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

WHATEVER IT TAKES

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News, Events & Updates

In This Issue

The Affordable Care Act Is Here

BY DANIEL T. YUNKER, SVP, MCHC / CEO LAND OF LINCOLN HEALTH AND FIRST ILLINOIS HFMA'S PRESIDENT

Key elements of the Affordable Care Act (ACA) are now rolling out across the state of Illinois and the nation, and consumers in need of health insurance are starting to shop for a health insurance plan. If they don't enroll, they will be faced with a fine as outlined in the new regulations. The good news is the ACA is ensuring consumers have more choice. But with more choice often comes more confusion.

Eligible consumers can shop for coverage through a new online tool that compares health plans side by side. This tool is called the Health Insurance Marketplace, often called "the exchange." The exchange will allow consumers to compare and purchase health insurance plans, and if they are eligible for a subsidy or discount, they can redeem that there too. All plans have to meet high standards for what they will cover, so people can feel confident they are getting a good product. The plans will be offered at four different levels: platinum, gold, silver and bronze, with platinum and gold plans providing the most coverage, and the bronze plan being the most affordable. There also will be catastrophic coverage available for certain populations.

Within the exchange, the ACA also supported the introduction of new entrants to join the marketplace to further expand choice for consumers. Called consumer operated and oriented plans (CO-OPs), CO-OP plans are consumer-run, and accountable to their individual membership in a way that most traditional for-profit plans typically are not.

To assist consumers within this new world of health insurance, the ACA requires states to establish an assistor program to help enroll individuals in the exchange. There will be navigators who will conduct public education activities to raise awareness about the exchange, in-person counselors who will answer basic questions about health insurance and guide Illinois residents through the application process, and certified application counselors who will have training and certification to enroll individuals in the new health coverage programs.

Now that this important and historic piece of the Affordable Care Act is here, the health care industry

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The Affordable Care Act Is Here

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must take responsibility for helping consumers in making the right purchasing decision for them. This can be done, for example, by creating better partnerships with the health care providers who come in contact with consumers every day.

As an industry, we must take ownership of educating and arming consumers with information to make the right choice of insurance coverage for them. The time is now for us to act.

Dan Yunker

SVP, MCHC / CEO Land of Lincoln Health and First Illinois HFMA's President

Recognition From National HFMA Continues

BY CARL PELLETTIERI, ESQ., PRINCIPAL, IMPACT HEALTHCARE SERVICES AND PRESIDENT-ELECT, HFMA FIRST ILLINOIS CHAPTER, AND MIKE NICHOLS, PARTNER, MCGLADREY LLP, CHAPTER PAST PRESIDENT AND CURRENT REGIONAL EXECUTIVE, REGION 7, HFMA

HFMA National Chair Steven Rose challenged all of us at the June ANI in Orlando to do "whatever it takes" to meet our goals and achieve superior results. We all know the demands of our job continue to escalate as we move quickly into healthcare reform and all that goes along with it. As the volunteer board of the First Illinois Chapter works with the multitude of volunteers in the chapter, we ask ourselves how we can deliver better education, timely topics, new energy and actual case studies of successful outcomes. We also listen to the results of the annual membership survey and have implemented many ideas in response to members' stated needs. We are very excited about the inaugural Fall Summit on November 4 and 5 because this event is designed to specifically address these areas and provide greater value to your chapter.

As the First Illinois Chapter continues to evolve, you should know that our history is rich and has been well recognized at the national level. Each month we report to national our performance in the categories of education hours, membership, member satisfaction, certification, days cash on hand, on-time reporting and provider board composition. Our results are monitored by National HFMA, and all 69 current HFMA chapters are ranked within each of the measurement categories. The results in previous years establish the goal levels for subsequent years and this information is captured in the chapter balanced scorecard system (CBSC) tool.

As all of our own organizations strive for recognition within our industry, so do the HFMA chapters. There are several awards available each year to recognize the chapters that have excelled at delivering their members superior education and innovative programs. These awards are based on achieving certain performance metrics identified in the CBSC. They are: C. Henry Hottum, recognizing Educational Performance Improvement; Awards for Excellence using a mathematical formula in four categories (platinum, gold, silver and bronze) to recognize Education, Membership Growth and Retention, and Certification; and the Helen M. Yerger, recognizing outstanding chapter performance in the categories of Collaboration, Education, Improvement, Innovation, Member Communications, Member Service, and Membership Recruitment and Retention. Our chapter even has a Yerger awards committee. This committee is charged with the responsibility of identifying areas of improvement and documenting the methodology and results behind these improvements. The Yerger awards are based on an application process, and the applications are judged by past chapter presidents from other chapters. One of the key criteria for successful Yerger applications is identifying a need within the chapter. These needs are often identified through the annual chapter membership survey. It's not about the awards themselves, but rather how the pursuit of the rewards improves your chapter.

Over the last five years the First Illinois Chapter has received the following: 8 Awards of Excellence, 12 Yerger awards, and 3 Hottum awards. The committee volunteers, board members and chapter officers that have worked tirelessly to make this happen should be congratulated. We stand near the top of the list on a national basis. When you fill out your chapter survey, please keep in mind our achievements and recognition. We are all volunteers doing our best on a daily basis to help our peers and colleagues navigate the world of healthcare.

We have an opportunity to continue in our leadership position into the foreseeable future. It will take all of us to voice our opinions, engage in volunteer opportunities and contribute in any way we can to succeed. In other words, do "whatever it takes" to make that happen. We look forward to seeing you at the Fall Summit.

Legislation Connection

BY CHERYL A. WESOLOWSKI, CHAIR

State of Illinois Update from the IL-MGMA Legislative Committee

To sum up the 2013 Legislative Session: Business as Usual. Issues that reached resolution: Gay Marriage, Gambling Extension, Concealed Carry, and Medical Marijuana. Issue not resolved: PENSION REFORM.

Il-MGMA Legislative Committee was watching the following bills as they made their way through the state legislation last session:

SB 1630: ANATOMIC PATHOLOGY BILLING:

This bill would eliminate pass through billing by physician offices. This bill failed to pass by the deadline and has been re-referred back to the House and Senate Committees. We will continue to watch and see if this bill gains new life this session.

HB 71: MEDICAID FRAUD-OBSTRUCTION:

Provides that anyone who knowingly obtains unauthorized medical benefits, or any other entity that assists, commits medical assistance fraud. The Governor signed the bill into law on August 16, 2013. This violation is a Class 4 felony.

SB 1194: INSURANCE NAVIGATOR ACT:

No entity can perform, offer to perform, or advertise any services in the State of Illinois, or receive funding from the State unless licensed as a navigator by the State of Illinois Department of Insurance. Governor Quinn signed this bill into law on August 23, 2013.

SB 26: MEDICAID-HEALTH BENEFITS SERVICE:

January 1, 2014, extends benefits under the State's medical assistance program to persons aged between 19 and 64, and who have an income at or below 133% of the federal poverty level plus 5% for the applicable family size. This bill could have the potential of expanded Medicaid coverage to half a million new enrollees in Illinois. The federal government will be picking up the tab for the new enrollees for the first three years under the Affordable Care Act. The Governor signed this into law on July 22, 2013.

IL-MGMA Legislative Committee has stayed engaged with the National MGMA Legislative Committee on the Health Insurance Exchanges. As of the writing of this article there are still many unanswered questions and uncertainties. The Health Exchange Marketplaces went go live on October 1, and open enrollment October 15. Hopefully, after the October 1 opening, healthcare providers will have some answers to their pressing questions: fee schedules, network participation, benefit design, and number of covered lives.

HB 3638 and SB 2585: DHFS-INS-RX DRUGS-FORMS:

Requires the Department of Healthcare and Family Services and the Department of Insurance to jointly develop a uniform prior authorization form for prescription drug benefits on or before July 1, 2014. Provides that on and after January 1, 2015, or six months after the form is developed, whichever is later, every prescribing provider may use that uniform prior authorization form to request prior authorization for coverage of prescription drug benefits, and every health care service plan shall accept that form as sufficient to request prior authorization for prescription drug benefits. Provides that on and after January 1, 2015, a health insurer that provides prescription drug benefits shall utilize and accept the prior authorization form. The bills were referred to the rules committees on May 29 and June 10, 2013.

Il-MGMA Legislative Committee will be solidly engaged in the activity on this bill. Currently, each health plan or health insurer has its own prior authorization form. The volume of different forms from each plan/insurer imposes a significant administrative burden on many health care stakeholders that can result in a significant delay of patient access to medication. Promoting the use of a uniform prior authorization form for medications would reduce overall healthcare costs, reduce administrative burden, and increase patient quality and satisfaction. Insurance carriers and Pharmacy Benefit Managers (PBMs) impose various "preauthorization" requirements before a physician is able to obtain needed pharmaceuticals or medical services for his or her patient. It's one of the many roadblocks to care patients face, and it results in countless hours of administrative time in a physician's office to secure insurance approvals. In almost all cases, the preauthorization is approved, but only after considerable delay, administrative expense for physicians and unnecessary suffering for patients.

According to a 2010 survey by the American Medical Association, physicians spend 20 hours per week on average just dealing with preauthorizations. Studies show that navigating the managed care maze costs physicians $23.2 to $31 billion a year. (http://www.ama-assn.org/ama/pub/news/news/survey-insurer-preauthorization.page).

There will be updates posted to the IL-MGMA website as this bill gains traction in the state legislation, and there will be call to action blasts as well. The House and Senate resumed on October 22 with a veto session.

Improving Transparency to Reduce Costs:
Exploring the Implications of Healthcare Reform

BY HFMA EDITORIAL STAFF

The big question in health care today is: How do we take the money we spend—which should be more than enough—and obtain better value?

The answer—and the path—for hospitals is complicated, says Bob Kocher, MD, former Obama administration healthcare adviser and a partner with Venrock. For years, hospitals have tried to increase their influence locally to command market share and to be broad in their scope of services. The problem is that many hospitals' prices today are out of whack compared to the value they provide, Kocher said. And as we transfer to more value-based systems, physicians will work to avoid hospitals (now cost centers), identify the lowest cost hospitals, and more.

Shared savings, for example, come largely out of hospital revenues. Kocher believes that to succeed in a value-based business environment, hospitals will need to become more narrow—focusing on 10 or 12 things they do well—and consider whether they can set a price for care. How will they create differentiation in a world that hasn't been differentiated very well?

Kocher also offered the following input regarding how hospitals should prepare for a world of increased transparency and healthcare reform.

On the race for physician employment:

One good affect is that physicians are learning how to be managed. Hospitals can also create physician teams that offer patient experiences that others can't create. Conversely, health plans are employing doctors to create alternatives to hospital-based networks. And doctors are employing doctors because they realize that under capitation, they will have unique opportunities to make money.

On the topic of transparency:

Most hospitals today exist in a Lake Wobegon world, where everyone seems above average. But:

- Data suggest little correlation between price and quality. The good news for patients is that you can almost always find a hospital that is lower cost. But it's terrifying for many hospitals as the data becomes more accessible.
- There is extensive (e.g., five-fold, seven-fold) variation in prices for the same procedures. As these variations become more transparent, people will make more rational decisions.
- When you make data intelligible, people act on the data. Castlight, a company on whose board Kocher serves, provides both simple quality ratings (essentially a 1- to 5-star rating) and prices on elective procedures in a tool for large employers' employees (website- and app-based).
- Reference pricing is another tactic increasing in use (employees are given a list of providers who will offer services below a certain price ceiling; if the employee chooses a higher-cost provider, the employee pays the cost above the reference price). Once employers begin reference pricing procedures or pharmaceuticals, virtually all employees will choose providers below the reference price.
- Engagement of patients + behavior change = reductions in net spending. Market share will change as people have more data.

What we know for sure, according to Kocher:

- Labor productivity will improve in health care.
- Price elasticity will change. Today, there is an inelastic relationship between price and demand in health care. Demand and price will become reattached and you will have much greater elasticity.
- Hospitals will complete on disease level value. The focus will be on creating differentiated disease-level teams.
- Risk will shift to patients and providers. As patients have more skin in the game, they will become more discriminate in how they purchase health care.

Predictions for the future:

- Emphasis will shift from benefit design to creating and delivering products.
- Prices will be more strongly linked to value and market share.
- Providers will sell (much) better outcomes, guarantees, and warranties.
- The focus will be on building healthcare businesses that emulate the best consumer product companies and experiences.

The Career Audit:
How to Get From Where You Are to Where You Want to Be

BY VICKIE AUSTIN

A financial professional audits an organization to assess the strength of its financial systems. As a business and career coach I was inspired by this concept, so I developed "The Career Audit" to assist people in examining and reviewing their careers. If you're not quite sure how to get from where you are to where you want to be, here are the elements of a "Career Audit" to help you assess your resources and build on your strengths:

✓ **You have a vision and a plan.** Leaders have vision and so do people who achieve career success. Where do you see yourself in the next three to five years? Can you articulate your vision in words, on paper? You can bet your hospital or organization has a strategic plan—why not you?

The biggest regret I hear from my clients who are in career transition—especially those who have been downsized or out-sourced due to changes in their organizations—is that they were too busy doing their jobs to think about their careers. You have the right and the obligation to keep your own career agenda first and foremost in your mind. Think of your plan as insurance against the winds of change. With healthcare in a state of flux and the prospect of companies merging or being acquired, you always need to have a "Plan B." Create a written plan with your goal, objectives, strategies and tactics to help you build a bridge from the present to the bright future you envision for yourself.

✓ **You have a mentor and/or a sponsor.** I interviewed HFMA leaders for a recent presentation I gave at ANI 2013 and learned that nearly every leader had a series of mentors and/or sponsors. Mentors act as advisors; sponsors serve as fierce advocates who use their own power and influence to open doors. Typically a mentor is someone outside your chain of command, and he or she can also be someone who is in another department or industry altogether. A sponsor has clout within your organization or industry and goes to bat for you when needed. Both can be critical to your career success. And when you're at a point in your career when you have experience and expertise to share, consider becoming a mentor or sponsor yourself. [For ideas on mentoring, read the 2013 edition of Managers as Mentors: Building Partnerships for Learning by Chip Bell and Marshall Goldsmith, published by Berrett-Koehler Publishers, Inc.]

✓ **You've built your "posse."** Just like a sheriff in the Wild West surrounded by his deputies, you want to have your own "posse." This is your support team, the people who cheer you on, celebrate your victories with you and support you through defeats. Your posse might include a close friend or confidante, your mentor or sponsor, a career coach, your personal trainer, your barber or stylist (or whoever helps you look that good!) and a spiritual advisor. Whoever you choose to be on your posse, remember that no one who is truly successful accomplishes that success alone.

✓ **You have the training and expertise you need to take you to the next level.** Once you have that vision and plan in place, you can judge what kind of training you'll need. Do you need an MBA? A CPA? Certifications? Ask your colleagues, mentor or sponsor what type of training you'll need to achieve your goal. Visit the HFMA website (www.hfma.org) to learn more about options for education and training that are available both online and on-site.

✓ **You honor and nurture your network—AKA your "Golden Rolodex."** Your network is the most valuable asset in your career toolbox. Comprised of people who a) know you and b) are breathing, your Golden Rolodex is your richest source of recommendations, contacts and referrals. People like to do business with people they know and trust, which is why your network is so important. Honor and nurture those relationships. Take people out to lunch and ask them what they're up to; share about your career aspirations and ask them for their ideas. Introduce folks to each other when you think there might be a mutual benefit to them and forget about the "credit" or reward. Those generous gestures will be returned to you tenfold.

Use this "Career Audit" to evaluate the strength of your own career plan and to identify where you may need to focus and add resources. Remember, no one can manage your career as well as you.

Vicki Austin

Vickie Austin is a business and career coach, founder of CHOICES Worldwide and a professional speaker on topics related to success. Need more information on how to create your own strategic plan or how to build your Golden Rolodex? Contact Vickie at vaustin@choicesworldwide.com, or call her at 312-213-1795. You can also follow her on Twitter at @Vickie_Austin or connect via www.linkedin.com/in/vickieaustin.

CFO Survey Results Show Shift in Hospital-Physician Dynamics

BY HFMA EDITORIAL STAFF

As hospitals prepare for the shift to value-based business models, a recent HFMA survey of healthcare CFOs shows the growth in physician employment is expected to continue, particularly as hospitals work toward strengthening capabilities related to care coordination, population health management, performance measurement, and more.

The survey, sponsored by McKesson, gained input from 139 healthcare CFOs regarding their organizations' physician affiliation strategies to assess the impact of changing care models on physician employment.

Physician relationships will be critical to hospitals' success in an accountable care environment, according to the CFOs surveyed. Nearly one-third of future physician affiliation strategies will be around co-managements, directorships, and other professional arrangements, survey results indicated.

Taking a Closer Look

The role of physician employment in improving care coordination, market share, and referrals will be key benefits of this physician affiliation strategy, particularly at a time when few hospitals have the structure, infrastructure, or capabilities to use data to manage population health within an accountable care environment:

- Forty percent of CFOs surveyed stated their organizations are "not at all prepared" to tackle population health management within an accountable care environment, and 53 percent believe their organizations are only somewhat prepared to do so.
- Only 14 percent of the CFOs surveyed indicated that their organizations are "very prepared" to manage care coordination under value-based business models, and 23 percent do not believe their organizations are prepared to manage care coordination at all.
- Although survey respondents reported an increase in collaboration with their physicians to improve care coordination and efficiency, only 20 percent believe their organizations are "very prepared" and have the necessary infrastructure to support quality and outcomes-based management.
- Seventy-one percent of healthcare CFOs surveyed believe their organizations are "somewhat prepared" to manage performance measurement and benchmarking within an accountable care environment, and 14 percent feel "very prepared" to do so.

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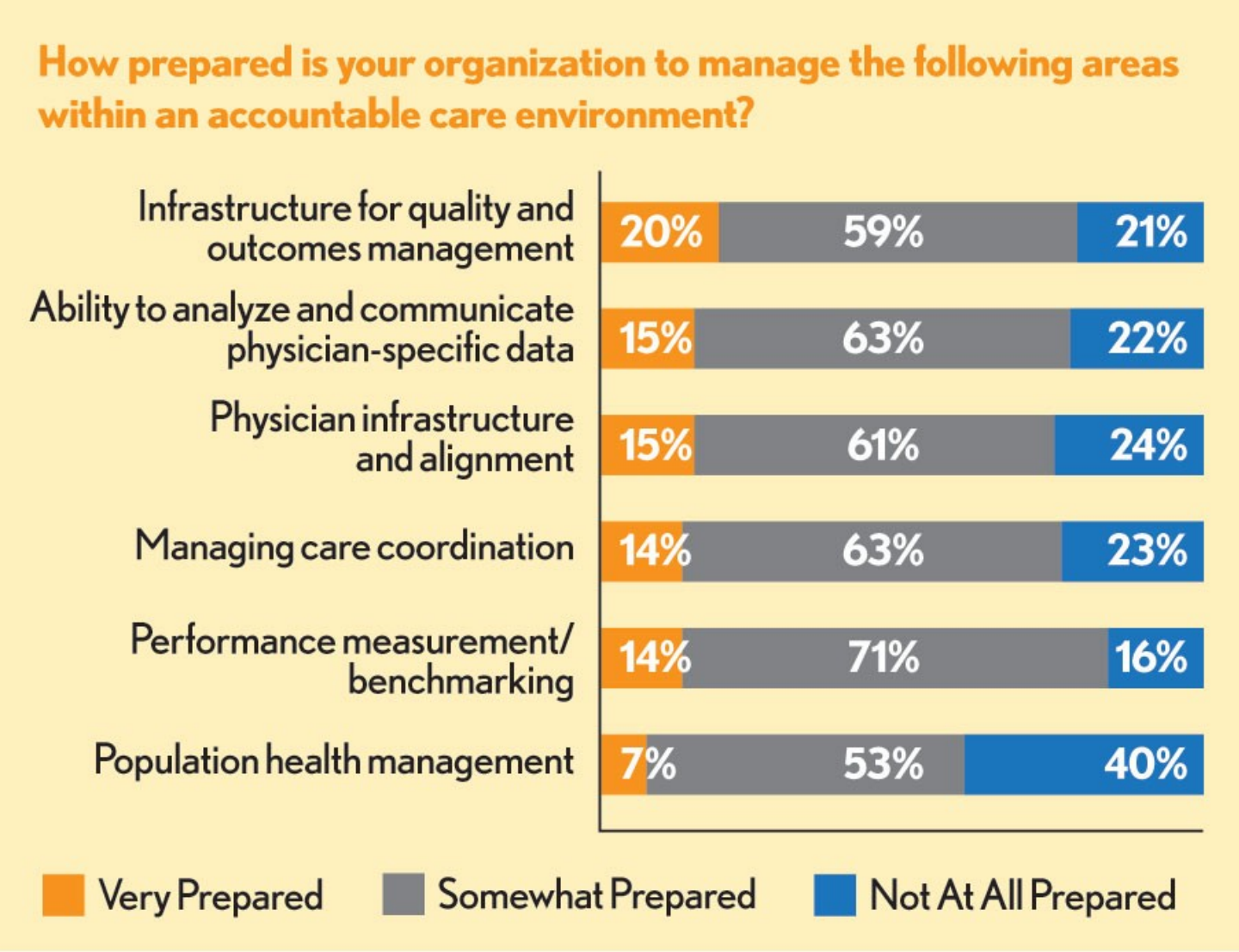

Source: Executive Survey on Hospital and Physician Affiliation Strategies. Sponsored by McKesson.

Care coordination is seen as the chief benefit to physician employment: Seventy-two percent of the survey respondents cited improved care coordination as the greatest short-term benefit of employing physicians, and most CFOs surveyed expect to begin reaping those benefits approximately two years after employment. However, fewer than one-fourth of CFOs surveyed expect physician employment to result in a positive ROI for their organizations after two years of employment.

Changing Expectations

The survey also confirmed that physician compensation will become increasingly value-driven. According to the findings, 77 percent of current physician agreements are based on productivity or volume. In the future, cost-of-care or efficiency-related incentives in physician agreements are expected to grow dramatically from 16 to 67 percent. Similarly, quality-related incentives are expected to increase from 65 to 85 percent.

"The survey demonstrates the shift from the 'fill your beds' mentality of the past based on fee-for-service," said Janice Wiitalia, director of research for the HFMA, who led the research project. "Everyone is starting to realize that the focus in a value-based environment is on keeping patients healthy, not the volume of care provided."

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Reducing Hospital Prices While Increasing Net Revenues

BY HFMA EDITORIAL STAFF

Hospital prices have been in the press recently. Newspapers around the country have been publishing stories highlighting the wide disparities in prices for common medical procedures and tests among hospitals in close proximity to each other. Concerned about its prices being high, one hospital undertook an initiative to reduce its prices. This hospital was able to dramatically decrease prices, improve its median ratio of prices to wage adjusted APC payments and increase net revenues.

Hospital Profile (Rounded Numbers)

Beds: 500 (Acute, Rehabilitation and Psychiatric)

Gross Revenues: $1.5 billion

Total Patient Days: 120,000

Discharges: 21,000

Payor Mix: 70% Governmental (i.e. Medicare, Medicaid and County)

Objectives

The management of this hospital undertook a major initiative to review and lower its hospital's prices. Specifically, management's objectives were to 1) decrease prices 2) have the new prices set at a reasonable percentile relative to comparable hospitals' prices and 3) decrease the ratio of prices to wage adjusted APC payments. In addition, management 1) wanted no change in gross revenues, 2) did not want a decrease in net revenues, 3) did not want prices to be below payment rates (e.g., wage adjusted APC payments) and 4) wanted prices to be based on a methodology that was reasonable and easy to understand. As part of this initiative, management also wanted to stop charging for general pharmacy and supply items since these items are generally not separately reimbursed by its third party payors.

Approach

The approach taken to achieve the objectives for this initiative was to construct models that calculate the changes in gross and net revenues resulting from pricing changes. Management provided its ideal price point relative to the comparable hospitals' prices and ideal ratio of prices to wage adjusted APC payments. Prices were developed based on the ideal price point and ratio of prices to wage adjusted APC payments. The changes in gross and net revenues were calculated using these prices. Management then reviewed the gross and net revenue changes and revised the price point and ratio of prices to wage adjusted APC payments. New prices were developed and the gross and net revenues were re-calculated. This process continued until an outcome was achieved that met all of the objectives for this initiative.

In the end, the prices were set at or below the 60th percentile of the comparable hospitals' prices with a median ratio of prices to wage adjusted APC payments of 2.5. There were a few prices (approximately 3%) that ended up being above the 60th percentile. The majority of these prices were above the 60th percentile so that the prices would be above the wage adjusted APC payments.

Current (Pre-Initiative) Prices and Rates

The following table presents what the hospital's current prices/rates were in three categories that represent the majority of the non supply/implant and pharmacy/pharmaceutical prices. The table shows the percentage of prices relative to the percentiles of the comparable hospitals' prices/rates. For example, two percent (2%) of the hospital's current room and board rates were higher than all of the comparable hospitals' rates, fifty-nine percent (59%) were greater than the 75th percentile of the comparable hospitals' rates and sixty-one percent (61%) were greater than the 60th percentile of the comparable hospitals' rates.

	Current Prices Relative to the Comparable Hospitals' Prices/Rates		
Category	**>100th**	**>75th**	**>60th**
Room & Board	2%	59%	61%
Non-Cost Based Items with CPT/HCPCS Codes[1]	20%	31%	39%
OR Time	25%	33%	36%
Overall for Above Categories	20%	32%	39%

[1]Cost–based items include pharmacy, pharmaceuticals, supplies, implants, etc.

The ratios of the current prices to the wage adjusted APC payments varied from 0.2 to 27.7. The median ratio of prices to wage adjusted APC payments was 3.0.

New Prices and Rates

Forty-four percent (44%) of the hospital's prices were decreased, forty-two percent (42%) of the prices remained the same and thirteen percent (13%) of the prices were increased. Ninety-seven percent (97%) of the room and board, non-cost based items with CPT/HCPCS codes and operating room time charges were set at or below the 60th percentile of the comparable hospitals' prices.

	Current Prices Relative to the Comparable Hospitals' Prices/Rates		
Category	**>100th**	**>75th**	**>60th**
Room & Board	0%	0%	0%
Non-Cost Based Items with CPT/HCPCS Codes[1]	1%	2%	3%
OR Time	0%	5%	15%
Overall for Above Categories	1%	2%	3%

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Comparing the new prices to the current prices, it can be seen that the profile of prices relative to the comparable hospitals' prices changed significantly. The percentage of prices that are the highest relative to the comparable hospitals' prices was reduced from twenty percent (20%) to one percent (1%) and the percentage of prices that are above the 60th percentile of the comparable hospitals' prices was reduced from thirty-nine percent (39%) to three percent (3%).

The median ratio of prices to wage adjusted APC payment was decreased from 3.0 to 2.5. The new ratio of 2.5 is twenty-two percent (22%) below the lowest ratio for the comparable hospitals. Also, the hospital stopped charging for general pharmacy and supply items which is essentially having a zero price for these items.

Gross and Net Revenue Impacts

Gross revenues are projected to increase by 0.4% as a result of the pricing changes. The change in net revenues related to all contracted commercial payment terms except the "lesser of" provisions and before the impact of the pricing changes on outlier payments is projected to be $1,500,000. The pricing changes are projected to result in a net revenue decrease of $400,000 because of the "lesser of" contract provisions. Outlier payments are projected to decrease by $400,000 as a result of the pricing changes. Overall, net revenues are projected to increase by $700,000.

Category	1st Year Change in Net Revenues
Net Impact Before Outlier Payments and "Lesser of" Provisions	$1,500,000
Impact of "Lesser of" Contract Provisions	-$400,000
Impact on Outlier Payments	-$400,000
Total Change in Net Revenues in First Year	$700,000

Key to Achieving Outcome

In the case of this hospital, the key to increasing net revenues while decreasing 44% of the prices and not changing 42% of the prices was accurately modeling all reimbursements impacted by price changes and modeling all contract provisions that would impact net revenues from changes in prices. Only by modeling all reimbursements and all contract provisions that would impact net revenues from pricing changes could net revenues be optimized for a given change (or no change) in gross revenues and the change in net revenues be accurately projected.

Reimbursements impacted by price changes include, but are not limited to, items paid a percentage of charges unless they are included in a case rate, items paid a percentage of charges up to a cap, claims paid a percentage of charges, claims paid a percentage of charges up to a cap, inpatient outliers, outpatient outliers, etc. Accurately modeling some of these reimbursements impacted by price changes was a significant undertaking. One of the reasons for the undertaking being significant was that claims data had to be utilized to model some managed care payors' payments because the payments were a percentage of charges up to cap for all charges on the claim excluding select carve-outs for implants and pharmaceuticals.

Also critical to achieving the desired outcome was the modeling of all contract provisions that impact net revenues when prices were changed. Two of the more significant contract provisions in the case of this hospital included "lesser of" provisions and caps on charge increases. If these contract provisions were not modeled, the hospital would have projected significantly more net revenues then what was achievable and would have ended up with less net revenues than if the provisions were modeled. The hospital would have ended up with less net revenues because modeling these provisions allowed the hospital to mitigate the impact that the contract provisions were having by appropriately adjusting prices.

Summary

Hospital prices are in the spotlight once again. This situation may prompt some hospitals to consider lowering their prices. These hospitals can take heart in the fact that one hospital was able to reduce a significant number of prices while increasing net revenues. The key to achieving this outcome was accurately modeling all reimbursements impacted by price changes and modeling all contract provisions that impact net revenues from pricing changes.

Mark Jeziorski is president of Sophical Solutions, LLC. He may be reached at markj@sophicalsolutions.com.

Ratings Expert Highlights Emerging Trends in the Move Toward Value

BY MOODY'S INVESTORS SERVICES

Moody's Investors Service is seeing 5 to 10 percent declines in volumes in various markets in the country, with some areas experiencing 12 percent declines—unlike anything Moody's has seen before. In a fee-for-service world, the downward trend is putting increased pressure on hospitals and health systems, which are already investing resources in the transition to a more value-based payment system.

Moody's has added new indicators looking at how hospitals are being paid (e.g., capitation, per diem, risk-based) as well as number of covered lives, readmission rates, physician employment—indicators that will help track the transition to value-based payment, Lisa Goldstein, associate managing director for Moody's, told healthcare finance professionals during a featured speaker session at ANI: The HFMA National Institute.

Creating value—the focus of a new report from Moody's, published in May—outlined four management objectives that Moody's is seeing emerge in hospitals around the country as hospitals work to create value and prepare for the new healthcare environment.

Achieve breakeven performance with Medicare rates. Action steps include the following:

- Compute the financial "gap" that would exist if all patients were paid on Medicare rates.
- Develop multi-year cost reduction strategies that go beyond low-hanging fruit and challenge historical business models based on volume.
- Open lower-cost clinical decision units for observation-stay patients.
- Coordinate better discharge planning with patient and family members.

Build scale through nontraditional methods. Considerations include the following:

- Optimal size can be different depending on location, services and mission.
- The rating impact of nontraditional consolidations will vary based on capital needs and impact on performance.
- What efficiencies and economies of scale can be gained through nontraditional methods?

Initiative examples of nontraditional methods highlighted included Walmart's designation of six centers of excellence for associates; the BJC Collaborative, which brings together four sizable healthcare systems for shared savings through group purchasing and shared best practices; Aspen Valley Hospital's participation in the Western Health Alliance, a network of rural hospitals to achieve savings (again, through group purchasing); and Novant Health's shared savings and services model with community hospitals.

Improve the patient experience. Action steps include the following:

- Expand the care team with physicians, physician assistants, and nurses, especially for chronic condition patients.
- Open urgent care access points and expand hours.
- Establish "care navigators" to ensure patients get post-acute care.
- Execute service contracts with physicians to ensure service standards are met.
- Partner with local employers to manage utilization in lower-cost settings (sometimes in the plant or on the corporate campus). Today, the corner drug store down the street is the new competition.

Cultivate informed leadership. This indicator is harder to measure, but perhaps the most important to consider, Goldstein says. Five factors looked at in all cases are the following:

- Market position (45 percent)
- Legal security and debt structure
- Operating performance/P&L performance (30 percent)
- Balance sheet and capital management (25 percent)
- Management and governance

The three factors above with percentages make a balanced scorecard, as they total 100 percent; the two other factors are hard to measure when they come into play, and they can drive a rating higher or lower. In terms of governance, it's a whole new day for hospitals and health systems: Individuals with process engineering, manufacturing, and consolidation experience are now being added to hospital boards of trustees. Moody's also looks at the extent to which leaders are evaluating all services and facilities for repurposing, the extent to which they are considering potential partners, and the degree to which they are assessing the business model for the organization.

The Threatened State of Graduate Medical Education

BY JOANNE FERRARA AND GARY STEVENS

Executive Summary:

Since its inception, Medicare has provided significant funds to support post-graduate resident training. These Medicare payments are broken down into two categories: direct graduate medical education (DGME) and indirect medical education (IME). Federal funding for academic medical centers continues to decrease with new payment changes being implemented currently and an administration proposing significant reduction of the IME add-on payments.

Background

Academic medical centers serve a unique and important role in the nation's health care system. They train our future health care professionals, serve a vital role in delivering patient care, and maintain an environment where medical research can thrive. As a result of the residency program requirements and their research missions, teaching hospitals offer highly specialized services.

The educational requirements for becoming a licensed physician in the United States end with a formal hands-on residency training program in a particular medical specialty. While still in medical school, students submit an application to enter a competitive program for available residency slots known as "the Match." After an interview process, students submit a ranked list of their desired programs and teaching hospitals to the nonprofit National Residency Matching Program (NRMP). At the same time, teaching hospitals rank their preferred candidates for each residency program and submit their list to the NRMP. The NRMP then combines the information and creates a master list of program-student matches. The results are released in March ("Match Day"), and both students and residency programs are contractually obligated to adhere to the Match results.

While these students are responsible for financing their undergraduate and medical school degrees, they receive salaries during their post-graduate residency training periods in exchange for work weeks. Teaching hospitals incur this cost and a significant amount of additional costs, above and beyond the routine costs associated with providing patient care.

Since its inception, Medicare has provided significant funds to support resident training, stating that "educational activities enhance the quality of care in an institution, and it is intended…that a part of the net cost of such activities (including stipends of trainees, as well as compensation of teachers and other costs) should be borne to an appropriate extent by the hospital insurance program." [1] Other federal payers also fund graduate medical education, including Medicaid (jointly with the states), the U.S. Department of Veterans Affairs, the U.S. Department of Defense, and the Bureau of Health Professions. State and local governments also fund graduate medical education, but the amounts vary widely. The payments provided by Medicare are broken down into two categories: direct graduate medical education (DGME) and indirect medical education (IME).

Direct Graduate Medical Education

DGME payments compensate hospitals for the direct costs associated with having a teaching program. Such costs include residents' salaries and benefits, salary and benefits of teaching physicians, and other direct costs. These payments are based on a hospital-specific per resident amount (PRA) that was established in 1984 and is updated annually for inflation. A hospital's total DGME payments can be determined by multiplying the PRA by the weighted number of full-time equivalent (FTE) residents working in all areas of the hospital (and in non-hospital sites, when applicable), and then applying the hospital's ratio of Medicare inpatient days to total inpatient days. The number of residents included in the calculation is subject to the levels that were capped in 1996. The per-resident payment amount varies by the residents' specialties, with higher payments for residents training in primary care.

Indirect Medical Education

IME payments compensate hospitals for their increased costs due to immeasurable differences in patients' severity of illness, greater use of newer technologies, and increased ancillary testing (thereby recognizing that residents learn by doing). The IME payment adjustment is a percentage add-on to the hospital's payment calculated under Medicare's inpatient prospective payment system, and it varies based on the intensity of the hospital's teaching programs as measured by the ratio of individual residents to hospital beds (IRB). Similar to DGME, the number of residents included in the calculation of IRB ratio was capped at 1996 levels. IME payments are more complex than DGME payments. When counting the number of residents, a hospital can only count their full-time equivalent residents who are working in the hospital's inpatient or outpatient department. If specific criteria are met, residents assigned to physicians' clinics (offices) can also be counted in this ratio. The IME formula is set by statute and is as follows:

Multiplier X ((1+Intern & Resident Bed Ratio (IRB))0.405-1)

For Federal FY 2008 and beyond, the multiplier is 1.35

Payment Changes

In the FFY 2013 IPPS/LTCH PPS final rule (77 FR 53413), the Centers for Medicare and Medicaid Services (CMS) finalized its policy to include labor and delivery patient days for bed counting for purposes of the IME IRB. To implement this policy, CMS amended the regulations at 42 CFR 412.105(b)(4) to remove from the list of excluded beds

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those beds associated with "ancillary labor/delivery services." This change was effective for cost reporting periods beginning on or after October 1, 2012.

In the FFY 2014 IPPS/LTCH PPS proposed rule (78 FR 27486), CMS is proposing that patient days associated with maternity patients, who were admitted as inpatients and were receiving ancillary labor and delivery services at the time the inpatient routine census is taken, be included in the Medicare utilization calculation. Regardless of whether the patient actually occupied a routine bed prior to occupying an ancillary labor and delivery bed and regardless of whether the patient occupies a "maternity suite" in which labor, delivery recovery, and postpartum care all take place in the same room. CMS understands that including labor and delivery inpatient days in the Medicare utilization ratio would reduce direct GME payments because the denominator of the ratio, which includes the hospital's total inpatient days, would usually increase at a higher rate than the numerator of the ratio. Nevertheless, CMS is proposing that this be effective for cost reporting periods beginning on or after October 1, 2013. CMS also noted that they will need to amend the applicable cost report worksheets and instructions (in particular, Worksheet S–3, Part 1) to allow for the inclusion of labor and delivery inpatient days in the Medicare utilization ratio.

What's next?

The next step appears to "Better Align Graduate Medical Education Payments with Patient Care Costs" as proposed in the administration's 2014 budget. The budget proposes to modify the IME add-on payments and save CMS almost $11 billion over the next 10 years.

Analyses over the past decade have identified physician shortages in underserved areas, many of them in primary care. These shortages will be a result of the GME system's inability to train enough residents to keep up with the rate of retiring physicians and to meet the growing demand of the anticipated millions who will be newly insured by 2014 under healthcare reform laws. Training more physicians to serve the future patient population will require more support, not less.

These cuts come at a critical time and these competing agendas should serve as a signal to the medical community that the current GME funding policy is not sustainable as is. Cuts to GME funding would jeopardize the ability of teaching hospitals to train the next generation of physicians, but this may only be the tip of the iceberg.

For more information please contact Joanne Ferrara at jferrara@besler.com or Gary Stevens at gstevens@besler.com with any questions or concerns you may have. Both can be reached by phone at 609-514-1400.

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[1] House Report Number 213 and Senate Report Number 404. 89th Congress, 1st Session House Report 32 and Senate Report 36, 1965.

37th Annual First Illinois Chapter HFMA Golf Invitational

August 30, 2013, Gleneagles Country Club, Lemont, IL

Closest to Pin, Holly Nay

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Winning Team: Tim Heinrich and Bob Kemp, not pictured: Scott French and Mike Mullen

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Sr Consultant
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Sam Mourad
Developer
Crowe Howath LLC

First Illinois Speaks
HFMA's First Illinois Chapter Newsletter

Publication Information

Editor 2013-2014
Jim Watson..... 630-928-5233 jim_watson@pbcgroup.com
Tim Manning..... 630-312-7807 timothy.manning@ahss.org

Official Chapter Photographer
Al Staidl 630-724-1197

Sponsorship
Jim Ventrone.....847-550-9814 jmv@ventroneltd.com

Design
DesignSpring Group, Kathy Bussert kbussert@designspringinc.com

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

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Publication Scheduling

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

First Illinois Speaks
HFMA's First Illinois Chapter Newsletter

event-filhfmaorg@comcast.net

Chapter Educational and Events Calendar 2013

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

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First Illinois HFMA Fall Summit
Arlington Park Racecourse, Arlington Heights, IL

Friday, November 22, 2013
CFO Webinar

Friday, December 20, 2013
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