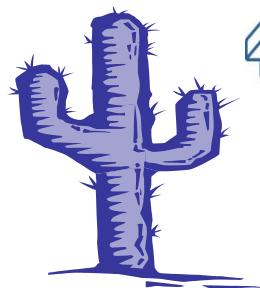


CACTUS CLARION



hfma™ arizona chapter
healthcare financial management association



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August 2010

Special Edition



From the Editor: The 1st Cactus Clarion Special Edition Newsletter

--- What's This? ---

Welcome to the first Special Edition Newsletter. On behalf of the chapter, I am excited about launching this initiative. The idea was born out of the number of requests we get for speaking opportunities at our conferences. Because there are so many, we are highly selective and attempt to line up speakers and topics that fit the current healthcare trends and appeal to a broad audience. But that leaves dozens of other interesting and informative speakers aside.

The solution was to reach out to our own membership and ask our generous sponsors, exhibitors and supporters to contribute to these special editions newsletters. Initial response has been fantastic, even though there has been a bit of a late start. Interested writers were asked to submit an article that discussed their area of expertise as a best practice, or relating to a topic on this year's conference agenda, or how their business is adapting and planning for the impact of healthcare reform: **Reform Readiness**.



Future editions of the Special Edition are planned for 30 days before the spring conference as well. We hope this initial launch will spawn more success for Volume 2.

Inside you will find over a dozen articles from companies that provide solutions in the revenue cycle arena. All are going to be represented in some form at the upcoming conference. If you see an article that sparks an interest, be sure to seek out the writer and thank him or her. I'm positive they will appreciate it.

THANK YOU to everyone who worked so hard on these articles including the newsletter committee and all the authors. If you have feedback or comments about the newsletter or any matters related to the committee please feel free to contact Tim Robertson at (602) 576-2352 or tim.robertson@adreima.com

In This Issue

What's this? Special Edition Cactus Clarion	1	Impact of Reform Act on Wage Index	11
4th Vendor Round Table at Conference	2	Managing the Retail Revenue Cycle	12
Hospital Based Training (HBT)	2	What to Know About Contract Negotiations	13
Integrated Services	3	Conference Golf Outing Registration	14
Increasing Your Self-Pay Collections	3	Repairing the Revenue Leak	15
Market Matters-Contract Management	5	New Retirement Fee Disclosure	16
Extension of Your Business Office	5	Reform Squeezes Revenue, Creates Ops	17
Chapter Program Calendar	7	Reform - Provider's Perspective	18
The Top 3 Sources of Revenue Leakage	8	Top 10 Things Hospitals Need to Know	19
Revenue Cycle Management-TransparentMgmt	10	Annual Sponsor Listing	20



Fourth Vendor Round Table to be Held at the Fall Conference

- Having great feedback over the past 2 years, the round table has become a standard track -

Arizona HFMA started conducting a Vendor Round table discussion at the fall conference in 2009. For those that may not be familiar with the session, it is open to anyone to attend, but specifically exhibitors, sponsors and all financial supporters of the conference are invited. The format is informal and is usually moderated by the Sponsorship Chair and one other Board Member. The purpose is to share recent initiatives the chapter is working on in relation to its partnership with this constituency and to solicit ideas for improving that partnership. All ideas are welcome and all opinions

are valued. After the session, notes are presented to the Board at the next meeting with recommendations for changes or initiatives that are in line with the chapter's goals.

This year's session will be moderated by the current Sponsorship Chair, Linda Hall, Director at Casa Grande Regional Medical Center and will be held in the 10:30 to Noon time slot on Thursday, September 16th. No prior sign up is required; just show up and share your opinions and contribute to the success.



Hospital Based Training (HBT)

- Free Provider Education on site Presented by Consulting/Partner Companies -

The Arizona HFMA Chapter is going to continue working on the Hospital Based Training (HBT) initiative throughout the rest of our program year. This program is designed to provide education to facilities that would like to receive free education on a number of different topics. As a Provider serving as an HFMA volunteer, committee member, board member, or leader we would like to ask each of you to consider scheduling 1 or 2 HBT sessions at your facility before the end of April. We will be happy to work with you to coordinate scheduling and logistics.

The first step in taking advantage of this program will be to contact Todd Dixon at 480-305-6121 or at TDixon@acclivityhealthcare.com and let him know what topics are at the top of the list from an educational perspective. The speakers will primarily come from various consulting/partner companies that provide services to help solve your day to day issues. We will be updating the list of speakers who are willing to provide free education at your facility as the year goes on but need your help with ideas on what subjects you would like to have covered.

2010 - 2011 Arizona Chapter Leaders

President:	Terry M. Brennan FHFMA	928-771-5660	Sponsorship:	Linda Hall CHFP	520-381-6934
President-Elect:	Connie Perez CHFP	602-636-5505	Awards:	Susan Eggman	520-495-0357
VP, Program:	Greg Wojtal CPA	602-747-3023	Audit:	Jeff Buehrle CPA	602-747-4289
Treasurer:	Jeff O'Malley	602-406-4488	Director:	Kathie Kirkland	623-434-6200
Secretary/Newsletter:	Tim Robertson	602-636-5563	Director:	Sue Ojeda	520-324-1155
Programs, Vice Chair	Ethel Hoffman FHFMA	602-512-8021	Past President:	Todd N. Dixon	480-305-6121
Membership:	Michael Kennedy	602-795-0044	AzHHA Liaison:	James F. Haynes CPA	602-445-4300

Integrated Services

Tony Maki, Health Care Partner, Moss Adams LLP

Moss Adams LLP, the largest CPA firm headquartered in the Western US, has developed a unique integrated approach to provide solutions to the health care marketplace. Our Health Care Industry Group is one of the firm's largest industry groups and includes full-time health care specialists who are resources to our clients and our audit professionals in industry-specific technical areas. Listening to what our health care clients need is critical to our approach. We have developed a robust health care consulting practice, which provides the following industry specific services:

- Inpatient and outpatient coding
- Hospital revenue cycle
- Payer operations reviews
- Claims denial management
- Physician operations reviews
- Hospital and physician risk assessments
- Hospital internals control reviews
- Medicare reimbursements/cost reports
- Information systems implementation
- EMR/EHR selection and implementation

As the above are stand alone services, the real value to our clients is integrating these specialists with our financial audit team. Combining the health care consultants with the health care audi-

tors provides a powerful integrated approach and team to address our client's issues. As a result, Moss Adams has built a strong team of professionals who are dedicated solely to health care accounting, auditing, and consulting. Our Health Care Industry Group represents more than 10% of our firm's overall revenues, and serves a growing roster of approximately 1,800 health care organizations.

Moss Adams was one of the first accounting firms in the nation to organize its professionals into firm-wide industry groups, each with its own distinct leadership team, strategic plan, continuing professional education, and service approach. This was a big change from the established accounting industry practice of setting up individual offices in different locations and populating them with generalists.

Please feel free to talk to a Moss Adams representative who will be present at the AzHFMA 2010 fall conference.

Az HFMA would like to thank Moss Adams LLP for their support as annual and conference sponsors.

Increasing Your Self-Pay Collections—Get Folks on the Phone!

Adam L. Plotkin, Principal/General Counsel, Healthcare Outsourcing Network, L.L.C.

After almost twenty (20) years of handling self-pay accounts, something has become abundantly clear to me. Interestingly, it has always been right here before our very eyes. The single best tool for collecting your accounts remains one of the oldest pieces of equipment out there—the trusty old telephone!

Remember folks, these are non-default accounts. Your patients have legitimate questions; questions

that cannot be answered by a letter, a pre-recorded message, an inbound voice recognition (“IVR”) system, etc. Sometimes, a patient simply needs a good old-fashioned human being to explain that the bill they already paid was for the anesthesiologist (or the ambulance, or the ER physician, etc.), not for the hospital. Get such a patient on the phone, odds are you can obtain payment right away. Simply send letters, pre-recorded messages, etc., and

(Continued on page 4)

(Increasing Self-Pay Collections continued from page 3)

the questions likely go unanswered, and that same account may end up in bad debt. This is a lose-lose scenario—the hospital pays a much higher bad debt fee, and the patient is forced to deal with the bad debt process.

Live telephone contact also serves another important purpose—it allows your facility to reach out to your patient community and serve a role as a good-will ambassador. When a patient answers the phone, rather than launching into a demand for payment, ask them how their hospital stay was and if they have any questions. Explain the billing process to them. In addition to building a rapport with the patient, you will also go a long way towards removing many of the common stalls employed to delay paying medical bills. For example, a patient who has had the billing process explained to him is far less likely to delay payment under the claim that he did not understand his bill, EOB, etc.

Once you do request payment, always remember to ask for payment in full. This is key, so let me say it again: ALWAYS ASK FOR PAYMENT IN FULL! When I visit hospital business offices, one of the biggest problems I hear are calls where the account representative is asking the patient for something less than payment in full. Now of course, not everyone can afford to make payment in full. But if you don't at least try for payment in full, NOBODY will make payment in full! Make the request, and then work backwards from that point. This way, those that can afford payment in full, make payment in full. Those that need a payment plan will still get their payment plan. But rest assured, a patient who has every intention of paying in full will gladly send you \$50.00 per month for ten (10) years if that is what you ask them to do.

Another often overlooked piece of a self-pay call is to verify existing information, and gather missing information. You already have the patient on the phone, so verify that you have a valid address and employment information. If you are missing any

information, now is your opportunity to garner it from the patient. We all know that the unfortunate reality is that some accounts will ultimately end up being turned to bad debt. Your chances of seeing your money on such accounts increases significantly if you are able to provide your bad debt vendor with current contact and employment information.

Finally, loop back to your role as a good-will ambassador for your facility and ask the patient if there are any other issues you can address. You will be amazed at the positive reactions you will get from patients by starting and ending your calls with something other than a demand for payment.

In summary, remember these five (5) steps: Step 1: get them on the phone; Step 2: be a good-will ambassador; Step 3: ask for payment in full; Step 4: verify and gather information; Step 5: ask if there are any other issues you can address. Your self-pay collections will increase, your days in A/R will decrease, and your customer service scores will rise too!

As you can see, it all starts with getting the patient on the phone. Letters, pre-recorded messages, IVR systems, and various other items are all part of any solid self-pay program. Believe me, we use them all. But at the end of the day, nothing will bring in your money like a live conversation. Make no mistake about it—a program based upon live calls requires more Full Time Employees, and absolutely requires the use of automated dialing technology. This is likely why most operations shy away from such an extensive calling philosophy. But as your recoveries soar, you will be glad you gave this plan a shot!

Healthcare Outsourcing Network, L.L.C. handles non-default self-pay and insurance receivables for hospitals throughout Arizona and across the United States.

Az HFMA would like to thank Healthcare Outsourcing Network LLC for their support as an annual sponsor.

PNC Healthcare Market Matters Newsletter (Excerpt from April 2008)

Justin Krauss, PNC Healthcare

A contract is a set of rules governing the relationship between business partners. Some of these rules relate to pricing and revenue, or revenue incentives and disincentives. The rules need to be documented in a contract management system so that actual performance under the contract (e.g., payer reimbursements) can be properly analyzed. In addition, applicable state and Federal laws must also be considered.

The best contract management technology includes advanced analytics. As an example, nearly every payer contract has underlying insurance plans negotiated with individual employers. Although the provisions for individual employer plans are not typically detailed in payer contracts, information gathered from patient/employee encounters, gathered over a period of time, can be used to develop underlying trends for larger employer groups. Strong analytics produce data that can be used to improve all aspects of the revenue cycle, from intake to claims sub-mission to denial management. Improved technologies for converting data from paper EOBs to “manufactured” 835s, as well as an increasing number of payers delivering native 835s, have dramatically increased the amount of data available for analysis.

If system integration with the contract management and claims systems is not possible, then manual

comparison of denials to contract terms for major payers, and an organized process for evaluating and resubmitting claims, are essential. Data from denial management reports should be compared to existing contracts and incorporated into claims scrubber business rules. Very often, payers have unwritten edits and reimbursement “tendencies” that can be documented as business rules for claim edits. Good contract management systems, properly used, should reduce denials before they happen. This assumes, of course, that payment data is compared routinely against the contract database, analyzed frequently, and then used to address issues at root cause throughout the revenue cycle. Bottom line impact can only be maximized if denials and contract discrepancies are identified and addressed immediately, not at the end of the fiscal year or when payer contracts are up for renewal.

For additional information on services provided by PNC Healthcare, contact Justin Krauss at justin.krauss@pnc.com. Visit www.pnc.com/healthcare to view the complete article, or to sign up for PNC Healthcare’s free Market Matters Newsletter. This article was printed with permission.

Az HFMA would like to thank PNC Healthcare for their support as an annual sponsor, conference sponsor and exhibitor.

Extension of your Business Office - A Self Pay Patient “Solution”

Gina Rago, Division Director of Operations, MDS (Medical Data Systems, Inc.)

Wilkes Regional Medical Center (Wilkes), implemented an extended business office solution. The facility was trying to improve their collections without disrupting the relationship with the community they serve. For more than 80 years, Wilkes has provided high quality and cost effective health care to the citizens of Wilkes County, North Carolina. The 130-bed community hospital is also home

to a 10-bed skilled nursing unit.

Wilkes’ business office team had always managed active A/R. Cash flow needed to be improved to meet the growing demand of healthcare expense. The management team at Wilkes wanted to place self-pay dollars 7 days after initial bill date, allow-

(Continued on page 6)

(Extension of Your Business Office continued from page 5)

ing the vendor to handle call volumes.

The selected exclusive EBO partner was able to handle inbound and outbound calls at levels the internal hospital reps could not. With a team of collectors, in a blended call center environment, the vendor was quickly able to assist patients and resolve balances due. The Patient Account Manager noted that “the volume of accounts placed with our vendor partner allows our patient accounting staff to concentrate on insurance billing and follow-up.”

Wilkes selected a partner with a sound implementation plan. Data interchanges were reviewed and programming was complete within 45 days of contract finalization. The partner selected was able to meet the tailored needs of the patient base as directed by Wilkes. Simple solutions included: approved scripting; charity care and payment plan guideline measuring; letter verbiage specifics; and providing an on-site liaison to bill insurance discovery and manage staff questions.

Some of the benefits that Wilkes Regional experienced through improved practices are:

- Wilkes Regional was able to eliminate the need for both CSR’s at the business office thereby eliminating labor costs.
- The solutions vendor team was available to answer patient calls from 8:00 a.m. – 10 p.m. Monday – Friday thereby eliminating communication challenges.

- Wilkes Regional was able to see a streamlined process of managing patient accounts and review activity on a daily basis which increased revenue and decreased patient complaints.
- The solutions partner provides insurance discovery, payment plan details, corrected address and adjustment data to the facility on a weekly basis.
- After partnering with an extended business office solution partner, Wilkes has seen an increase in cash of over \$500,000 compared to the previous year.
- Payment plans are setup within established budgetary guidelines and the solutions partners report such information back to the facility for anticipated revenue dollars.

In summary, when considering a solutions partner, select one that is able to quickly implement a proven revenue solution to greatly improve cash flow at the facility level, allow for inbound and outbound traffic volumes in an expeditious manner thereby increasing revenues, comply and tailor its work processes to achieve patient and business office satisfaction, and provide detailed reports.

For more information, contact:

Chris Vairo, Vice President of Business Development – MDS

Email: cvairo@meddatsys.com

Az HFMA would like to thank Medical Data Systems for their support as an annual sponsor and conference sponsors.



Reform Readiness

Fall Conference ~ September 15-17
Ritz-Carlton Dove Mountain, Marana

Registration Deadline is September 8th

Register Online at http://www.azhfma.org/events_detail.cfm?pk_event=58



Future Az HFMA Education Programs

Visit www.azhfma.org/events_list.cfm
for More Details and To Register



September 15-17 Reform Readiness

Ritz-Carlton, Dove Mountain in Marana

General Sessions, 2 sets of 4 Breakout Sessions,
Golf Outing, Exhibit Hall

Registration Options: Full Conference and Single
Day for each of the three days

Registration Deadline: September 8th

12.5 CPE hours for full conference attendance
~~~~~

### September 22 ~ Components of a Competency Assessment Program and Creating Competencies

Region 10 Webinar presented by Idaho Chapter  
10:00 - 11:00 am  
~~~~~

October 12 ~ Next Lunch N'Learn

Topic TBA

Embassy Suites Biltmore: 11:30 am - 1:30 pm
~~~~~

### Hospital Based Training

Concept of these "best practices" sessions benefit:

- > Providers- receive free education at their facilities in a short format (1-2 hours)
- > Vendors- present themselves professionally and offer solutions to various problems and issues

*Interested?? - Contact Todd Dixon at 480-305-6121 or  
e-mail [tdixon@acclivityhealthcare.com](mailto:tdixon@acclivityhealthcare.com)*

## Program Calendar for other Arizona Healthcare Associations

### AAHAM

September 24: Flagstaff

For more information, Visit  
[www.aaham.org/cactuswren](http://www.aaham.org/cactuswren)  
website or contact John Roach  
at 623-876-5706.

### AZ MGMA

September 16, 10:00 am - 4:00 pm: "Managing Medical Data with Microsoft Excel"; Embassy Suites Biltmore, Phoenix

October 12, 7:30 am: "Patient Satisfaction Surveys"; Arizona Inn, Tucson

October 13, 11:30 am: "Patient Satisfaction Surveys"; Embassy Suites Phoenix Biltmore

Visit [www.azmgma.org](http://www.azmgma.org)

### AzHHA

September 16, 9:00 -10:30 am: "Preparing for the Meaningful Use Final Rules"; Webinar

October 14 & 15: Annual Membership Conference "Bringing the Future into Focus"; The Buttes, Tempe

Visit [www.azhha.org](http://www.azhha.org)

## The Top 3 Sources of Revenue Leakage

Michael Eade, Regional Manager, Craneware, Inc.

As hospitals contemplate new healthcare reform legislation and how it may impact their financial performance, most remain focused on providing quality care to the communities they serve while seeking to contain costs. Yet, Thomson Reuters research indicates that the most successful hospitals are those that are focused on enhancing revenues rather than just controlling costs. Controlling revenue leakage – the difference between the amount of revenue providers are entitled to and the amount of reimbursement they eventually receive – is the key to optimizing revenue.

Revenue leakage is a significant problem, with vast amounts of reimbursement lost daily due to inaccurate pricing, charging, and coding of patient care services and supplies. Most healthcare organizations realize they are missing revenue, but are unable to detect the sources of leakage and therefore do not realize the extent of that leakage.

Having served more than 1,000 healthcare organizations, from small community hospitals to large healthcare networks, Craneware has used its experience to identify and define the top sources of revenue leakage that can be prevented. They are:

### **Infusion Therapy**

As the number one source of revenue leakage in most hospitals, Hierarchical Condition Category and time-based charging for infusion therapy makes it extremely difficult for facilities to accurately capture correct charges for outpatient infusion service lines.

### **Surgical Components in Radiology**

Craneware has found that interventional components are often not charged for in many of the numerous minor, diagnostic surgical procedures performed in diagnostic radiology (e.g., MRI, CT, and ultrasound) These procedures include many biopsies, drainages and arthrogram injections. In other words, while the cost associated with the radiology

supervision and interpretation is usually charged, the smaller associated procedures are frequently left out of the charges.

### **Chargeable Supplies and Devices**

Many healthcare organizations also recognize that they do not receive all of the reimbursement they are entitled to for chargeable supplies. However, the traditional process of using spreadsheets to manage the many points of contact between purchasing, clinical use, and reimbursement makes identifying revenue leakage gaps a challenging, resource-intensive task. As is common, the more processes rely on human best efforts, the more likely it is that the organization will have lost or degraded data anywhere along that path.

Most hospitals cannot link purchasing history data in the item master to chargemaster data for comparison, except through such manual methods as spreadsheets. According to a survey completed by Porter Research in 2009, 75 percent of hospitals do not currently use any automation tools to compare their supply purchase histories with actual billing for supplies. Inadequately linked systems combined with manual updates lead to significant revenue leakage for separately chargeable supplies. This issue is further compounded by lack of reconciliation between supply purchases and the chargemaster.

By dynamically linking the item master with the chargemaster, hospitals can gain unsurpassed visibility into supply costs and charges. This visibility empowers hospitals to readily manage the large amounts of data involved by clearly identifying the exceptions to industry best practices. This enables those exceptions to be brought back into alignment with optimal business processes for improved financial performance.

Ensuring that the chargemaster is up-to-date, and that chargeable supplies and devices are being in-

*(Continued on page 9)*

*(The Top 3 Sources of Revenue Leakage continued from page 8)*

cluded in the chargemaster, are key factors in producing accurate claims. By automating chargemaster management processes, healthcare organizations can validate that all appropriate line items are accurately included in the final charges. This has shown to make a significant difference in hospitals' financial success, as well as their compliance and operational efficiency.

**Stop Revenue Leakage**

Identifying gaps such as these is the first step to promoting revenue integrity within your organization. Revenue integrity is the achievement of optimized operational efficiency, compliance and legitimate reimbursement.

Assuring revenue integrity using automation is integral to optimal financial performance in the coming era of healthcare. For this reason, leading hospitals are turning to automated tools, such as those provided by Craneware, to achieve financial improvement, support compliance and ensure operational efficiency.

For relevant, informative material on how to attain revenue integrity within your organization, visit [stoptheleakage.com](http://stoptheleakage.com). Recently launched by Craneware, this educational campaign provides greater insights into the sources of revenue leakage within hospitals, real-life examples of how healthcare organizations are overcoming these challenges and best practices for implementing proven tactics in your facility.

In addition, as part of Craneware's ongoing commitment towards helping hospitals identify, address and prevent revenue leakage from their organizations, Craneware will host a

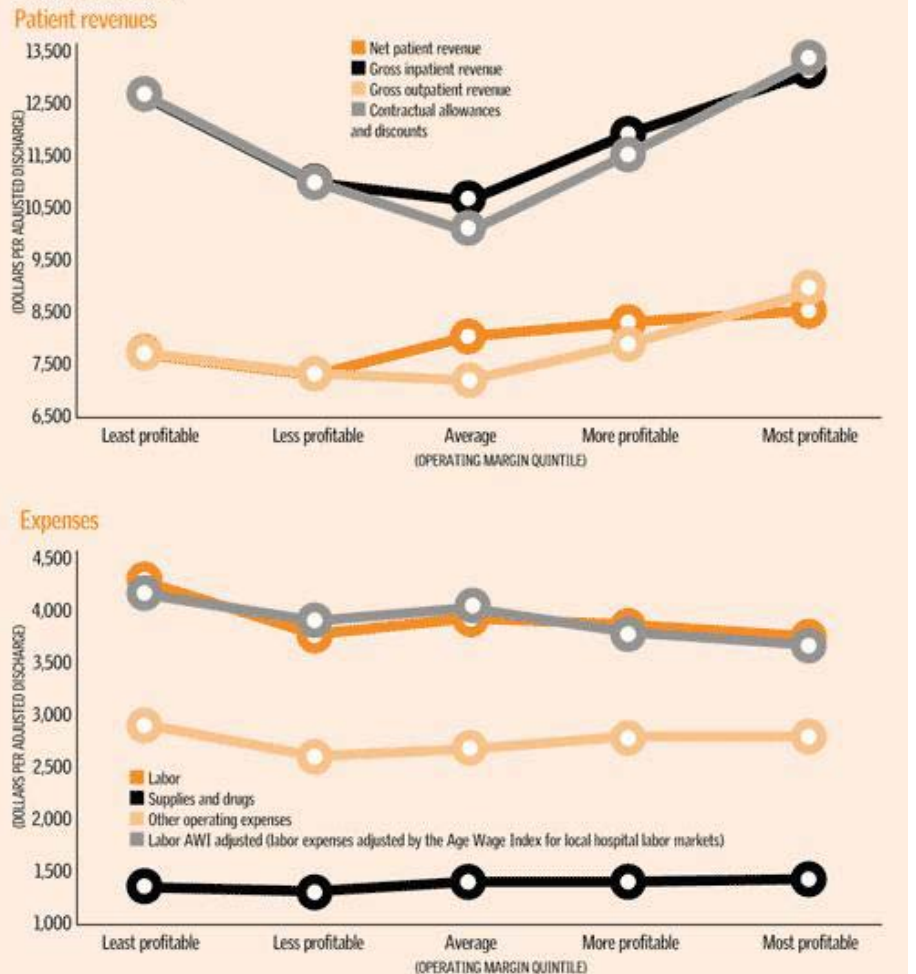
series of educational events October 4-6 at the Hotel Valley Ho in Scottsdale. On October 6 is an Emergency Department billing BootCamp session, which will be open to staff from any hospitals.

October 5 - 6 sessions are for Craneware clients only to participate in a collaborative network, sharing best practices and dialoging on industry trends that affect financial performance. An October 4 bonus session will help hospitals optimize billing for their physician practices by using automation. To register these sessions, visit [craneware.com](http://craneware.com).

*Az HFMA would like to thank Craneware for their support as an annual and conference sponsor.*

**MONEY IN, MONEY OUT**

There is a wide disparity between the operating margins of the most and least profitable hospitals in the United States. When compared to the least profitable hospitals, the most profitable hospitals derive more of their advantage from enhancing revenues than from controlling costs. More profitable hospitals spend more for supplies, drugs, and other direct expenses than their less profitable counterparts. More profitable hospitals also pay higher salaries and benefits, but have more productive employees, offsetting higher compensation levels.



SOURCE: Thomson Reuters

# Revenue Cycle Outsourcing – Transparent Measurement and Control

Chris Becraft, President, Collection Service Bureau (CSB)

Healthcare Reform will continue to drive the outsourcing of revenue cycle processes to companies that specialize in key aspects of the process. It's no secret that the healthcare revenue cycle is complex and attempting to be a "Jack of all Trades" is why providers currently struggle to align their internal efficiencies. It is simply too much to ask of most organizations to maximize the process from beginning to end on their own. Outsource partners who specialize in key aspects of the revenue cycle can and will do certain things better but providers need to have the tools to manage that relationship.

Many providers understandably worry about a loss of control when outsourcing a portion of their revenue cycle and that is why best practices dictate a transparent flow of communication and business intelligence from the partner to the provider throughout the process.

Let's consider self pay active receivables outsourcing. Providers should insist on real time access to A/R inventory data that includes: placements, recoveries, close and returns, and inventory by aging bucket or status. Providers should be able to drill down from top level detail to individual accounts for auditing purposes. In other words, the information flow should be transparent and as accessible from 10,000 feet as from the ground.

As an example of what to expect, take CSB's proprietary Business Intelligence Portal (figure 1). Provider management may want to review a slice of their Active A/R by aging bucket, and maybe even the accounts by status that make up that bucket. A drill down on any bucket will show you that. Further drill downs will get you to a listing of accounts that make up that status class while a final drill down will take you to any individual accounts for an account level audit. This is 10,000 to the ground in 4 hyperlinks and what you should expect in order to measure

and manage your receivables.

Measuring the work efforts of your outsourcing partner's statements and phone calls seems to be a constant source of concern for many providers. Providers should insist that this information be accessible at any time, for any time period of interest to their organization.

Using CSB's BI Portal again as an example (figure 2), providers can review the statements sent and the calling for any pe-

| Client Name | Client Code | Letter Count | Call Count |
|-------------|-------------|--------------|------------|
| Mercy Care  | MER999      | 1324         | 10452      |
| Mercy Care  | MER999      | 335          | 2798       |
| Total:      |             | 1,659        | 13,250     |

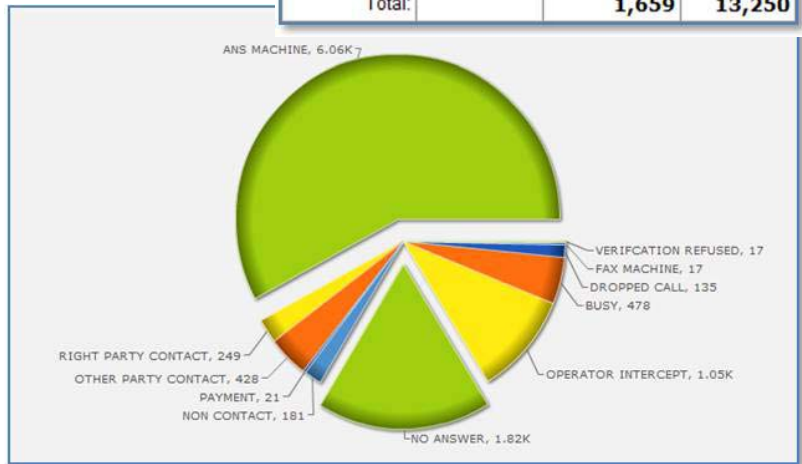


Figure 2 - CSB's BI Portal - Activity Report

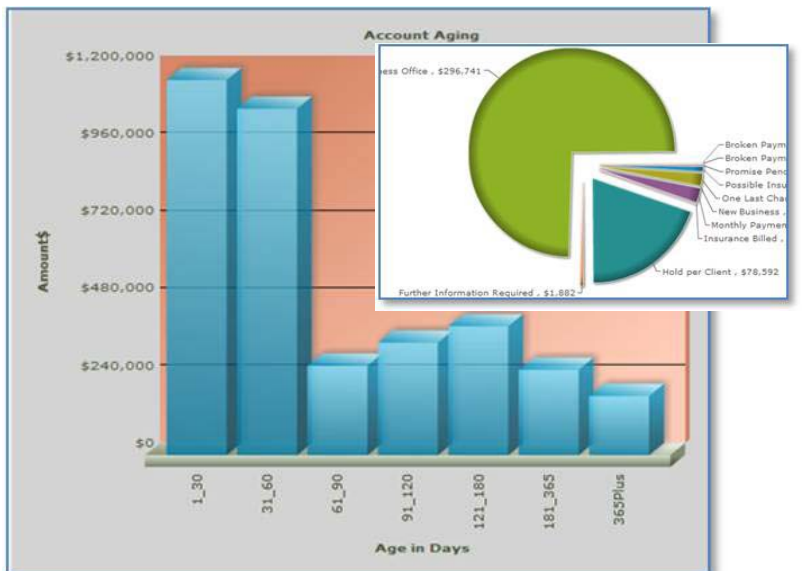


Figure 1 – CSB's BI Portal – Aging Report

# Impact of the Patient Protection and Affordable Care Act Upon the Wage Index

K. Michael Webdale, CPA, Senior Vice President, R-C Healthcare Management Services, Inc.

## Geographic Reclassification Requirements Re-set

Prior to the passage of the Patient Protection and Affordable Care Act (PPACA), CMS implemented a two-year phase which systematically increased geographic reclassification requirements for hospitals. The PPACA resets those requirements back to their former levels. Under these new requirements, an urban hospital's three-year average hourly wage (AHW) must be at least 84% of the AHW of the area into which it wishes to reclassify (with levels of 82% for rural hospitals and 85% for groups of hospitals) in order for the hospital to be

*(Revenue Cycle Outsourcing continued from page 10)*

eligible. A drill down takes you to the detail of that activity, such as answer machines, no answer, payments, etc.

This is just a brief overview of some of the best practices tools that should be utilized when measuring and managing an outsourcing partnership. High quality companies will make these kinds of online tools available as part of their services and can be used as an informal litmus test of the expertise of any outsourcing provider you may be considering. In short, knowing what your partner is doing should never be a mystery; it should be obvious, transparent and available whenever it is convenient for you.

Chris Becraft is President of CSB - Collection Service Bureau, Inc. ([www.csbcollections.com](http://www.csbcollections.com)) – a 100% healthcare outsourcing company specializing in active and aged healthcare receivables management. He can be reached at [chris@csbcollections.com](mailto:chris@csbcollections.com)

*Az HFMA would like to thank Collection Service Bureau for their support as a conference exhibitor.*

eligible. If a hospital had previously submitted an application to reclassify and that application was denied because the hospital did not meet the higher threshold requirements, that hospital will now be allowed to reclassify under the PPACA's lower threshold requirements. However, a different standard pertains to those hospitals that did not apply for a reclassification prior to the PPACA taking effect. Even though these hospitals may now qualify to reclassify under the new, reduced threshold requirements, CMS is not allowing them to apply for reclassification. In effect, these hospitals are being punished for following the rules and not requesting a reclassification for which they did not qualify at the time, while other hospitals are being rewarded because they did request a reclassification.

## Rural Floor Budget Neutrality Adjustment

It is a CMS requirement that no hospital within a state can receive a wage index less than that of its rural hospitals. Because the wage index is budget-neutral, in the past if a CBSA received an increase in its wage index due to the rural floor adjustment, the money to pay for that increase was taken from the national pool. Over the past two years, CMS has been progressively shifting the responsibility for paying for these increases from the national level to an individual state level. The PPACA restored this responsibility back to the national level, which caused the wage index of every CBSA in the country to decrease by .34 percentage points or approximately \$17 per Medicare PPS discharge.

## Frontier States Wage Index Floor

The PPACA established a Frontier States wage index floor beginning in FFY 2011. No hospital located within a state designated as a Frontier State can have a wage index less than 1.00. Five states qualify to be Frontier States, namely Montana, Nevada, North Dakota, South Dakota and Wyoming.

*(Continued on page 12)*

*(Impact of the Patient Protection and Affordable Care Act on the Wage Index continued from page 11)*

The largest increase in the wage index for any individual Frontier State hospital is more than 20 percentage points, which equates to additional reimbursement in excess of \$1,000 per Medicare PPS discharge. This provision, which affects 50 hospitals at a cost of \$90 million dollars, is not budget-neutral.

### Arizona Wage Index History

CMS has released the FFY 2011 Area Wage Indices (AWIs), which take effect on October 1, 2010. Below is a chart detailing the changes in the AWIs from FFY 2010 to FFY 2011 for each of the Arizona CBSAs and the Rural Area.

|                          | FFY 2010 | FFY 2011 | % Point Chg |
|--------------------------|----------|----------|-------------|
| Flagstaff                | 1.2450   | 1.2394   | -0.56       |
| Lake Havasu City-Kingman | 1.0590   | 1.0236   | -3.54       |
| Phoenix-Mesa-Glendale    | 1.0472   | 1.0463   | -0.09       |
| Prescott                 | 1.0169   | 1.2257   | 20.88       |
| Tucson                   | 0.9686   | 0.9643   | -0.43       |
| Yuma                     | 0.9284   | 0.9408   | 1.24        |
| Rural AZ                 | 0.8801   | 0.9088   | 2.87        |

The Prescott CBSA experienced a dramatic increase in its AWI, which appears to be valid due to wage increases and corrections made in the hospitals' Worksheet S-3 wage data. Outpatient reimbursement will be impacted by the wage index as of January 1, 2011.

R-C Healthcare Management launched the wage index consulting industry and has been providing hospitals throughout the United States with our premier wage index optimization services since 1990. To learn more, please call us at (800) 862-5368 or visit our websites at [www.rcmgmt.com](http://www.rcmgmt.com) and [www.wageindex.com](http://www.wageindex.com).

*Az HFMA would like to thank R-C Healthcare Management Services for their support as an annual sponsor.*

## Managing the Retail Revenue Cycle

Passport Health Communications Inc.

The health care revenue cycle has changed. Record levels of uninsured patients get national attention, but insured patients' personal financial responsibility is growing at a rapid pace. Health Savings Account enrollment is increasing at an annual rate of 25 to 30 percent, and approximately one in four covered workers has an annual deductible of at least \$1,000.

Most insured patients are able and willing to pay their out-of-pocket medical expenses. It is the health care industry's inefficient processes that harbors a culture of non-payment among patients and allows \$60 billion in annual patient bad debt to get progressively worse. Studies show that by the time a patient bill is mailed 30 days or longer after service, after the insurance claim has been paid, much of the opportunity to collect from the patient is already lost. Providers can expect to collect only 50 to 70 percent of an insured patient's balance after he or she is treated and leaves. For uninsured patients they can expect to collect only 5 to 10 percent after service.

Hospitals and physician practices must adapt their mindsets to begin operating more like the retail sector, modifying strategies and implementing tools and processes to collect payment prior to or at the point of service.

Passport Health Communications Inc. works with one in three U.S. hospitals and is helping health care organizations adjust to the Retail Revenue Cycle by making patient collections a seamless and consistent part of Patient Access: Verifying insurance eligibility and coverage, providing accurate price estimates, accessing patients' medical credit scores, offering payment plans and other financing options and electronically processing patient payments.

Visit our booth at the upcoming AZ HFMA conference to learn about the software and services in the [Passport eCare® Patient Access Suite](#), including [Payment Navigator](#), a new Patient Financial Triage

*(Continued on page 13)*

# What Every Hospital Should Know About Contract Negotiations

MedAssets

Few companies would go into a critical negotiation process without a plan of action, yet hospitals across the country do that in payor negotiations. Below are five steps to negotiating contracts to maximize revenue and capture and maintain profitability by product lines:

**1. Embrace Modeling Technology** – “What if ...?” scenarios before the negotiations process help providers create your own game plan – before the first payor proposal. Negotiators can view current net revenue per day against cost information and quickly determine current utilization of services from a given payor. Negotiators can also compare the current contract to the proposal to understand the overall financial impact for their book of business, leveling the playing field with payors.

**2. Invest in Training Employees** – Data is only as good as the claims available within the system. Employees must select the proper set of claims and corresponding data and then interpret that data – a difficult process without proper training. Empower employees to ask why are we not getting reimbursed and why are payors reimbursing this way?

*(Managing the Retain Revenue Cycle continued from page 12)*

tool for assessing charity care and identifying government assistance for self-pay patients. In the meantime, visit our [website](#) to learn more about the Retail Revenue Cycle and take advantage of these and other free resources:

- ◆ [Recorded webinar: The Retail Revenue Cycle](#)
- ◆ [White paper: “Cash, Check or Charge” \(Increasing Importance of Patient Payments\)](#)
- ◆ [Overview of Passport’s Payment Management solutions](#)
- ◆ [Patient Access Best Practices: Success Stories 2010](#)

Please visit [www.passporthealth.com](http://www.passporthealth.com) or call (888) 661-5657 for more information.

*Az HFMA would like to thank Passport Health Communications for their support as a conference exhibitor.*

Give them tools to collect underpayments and fight for revenue. Educate and train employees on your contract management solution and create individual procedures to enable a repeatable process for recovering revenue and promoting better financial forecasting.

**3. Examine Your Source** – If you have a problem with one, you likely have that same problem with other payors, and it might be on your end. Improper billing, coding, charging patterns and incorrectly loaded contract terms are often culprits, and services affected include cardiac care, high cost drugs and implants. Look for root causes and prepare to implement true cultural changes to resolve the challenges. Train internal auditors and incentivize them to get to the root of issues to truly maximize returns. Today’s solutions have analysis capabilities to help.

**4. Have Plans A, B and C** – Successful projects address crucial issues, such as how to handle “what if” scenarios and how to make enterprise-wide cultural changes, not just departmental changes, around negotiations. Start with a key goal in mind – net revenue growth. Identify specific volume and growth expectations, using the prior year as the basis. To ensure the total net revenue goal is met, revisit prior payor behavior for trends in areas such as underpayments, overpayments, denials and patient liability shifts. This helps forecast how much administrative time will be spent on a particular negotiation and identify prospective views of what might roll to bad debt.

**6. Know Where You Net Out** – Contract modeling calculates utilization, net revenue per day per contract, average Length of Visit by service line type and Total Patient Days IP/OP. Net revenue per day serves as a benchmark of how much money a hospital must bring in per patient per day to ensure profitability, which comes up during contract negotiations. Armed with information, all internal parties involved can see the causes of any reimbursement or pricing issues and work together to resolve them in advance of negotiation sessions.

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## Golf Outing

Get Your Team Together and Join Us for a Round of Fun and Prizes!!



Details: Ritz-Carlton Golf Club, Dove Mountain – Tortolito and Wild Burro Courses  
 6501 Boulder Bridge Pass, Marana, AZ 85658, 520-572-3500;  
<http://www.ritzcarlton.com/en/Properties/DoveMountain/Golf/Default.htm>  
 Wednesday, September 15, 2010  
 8:00 am Shotgun Start      4 Person Team Scramble

Contests: 1<sup>st</sup>, 2<sup>nd</sup>, & 3<sup>rd</sup> Place Teams / Longest Putt / Longest Drive (Men & Women) / Closest to the Pin  
 Awards will be presented at the Reception at Dove Mountain at 5:30 pm

**REGISTER ONLINE:** [http://www.azhfma.org/events\\_detail.cfm?pk\\_event=56](http://www.azhfma.org/events_detail.cfm?pk_event=56)

Tournament Fees: ( √ your choice)

- G2.  (After 8/20) Foursome with Tee Box Sponsorship - \$515 \_\_\_\_\_  
 Foursome - \$ 440 \_\_\_\_\_  
 Player - \$ 110       (# players) X \$110 = \_\_\_\_\_

**SPONSORSHIP OPPORTUNITIES** (All Options: Signage at golf registration, Recognition at reception)

- G3.  Tee Box - \$150 (Tee Box Sign) \_\_\_\_\_  
 G4.  1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup> Place Prize Money - \$400 (Presenter at reception) \_\_\_\_\_  
 G5.  Longest Drive - 2 contests @ \$100 (Designated Tee Signs) \_\_\_\_\_  
 G8.  Raffle Hole - \$150 (Conduct contest at designated hole. Provide prize) \_\_\_\_\_  
 G9.  Lunch Sponsor – \$500 (\$10 voucher with your company logo on it.) \_\_\_\_\_  
**Total Due** \_\_\_\_\_

**On the Day of the Event:** Raffle Tickets will be sold for great prizes! If your company would like to donate a prize, please contact us at 602-494-4230. A sign at the golf registration will highlight your donation.  
Mulligans can be purchased @ \$5 each or 5 for \$20 (maximum)

### Final Deadline – Thursday, September 7th

Player 1 Name \_\_\_\_\_ e-mail or phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Foursome Name (optional) \_\_\_\_\_

Player 2 Name \_\_\_\_\_ e-mail or phone \_\_\_\_\_

Player 3 Name \_\_\_\_\_ e-Mail or phone \_\_\_\_\_

Player 4 Name \_\_\_\_\_ e-mail or phone \_\_\_\_\_

**Checks payable to:** Az HFMA      **Mail Registration and Payments to:** Az HFMA, 10221 N. 32nd Street - Suite D - Phoenix, AZ 85028

**Credit Card Payment:**  Visa     Mastercard     American Express

Credit Card #: \_\_\_\_\_ Exp Date: \_\_\_\_\_ Security Code: \_\_\_\_\_

Cardholder's Name (print): \_\_\_\_\_ Signature: \_\_\_\_\_

Cardholder's Billing Address: \_\_\_\_\_

**FAX Registrations to:** 602-996-2330; For Questions and Further Details Contact: Linda Cherner @ 602-494-4230

Golf Attire: Shirts tucked in with collars, Non-denim golf slacks or shorts, Hats worn forward position & golf shoes with non-metal spikes.  
 Cell phone use is discouraged in indoor clubhouse common areas.

## Repairing the Revenue Leak: Integrate Disparate Revenue Processes

Ken R. Cassell, MBA, Sr. VP Business Development – SW Region, The White Stone Group, Inc.

Pressure is mounting on hospitals to increase efficiency, improve margins and support revenue-driving functions. The White Stone Group, Inc., enhances financial strength and operational performance for healthcare providers by delivering software solutions that track communication across the continuum of care.

The company's Trace system captures phone, fax and electronic communication for use in revenue cycle management. Trace captures activity surrounding scheduling, registration and authorization and indexes records for efficient processing, routing and retrieval. Results are improved outcomes in efficiency, compliance and reimbursement.

### **Scheduling.**

Physician orders and booking requests present a challenge to many hospitals. Paper processes place a strain on throughput, productivity and storage. Without a central intake area, orders are easily misplaced or sent to the wrong locations. While scanning systems provide electronic copies, storage solutions don't always prevent records from being moved, deleted or duplicated in multiple folders.

An alternative is a paperless process that routes all faxes through a web-based tracking system. With Trace, orders are indexed by patient and routed to appropriate clinical areas for service. By archiving faxes, hospitals have eliminated the need to request re-faxes of missing orders, improving physician satisfaction and streamlining patient throughput.

### **Patient Registration.**

Registration staff often struggle to keep track of accurate patient data. Documents such as insurance cards, out-of-pocket information and procedure instructions are filed in multiple work stations or misplaced all-together. If brought into question, the hospital sits on the losing end of the he-said, she-said battle.

Hospitals can use Trace to capture and store regis-

tration records. Phone calls, faxes and images are digitally recorded, indexed by patient and archived in a searchable web database for retrieval system-wide. By reducing time spent managing paperwork, staff collect more information on the front-end to ensure accurate payment for service.

Once captured, records can be used as evidence of instructions provided for scheduled procedures, resolving conflicts with physicians and patients. Hospitals can also increase self-pay collections by documenting calls related to patient financial responsibility.

### **Pre-Authorization.**

Hospitals spend valuable resources working to notify and secure authorizations from varying payer organizations, each with their own set of processes and criteria. In the end, evidence is hard to find and often insufficient to defend against denials. Trace documents each step of the authorization process to level the playing field with payers.

Hospitals use Trace to record, index and archive phone calls surrounding authorization. If a denial is issued, the call can be replayed or transcribed as evidence of prior approval. For online verification, screen captures of payer web sites are used as evidence of benefits and eligibility at the time of service. Faxes and their transmission data also document evidence of timely notification. All records are centralized in a single database, searchable by patient, date of service or any other specified criteria.

In addition to reimbursement, Trace streamlines workflow by facilitating data-sharing and notification among departments. The front-end can easily notify the back-end of important records without playing phone tag or faxing paper copies. Telecommuters can access and forward records electronically from home offices. System monitoring and benchmarking also help ensure tasks are completed on time and appropriately for each patient.

*(Continued on page 16)*

# 10 Months and Counting . . .

## New Retirement Fee Disclosure Requirements

### \$153 Million Cost to Comply

Pension Trend

#### Executive Summary:

- Department of Labor (DOL) regulations issued July 2010 and effective July 16, 2011 require sponsors of Defined Contribution (401(k), Profit Sharing, etc.) and Defined Benefit plans to report provider fees to participants.
- Most sweeping change to ERISA Section 408(b)(2) since its inception.
- Changes include enforcement provisions which can result in prohibited transaction excise tax and penalties.
- If organization sponsors a plan which does not “technically qualify” under 408(b)(2), is “best practices” to use 408(b)(2) as benchmark for vendors?

#### Background:

- The Employee Retirement Income Security Act

*(Repairing the Revenue Leak continued from page 15)*

Today’s complex healthcare environment involves countless interactions with physicians, patients and payers. Documentation strategies that rely on paper-driven, manual processes no longer fit the bill for today’s fast-paced work environment. Revenue cycle teams need tools to streamline and document administrative data for improved throughput, productivity and reimbursement.

The company’s Trace platform captures and indexes healthcare communication for use in revenue cycle management. Nearly 400 hospitals nationwide are already using Trace to protect revenue, prove compliance and drive performance. For more information, visit [TraceCommunication.com](http://TraceCommunication.com).

*Az HFMA would like to thank the White Stone Group for their support as a conference exhibitor.*

(ERISA) requires plan fiduciaries, when selecting and monitoring retirement plan services and plan investments, to act prudently and solely in the interest of the plan participants and beneficiaries.

- Plan sponsor must ensure that arrangements with service providers are “reasonable” and that only “reasonable” compensation is paid for services.
- New regulation requires written disclosure of: who are service providers, fiduciary status, fees, services, etc.
- Delayed effective date was designed to allow sponsors ability to negotiate and receive written contracts as required.
- Fees also need to be disclosed to plan participants, detail of disclosure format to be published later in 2010.

#### Parting Comments:

- DOL estimates first year costs attributable to reviewing and analyzing service providers and the regulation to be \$153 million, \$37 million in the second year.
- “Push back” expected from insurance industry
- Many sponsors are looking to benchmark and RFP current vendor today so as to not be disclosing fees to their participants which could cause concern “who was watching this on my behalf?”
- PensionTrend, as an ERISA Section 3(21) and 3(38) fiduciary, can guide sponsors though these new and yet uncharted waters.

*Az HFMA would like to thank Pension Trend for their support as a conference exhibitor.*

## Healthcare Reform Squeezes Hospital Revenue Cycles, Creates Opportunity

Chris Snyder, H & R Accounts, Inc.,  
Linc Fish, Benchmark Revenue Management

Everyone knows monumental changes are taking place in the healthcare industry. Particularly in the aftermath of the past year's intense legislative and political attention, hospital executives everywhere are trying to determine what the new slate of reforms will mean to their bottom line and how they can best prepare their organizations.

As always, with change comes opportunity. We believe the hospital revenue cycle remains the core driver of any hospital's financial health, and therefore, our answer points directly at making the revenue cycle transparent and efficient. This allows a hospital to not only maximize its net revenue, but also to free up additional resources that can be better devoted to actual medical treatment. Transparency and efficiency, however, have become such buzzwords that they have all but lost their meaning. Perhaps we can find it again.

**Transparency.** Revenue cycle transparency has been trivialized to mean any sort of reporting on revenue cycle metrics. A truly transparent revenue cycle is one that not only includes indicators on virtually any financial and productivity metric, but also allows drilling-down to the raw data to reveal the source of any issue. Far too often, we talk with revenue cycle professionals who know "in their gut" they have an issue, but the lack of transparency of their own data means it does not come to the surface. It is not enough, for example, to know that we "have a lot of coding-related denials." We need to know specifically which denials, what coding errors, and which coders are at the bottom of the issue. That's transparency, and that's what allows for real change.

Achieving transparency generally involves extracting your data and working with it outside of your current system. There are several options, but very few current patient accounting systems allow for true transparency through their reporting methodologies.

**Efficiency.** Just working effectively isn't enough. We can process information and handle claims very effectively, but unless we are documenting appropriately, prioritizing everything we touch, and doing it at a cost that makes sense, we are not working efficiently. It is quite common to see staff doing excellent follow-up work on certain accounts, while other accounts with a higher value and probability of return sit and wait for attention - sometimes not even touched before they become obsolete.

Working efficiently may –counter-intuitively—mean working fewer items. That's right: do less work. But work the right claims, work them thoroughly and effectively, and your net revenue yield will grow. By knowing which accounts to focus on, you can also drive down your cost-to-collect. For example, prioritizing work not by balance or alpha-split, but instead by taking into account the potential cash collection of each item, allows you to do an automated cost-benefit analysis on which claims to focus on. Given the chance, most PFS Directors would rather follow up on a \$50,000 item with an 80% chance of successful collection than a \$100,000 item with a 20% chance. That type of information is already in your data, waiting to be collected and used.

Achieving transparent and efficient revenue cycle is critical to any hospital that intends to survive the future of financial healthcare markets. Even hospitals whose balance sheet currently appears healthy will be squeezed and therefore must prepare by implementing revenue cycle stabilization strategies. Transparency and efficiency will ensure that the hospital's mission, as well as its business, survives long into the future.

*Az HFMA would like to thank H & R Accounts for their support as an annual sponsor.*

## Healthcare Reform... the provider's perspective

MRA

With President Obama's signing of the Patient Protection and Affordable Care Act and the Health Care & Education Reconciliation Acts in March, a new landscape of the U.S. healthcare system emerged. This historical law immediately triggered policy changes aimed at expanding access to healthcare coverage, and sparked uncertainty among healthcare providers as to the future impact of these changes.

**The following information focuses on a few key areas of reform that will have lasting impacts on healthcare providers.**

### TIMEFRAME FOR IMPLEMENTATION:

**While most of the reform provisions impacting providers will occur in phases over the next few years, take note of these immediate changes that may impact your bottom line:**

- o **Payment Cuts:** The new law reduces market basket payment updates for hospitals, inpatient rehabilitation facilities, nursing homes and others by 0.25%, beginning in April 2010.
- o **Expanded Coverage Options:** A new directive provides immediate assistance for the uninsured with pre-existing conditions, and mandates that individuals may be covered through parents' insurance up to age 26 (beginning September 2010).
- o **Waste, Fraud and Abuse:** Medicare claims submissions are reduced to one year from the date of service, for services rendered after Jan. 1, 2010.

### MEDICARE PAYMENT CUTS:

**Hospitals are positioned to lose an estimated \$155 billion over the next 10 years in cuts to federally funded Medicare programs.**

- o As of April 2010, the new law began reducing hospital market basket updates (a fixed weight index used by CMS to set payments) to provider payments under Medicare to account for productivity improvements in hospitals.
- o Medicare and Medicaid Disproportionate Share Hospital (DSH) cuts begin in 2014, which require Health and Human Services (HHS) to update Medicare hospital payments to account for hospitals' uncompensated care costs in relation to increases in the number of insured patients.
- o The new Medicare cuts begin amidst the Centers for Medicare and Medicaid Services (CMS) regulatory offset regarding Inpatient Prospective Payment System (IPPS) payments, which will be reduced by

6 to 8 percent over the next few years, beginning in 2011.

### EXPERIMENTAL DELIVERY METHODS:

**The new legislation employs experimental methods designed to make the healthcare delivery system more cost-efficient.**

- o There will be a 5 year "pilot project" on bundled payments to providers for 10 commonly used conditions to be selected by HHS Secretary.
- o Accountable Care Organizations (ACO's) enhances payment for primary care services and encourages providers to join together to form ACO's to gain economic efficiencies and to improve quality of care.
- o Beginning 2013, the Department of Health and Human Services (HHS) will reduce Medicare hospital payments for preventable readmissions for certain high volume or high expenditure procedures. In 2015, the new reform mandates a reduction in Medicare payments to hospitals ranking in the top 25th percentile for rates of certain hospital-acquired illnesses

### HEALTHCARE REFORM FACTS:

- o The new law adds 32 million Americans to the ranks of the health insured. Congress estimates that costs for reform will exceed \$938 billion over the next decade.
- o New regulations will prohibit insurers from restricting annual and lifetime limits.
- o Reimbursement for primary care services will increase through the expansion of state Medicaid programs.
- o A new individual and employer mandate will compel all Americans to obtain coverage, or face a monetary penalty.

### ABOUT MRA:

- o MRA is a leading third party billing company that maximizes results for healthcare providers and their patients by focusing exclusively on accident and complex claim management.
- o MRA serves more than 300 Hospitals across the United States, processing over \$1 Billion annually.
- o For more information, call 877-324-2722 or visit [www.MRAresults.com](http://www.MRAresults.com)

*Az HFMA would like to thank MRA for their support as a conference exhibitor.*

# Top 10 Things Hospitals Need to Know About Health Reform....But Were Afraid to Ask

Susan DeVore, President and CEO, Premier

## 1. Understanding Financial Implications

Hospitals should take steps now to either build impact calculators themselves, or work with a consultant to do so.

## 2. Doing More With Less

Although reimbursement increasingly will be tied to performance, all hospitals will have to absorb cuts. Taken together, analysis indicates hospitals need to cut Medicare expenses by 10 percent just to preserve today's margins.

## 3. Optimize Revenue Cycle, Labor and Supply Chain

In labor, hospitals need to invest in automation and process improvements to ensure employees are performing to the "top" of their licensure and operating efficiently. In supply chain, hospitals need to drive down prices through group purchasing, and take a critical look at supply utilization.

## 4. Moving Patients from Self-Pay to Covered

Hospitals need to train staff to understand the variety of public and private options, and help patients enroll as soon as they are eligible and before services are provided, if possible.

## 5. Quality is Job #1

Because payment cuts for events like hospital-acquired conditions are levied against those in the bottom performance quartiles, hospitals need a clinical comparative database to assess how they measure up. They may also need solutions that enhance quality and safety, such as electronic infection surveillance or quality measures reporting tools.

## 6. Transparency

Hospitals need to start measuring themselves to ensure public reports indicate high quality and cost-effectiveness and prepare for transparency provisions such as comparative effectiveness research.

sions such as comparative effectiveness research.

## 7. Dealing with Infections

Hospitals may be assisted in this effort using an electronic infection surveillance system, training clinicians on the use of evidence-based care, as well as correct documentation and conditions that are present on admission, etc.

## 8. Physician Alignment

Hospitals and physicians need to be on the same page before embarking on clinical quality or process changes.

## 9. Moving From Volume to Value: ACOs

work must begin now to develop care networks, payer partnerships and other capabilities necessary to evolve from volume to value.

## 10. Obtaining HITECH Funding and Qualifying for Grants and Pilots

Although not a part of reform, funding for health information technology (HIT) will enable hospitals to achieve quality, safety and cost goals. To qualify for funding, hospitals need implementation plans that fit within the government's overarching vision, while addressing the business relationships, processes and technology platforms that work best for unique local networks.

Premier, a performance improvement alliance of more than 2,300 U.S. hospitals and nearly 70,000 other healthcare sites working together to achieve high quality, cost-effective care.

To read the entire article in its entirety, visit <http://www.hfma.org/Templates/InteriorMaster.aspx?id=22138>.

*Az HFMA would like to thank Premier for their support as a conference exhibitor.*

This *Special Edition of the Cactus Clarion* is being published prior to the Fall Conference showcasing articles about Reform written by companies who support the Conference and the chapter. *The Cactus Clarion* is published quarterly through the program year (June through May). Submit articles to Tim Robertson, Editor, at [tim.robertson@adreima.com](mailto:tim.robertson@adreima.com). Jim Hammond is the Copy/Proof Reader for this publication.

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Please contact the chapter office at 602-494-4230 for more information regarding advertisement format, specifications and rates.

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