hfma healthcare financial management association

first illinois speaks

A Newsletter from HFMA's First Illinois Chapter

November, 2005

the Business of Caring

Charity Care Controversies

Part Two: Addressing the Core Issues

BY JAMES UNLAND

Editors Note: In our last issue, James Unland described the scope of these now multifaceted controversies. This issue he cites approaches that address the underlying simplicities and complexities of needed policy changes and process improvements.

INSIDE:

Highlights and Recap
First Illinois Chapter Events

A review of the
August Meeting
HFMA 101: It's All About You

HFMA and Association
of Illinois Patient Access
Management Joint Program,
Navy Pier
September 22, 2005

Inside This Issue

A Hospital's Board Chair Sends A Message

Human stress can jump through a phone connection in the tone of a complete stranger, in this case an out-of-state hospital CFO:

"One of our HFMA members gave me your cell number, Mr. Unland, and I'm told you've worked on this hospital pricing and charity care business. I need some advice quickly."

"Why the urgency?" I asked.

"The chairman of our board ordered me to quickly take steps to keep our hospital out of this controversy."

It was early July of 2004, shortly following the hearing of the U.S. House Subcommittee on Oversight hearing on hospital pricing and collection practices. The hospital's board chair had taken the CFO aside that morning and told her to take steps to assure that their hospital would never be sued or investigated for overcharging the uninsured or for its collection practices.

"I told him," she explained, "that we were unlikely to be sued and that I had read legal commentaries stating that billing charge master rates and sending accounts to collections was not illegal," she said. "But instead of calming him, it set him off. He said to me: 'I don't care if it's legal to charge the uninsured these goofy charge master rates that you and I both know arose from years of contracting games. This isn't about what's legal.'

"He asked me how many people we had sent to collections, how many we were suing and how much we're collecting from the uninsured to begin with. He told me to change my thinking, to forget about the AHA's party line and to start thinking

continued on page 12

President's Message

R U NEU?

As our year progresses we continue to keep busy with work, First Illinois Chapter activities, following tragic national and world news – but also get a little bit of good news…

At my "paying job" I am truly lucky to have the support of my CEO, David Dorman, as well as the awe inspiring energy of my support staff. Thank you – everyone – at Healthcare Financial Resources, Inc for all that you do both on the job and for supporting HFMA.

First Illinois Chapter activities have rolled along… In August 47 people attended the education program HFMA 101 "It's About You". Six of those who attended were non-members – 5 became members by the end of the morning (and one promised to sign up by the end of the month)! Another Six of those present identified themselves as interested in becoming certified in HFMA. The rest were satisfied to learn more about HFMA both locally and nationally. The Chapter is planning to provide a February program "HFMA 201". The goal of the next program is to explain and recruit chapter leadership for the 2006 – 2007 year. Upcoming programs and events are scheduled for October 20, 2005 when we will have our new member breakfast and Revenue Cycle education program. Then on November 17, 2005 the IT committee will host a half day education program in Downers Grove, Illinois. I look forward to meeting many of our new members at these events.

It seems that since late August we have been faced with horrific news from both inside the United States as well as world wide. Beginning with hurricane Katrina, followed by hurricane Rita which devastated the Gulf Coast, we were then saddened by the devastation caused by hurricane Stan (Central America) then the awful earth quakes in the Middle East. Each of these natural disasters has had a huge impact on the lives and health of thousands of people locally and abroad. First Illinois HFMA officers have dialoged since mid September about how we as a chapter may give a portion of our resources in an effort to provide a small amount of relief. At our October 14, 2005 board meeting the directors and officers approved a chapter donation of $1215. This amount represents one dollar for every active member in our chapter as of September 30, 2005. The charity that will receive our donation is The Care Fund (www.thecarefund.net). This organization is comprised of the hospital associations in Alabama, Louisiana, and Mississippi. The organization is committed to not charging an administration fee for operating the fund. All distributions will be made to the men and women in the affected area who work in hospitals.

And now for the good news – a ray of sunshine has graced the city of Chicago; one that we have not seen since 1959. Yes, the Chicago White Sox won the American League Pennant on October 16th and will play in the world series starting on October 22, 2005. The White Sox will play either St Louis or Houston in the MLB World Series – GO SOX!

R U NEU (Are You New?) is a reoccurring theme for our chapter this year. I encourage you to get out and get involved in our chapter work. You will find our volunteer work both professionally and personally rewarding. As always, if you have a problem or question that could be answered by our chapter leadership, please let me know. We are here for you.

Sincerely,

Jim Heinking, CHFP
President
First Illinois Chapter HFMA

the Business of Caring

First Illinois Chapter News, Upcoming Chapter Events & Committee Updates

Upcoming Chapter Events –

Accounting and Reimbursement Committee:

Just a reminder – the 2005-06 Accounting and Reimbursement Committee Education Program will take place on Thursday, January 19th, 2006 at the William Tell Inn in Countryside. Watch your mail in the next several weeks for program reminders and registration forms.

Managed Care Committee:

The annual Managed Care Education Program is scheduled for Thursday, March 16th, 2006 at the William Tell Inn in Countryside. Program details are being assembled, however, committee co-chairs Brian Washa and John Wyrostek report that the program will focus on a broad variety of relevant and timely managed topics. Look for more details in the February 2006 issue of First Illinois Speaks.

Medical Group Practice Committee:

This year's Medical Group Practice Program will be held on Thursday, February 16th, 2006 – the location will be announced at a later date. Chairperson Elaine Scheye is assembling another timely and challenging program for medical practice administrators. Look for more details in the next issue of *First Illinois Speaks*.

Liz Simpkin, a First Illinois Chapter Director, recently completed a three-day walk to raise money for the treatment and research of breast cancer. Way to go Liz! You inspire us.

CFO Committee

The CFO Committee has had a busy fall. Linda Klute of Tatum Partners presented info on interim CFO life at the September 9th meeting. Tom Rowen, economist from Fifth Third Bank gave a presentation on interest rates and an economic forecast at the October 14th meeting. The May golf outing will be held at Calumet Country Club again this year. Meetings are held the 2nd Friday of every month at HFMA national headquarters in Westchester.

IT Committee:

On November 17, 2005, the Information Technology committee hosted an educational seminar at the ARMAMRK corporate headquarters in Downers Grove, IL. The theme of the half day seminar was "Achieving Bottom Line Results Through IT". Cases studies demonstrated how information technology has directly improved net income and operational efficiencies. Additionally a panel of CIOs and CFOs discussed how they measure IT value while maintaining successful working relationships. Our keynote speaker, Alden Solovy, Executive Editor of Hospital & Health Networks provided an entertaining view of the Most Wired Hospitals. A catered lunch provided the opportunity to catch up with old friends and make new ones.

Revenue Cycle Committee:

The 2005-06 Revenue Cycle Program for 2005-06 was held on Thursday, October 20th, 2005, with approximately 105 attendees and broad roster of speakers. A complete program summary, along with photos, will be available in the February edition of First Illinois Speaks.

Website Committee:

Congratulations to the entire website committee. Thanks to their efforts, the First Illinois Chapter website has been re-branded for consistency with other chapter communications. If you haven't already done so, check it out! (http://firstillinoishfma.org)

Directory Committee Updates

"We hope that all First Illinois members have received their 2005-2006 Chapter Directory. If you have not, please contact Jane Bachmann at 708/383-1860, and she will get you a copy. Upon review of the final printed copy, we found that there was a formatting error on pages 51 and 52. The correct data is reprinted below. We apologize for any inconvenience or confusion this might have caused. — *Jane Bachmann, Dave Golom, Membership Directory Co-Chairs.*

CHAPTER RECIPIENTS - FIRST ILLINOIS CHAPTER

	Follmer	Reeves	Muncie
James D. Allen	1989		
Keith R. Alman	1998		
Guy R. Alton, FHFMA, CPA	1994	2001	
Charles W. Andrew, FHFMA, CPA	2001		
E. Dean Antrobus	1992		
Laurence S. Appel, FHFMA, CPA	1995	1998	2002
Jane M. Bachmann	1989	1997	2002
Tony Banda, CPA	2001		
Allwyn J. Baptist, CPA	1984	1988	1992
Nancy C. Bartelt	1988	1992	2001
Charles A. Barth, FHFMA, CPA	1987	1993	2003
Sandra M. Beimfohr, CHFP	1994	2001	
Seymour Berebitsky	1990		
Odin Berg	2004		
Steven Berger, FHFMA, CPA	1989	1995	1998
William H. Blum, CPA	1983	1988	1992
Ronald J. Bordui, FHFMA	1974	1981	2000
Philip Brand	2004		
William E. Brennan	1998		
William D. Broderick, CPA	1991		
Joel W. Brody, FHFMA	1992		
James B. Brotnow	1985		
John Brugioni, FHFMA, CPA	1995	2004	
David Burik	1998		
John Burke	2003		
Linda K. Burt, CPA	1993	2003	
Rebecca S. Busch	2000		
Paul J. Canchester	1989		
Robert H. Carlisle, FHFMA, CPA	1994	1997	2000
Anthony J. Casale	1987		
Teresa Y. Chan, FHFMA	1996	2003	
Gary W. Chawk, FHFMA, CPA	1993	2001	
Terry A. Cherep, CPA	1990		
Ellyn M. Chin, FHFMA, CPA	2000		
Anthony L. Chirchirillo, CPA	1990		
Michael R. Cohen	1991	2004	
Lawrence K. Connell, CHFP	1996	2002	
John Cookinham	2000		
John D. Czech	1982		
Kathleen H. Dayon, CHFP	2002		
Martin J. D'Cruz, FHFMA	2001	2004	

CHAPTER RECIPIENTS
FIRST ILLINOIS CHAPTER

John R. Depa, CPA	1983	1990	
Edward S. Dettloff	1974	1987	
William L. Devoney, FHFMA, CPA	1996	2001	
Michael Doody	2003		
David C. Dorman	1994	2001	
James F. Doyle, FHFMA, CPA	1990	1995	2001
Truman Esmond	1980	1985	
Richard L. Felbinger	1994		
David S. Felsenthal	1998		
Anthony J. Filer	1998		
Bruce W. Fisher, FHFMA, CPA	1979	1983	1990
Loren W. Foelske	1987	2002	
James T. Frankenbach, CPA	1989	1993	
Karen Gagnon	2003		
Russell Gardner	1999		
Gary M.. Gasbarra, CPA	1994	1998	
Donna L. Gellatly, FHFMA, CPA	1996	2004	
Gary L. Gephart, CPA	1997		
Peter C. Gerali, CPA	1994		
Donald A. Gilardi	1998		
Jack A. Gilbert, CPA	1998		
Edward Giniat, CPA	1995		
Philip A. Gintzler, CPA	1985		
Thomas J. Glaser	1998	2004	
Theodore L. Goldberg, CPA	1987	2000	
David A. Golom, FHFMA	1997	2000	2004
Robert C. Good, CPA	1986	1990	
Michael P. Grady, FHFMA, CPA	1989	1995	1999
Anthony Greco	1988		
Daniel T. Gregorio, CHFP, CPA	1990	1994	1997
Karen L. Hackett, FHFMA	1994	2002	
Robert E. Hamann	1965	1972	1989
Richard Hamilton	2003		
Van. A. Hanover, FHFMA, CPA	1998		
Michael Hedderman, CPA	2003		
Melvin H. Heiden	1973		
James Heinking	2004		
Michael C. Hendershot	1994		
Doris L. Hendrickson, CPA	1993		
Mark C. Herbers, CPA	1989	1996	

From the Editors

The Balancing Act

BY PAULA R. DILLON AND HOLLY SOVA

Paula Dillon

Holly Sova

Given Wall Street expectations, downsizing, upsizing, rightsizing, etc. and carrying workloads for multiple parties, longer workweeks are par for the course. So how does one find balance in a world gone hectic and exactly what is balance?

As we launch the 2nd issue of the *First Illinois Speaks* edition for the 2005-06 Chapter Year, it is interesting to note the dynamics involved in producing a newsletter. We collect differing opinions; our fellow staff is diverse in interests, and backgrounds (and occasionally physical location); you the reader represent very different constituencies. The end product, we hope, is a harmonious balance among vendor information, chapter updates, new member tips, interesting photos, as well as informative, relevant articles. We strive to balance the content, layout and structure of the finished piece so that all its elements are evenly balanced.

Achieving balance in our professional lives is not as easy. We cope with the ever-present demands of day-to-day rigors. Widespread interest, however, on the part of healthcare professionals in 'giving back' to or through industry activities has always impressed us. The very persistence of getting involved through formal volunteering, committee work, or even informal mentoring etc, indicates to us that doing so is key to true balance. Amazingly, it is possible to add a certain amount of volunteer activity to an already hectic schedule when the involvement brings perspective and satisfaction.

Finding balance between volunteer work and "real work" requires a concerted effort to prioritize those elements in life that are important and that give us real satisfaction. Countless hours at a job, while it may support one's career, can not be truly satisfying unless balanced by other interests to offset your thinking and diversifying your background.

The 1st Illinois Chapter provides numerous opportunities to volunteer, socialize and expand one's professional horizon. We encourage First Illinois Chapter members, both veteran and newcomers, to go find that balance that you are seeking.

Spotlight: HFMA National Leaders with First Illinois Roots

BY HOLLY SOVA

Mr. Quint Studer's success has become Ms. Cathy Jacobson's problem. HFMA membership has grown significantly in the past few years: meanwhile its core remains hospital finance professionals, primarily from non-profit facilities. Diversity, however, both these leaders say, is good for our organization and our individual careers.

What do YOU say HFMA should be? Email any of our chapter leaders; we want your input. But first, read on to learn about two HFMA national leaders with roots in Illinois, and find out about their impact on our association.

Quint Studer
The Studer Group

Cathy Jacobson
Senior Vice President,
Finance, CFO and Treasurer
Rush University Medical Center

One who can shed light on HFMA's national organization, and do so frankly, is Quint Studer. He no longer has obligations to our association's national "inner circle." Although his past work is credited by Ms. Jacobson and others as having had a large role in the health of HMFA membership today.

Mr. Studer's 20-year career in health care includes Chicago roots. He rose from staff level to become COO of Holy Cross Hospital before leaving the south-side not-for-profit in 1996. He served four years as President of Baptists Hospital Inc in Florida. He left to found The Studer Group. He now specializes in advising health care leaders on how to connect employees to a sense of purpose, of making a difference by contributing to worthwhile outcomes.

HFMA's national organization saw in Mr. Studer a leader who could connect an organization to the passion of its members. As Mr. Studer puts it, people in health care finance already have a tremendous amount of passion. HFMA 's role must be to provide access to tools that allow them to do their jobs. Mr. Studer set about finding out and getting HFMA to deliver specifically what HFMA members want: improved and expanded educational conferences, products and resources.

Especially important was strengthening national's support of local chapters and their ability to provide quality programs and useful networking opportunities. In this way, HMFA was able to attract a larger membership, retain members, and begin to reach out beyond its core. This success engenders additional growth as more conference attendees attract more vendors which in turn give members opportunities to learn and select from a variety of vendors.

There was one thing Mr. Studer seemed keen to get across in our conversation. He observed that HFMA is one of the most value-driven, integrity-based organizations he has ever seen. Time and again he observed HFMA national representatives facing a choice between what was more profitable for HFMA vs. what would best serve members. Each time Mr. Studer saw our national leadership putting the interests of members first.

Among our chapter membership is Cathy Jacobson, who is serving her 2nd of a 3-year term on HFMA's National Board of Directors. She holds this responsibility while continuing as Senior Vice President, Finance, Chief Financial Officer and Treasurer at Rush University Medical Center.

Impressive.

Actually, neither of these is her most important role. She also answers to a nine-, a seven- and a five-year-old. Her secret? Initial credit goes to a wonderfully-supportive husband who decided two years ago to commit himself to child-rearing full-time. When pressed further, "Why do I work so hard? I love my job. I am very, very lucky. I love coming to work everyday. I am lucky to work for an organization that allows me the flexibility to accommodate both HFMA activities as well as family priorities."

Her employer benefits certainly, from its flexibility in facilitating employee HMFA involvement. Ms. Jacobson refers to HFMA as a weekly, if not a daily resource. Even in the years when one is not participating actively, reading HFMA publications and emailing back and forth with fellow members can be of immense value. Of course, she advises, attending educational and networking events maximizes membership benefits.

Ms. Jacobson's HFMA participation is active, to say the least. As a member of the National Board, she is on the Strategic Planning Committee. There she and fellow committee members face a "wonderful problem to have" which is how to take a very successful organization to the next level. HFMA, as Ms. Jacobson tells it, has done an excellent job focusing on its core serving hospital finance professionals which make up the majority of membership. HFMA's challenge is to remain cognizant of its majority, while addressing the needs and specialty interests of individuals on different sides of the industry and at different points in their career. This organizational goal aligns with Ms. Jacobson's recommendations for the aspiring professional: understand various aspects of the health care industry by working in different settings. While it is critical to be grounded technically, it is also key to become well rounded outside of

continued on page 5

Spotlight: HFMA National Leaders with First Illinois Roots (continued from page 4)

one's niche. Do not lock yourself into hospital finance departments exclusively. One gains a hugely different and hugely valuable perspective by working on the payer side or in operations, for example

Prior to Ms. Jacobson's current national board tenure, she served for six years on the national Principles & Practices Board. It was in that role that she experienced one of the highlights of her career. She was called upon to present to the Financial Accounting Standards Board (FASB) HFMA's position on proposed accounting guidance. She was honored to meet with FASB's leaders, let alone to have the opportunity to influence their decision on national accounting rules.

What Ms. Jacobson enjoys most about her role at Rush University Medical Center (RUMC) is the chance to help shape the organization's future. She explained that while the financial well-being of present operations is also her responsibility, she finds the time to plan for the long term "by putting very good people in place that report to me." Fun for Ms. Jacobson is the challenge of strategic planning around building the resources that will allow RUMC to do both what it needs and what it wants to do as the health care landscape develops.

Fun? When not enjoying time with her children, which takes up most of her non-work time, rare Cathy-time is curling up with a good book, or shouting out at a White Sox game.

Given this issue's article on the growing CDHP trend, it seemed appropriate to ask Ms. Jacobson's view of how providers should respond. She sees branding and advertising as increasingly important. A provider's strategic positioning should focus on demonstrating and communicating to consumers: 1) that quality health care is not a commodity; and 2) that the organization delivers a proven difference in quality. While outside organizations and vendors push their definitions of quality, a wise organization will establish its own quality metrics and be able to educate and influence consumers around their story.

Price matters. Providers need to ensure they have tools such as demand pricing systems, as prospective patients more and more expect to know in advance the cost of care.

Mr. Studer is a member of HFMA's Florida Chapter. He can be reached at quint@studergroup.com.

Ms. Jacobson is a member of our First Illinois Chapter. She can be reached at Catherine_a_jacobson@rush.edu.

HFMA Events

HFMA 101: It's All About You

August 2005

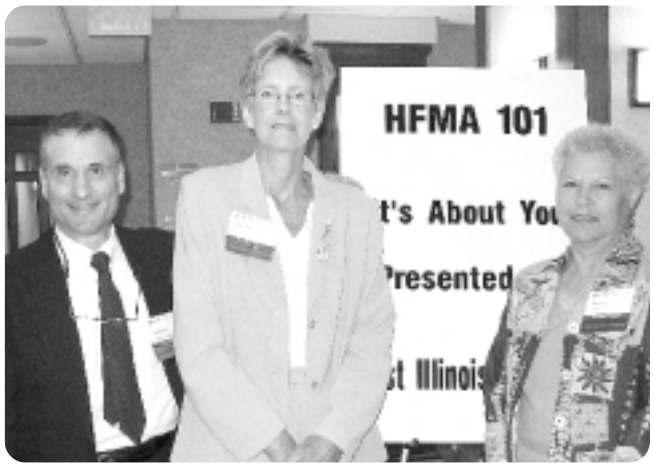
Over forty HFMA members, some veteran and some first-timers, attended HFMA 101, our chapter's first program of its kind, and the beginning of an annual event. The day's activities were meant to acquaint members with the organization's goals, as well as provide an opportunity to connect with chapter leadership and officers. It was a great day for asking questions about the activities, resources and networking that make up HFMA.

Several chapter officers and directors spoke on a variety of topics. Jim Heinking, President of First Illinois HFMA, presented an overview of our chapter, including statistics on recent membership increases.

The day also featured the talents of motivational speaker and creative strategist Gregg Fraley, who highlighted the various principles of creativity. He spoke on how applying creativity to volunteer work helps individuals advance both professionally and personally.

The entire day emphasized not only the importance of being creative in order to achieve success, but also the multitude of resources that are available continually to HFMA members.

If you missed this program, don't worry. Given the level of positive feedback received, an HFMA 201 program is planned for February 2006. We hope to see many of you there!



John Brugioni, Gail Walker, Susan Hull

Martin D'Cruz, Brian Sinclair, Cathy Jacobson, Mike Nicols, Vince Prior, Jim Heinking

Janet Blue and Brian Sinclair

Gregg Fraley

Front row - L to R: Cliff Larson,Terri Lewand, Gina Kociuba, Rich LeBoutillier, Carol Pistorio, Tim Ruby. Back row - L to R: Dave Wisted, Tim Carlson, Jim Murray, Connor Long, Michael Apolskis, Jim Heinking, Mark Romness, Mike Eckburg, Steven Kulhanek

HFMA and Association of Illinois Patient Access Management Joint Program, Mystic Blue, Navy Pier

September 22, 2005

Katherine Murphy, Mystery Man, Bernie Encarnacian

On the boat.

Vince Pryor and Susan Adams

Hans Morefield

Janer Blue

On the boat.

High Deductible Health Plans – a Ripple Now; a Tsunami to Come

BY CATHY PETERSON

This article will review the following key issues:

1. The differences between the types of high deductible health plans (HDHPs)
2. Why they will grow rapidly
3. Their pros and cons
4. Actions hospitals should take to be ready for the changes

For a larger image of the graph below, and a comparison chart of HDHP types, see the newsletter on our redesigned website: http://firstillinoishfma.org.

Comparing HSAs and HRAs

Consumer-driven health plans (CDHP) are seen by many as the last major weapon for limiting the growth in health spending. The stated goal of such plans is to make patients more prudent purchasers. The underlying assumption is that only by being fully exposed to the real cost of health care will patients make good decisions, have an incentive to control spending, and select cost-effective providers.

There are three basic types of CDHPs, also known as high deductible health plans (HDHPs):

1. HRAs – Health Reimbursement Accounts (or Arrangement – depending on the source);
2. HSAs - Health Savings Accounts; and
3. options that do not meet federal requirements of HSA or HRA accounts but are similar in that deductibles are at least $1,000/$2000 for individuals and families respectively. The common element among these plans is significant financial incentives for the insured to manage spending on healthcare. In response to increased consumer responsibility, insurers are attempting provide consumer-friendly tools to make better decisions regarding quality and cost.

Under an HSA, deductibles are much higher and employer contributions are much lower as compared to HRA plans. Consider that before an HSA plan starts paying for most services, the family deductible, not just the individual deductible, must be met. Thus, the deductible under an HSA is usually at least twice that as under an HRA. With a HRA, if a provider's claim can be paid from the employer's contribution, it is almost always automatically adjudicated. With an HSA, the employee has an option, and many employees have not selected automatic adjudication.

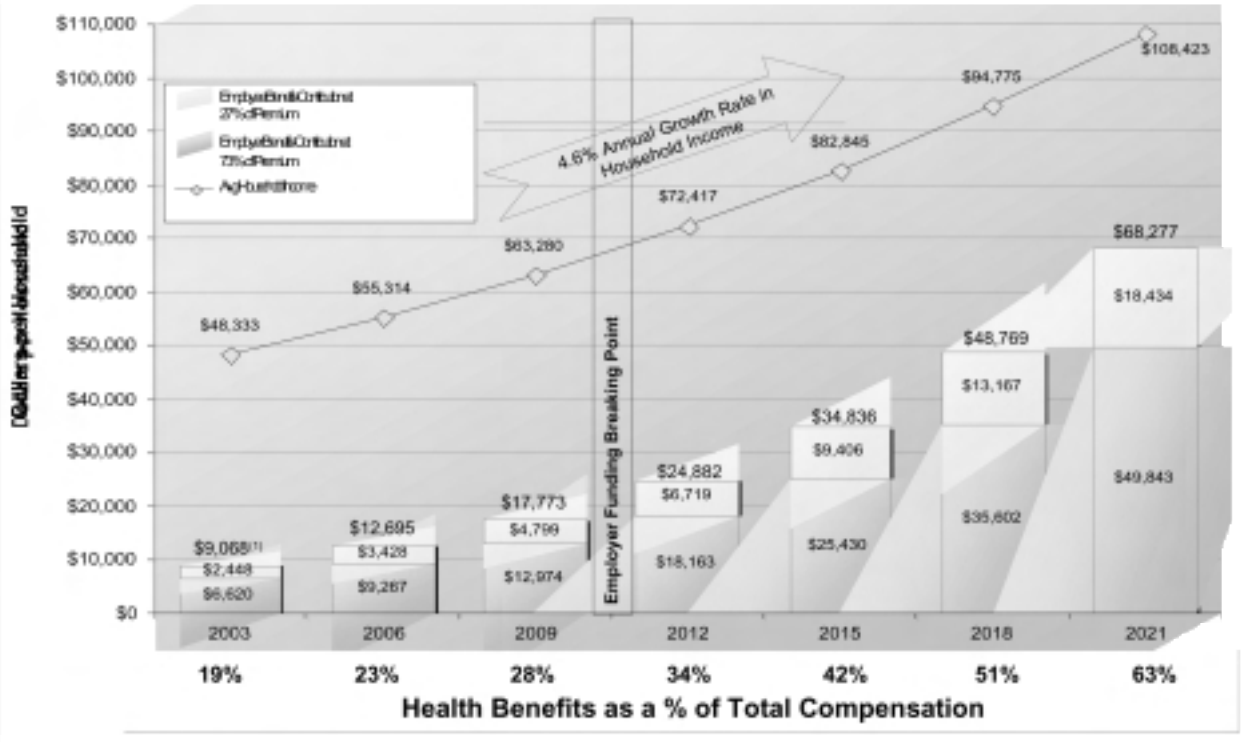
2. Why will HDHPs grow rapidly?

Over the last five years health insurance premiums have grown 73%, putting great strain on employers. Meanwhile, cumulative inflation amounted to around 14%, and cumulative wage growth was 15%.[1]

The average health insurance premium for a family of four today is almost $11,000. For low-wage employees, this may be 50% of their income. For most workers, 18-20% of total compensation is in the form of health benefits. Already employers are seriously strained. Now consider future predictions. The graph below assumes health insurance premiums will

continued on page 10

The Employer's Perspective



1. Projected 2003 Average Health Insurance Premium for Family Coverage (*Source: Kaiser/HRET Survey of Employer-Sponsored Health Plans; BLS - 2003 National Compensation Survey*)

increase 12% annually, and household incomes will increase 4.6% a year. Such projections demonstrate that health benefits as a percent of total compensation would be 28% in 4 years. In ten years, the proportion would jump to 42% of compensation. Clearly, this is not a viable option for employers.

HDHPs offer employers a way to reduce premiums and slow their rate of increase. So, not surprisingly, more and more employers are embracing HDHPs. In 2005, 20% of those employers offering health insurance offered a HDHP. Thirty-three percent of companies with over 5,000 employees were more likely to offer them.

Of all employees offered an HRA, only one out of four select it. However, it would be unwise to write these plans off as a failed initiative. Depending on the source, forecasts range from 18 to 23 million HSAs by 2013. In addition, Forrester Research stated that "by 2010, participants in consumer driven health plans will equal HMOs". Driving this is the belief by employers that HSAs are the most effective cost containment strategy (1).

The Midwest has often been slow to adopt new trends. Given the financial pressures on employers, however, this trend cannot be delayed for long.

3. Pros & Cons of HDHPs

The pros and cons of these plans are many, but are simply too new for their effects to have been researched conclusively.

4. Recommendations for Hospitals

HDHP will require hospitals to make changes including enhancing their financial procedures and improving their quality and customer service focus. Many of the necessary financial changes are discussed below:

Get better at collecting from patients.

With higher deductibles and out-of-pocket maximums comes higher bad debt, especially if additional actions are not put into place. Most hospitals have a very poor record of collecting significant patient balances. Insurance contracts require that participating providers not bill the patient for deductible or co-insurance until after the explanation of benefits (EOB) has been issued. One approach is to ask patients at the time of service for a credit or debit card to be charged only after the EOB is received. Another way is to have patients sign a written agreement authorizing automatic check debits in the amount determined by and at the time of the EOB, and get their agreement in writing or working out a payment plan with the patient. Be especially prepared to handle such situations early in the calendar year and for outpatient services. To accomplish this, the hospital needs to systematically identify the patients with HDHPs.

Train staff on how to collect from patients to maintain a positive relationship.

There will be many more such interactions, and handling them well can help you make sure you don't lose valuable customers. Non-clinical contacts are very important to the overall relationship. Additionally, it may be advantageous to direct the patient to the patient accounts staff prior to leaving. If the patient must go to another part of the hospital to make a payment, it is less likely to happen.

Develop more options to facilitate payment.

Because many patients will be facing larger payments, the hospital will need to be able to offer additional payment approaches. One example is developing special payment plans for long term and good customers. Does your hospital have the ability to automatically charge their credit or debit card monthly without contacting them if they have authorized the payments?

Expand the patient accounting and collection staff hours

Reorganize based on the fact that you will have more consumer debt. Providing accessiblility to patients outside of *their* working hours will be helpful to them, and key to your collections.

continued on page 18

Are You Ready for Tomorrow's Workforce Challenge?

Five Steps to Transform Your Workforce

BY JANE SEEL

This article looks at how one large health system provider, facing the national healthcare dilemma of how to do more with less, successfully realized increased workforce efficiencies and effectiveness while significantly improving employee and patient satisfaction. This healthcare provider pursued an enterprise model that totally transformed their workforce and business. Standardization across the enterprise was key to enabling process improvement and the transformation of its workforce.

This healthcare provider's challenge was to provide optimal patient care while facing projected staffing shortages and significant increases in patient volume. With the aging of the American population, an increase in patient volumes is a challenge predictably faced by many healthcare facilities across the nation.

Every healthcare organization should have a plan to support long-term growth and create a transformed environment where employees have the ability to provide patients with the best care possible. Each executive—from CEO and CFO to CIO, Nursing and HR leaders—has a stake in and a lever to influence this transformation process. By following this deliberate path, their clinicians will reap the working satisfaction that typically fostered the decision to pursue a healthcare career in the first place. Plus, patients will benefit from the improved care that engaged caregivers working in a transformed environment are able to provide.

Establishing and maintaining a transformed working environment in the face of these healthcare industry challenges boils down to a five-step program highlighted in the paragraphs below. Aligning key management across each major department is central to developing strategies that meet impending industry needs. By taking this deliberate path, healthcare providers will be in a position to support patient growth even in light of labor shortages and minimize: 1) employee turnover; 2) escalating labor costs & agency fees; and 3) inconsistent patient care resulting from ineffective staff scheduling. Neglecting to take transformation steps will result in reliance upon flexible staffing (overtime, forced stay, call-back, agency, etc.), the realization of spiraling labor costs, unhappy patients and other unacceptable consequences.

Five Key Workforce Transformation Steps

Aligning Workforce Operations with Industry Needs

1. Analyze the Business Case by evaluating current workforce strategies against internal transformation targets, leading practices and satisfaction indices
2. Assess Readiness to deal with critical workforce challenges and isolate areas needing improvement with specific change management strategies
3. Standardize and Consolidate workforce processes to increase operational efficiency
4. Identify Workforce Process Improvements and create future-state business processes (e.g. compliance procedures, communication practices, automation) based upon leading practices
5. Implement Processes with Enabling Technologies and conduct post-Live assessments to measure improvements against transformation goals

Analyze the Business Case

During this first step of the large healthcare provider's transformation effort, significant performance and satisfaction differences surfaced across locations within their health system. A root-cause analysis focused on these differences largely made the case for improved operational benefits. Additional transformation goals were identified by evaluating existing workforce strategies and measures against industry leading practices. Business Case criteria were quantified with cost estimates as appropriate for budgetary consideration. This first step builds a foundation for the workforce's transformation.

Assess Readiness

It is extremely important to understand the magnitude of the effort needed to move from your current-state operation to a transformed state. Self-evaluation is a process that requires candor, deliberation and transparency. It can expose operational challenges that stand in the way of workforce transformation success. Identifying and assessing strengths and weaknesses—especially in terms of technology, structure, and processes—ensures that you won't deploy an ineffective, band-aid solution where major surgery is required. Also, forecasting the organization's receptivity to change is needed to properly allocate costs, expenses and resources. The change management strategies in this step, are designed to facilitate extensive change, but must be tailored to fit specific situations and be accompanied by well thought-out risk evaluations and clearly defined mitigation plans.

continued on page 16

about what we could collect by revising our pricing and payment terms. Then he told me that if he ever read about our hospital in the paper in regards to these matters or if we're ever sued or investigated, I shouldn't bother coming back to work.

"Our CEO isn't into this stuff. This is on my shoulders, Jim."

The Real Message: Do What's Right

Subsequent conversations with the man pointed to a distinction in his mind between what may be 'legal' in terms of hospitals' rights to price at charge master and aggressively pursue collections versus what he viewed as the right thing to do in terms of: (a) his own calculation of risk/return in the context of the risks of doing nothing, (b) community relations issues and (c) the hospital's longer term financial, political (i.e. legislative) and strategic interests.

"The Scruggs federal suits are a joke, no question about it," said the hospital's board chairman, himself an attorney. "But we're exposed with respect to state law, especially if the attorney general gets riled up. Plus I'm not into being sued and hearing people tell their horror stories to local juries. Think of the publicity. Even more, this has the potential to be a horrendous distraction from and barrier to our legislative agenda, all over a pitifully low net yield from the uninsured in the first place."

It turned out that the hospital had been collecting about 5% on a blended yield basis of what it had been 'charging' the uninsured, net of monies paid to collection agencies, etc. All collections had been delegated out. When I started working with them the hospital had no idea whom it was suing, for how much or how aggressive its collectors were.

I got to the hospital's patient accounts manager and asked her a crucial question which, by that point in time (mid-2004), I'd been asking others around the U.S.: "If pricing to the uninsured approximated the level insurance companies pay would your billing be viewed as fair, and do you think patients would take their bills more seriously and pay more money?" I asked.

"They would definitely take bills more seriously, wouldn't you? But whether they would pay more money depends on payment terms. The price is just one part of this; extending payments over time is the other piece," she said.

"So if all this happened would you be sending fewer accounts to collections?" I asked.

"Yes. We send out way too many now. It would be great to get more payments in here. But that means looking at a lot of interrelated factors, including operational issues," she said.

> Thus, the solution for many hospitals — correctly — is to have some upper limit in respect to the income level to which the 'repricing to the uninsured' applies.

Three Legs of A Stool

Many hospitals, and at least one hospital association (Minnesota), are proactively trying to address: (a) pricing to the uninsured, (b) collection policies and techniques and (c) the provision of 'charity care.'

Space does not permit an extensive discussion of 'charity care' in itself. Suffice it to say that the provision of charity care is somewhat distinct from but still related to (a) and (b) above. Recognize that pricing and collections are related to charity care both operationally and in terms of the possible resultant 'net yield.'

The problem is that 'charity care' represents both an operational, patient-specific, 'economic triaging' challenge *and* an issue of overall financial impact to the hospital. The latter has investment banking and capital access implications, and therefore needs to be addressed separately. The importance of that separation is why I have opposed legislatively-mandated charity care minimums. Instead I advocate a revision of pricing and collection parameters at the hospital or, preferably, hospital association.level.

The 'Charge Master' Entanglement

Knowing that hospitals aren't collecting much from the uninsured anyway, the risk analyst's first instinct is to ask: why the heck not just price to all uninsured at an insurance company level across the board? However, we all know that with the existing reimbursement system, the 'charge master' structure cannot be thrown out or rendered irrelevant since it remains a vital contracting reference point.

Thus, the solution for many hospitals—correctly—is to have some upper limit *in respect to the income level to which the 'repricing to the uninsured' applies.*

For example, the Minnesota Hospital Association agreed that the upper limit is a 'household income' of $125,000 (Section 33 of the May 5, 2005 court settlement agreement[3]). I am not endorsing $125,000 as the only defensible amount of 'upper income limit' to which discounted fees apply. (In the Minnesota case discounted fees meant 'most favored managed care price'.) Nor am I endorsing all of the other economic and noneconomic aspects of the so-called "Minnesota Agreement.'

Moving beyond the 'cap' issue, the question then arises: *What is the right amount or percentage of discount?* Both the Minnesota Hospital Association and Tenet Healthcare seem to prefer a 'most favored payor' approach. In Tenet's case their settlement refers to appropriate discounts as 'managed care' prices, etc.

Some of my hospital clients who are grappling with this 'pricing' issue

continued on page 13

 (continued from page 12)

are attempting to approach the question wearing the other shoe, so to speak. Quite rightly these hospitals are putting themselves in the position of a consumer group or legislator and recognizing this overriding fact: the uninsured population is paying only a tiny fraction of charges anyway. Tired continually revisiting this controversy and of course not wanting to expose themselves to lawsuits and investigations, these open-eyed providers seek to deal with this issue of pricing to the uninsured once and for all and, hence, frame the question this way:

Is there a 'pricing arrangement' or 'level' that's going to be perceived as being 'fair' in the eyes of consumers in general, consumer advocacy groups, legislators, attorneys general, our hospital's local media and others, and if so, is this a pricing level that, combined with payment terms, might actually increase our net yield from the uninsured?

Each time I pour over a hospital-specific financial analysis, the facts point to an answer, at least to the second part of the question. In the words of one patient accounts manager: "We can't do any worse. Right now we're basically feeding collection agencies. Maybe it's time to try being fair and, in so doing, try to collect more money. Wouldn't that be a kick?"

The first part of the above question — engendering the perception of 'fairness' by different groups (even leaving aside attorneys general) – does not have such a simple answer. Advocates for the very poor uninsured argue that a managed care price is still way too high—preferring instead a level closer to Medicaid. In my view, this can be addressed with at least some probability of success by a hospital that has a relatively good 'charity care' policy in place to help the very low income people. That policy would include some kind of sliding-scale approach to charges, and in doing so combine charity with revenue. The linkages among the aforementioned 'three legs of the stool' matter simplifies why this approach is best.

The Advantage of a Group Acting In Concert

"Even aside from our attorney general pressuring hospitals up here, we needed to move as a group to revise our pricing and collection policies," Bruce Rueben, President of the Minnesota Hospital Association, told me recently.

Why? Because when only a few hospitals in an area that reprice to the uninsured and revise their collection practices put themselves in a position of becoming magnets for the uninsured. On a microeconomic scale, this happened in Champaign-Urbana.

"Under my leadership as CEO of Provena Covenant, we took more progressive actions than the hospital across town," said Mark Wiener recently. "It's better if all the hospitals in a market, or even a state, adopt somewhat consistent policies."

From the view of a credit analyst, consistent policies in pricing to and collections from the uninsured avoid the issue of disproportionately burdening any single hospital.

Is Being Proactive A Burden Or An Opportunity?

Wiener and Provena Covenant broke the ice with a local consumer group, turned around relations and took a number of steps that brought results. For example, while that hospital had been suing hundreds of patients annually in past years, in 2004 they sued only four patients.

"Patients are not stupid. They know fair from unfair, they know hospital pricing is otherworldly," says Claudia Lennhoff, head of the Champaign County consumers group.

"We all need to focus more on fair pricing, fair collection practices and trying to increase the yields from the uninsured. In doing that we'll also meet the expectations of the public about what a community hospital should be," says Bruce Rueben of the Minnesota Hospital Association. "Things are calming down up here since we made our agreement with the Attorney General. That's because hospital CFOs are finding out that they are actually able to collect more money with a fairness approach."

Refocusing The Discussion: Advancing The State-of-the-Art

To the risk analyst these three–year-old controversies involve a cockeyed dynamic which juxtapose high legal and regulatory risks against very low net collection yields. The discussion needs to move away from defending hospitals' narrow legal rights and toward increasing the net yield from the uninsured in a way that also mitigates these controversies.

This means addressing the 'three legs of the stool' – pricing, collections and charity care – in respect to both 'policies' and 'process improvements.'

If one is to make a fairness policy into good business, an entirely different set of challenges arises out of a focus on the revenue side of the uninsured problem. But to me, this is an opportunity for collaboration among HFMA members to advance the operational state-of-the-art.

A final note. When the late Robert Shelton pioneered the concept that became the HFMA, the organization was hospital-oriented. When I first joined the HFMA in 1976 it was the *Hospital* Financial Management Association. Although our friends in the collection business have a role to play, we all need to remember where this association came from and where our energies need to be focused – on increasing net cash flow to hospitals.

About the author: James Unland is a member of HFMA's First Illinois Chapter and can be reached at 800-423-5157 healthcapitalgroup@ yahoo.com

[1] Many resources for HFMA members on these matters are at: www.healthbusinessandpolicy.com/HFMA.htm

[2] James Unland is President of The Health Capital Group and can be reached by email at: HealthCapitalGroup@yahoo.com.

[3] See: www.healthbusinessandpolicy.com/Minnesota.htm

Enhancing Revenue by Linking Your Supply Chain

BY JIM RICHARDSON

As in any other business, accurate service-unit cost information is critical to assuring a hospital's financial well-being. While there are multiple players (physicians, insurance companies, employers and governmental agencies) involved in providing patient service and in receiving corresponding revenue; the bottom line for the hospital is to provide the quality services required and receive adequate revenue to stay in business.

Two primary obstacles historically faced by hospital administrators are lack of accurate supply cost information and an inability to accurately link supply costs to individual patient charges. A hospital's two largest cost items are patient supplies and labor, both of which are increasing every year. While labor costs are relatively easy to measure and forecast, supply costs consist of tens of thousands of items, whose prices change almost daily. While price changes are to be maintained in the hospital supply item master file, it is a challenge for every hospital to actually keep the pricing up-to-date in practice. Patient revenue is derived from a charge master file, which is usually disparate from the supply master file. This requires the updating of two systems, a daunting if not impossible task. As a result most providers are not able to accurately charge patients for the supplies required in the service of that patient. In many cases, revenue opportunities are lost, because accurate supply data has not been linked to patient charge data.

Sources of Additional Revenue[1]

- High Tech devices, such as cardiac stents, implantables, and orthopedic devices, if coded and costed correctly, will generally be reimbursed by payers. Without accurate pricing and coding, most hospitals will not get paid for their actual costs of these expensive items.
- Carve-outs to charge-sensitive contracts- the average hospital receives 10%-20% of its revenue from supply charge-sensitive managed care contracts. This percentage is generally even higher where managed care companies pay on a percentage-of-charge basis. When negotiated correctly—-using actual supply cost data—-these contracts can return hospitals not only their full cost, but also some mark-up for any high technology devices used.
- Price Changes- Unfortunately, hospital charge master rates are based on original acquisition costs of supplies and equipment, with no automatic way of updating when prices go up. If the supply master were linked to the charge master, price increases could be captured electronically, and charges would reflect the most recent prices for supplies and equipment.

Hospitals that can measure their costs by procedure (and by physician) accurately can more easily identify savings and financing opportunities. Without accurate data, it is impossible to measure the profitability of different service lines, and therefore plan growth strategies for the future. The ability to gain accurate cost data and become more profitable may also result in higher credit ratings for hospitals, allowing them to finance future growth.

Sarbanes-Oxley Implications

Profitable corporations spend lots to comply with federal regulations. Although not required under the 2002 Sarbanes-Oxley Act, non-profits are experiencing increased demands for financial disclosure and defensible pricing practices. Many health care providers are voluntarily complying with Sarbanes-Oxley requirements in order to maintain public trust, as well as to improve internal financial controls and disclosure.[2] The ability to account for supply and equipment costs, as well as to automatically link these costs with

continued on page 15

patient revenues, is an important step toward maintaining the financial control necessary to comply with the federal regulations.

The Hospital Cash Leak

Cash leaks are an inherent result of a lack of efficient business processes in both the supply chain and the revenue cycle. In the supply chain processes, a hospital must deal with:

- Incorrect invoices
- Off-contract spending
- Unclean master file data
- Continuous pricing updates
- Lack of resources to deal with these issues

On the revenue cycle side, hospitals must:

- Maintain accurate and compliant data in the charge master file
- Capture all appropriate charges for each patient
- Ensure that all patient identifiable charges are defendable and cover costs
- Make sure that patient charges are consistent with approved mark-up strategies
- Comply with dynamic payer rules

Each of these issues, left unaddressed, can have significant financial impacts. For example, lost revenue associated with a missed charge, incorrect invoice, or inaccurate charge code, is amplified as supply costs increase. Research shows that less than 10% of US hospitals have an automatic link between their supply information and their patient charge master. This is due mainly to the many disparate systems used by health care providers, which are difficult, if not impossible to integrate. To add to the situation, in many instances related supply items are not accurately linked (e.g., heart valve linked to heart cath tubing).[3] Exacerbating this problem further, most such instances occur in high tech, high cost items (cardiac and orthopedic implants).

Help Is On The Way

Fortunately, technologies are available to address many of these issues. It is possible to provide your financial management staff with valuable data in formats specifically designed for optimizing the supply chain and revenue cycle. For example, one healthcare information system company has developed technology which leverages their extensive databases of supply items, vendors, and charge description best practice data, and electronically links any hospital's supply item master data with its charge description master data. This technology links the data across several systems and files, with accuracy and normalcy of data checks in the process. Not only does this system accurately link supply data with charge data, but it also provides useful screens and dashboards, pricing benchmarks, search and sort capabilities, and mark-up simulations. These allow a hospital to "plug the cash leaks" and take advantage of new revenue opportunities. Implementation and time-to-benefit can be as short as 6 months, depending on the complexity of the organization.

Costs/Benefits

The cost of implementing this technology will, of course, vary depending on several factors including:

- Hospital Size
- Number of different supply item master files
- Number of master file supply items
- Number charge master items with volume
- Existing I/T systems
- Existing business processes

However, the *Good News* is that the technology can be implemented in most hospitals, regardless of existing systems, and implementation costs are relatively inexpensive, especially compared to the benefits received:

- Provides accurate supply item pricing & revenue capture
- Ensures defendable markups for all patient identifiable supplies (Sarbanes-Oxley)
- Provides pricing benchmarks against competitors
- Enables real-time, on-going review of hospital markup strategy
- Provides on-going accurate cost determination for each chargeable supply item (actual vs. estimates)
- Hundreds of hours of analysis can be performed in just a few minutes.
- Produces clean, accurate data and management reports which indicate areas for financial or compliance improvement
- Enables ongoing monitoring of cost/charge relationships
- Provides the capability to compare purchase volume to charge volume

continued on page 18

Are You Ready for Tomorrow's Workforce Challange? (continued from page 11)

Standardize and Consolidate

By the time you reach this step, you should have a clear picture of your current workforce operations, future-state objectives and the amount of effort required to move to a transformed workforce environment. Now you are ready to standardize and consolidate workforce processes across the organization. The objective of these standardized or consolidated enterprise processes is to enhance both the employee and patient experience while promoting operational efficiency. Common data standards and measurement metrics are also created to facilitate process adoption and comparability for future-state management across the enterprise.

Identify Workforce Process Improvements

An organization can implement growth strategies successfully only if it has the right mix of metrics and processes in place throughout the enterprise. With standardized workforce processes and measures established, you are positioned to develop future-state workforce processes based upon leading practices. These newly designed processes should increase automation, promote self-service capabilities, satisfy regulatory requirements, and foster clear employee communications. Most importantly, workforce decision-making information should be broadly disseminated across the enterprise.

Implement Processes with Enabling Technologies

Looking at a Blueprint Design of the future-state, standardized and improved processes rely on supporting technologies, also standardized across the enterprise. Configure these enabling technologies based upon future-state process requirements rather than current- state requirements. Develop standard workloads from Acuity and Census data to promote staffing balance. Move from disparate legacy platforms to a uniform system through data conversions with applied end-to-end business processes. Subject both processes and technologies to unit and parallel testing. Change management plans are executed and users are trained on processes, metrics and technologies. After Go Live, labor productivity is analyzed against transformation objectives (effectiveness) and costs are compared against budgets (efficiency).

From an operational perspective, transformed workforce processes, policies and systems empower management. Collaborative and practical front-line staffing decisions are feasible. Accountability to service levels and budgets is possible across the healthcare system. Automated staff scheduling for Nurses and allied health professionals optimizes staffing levels in a patient-focused, cost effective manner. Marked reduction in agency nursing and other costly staffing tactics is the result. Employee retention tends to increase dramatically as clinicians are offered an automated self-scheduling process and no longer experience forced-stays and over- or under-staffing situations. Best of all, patients receive the optimal care you are committed to provide.

Says Craig Gooch, Managing Director in BearingPoint's Healthcare Practice, "as healthcare providers deal with future challenges, transformed workforce strategies enable them to function as an enterprise, with access to timely, system-wide workforce management information and metrics. Process and technology standardization increase the availability of comprehensive, real-time decision-making labor analytics and provide increased patient and employee satisfaction along with significant cost savings."

About the author: Jane Seel can be reached at (610) 263-7389 or jane.seel@bearingpoint.com

Accurate ED Costing Impacts Hospital Care Strategies

BY MARK PAWLICKI

Two health systems in America are described by a 2004 report issued by the Centers for Disease Control. One cares for the insured and wealthy, and one consists of safety-net hospitals serving a large portion of underinsured[1]. Thirty-five percent of American hospitals are defined as safety-net hospitals and are facing financial hardship and even collapse. When a safety-net hospital fails, remaining area hospitals inherit risk, creating challenges for *all* hospitals in the community.

Hospitals fortunate enough to serve fully-insured patients are doing well. For these hospitals, the Emergency Department (ED) is often their strongest source of inpatient admissions and their most positive connection to their community. That positive connection changes as the number of patients facing access challenges grows, particularly as populations shift. Such a gradual change may go unnoticed for several years. Current methods of cost and income tracking often fail to provide financial executives with the early warnings of such a change. Meanwhile it's important to identify and fully assess the associated growing costs.

Emergency Visits: The real numbers

To many financial executives, the costs of additional Medicaid patients seem nominal. They believe that a limited addition to census can be absorbed and treated by on-duty staff. Medicaid ED reimbursement rates are therefore assumed sufficient to cover these marginal costs.

There is a serious flaw in that argument, according to a recent Rand study. (2) The flaw becomes more evident as the ED census and proportion of underinsured patients grows. EDs operate in a much more flexible manner than is apparent under traditional cost methods. Flexing staff coverage is a strategy virtually all ED's use as to adjust to changing census. For example, when an ED experiences a quiet shift, staff leave early, thereby reducing costs. The Rand study also found that larger patient volumes do not lead to efficiencies of scale. Such observations suggest that hospitals should change their ED cost-allocation formula — marginal expense should not be nominal . It should include the entire cost of the average ED patient.

This is a huge accounting swing and one that makes good sense. EDs are expensive places to do primary care. The Rand study authors calculated marginal costs of an ED visit at a trauma hospital to be $412 and at non-trauma facilities to be $295. In contrast, a Federally Qualified Community Health Clinic (FQHC) can see a primary care patient for $130.

Balancing Access with Appropriateness

Avoiding malpractice suits in emergency medicine requires vigilance and often results in sophisticated testing for minor diagnoses. For example, a person having headache symptoms and presenting to an ED may well receive a head CT scan. In contrast, a family physician is more likely consider ibuprofen to be the appropriate first level standard of care. The cost differential is obvious!

To use resources efficiently, we need to deal with the larger concern of the whole lifetime cost of a medical condition. The Rand study authors calculated the cost of the ED visit itself, which is only a fraction of costs potentially necessary to treat those who have unmanaged chronic illnesses. It is widely recognized that EDs simply cannot provide quality primary care for chronic conditions; continuity of care for these patients is unavailable through an ED. A well-managed asthma patient, for example, will likely never need an ED. Yet an unmanaged asthma patient may require extensive treatment, perhaps even an ICU admittance all of which will completely tip the financial boat.

> "Perhaps ED physicians could trade in their safety-nets for a role that is modeled on air traffic controllers."

Adding to these observations is a recent Commonwealth Fund study.[3] The authors found that conditions which might have been successfully managed as primary care matters, had they been addressed earlier, are by the time they are seen in the ED, *two to ten times* more likely to result in hospital admission and mortality. If hospitals would respond to patients based on an accounting horizon that spans the patient's lifetime, then hospital financial managers would have a different view of primary care in the ED.

It takes the combined efforts of the entire hospital to reverse the practice that sends every inconvenience to the ED for solutions. It also takes nuance and determination to change your ED from a site that sees everyone indiscriminately to one in which decisions are made about whether an EMTALA-defined emergency medical condition exists.

The change is possible. California's UC Davis has had a long-standing policy of referral to well-established, local state-run clinics. Wisconsin's Aurora Health Care began a more comprehensive reform effort at its downtown Milwaukee affiliate, Aurora Sinai Medical Center. With a focus on solutions and destinations for patients, it has achieved a near 40% reduction in its ED census without an increase in surrounding hospitals' ED utilization. When asked where those patients go, Dr. John Whitcomb, the ASMC ED Medical Director said, "We have set up a whole network of destinations. You have to look for small successes. Many complaints presented in the ED don't need to go anywhere. It's all in the training of your staff and physicians."

A new model for the ED

Perhaps ED physicians could trade in their safety-nets for a role that is modeled on air traffic controllers whose job is to maximize limited airport resources. Imagine looking to our ED physicians to decide who lands, who takes off for what destination and when. While these roles may not be the flashiest, nor the most high-tech, the ED physicians would serve as critical partners. The production model based on RVU's does not easily adapt to this role.

continued on page 19

Enhancing Revenue by Linking Your Supply Chain

(continued from page 15)

Preparing for the Future

Hospitals are busy preparing for increased competition and greater public attention to pricing. To stay competitive, and financially viable, health care providers have realized that accurate cost and revenue data are vital for their future. Significant increases to revenues and profit are rare in the health care industry, but the automatic linkage of supply chain data with revenue will have a major impact. The integration of this data very soon will simply be a given, just as it has been in other industries. The sooner hospitals start on this effort, the better prepared they will be to meet the challenge of cost-effectively managing their supply chain.

About the Author: Jim Richardson may be contacted at jim.richardson@bearingpoint.com.

[1] HFMA Article, "Linking Supply Costs and Revenue: The Time Has Come" May 2004.
[2] O'Neill, Patricia S. and Cutting, Thomas C., "Bondholder Disclosure and Sarbanes-Oxley: How One Medical Center Aligned Best Practices" *Healthcare Financial Management* August 2005.
[3] MedAssets, Inc. Research Data

High Deductible Health Plans

(continued from page 10)

By insurer, track the amount that must be collected from patients

If the patient portion becomes too burdensome for the hospital, then it is time to renegotiate insurance contracts. It is reasonable to expect insurers to adjust their contracts for the fact that hospitals are giving significant discounts and paying additional charges for processing debit cards.

Enhance your bills

Patients will be spending dramatically more time reviewing them. If they are not easily understandable and accurate, it will cause dissatisfaction and take significant administrative time.

Enable on-line bill inquiry and payment

Business-to-consumer industries have long known this is key to decreasing administrative expenses and increasing cash flow. With increased patient involvement, this only makes sense for hospitals as well.

Update material given to patients regarding billing, cash payments, and charity care

There will be more requests for this material than in the past. It is good customer service to have easily-understood and professional-looking material readily available.

Evaluate your prices, particularly for outpatient services; make sure they are competitive

Consumers will be calling and comparing prices. If they are not competitive, you are likely to lose the business.

Train staff on how to provide information on your prices.

Do you have the capability of giving patients the contracted rate if they are a current patient and you know who their insurer is? If they have an insurer with whom the hospital contracts, then the charge is not the correct rate. It is not to the hospital's advantage to quote an unnecessarily high rate.

Be able to tell your patients what the estimated allowable is for a service, not the charge

This is what they really need to know. If your competitor gives them the allowable, and you give them the charge . . . they are likely to go elsewhere.

About the Author: Cathy Peterson is a member of HFMA's First Illinois Chapter and can be reached at 773-580-6800 or cathy.peterson@att.net.

[1] The Kaiser Family Foundation and Health Research and Educational Trust: "employer Health Benefits – 2005 Summary of Findings."

Publication Information

Editors 2005-2006
Paula Dillon.....(630) 737-7212 pauladillon@firsthealth.com
Holly Sova .....(847) 226-9087 hollymariesova@msn.com
Official Chapter photographer
Al Staidl
Advertising
Jim Ventrone.....(847) 550-9814 jmv@ventroneltd.com
Design
Publishing Solutions....(312) 226-2227 jody@pubsol.net

HFMA Editorial Guidelines

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

Style

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

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

Founders Points

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

Publication Scheduling

Publication Date	Articles Received by
February 2006	December 16, 2005
April 2006	February 18, 2006

New Members The Chapter welcomes the following new and transferred members:

Maria Aberin
Evanston Northwestern Healthcare

Kelly Arduino
Raymond James

Pedro Avalos
Evanston Northwestern Healthcare

Todd Balhmann
University of Chicago Physicians Group

Sean Barden
Lake Forest Hospital

Charles Behl, Jr.
Rush University Health Center

Katrina Bentoumsi
Norwegian-American Hospital

Carl Bertrams, Jr.
3M Health Information Systems

Lizbeth Bergquit
Alexian Brothers Health System

Susan Berry
CCH Incorporated

John Bisaha
The Gallup Organization of Chicago

Jacqueline Brice

Dana Burchell
Centegra Health System

John Callahan
McDermott, Will & Emery, LLP

James Cartwright
PainCare America, LLC

Patrick Collins
American Appraisal Associates

Michael Cruz
Healthcare Financial Resources, Inc.

Thomas Cutting
Rush University Medical Center

April Damaska
Centegra Health Systems

Tina DeMarco
Accenture, LLP

Anjali Dev
Cerner Corporation

Luba Dezurko
Healthcare Financial Resources, Inc.

Carol Dickman

Darcy Dipane
Huron Consulting Group

Robert Dubow
PainCare America, LLC

Suzanne Eckstein
Alverno Information Services

Michael Erickson
Sherman Hospital

Meg Flanagan
HFMA

Caren Gegenheimer
Family Care Center of Indiana

Jason Giancaterina
Provena Saint Joseph Hospital

Marque Guest
RMS Lifeline

Eileen Godenius
McGladrey & Pullen, LLP

Srinivasan Gowrishankar
Huron Consulting Group

Pamela Thomas-Hall
Provident Hospital of Cook County

Brian Harter
Delnor Community Hospital

Brandon Hatch
Deloitte Consulting LLP

Melanie Hennessy, CPA
Holy Family Medical Center

Quentin Ihne
Alexian Brothers Health System

Anita Iyenger
Mitretek Healthcare

Linda Krish
Health Management System

Maribel Lara
Sherman Hospital

Kevin Larkin
Provena Saint Joseph Hospital

Amy Lee
Trinity Regional Health System

Didi Lee
Senex Services Corporation

John Leone
Healthcare Financial Resources, Inc.

Philip Magin
Shriners Children's Hospital

George Mann, III
Maintenance Value Plan

Kathleen Masterson
University of Chicago

Christopher McMillan
Ernst & Young, LLP

Daniel Mruz
Victory Memorial Hospital

Janet Nelson
Marianjoy Rehabilitation Hospital

Kay Parkinson

Michele Pasqua
Healthcare Financial Resources, Inc.

Carol Pistorio
Chartone

Pamela Watson-Pitts
John H. Stroger Hospital of Cook County

Anahita Rahman
Ernst & Young

Arvind Ramanthan
Edward Cardiovascular Institute

Christopher Rohn
Huron Consulting Group

Sue Roeder
University of Chicago Hospitals

Mark Romness
BearingPoint, Inc.

Richard Rosenbaum
RX Financial Security

Brenda Schillinger
Springfield Service Corporation

Charles Scott

Janet Skurski, RN, BSN, OCN
OSF Saint Anthony Medical Center

Dee Sortino
Damer & Cartwright Pharmacy

Anita Stefanich
Brookdale Living Communities

James Swanson
Accelerated Receivables Management

Brenda Taylor
Oak Park Hospital

Alicia Temesvari
Standard Register

Louis Terranova
American Academy of Pediatrics

Mark Thierer
Physicians Interactive

Larry Tracy
Evanston Northwestern Healthcare

Steve Urosevich
Van Ru Credit Corporation

Giri Venkatraman
SG-2, LLC

Sherril Vincent
Alexian Brothers Medical Center

Rose Vitacco
St. Alexius Medical Center

Susan Wilczenski
Sinai Health System

Wendy Yee
University of Chicago Hospitals

Accurate ED Costing Impacts Hospital Care Strategies ... (continued from page 16)

Looking through the lens of "lifetime" accounting, we should get past the argument of marginal or average cost and recognize Emergency Medicine for the role it could and should play — the critical juncture in access to the right place, and the right care provider.

This new role can become the model on which much of health care reform can be better designed for Medicaid, and other vulnerable, uninsured or underinsured populations. Our EDs are the natural destination for medical solutions. Instead of attempting to do everything for everyone, our EDs should become triage partners, air-traffic controllers directing entry into a hospital, and into all of health care. Access specialists, EMTALA watchdogs, air traffic controller: all are terms that would define this new role. It would help us put our hospitals' fiscal house in order and rescue our strained and nearly broken Medicaid system.

It's time for our hospitals to manage patients in collaboration with our safety-net payers: Medicaid and local governments. Hospital financial managers should examine the long-term costs of appropriate care and move towards "lifetime" accounting. What we are doing right now is the most expensive way of all. Crisis management is not good for medicine.

About the author: Mark Pawlicki is a First Illinois Chapter HFMA member. He can be reached at 414-460-1900 or mepawlicki@medtri.com

[1] CDC Series 13, Report 155, May 2004. Characteristics of Emergency Departments Serving High Volumes of Safety-net Patients: United States, 2000. Data from the National Health Care Survey

[2] Bamezai, A, Melnick G, Nawathe, A, The Cost of an Emergency Department Visit and Its Relationship to Emergency Department Volume. Ann Emerg Med. 2005;(45:483-490)

[3] Billings, J Parikh N, Mijanovish T, Emergency department use: New York City. The Commonwealth Fund, Oct 2000 (4)Williams, RM. Distribution of emergency department costs. Ann Emerg Med. 1996; 28:671-676.

first illinois speaks
hfma healthcare financial management association
A Newsletter from HFMA's First Illinois Chapter

Healthcare Financial Management Association First Illinois Chapter

2005-2006 Calendar

January 19, 2006
Accounting and Reimbursement, Full Day, William Tell Inn, Countryside

February 3, 2006
HFMA Educational Program, HFMA 201, Location TBD

February 16, 2006
Medical Groups and Physicians, Full Day, Gardner, Carton & Douglas, Chicago

March 15, 2006
Managed Care, Full Day, William Tell Inn, Countryside

May 5, 2006
CFO Meeting and Golf Outing, Full Day, Calumet Country Club

May 26, 2006
Annual Golf Outing, Full Day, St. Andrews & Klein Creek

The First Illinois Chapter

The First Illinois Chapter wishes to recognize and thank our sponsors for the 2005-2006 Chapter year. Thank you all for your generous support of the Chapter and its activities.

Platinum Sponsors
Nebo Systems, Inc.
RSM McGladrey and McGladrey & Pullen, LLP

Gold Sponsors
Crowe Chizek & Co. LLP
Healthcare Financial Resources, Inc.
HealthCom Partners, LLC
JPMorgan Chase Bank

Silver Sponsors
Harris & Harris, Ltd.
Mailco, Inc.
Pellettieri & Associates, P.C.
Virtual Recovery, Inc.

Bronze Sponsors
Accelerated Receivables Management
CMD Outsourcing Solutions, Inc.
H&R Accounts, Inc.
MedAssist, Inc.
Medical Recovery Specialists
On Target Staff
R&B Solutions
Revenue Cycle Solutions
Senex Services
Strategic Reimbursement
United Collections Bureau, Inc.
Ventrone, LTD