



# first illinois speaks

A Newsletter from HFMA's First Illinois Chapter

February 2005

## beyond the numbers

### INSIDE:

Highlights and Recap  
First Illinois Chapter Events

A review of the  
REGION 7 SYMPOSIUM  
October 21-22, 2004  
and the  
First Illinois Chapter

Revenue Cycle Seminar  
November 18, 2004

# Blue Cross and Medicare Cost Finding Differences

## Gold Mine or Land Mine?

BY BILL COSGROVE, TONY LEONE AND MIKE NICHOLS

Illinois hospitals have been required to file Blue Cross Cost Statements and Medicare cost reports for decades. The purpose of both documents is to provide a consistent mechanism

to determine and report costs, as defined by the rules of each program. The Blue Cross cost statement focuses on the determination of inpatient Blue Cross cost, most often expressed in terms of an overall per diem cost amount. In developing the inpatient costs, emphasis is also placed on identifying and "carving out" outpatient costs.

Alternatively, the Medicare cost report is used to develop both the inpatient and outpatient Medicare costs, further delineated by type of service (acute; psychiatric; rehabilitation; skilled, etc). Since most providers and provider components are not reimbursed on the basis of reasonable costs, the role of the Medicare cost report is changing, but remains a

powerful tool to provide CMS with significant comparative data.

Although more complex in many ways, the Medicare cost report has been a relatively static document over the last two decades.

The relationship between the Blue Cross and Medicare cost reports is significant because Blue Cross auditors like to use the Medicare report as a basis of their own cost finding determination. This represents a challenge to many hospitals because there are significant differences between the use of the reports, as well as the underlying regulatory or contractual basis for the cost finding process. As noted above, the Medicare report is used across the nation for all Medicare certified

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## President's Message

### Greetings and Best Wishes for 2005.

There has never been a more challenging time to be a healthcare leader. The cost of healthcare is skyrocketing and healthcare budgets are being reduced in states across the country. Quality of care and patient safety are becoming even more pressing concerns. The cost of employer-sponsored health insurance continues to rise at double-digit rates in 2005, far exceeding growth in employees' incomes.

Employers and employees continue to grapple, as they have for several years now, with whether and when they can expect relief from the rapid growth in health insurance premiums. The reality is that unless strong steps are taken to lower the high rate of healthcare spending growth, relief is unlikely. The dominant driver of private health insurance premiums is the underlying spending trend for medical services typically covered by health insurance, such as medical technology, hospital services, physician services, and pharmacy costs. While spending growth for these services slowed in both 2002 and 2003 after peaking at 10 percent in 2001, spending continued to outpace growth in the U.S. economy by a considerable margin. Research has shown that if health care costs rise at a significantly faster rate than incomes, more people will become uninsured. In fact, the gap between trends in health care costs and incomes is the most important factor behind the long-term trend toward a smaller proportion of people having private health insurance.

How do we combat and control costs? Employers have responded by shifting more health costs to workers, particularly through higher patient cost sharing under benefit models such as Consumer Driven Health Plans (CDHP). These models are designed to more effectively engage the consumer in the purchasing, cost and utilization of their healthcare services. At the same time, more employers are embracing disease management programs that can show results over a period of time, through the use of Predictive Modeling techniques. The premise of Predictive Modeling is that if you find the right people and intervene before they reach acute crisis, costs can be better managed. For disease management programs to be effective, employees will have to take ownership of their health, aided by their employers providing incentives.

As HFMA members, we are dedicated to expanding our professional education and preparing to meet our industry's challenges. I look forward to meeting those challenges with you!

Martin D'Cruz, FHFMA  
President  
First Illinois Chapter HFMA



## First Illinois Chapter News, Upcoming Events & Committee Updates

### Managed Care Committee

The Managed Care committee meets in the HFMA boardroom at 7:30 AM the third Friday of every month. The committee is responsible for planning the annual Managed Care Conference, and this year we have also invited special guest speakers to speak to the group on relevant and current topics. On October 15, Ken Maginot, Partner with Mercer Human Resource Consulting presented on current employer trends and the economic impact of projected and incurred healthcare spending increases. Ken provided valuable insight and his time was appreciated by the committee.

For the annual Managed Care Conference, the 2005 theme centers on the healthcare purchaser. The title of the conference will be "Managed Care Innovations – The New Era in Healthcare" and we will have speakers from all aspects of healthcare (employers, purchasers, healthplans, and providers). The conference will provide valuable insight into the new trends in managed care contracting and provide each participant with a unique view from the

purchaser and plan perspective. For more information, contact committee chairs Todd Anderson at [todd.anderson@ahss.org](mailto:todd.anderson@ahss.org) or Phil Kamp at [pkamp@valence-health.com](mailto:pkamp@valence-health.com).

### Medical Groups and Physicians Committee

This year's Medical Groups and Physician's program is titled: "Solutions – for Today's Most Pressing Issues Facing Physicians, Medical Groups, and Healthcare Organizations." The program will be held Thursday February 17 at the downtown offices of Gardner, Carton and Douglas. Watch your mail for more information and registration details.

Learn about issues affecting your organization's access to the capital markets with findings from the HFMA "Financing the Future" series; obtain a legal issues update; consider whether non-profit hospitals deserve their tax-exempt status; learn about charity care uninsured class action litigation, and Medicare and discount policies, and examine medical staff issues and disputes. And if that's not enough, hear a lead-

*continued on page 3*

### Online registration – Try it, you'll like it!

Have you visited the First Illinois HFMA website lately? Now you can register online for education programs. Janet Blue, Registration Chair, reports that currently only 1% of registrations are received via the web, but she would love to see that number increase – no problems reading handwriting, easily accessible, not to mention less work for both the program attendee and the registration team!

To register via the Website, go to [www.FirstIllinoisHFMA.org](http://www.FirstIllinoisHFMA.org) and click on "Calendar." For each upcoming program you'll find a choice of "Paper Registration" or "Web Registration." If you have any questions, please contact Janet Blue at (630) 916-1166 ext. 120, or [janet.blue@csistaff.com](mailto:janet.blue@csistaff.com)

## First Illinois Chapter News, Upcoming Events & Committee Updates *continued from page 2*

ing hematology/oncology specialist and Director of Outpatient Services discuss impact of chemotherapy drug price reductions, and how the choice of setting will affect practice expenses.

Please join us for a day of significant updates on today's most pressing issues facing physicians, medical groups, and hospitals. If you have any questions or input for the committee, please contact Committee Chair Elaine Scheye at [elaine\\_scheye@thescheyegroupltd.com](mailto:elaine_scheye@thescheyegroupltd.com).

### Accounting and Reimbursement Committee

The Accounting and Reimbursement Committee's annual education program, "Who Moved my Cheese" was held at the William Tell Holiday Inn in Countryside on January 13th, 2005. This year's session was once again an unparalleled professional development opportunity. Whether you are struggling with constantly changing regulations, balancing limited resources or striving for ways to manage increasing charity care, our program had an applicable session for you.

Attendees had the chance to expand their interaction with the best and brightest healthcare leaders, while thinking outside organizational limitations. They heard from distinguished speakers on topics ranging from treating the uninsured and underinsured to the impact of Sarbanes-Oxley on not-for-profit health care organizations, along with a wide array of regulatory and government programs updates.

Congratulations to the committee for developing another great program! You can reach committee chairs Patt Marlinghaus at [patt\\_marlinghaus@rsh.net](mailto:patt_marlinghaus@rsh.net) or Brian Katz at [brkatz@deloitte.com](mailto:brkatz@deloitte.com).

### Membership Relations Committee

The First Illinois HFMA Membership Relations committee communicates with all new and transferred-in members, telling them of our activities and committees that they might want to join. We encourage members to be active within any of our committees. We send each new member a First Illinois HFMA Membership directory, and call new member to see how HFMA can assist with their professional career through their involvement within HFMA.

We are proud to report membership growth for the First Illinois Chapter since 2000:

2000 – 1,115 members  
2001 – 1,090  
2002 – 1,111  
2003 – 1,118  
2004 – 1,175

We always welcome any member who wants to join our committee. It's a great way to get to know more of your fellow healthcare financial professionals in the Chicago area. Please contact Al Staidl: 630-724-1197 or [maris65@sbcglobal.net](mailto:maris65@sbcglobal.net).



Al Staidl, Chair, and Paula Dillon of the Membership Committee. Not shown: Jason Almiro, Kevin Fitch, Larry Kloc, Len Pishko, Michelle Holtzman.

## A Special Thank You to the Sponsors of First Illinois HFMA

Promoting professional education is a key reason HFMA exists. Educational costs continue to rise annually, but thanks to the generosity of our sponsors, the First Illinois chapter has been able to continue to offer excellent programs at reasonable cost. We want to thank these sponsors for their support in helping the chapter serve our members.

The First Illinois sponsors have been a sensational group to work with. They have readily come forward to participate in our sponsorship program. We ask you to join us in recognizing and supporting these organizations.

Thank You . . . Thank You . . . Thank You

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### Chapter Audit – A Clean Bill of Health for First Illinois

The Board of Directors of the First Illinois Chapter of HFMA engaged the public accounting firm of Arnold N. Schorn & Co. to complete a financial audit of the financial operations for the fiscal year ending May 31, 2004. The engagement also provides for Schorn & Co. to complete the audit for fiscal years 2005 and 2006.

The audit reviewed our chapter's financial position and statements in accordance with generally accepted auditing standards in the United States. After a thorough review of the financial

statements and procedures, First Illinois Chapter of HFMA received a clean bill of health from the auditors, stating that in their opinion, the financial statement represents fairly, in all material respects, the financial position of the chapter.

### Update – New Education Program location

Have you been to the William Tell Inn yet? The Facilities Oversight Committee, led by Chair David Golom, FHFMA, selected the new location for several of this year's education programs, based on feedback from

*continued on page 14*

# The Charity Care Controversy

## Two HFMA Members Question Ambiguous Government Policies, Clarify Some Issues

BY CHARLES MACKELVIE AND JAMES UNLAND

**Q** What are the core elements of this multifaceted controversy from the points of view of those accusing hospitals of wrongdoing?

**Unland:** In my conversations with city councils to county boards to community groups to state legislatures to Congress and, of course, to the tobacco class action lawyers the same three issues come up consistently: (1) accusations that hospitals over-price or price discriminate to the uninsured, underinsured and medically indigent by virtue of charging what we all know as the 'chargemaster' price; (2) accusations that some hospitals fail to inform people about the availability of charity care or otherwise make the process of obtaining charity care unduly burdensome and; (3) accusations that collection policies and procedures are overly harsh.

**MacKelvie:** I think Jim would agree that none of these constituencies appreciate the intricacies of hospital reimbursement issues and the challenges imposed by the Byzantine nature of the Medicare regulations.

**Unland:** The 'comprehension gap' is very wide, no question about it. In mid-summer I brought some community group leaders together with Dick Clarke, President and CEO of the

HFMA, and it became clear that our industry needs to educate communities on what we're all up against in terms of our dysfunctional reimbursement system. But I do think that Dick and some of the rest of us have established to community groups the fact that hospital CFOs and other staff are not out to deliberately harm any patient. And Provena Covenant in Champaign-Urbana actually took the step of forming a joint 'medical debt committee' with the local community group so that community group member can learn first-hand just how complicated these matters are.

**Q** Are there still ambiguities in government policies related to patient discounts, and if so, what are they?

**MacKelvie:** I could write a book on just this, but let me make a couple of short points:

- There is an apparent conflict between the informal comments of CMS and HHS officials regarding the Medicare payment consequences of a hospital providing discounts to all uninsured patients without regard to financial need. Specifically, whether such discounts might adversely affect a hospital's cost-to-charge ratio.
- There is some concern that providing across-the-board discounts to all uninsured

patients, without regard to financial need, might cause the OIG or CMS to question the integrity of a hospital's 'chargemaster,' if no patients end up paying the hospital's full charges.

- In addition, while many hospitals would like to publicly disseminate more information about their discount policies, there is a lack of clarity regarding when the OIG might consider such activities to constitute an advertisement or solicitation, and run afoul of patient inducement prohibitions.

**Unland:** It was crystal clear in the June 2004 teleconference that CMS and OIG don't even totally understand what the other does and have a 'left hand not talking to the right hand' kind of problem. Furthermore, I was discouraged that a top CMS official at the last minute cancelled a planned appearance before the New Hampshire/Vermont HFMA chapter last September. It is hypocritical, putting it mildly, for Tommy Thompson to scold the hospital industry about 'charity care' without moving decisively with the industry at the table to resolve regulatory ambiguities. And, unfortunately, the federal government's unwillingness to do this in some ways puts hospitals who want to resolve these issues in an untenable position when they are attacked by county boards, city councils or Richard Scruggs.

**Q** Are there steps that should be taken regarding pricing and discounting policies for uninsured and underinsured patients?

**MacKelvie:** While the steps that should be taken will depend on each hospital's practices, some important steps include:

- Ensuring that discounts are offered based on each patient's financial needs and that hospital policies are compliant with current Medicare regulations and guidance.
- Ensuring that there is an appropriate process for adequately documenting patient need determinations.
- Ensuring that discounts are not designed to generate business payable by Federal health care programs or likely to influence a beneficiary's selection of the hospital.

**Unland:** It's crucial that every hospital analyze its own resources and the prospective financial impact of such steps, especially the free care and discounting steps. In doing independent 'financial impact analyses' for hospitals I also take pains to interview the patient accounts departments and collections people. Surprisingly, some in-hospital patient counselors say that discounting to the level of, for example, insurance reimbursement might actually increase the real dollar yield in that patients who

believe they are being treated fairly from a 'price' standpoint have a higher likelihood of taking their hospital obligations seriously.

**Q** What are the most important things to do in an independent financial 'impact analysis' pertaining to charity care and discounting?

**MacKelvie:** I think it's imperative for a hospital to draw a big circle around all of the interrelated issues, including making sure that a financial analysis is done in concert with a review of charity care policies and procedures.

**Unland:** I agree. I would add to that that as the financial analysis proceeds, legal and reimbursement expertise needs to be brought into the project. I myself would never recommend a revision of either policies or pricing without a concomitant legal and reimbursement review. Some other items to look at in a financial impact analysis include:

- Historical and recent patient payor mix.
- Historical and recent incurred medical liabilities by patient type.
- Actual collections experience, both on an absolute basis and as a percentage of billed charges, by patient type.

I then construct a financial model within which I can test the financial impact of various assumptions relating to the number of expected patients, charity care cases, partial payment cases, and the impact of varying discounting assumptions to the affected population. In addition, I do an 'operational impact

analysis' to try to hear from the on-the-ground patient encounter personnel how changes can be implemented as well as their ideas, some of which are often quite creative and helpful.

**MacKelvie:** One challenge that Jim and I both have is to get hospitals to involve several different departments.

**Unland:** And to involve their boards, especially the finance committee.

**MacKelvie:** The Medicare regulations and related compliance implications can be so complicated that even inside hospital executives often get, quite understandably, confused. A lot of patience and education is involved, particularly with CEOs and board members who don't deal with these matters routinely.

**Q** At the end of the day, in addressing charity care and discounting, what comes out of the process?

**MacKelvie:** A hospital wants to create a step-by-step policy and an accompanying operational implementation framework that can be approved by its board and announced, within reason, to its patients. I say 'within reason' in that hospitals need to avoid being accused of advertising or solicitation activities that might violate patient inducement prohibitions.

**Unland:** And I can assure everyone of one thing: whatever is done now will need to be updated as both the government and the industry continue dealing with all of this. So, it's important in my view to start with just the 'charity care' issue and that population, within a hospital's realistic resources. Later on, perhaps

broader discounting and differential pricing will become practical and safe, but it's too early to say.

**MacKelvie:** Whatever a hospital does will surely require operational and patient-encounter changes. So make sure that all appropriate levels of management get involved at the right time, particularly when the financial impact analysis that Jim talked about is being done. The kinds of changes we are talking about are not accomplished in a week or two, so be realistic about the overall timetable with respect to both the decision processes and the implementation processes. ☞

*Charles MacKelvie is an attorney with The MacKelvie Law Firm.*

*James Unland is President of The Health Capital Group, and a member of the First Illinois Chapter of HFMA. He can be reached at (800)423-5157 or capitalexerts@yahoo.com*



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## First Illinois Chapter

### 2004 HFMA Revenue Cycle Seminar Revenue Cycle Realities.... The Changing Landscape

BY ELEANOR MICHALEK



Eleanor Michalek,  
Committee Chair

The recent Revenue Cycle Seminar held at the William Tell Holiday Inn on November 18 was very well

attended. The morning presentation focused on what's happening at the state and local level in regards to the uninsured and underinsured. The afternoon consisted of a panel discussion moderated by James Heinking with panelists from key Patient Financial Services leadership at local hospitals. The following are a few highlights from the day.

Carl Pelletieri, Esq., presented an excellent overview of the history on many of the issues relative to the uninsured/underinsured faced by some of the local health systems and how each system responded. He also provided recent census data on the numbers of the uninsured and how this growing population has escalated the growing controversy surrounding the administration of charity care.

Isaac Schreiber, Esq., provided an overview of the many legal components of the hospital collection process and highlighted his suggestions of where facilities should focus their efforts in an attempt to mitigate patient complaints.

Jean Kummerer, Director of Patient Accounts at Advocate Illinois Masonic gave a very engaging presentation of how one facility took the negative press regarding hospital collections and transformed perception by developing a community outreach program. This program involves having members of the community sit on the hospital committee that evaluates charity care requests.

As Program Chair, I want to commend the Revenue Cycle committee members for the excellent planning and great synergy that led to the day's agenda. ☘

*Eleanor Michalek is Director of Patient Financial Services, Provena St. Joseph Hospital Elgin, and Chair of the Revenue Cycle Committee. She can be reached at (847)695-3200 or eleanormichalek@provenahealth.com.*



Panel discussion: Nancy Hermann, Larry Connell, Jim Hobbs, Jean Kummerer, Bret Kleebauer

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## A review of the Region 7 Symposium "Setting the Pace"

BY SARAH G. HULL, HFMA, REGIONAL EXECUTIVE FOR HFMA REGION 7



Oct 21-22, 2004  
Hyatt Regency Chicago

On October 21st and 22nd, close to 200 members from the five chapters in Region 7 of HFMA descended on the city of Chicago for what proved to be a wonderful education and networking opportunity. These individuals attended the Region 7 Symposium, "Setting the Pace", which provided two tracks of education including topics of general interest to finance professionals, such as capital access, patient safety, revenue cycle payment accuracy, supply chain, consumer driven health plans, and developing medical staffs. If these individuals were looking for more specific, nuts and bolts education they were rewarded with topics such as preparation of 990s for non-profits, Medicare wage index and charging rule, APCs, and pay for performance. And, if these individuals were looking for personal growth, they could learn the People First Philosophy, and were able to take the HFMA certification coaching course and sit for the exam on site. All said, there were a lot of opportunities for

learning. At the same time, they were able to visit over 50 vendors to learn about products to assist with them in their healthcare roles, and network with members of their own chapter, as well as four others in Illinois, Indiana and Wisconsin. Joyce Zimowski, the National Chair of HFMA attended the conference, and presented information on the emerging hot topic of providing care to the uninsured. The setting for the conference was downtown Chicago and the ambiance was fast paced, much like the speed of healthcare these days. This observer enjoyed the conference, learned a lot, met many new people, discussed new software and productivity tools available for medical practices, and after all that, took a deep breath upon setting my sights north for home. It was well worth the time and investment to attend, and made me realize that healthcare is ever changing, so we need to be mindful to keep abreast of trends and technology. Region 7 did their part to help me "set the pace."



For those who are unaware, this was the second Regional 7 symposium. The first was held in October of 2001 and was a big success. The committee of volunteers from the Wisconsin, Indiana, First Illinois, McMahan Illini and Southern Illinois chapters of HFMA felt the symposium accomplished their goal of providing national level education with vendor opportunities, closer to home. They agreed to continue to coordinate the symposium every three years. The planning for this year's conference fell primarily on the five Presidents of the chapters: Chris Ergen (WI), Carol Naffziger (IN), Martin D'Cruz (1st IL), Fred Kalsbeek (McMahon) and Loretta Duncan (So. IL). They were assisted by others in their chapters, agreed the conference was a lot of work, but worth the effort. They are in the process of evaluating continuing the symposium in 2007, or earlier. Your feedback is welcome, and encouraged. ☘

*Sarah Hull is Chief Financial Officer of Ministry Medical Group in Wausau Wisconsin, and is the 2004-2005 Regional Executive for Region 7 of HFMA. She can be reached at [hulls@ministryhealth.org](mailto:hulls@ministryhealth.org).*



Martin D'Cruz, President, First Illinois; Jim Heinking, President-Elect, First Illinois; Christine Ergen, President, Wisconsin; Steve Tenhouse, McMahan-Illini Chapter; Carol Naffziger, President, Indiana; and Loretta Duncan, President, Southern Illinois Chapter

# A Prescription for Hospital Pharmacies – Review Your Mark-up Formula

BY FRANCES X. HOLLWECK AND BRIAN SANDERSON

Today's regulatory environment has forced providers around the country to address many issues and processes which have little or no improvement to the bottom line. Hospital pharmacies are no exception. The enactment of the "Medicare Drug Improvement & Modernization Act of 2003" (MMA) will decrease reimbursement for certain drugs while simultaneously changing various coding requirements, placing additional challenges on hospital pharmacies to improve net patient service revenues. As hospital pharmacists and administrators struggle to contain and implement the requisite changes within the Pharmacy department, it is not uncommon for the formulary's mark-up schedule to be overlooked and unchanged for years. MMA will likely provide some organizations with the opportunity to revisit their charge structures in the context of regulatory compliance – with a net patient service revenue upside.

"Injections" is often not granular enough to identify the various types of injections (e.g., Chemotherapy Injections). A look at the various types of pharmaceuticals in your formulary may reveal that additional categories would benefit your organization's mark-up structure.

## Indicators

A key step to identify how your organization's pharmacy mark-up schedule compares to national standards is to prepare some high-level calculations. There are a few industry benchmarks that serve as baseline indicators to measure the overall performance of your pharmacy's charge structure. These indicators, in the form of ratios, can help to identify whether or not your mark-up schedule needs restructuring.

- Ratio of Pharmacy Gross Revenues to Expenses (including salaries and other expenses). Typical range is 3:1 to 8:1.

- Ratio of Pharmacy Gross Revenues per Patient Day (excluding new born days). Typical range is \$200 to \$1000 per day.

- Ratio of Pharmacy Gross Revenues to Drug Expense (include cost of drugs and IV solutions only). Typical range is 4:1 to 12:1.

If the results of your calculations place your organization in the bottom half of these measurements, an opportunity may exist to enhance your mark-up schedule while staying competitive within the market place.

## Compliance

In addition to ensuring that your mark-up formula seems reasonable using the above formulas, it is important to ensure that the mark-up formula is executed properly. It is recommended to test a sample drug population annually, if not quarterly, to determine how well your system complies, and to mitigate lost charges.

Unless your organization utilizes a sophisticated pharmacy system that automatically links cost, or some other baseline, to your mark-up schedule in real-time, chances are that your organization has invalidated your mark-up schedule with yearly "across-the-board" price increases. Typically, the yearly increase in drug acquisition costs exceeds the hospital increases, and you may soon find that your charges do not adequately reflect your costs. This non-compliance can quickly add up to tens of thousands of dollars in lost revenues.

ABC HOSPITAL				
Drug Classification	Cost Tier		AWP	Mark-up Formula
	AWP	To		
Injections	\$ -	To	\$50.00	AWP x 4.40 - 5.20
Injections	\$ 50.01	To	up	AWP x 3.00
Oral Solids	\$ -	To	\$10.00	AWP x 3.80- 4.50
Oral Solids	\$ 10.01	To	up	AWP x 3.5
Liquids	\$ -	To	\$10.00	AWP x 4.70 - 5.00
Liquids	\$ 10.01	To	up	AWP x 3.20
Ointments / Creams	\$ -	To	\$20.00	AWP x 4.70 - 5.20
Ointments / Creams	\$ 20.01	To	up	AWP x 3.20
Oint/Ophth/Inh/Otic	\$ -	To	\$ 9.00	AWP x 3.00 - 4.00
Oint/Ophth/Inh/Otic	\$ 9.01	To	up	AWP x 2.50
Suppositories	\$ -	To	\$10.00	AWP x 4.70 - 5.20
Suppositories	\$ 10.01	To	up	AWP x 3.20
Enemas / Douche	\$ -	To	\$10.00	AWP x 3.20 - 5.00
Enemas / Douche	\$ 10.01	To	up	AWP x 3.00

This is an example of a drug category that is capping the maximum mark-up at AWP x 3.20 for all Liquids with an AWP greater than \$10.01. By altering the dollar limits to \$15.00 and \$15.01, instead of \$10.00 and \$10.01, you could expect to see an increase in revenue. Modeling various scenarios will help you determine the proper tiered structure for your organization.

**Figure 1:** Example of an Actual Pharmacy Mark-up Schedule – While this provider was satisfied with their level of mark-up, a thorough review revealed opportunities to alter the tiered ranges of costs and to increase the number of drug classifications, thus providing greater granularity and control of the charging mechanism. A seven figure net revenue benefit was estimated to result from these changes.

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### Structure

If your next internal review identifies that your key indicators rank in the lower half of those exhibited above and that there is poor compliance with respect to your mark-up schedule, it may be a sign of an ineffective mark-up structure, that is, one that is too difficult or convoluted to follow. Common mark-up schedules utilize various forms of cost (e.g., acquisition cost, weighted average cost, etc.) as the cost basis before applying the mark-up factor. However, Average Wholesale Price (AWP) is quickly becoming industry best practice as it has shown to be more stable over time, and because it can easily be obtained from your local vendor.

A simple yet effective mark-up schedule utilizes AWP as the cost basis for drugs and IVs and classifies drugs by delivery method (i.e., Tablet, Topical, or Injection, etc). For example, "Tablets" may simply have a formula of AWP times 1.5 ( $AWP * 1.5$ ). However, the formula may include a labor component, if necessary. For example, "Chemotherapy Injections" may have a more complex formula of AWP times 4 plus \$10 ( $AWP * 4.0 + \$10$ ) to reflect potential preparation costs. Although mark-up formulas will vary by provider, one message should hold true - a proper pharmacy mark-up structure will reflect the complexity of care provided, yet be simple enough to execute and manage.

### Final Thoughts

Recent media attention has challenged many organizations with their ability to justify prices. Random, across the board price increases which are grounded in "market comparisons" do not provide adequate explanation for the price of certain pharmaceuticals. With charge description masters becoming more transparent to consumers and employers (especially with recent legislation in California), hospitals now need to have a better basis for pricing - and pharmacy pricing is often the first area to be addressed.

No single mark-up formula works for all providers. Depending on the complexity of care provided at your organization and your organization's philosophy on pricing, your mark-up

schedule should be tailored to fit your organization's needs. Identifying where your organization compares to the competition with the help of some simple financial ratios, and performing internal due diligence to determine how compliant your organization is with respect to your mark-up formula, will help you gain perspective into how well the pharmacy mark-up formula is serving your organization. ☞

*Francis Hollweck is Senior Advisor and Brian Sanderson is Senior Manager with Ernst & Young LLP, Health Sciences Advisory Services. Both are members of the Illinois Chapter of HFMA. They can be reached at [francis.hollweck@ey.com](mailto:francis.hollweck@ey.com) or [brian.sanderson@ey.com](mailto:brian.sanderson@ey.com) or [brian.sanderson@ey.com](mailto:brian.sanderson@ey.com).*

**Declining reimbursement.  
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# Founders Merit Awards for 2004

BY BRIAN SINCLAIR, AWARDS COMMITTEE CHAIR

Congratulations are in order for the recipients of the 2004 Founders Merit Awards. National HFMA recognizes that its strength lies in the volunteers who contribute their time, ideas and energy to serve the healthcare industry and their local chapter. The Founders Merit Award program was established to acknowledge the contributions made by individual HFMA members.

This year the awards program was modified by National HFMA. It is still a merit plan, which assigns a range of point values to specific chapter activities, such as committee participation, educational presentations, and serving as a chapter officer. The Follmer Bronze Award is awarded when a member has accrued 25 points, the Reeves Silver Award is earned after an additional 25 points are accumulated, and the Muncie Gold Award is presented after a final 50 points are earned. A fourth award, the Founders Medal of Honor, may be conferred by nomination of the Chapter Board of Directors to qualifying members. This award recognizes significant continuous service after completing the medal program.

The 2004 award recipients are:

#### Follmer Bronze Award

Odin Berg  
Philip Brand, FHFMA  
James Heinking  
Philip Kamp  
Clara Kridle  
Gary Krugel  
Patricia Marlinghaus  
Peter McCanna  
Sandra Mendel  
K. Michael Nichols, CHFP  
Greg Pagliuzza  
Terry Stofferson  
Chester Szerlag

#### Reeves Silver Award

John Brugioni, FHFMA  
Michael Cohen  
Martin D'Cruz, FHFMA  
Donna Gellatly, FHFMA  
Thomas Glaser, FHFMA  
Lawrence Majka

#### Muncie Gold Award

David Golom, FHFMA  
James Lipinski  
Paula Wilke, CHFP

Each of these award recipients will receive a personalized inscribed plaque from HFMA to officially recognize their achievements. The First Illinois Chapter officers and directors also extend their congratulations and appreciation for the support and participation of the award recipients.

Please refer to your chapter membership directory for more information regarding the awards series, scoring details and a listing of all former recipients. If you have any questions regarding the awards or your current point status, please call Brian Sinclair, Chairperson, Awards Committee, at (630)307-9138. ☎

# Make a Commitment to HFMA Certification

BY SUZANNE LESTINA, CERTIFICATION COMMITTEE CHAIR

It wouldn't be "A New Year" without new changes and the HFMA Certification process is certainly full of them. 2005 brings new study guides, certification exams, and certification maintenance responsibilities. As with any change, there are good changes and not so good changes. I would like to take this opportunity to highlight some of the changes that have been put into place.

Let's start with the not-so-good news: the 2003-2004 course materials and exam expires December 31, 2004. Unfortunately, for those of you studying diligently to take the test, you've missed the boat!

The 2003-2004 exam was available only until December 31, 2004. Candidates who were unsuccessful on a 2003-2004 exam prior to December 31, 2004 will be allowed to retake the exam until April 9, 2005, after the mandatory 90-day wait period has been met. The 2003-2004 exams will not be available after April 9, 2005 for any subsequent retakes. Successful candidates completing the course for CPE must meet the minimum requirements and submit all required documentation by January 17, 2005. The remaining inventory of 2003-2004 self-study guides is available at \$100 per course.

*continued on page 11*

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## Make a Commitment to HFMA Certification

(continued from page 10)

The good news is that the 2005-2006 courses are ready. The following 2005-2006 courses are available as of December 8, 2004:

- Core
- Accounting and Finance
- Patient Financial Services
- Physician Practice Management
- Managed Care (*late January*)

The price remains \$295 for the Core program and \$275 for each of the specialties, plus shipping and sales tax, if applicable. HFMA cannot take phone orders. You must complete an order form and send it in with payment for HFMA to process your order.

A few years ago, our chapter purchased several of the study guides to help defray the cost of preparing for the exam to our members. The chapter would like to explore purchasing a complete set of new study guides (core plus the four specialties.) We would appreciate input from the members regarding a want or need for this and how we can ensure the study guides are returned and passed on so that other members can enjoy this benefit.

We are also offering more flexible ways of delivering the exam. You can always schedule your exam with me or the chapter proctors (you can obtain a list of proctors from the National HFMA website at [www.hfma.org](http://www.hfma.org)). You can also schedule your exam date and time directly with National HFMA staff. Staff members are available weekdays from 8:00 am – 5:00 CST. Additionally, National HFMA is offering weekend support for certification testing. This support is available on the follow-

ing Saturdays from 8:00 am to noon CST, and with advance arrangements from a chapter only.

- April 2
- June 18
- October 11
- December 10

Staff support will NOT be available on any other weekend dates.

As a final reminder, remember that certified members are responsible for maintaining their own education record on line for purposes of recording eligible activities toward the certification maintenance requirements. This includes eligible activities attended through a chapter, another professional organization, or an employer. If you attend an educational event sponsored by HFMA National and for which CPE has been awarded you do not need to

record those, as HFMA automatically adds that to your education record. Keep in mind that HFMA reserves the right to audit the education records, so members should retain necessary documentation for the current maintenance reporting cycle. The on-line record is located on the web site at:

[http://www.hfma.org/careers/certification\\_program/certification\\_for\\_m.htm](http://www.hfma.org/careers/certification_program/certification_for_m.htm).

Detailed information about eligible activities and maintenance requirements is also located in a link on this page. In the near future, members will be able to view their contact hour point total to help them track their requirements. The maintenance cycle is a three-year period, ending on May 31 of a given year; the required 90 contact hours must be reported by that date. If

requirements are not met by December 31 of the member's maintenance year, he/she will lose designation and be required to complete the requirements again (including successfully completing the Core and one of the specialty exams) and submit a new CHFP application. However, HFMA will continue to notify candidates who are due to maintain, to ensure the candidates are fully aware of the deadline and consequences of not fulfilling the requirement.

Whew, that's a lot of certification information, and I would love to hear your feedback. If you have questions or are interested in pursuing certification, feel free to reach me at (815) 397-0078 or contact me by e-mail at [s\\_lestina@gustassoc.com](mailto:s_lestina@gustassoc.com). ☎



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“Hospitals should evaluate the impact of proposed cost finding changes both in terms of the settlement impact under the indemnity contract, as well as the change in the per diem cost.”

hospital entities. The Blue Cross cost statement is fairly unique to Illinois. More importantly, the Medicare cost finding principles are based on a history of promulgated regulations, case law, and administrative decisions and rulemaking. By contrast, the Blue Cross cost finding rules are considerably more subjective.

Historically, hospitals received a considerable portion of their inpatient Blue Cross business through the indemnity contract (cost plus 5%) and therefore the Blue Cross cost statement was a significant factor in their overall reimbursement strategy. Presently, the indemnity business has been greatly reduced, with the majority of the Blue Cross business covered under PPO and HMO contracts. Under these PPO and HMO arrangements, the hospitals receive negotiated rates for inpatient and outpatient services. These rates may or may not be tied to some multiple of the Medicare payment for a similar service. Although these claims will be adjudicated at full charges, Blue Cross reduces its actual payments to the provider through the complex UPP system. The mechanics and intricacies of that methodology are not addressed here.

*The real issue is that regardless of the negotiated rate, Blue Cross will evaluate its total payments to a provider against the per diem cost determined through the hospital's Blue Cross indemnity*

*cost report.* The Blue Cross PPO contract contains a clause (often known as the “most favored nations” clause (*Article IV, Section K*) that permits Blue Cross to perform a retroactive re-determination of the amounts payable under the PPO contract. Blue Cross is effectively making a cost-based determination and applying it to the PPO and potentially HMO product lines. Due to the UPP mechanism, Blue Cross has the ability to recoup “excess payments” in future periods. *The pitfall for hospitals is that they are usually unaware of this Blue Cross process until they receive the bill for the re-determination.*

Hospitals should evaluate the impact of proposed cost finding changes both in terms of the settlement impact under the indemnity contract, as well as the change in the per diem cost. This approach should be applied to both cost report filing and proposed Blue Cross audit adjustments. This discerning review should be considered whether the hospital uses the traditional (per diem) or alternative (departmental) cost finding method. Depending on a provider's indemnity and PPO mix, an adjustment that increases the Blue Cross indemnity by \$1,000 may ultimately result in an additional \$100,000 PPO “liability”.

Blue Cross is aware of this situation. On one hand there are

certain issues where Blue Cross takes a hard line and the audit adjustments are not negotiable. However there are other issues where hospitals can prevail to get audit adjustments changed. This may be accomplished by providing additional documentation, or developing logical, supportable positions or identifying errors that Blue Cross may have made. The best time to resolve any issues is before the indemnity cost report is finalized. Alternatively, if Blue Cross pursues a re-determination, as discussed above, proposed resolutions may be presented at that time, but this may not result in the desired resolution.

The list below outlines some of the differences to be considered in evaluating your facilities Blue Cross Cost finding approach. There may be other differences, depending on the specific hospital situation and these should be evaluated for both indemnity and PPO/HMO cost-based determinations.

### 1. Patient Days

The Blue Cross inpatient cost finding ultimately comes down to a per diem amount. Therefore an understanding of patient days used in the calculation represents a critical success factor. Simply, Blue Cross will include all inpatient hospital days. This value will be all the routine, special care and distinct part unit days. Regular nursery, Skilled Nursing, Hospice and Observation Unit days would be excluded. This is simple enough, except that special consideration is afforded to one-day stays, boarder baby days, (pediatric) nursery days and potentially

days attributable to special residential programs (such as adolescent behavioral medicine).

These issues can be resolved by using the matching principle. Basically if the cost in the numerator of the equation is considered allowable, and the days are included in the Blue Cross settlement data, then the corresponding days should be included in the denominator of the equation. These issues may vary between years due to actual hospital operations and billing practices, as well as the actual Blue Cross experience data.

### 2. Expense Groupings/ Cost Centers

*There is nothing that precludes hospitals from using different groupings for their Blue Cross cost statement and Medicare report.* For example Medicare defines capital related costs to include depreciation, interest, rentals, and property insurance. Blue Cross treats depreciation as distinct from the other capital related costs because it is deemed to be 100% inpatient. Many hospitals have benefited from fragmenting the Administrative and General cost centers for Blue Cross and not splitting them for Medicare purposes. However, other hospitals have had the opposite experience.

Generally, Blue Cross will permit a greater number of both overhead and revenue producing cost centers than Medicare. One example is malpractice insurance cost, discussed in detail below. However, once established, it is difficult to collapse both overhead and revenue producing cost centers, unless the hospital can demonstrate that the service no longer exists.

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## Blue Cross and Medicare Cost Finding Differences

(continued from page 12)

There are certain types of cost centers that Blue Cross has taken a fairly consistent position that they should be treated as 100% outpatient, or more correctly non-inpatient cost centers. These include hospital-based skilled nursing facility (SNF); sleep study programs, cardiac rehabilitation, outpatient therapy areas and physician clinics/practices. While these areas would likely be primarily non-inpatient, there is a negative impact associated with the method of allocating the overhead costs between the inpatient and outpatient areas. Some other examples include splitting various diagnostic imaging and surgical services areas based on general ledger groupings. These grouping alternatives may not be consistent with the actual operating structure of the hospital. Blue Cross also considers the ancillary services attributable to SNF patients to be non-inpatient. This is handled through the charge distribution (discussed below).

Another interesting example of cost center combinations is obstetrics/maternity care. Medicare generally requires the obstetrical component to be combined with the adults and pediatrics cost center. Nursery services are a separate "routine" area and the delivery/labor component is treated as ancillary cost center. Many hospitals have benefited from combining these centers and apportioning the costs to Blue Cross based on a departmental charge methodology as opposed to a combination of per diem and charged based apportionment methods. All of these examples depend on the specific hospital situations.

### 3. Expense Adjustments

Medicare expense adjustments fall into the following categories: miscellaneous income/cost recoveries; non-allowable costs; provider-based physicians and related party transactions. Blue cross cost finding addresses consistent categories, but there are important differences.

Medicare requires that general, unrestricted, realized investment income would reduce allowable interest expense. Medicare also treats interest expense arising from certain situations as non-allowable. Blue Cross primarily treats all gross interest expense as an allowable cost. Alternatively, Blue Cross requires restricted (or even designated) grant income to reduce allowable costs, while Medicare does not require this income to be offset.

Medicare treats most public relations/marketing/advertising expenses as non-allowable, while Blue Cross generally recognizes that these expenses recorded under GAAP are necessary business expenses. There may be other categories of cost specifically addressed in the Medicare provider reimbursement manual that need to be removed, and the Blue Cross treatment may vary depending on the specific fact pattern. An interesting future issue may relate to the disposition of the recently enacted Medicaid assessment.

In terms of hospital-based physicians, Medicare treats as non-allowable all physician costs that are either considered direct patient care (Part B services) or non-documented provider component (Part A) costs. Blue Cross correctly applies the matching principle in this area and only

requires offset of those professional component costs where the hospital is billing a professional component charge. Generally, Blue Cross will accept contracts in support of provider component physician costs. Both Medicare and Blue Cross treat CRNA cost as physician compensation.

### 4. Cost Allocation Statistics

Under the Medicare step-down cost finding process any overhead cost center (except depreciation) has the ability to be allocated to any other overhead department, as well as the revenue producing and non-allowable cost centers. Since the purpose of the Blue Cross cost statement is to develop inpatient costs, the overhead cost allocation methodology is somewhat different. As noted above depreciation expense is

treated as a 100% inpatient cost and apportioned to Blue Cross based directly on Blue Cross utilization. This is generally very favorable to providers. Employee benefits and Administrative and General costs may be allocated on FTEs, as opposed to gross salaries and accumulated cost in the Medicare model. Malpractice expense is only allocated to selected ancillary departments where Blue Cross believes all malpractice claims occur. Medicare treats this cost as an administrative cost.

A significant issue related to the cost allocation statistics is the departments to be included in developing the statistical weighting, as well as the overall total, or denominator of the equation. A strong argument can generally be made that off-site departments

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*continued on page 14*

should be excluded from occupancy related statistical allocations, as well as the cafeteria allocation. The discussion becomes somewhat unclear in other areas, such as FTEs and charges. For example, should volunteer equivalent FTES, interns and residents or contract labor be included in the A&G allocation? Should the nursing administration department FTEs be included in the denominator of the nursing administration statistic? Should revenue based statistics be gross or net of professional component charges? How should other revenue producing areas such as HHA and Hospice be handled? These are just a few examples of the areas to be considered.

#### 5. Gross Charges

Gross charges are handled fairly consistently between Medicare and Blue Cross. An important consideration for Blue Cross is the proper segregation of total departmental inpatient and outpatient charges. This segregation will impact both the outpatient cost "carve out" and the Blue Cross inpatient utilization percentage on a departmental bases. For example, should a hospital truly have any outpatient charges in its ICU?

There are other issues related to gross charges. Both programs require professional component charges to be netted. Blue Cross generally requires charges to be "grossed up" (i.e. reference lab situations) when these adjustments are reflected in the Medicare cost report. This seems to be a departure from the long-standing Blue Cross policy of following GAAP. Revenue adjustments made for charge apportionment purposes is not GAAP,

but is specifically required in certain situations under Medicare program instructions. Further, if a hospital is truly self-insured for employee hospitalization, Medicare requires that the days, expenses and related charges be netted from the totals used for cost apportionment purposes. Blue Cross does not follow this treatment. Rather, Blue Cross removes the "profit" by applying the hospital's overall cost to charge ratio to the employee charges booked as expense and removing the difference through a cost offset. This approach may be flawed if the hospital does not record the full charge as expense or if the departmental charge data contains non-employee data. Gross charges represent a key area where the matching principle must be observed in order to achieve an accurate cost finding.

#### 6. Program Charges

Providers using the alternative method need to develop and maintain departmental charge data to correspond with the settlement data used in the cost report. The departmental matching would also include adjustments to remove professional component charges as well as SNF ancillary services. Should the distribution be based on all inpatients identified as Blue Cross, or should the distribution only be based on those patients covered under an indemnity plan code? Should the charge distribution used for the indemnity cost report also then be applied to any PPO re-determination or should a different distribution be used? Since the charge distribution is the basis for apportionment, the challenge is identifying the best data to be used.

#### Gold Mine

This article has demonstrated many ways in which the Blue Cross cost finding differs from the Medicare model. Understanding those differences creates many opportunities for hospitals to approach or maintain reasonable payment levels under both the indemnity or PPO contracts.

#### Land Mine

The result of the audit process on individual facilities may be a wake up call as auditors may make significant adverse determinations regarding the reasonableness and allowable nature of certain categories of cost. Hospitals that are not successful in understanding the differences and using those differences to their advantage may experience significant reductions in reimbursement and increased withholding from their UPP checks. *Hospitals also need to avoid the mistake of not paying attention to small changes in the indemnity settlement and losing track of the impact on the overall per diem as it may relate to PPO and HMO contracts.*

#### Conclusion

Due to significant differences between the Blue Cross and Medicare cost finding methodologies, providers need to give careful consideration to the elections in their filed Blue Cross cost statements. They should also pay close attention to proposed audit adjustments as well as the departmental charge distribution. This is important because the final settlement of PPO and HMO contracts may be linked to the indemnity Blue Cross cost statement. Using this approach may result in more favorable indemnity and PPO reimbursement and protect previously accepted cost finding techniques. ☞

*Bill Cosgrove and Tony Leone are Managers and Mike Nichols is a Director within the Health Care Consulting practice of RSM McGladrey. They can be reached at (847) 413-6900 or by email to [mike.nichols@rsmi.com](mailto:mike.nichols@rsmi.com).*

### First Illinois Chapter News Update – New Education Program Location

(continued from page 3)

members about preferred locations and amenities.

The first program to be held at the new location was the November 18th Revenue Cycle program (see related story and photos in this issue). We are delighted to report that responses from those who attended the program were

very favorable. Attendees gave high marks for both atmosphere and food service.

The William Tell Inn is located at 6201 W. Joliet Road in Countryside, near I-55 and Joliet Rd. Hope to see you there at a future program! ☞



**Healthcare Financial Management Association  
First Illinois Chapter**

**2005 Calendar**

2/17	Medical Groups and Physicians	Full Day	Gardner, Carton & Douglas, Chicago
3/24	Managed Care	Full Day	William Tell Inn, Countryside
5/06	CFO Meeting	Full Day	Location TBD
5/27	Annual Golf Outing	Full Day	Location TBD



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