inspired us and brought us closer to creating our future!

Together, this chapter has accomplished some great things. Our chapter survey will provide direction for our future. To those members that completed the survey, thank you. Our education sessions had record attendance. To those members that attended the education sessions, thank you. The education evaluations provided positive comments regarding program content and will be the baseline for future education growth. To the members that planned and produced our education sessions, thank you.

Our sponsors have demonstrated incredible support for this chapter. We have experienced an increase in sponsorship although the economy has not been at its best. To those sponsors that continue to support our chapter, thank you.

Chapter leaders had the opportunity to participate in facilitated strategic planning sessions that not only provided us with new tools on how to conduct our business but also reminded each of us that we truly are called to serve. To those members that feel compelled to serve, thank you. Our chapter experienced another year of growth through increased membership. To all our members: renewing; transferring; and new, thank you. Our directory, newsletter, and website provided the chapter with greater communication opportunities.

continued on page 2

The Emergence of "Consumer-Driven Health Care"

And its Implications to Health Care Providers

By Jim Watson, Professional Business Consultants, Inc. (PBC)

Editor's Note: The contributing author will co-chair the "First Illinois Speaks" newsletter committee for the chapter's 2003-2004 fiscal year.

The Birth of Consumer-Driven Health Care

As employers and healthcare payors moved into 2003, there was consensus that healthcare costs were again rising dramatically, and unlike the at-hand solutions that managed care provided in the 1980s and 1990s, there was only one viable solution to manage the new cost trends: *Engage the consumer in the purchasing, cost and utilization of their healthcare services.*

And so consumer-driven health care (CDHC) was born. In its early stages, CDHC is manifesting itself largely in higher deductibles, higher co-payments, and reduced benefits. There is also a growing array of consumer-driven healthcare plans (CDHCPs) being offered by all the national carriers and an expanding industry of start-up companies. In 2003, CDHC is mainly focused on cost management and cost shifting. In the longer term, the goal of CDHC and CDHCPs is to engage the consumer in a more sophisticated process of benefits purchasing, provider selection, and management of consumption of services.

This growing trend has significant implications to healthcare providers, and we are just now beginning to see CDHC become part of the national healthcare lexicon. To understand how this movement was born, it helps to understand how the U.S. healthcare system has evolved over the past 50 years. That evolution provides insight regarding healthcare consumption, management and cost. Employer-sponsored benefits were born in the 1950s as a way for employers to attract and retain employees, and that premise still holds true today. As American businesses continue to reel in the slumping economy of the new Millennium, managing an apparent endless cycle of dramatic healthcare cost increases, and, questioning the continuation of funding healthcare benefits, is an issue that employers large and small are addressing with new vigor.

The transformation of managed care

Managed care did its job in the 80s and 90s, but it is not the answer to the next round of cost inflation. Growth in managed care was great in the 80s and 90s because there was political support, economic conditions were right, and consumers adjusted to the managed care model. Utilization was reduced, unit costs were reduced, and we saw some stabilization in healthcare cost inflation. Managed care was effective, but it was also controversial. So in the late 1990s we started to see a backlash against managed care that left the industry with the choice to re-invent itself or die. In the past 2-3 years we have seen a transformation in the managed care industry, with health plans emerging with an entirely new set of value propositions and management tools:

- Managing transactions and information, but not managing care;
- Medical Management philosophies based on retrospective evaluation of care, not prospective review, management and denial of utilization of services;
- Product development focused on new employee contribution strategies, network access and funding options;
- A movement away from the notion that healthcare is best managed locally, and a movement to standardization across markets to ensure a consistent national enterprise;
- An explosion in self-service (websites, on-line enrollment, claims status, provider directories) to reduce administrative costs.

Truly, managed care companies and the health plans they offer are not the same as they were in the '80s and '90s. They are more like Financial Services Organizations (FSOs) than HMOs. Today, 80% of the marketshare is owned by the top 5 payors, all for-profit and publicly traded. These companies must produce a financial return now, next quarter and next year, and that can't be done if you are taking health insurance risk in today's society. So, naturally, the movement is away from fully insured products, first dollar coverage and plans where everything costs the consumer $10.

Health care providers not as flexible to move quickly

On the other side of the coin, providers have not aggregated to the degree that payors have consolidated. Healthcare providers still compete in somewhat of a "cottage industry" with great variance in business practice, standard operating procedures, and patient care plans across providers nationally and even within the same marketplace. Providers do not have the financial resources or even the business flexibility to transform in the manner that health plans have. So in this regard, providers are disadvantaged in the delivery of

continued on page 5

From the President (continued)

To those that worked diligently on our important communication tools, planning and writing, thank you. In addition, our chapter had the highest number of members earn awards this year. These awards are presented in recognition of participation in HFMA, to each one, thank you. Congratulations to all of you who helped make this year such a success!

Ahh, now is the time to say, "I am through." It is my turn to sit back and watch as those that follow me step up to the plate and deliver even better and more rewarding accomplishments for our members.

And, for a while I really did think I was "through". Through being the president, through being a leader, through serving the members. Then, I recently read an article about running by John "The Penguin" Bingham. If you are a runner, you have heard of "The Penguin". If you're not a runner, "The Penguin" is an inspiration to runners like me, "middle of the packers" that will never reach an elite status but run because we love running. John, like me is a "middle of the packer". We are content to run simply because running inspires, running is a passion, and we are driven by this passion. In this article from the May 2003 "Runner's World", John wrote the following; "Through" is a relative term when you're a runner, because being a runner isn't about running. It's about searching and finding, experiencing fear and courage, learning lessons and living a life where your imagination is your only limit."

As I read those words, I was reminded that we, as HFMA members can never be "through" because HFMA is not just about being a member. It is about searching and finding, experiencing fear and courage, learning lessons and living a life where your imagination is your only limit. I will never be "through" as an HFMA member.

Know No Limits!

It has been an honor and privilege to serve the First Illinois Chapter as its president this last year. I look forward to future opportunities to serve the Chapter and the National HFMA organization. Let's continue, together, to search for and experience new ways to continue to make the "First Illinois Chapter" the Best HFMA chapter. Please accept my personal best wishes for your success. Thank you, all, for everything!

Sincerely,

Suzanne Lestina
HFMA President

First Illinois Chapter Leadership

Chapter Leadership Outline Direction, Goals and Action

The chapter leadership recently held a strategy session to formulate and implement initiatives for the future of the chapter. The items below summarize the proposed directional statements for the 2003-2004 chapter year:

1. Design and implement a comprehensive communications plan.
   - Form a committee to focus on consolidating and standardizing chapter communication.
   - Enhance the chapter's website to include online registration, the membership directory, ballots, announcements and recruitment.
   - Investigate and evaluate teleconferencing capabilities for committee meetings and educational events.

2. Emphasize the value of membership to grow our chapter size and participation.
   - Demonstrate value of HFMA membership relative to job performance.
   - Provide enhanced networking opportunities.
   - Contact individuals new to the market.
   - Provide accessibility of information to our members.

3. Develop and implement a mentoring program.
   - Identify interested parties.
   - Establish a mentoring committee.
   - Create socialization guidelines.
   - Create a communication and data linkage to the membership relations committee.

4. Enhance educational opportunities.
   - Continue to provide high value programs.
   - Evaluate new program forums such as web based educational sessions.
   - Explore alternative sites for educational events
   - Consider an annual interdisciplinary program.
   - Incorporate program evaluations into future events.

These directional statements also create additional opportunities for chapter involvement. If you have any ideas about these statements or are interested in helping to implement these concepts contact any of the chapter leadership, committee chairs or board members.

Editor's Note: The following is reprinted with permission of the author.

The Revised Provider Reimbursement Review Board (PRRB) Instructions and the Medicare Mediation Process

Centers for Medicare and Medicaid Services Office of Hearings Mediation Option

Kathleen Scully-Hayes, Esquire
Office of Hearings, Centers for Medicare and Medicaid Services
Baltimore, Maryland, (410) 786-2055
kscullyhayes@cms.gov

I. What is mediation?

Mediation is one of several non-binding alternative dispute resolution options. In mediation, a trained, impartial third party helps two or more parties negotiate to resolve their dispute. Mediation emphasizes problem solving rather than gearing up for protracted adversary proceedings. The mediator works to gain the trust of the disputing parties, has no stake in the outcome, is not a judge (unlike arbitration or court proceedings), and has no power to make decisions. Mediators often use their knowledge of negotiation and consensus-building processes and their persuasion skills to help parties see negotiating strategies that allow them to reach their respective objectives. Mediation is a voluntary, informal process. Rules of evidence do not apply. Testimony is not taken. Witnesses are neither sworn nor used to support or defend positions. Interrogatories, depositions, and transcripts are not required. Parties are not forced to reach agreement.

II. Why is the Provider Reimbursement Review Board (PRRB) using mediation to resolve some of its cases?

The PRRB currently has a caseload of more than 10,000 pending cases. It takes approximately three years from the time a request for hearing is filed with the Board until a hearing is held, and it takes approximately one more year from the date of the hearing until a decision is issued by the Board. While the Board has undertaken several measures to reduce its caseload, the number of new cases filed each year continues to increase. However, approximately 90% of all cases filed with the Board settle or are withdrawn at some point before the scheduled hearing date, and of that figure approximately 85% settle within days before the scheduled hearing. In most of these cases, before settlement discussions are entered into by the parties, considerable resources have been expended by the Board staff and by the parties. Moreover, by the time a case is scheduled for hearing, relevant documentation can no longer be located. The Board believes that if the parties engaged in mediated settlement discussions early in the process, areas of dispute would be narrowed and or resolved more quickly, which would assist in significantly decreasing both the time necessary to resolve these disputes and the parties' expenses in pursuing the appeal.

III. What kinds of PRRB cases will benefit from mediation?

The majority of the cases pending before the Board would probably benefit from mediation. More specifically, cases with issues involving factual disputes are good candidates. Cases involving clearly delineated CMS policy application disputes would not benefit from mediation.

IV. Will the Board still require position papers from the parties?

The Board believes that for mediation to be successful, there should be two outcomes. First, the cases should move through the system much more quickly, and second the amount of resources expended by the parties should be less than the resources required for a case to go to hearing before the Board. However, experience has shown that it is not until the parties have identified the issues and their respective positions in writing that settlement discussions begin. Thus, parties that agree to participate in mediation will not be required to file standard position papers, but will file issue summaries. Each summary will set forth the issue and summarize the party's position in two pages or less per issue. Issue papers are exchanged by the parties shortly before the mediation session occurs.

V. Who will conduct the mediation? Who will attend for the parties?

Office of Hearings staff members who have been trained as mediators through the HHS Departmental Appeals Board Shared Neutrals Program will conduct the mediation sessions.

Although each party is welcome to bring whomever they wish to observe the mediation, there will generally be one spokesperson per party at the mediation table. However, the discussion is very informal and all participants are welcome to comment during the session. Throughout the mediation session, each party has the opportunity to meet privately to discuss their options and strategies. The provider has the option of having counsel participate in the mediation as the provider's representative. It is anticipated that the intermediary representative will be from the local plan. It is recommended that the person participating in the mediation have the authority to settle the case, though it may be necessary for that person to obtain approval of any agreements. Parties needing to obtain prior approval will be afforded the opportunity to do so.

VI. How exactly will the process work?

Once a case has been filed with the Board, and a request has been made by either the provider or the intermediary that the case be considered for mediation, the Office of Hearings will review the case and contact the opposing party to determine interest.

Once parties have indicated interest and signed an agreement to mediate, the case will be assigned a mediation date (generally within 90 days), and the parties will be directed to file issue summaries within 45 days. A few weeks before the mediation is scheduled to occur, the mediators will contact the parties and review the procedural aspects of the mediation. On the date scheduled for the mediation, the parties will meet with the mediators, generally for several hours at the intermediary's offices, and will attempt to reach consensus on the issues. If the parties are able to fully resolve the case as a result of the mediation, the parties will sign a settlement agreement at the conclusion of the mediation and the case will be closed. If the parties are unable to resolve all

continued on page 4

You Gotta LOVE The Elderly!

A pastor goes to a nursing home to visit an elderly parishioner.

As he is sitting there, he notices a bowl of peanuts beside her bed and takes one. As they continue their conversation, he can't help himself and eats one after another.

By the time they are through visiting, the bowl is empty. He says, "Mrs. Jones, I'm so sorry, but I seem to have eaten all of your peanuts."

That's O.K.," she says. "They would have just sat there anyway.

Without my teeth, all I can do is suck the chocolate off and put em back in the bowl."

The Revised Provider Reimbursement Review Board (PRRB) Instructions and the Medicare Mediation Process

… *continued from page 3*

issues under appeal, and reach impasse, the case will be scheduled for hearing and a briefing schedule will be set for the remaining issues.

VII. Who should I contact if I am interested in having a case considered for mediation?

Call or write to Paul Crofton (410) 786-9415, or Kathleen Scully-Hayes (410) 786-2055, at the Office of Hearings, Suite L, 2520 Lord Baltimore Drive, Baltimore, MD 21244-2670. Requests may be sent by fax as well. (410) 786-5298.

Questions about this author should be directed to the author.

Visit the CMS website to obtain the recently updated PRRB instructions.

Consumer-Driven Health Care... *continued from page 1*

healthcare compared to the options in healthcare financing that are at the disposal of payors.

Even the recent explosion in utilization caused by a variety of factors is a double-edged sword for providers. While utilization skyrockets, so does the cost to provide services and expand for the future service needs of the provider's community. But reimbursement trends come nowhere near covering the cost of the utilization trends or cost of capital for future expansion.

Setting the stage for CDHC and CDHCPs: Shopping for health care like other goods in retail

As 2001 turned to 2002, health plans and employers faced the reality that they could not manage health care cost trends and keep consumers happy under the current rules of the game, not now, not ever. In June 2002, the IRS paved the way for growth in CDHCPs by allowing unspent MSAs to rollover. This change is significant to employers and consumers, but the ruling came too late in the benefits planning year to allow employers and payors to effectively implement CDHCPs on a broad scale for the January 2003 open enrollment season. But even with this small "ramp up" window, enrollment in CDHCPs increased 500% in 2003, with enrollment in these plans topping half a million people. The stage is set for this to quadruple in 2004, according to benefit manager estimations.

Questions Provide Answers to Definition of CDHC

So what exactly is "consumer-driven health care" and "consumer-driven healthcare plans" (also sometimes generically referred to as "defined contribution plans")? We answer that question with three related questions:

- Why don't consumers understand the costs of healthcare?
- How do consumers define "good service" and "good quality"?
- Are provider marketing and branding strategies and campaigns effective at influencing the answer to these 2 questions?

Consumers don't understand the cost of healthcare because they've never had to pay much for healthcare, either as a percentage of the total premium or as a percentage of the cost of an episode of care. We've grown up as a generation of healthcare consumers that think everything costs $10, because that's about all we pay when we have a physician office visit or get a prescription. Heck, hospitalizations are free.

We blur the distinction between "good service" and good quality" and say they are both good if (a) the receptionist is nice to us when we go to the doctor or hospital, (b) we don't have to wait a long time in the waiting room, and (c) we don't get a bill. These may be service indicators, but not quality indicators. The fact of the matter is that consumers have no credible "quality indicators" upon which to decide whether or not they've gotten good quality of care. We have basic concepts of procedural volume, mortality, and morbidity from reading hospital "report cards", but those really just scratches the surface and there is nothing to report with regard to physician office visits and outpatient care. Providers would like to have such data to report, but getting anyone to agree on numerators, denominators, acuity, and other factors in the equation is an impossible task. So provider marketing and branding campaigns do little to influence consumer knowledge of healthcare cost, quality, and service. These campaigns are either aimed at product branding and awareness to build brand loyalty or purely plays to consumer emotion.

Consumers don't shop, and frankly can't shop, for healthcare like they do for other goods and services. CDHC is an attempt to put healthcare into the "retail" world, allowing consumers to purchase healthcare based on retail-type indicators of cost, quality and service. This is the immediate focus. Once we can train ourselves to do that, one of the secondary benefits will be in consumption management. Once we know what it costs, and have to pay for more of it, we will shop better and we will spend (consume) less.

An overview of emerging CDHCP models:

The current models of CDHCPs generically can be classified as cost-focused, utilizing high deductibles, an employer-funded Medical Savings Account (MSA), and catastrophic PPO-type indemnification for catastrophic/high cost events. There is too much variety across the product designs and benefit plans within the emerging CDHCP portfolio to adequately detail them each in this article. Some are employing "tiered networks" that base patient copay/deductibles on the rates that are paid to the provider (higher provider reimbursement rates, higher patient portion). Some utilize the "build your own benefit network" model where a consumer picks 15 routine physicians and a primary hospital, and their premiums, deductibles and co-payments are calculated as a function of the reimbursement rates the payor has contracted for. Again, higher cost providers, higher patient financial responsibility.

The obvious implication is that these plans may be steering patients to providers purely on an economic basis. The smarter plans realize this, and don't view this as a viable strategy. But again, these are the early generation health plan models of CDHC, which for now is largely cost management-based.
Future models will also be cost management-based, but come with additional tools and information for evaluating benefit plan and healthcare provider choices on service and quality indicators as well. Even now, most of the national health plans have developed relatively sophisticated websites, with tools and calculators to help consumers know where to go for what, and how much it will cost them (in terms of hospitals and surgical procedures).

There are benefits to consumers in CDHCPs not found in your typical HMO or PPO plan:

- Coverage: CDHCPs allow consumers to purchase coverage for things not typically covered by HMOs or other benefit plans (laser eye surgery, acupuncture, other "lifestyle" services).
- Access: There are fewer barriers to access in CDHCPs (referral mechanisms, pre-authorization requirements).
- Financial: There is the financial benefit of MSA rollover now that the IRS has changed the rules.
- Choice: Moreover, consumer choices in health plans are much greater with the birth of CDHCPs that go beyond the standard "dual choice" (HMO, PPO) offerings of employers.

There are also obvious implications to consumers with this new generation of health plans:

More financial burden: CDHCPs shift greater premium percentages to the consumer, have higher co-payments, deductibles and stoploss thresholds than traditional managed care plans.

Accountability for healthcare utilization: Some plans offer members "points" for lifestyle behavior that support better health (points for non-smokers, exercise, etc.).

Shopping for healthcare: Consumers are incentivized to research the most appropriate healthcare provider to seek services from. Most payor websites now have financial calculators to help consumers determine what their cost will be under their benefit plan based on the rate that the provider charges the health plan.

Record-keeping: Consumers will need to track claims and payments for healthcare to account for their out-of-pocket costs, and which costs apply to their deductibles, co-payments, and when they have reached their out-of-pocket maximums and subsequent conversion to MSA and stoploss coverage. Again, many of the CDHCPs have tools for their members, but this is a new burden for consumers to bear.

Benefits and implications to healthcare providers

Historically, marketing and positioning by healthcare providers have been driven by marketshare increase initiatives. Physicians expand the ancillary capabilities within their offices for patient convenience and for practice revenue generation. Some recently have begun "boutique" type strategies that create the perception of patient pampering, including limiting their practice to patients that sign-up for retainer-type arrangements guaranteeing access and a defined number of services per year. Other physicians position their practice in selectively contracting with only certain health plans, giving those health plans an added marketing edge.

Hospitals' marketing, positioning and advertising strategies have been largely "emotion-based", portraying compassionate care or playing on fears of future illness. Hospitals have also focused their marketing efforts on lifestyle services that are paid for by consumers, a growing source of good revenue. Medicare is still a relatively good payor for most hospitals, so hospitals devote a portion of their marketing efforts to Medicare enrollees. A few hospitals are able to market themselves based on clinical supremacy, especially for inpatient procedures that are more conducive to reporting volumes and outcomes than outpatient services or physician office-based services.

CDHC will move our traditional notion of healthcare marketing into retail type strategies, focused on promoting cost/pricing position, quality of care, and customer service. Hospitals and physicians will focus on "consumer touch points" along their continuum. The healthcare system can be viewed generically (for all types of healthcare providers) as a three-piece "Delivery Model":

THE FRONT END: Facility Branding, Patient Access, and Facility Environment

THE MIDDLE: Services provided, Staff providing the services, payor contracts

THE BACK END: Billing/Collection, Outcomes/Reporting, Patient Retention

continued on page 6

The "front end" of this model is the traditional branding strategies we see in play today. It also describes how patients access the healthcare system, and what the physical characteristics of the facility are upon access. The middle of the model, which is the nucleus that holds together and flows in and out of both the front-end and the back-end, describes the services provided by the facility, the staff providing the services, and the payor contracts the drive facility revenue and contain different administrative requirements of the front and back ends. The "back-end" describes how the facility bills and collects payments for services rendered, how the facility produces and reports the outcomes of the services it provides, and how it uses the billing and collection process to retain patients in the future.
From a financial perspective, the three-piece "Delivery Model" is the revenue cycle. In CDHC, the revenue cycle takes on an added consumer perspective in all aspects. At each consumer touch point in the Delivery Cycle, there are implications to providers in CDHC:

Front-End Positioning:

Branding will take on a more consumer-focused approach, expanding the emotion-based clinical aspects of current branding to include more financial and service aspects in attracting and retaining a patient base. Providers will move to make patient registration more patient-friendly (on-line registration, obtaining test result easier, pre-registration options) to eliminate the logjams that can typically occur every morning in a hospital. Increasingly, financial arrangements will need to be made in advance with consumers since they will own a larger portion of the bill. These arrangements may include individual pricing and fee negotiation discussions with patients, something not historically done. Insurance master maintenance will likely become even more challenging with the addition of new CDHC plans, with added importance at the front end to avoid billing and collection problems at the back end. Moreover, the general "atmosphere" of your facility will take on added importance with consumers; and differentiation from competition will take on added importance. An obvious Nordstrom's comparison is called to mind here considering how that retail store created a brand and took considerable marketshare simply by creating a consumer-friendly environment. It will be difficult for most healthcare providers to "pamper" patients at any consumer touch point, especially physician practices, but some will try and some will be successful.

Perhaps the most complex issue to consider here is pricing. As a member of the CDHP product development team for the largest carrier in the country, I was fascinated by the reactions from physicians and hospital executives when we discussed how they wanted to be priced in our "tiered networks". Never having had to consider their pricing strategies before, the "deer in headlights" look would often overtake these healthcare providers as they considered whether they wanted to be listed in the low co-pay section of the provider directory of the high co-pay section. If I'm low cost, am I low quality or sensitive to consumer costs? If I'm high cost, am I high quality or just high cost?

Managing the Middle:

There are several considerations in CDHC in this area. Service-line development and ancillary service offerings may be "lower-end", targeted at services consumers will pay for themselves and also requiring less capital investment. The development and marketing of such services will be an immediate opportunity in CDHC, since there is somewhat of a pent-up demand for services that health plans do not currently cover. People will pay for these services as part of their discretionary spending.

Another consideration is how to contract with CDHCPs, especially with established multi-line carriers. Issues of steerage, patient collections and balance billing, payment timeliness, and silent PPO protection are obvious. Will providers increase the contracted rates for these plans under the assumption that a greater portion of the contracted reimbursement will go to the consumer and subsequently cost more to collect (or go to Bad Debt)?

There will be a heightened need for friendly customer service, if consumers are shopping around for the care they pay for. An unpleasant clerk can mean a lost consumer for life. Lastly, how will CDHCPs affect the relationship with a hospital's medical staff and the managed care contracting and consumer marketing strategies of the respective organizations? This becomes especially complex for hospitals in a market that is moving away from economically aligned physician groups. What is the future value proposition of organized physician networks in CDHCPs? Different specialties will have different issues to consider. One final and significant implication, especially to physicians, is the likelihood that utilization will drop dramatically for discretionary consumption. When going to the doctor for that cold or flu symptom will cost $50 instead of $10, many consumers will choose not to go.

Back-end considerations:

The patient accounting implications in CDHC and CDHCPs are enormous. Healthcare providers will be collecting increasing portions of the bill from the consumer down the street, not the big bad insurance company downtown. Aggressive consumer collections are probably not a good strategy considering we want these consumers to come back for a lifetime of care. It is a safe bet that Accounts Receivables and Bad Debt would increase in CDHC, as our generation's paradigms will be slow to shift and accept our responsibility to pay for things someone else has always paid. Healthcare bills will go to the bottom of the pile.

However, there is opportunity in the back-end for healthcare providers. Outcomes reporting, performance data sharing and other quantifiable indicators will emerge with the ability to be reported to consumers. Through the collection process, providers will find ways to integrate marketing and patient retention vehicles to keep people coming back. This is new thinking for most physicians, hospitals and healthcare providers, but out of necessity creativity is born.

Summary & Conclusion:

CDHC and CDHCPs are the last; maybe desperate attempt by employers and health plans to do something to manage both the cost of healthcare and the utilization of healthcare services. The employer benefits market is ready for CDHC, as employers struggle to manage all expenses in the declining economy. With healthcare costs being their second largest expense for employers (behind salaries), now more than ever employers are asking themselves how they ever got saddled with paying for people's healthcare coverage to begin with. If CDHC does not succeed in managing these costs, we may see a trend toward abandonment of employer-sponsored healthcare coverage that could pave the way for a national healthcare system overseen by the government. To summarize CDHC and CDHCPs:

- CDHC is largely about getting employers out of healthcare and getting the consumer more involved in healthcare
- Early generation CDHC and CDHCPs are largely manifested in cost shifting, with future generations focusing not only on cost but on quality and service
- All national carriers and a new industry of start-up CDHCPs are poised to explode onto the marketplace in 2003-2004
- This will be a major strategic management issue for employers, health plans, consumers and healthcare providers
- Healthcare providers will find the need to articulate their competitive position just like a retail business, on retail-type indicators (cost, quality, service)
- Healthcare providers will need to justify their pricing strategies on the "front-end" and manage their A/R increasingly with consumers (not insurance companies) on the "back-end"
- Healthcare providers will be asked clinically based questions heretofore considered taboo from a new generation of consumers not afraid to ask.

Questions about this article should be directed to the author at (630) 571-6770

2002 HFMA First Illinois Chapter Membership Survey Results

Compiled by the Market & Research Division of Smith, Bucklin & Associates, Inc.

Membership assessment surveys are a useful, objective management tool for measuring success in meeting member needs. Moreover, membership needs research assists in identifying opportunities to increase the quality of membership services and programs. Such evaluations have been used as tools to assist management in strategic planning of membership services to assess members' reactions to the services offered, thereby revealing what particular areas may be in need of improvement and with which areas members are satisfied.

The purpose of the 2002 First Illinois Chapter Member Survey was to add value to the HFMA membership experience by identifying what members want to get out of their membership. The results from this report will be useful for planning future Chapter events.

Survey Background

In early November, a solicitation greeting and the five-page 2002 First Illinois Chapter Member Survey was distributed electronically to 894 HFMA members. In order to increase the response rate, participants that completed the survey were entered into a drawing to win one of five free educational programs offered by First Illinois HFMA Chapter.

In order to ensure confidentiality, only the Market Research & Statistics Division of Smith, Bucklin & Associates, Inc. had access to individual responses. When compiling data for this report, information was combined in the aggregate and analyzed. The survey deadline was Wednesday, November 27, 2002.

Overall, 183 surveys were returned. Responses from these surveys are included in the results. This represents a 20% response rate. The margin of error is +/- 7% at the 95% confidence level. This

> "... the reader can be 95% confident that all 894 potential respondents would have answered within 7% of the results shown in this report."

means that the reader can be 95% confident that all 894 potential respondents would have answered within 7% of the results shown in this report.

How to Read This Report

This report is divided in to three key sections: Survey Highlights, Member Demographics and Survey Results. The Survey Highlights identifies key findings of the report, while the Member Demographics and Survey Results sections consist of more detailed information regarding the questionnaire. In this section, results for each question from the survey are presented in tables and/or graphs. In addition, the open-ended responses for the "other" category are shown as they related to each survey question. Appended to the report is a copy of the survey for which results are presented in this report (refer to Appendix).

The following are the definitions for the statistics shown in this report:

- The mean statistic or average is the sum of all values divided by the total number of responses. The mean is a measure of central tendency.
- Percentages are derived by dividing the number of responses per category by the total number of responses to the survey question. Percentages are shown in shown in whole percents. It is important to note, multiple responses (i.e. "check all that apply") were allowed for some survey questions. Therefore, some percentages will not total to 100%.
- The base indicates the total number of responses analyzed for a given survey question.

When no responses were received, tables show a dash ("-") which indicates that no respondents selected that particular option or value. Tables show an asterisk ("*") to denote that less than 0.5% is represented for a response category. A double asterisk ("**) is shown to indicate that a particular statistic was not calculated in the corresponding study year.

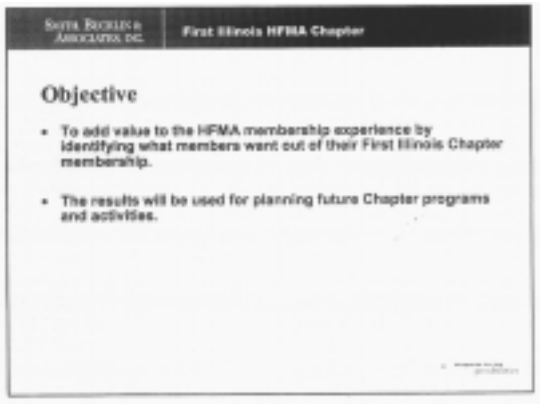
For comparison purposes, results were often crosstabulated by the number of years of membership and job title. When available, the 2002 survey results were benchmarked against 1999 survey results.

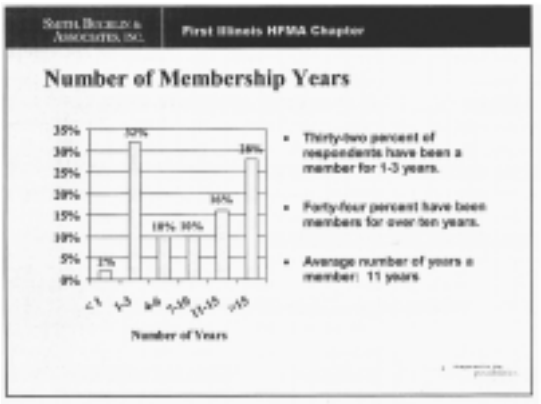
A Word of Caution

Users of this report should consider the following issues when reviewing, discussing or making decisions based on the findings indicated in this document. Key issues include:

- The margin of error is only an approximation since participation was voluntary and hence not purely random.
- The results are based on a sample of HFMA members and may vary had all members in the profession participated.
- The results of questions containing a small number of respondents may not be strongly representative of that particular area and judgment based on small samples should be made with caution.

continued on page 8





2002 Membership Survey results ... *continued from page 7*

Smith Buckles & Associates, Inc. — First Illinois HFMA Chapter

Job Title

(in % Rank order)	2002 Survey Results	1999 Survey Results
Financial Director	28%	18%
Consultant	20%	16%
Other	18%	4%
Financial Officer	18%	14%
Operational Staff	6%	10%
Ban. Office Mgr./Patient Financial Services Mgr.	4%	4%
Executive Officer	4%	20%
Other Manager/Supervisor	4%	12%

Smith Buckles & Associates, Inc. — First Illinois HFMA Chapter

Employer

Top Five in % Rank Order:	Percent
Hospital	39%
Other (Association, Staffing Agency, College/University, Vendor)	29%
Consulting firm	16%
Multi-facility Corporate HQ	7%
Integrated Delivery System	9%

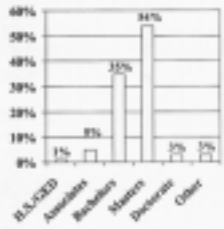
Smith Buckles & Associates, Inc. — First Illinois HFMA Chapter

Number of Years in the Profession

- Fifty-eight percent of respondents have been working in healthcare financial management for more than 15 years.
- Average number of years in healthcare financial management: 17 years

Smith Buckles & Associates, Inc. — First Illinois HFMA Chapter

Highest Level of Education



- Fifty-four percent of respondents have earned a Masters degree.
- Thirty-five percent have earned a Bachelors degree.

Smith Buckles & Associates, Inc. — First Illinois HFMA Chapter

Rating Scales

Satisfaction:
4 = Very Satisfied
3 = Satisfied
2 = Dissatisfied
1 = Very Dissatisfied

Value:
4 = Very Valuable
3 = Valuable
2 = Not Very Valuable
1 = Not at all Valuable

Involvement:
4 = Very Involved
3 = Somewhat Involved
2 = Rarely Involved
1 = Not Involved

Smith Buckles & Associates, Inc. — First Illinois HFMA Chapter

Gender

Years a Member	Female	Male	Base
< 1	75%	25%	4
1 – 3	51%	49%	55
4 – 6	50%	50%	18
7 – 10	56%	44%	18
11 – 15	32%	68%	28
> 15	10%	90%	48

Smith Buckles & Associates, Inc. — First Illinois HFMA Chapter

Satisfaction with Educational Programs

Aspect: (in Mean rank order)	Very Satisfied/ Satisfied	Dissatisfied/ Very Dissatisfied	Mean
Speakers	94%	6%	3.17
Overall	90%	10%	3.16
Location	86%	14%	3.15
Topics	88%	12%	3.13
Cost	85%	15%	3.11

Smith Buckles & Associates, Inc. — First Illinois HFMA Chapter

Educational Program: Positive Comments

- Excellent topics:
  - Relevant
  - Timely
  - Like the variety of topics
- Geared toward healthcare and healthcare financial professionals
- Generally excellent speakers:
  - Good Variety
  - Informative
  - Knowledgeable
  - Experienced

First Illinois Chapter

Chapter Board Strategy Session

Identify Chapter Opportunities at Strategy Session
(L-R) Liz Simpkin, Patt Marlinghaus, David Golom, Steve Perlin

The Way HFMA Should Work

Chapter Leadership Pause for a "Kodak Moment"
at Recent Strategic Planning Session

Pondering Chapter Strengths at Strategy Session
(L-R) Elaine Scheye, Brian Sinclair, Al Staidl

Steve Perlin receives Follmer Bronze Award at Strategic Planning Session

Len Pishko honored with Reeves Silver Award

Incoming President Paula Wilke is presented with Reeves Silver Award

First Illinois Chapter

HFMA Welcomes New and Transferring Members

Paul Mastrapa
Option Care, Inc.

Tina Clark
The Tintari Group

Robert Ricobene
Cash Flow Consultants

Lauren D. Bruno
Dependon Collection Service, Inc.

Andrea E. Zak
Dependon Collection Service, Inc.

Shannon D. Lane
Evanston Northwestern Healthcare

Dana C. Padgett
Provena Health

Angela Darrow
CCH, Inc.

Lawrence L. Lake
Protiviti, Inc.

Vaishali Dave
KPMG LLP

Jennifer J. Stogentin
Delnor Community Hospital

Irene Buzyna
Frontenac Company

Tim Heyer
Healthcare Financial Resources

Todd D. Anderson
Adventist Health Systems Midwest Region

Wendy Wuchek, JD
CCH, Inc.

Chris S. Schwartz

Tammy S. Banks
American Medical Association

Judith Storfjell
University of Illinois, College of Nursing

David A. Jupp
IMA Consulting

Margaret Leonard
Illinois Hospital Association

Patrick N. Flaherty
Web MD/Expressmill

Cheryl Ann Staske
Carle Foundation Hospital

Regina E. Alex
Carle Foundation Hospital

J. Michael Davis
Ernst & Young LLP

Michael Dunlap
Protiviti, Inc.

Willie E. Carrington
Carrington & Carrington, Ltd.

Cyndy Novak
Medtronic

Andrew C. Goff
Healthcare Finance Group, Inc.

Edward Y. Lau
Law Offices of Edward Y. Lau

Jerrod V. Olszewski
Katz Friedman Eagle Eisenste

Anthony J. Filer
Provena Health

Kathy Dombrowsky
Harris & Harris Ltd.

Janet D. Graham-Taylor
Chicago Heart & Vascular Consultants, Ltd

Angelique A. Gunderson
CCH Incorporated

Lee Remen
Healthware Systems

Merrill Kaney
ARAMARK Servicemaster

Daniel B. Cook
Aim Healthcare Services, Inc.

Steve L. Lefar
MediRegs

Jerry R. Berg
UBS Paine Webber

Joseph A. Schauenberg

Brenda Johnson
Oak Forest Hospital of Cook County

Liz Dornhecker
Oak Forest Hospital of Cook County

Suzanne M. Hall
Aetna

Kimberly Martin
Solucient

Janet Blue
CSI Staff

Timothy C. Kocher
Ciber, Incorporated

Gary W. Chawk, FHFMA, CPA, MBA, CHE
Porter Memorial Hospital

Bethany Anderson
Jacobson Group

Award Recipients Honored at Chapter Meeting

Loren Foelske receives Reeves Silver Award

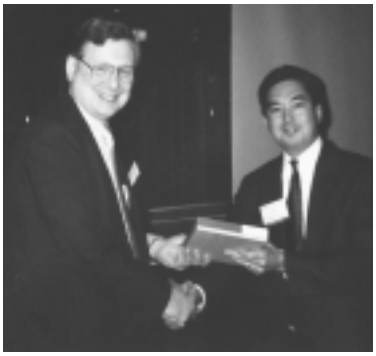
Randy Ruther, FHFMA, CPA receives Reeves Silver Award

Reeves Silver Award

Brian Sinclair presents Muncie Gold Award to Larry Appel

Brian Sinclair presents Follmer Bronze award to Katherine Lenhart

Jane Bachmann honored with Muncie Gold Award



Past Chapter President, Eric Lundahl receives Reeves Silver Award from Brian Sinclair

SPONSORSHIP PROGRAM

The First Illinois Chapter relies heavily on corporate sponsors and advertisers to support Chapter activities. To this end, we have embarked on a new approach to retain our current sponsors and obtain new sponsors. This approach addresses many of the concerns of our past supporters, namely:

- More options in sponsorship to reach the targeted audience
- Greater recognition of and benefits to our sponsors
- The option to eliminate multiple requests for support

The sponsorship options are as follows:

- First Illinois Speaks Advertisements – (*Please see the ads in this issue*)
- Limited Membership Directory Advertisements *(New!)*
- Educational Program Support *(Not new but better coordinated and easier to do!)*
- Golf Outing sponsorship *(A streamlined approach has been added)*
- Sponsorship Packages – *(New – designed to be flexible and coordinated)*

While our new approach is new, we are very pleased with the response to date.
To learn more about becoming a sponsor or to sign up, just contact Jim Ventrone at 847-550-9814 or email at jmv@ventroneltd.com

SURVEY HIGHLIGHTS

Member Demographics

- 32% of respondents have been a member of HFMA for 1-3 years, while 44% of respondents have been members for over 10 years.
- 'Financial Directors' (26%) and 'Consultants' (20%) make up the majority of the respondents. Only 4% of respondents are 'Business Office Managers and Other Managers or Supervisors.'
- 55% of respondents describe their employer as a 'hospital' or 'other.' According to respondents, 'other' employers include 'Associations, Staffing Agencies, Community Mental Health or Vendors.'
- 58% of respondents have been working in healthcare financial management for 'more than 15 years.' In addition, 54% of respondents have earned a 'Master's degree.'
- More than half of the respondents (62%) indicated that they are 'female'. Of all the respondents , more than half (61%) would like to be entered into the drawing for the chance to win one of 5 educational programs.

Survey Results

- According to respondents, 94% are either 'very satisfied' or 'satisfied' with the speakers at the education programs. The majority of the respondents (90%) are either 'very satisfied' or 'satisfied' with the educational program overall and most of the respondents (87%) are 'very satisfied' or 'satisfied' with the location of the programs.
- Respondents 'satisfied' with the educational programs indicated that the 'topics/sessions were timely, diverse and valuable.' They believe that HFMA offers a variety of programs concerning current topics of interest. They feel the speakers are excellent. For the respondents that are 'dissatisfied' with areas of educational programs, the majority list cost as a factor. They feel the programs are 'too expensive'.
- 94% of respondents that have been members of HFMA for 4-6 years are either 'very satisfied' or 'satisfied' with the education program overall. In addition, 100% of respondents that have been members for 11-15 years are 'very satisfied' or 'satisfied' with the topics addressed at the educational programs.
- Overall, respondents rated HFMA's Accounting and Reimbursement program as the 'most valuable' (mean = 3.29 on a 4 point scale) amongst the programs the Chapter offers. This program was held in January. In comparison, the 'Continuum of Care' program hosted in November was rated the lowest (mean = 2.69 on a 4 point scale). Slightly over half of the respondents (54%) attended a First Illinois HFMA program 'less than one year ago.'
- 84% of respondents are 'aware and satisfied' with HFMA's 'Directory'. Interestingly, 43% were 'aware of an had no opinion' or 'aware of and dissatisfied' with the Certification Program.
- More than 3/4 of the respondents (77%) visit the First Illinois Chapter Web site less frequently than monthly. The two primary reasons that a member visits the Web site are to 'view the Calendar of Events' or to 'obtain information on educational opportunities.'
- Only 10% of respondents are certified healthcare financial professionals. Of those respondents that are certified, all responding Financial Officers and Operational Staff are a 'Fellow of HFMA (FHFMA).' Of the members that are not a CHEP, 27% are 'unfamiliar with the process' and 23% 'don't see the value of certification'.
- Interestingly, 65% of respondents are 'rarely involved' or not involved' in the First Illinois HFMA Chapter. 37% of these respondents are 'not involved' or 'rarely involved' because they 'personally don't have enough time' while 17% are 'not aware of opportunities to get involved.'
- On a scale from 1 (least satisfied) to 10 (most satisfied), respondents rated their satisfaction with the First Illinois HFMA Chapter a score of 7.05 in 2002 compared to 6.35 in 1999. Overall, the majority of respondents (91%) indicated that they 'receive value for the cost of their membership.'
- 87% of survey participants 'plan on renewing their HFMA membership' at the end of their current annual membership period. Of those respondents that are not planning on renewing, 50% are not planning on renewing because of 'cost' or they believe the 'benefits are not valuable.'

Questions or comments regarding the survey or the results may be sent to Jim Heinking at jheinking@hfri.net.

2003 HFMA Conferences and Clusters

June 22-26	HFMA Annual National Institute	Baltimore Convention Center
October 26-30	Atlanta Cluster	Hilton Atlanta (downtown) Atlanta, GA
November 16-20	Phoenix Cluster	Point Hilton Tapatio Cliffs Resort Phoenix, AZ
December 7-11	Chicago Cluster	Wyndham Chicago Chicago, IL

First Illinois Speaks

A Newsletter from HFMA's First Illinois Chapter

hfma healthcare financial management association

create the future

Printer: Be sure to show this flap on OUTSIDE FOLD

In This Issue

President's Message 1
The Emergence of "Consumer-Driven Health Care . . . 1
First Illinois Chapter Leadership Outline Direction, Goals and Action 2
The Revised Provider Reimbursement Review Board Instructions and the MedicareMediation Process 3
First Illinois Chapter Membership Survey 2002 Results . . 7
First Illinois Chapter Strategic Planning Session 8
First Illinois Chapter New and Transferring Members . . 10
Calendar of Events. 12

create the future

Editor:
Mike Nichols, CPA
Director
RSM McGladrey, Inc.
501 Seventh St., 6th Floor
Rockford, IL 61110-4539
Phone: 630/588-0450
Fax: 630/588-0453
Email: michael.nichols@RSMI.com

First Illinois Speaks

The First Illinois Chapter wants to thank our Bronze, Silver, Gold and Platinum Sponsors for their generous support of the Chapter

Gold Sponsors

Nebo Systems, Inc
Gustafson & Associates

Silver Sponsors

Pellettieri & Associates, P.C.
CSI Staff
Transolutions Transcription Services

Bronze Sponsors

Health Management Systems
Medassist Inc.
OSI Support Services, Inc.
Financial Resources Initiatives, Inc
Van Ru Credit Corporation
Tri-County Accounts Bureau, Inc.
United Collection Bureau, Inc.