

The Buckeye Connection

Fall 2005

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Interested in assisting with the newsletter? Please contact Mark Kosarko (614-232-7138) or Holly Tedhams (614-232-7969).

A Year to Get Involved...A Year to Celebrate

President's Message

By Lola Popcevski, Chapter President

Welcome to the 2005-2006 Central Ohio Chapter of HFMA! I hope you are all anxious to get involved and make this year another productive one. We have enclosed a programming calendar which outlines our planned educational and social events for the upcoming year.

For those of you who are new to our chapter, on behalf of myself, and my fellow officers: George Gevas (President-Elect), Margaret Schuler (Secretary), and Brad Chelton (Treasurer), again, welcome! Many times we join organizations and are neither exposed to their purpose nor the opportunities which await us as active members. In an effort to try to avoid this situation, we are planning to have an "HFMA 101" session in November. This session is not just for new members, but also for members who have been involved over the past years without having had such an introduction to the Chapter.

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President's Message (continued)

The purpose of the session is to familiarize our members with our Chapter's mission, vision, and values. We also plan to use this time share our Chapter's strategic plan. Finally, we want to take advantage of this time to share with our members the purpose and responsibility of each committee and also to present the opportunity for members to become active in these committees. We hope that this involvement will benefit members not only through networking opportunities but also in preparation to assume leadership positions within our organization in the years ahead if so desired. We plan for this to be a brief session followed by a happy hour for members to get to know each other and our leadership team. Please plan to join us.

Our educational calendar for the upcoming year includes our annual co-sponsorship with the OSCPA for the well-known Health Care Conference. Of course, there is also the annual OHA Regulatory Update, affectionately referred to as the "Larry & Larry show". Due to the overwhelming success of this past year's "Uninsured/Underinsured" event which was co-sponsored with COPAM, we are planning to co-sponsor another exciting educational event in February. We also plan to once again co-sponsor the annual Gerry Haggarty event with the Northeast Ohio chapter this spring. Please see the enclosed calendar for our other planned educational and social activities.

I would also like to point out that this year is unique as it marks our Chapter's 50th Anniversary. We have been busy planning a celebratory event in honor of this milestone for our Chapter. Look for more information on this topic to appear on our website, www.

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President's Message (continued)

centralohiohfma.org, as well as in upcoming newsletters. We are in the process of finalizing the date, but are looking for opportunities in late February/early March.

In closing, I encourage you all to become actively involved in our Chapter this year. If you have a suggestion or idea, please let yourself be heard. All of our officers and committee chairs would love to hear from you on how to make our organization even more effective. Our contact information is listed in this newsletter as well as on the website. Although I will personally be out on maternity leave until November, I leave the Chapter in the capable hands of my successors who will be happy to respond to you. We look forward to hearing from you.

Enjoy the rest of your summer and I hope to see you at many of this year's events!

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The Chargemaster is a Key Strategic Asset – But is it a Priority?

***by
Sandy Rasmussen, Colleen Malmgren
July 27, 2005***

Think about it. The Charge Description Master embodies the entirety of what you do as an organization. When the patients walks out the door, the claim is a reflection of every service delivered during their hospital visit. The accuracy of the claim is a snap shot used by customers, external stakeholders, regulators and competitors every day to measure your economic value. How much do you really know about what it takes at the front-end of your process to consistently deliver an accurate claim? Is your investment in people, processes and technology balanced between the backend billing and collection process and the front-end processes through which the bill is created?

An often under examined role in the charge capture process is maintenance of the CDM. The significance of the CDM Coordinator has evolved dramatically since the inception of APC's. The function of maintaining an electronic table of descriptions and prices is still often perceived as primarily a clerical job. Can just about anybody maintain this strategic asset and maximize its value to the hospital? The answer is yes and no.

The significance of the CDM to the hospital's profitability cannot be understated. Three years into managing under APC's, Fairview Health Services in Minneapolis, MN began a formal assessment of how well they were performing under the new reimbursement system. A multi-disciplinary task force spent several months flowcharting the life cycle of an APC claim from pre-registration through final payment of the claim. Throughout the documentation project billing issues generated by the process were identified, categorized, quantified and characterized by their impact: increased cost, increased cycle time, risk to revenue, risk to reimbursement and compliance risk.

One of the most significant details captured during the project was the dependency of each issue on earlier parts of the revenue cycle process. At Fairview the Number One#1 cause of issues throughout the life cycle of the claim originated with errors in the CDM. To further complicate matters, the task force determined that failure to fix the transaction at the point the error was created, resulted in a pattern of errors not detected in the follow-up and collections process. Recurring rejections of the same claim often occurred as the system re-worked the problem claim, failing to recognize key interdependencies within the information systems.

The results of the study focused a magnifying glass on the CDM Maintenance team and inconsistent processes that relied almost entirely on individual expertise and best effort. A crossroad was reached. Was the problem the people or the process? Was the nature of CDM maintenance something that could be standardized? Examination of the coding and regulatory environment, and the multitude of experts involved in the process, produced clear evidence of complexities beyond the capacity of individual initiative to consistently and reliably manage. The role of the CDM Coordinator went well beyond the collection of change requests and data entry into an electronic table. The job had clearly evolved to require both technical knowledge and critical organizational thinking skills including:

- Decision making facilitator among internal experts including clinicians, HIM, compliance, regulatory billing, finance and contracting
- Reference librarian and interpreter of all relevant regulatory literature regarding proper charging and coding practices
- Internal control point to assure proper review and approval of new services from budgeting to pricing.
- Synchronization monitor among disparate systems and charging documents impacted by changes to the CDM

Recognizing the breadth and complexity of the CDM maintenance process, a recommendation was made to pursue re-design with the support of appropriate workflow automation and decision support tools, policies and procedures to achieve the following:

- Support effective communication and documentation across key participants in the maintenance process.
- Assure ongoing structural integrity and standardization of the CDM
- Routinely provide objective, reliable accuracy and compliance checks.
- Maintain a system of controls to monitor and report errors and delays with clear accountability to take action.
- Improve administrative efficiency, reliability and cycle time through automation of routine tasks.

Charge master tools have become readily available to support many of these objectives. The potential return on investment and relatively short payback period makes them an affordable solution. To maximize that return and fully exploit the CDM as a strategic asset, a thoughtful plan to integrate the technology with the people and processes involved is necessary.

Eighteen months after outlining their goals and objectives Fairview's CDM maintenance management process has undergone a metamorphosis. The CDM Team performs 100 percent% of their daily maintenance within a charge master tool using Craneware's Chargemaster Toolkit. As a result they have achieved a consistent, reliable, workflow applying the same standard of quality to all departments. Clinical managers are better informed and engaged as partners in the process because they have direct access to their CDM data and easy to use technical resources. Through the continuous dialogue the tool has created, we have begun to meet people we didn't even know needed to be involved in the process. Today users of the tool go well beyond department management to department coders and charge techs for example. By focusing on people, process and technology we have empowered all participants to become highly motivated and informed contributors.


About the authors:

Colleen Malmgren is the CDM Manager for Fairview Health Services in Minneapolis, MN. She holds a Masters degree in Health Sciences Administration and is a Registered Health Information Administrator.

Sandy Rasmussen is the an Industry Financial Consultant for Craneware, the Number One# 1 selling Chargemaster Management Solution, and owner of Creative Business Group Consulting.. Craneware, Inc., is an HFMA peer reviewed partner and VHA revenue cycle solutions supplier that provides high value, easy to install and use financial software solutions that empower 650+ healthcare providers to improve their daily operations, optimize revenue, encourage compliance, and use information more efficiently to impact business decisions.

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Medicare Contracting Reform

By Sheryl L. Wildoner, BBA, RT(R)(CT), RCC

Replacing the current contracts under which Medicare programs are administered, with a new regional contracting structure is expected to save nearly \$900 million by 2010 according to President Bush's budget projections. Since inception, the Medicare program has been required to contract with health insurance companies for claims processing and related administrative functions. To promote efficiency and improved service through competition and flexibility, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 calls for a structural overhaul that will integrate claims processing for both Parts A and B under twenty-three new Medicare Administrative Contractor (MAC) authorities.

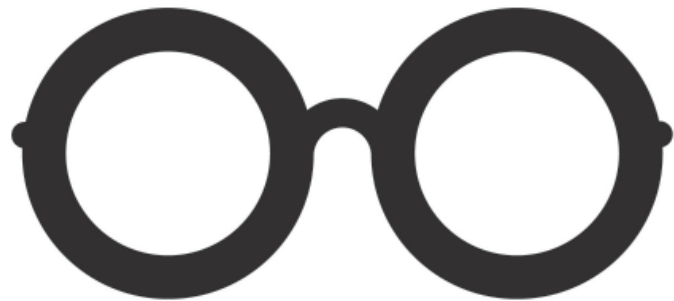
In February, the Department of Health & Human Services described the coming transition. CMS plans to award contracts for fifteen "primary" MAC jurisdictions, each of which will service the majority of providers (both Part A and Part B) within its respective region. Home health and hospice providers, however, will be serviced by four specialty MAC authorities, and durable medical equipment suppliers will be serviced by another four specialty MAC authorities. Each of the eight specialty authorities will have its own regional jurisdiction which will overlay the boundaries of the fifteen primary MAC jurisdictions. The primary jurisdictions will be substantially more alike in size than the current existing fiscal intermediaries and carriers.

HHS designed the twenty-three new MAC jurisdictions based on three criteria:

- promote competition
- balance the allocation of workloads
- to account for integration of claims processing activities

Competition for the new contracts begins October 2005. The transition will occur in three stages. The "start up" will occur June 2006 in MAC number 3. Jurisdiction number 3, encompassing Arizona, South and North Dakota, Utah and Wyoming, while large geographically, represents only 3 percent of the national fee-for-service claims volume. By June of 2006 all the primary MAC contracts shall have been awarded. Illinois, Minnesota and Wisconsin will comprise primary MAC 6. Indiana and Michigan will comprise primary MAC 8.

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The specialty MAC contracts are scheduled for award by December of 2005. Look for the entire MAC transition to be completed by October 2011. Contracts will require annual renewal, subject to the MAC's performance in the previous year, for a period of five years. At the end of the fifth year, a contract expires and requires renegotiation.

Statistics for Illinois are not at hand, but as a comparison, in Michigan and Indiana in 2003 five contractors processed claims for 2,322,941 Medicare beneficiaries to 49,807 practitioners, and 327 hospitals. This equates to 6.5% of the nation's claims workload. The resounding question is how will Medicare contracting reform affect Medicare providers and beneficiaries?

- Through competition the MACs are expected to provide improved service and performance to all providers in their jurisdictions, including improved response time.
- The MAC will serve as the single point of contact for providers and suppliers for all claims-related business. In addition to processing claims, the MAC will be able to assist providers and suppliers with obtaining information on behalf of patients about items or services received from another provider or supplier that could affect claims payment.
- Improved provider education and training for small providers or suppliers as well as a role in contractor evaluation via surveys.
- Integrated and consistent coverage policies for both Part A and B per jurisdiction
- Availability of prescription drug coverage and finding and comparing nursing homes. A beneficiary's first point of entry for resolution of questions about Medicare coverage will be 1-800-MEDICARE, which will take them through a more advanced customer service network.
- Reduction in the number of "explanation of benefits" statements a beneficiary will receive and need to organize.

- CMS will evaluate the MACs, in part, based on beneficiary and provider satisfaction with their services through performance requirements and measurement standards. This performance management approach will help improve customer service to all Medicare beneficiaries.

CMS plans to closely monitor this transition to limit negative impact on providers and beneficiaries.

CMS released its first RFI on FedBizOpps February 25, 2005 requesting information from any entity interested in competing for the primary A/B MAC workload. On April 11, 2005, CMS released a second RFI on FedBizOpps, which identifies the requirements and standards for the primary A/B MACs. For RFI details visit <http://www.fedbizopps.gov/>. Additional information about Medicare contracting reform can be found on CMS's website at <http://www.cms.hhs.gov/medicarereform/contractingreform/>.

Sheryl L. Wildoner, BBA, RT(R)(CT) is RCC Coding Consultant with The Rybar Group, Inc. Sheryl can be reached at 810-750-6822 ext. 112 or swildoner@theyrbargroup.com

***Critical Access Hospital Status and FHA
Sec. 242 Mortgage Insurance Program
Help a Hospital Help Others:
A Case Study***

***By Bill Wilson, Lancaster Pollard, Senior
Vice President, and Gerard D. Klein, Bucyrus
Community Hospital Chief Executive Officer***

Bucyrus Community Hospital serves a region of about 25,000 people in north central Ohio. The 25-bed hospital offers key community services, providing essential emergency treatment, inpatient and outpatient services, charity care, and smoking cessation and nutrition programs. It was certified as a Critical Access Hospital in January 2003.

A 2002 focus group identified substantial barriers to Bucyrus' long-term prosperity. Newer health care equipment was prohibitively expensive, and community residents were willing to drive more than 60 miles to large hospitals in the capital city of Columbus to receive what they perceived as more advanced treatment, despite Bucyrus' proven capability and an affiliation with a larger health network that gave it access to more services patients needed. Staff retention and physicians' hesitancy to recommend the hospital also were deemed barriers to serving in perpetuity. Community perceptions of the hospital had begun to deteriorate, as descriptions of the hospital included "backwoods" and "Band-Aid station."

A long-term plan for survival would have to include a major overhaul to better meet patient expectations and attract staff. The board had to decide whether to build new or substantially renovate its 95-year-old facility to bring it up to standards and attract patients.

Once architecture and design work had been completed, board members decided it would be more cost-effective to renovate the existing building, which is conveniently located on the main downtown street. The hospital had been expanded three times over its lifetime, and keeping the existing building had implications for the community whose investment had supported its other capital projects over the years.

The hospital engaged investment and mortgage banking firm Lancaster Pollard to evaluate its situation, educate hospital leaders on funding options, and create a long-term financial plan to provide upgrades and reestablish a reputation as a valuable resource that would match Bucyrus' ongoing community commitment.

Bucyrus, like many smaller hospitals, was unable to secure an adequate loan on its own. The interest rates it would have qualified for would have made borrowing prohibitively expensive. It also was unable to secure private credit enhancements because of its non-investment grade credit strength. Federal support options were the only cost-effective, realistic alternative.

The Federal Housing Authority's 242 program offered several benefits that made it the best opportunity for Bucyrus.

The hospital's actual operations were in the red for two of the three years previous to its financing. Its balance sheet did not yet reflect the hospital's improved financial condition, which was a result of newly accessed cost-based Medicare reimbursement as a Critical Access Hospital. It would not have qualified for the traditional FHA 242 program because it did not have positive historic operating margins.

As a Critical Access Hospital, however, Bucyrus was allowed under the program to recast its financials as if it had been receiving cost-based Medicare reimbursement for the three years previous to its mortgage insurance application. The recasting dramatically affected Bucyrus' financial picture, giving it positive operating earnings and the more than 1.25x historic debt service ratio it needed to qualify for the federal enhancement.

The 242 program also gave Bucyrus the option to borrow the entire amount of the project because of the way the program calculates its loan-to-value ratio. The 242 program allows hospitals to borrow up to 90 percent of the value of the project. Project value for the 242 program, however, is calculated in such a way that it can exceed the actual project cost. Project



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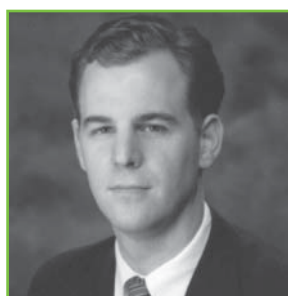
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Sec. 242 Mortgage Insurance Program
Help a Hospital Help Others:
A Case Study
(continued)**

value calculations can include existing assets in addition to the actual project costs of new financing or construction. If the entire project cost is 90 percent or less of the project value, then the 242 program can fund the entire project cost.

Bucyrus' renovation and refinance project cost was priced at \$26.8 million, so it still would have had to come up with \$2.68 million (10 percent) in additional funding. But with the \$5.9 million value of the existing physical plant, property and equipment, Bucyrus' project value increased to \$32.7 million. The hospital could have borrowed up to \$29 million (90 percent of \$32.7 million) with the 242 program. Ultimately it borrowed nearly \$26 million to cover most of its project costs. Bucyrus strategically chose to invest some of its own money in the renovation to assure its operating margins could handle the debt service and keep the hospital financially stable in the long term.

Because of the federal mortgage insurance, Bucyrus will fund renovations and three major additions that include a new main entry and more patient-friendly waiting area, a new operating room to serve profitable surgery needs, a new emergency room and a new nine-bed oncology department. The hospitals' heliport will be moved to improve Bucyrus' service to its Life Flight/Mobile Life partners. The notes also refinance existing indebtedness to lower interest payments.

The financing was an ideal fit for Bucyrus Community Hospital's long-term plan to strengthen its reputation and improve its service by adapting to changing technologies and patient demands. The renovations will keep the hospital competitive and reassure community members that it will continue serving them in the best way possible.



Bill Wilson is a senior vice president with Lancaster Pollard, a financial services and asset management company headquartered in Columbus, Ohio, with regional offices in Atlanta, Denver and Kansas City. Lancaster Pollard

specializes in tailored financial solutions for the health care sector. An FHA/GNMA/USDA-approved investment and mortgage banking firm, its services include the FHA Sec. 242 mortgage insurance and USDA Community Facilities loan guarantee programs, as well as conventional revenue bonds and other creative financing options. Contact them at 65 E. State St., 16th Floor, Columbus, OH 43215 or by phone at (614) 224-8800. Information on financial options and news about the health care sector is available at www.lancasterpollard.com.



Gerard D. Klein is the president and chief executive officer of Bucyrus Community Hospital, a resource that helps its neighbors understand that being well means being happy and taking care of oneself, not just being

healthy. He chairs the Ohio State Health Network Board Committee and the Small and Rural Hospital Committee of the Ohio Hospital Association. In addition to providing emergency services, the hospital dedicates itself to education and partners in several community nutrition and wellness programs. It was named "Business of the Year" by the Bucyrus Area Chamber of Commerce in 2002. Contact the hospital at 629 N Sandusky Ave., Bucyrus, Ohio 44820, by phone at (419) 562-4677, or on the Web at www.bchonline.org.

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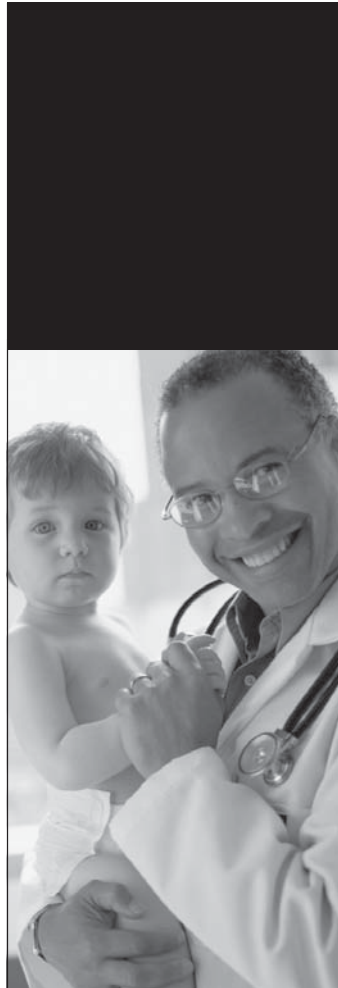
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