



The Gem Statement



President's Message



It is hard to believe that 2009 is complete. In assessing the first six months of my term, I keep coming to

back to how fortunate I am to be around such great people. Specifically, I am so thankful to have the support of all of the other officers, board members, sponsors, and chapter members that have lead to three great conferences with wonderful reviews. Coming off the holidays and the New Year, I thought it was appropriate to remind you of the upcoming chapter events.

1. Revenue Cycle Webinars, January 19, 2010
2. Revenue Cycle Webinars, February 16, 2010
3. Revenue Cycle Webinars, March 16, 2010
4. Conference Call March 2nd, TBD

5. HFMA Road Show with Day Egusquiza, March 8 or 9th, Pocatello
6. HFMA Road Show, TBD, Lewiston, Idaho
7. Spring Joint WA/Idaho Meeting, May 26th-28th, Spokane, WA

For those you that remember in October we partnered with National HFMA to do a chapter wide survey to assess our strengths and weaknesses. Although we haven't received the results, we are extremely excited to use this data to better serve you. As always, please do not hesitate to contact me with any questions, suggestions, or concerns. Our leadership team is very aware that we are here to serve you! I wanted to make a point to thank Michele Marcum for creating and mailing our chapter directory. Year end and year out, Michele takes on this thankless job in hopes to providing you a tool to assist in networking and interacting with your peers—Thanks Michele!

I would like to thank you for your support of Idaho HFMA over the past year. My term as President of ID HFMA has gone extremely fast and with five months to go, I am energized to finish strong and continue providing value to you our chapter members. I look forward to seeing you at the Road Shows In both Pocatello and Lewiston, and hope you join us on the webinars--Please remember to invite as many of your staff/team to join us on the call—it doesn't cost anymore!!!!



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Special points of interest:

- HIT Stimulus Funds
- Part II of Richard Clarke's "The Burning Platform"
- Electronic Health Records
- Revenue Cycle Webinars
- Health Care Costs by Region

The Credit Card Accountability, Responsibility and Disclosure (CARD) Act A Bitter Pill for Healthcare Providers

By Mitch Partridge, CEO, CSI Financial Services

Though few of us can remember what life was like without credit cards, a certain percentage of us may soon be forced to return to those bygone days. Thanks to the CARD Act, the popular commercial of the last century, "Don't leave home without it," may be more of an anachronism than we could have ever imagined.

According to many industry sources, restrictions imposed by the CARD Act on the credit card industry will hurt consumers more than it helps them.

Over the last 18 months, healthcare providers have witnessed first hand the financial stresses placed on their patients. Faced with a massive economic downturn and a doubling of credit card default rates since 2006, credit card issuers began tightening credit and raising standards even before the CARD Act was proposed. During the past year, issuers cut the number of issued cards by 82 million, or 19%, while also slashing credit limits by \$721 billion. Even more dramatic, the number of new cards issued decreased from 4.7 million in June 2008 to 2.6 million in June 2009.

Credit tightening strategies will become even higher priorities for lenders when the CARD Act takes effect. Because lenders will no longer be able to charge fees and higher interest rates to their borrowers with impaired credit, their yields will suffer. To make up for the shortfall, credit card issuers are expected to limit credit for existing borrowers, impose higher rates overall, and require larger minimum monthly payments to further reduce their risk.

How the CARD Act will Help Patients:

- Increases in interest rates will only be allowed in certain situations
- Limitations on penalties relating to late fees
- Restrictions on low annual percentage rates that change unpredictably
- Tighter regulation on late billing practices, which will make it easier for consumers to pay on time

Furthermore, only individuals with pristine credit (above 700 one industry expert predicts) will receive new credit lines, leaving people who might have gotten credit in the past out in the cold -- and often unable to pay healthcare bills. That means that healthcare providers will have to create viable repayment options, or partner with a lender that understands healthcare and can effectively lend into this market.

How the CARD Act will Hurt Providers

- Lenders will reduce available credit to patients, only lending to individuals with good credit – many patients that used to pay with credit cards will no longer have that option
- Qualifying borrowers will face increased interest rates and larger minimum monthly payments – making them reluctant to use credit cards to pay for healthcare obligations
- Healthcare providers must seek alternative strategies such as internal payment plans or partnership with a third-party

Healthcare providers like Florida Hospital readily attest to the benefits of planning ahead. As Coy Ingram, Director of Self Pay Management, notes, "We implemented a patient loan program in April 2007, making revolving lines of credit available to patients at all points of patient access and from the financial services business office. In the first 12 months, we qualified approximately 15,000 patients for the program, increased cash collections and significantly reduced bad debt write-offs."

Cedars-Sinai Outpatient Cancer Center implemented a similar program in mid-2006. According to the Center's Patient Accounts Manager, Dennis Hacela, "The program we chose was simple to integrate into our existing revenue cycle. It quickly reduced the number of accounts we had previously referred to collections and, most importantly, also increased patient satisfaction."

The CARD Act is scheduled to take effect in February, 2010. As the two previous examples illustrate, hospitals should be strategizing now so that they are in a position to help their patients -- and also help themselves.

About the author: Mitch Partridge is CEO of the San Diego based CSI Financial Services.



The Burning Platform: Producing Change in Difficult Economic Times-Part Two

Richard L. Clarke, D.H.A., FHFMA, President & CEO,
Healthcare Financial Management Association



Part Two—continued from October newsletter.

Healthcare Reform

The economic events of 2008 played out against the backdrop of a political season that has ushered in a new administration and Congress eager to take on healthcare reform. Some of the reform proposals may bode well for healthcare providers; others might present new challenges to hospitals and health systems.

Elements of Reform

There are several reform proposals circulating, but a basic blueprint for reform includes the following:

An effort to achieve near-universal insurance coverage. This effort would likely build upon the current employer-based insurance model, but may well feature a public insurance alternative that would compete with private plans in a national insurance exchange. Both an employer mandate to “play or pay” (i.e., provide employees coverage or pay a fine) and an individual mandate to obtain coverage are being considered. In the short term, expanded funding for Medicaid and the State Children’s Health Insurance Plan (SCHIP) would help ease the burden of the uninsured.

•More aggressive use of healthcare IT. The use of healthcare IT—particularly electronic health records—would probably be supported initially through government subsidies for IT acquisition. A down payment of just under \$20 billion was contained in the economic stimulus package signed by President Obama on February 17, 2009. And Peter Orszag, the

new director of the Office of Management and Budget and former director of the Congressional Budget Office, has argued that adoption of healthcare IT eventually should be made a condition of payment by government programs.

•Reimbursement based on comparative effectiveness research. Data collected through a national healthcare IT system will help feed comparative effectiveness research to develop standards of evidence-based care; indeed, the economic stimulus package signed in February included comparative effectiveness research money along with healthcare IT funding. There has been some discussion of a federal health board that would oversee development of these standards. In any event, such standards would inevitably drive the reimbursement policies of major government programs such as Medicare and Medicaid in an effort to achieve cost-effective, high-quality outcomes.

Implications of Reform

The effort to achieve near-universal coverage, if enacted, would presumably reduce bad debt at most providers. However, the availability of a public insurance plan might be a mixed blessing if individuals previously covered by private insurance move to public coverage. Current government programs often do not reimburse hospitals for their full costs of treatment. Some hospitals report that reimbursement for adult Medicaid patients is less than half the cost of caring for those patients. In other places—including the “tweener” hospitals that are too big to qualify for Critical Access status but too small for the Rural Referral Center program—Medicare reimburses at approximately 65 percent of costs. A substantial increase in patients whose care is reimbursed at government rates would likely have a negative impact on many providers’ margins, especially if enrollment in these programs is not restricted to individuals who truly cannot afford other coverage.

If private plans are required to compete against a public plan in a national insurance pool, they are likely to experience tighter margins. Private plans that participate in the pool will probably be required to accept all applicants, for example, and will not be able to base premiums on preexisting health status. Tighter margins for these plans will mean tougher negotiations with providers on payment rates.

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The Burning Platform: Producing Change in Difficult Economic Times-Part Two (Continued)

Universal coverage might also affect the tax-exempt status of not-for-profit hospitals and health systems. This status is justified in large part by the community benefit that hospitals provide in return for their exemption, a significant portion of which is charity care. Some members of Congress are already critical of the amount of community benefit provided by hospitals and have indicated a desire to establish minimum thresholds for charity care in any healthcare reform package. Providers should be paying close attention to the other types and amounts of community benefit they provide in the event of a reduction in charity care. A focus on quality and evidence-based standards of care has been building for some time, and is likely to intensify as a result of healthcare reform. Several providers have already participated in pilot demonstrations of programs that link payment to the quality of patient outcomes, and they believe that programs such as pay-for-performance have the potential to improve efficiency and the quality of patient outcomes. But these providers worry that the financial incentives for outcome-based incentives will not provide adequate compensation.

Kevin Brennan, executive vice president and CFO at Geisinger Health System, notes that his organization has participated in several pay-for-performance programs and sees them as an effective means of encouraging efficiency and cost savings. "However," he cautions, "we have not yet realized any significant net economic benefit as the level of incremental reimbursement for pay-for-performance has been nominal." Catherine Jacobson, senior vice president of Strategic Planning & Finance, CFO, and treasurer at Rush University Medical Center in Chicago and HFMA's chair-elect, states "If you really look at what a change in quality outcomes can do to your reimbursement today, you will find significant negative penalties to providers. Providers get paid for intensity and frequency even if that intensity is the result of poor quality. To replace this reimbursement, the incentives for quality have to make up for this, and the amounts are significant. We aren't talking about one percent of payment, but closer to 10 percent or more."

Healthcare IT is another area where providers see great potential for improved outcomes and greater efficiency, but an uncertain economic benefit, at least in the short term. One major problem to date has been the lack of national standards for healthcare IT. A reform proposal that establishes these standards would be welcome. Hospitals have implemented electronic health records (EHRs) and other forms of healthcare IT that support strategies of improved throughput and

safety. While they are seeing improved efficiencies and better opportunities to track and measure outcomes, they also note that many of the financial benefits of these systems flow to payers. To the extent that the government's new economic stimulus plan helps underwrite the costs of EHRs and related healthcare IT investments, providers will be encouraged to adopt and implement these systems.

Hospitals and health systems thus face two major challenges in the coming years. On the one hand are financial and economic pressures on providers, which the current recession has aggravated. On the other hand is imminent national healthcare reform, which is likely to impose at least some short-term costs on providers while intensifying a push for cost-effective, high-quality outcomes.

A Strategy for Change

To meet the challenges facing healthcare, providers must pursue a *value strategy*, focusing on the need to lower cost while improving quality. Low cost and high quality are not irreconcilable differences. The work of researchers at the Dartmouth Institute for Health Policy & Clinical Practice, for example, has demonstrated that lower cost, less intensive care often delivers higher quality, greater patient satisfaction, and population based outcomes equal to or better than more intensive—and more expensive—care.¹⁰

Cost reduction strategies are an immediate need, and providers who fail to contain costs will face continuing erosion of their margins, credit rating downgrades, and constraints on their ability to invest in needed capital improvements. But cost containment cannot come at the expense of quality.

The failure to set a hospital or health system on a value strategy path will have negative consequences today and in the future. And there are many examples of companies in other industries that failed to respond to the pressures to reduce cost while increasing quality, including the automotive, airline, and financial services industries. Executives in these industries had to drive their costs down to the price the market was willing to pay or go out of business. They offer an important lesson for healthcare leaders.

Cost reduction strategies are an immediate need, and providers who fail to contain costs will face continuing erosion of their margins, credit rating downgrades, and constraints on their ability to invest in needed capital improvements. But cost containment cannot come at the expense of quality. In an era of consumerism, tight competition, and performance-based payment, quality setbacks will almost certainly result in lost volume, higher costs, and diminished reimbursements.

The Process of Change

It is incumbent on boards of trustees to provide strong gov-

The Burning Platform: Producing Change in Difficult Economic Times-Part Two (Continued)

governance and to serve as change agents as hospitals and health systems respond to the challenges facing the industry. Lisa Goldstein, a senior vice president at Moody's Investors Service and leader of its public finance group's healthcare team, has recently described the role of failed board governance as a lesson learned from the bankruptcy of the Allegheny Health and Education Research Foundation (AHERF) in 1998. In that case, a minimally involved board allowed the management team to dominate decision making and neglected to hold the management accountable for its decisions. She comments:

"Today, as hospitals across the country seek to populate their boards with financial and industry experts, board members at the most successful organizations will use their expertise from their own professions to question management's strategies. These boards will educate themselves on the challenges in the industry and establish appropriate benchmarks to measure key financial and quality outcomes."

The Roles of the Board

Goldstein's emphasis on an active, questioning board aligns closely with the concept of a board's generative role.¹² A generative board works in tandem with the executive team, especially at times when an organization faces ambiguities or problematic situations, to grapple with the issues the organization confronts and to generate ideas that potentially reframe or refocus the organization's priorities and goals. A board's generative function can take two forms. It can oversee the generative work of the executive team, serving as a sounding board for ideas produced by the team by questioning, probing, or recasting the problems or opportunities the team has identified, the frames it is using to view the issues, and the proposals it is recommending. Or the board can initiate generative work with the executive team, suspending the rules of a traditional board meeting to engage in open and robust dialogue about generative ideas and possibilities.

A board that supports its hospital's executive team in the process of change through the full exercise of its fiduciary, strategic, and generative roles will demonstrate that it has learned the lessons of past governance failures. Active, inquisitive, and informed, it will help to secure the best future for the organization and the many stakeholders it serves.

To fulfill its generative function, a board must actively seek and request information that often differs significantly from the materials presented at board meetings:

- What issues is the executive team struggling with?
- Where are there uncertainties or ambiguities in forecasts or projections, or in the data resulting from current operations?
- What issues are similarly situated providers facing, and how are they responding?
- What insights could be gained by meeting with third-party payers or credit rating analysts?
- How does the community perceive the hospital? What insights might various members of the staff provide?
- Does the hospital act in ways that align with its mission, or do the hospital's actions suggest the need for new organizational goals?
- And finally, what are the true measures of success?

In this setting, the board should not expect management to provide well thought out recommendations, but rather talk with management about the mission and strategy implications of the questions being asked. The board should make clear that it does not want "pre-digested" responses to these questions. It needs to see raw data, points of conflict or uncertainty, and different viewpoints to do its work.

The need to respond to the challenges facing healthcare organizations requires innovative responses and new approaches. The active questioning that informs a board's generative role should also inform a board's more familiar fiduciary and strategic roles. Boards should move from a role of fiduciary oversight (is the budget balanced?) to fiduciary inquiry (does the budget reflect our priorities?).¹³ Rather than structuring a board's committees primarily around administrative operations at the hospital, committees should be organized more flexibly around the hospital's strategic priorities, and rely more on *ad hoc* committees and task forces that have less chance of becoming ossified than rigid committee structures.

Engaging the board actively in its generative, fiduciary, and strategic roles will likely produce both tangible and intangible benefits. Governance is one of the key factors that credit rating agencies use in evaluating a hospital. They will be looking for a board that sets priorities and holds its executive team accountable, while giving management the support and space it needs to execute

The Burning Platform: Producing Change in Difficult Economic Times-Part Two (Continued)

the plan within the day-to-day operations of the hospital. At a time when credit ratings will prove critical to a hospital's ability to access capital, demonstrations of the board's leadership ability simply make good business sense. And at a time when many executive teams will be called upon to make difficult decisions and effect real change within their organizations,

13 Chait, Ryan, and Taylor (2005), p. 38.

14 *Ibid.*, pp. 70–71. they will need the support of a strong and visible board.

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Leading Change

True change—change that is lasting, produces measurable success, and ultimately permeates and reshapes the culture of an organization—is never easy to achieve. And even though a financial crisis is often a catalyst for change, initiating change in the midst of a crisis is not ideal. Employees are alarmed by the news of layoffs and may well view change efforts with suspicion, immediate pressures may encourage a panicked response that produces short-term effects but defeats long-term goals, and the resources that can smooth over transition bumps in happier times may not be available. Delaying needed change is not a viable option, but leaders of change must move forward with a clear vision of the challenges they are likely to face.

John Kotter, a leading expert on change, has defined an eight-step process of creating change within an organization.¹⁵ The board has a key role to play in each of these steps:

••**Establish a sense of urgency.** The board should make clear to the executive team that it understands the challenges facing healthcare providers today, and that it expects and supports efforts to meet these challenges. The board should also recognize that opportunities as well as challenges exist in the current environment, and that pursuing these opportunities may also facilitate needed change.

••**Create the guiding coalition.** In exercising its oversight function, the board should ask for and question the composition of the coalition that the executive team proposes to lead change within the organization. Is both managerial and leadership talent represented on the team? Are there sufficient points of view represented to ensure that the coalition will have the information it needs to successfully guide change? Do the members of the coalition have both the authority and the credibility they need with other employees?

••**Develop a vision and strategy.** This step in the change process overlaps with the generative role of the board. The board should be actively involved in questioning and shaping the vision and strategy for change, and should closely monitor the change process to ensure that the vision for change remains in focus.

••**Communicate the change vision.** Actions speak louder than words. If cost containment is a major emphasis of the change process, for example, a board retreat at an expensive resort sends a message that weakens the case for change. Remember, too, that hospitals and health systems have many stakeholders beyond the hospital's walls. Communicating change requires allaying the concerns of the community, political leaders, and others over the impact of change on the care the hospital provides.

••**Empower broad-based action.** The process of change requires that employees throughout the organization feel that they have the resources and support they need to make the changes required of them. Board members should reach out beyond the executive team to solicit employee opinions on any obstacles to, and the progress, of change.

••**Generate and communicate short-term wins.** The board should encourage the executive team to build short-term wins into the plan for change. Such wins provide feedback on the viability of the plan, demonstrate that sacrifices are paying off, reward change agents for their efforts, undermine resistance to change, and build the momentum for change.¹⁶

••**Consolidate gains and produce more change.**

Boards must share with the executive team a sense of patience and perseverance to move beyond initial short-term wins and stay the course of change. At a distance from the daily efforts at change within the organization, a board is ideally positioned to maintain the organization's vision of change.

••**Anchor new approaches in the culture.** A board that engages with management leadership in a successful process of change, and that fully embraces a board's different roles, is likely to see a new culture emerge within the board, defined by active inquiry, informed oversight, and confidence in the organization's ability to effect change.



Electronic Health Records: What Are the Risks?

By Lori Laubach, Partner, Health Care Consulting Group

Electronic health records (EHRs) offer many benefits, including greater hospital efficiency, and they have significant momentum in the public sector today, thanks in part to the \$18.9 billion in stimulus monies that have been earmarked for the implementation of EHRs.

But digital medical data present potential risks that must be addressed up front, before unintended consequences set in and real problems occur.

Right now one of the main concerns when it comes to EHRs is authorship integrity risk.

Who's to say that someone hasn't borrowed record entries from another source or author? Or that someone isn't representing or displaying the past as current documentation? Or that someone isn't misrepresenting or inflating the nature and intensity of services provided?

There's also a risk related to auditing integrity. Inadequate auditing functions make it impossible to detect when an EHR entry was modified or borrowed from another source and misrepresented as an original entry by an authorized user.

Technology is a positive, but when we're dealing with EHRs, we must be mindful of the risk of documentation integrity, which becomes a reality when there's automated insertion of clinical data and visit documentation using templates or similar tools that have predetermined documentation components with uncontrolled and uncertain clinical relevance.

Automated coding by the EHR can lead to a regulatory compliance risk as well if the coding protocols implemented do not meet regulatory guidance or are misleading. Patient identification and demographic data risks are an issue too. The potential problem here is that automated demographic or registration entries can generate erroneous patient or insurance information.

As health care consultants, our job is to anticipate EHR problems like these and solve them as quickly as possible in order to harness technology's vast potential and improve the quality of health care in our communities.



Electronic Health Records: Additional Issues

By Schawn Pedersen, CPC, CEMC, Manager, Health Care Consulting Group

There are a number of additional issues that require attention when you're deploying EHR systems. This technology has the potential to create enormous and sweeping cost-saving efficiencies, but it also has the ability to wreak havoc on health care entities in the implementation phase.

The first areas to focus on are the cut-and-paste and copy-and-paste functions. When blocks of text or complete notes from another physician encounter are pasted into those for a current encounter, the credibility of the document is frequently compromised.

Another risk area is the use of templates. In many cases there's a lack of sufficient documentation to support an encounter. Many templates are also developed to chart by exception. In other words, the template is completed, usually by clicking on check boxes, only for any abnormal findings.

Some EHR systems may not accurately match the medical necessity of the encounter with the level of service to be billed. There's also risk that providers will be coached to add documentation to meet a specific level of service.

The amendment process with EHRs is especially vexing. It's hard, for instance, to know what the EHR looked like at the time the physician started making changes. And too often EHR technology doesn't allow physicians to understand why other practitioners may have made certain clinical decisions.

There's also a concern with abbreviation transfers from paper records to EHRs, the problem list needs to be updated on a timely basis, and the code tables within an EHR need to be maintained and updated.



New Member Spotlight

Please join us in welcoming our newest Chapter Members!

Welcome! We look forward to seeing you at our next meeting!

Karen Spitz, *Account Executive, Chivaroli & Associates.*

John D. Adams, *Controller, West Valley Medical Center.*



Mark your calendars:

Spring Joint Meeting WA/ID chapters

May 26-May 28th, 2010 in Spokane, WA

We look forward to seeing you there!

HFMA Idaho Chapter—Revenue Cycle Webinars



Idaho Chapter HFMA presents:

Revenue Cycle Webinars

When: January 19, 2010

February 16, 2010

March 16, 2010

Time: 10:00a.m. – 11:00a.m. Mountain (9:00a.m. Pacific)

Speaker: Claudia Birkenshaw Garabelli

Who: Anyone in your facility who wants to learn more about the revenue cycle.

Cost: \$20 per session or \$50 for all three per facility (invite as many people as you want).

Webinar Descriptions:

January 19, 2010 – Core Components of a Solid Charge Master

Identify the core components of a solid charge master. Review real life examples of payer's coding requirements. Explore how the charge master codes relate to a UB-04 claim and ramifications to reimbursement.

February 16, 2010 – Key Components of the Middle and Back End of the Revenue Cycle

Understand the various components of the middle and back end of the revenue cycle, including the charge master, HIM, and the claim scrubber. Identify three reasons why claims are not paid. Analyze issues related to "Discharged but Not Final Billed".

March 16, 2010 – Revenue Cycle and Reviewing Key Indicators

List guidelines to develop your Key Performance Indicators (KPIs). Discuss some commonly used KPIs and current trends within the industry.

Speaker Biography:

Claudia Birkenshaw Garabelli, MSA

BRIDGEFRONT Healthcare Education – Redefined

Claudia has 30 years of healthcare finance experience, including 18 years of managerial service in Patient Accounting at three hospitals and six years as a revenue cycle consultant. She is a recognized national expert in the healthcare revenue cycle, especially related to hospital billing, compliance, and reimbursement. – Claudia's super informative. Very knowledgeable on all areas of PBS & well presented. Keeps the topic interesting & brings the topic to the level of the audience. Gives great examples, very practical. Awesome content. Keeps the class exciting.

Registration Form located at: http://www.idahohfma.org/site/epage/86774_318.htm

Explaining Health Care Reform—How Do Health Care Costs Vary By Region?

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Research about health care costs shows wide variations in spending across the U.S., with spending more than three times higher in some regions than others. Researchers have found that patients in higher cost areas were not necessarily receiving better care; rather, the cost variations were explained by the availability and volume of services used by similar patients. An understanding of these regional spending differences could answer questions about whether our health care system includes waste or inappropriate treatment practices, what could be done to address these problems and any impact on providers and patients, how much money could be saved, and what role such changes would play in health care reform. Although regional variations in health spending have been studied for decades, renewed focus on this issue is evidenced by interest on Capitol Hill, in the Obama Administration, and by recent articles in peer-reviewed literature and the media (including an article by A. Gawande in *The New Yorker*¹) because of the role of health care costs in health care reform and the potential source of funds if addressing cost variations can yield savings.

Regional Variations in Health Care Spending

Regional variations in health care spending have been studied for more than three decades, primarily by John Wennberg and colleagues at the Dartmouth Institute for Health Policy and Clinical Practice through the Dartmouth Atlas Project. The Project analyzes the costs for services provided to beneficiaries in traditional fee-for-service Medicare (excluding Medicare Advantage enrollees) in geographic areas known as “hospital referral regions” and the factors that may contribute to these varying costs, including the supply of resources (such as hospital beds and specialist physicians), utilization of services, quality of care, and patient health status. The Project defines hospital referral regions as regional health care markets based on where patients are referred for major or specialized inpatient medical care, each having a minimum population size of 120,000 and containing at least one hospital that performs major cardiovascular procedures and neurosurgery.

The Dartmouth Atlas Project uses Medicare data

because of the availability of billing records for Medicare’s fee-for-service patients, data that is not available for the total privately insured population. The Project’s website indicates that several state-based studies of all health insurance claims (both Medicare and commercial) have found that variations in resources and quality in the non-Medicare population closely resemble those in the Medicare population.²

Data from the Dartmouth Atlas Project show that nationally, Medicare spent an average of \$8,304 per enrollee in 2006. However, considerable variation in spending occurred among the 306 U.S. hospital referral regions, with the highest-cost regions spending more than three times the amounts spent in the lowest-cost regions. The highest-spending regions were Miami, Florida (\$16,351) and McAllen, Texas (\$14,946), compared to the lowest-spending regions of Honolulu, Hawaii (\$5,311) and Minot, North Dakota (\$5,542). State spending also showed variation, from a high of \$9,564 in New York to just over half that amount (\$5,311) in Hawaii.³

Trends in the spending rates of increase from 1992–2006 also varied considerably from region to region. The per capita rate of increase in inflation-adjusted Medicare spending averaged 3.5% nationally, but ranged from a low of 1.6% in the Honolulu, Hawaii hospital referral region to almost four times that rate (6.2%) in the Lincoln, Nebraska region.⁴

A February 2008 Congressional Budget Office (CBO) study of geographic variation in health care spending also found large differences across the country in spending for the care of similar patients, using primarily Medicare data but also total health care spending data. CBO found that the geographic variation in Medicare spending from the lowest to the highest spending areas has narrowed in recent years, while the variation in total health care spending has increased. Geographic variation in spending by the Department of Veterans Affairs has also increased in recent years so that it is similar to Medicare’s. Spending variation in the U.S. has been much larger than in Canada and somewhat larger than in the United Kingdom, countries where the financing of health care is more centralized than in the United States.⁵

A December 2009 report by the Medicare Payment Advisory Commission (MedPAC) finds wide regional variation in Medicare spending per beneficiary, and

Explaining Health Care Reform—How Do Health Care Costs Vary By Region? (Continued)

less regional variation in Medicare per beneficiary utilization of services, which MedPAC says are not equivalent measures and should not be confused. MedPAC found that Medicare spending per beneficiary in areas at the 90th percentile of national average Medicare spending was 55% higher than at the 10th percentile (or, looking at the extremes, the highest spending area was more than two and a half times the lowest spending area). To analyze Medicare service use, MedPAC adjusted Medicare spending data for differing regional Medicare payments (e.g., wages, special payments to teaching hospitals, rural add-on payments, etc.) and for average health status, and found that service use in areas at the 90th percentile of national average Medicare service use was 30% higher than at the 10th percentile (looking at the extremes, the area with the greatest service use—Miami-Dade County—had twice the level of service use as the lowest area—nonmetropolitan Hawaii). Another finding was that areas with high levels of service use are not always the areas with high growth rates.⁶

Reasons for Regional Variation in Health Care Spending

Many reasons are cited for geographic variations in health care spending, including differences in the local population's demographics and severity of illness, the number and type of

health care resources (hospitals, primary care and specialist doctors, teaching hospitals, etc.) in the local area, provider medical training and practice patterns, provider prices, public and private provider payment systems and payment incentives, patient preferences, the financial investment of providers in local health care resources, waste and inefficiency, fraud and abuse, malpractice-related costs, and the economic, social, and cultural characteristics of the community.

Key Questions

What can be learned from geographic regions that have comparatively higher or lower health care spending?

Lower health care spending in one region compared to another can be due to a number of factors. Relevant to payers for health care (including government programs, private insurance, and individuals) is whether these spending differences are due to forms of inefficiency such as overuse of services where the risk of harm exceeds the likely benefit, underuse of services, or misuse of services including incorrect diagnoses, medical errors, and other sources of avoidable complications.¹⁹ Not all approaches to reducing geographic variation in health care spending would improve the overall efficiency of medical practice. CBO points out that reducing payments to high-spending

areas and increasing payments to low-spending areas reduces spending variation, but results in worse outcomes if quality decreases in the high-spending areas more than it improves in the low-spending areas.²⁰ Another important question is whether appropriate treatment for individual patients is compromised when payment/spending is reduced in a local area by using average payment levels.

2. What types of approaches have been suggested to address regional differences in health care spending?

Several types of approaches have been suggested to address regional differences in health care spending:

- **Payment reform.** Payment reform could range from reducing Medicare and private payer payments to high-spending areas and raising payments to low-spending areas, to a broader restructuring of payment systems such as more accountable systems using partial capitation, bundled payments, or shared savings.²¹ Payment reductions to high-spending areas have been presented as a method of freeing up funds for one of the key health reform goals—providing coverage to the uninsured. However, reducing reimbursements does not necessarily mean that high-spending areas will make the changes necessary for them to function like low-spending areas.
- **Delivery reform.** Payment reform and delivery reform can be linked if the payments are designed to reward providers for delivering efficient care. Approaches include more organized systems of care such as accountable care organizations, which are local networks of providers that manage the full continuum of care for the patients in their network and are paid based on providing efficient and high quality care.
- **Improvements in medical practice.** Ways of reducing geographic variation by making medical practice more efficient and improving quality of care include comparative effectiveness research to help distinguish between necessary and unnecessary care, and the development of practice guidelines and best practices. To have any impact, such information must be disseminated, and incentives to provide care consistent with these findings could be created.

- **Information.** Information about the cost and nature of medical practice in different parts of the country could be gathered, using uniform tools of health information technology. This information would then be disseminated to high-cost practices with the goal of encouraging them to make changes so that their practices and costs are more similar to those of lower-cost areas. An example of such a program is Medicare's Physician Resource Use Measurement and Reporting Program.²²

3. What specific proposals have been made to address regional differences in health care spending? How much could be saved?

A variety of proposals address payment reform, delivery reform, and changing the way doctors practice medicine:

Explaining Health Care Reform—How Do Health Care Costs Vary By Region? (Continued)

• **Congressional Budget Office.** In its February 2008 report, CBO provided options to improve the efficiency of the health care system it was currently analyzing, including increasing the bundling of services in payments to providers; providing incentives for providers to provide care that is consistent with accepted guidelines for low-cost, highly effective care; and generating more information about variation in practice patterns and the relative cost-effectiveness of different procedures for different populations. In a December 2008 report, CBO provided options with incentives for both providers and beneficiaries for reducing regional variations in Medicare's spending, with total savings over the period 2010 to 2019 as follows: reducing Medicare physician fees in unusually high-spending areas (\$5 billion estimated savings), reducing Medicare payment rates for hospitals in areas with a high volume of elective admissions (\$3 billion savings), reducing Medicare payment rates across the board in high spending areas (\$51 billion savings), and imposing a surcharge on Medicare beneficiary cost sharing in high-cost areas and prohibiting Medigap plans from covering the surcharge (\$21 billion savings).²⁴ Careful analysis may be needed to understand both the extent to which these policies would address the underlying problems that result in geographic spending variation and the implications for beneficiaries and providers, particularly in high-cost areas.

• **Dartmouth Atlas.** Dartmouth Atlas researchers estimated that if 1996 Medicare spending levels (adjusted for age, sex, and race) in the low-cost regions were realized in the high-cost regions, Medicare spending could have been reduced 29%. More recent Dartmouth Atlas studies found that if Medicare's annual growth in per capita spending were reduced from the national average (3.5% annual average from 1992 to 2006) to the rate in San Francisco (2.4%), Medicare could save a cumulative \$1.42 trillion by 2023.

Such Medicare payment reform could be accomplished by giving local regions a fixed budget for Medicare services, though the Dartmouth Atlas researchers point out that this approach would do little to address the quality and efficiency of Medicare. They propose instead the development of accountable care organizations, which would be responsible for the quality and cost of care for a population of Medicare beneficiaries.

Dartmouth Atlas researchers also suggest that for health costs reductions, physicians must lead the way to help patients understand various treatments approaches and their costs, to argue against oversupply, and to support high quality, low-cost alternatives.

4. What are the implications of geographic variations in spending for recent health care reform activity and Medicare reform? Recent health care reform activity has focused attention by the media, academics, and

policymakers on regional spending differences primarily to highlight solutions to rising health care cost issues; additionally, any savings could be a source of funding for health reform proposals such as providing coverage for the uninsured. Addressing regional spending variation is one of the few approaches that appear to have the potential for cost savings.

Most of the proposals for reducing geographic spending variations have focused on the Medicare program because Medicare has better data to study the issue, and because Medicare has a substantial cost impact on the federal budget. However, research indicates that geographic spending variation, whether in the Medicare program or the privately insured population, is not just a cost issue but also about the way medicine is practiced in different geographic areas, the availability of health care resources, and the quality of care provided. The House-passed health reform legislation in the 111th Congress (H.R. 3962) requires the Institute of Medicine to study the extent and causes of geographic variation in health care spending among all payers and to recommend Medicare changes to address such variation; taking these Medicare recommendations into account, the Secretary of Health and Human Services must develop a plan and implement such changes unless Congress votes to disapprove them. The Senate Leadership bill (H.R. 3590) does not contain a similar provision. The House and Senate bills contain other approaches to address geographic spending variation, including studies of Medicare's geographic payment adjustment factors, centers for comparative effectiveness research, pilot programs to study accountable care organizations, and programs focusing on quality improvements.

Conclusion

Regional differences in health care spending draw attention to the need to understand how health care is provided to different populations and is paid for by different public and private programs in different areas of the country. The reasons for these regional differences focus on an area's supply of health care resources such as hospitals and doctors, the health status of the area's population, the way medicine is practiced, provider payment systems and incentives, the quality of health care provided, inefficiencies in health care delivery, and any fraud, among other factors. While regional spending differences could be addressed by simply reducing reimbursement to high-cost areas, most proposals prefer to determine how health care can be provided in the most efficient and cost-effective way throughout the country, keeping in mind the goal of providing quality care that addresses the needs of individual patients.



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- Whether a service is a covered benefit
- Whether the service requires a referral or an authorization
- Whether the service needs medical review

Users will enter codes (CPT, HCPCS) and additional information, e.g., code type, plan, ICD9, date of service, age, and gender.

The tool will display benefit exceptions, if applicable, based on search criteria. Self-help documents will be accessible from the tool (similar to other help documents on the secure provider portal) to assist providers in executing searches and interpreting the results.

If you're not registered yet, please go to www.triwest.com/provider, click on the "Register Today!" icon and follow the easy instructions. Once you're registered, you can:

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