hfma Kentucky Chapter
healthcare financial management association

The Financial Diagnosis

NOVEMBER 2012

Inside

SAVE THE DATE!
2012 AR Focus Workshop

November 09, 2012
7:30 AM - 3:30 PM
Marriot Louisville East
1903 Embassy Square Boulevard
Louisville, KY 40299

Letter from the President

Fall has arrived and for HFMA it's time for the Annual Chapter Membership Satisfaction survey! The survey is conducted by National and is scheduled to be sent out to all HFMA members after October 29th with responses due by November 30, 2012. Each year, the results are shared with the Chapter and it is your answers and comments the KY HFMA education committee's search out ideas and insight of topics to bring to you. I will keep it brief as many of your organizations utilize some form of a patient or client survey so I know you understand the importance and value of participation. I'll simply ask that you take a few minutes to complete the annual survey for the KY Chapter. THANK YOU!

Another method of measuring the success of each Chapter of HMFA is the Chapter Balance Score Card (CBSC). Each has specific goals and performance activities that are tracked and reported to National HFMA. Reporting began on May 1, 2012 and runs through April 30, 2013. Overall, the score card for the KY Chapter looks good:

Area	Measurable	Goal	Actual YTD
Education	Registrant Hours per Member and Total Registrant Hours	15.9	11.4
Membership	Member Retention Percentage	604 members	565 members
Certification	Percent of members certified or 1 more exam taken from prior year	HFMA average 8.2% or 5 exams taken	8.6% KY HFMA members certified 4 exams taken
Finance	Number of Days Cash on Hand	150-600	222

The education hours are firm and it's still early as the results do not include the Fall Institute yet. In August, KY HFMA hosted the Region IV Mid-Atlantic conference with attendance of 217 HFMA members, 80 non-members for a total of 297 attendees. The event was a success, with the Chapter receiving high marks from the Maryland, West Virginia, North Carolina, and the Virginia– Washington, DC Chapters. Education hours for National events and webinars are included.

For this time of the year, it is not uncommon for membership to decrease as members are still renewing their membership dues, some change careers, and others are fortunate to retire. If you know of someone that is interested in joining HFMA, National HFMA offers the opportunity for members to participate in the Member-Get-A-Member campaign and you can "earn valuable rewards when you share your commitment to HFMA".

There has been a number of member's to express interest in obtaining a study guide for certification and have received their passwords. I commend the members that are studying and the members that have taken the exam. If you would like to obtain information on certification, please contact Cindy Sharp at 1-812-949-5690 or csharp@fmhhs.com.

As requested by the members, the KY Chapter has elected to print the membership directory again this year; it should be arriving in your mail soon.

The A/R Focus Workshop is scheduled for Friday, November 9th at the Marriot Louisville East. There will be three tracks, Patient Access, Revenue Cycle, and Compliance/Reimbursement. I look forward to seeing many of the revenue cycle leaders at this event.

The Board and committee members are dedicated to the success of the Chapter. I appreciate you taking the time to participate in the Annual Chapter Survey.

Thank you for allowing me to serve.
Theresa Scholl

Theresa Scholl, President
Kentucky Chapter – HFMA
2012 - 2013

Please visit the KY Chapter's website for its new look!

http://www.hfmaky.org/

Value Based Purchasing

Author: Will Showmaker, Vice President of Business Services, American Hospital Directory, Inc., Louisville, KY

Hospitals face a new benchmark system with the implementation of Medicare's Value Based Purchasing (VBP) program. This system will not only affect program revenues, but also place their operations under further public scrutiny. It will be some time before the program can be deemed effective as a quality improvement initiative, however, its impact on the public perception of the industry will be immediate as media outlets on both local and national levels begin reporting on the performance of America's hospitals under the scheme.

VBP also poses itself to be a measurable opportunity for facilities to reap additional payment dollars from Medicare should they perform well. Under VBP's revenue redistribution model, those hospitals who fail to meet the benchmarks will bear the burden of funding these payments to higher performers. Both groups will also be faced with the need to either maintain or improve their performance in coming years in order to maximize payment dollars and foster a public image.

This study builds on an earlier study published in the January 2012 issue of hfm (Klein, E., and Shoemaker, P., "Value-Based Purchasing: A Preview of Quality Scoring and Incentive Payments"), which described the VBP program's design and assessed how hospitals might fare under the program. The same techniques that were used in the previous study to project a TPS for each hospital are used in this analysis. Using these estimates based upon prior periods of the scoring data CMS will use in the first year of the program, we analyzed the performance of each hospital nationwide and calculated a projected financial impact. This study will utilize these figures to compare the performance of Kentucky's acute care hospitals in relation to their national peers.

The first measure we examined was the Total Performance Score, which serves as the ranking mechanism under VBP, and calculated a state average score as shown below. As a whole, Kentucky's hospitals are right on with the national average for program scoring. However, more detailed examination reveals several significant variations that can be viewed as either deficiencies or opportunities among Kentucky's urban providers.

	Number of Hospitals	TPS Average
State	62	39.69
National	3,167	39.56
Urban - KY	23	33.74
Urban - National	2,334	39.43
Rural - KY	39	43.21
Rural - National	833	39.92

The average national TPS score can be thought of as the 'break-even' point under VBP where hospitals under the average face Medicare revenue reductions while those above stand to gain additional payments. When comparing the average TPS score for Kentucky's urban and rural providers, rural facilities outperform both the national and rural average TPS scores while the urban counterparts fall well short of the overall and urban national averages. The financial impact of this variation is significant enough to create a situation where Kentucky urban hospitals, on average, stand to lose payment dollars while those providers in rural areas stand to be better off under VBP. Digging into this disparity yields a clear reason for the variation.

The TPS score is calculated using two components: Patient Experience of Care (PEOC) and Clinical Process of Care (CPOC) measures. Evaluating the PEOC scores for Kentucky's urban and rural hospitals shows that each performs at about the same level. While not a contributing factor into their varied performance, the scoring of Kentucky's urban providers at this level is worth noting in that they exceed the urban national average for PEOC scoring. In spite of this performance for patient satisfaction, Kentucky's urban hospital's performance under other measures is low enough to drag their overall performance down to the level of losing out on Medicare payments.

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	PEOC Average Score	CPOC Average Score
State	40.73	39.19
National	34.90	41.48
Urban - KY	40.70	30.70
Urban - National	33.06	42.09
Rural - KY	40.74	44.21
Rural - National	40.07	39.77

Kentucky as a whole is an under-performer for CPOC measures. However, this overall average is primarily the result of poor performance by urban providers. In fact, the urban scoring is low enough to diminish the overall state scoring average below the national average despite a stronger than average performance by rural providers. This situation is of particular note in that it flies in the face of a national trend for urban hospitals to outperform their rural counterparts.

So what is to be done with this information? Hospitals can use these data to evaluate their own performance in comparison with peers and evaluate their own opportunities. This is preliminary data and not the actual figures CMS will measure during the first year of the VBP program. It should be viewed as both a warning and an opportunity for low performing hospitals. As a warning, should similar results also appear in the figures released by CMS in coming months, hospitals need to be prepared to address the concerns and questions which will surely be raised by community interests and the media in response to the results.

As an opportunity, these figures indicate that there is significant room for improvement for many hospitals, particularly many in urban areas, to investigate and improve their performance on CPOC scores. As other research articles have illustrated a focus on quality improvement can reap significant cost savings. Those savings coupled with reducing a potential loss of Medicare revenues could prove in the best interest of underperforming hospitals. Kentucky urban providers already seem to have a significant advantage to other urban hospitals in terms of patient satisfaction which offers the potential to leverage this advantage and be net winners under VBP.

The Prudent Fiduciary in Non-Profit Health Care Organizations

Trustees and directors of non-profit health care organizations have unique responsibilities beyond the normal legal accountabilities of charitable trustees and directors. They oversee the ways in which their organizations meet professionally recognized standards of care in the conduct of their institutions, in the professional conduct of their medical staff, and in the quality of care they provide to patients. The consequences of their oversight can have life or death implications.

In this era of increasing accountability for quality and patient safety, it can be difficult for health care trustees and directors to keep their eyes focused on the organization's investments—the very thing that drives its financial viability. This article focuses on the myriad and complex responsibilities involved in charitable investing; highlighting some key considerations every director or trustee should keep in mind.

There are several key differentiating points between charitable trustees and directors:

- Trustees operate under common law rules, as interpreted by the courts. The fiduciary duties of charitable directors are set by state incorporation statutes.
- Trustees traditionally have fallen under a stricter legal standard than charitable directors. They are expected to show the same prudence as any competent investor would under similar circumstances. They may be held personally liable for fiduciary negligence.
- Charitable trustees and directors both are subject to the regulatory supervision of their state Attorney General, who can seek sanctions against them in cases involving fiduciary negligence or malfeasance.
- Nonprofit directors are granted wider discretion under a legal principle known as the "business judgment" rule. However, they also are expected to exercise prudent financial judgment.

In addition to the broad standards applied to trustees and directors, most states also have laws that specifically regulate the investment of charitable funds. Many are based on model statutes drafted by the National Conference of Commissioners on Uniform State Laws (NCCUSL), an advisory panel of judges and other experts. The two most important of these model acts are:

- The Uniform Prudent Investor Act (UPIA), which clarifies the right of trustees to delegate their investment powers to outside money managers and requires them to diversify their holdings and adequately balance potential risk against potential return at the portfolio level; and
- The Uniform Prudent Management of Institutional Funds Act (UPMIFA), which extends the prudent investor requirements of the UPIA to directors of charitable corporations. UPIA expressly provides for diversification of assets, pooling of assets, and total return investment, to implement whole portfolio management, which helps bring the laws governing charitable institutions in line with modern investment and expenditure practice.

A key rule governing trustees and directors is the "Prudent Investor" or "Prudent Man" rule. Trustees and directors are expected to show the same degree of skill and attention as any prudent investor would in a similar situation. Investment decisions are judged not by the actual results, but rather by the soundness of the decision-making process that led to those results.

Over the years, however, the original intent of the "Prudent Investor" rule was lost as courts and state lawmakers interpreted and reinterpreted the standard. Some states, for example, adopted "legal lists" of

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authorized trust investments. In a number of states, courts also took the approach that prudence should be judged on an asset-by-asset basis, ignoring overall portfolio performance. This meant trustees could be—and often were—held liable for losses on specific securities, even when the portfolio as a whole delivered stable, adequate returns.

The prevailing legal doctrine also frowned on the use of outside investment advisors or portfolio managers, which was held to be an improper delegation of a trustee's fiduciary responsibilities. These interpretations made it hard, if not impossible, for many charitable trustees to manage their endowments effectively. Academic research has documented that the old rules had a significant distorting effect on the performance of many trust funds over the years, reducing returns and increasing portfolio risk.

In 1992, the American Law Institute, a nonprofit group that seeks to clarify principles of common law, published the first of several newly interpreted definitions of the Prudent Investor rule. The new interpretations didn't abolish the Prudent Investor rule, but they did redefine it in ways that should allow trustees and directors to do a more efficient job of managing their investment responsibilities. Some of these changes:

- Investments should be judged based on the total portfolio. Losses on a particular asset, no matter how large, are not grounds for liability as long as the decision to purchase that asset was part of a sound overall portfolio strategy.
- No investments are flatly forbidden. Charitable fiduciaries may invest in any asset that reasonably can be expected to improve portfolio performance.
- Risk is to be managed, not avoided. The new interpretation accepts that risk is inevitable in any investment program and must be managed at the portfolio level.
- Delegation is clearly authorized. Charitable fiduciaries may rely upon independent investment managers—as long as they exercise due diligence in selecting, evaluating and monitoring those managers.

It is important for charitable trustees and directors to understand that while the new standard gives them the tools they need to manage their duties more effectively; it also expects them to use these tools wisely. In other words, the bar—the legally acceptable level of financial skill and care—has been raised.

The potential penalties for getting it wrong have also increased. If a trustee fails to obtain the returns—adjusted for risk— that reasonably could have been expected under prevailing market conditions, he or she could be held liable for the difference. In addition, trustees need to be mindful of the corrosive effect that inflation may have on the value of an endowment over time. The new rule makes it clear that erosion of purchasing power is equivalent to a loss of trust principal and must be guarded against.

The Prudent Investor rule imposes some tough tests, but it does recognize, in the words of Yale University law professor John Langbein, that "managing a portfolio is as demanding a specialty as stomach surgery or nuclear engineering. There is no more reason to expect the ordinary individual serving as trustee to possess the requisite investment experience than to expect ordinary citizens to possess expertise in gastroenterology or atomic science."

The role of a trustee or director can be enormously rewarding. However, the responsibilities involved in charitable investing are substantial, and—as many readers probably have already concluded—can be complex. Knowing what is best requires a clear understanding of sound investment practice, and charitable fiduciaries should keep these following points in mind:

- The definition of prudence is changing and trustees and directors need to change with it. They are expected to understand the trade-off between potential risk and return and design their strategies accordingly.
- Diversification is required in most cases. Fiduciaries need to develop asset allocation policies to ensure the portfolio returns they seek are commensurate with the risks they take.
- Having a defined investment process is one of the best defenses against accusations of imprudence. Charitable fiduciaries should make sure they can thoroughly document their decisions.
- The use of outside portfolio managers and advisors is permitted, and may be required in some circumstances. Fiduciaries need to show due diligence in screening and evaluating managers.

A fiduciary duty represents the highest standard of care in either equity or law. During the current economic downturn, trustees and directors of health care organizations carry the onus of protecting not only their patients, but the financial stability of their institutions. Health care boards need to be able to prove that they have performed their fiduciary duty in being well positioned to evaluate and manage their investments in an increasingly complex financial climate.

Managed Care Revenue Recovery: Get the Dollars You are Owed

Author: Megan M. Lemma, MBA, Indiana Pressler Memorial Chapter, Senior Consultant, Blue and Co., LLC

With changes to Medicaid and Medicare reimbursement looming on the horizon, providers are challenged with finding resources devoted to chasing down managed care reimbursement. Although payors are generally reimbursing at the correct rates, a comprehensive audit of claims data will reveal an alarming number of claims underpaid by 1-2%. These underpayments add up quickly, totaling in the hundreds of thousands of dollars in recoverable revenue for a SINGLE PAYOR!

Back in the dark ages, payor customer service, provider service and claims processors were all housed in the same facility and able to communicate face to face when a payment issue was discovered in the "field". Changes in the payor industry, namely acquisitions and subsequent consolidation have resulted in these basic payor functions occurring in different regions, sometimes different countries. When considered from this perspective, it is easy to understand how system glitches, payment errors, and even training issues lead to incorrect provider reimbursement. It quite simply takes longer for the right hand to figure out what the left hand is up to.

Payors are obligated to reimburse providers at the contracted rate for a particular performance period, usually a calendar year. Most managed care contracts provide for an annual rate revision, based on the hospital's chargemaster increases and sometimes the appropriate Consumer Price Index (CPI). "Clean" claims, appropriately submitted for payment and not considered at this annual rate technically breach the agreement with the hospital. Since "breach of contract" is not a congenial term, payors are generally more than happy to issue payment on claims reconsidered at the appropriate, contracted rate.

Contract management systems are an excellent innovation and a key component of revenue cycle management processes. However, the setup and maintenance of the system and corresponding process requires considerable initial efforts and constant oversight. Think about it; breaking down standard reimbursement methodologies employed by commercial payors is a daunting task. Are you completely confident the correct DRG is tied to the appropriate rate, and that correct units will automatically be calculated into the final expected payment?

Conversely, one would think that small hospitals, most often reimbursed on a percent of charge, would have no issues surrounding correct reimbursement from commercial payors. Once annual rates are implemented, claims should logically pay at the correct percentage. However, we all know this is the exception rather than the rule. Small facilities, especially critical access hospitals, simply do not have the resources to devote to validating correct reimbursement on every commercial claim and certainly do not have contract management systems taking contractuals at the time of billing.

The approach to auditing commercial managed care reimbursement is straightforward, yet potentially overwhelming. However, taking this action in manageable pieces will pay off and enhance revenue protection efforts. The following steps outline an initial auditing process to identify recoverable managed care reimbursement:

1. Review managed care contracts, capturing rates and terms impacting reimbursement (Look for terms that will either make or cost you money):
    a. Annual rate adjustment language and any corresponding calculations.
    b. Requirements surrounding annual rate adjustments such as chargemaster and rate increase documentation.
2. Analyze up to two years of paid claims data by individual account, comparing payments against the expected, contracted amount:
    a. Audit contract management systems and validate contract terms are modeled appropriately, calculating expected reimbursement appropriately, and reporting variances accurately.
    b. If a contract management system is not employed, calculate expected payments by consolidating account information on a single line item and factoring in payor adjustments and payments against billed charges.
    c. Include financial class and place of service to determine if specific services, e.g., ED chargers are consistently underpaid.
3. Calculate the total variance, by payor, including overpayments, documenting reported contract amounts and actual contracted rates:
    a. Validate underpaid amounts in your AR system on a sample of claims to demonstrate the variance pattern.
    b. Compile all contract documentation supporting the corrected, expected payment, e.g., current rate amendment documentation.

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4. Identify the appropriate payor contact and develop an outreach strategy to recover dollars on underpaid amounts:
    a. Implement any corrective measures to avoid future underpayments, e.g., correct reimbursement for ED charges, or more specific financial class definition to receive the correct level of payment.
    b. Consider regular calls with payor contacts (at least quarterly) to discuss any payment variances, denial trends, or customer service issues.

Hospital leadership hesitant to pursue underpaid claims for fear of the payor retaliating during the next round of rate discussion need only consult their respective managed care contracts. Seeking payment owed on underpaid claims has nothing to do with next year's chargemaster increase.

Payors are implementing audits designed to recover perceived overpayments. Providers need to consider auditing managed care payments to identify underpaid variances and recoverable revenue. This applies to providers of all sizes. Large systems need to perform regular audits of their contract management systems, and small hospitals need to perform comprehensive, regular audits of paid claims.

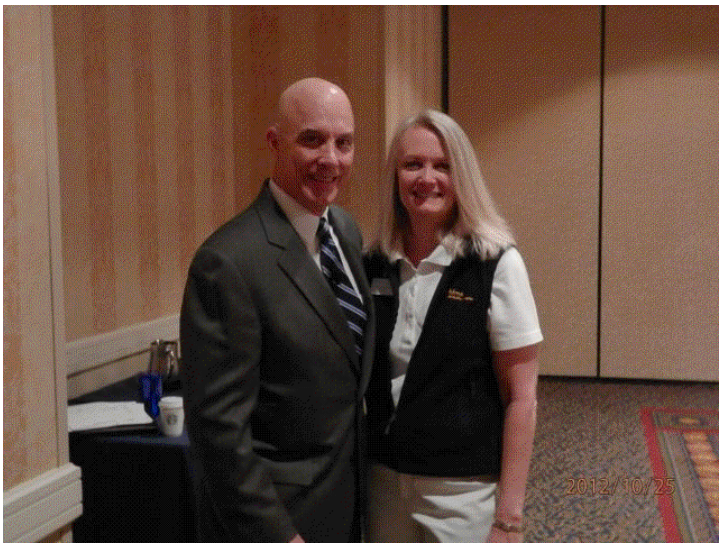
Additionally, it is important to develop and maintain professional relationships with your payor counterparts. Many issues can be addressed with a phone call to the appropriate contact, provided your team has assembled documentation supporting your claim. As in any problematic situation, payors are prone to respond in a timelier manner if the solution is presented to them. Namely, underpaid claims and supporting reimbursement documentation.

I've looked at thousands of claims in several different capacities throughout my career, and find the same variables in each situation. Payors have system issues like the rest of us. Even simple reimbursement methodologies can experience a "glitch" resulting in underpaid claims. Contract management systems and corresponding reporting mechanisms are not infallible as incorrect programming can lead to incorrect variance documentation. And finally, like it or not, providers need to audit every single claim to insure correct reimbursement from commercial payors.

2012 Fall Education Institute – KY Chapter

Author: Dan Schoenbaechler, CPA CHFP, Dean Dorton Allen Ford, PLLC

The KY Chapter's Fall Education Institute was held at Marriott's Griffin Gate in Lexington, KY on October 25 and 26. The keynote speaker, David Yoho of Professional Educators, presented "Letting Others Have Your Way." He is one of America's most respected business advisers and has been honored with the designation CPAE, which is a designation held by only 175 members of the Speakers Hall of Fame and includes members such as General Colin Powell, President Ronald Regan, Dr. Norman Vincent Peale, Elizabeth Jeffries, Liz Curtis Higgs and Zig Ziglar.



Keynote speaker **David Yoho** and KY HFMA President **Theresa Scholl.**

The Thursday morning general session, "The Joplin Story: Collaboration and Integration," was presented by Greg Meier of ROi. Morning breakout sessions included "Healthcare Future/Improving Lives Through the Sharing of Knowledge" presented by Kevin Rapp of Microsoft, "EFT/ERA Standards and Operating Rules – A Whole Lotta Shakin' Goin' On!" presented by Pam Grosze of PNC Healthcare, and Denial Prevention presented by Linda Fotheringill of Washington and West, LLC.

The Thursday afternoon started with a general session that included a CIO Panel discussion. The moderator was Rodney Murphy, CIO of the KY Cabinet for Health and Family Services. The panelists included Randy McCleese of St. Claire Regional Medical Center, Jackie Lucas of Baptist Healthcare System, Dr. Carol Steltenkamp of the University of Kentucky Healthcare, and Sheldon Tyndall of TJ Samson Community Hospital.

The Thursday afternoon breakout sessions included Medicare Readmission Penalties for 2013 presented by Mark Aspenson of Avery Telehealth, "Maximizing Schedule H Charity Reporting With Minimal Financial Impact" by Arvind Krishnaswami and Jack Hodge of Medlytix, LLC, and "National Perspectives on Labor Management: Use of Comparative Data and Benchmarking For Effective Budgeting" presented by Craig Dickinson of Premier, Inc. Two general sessions followed with a review of the HFMA Peer Review Process provided by Jonah Michael of First American Healthcare Finance and the KHA Update presented by Steve Miller of the Kentucky Hospital Association.

Friday morning began with a general session on "Finding Your Niche: 5 Key Points for Healthcare Industry Executives" presented by Michael Lincoln of Lillibridge Healthcare Services, Inc. Morning breakout sessions included a discussion on internal audits presented by Brad Adams of Vanderbilt University Medical Center, a discussion on managing physician relations after integration presented by Dr. Wayne Villanueva from Baptist Neurological Surgery and Steven Ratliff of Blue & Co. A general session on the impact of "Healthcare Reform and Other Trends on the Supply Chain" by Dayla Sutton – Premier, Inc. concluded this seminar.

2012 Fall Education Institute – KY Chapter Pictures

Members of the **Kentucky Chapter HFMA Leadership team** pose for the camera at the Fall Education Institute.

$100.00 winner with **David Yoho**!

David Yoho!

Fall Institute participants enjoyed casino games.

More casino night fun!

HFMA members enjoying a quick coffee break.

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Director of Physician Billing
Norton Healthcare

Abbie Murrison
Revenue Cycle Systems Analyst
Norton Healthcare

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New Certified Healthcare Financial Professionals (CHFP)

Tony Sudduth - June 2012

Jennifer Thomas - June 2012

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Tony Sudduth, FHFMA

Adam Shewmaker, FHFMA

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EDITORIAL MISSION

The Financial Diagnosis supports the mission of the Kentucky Chapter by serving as a key source for individuals involving in or interested in the financial management of healthcare.

PUBLICATION OBJECTIVE

The Financial Diagnosis is the official publication of the Kentucky Chapter HFMA and is written and edited principally to provide members with information regarding Chapter and national activities, current and useful news of both national and local significance, information about seminars and conferences and networking with colleagues, and to serve as a forum for the exchange of ideas and information.

ARTICLE SUBMISSION

The Financial Diagnosis encourages submission of material for publication. Articles should be typewritten and submitted electronically to the Editor by the deadlines listed below. The Editor reserves the right to edit, accept or reject materials whether solicited or not.

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