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healthcare financial management association

First Illinois Speaks

A Newsletter from HFMA's First Illinois Chapter

January 2003

From the President

We Can Make a Difference

create the future

By the time you read this message, the holiday season will have passed. But I would still like to wish each of you a peaceful and joyous year. This marks the half waypoint of my year as President. A moment to stop and reflect on all that has been accomplished and prepare to move toward the future.

So much has already been accomplished this year. Committee chairs have put together great programs that were well attended. The HFMA national chair, Phyllis Cowling and HFMA's president, Dick Clark joined us for a day and had the opportunity to learn a little more about our chapter and our members. We bid farewell to members that moved on to exciting new job opportunities, and welcomed many more new ones. We conducted a survey to find out what we can do better to provide value to our members. (The results will be published in the next newsletter, along with our strategic plan.) We developed and implemented an officer's manual that provides guidance to our chapter leaders today and will support our future leaders. We have 25 members that have received the Follmer Bronze, Reeves Silver and Muncie Gold awards for their work in HFMA. I have had the pleasure of watching members step up to the plate in a time of need and go above and beyond my expectations with their support and dedication. This has been such an incredible experience and I look forward to what we can accomplish together in the future.

I've also had the opportunity to meet members that I did not know very well and they shared their concerns regarding lack of time or ability to affect change. It seems that so many of us today feel overwhelmed by our responsibilities, both personal and professional, that members feel they cannot make a difference. I think each of you can!

I would like to prove that point with a story about a worker that made a difference.

The Monday after Thanksgiving I had to fly out of town on business. For those of you that may recall, it snowed that afternoon, evening and into the next day. Many flights were delayed and eventually cancelled. Travelers ended up sleeping on cots at the airport. I was one of the fortunate ones. I was able to get out that night.

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Enriched Business Intelligence Stimulates Revenue Cycle Management

"...modern health care is the most complex activity ever undertaken by human beings."

Ken Kizer, MD, MPH, President and CEO of the National Quality Forum

When Ken Kizer reflects on healthcare quality and quality improvement, is he not also speaking to many of the same factors that make the revenue cycle so challenging?

- Technologies that leave a tangled mass of disparate applications, lacking the ability to communicate and perform
- Widely differing professional backgrounds, experience and training
- Unclear lines of accountabilities and dependencies
- Variable physical settings
- Communication barriers
- Time pressured environment

Background

Simplicity has historically evaded revenue cycle management and, as a result, financial performance continues to suffer. Revenue cycle operations produce an ocean of data. And this ocean is not fed by a single source of data but, instead, is fed by data from disparate internal and external computing sources – credit scores, patient access systems, medical records, charge masters, aged trial balances, and payer electronic remittances to name a few. Effective revenue cycle management demands that these huge amounts of data be retrieved, intelligently searched, analyzed, and distributed.

But in most cases, the critical decisions of operational finance managers are beholden to data that has been cut and sliced for them by information managers. Critical day-to-day information is held in your data "jailhouse." As a result, CFOs report the performance of accounts receivable assets to their Boards using information that is dated and static. Business office operations struggle to get accurate, timely information into the right hands for account follow-up and process improvement. Typically, day-to-day revenue cycle management is based on partial information or information that is several days, weeks or even months old.

The inability to optimize performance of AR, cash collections, denials and write-offs is not for lack of data. To the contrary, healthcare financial professionals have access to plenty of data. What they do not typically have access to is the right information, at the right time, to make the best decisions to benefit the organization. This is an important distinction.

Business Intelligence (BI)

Business intelligence is a set of software solutions that enable people to access the data in a very easy way and to analyze that data and to share it with others. Users of business intelligence applications are able to interact with that data without going through the organization's information technology department. It enables users to break complex situations into manageable projects by analyzing available data to reveal valuable information. Business intelligence gives organizations the power to drill down to the appropriate level of information needed by each user. Of course, the key is not just analyzing data, but transforming that data into a knowledge that you transform into an action that will in the end improve net operating revenue.

Providers who are using enriched business intelligence applications today are realizing robust returns. Some of these returns result from finding "pockets of gold." For example, immediately after implementation of a BI application, an Atlanta-area hospital "found" outstanding Medicare accounts greater than 300 days old, which resulted in a Medicare payment of $100,000. They also identified DRG assignment issues having a potential reimbursement impact of $400,000..

Examples of Business Intelligence/History

Whether by increasing revenues or decreasing costs, business intelligence is being used in other industries to increase profitability. For example, a convenience store executive analyzes sales trends of diapers and looks for related products whose sales closely followed diapers. She is surprised to find that one is beer. Interviews with customers determine that wives are sending their husbands out to pick up diapers for their babies. While the husbands are at the store, the urge hits them to pick up a six-pack or two. So now you know why you may find diapers and beer placed closely together at convenience stores.

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From the President (continued)

I had called ahead and learned that my flight was delayed so I anticipated there would be a delay. However, I was unprepared for the mass confusion at the airport because apparently it wasn't just my flight but every single one of them that was affected by the little harmless snowstorm! Incidentally, I was traveling with my young daughter.

After several hours and several gate changes in the extremely long United terminal, the natives were getting quite restless. And then something happened. A United gate attendant got on the intercom and asked everyone in the waiting area if we could all agree to be nicer to each other. He observed that no one, including himself, wanted to be there, so couldn't we all try to be nice to one another. I don't know what prompted him to do this, but something interesting happened. The waiting area got a little quieter. About 10 minutes later the same United worker got on the intercom again and asked everyone waiting if they wanted to guess the answer to a riddle. He said he would give a prize to the person who guessed first but that you had to raise you hand and walk up to the counter and if you shouted the answer out, he was going to rebook you in a middle seat on a flight going out next week! Many people laughed and eventually someone solved the riddle and gave him the answer. The customer's prize was a United Airlines $25.00 gift certificate. Well, that just made everyone in the waiting area laugh and something interesting happened. The passengers begin casually chatting, becoming friendlier and beginning to relax.

About 10 minutes later the same United attendant got back on the intercom and asked if there was anyone in the waiting area that would sing "The Sun will Come Out Tomorrow" for a prize. Someone yelled out "not for a United gift certificate," and everyone laughed again. The United attendant said, "Not this time, I'll give the volunteer $50.00 cash". A few minutes later a young lady of about 15 came up to the counter to sing. People around me said "oh how cute." Then she started singing and suddenly, the entire gate area became so quiet you could have heard a pin drop. This young lady had an incredible voice and when she was done singing, there was a moment of silence and then everyone in that waiting room burst out in applause. In a way, the sun did come out. People were actually being courteous. A gentleman offered me his seat, people shared stories and wished each other well and for the rest of the time we waited, the waiting area atmosphere was friendly and calm.

One United employee took a look at his work environment and decided he needed to change it. One person was not daunted by the task before him, and took the initiative to make a difference. He couldn't change the weather, he couldn't bring the planes in any faster but he could change how everyone was going to deal with a difficult situation. His decision to have a positive attitude affected everyone in that waiting room and changed the direction we were all heading.

You see one person can make a difference. Each member of this chapter has the ability to affect change. All it takes is the decision to start, and the knowledge to know that your participation and contribution will add value to this organization. You can affect the future of this organization. Join me in helping to successfully accomplish our goals to move our chapter into a better future.

Suzanne Lestina
HFMA President

Founders Merit Awards for 2002

By Brian Sinclair, Senior Vice President, Financial Resources Initiatives, Inc. and Chairperson, Awards Committee

Congratulations are in order for the recipients of the 2002 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.

These awards are part of a merit plan, which assigns a range of point values to specific chapter activities, such as meeting attendance, committee participation, educational presentations, and serving as a chapter officer. A maximum of 40 points can be earned per year with no carryover. The Follmer Bronze Award is awarded when a member has accrued 100 points, the Reeves Silver Award is earned after an additional 100 points are accumulated, and the Munice Gold Award is presented after a final 100 points are earned. A fourth award, the Founders Medal of Honor, may be conferred by nomination of the Chapter Board of Directors. This award recognizes significant continuous service after completing the medal program.

The 2002 award recipients are:

Follmer Bronze Award	Reeves Silver Award	Munice Gold Award
Tom T. Chan FHFMA, CPA	Lawrence K. Connell, CHFP	Laurence S. Appel, FHFMA, CPA
Jonathan H. Kaplan	Loren W. Foelske	Jane M. Bachmann
Katherine B. Lenhart	Karen L. Hackett, FHFMA	William Laddison Waldo, FHFMA, CPA
Mark E. Mitchell, CPA	Q. Jerry Jawed, FHFMA	
Steven M. Perlin	Phillip D. Johnson	
Elizabeth R. Propp	Suzanne K. Lestina, CHFP	
Stephan P. Pyrcioch	Eric S. Lundahl	
Sydney P. Scarborough	Leonard A. Pishko	
Jason H. Sussman, CPA	Thomas J. Rehak	
	Randy Ruther, FHFMA, CPA	
	Charles L. Stanislao	
	James M. Warner	
	Paula T, 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.

The IPA / PHO Risk Dilemma:

A Survey of the Chicago Market

By Elizabeth Simpkin and Karen Janousek

An expanded version of this survey will be published in an upcoming issue of the Journal of Health Care Finance. First Illinois member Jim Unland, President of the Health Capital Group and Editor of the Journal of Health Care Finance, has made available a pre-publication full version for HFMA First Illinois Chapter members on the web site: http://www.capitalexperts.com/JournalArticles.htm.

Like other markets across the country, the managed care market in Chicago is experiencing rapid change. Rising medical costs, increased consumerism, financial failures and changing payer and provider relationships are combining to create an atmosphere of great uncertainty. Capitated enrollment has declined since 2000; and while the dominant HMO in the market continues to contract only on a full-professional risk basis, other HMOs appear to be moving away from capitation. Physician organizations established primarily as vehicles to access and manage capitation contracts are looking for new ways to provide value to their physician members. Physician Hospital Organizations (PHOs) in particular are reassessing how the organization can continue to serve the interests of both the physicians and their hospital partners. Given the overall decrease in HMO enrollment, providers are wondering whether to continue to invest in infrastructure to manage risk. They are also concerned about their ability to continue under risk contracting without capitation increases. In this atmosphere, we undertook a survey of Chicago physician organizations to examine the issues they face.

Chicago Market Survey

To better understand issues facing physician organizations – IPAs, PHOs, Medical Groups and hospital owned entities – The Lowell Group conducted a survey of Chicago area physician organizations. Executive Directors of 23 Medical Groups, IPAs and PHOs and two MSOs were surveyed during April and May, 2002. The executives surveyed represent a cross-section of provider entities in the Chicago metropolitan area, including city and suburban locations, and varying ownership models. Together, the survey respondents represent over 400,000 covered lives. (see Figure 1).

Top issues for Physician Organizations

Survey respondents were asked to look ahead for the next one to three years to identify the most pressing issues facing physician organizations in Chicago. While many issues were mentioned, there was substantial consistency around three issues.

Issue One – Financial health of the organization

All organizations surveyed expressed the need to improve the financial performance of their physician organization, through increased revenues and/or improved cost management. Rate increases were the most commonly cited need by survey respondents, noting that capitation rates have not kept pace with increasing costs. Most believe rate increases and/or incentive fund increases are necessary for continued participation in risk contracts; several went so far as to say unsustainable capitation rates will force their organizations to terminate some or all risk contracts. Some organizations couched their response in terms of the need to control costs both through appropriate medical management and through efficient administrative practices. Several executives cited legislative mandates, such as "prudent layperson" definitions in Emergency Room coverage, as contributing to the cost of healthcare while constraining what provider organizations can do to effectively manage the cost of capitated services. Finally, while groups are looking to incentive funds and health-plan quality initiatives for needed revenues, there is doubt about their ability to earn incentive money as the programs are structured today.

Issue Two – Future of the managed care industry

Provider organizations are asking about the future of risk and what types of managed care/health benefit plans will emerge over the next few years. Several of the executives expressed the need to understand the future direction of health insurance in order to understand whether and to what extent capitated HMO membership will continue to be a factor for their organizations. Provider organizations are also trying to look ahead to new benefit plans, such as consumer-driven and defined contribution plans, in order to position themselves for both the opportunities and the administrative requirements of participating in such new products.

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Figure 1: Surveyed Organizations and Capitated Enrollment by Type of Organization

Type of Organization	N	Lives
Hospital Organization (HO)	6	49,900
Independent Physician Association (IPA)	4	119,300
Medical Group (MG)	2	25,000
Physician Hospital Organization (PHO)	11	212,500
Management Services Organization (MSO)	2	N/A
TOTAL:	**25**	**406,700**

Hospital Organization (HO): 100% hospital/health system owned
Independent Physician Association (IPA): Physician owned, independent physician practices
Medical Group (MG): Physician owned, employed physicians
Physician Hospital Organization (PHO): Joint physician and hospital ownership
Management Services Organization (MSO): Administrative entity only

What are We Without Risk?
Physician Organization at the Crossroads

Synopsis

The managed care market is experiencing rapid change. As HMO enrollment flattens or even declines, and capitation becomes less sustainable for many, physician organizations are reevaluating their continued participation in risk-based contracts, and struggling to define their future roles. Physician organizations are looking for new ways to provide value to their physician members. Physician Hospital Organizations (PHOs) in particular are reassessing how the organization can continue to serve the interests of both the physicians and their hospital partners. To better understand concerns of physician organizations, The Lowell Group surveyed Chicago area provider executives on their top issues. Three major concerns emerged: protecting the financial health of the organization; predicting the future of the managed care industry; and evolving the physician organization to meet changing market conditions.

Authors:

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Karen Janousek is Chief Executive Officer of Chicago Health Systems. Chicago Health Systems provides managed care contracting and implementation strategy and MSO operations to hospitals and physician organizations in Chicago. Ms. Janousek has 15+ years experience in healthcare, including extensive involvement in managed care operations and managed care strategy development, with significant experience in startup and wind-down of business operations. She can be reached at (708)783-7185 or kjanouse@macneal.com.

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New Employer?
New Fax Number?
Make a Change…..
…..to your HFMA membership data.

HFMA members are able to change their own member-specific data on the HFMA website at www.hfma.org.

HFMA WEB SITE

Here's a brief walk-through of the website options.

At the hfma.org website, select "Member Login" from the top righthand options. This should take you to a screen that asks for your e-mail address or Member ID, and your password. Your password will be your last name. Next there is the option directly below this that says "Login".

Select this and you will access a screen that says, "User Name Accepted..." and a note that says, "Please click 'here'....." which will lead you into the next screen.

Next you should see a screen that says, "Login successful..." at which point you will go to the "Membership" keyword in the righthand options. It will have a set of drop-down menus that have several options: select "Membership Directory". A screen will appear with lots of instructions; your limited "Profile" data will appear at the left.

Click on your Profile data and an edit screen will appear with all of your HFMA data.

It is a little confusing the first time you go through this series but a handy tool for individual members.

Please call Jane Bachamnn, Membership Directory Chair, (708/383-1860) if you have further questions.

A Survey of the Chicago Market

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Issue Three – Evolution of the Physician Organization
The third common issue is that of evolving the organization to meet changing market conditions. Nearly all organizations acknowledged change in the capitated market, and recognized a need for their organizations to evolve accordingly. Where the answers differed depended upon whether the organization expects growth or decline in capitated enrollment in their unique location. For groups who expect enrollment to grow, the evolution will be in continued medical and economic performance improvement. Groups whose membership is flat or declining are now beginning to define the organization's future, but are hampered by market uncertainty.

Future of Risk Contracting

Physician organizations are reevaluating their participation in risk contracts. All executives surveyed indicated that their organizations are reconsidering risk contracting. Sharp divisions were noted between those who are strongly committed to a capitated model and believe that it can work if rates are set fairly to keep pace with cost increases; and those who have come to believe that physician organizations cannot or should not take on the role of "insurer." In the middle are groups who feel capitation could work but recognize that in the current market they can maximize revenue by seeing more fee-for-service patients. As well, there are groups who expressed willingness to remain in risk if they could carve out some categories of services, or otherwise mitigate full professional risk. Finally, PHOs are increasingly under pressure from their hospital partners to reexamine risk, as hospitals, too, are experiencing increased volumes of fee-for-service patients, and are less willing to support the PHO through subcapitation or deeply discounted rates for outpatient services.

Physicians are pushing to exit risk contracts. Six of the organizations reported that physicians are the primary force pushing to limit or exit risk contracts. Physicians have not embraced the role of managing care for HMO patients, don't like and don't want risk contracts, and are making their position felt in many organizations.

PHOs believe they remain important to their hospital/health system partners, but support from the hospital/health system may be eroding. Of the 11 PHOs in the survey, only three indicated support from the hospital or health system partners will continue to be available as readily as in the past. Two PHOs stated that the hospital or health system would offer continued support only if a sufficient return on investment is available. Financial support is seen to be in question as other financial pressures capture the attention of hospital management. Further, the ability/willingness to tolerate losses either directly funded or funded through deep discounts to the PHO may be decreasing, particularly for those organizations where hospital capacity is strained

Physician organizations want HMOs to step up to more responsible financial oversight. Although it was not a survey question, several executives suggested financial oversight of risk-taking provider organizations is inadequate. They feel the HMOs have a responsibility to do a better job of ensuring financial stability of the provider groups in their networks. Further, they believe such oversight will be in the best interests of all, as financial failures among groups leave unpaid debts to be absorbed by the HMOs and provider creditors.

What Are We Without Risk?

Physician organizations have choices to make: will they exit risk contracting and close their business operations entirely? Will they terminate risk contracts, and convert to a fee-for-service only model? Or will they continue to improve their capabilities and stay in risk?

Choosing to close an operation is a difficult decision process. Unfortunately, some organizations that exit may do so through financial failure, as has already occurred in this and other markets; but likely others will make a sound business decision to close, with a clear exit strategy and responsible discharge of obligations.

For organizations that decide to terminate risk, but remain in operation, the challenge will be to retool to provide services needed and valued by physicians, such as fee-for-service contracting and other value-added services. As well, the physician organization will need to develop a tactical plan to smoothly execute the termination of existing risk contracts, and the conversion to a new business model.

Finally, for those groups who have good infrastructure and belief in their capability to succeed under risk, the challenge will be to continue to improve both their operations and medical management. Successful organizations will retain existing members and grow their membership from new enrollment and by attracting members from other groups that exit risk. Doing so will require an effective marketing strategy targeted toward patients, payers and employers.

The one thing physician organizations cannot do is allow uncertainty to paralyze them. Now more than ever they must apply strong strategic planning to envision and prepare for the next evolution of health care delivery. Physician organizations must step up to the challenge of making good business decisions about risk contracting, while simultaneously evolving their organizations to meet the needs of their physician members and consumers in a changing managed care market. While tactics may vary by market, ultimately, physician organizations must make business decisions that support their true goals: serving physicians, patients and purchasers of care, and owners.

THE KEY PROVISIONS OF
HIPAA
PRIVACY RULE

HIPAA Privacy Compliance Deadline Nearing

By Gaylee Morgan, Steve Scheer and Gary Crayton, Health Management Associates

HIPAA History

On August 21, 1996, President Clinton signed into law the Health Insurance Portability and Accountability Act, commonly known as HIPAA. As its name implies, HIPAA included a number of provisions to make health coverage more portable for employees changing jobs by limiting exclusions for pre-existing conditions.

HIPAA also included a set of "Administrative Simplification" provisions, which were intended to "improve the efficiency and effectiveness of the health care system by facilitating the electronic exchange of information …"[1] To implement these provisions, HIPAA directed HHS to adopt uniform, national standards for transactions, unique health identifiers, code sets for the data elements of the transactions, security of health information, and electronic signatures. Most of these standards have been either adopted in final form or published in proposed form for comment. Table 1 below provides a summary of HIPAA administrative simplification standards.

In drafting HIPAA, Congress recognized the threats to confidentiality posed by the growing complexity of the health care system and the increased use of electronic data interchange that HIPAA itself was intended to encourage. Thus, the Administrative Simplification provisions of HIPAA authorized the U.S. Department of Health and Human Services (HHS) to issue standards for the privacy of individually identifiable health information if Congress failed to enact health care privacy legislation by August 21, 1999. Congress failed to meet this self-imposed deadline, and HHS published proposed regulations on November 3, 1999. The Department reviewed more than 52,000 comments in response to the proposed rule and published a final rule shortly before the end of the Clinton administration. The Bush administration published a revised final rule on August 14, 2002.

This article provides a very brief overview of the key provisions of the HIPAA privacy rule. It also raises important issues and questions that providers and health plans will want to consider as they move their organizations toward compliance.

HIPAA Privacy "Cheat Sheet"

Table 2 provides a brief overview of the key provisions of the HIPAA privacy rule. It does not include all provisions, nor is it a comprehensive resource on the provisions that are included. Rather, this table is intended to serve as a first point of reference – or a "cheat sheet", in effect – for the provisions of the privacy rule that are most likely to be of interest to providers and health plans.

Are We HIPAA-compliant?

As noted above, most covered entities must comply with the final privacy rule by April 14, 2003. Many organizations are already in substantial compliance or have spent months developing and implementing their compliance plans. Other organizations, whether in a state of "HIPAA denial" or merely holding off until final rule changes were published, now find themselves scrambling to meet the deadline. This latter group may be in the majority, according to a recent letter from the National Committee on Vital and Health Statistics (NCVHS) to HHS Secretary Tommy Thompson.[3] Based on hearings held earlier this year, the NCVHS reported that it was "both surprised and disturbed at the generally low level of implementation activities and the high levels of confusion and frustration" surrounding the rule.

While the HIPAA privacy rule is dense and complicated, it need not be intimidating. Covered entities that believe they are not yet HIPAA-compliant should consider the following:

- Focus on reasonable, cost-effective solutions. The requirements of the HIPAA privacy rule are intended to be "scalable," meaning that a small physicians' office does not have to implement the same kinds of procedures and systems as a large health system. For example, the rule requires that covered entities have adequate safeguards in place to prevent unauthorized access to protected health information. For large health plans, this could require sophisticated security upgrades. For a small doctors' office, it could be as simple as a new lock on a door or file cabinet.

- If you haven't already done so, make sure that your organization designates a Privacy Officer. This need not be a new position, in fact there are many reasons why it may be in the organization's interest to appoint an existing employee who is familiar with the existing information management practices. This individual will need to take the lead in understanding the requirements of HIPAA and developing and implementing policies to bring the organization into HIPAA compliance. In larger organizations, this individual should have the ability to work with middle and upper management to develop and operationalize policies that are effective but impose a minimal burden. HIPAA compliance will affect the entire organization. Therefore, the privacy officer should be someone who can approach compliance issues with a view toward the organization as a whole.

- Complete an assessment of current practices and a "gap analysis." For each provision of the regulation, the organization should review and document its current practices, and determine if these practices meet or exceed the HIPAA standards. If not, the organization should develop a range of options for achieving compliance and evaluate the options on the basis of likely effectiveness, cost, ease of implementation, and other factors the organization considers important.

- Develop a comprehensive and specific plan of action. After the organization completes its gap analysis and analyzes the pros and cons of various compliance options, it needs to develop a detailed work plan for the development and implementation of internal policy and systems changes. This work plan should spell out in detail the actions that need to be taken (and the time line for implementation) to implement a fully HIPAA-compliant set of policies.

- Document and update privacy policies, and ensure that employees are trained. HIPAA requires that covered entities maintain their privacy policies in written form and update documentation when substantive changes are made to the policies. HIPAA also requires that employees receive initial training on the organization's privacy policies and supplemental training when substantive changes are made to the policies.

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Table 1: Summary of HIPAA Administrative Simplification Standards

STANDARD	STATUS[2]	CITATION
Electronic Transactions Standards	Final rule published 8/17/2000; compliance date was 10/16/2002 with optional extension to 10/16/2003. Proposed revisions to the rule were published on 5/31/02 but have not been finalized yet.	45 CFR 160 and 162
Identifier for Employers Security Standards	Final rule published 5/31/02; compliance date was 7/30/02 Proposed rule published 8/12/98; estimated publication date for final rule is 10/02 to 12/02	45 CFR 160 and 162 63 FR 43242
Health Care Provider Identifier	Proposed rule published 5/7/98; final rule currently in clearance.	63 FR 25320
Claims Attachments Standard	Proposed rule not published yet.	N/A
Health Plan Identifier	Proposed rule not published yet.	N/A
Electronic Signature Standard	Originally part of Security Standards proposed rule, but withdrawn due to lack of consensus; regulation will not be published until industry develops a consensus recommendation.	N/A
First Report of Injury Standard	Proposed rule expected to be published later this year after industry develops a consensus standard.	N/A
Unique Health Identifier for Individuals	Work halted due to privacy concerns.	N/A
Privacy of Individually Identifiable Health Information	Modifications to final rule published August 14, 2002; compliance date is 4/14/2003 (small health plans have an additional year to comply).	45 CFR 160 and 164

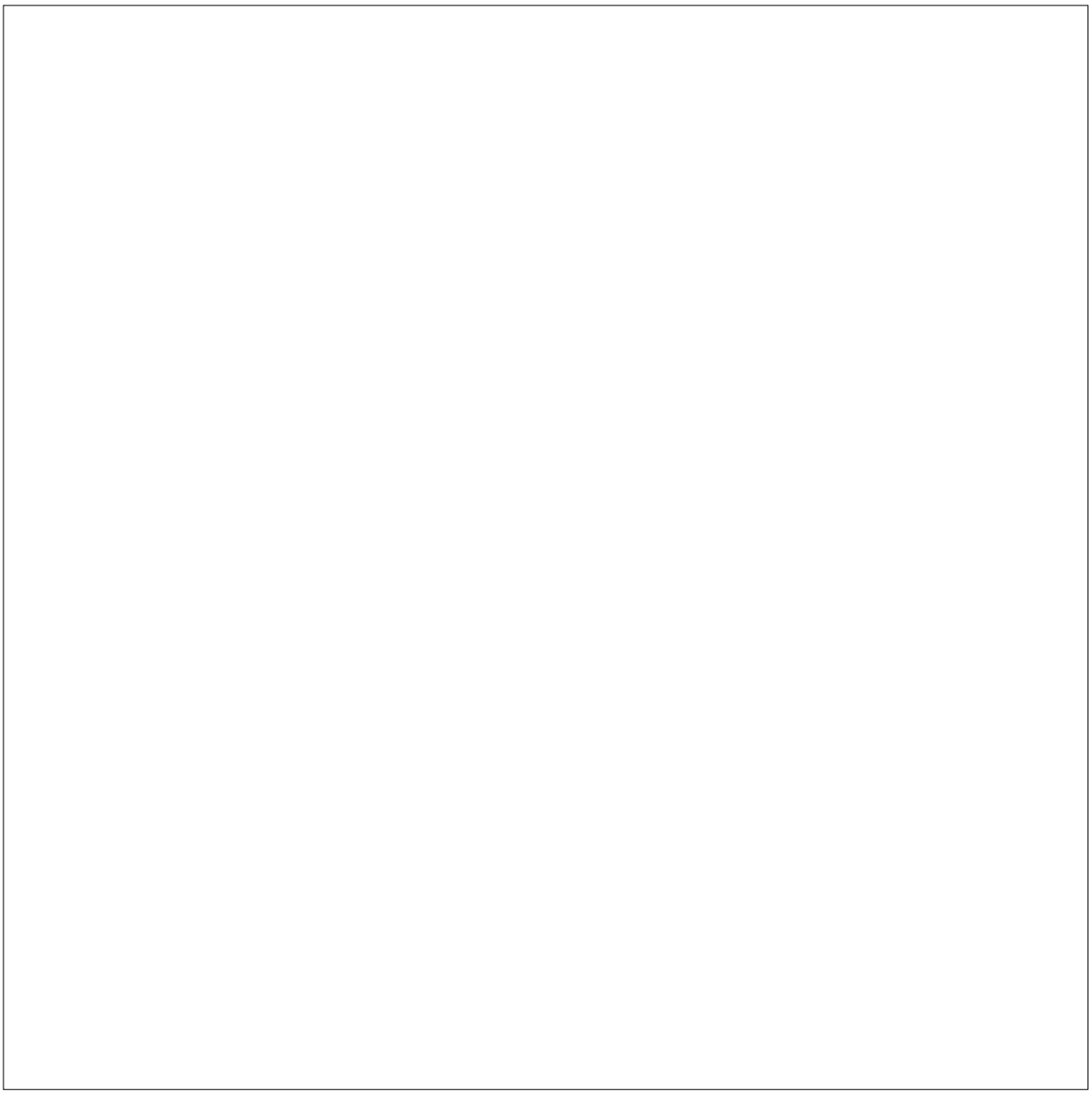

Table 2: HIPAA Privacy "Cheat Sheet"

PROVISION	CITATION	EXPLANATION
General requirements information	45 CFR 160.103 45 CFR 164.501	Entities covered ("covered entities") by the rule are health plans, health care clearinghouses, and health care providers who transmit any health in electronic form. Only health information that identifies an individual, or could reasonably be expected to identify an individual, is covered by the rule.
Business associates	45 CFR 164.502 45 CFR 164.532	Covered entities may disclose protected health information to their business associates as long as the covered entity obtains assurances that the business associate will safeguard the information. The final rule gives covered entities up to an additional year beyond the compliance date to change existing written contracts with their business associates.
Treatment, payment and health care operations	45 CFR 164.506	Covered entities must provide patients with notice of the patient's privacy rights and the privacy practices of the covered entity. Direct treatment providers must make a good faith effort to obtain patients' written acknowledgement of receipt of the notice. One of the most significant changes from earlier versions of the rule is that it is now *optional* for covered entities to obtain consent from patients for routine health care delivery purposes (treatment, payment and operations).
Uses and disclosures for which authorization is required	45 CFR 164.508	With the exception of treatment, payment, health care operations and certain disclosures considered necessary for the public good, covered entities may not use or disclose protected health information without a valid authorization from the individual. The core elements of a valid authorization are detailed at 45 CFR 164.508(c). Examples of activities requiring authorization include the use or disclosure of protected health information for marketing purposes or for pre-employment reviews or background checks.
Uses and disclosures for which authorization is not required	45 CFR 164.512	Certain uses and disclosures of health information are considered essential for serving the public good and, therefore, do not require patient consent. These include uses and disclosures: required by law, for public health purposes, for health oversight activities, for judicial and administrative proceedings, for law enforcement purposes, for research purposes, to avert a serious threat to health or safety, and for certain other purposes. Each of these uses and disclosures is subject to specific standards and limitations.
Minimum necessary	45 CFR 164.514	Covered entities must limit their disclosures of and requests for protected health information to only that information that is reasonably necessary to accomplish the purpose for which the information is sought.
Notice requirements	45 CFR 164.520	Covered entities must provide a notice written in plain language that explains how the covered entity may use individuals' health information without consent. The notice must also explain the individual's rights with respect to their health information.
Access and rights of the individual	45 CFR 164.522 45 CFR 164.524 45 CFR 164.526 45 CFR 164.528	Individuals have the right to request restriction of uses and disclosures by covered entities for treatment, payment and health care operations. However, the covered entity is not obligated to agree to such restrictions. With few exceptions, individuals have the right to access, inspect and obtain a copy of their health information within 30 days of making a request (covered entities may impose a "reasonable, cost-based fee" to cover copying, postage and related costs of supplying this information). Individuals have the right to request that the covered entity amend information contained in its records if the individual believes the information is inaccurate or incomplete. Individuals also have the right to request an accounting of disclosures of their health information made by the covered entity with the exception of disclosures for treatment, payment and health care operations and certain other exceptions.
Administrative requirements	45 CFR 164.530	Covered entities must designate a "privacy official" who is responsible for developing and implementing privacy policies for the entity. The covered entity must develop, implement, and document policies and procedures to ensure compliance with the privacy rule and must ensure that its employees are adequately trained in these policies and procedures.

Only time will tell how aggressively HHS will enforce HIPAA privacy, but the rule itself outlines the framework for enforcement. Any individual who believes a covered entity is not complying with the HIPAA privacy requirements may file a complaint with the HHS Secretary. The Secretary is also authorized to conduct compliance reviews to determine whether a covered entity is compliant. Penalties for failure to comply range from $100 for a minor violation to $250,000 and 10 years in prison for a serious offense committed with the intent to sell or otherwise use individually identifiable health information for personal gain or to cause "malicious harm."

Editors Note: *This article was reviewed by Curt Siegel and Tim Stevens of RSM McGladrey, Inc.*

Health Management Associates (HMA) is a health policy consulting firm specializing in the areas of health care program development, health economics and finance, program evaluation, and data management and analysis. HMA has worked with a number of organizations to address HIPAA privacy issues and implement HIPAA-compliant policies. For further information on HMA, see http://www.hlthmgt.com.

For more information

As many expected, the complexity of the privacy rule has contributed to the creation of an entire new industry to help covered entities understand and implement the rule's provisions. Organizations have numerous resources available to them to help with evaluating current practices and implementing new HIPAA-compliant practices. Consulting firms are offering a wide range of HIPAA compliance services for health care providers and payers. Many professional organizations and trade associations have dedicated significant resources toward helping their members in this area. There are also several sources of information and technical assistance within the federal government. For example, the HHS Office of Civil Rights (OCR), which has been charged with enforcing the privacy rule, provides technical assistance through its web site at http://www.hhs.gov/ocr/hipaa. Current postings also include sample contract provisions for business associates of covered entities. The following web sites contain additional information on the HIPAA administrative simplification regulations, including full text of the regulations themselves.

http://www.gpo.gov/su_docs/aces/aces140.html (searchable Federal Register web site)
http://www.gpo.gov/nara/cfr/index.html (searchable Code of Federal Regulations web site)
http://cms.hhs.gov/hipaa/hipaa2/default.asp (CMS HIPAA Administrative Simplification web site)
http://aspe.os.dhhs.gov/admnsimp/ (HHS Administrative Simplification web site)

[1] 45 CFR Parts 160 and 164, *Standards for Privacy of Individually Identifiable Health Information; Final Rule*. August 14, 2002.
[2] Based on a presentation by HHS Staff at the February 2002 Meeting of the NUCC/NUBC; amended, updated and posted on the web by Phoenix Health Systems.
[3] Letter from NCVHS Chair John R. Lumpkin to HHS Secretary Tommy Thompson, September 27, 2002.

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Enriched Business Intelligence Stimulates Revenue ... *continued from page 6*

With enriched BI applications, these questions don't require a consultant, a project team, or even an ad hoc report request. Instead, executives and managers are able to use enterprise data routinely in making decisions.

Many organizations utilize I.T. and Business Office professionals to download data into spreadsheets for these purposes. How much time is spent in your organization each month to produce multiple scenarios:

- What if we looked at the data over a longer period of time?
- What if we wanted to see how Payer A is performing vs. Payer B for the same type of services during the last quarter?
- What if we want to understand the difference between aging as it relates to patient discharge date vs. the date the bill went out the door?

HFMA's recent study "The Patient Revenue Cycle At The Crossroads" reveals that a majority of provider organizations are outsourcing PFS services such as collections, temporary help and revenue recovery. How do you know if you are giving away the easy dollars?

Utilizing business intelligence tools, the user asks these questions directly and obtains the answer in seconds, instead of asking someone else to make another cut of the data each time. These types of tools enable fluid analysis and timely decision making. Here's another example:

A hospital in South Carolina determined that, by utilizing BI, they will cut their time and effort on calculating contractual write offs at month end by 250%.

BI and Application Service Providers

In the current economic environment hospitals are faced with limited capital dollars and constant changes in the administrative landscape. The ability to leverage existing information systems is attractive to many. However, most organizations are limited in their ability to develop enriched BI systems, and off-the-shelf decision support applications may not be flexible enough to serve an ever-changing administrative landscape. In order to realize BI value, you need a system that is fast, but that will not burden your other critical I.T. functions. One potential solution is to use an Application Service Provider (ASP). "ASPs" allow organizations to "rent" applications over the Internet, instead of investing considerable sums for servers and software that can be quickly rendered obsolete. The ASP model can also resolve complex integration issues.

"ASPs" leverage the Internet to create efficiencies. The Internet is, simply, a low-cost communications technology. That is a big deal, though, when you add up the potential cost reductions of transactions and information retrieval. Furthermore, the Internet is a highly flexible medium. Unlike electronic data exchange (EDI), which typically requires expensive network connections, the Internet offers a far less costly alternative, opening the door to efficiency gains for small companies as well as large corporations. Many software applications have been "Web-enabled." By contrast, enriched ASPs can provide fully interactive, wide-open business intelligence engines.

Case Study

A west coast, multi-hospital organization recognized that its internal processes were not adequately addressing progressive deterioration of Medicaid receivables – with increased days outstanding and exorbitant levels of bad debt write-offs and, consequently, poor cash performance. Substantial expenses were being incurred in working with disparate IT systems, temporary staffing and consulting assignments for process redesign and historical financial reimbursement analyses.

The provider implemented an Internet-based denial and reporting system, which provided an immediate and accurate response on all electronic claim adjudication information. In addition, the system leveraged existing aging trial balance (ATB) files to identify and quantify specific areas for understanding and process improvement for reimbursement performance levels. The system also leveraged eligibility verification to confirm coverage and identify the appropriate payer intermediary, with automated performance results produced by region, by hospital, and by point of service.

During the first twelve months of implementation, the provider organization experienced substantial improvements in cash collections, redirected millions of AR dollars to the proper payer, and reallocated considerable FTE resources away from data extraction and management.

The system has been expanded to include electronic cash posting, product-line profitability measurements, and monitoring revenue cycle performance in ways that otherwise not readily available.

Return On Investment

The technology advancements mentioned earlier have allowed enriched business intelligence application costs to more attractively match the cost of investment. When it comes to determining whether your BI system is providing a good return on investment, measuring some factors is straightforward, and measuring others is not. Enriched BI applications can be enormous time savers. You can get an adequate return on investment if employees use the decision support tools just to generate good answers, but you can get a spectacular return if employees use it to generate good questions.

Although a specific return on investment in business intelligence is difficult to measure financially, sources of improvements to the bottom line from such an investment are easy to distinguish. The ability to find patterns and predict trends can have tremendous value by increasing revenues, maximizing operating efficiency, cutting costs, or improving customer satisfaction. Ask a former number-crunching employee who is now making strategic decisions for the organization about the value of the BI system, and you'll likely hear more than just a dollar amount.

Instead of relying upon monthly reports to manage AR, a Florida hospital that implemented BI now identifies accounts on current time basis that are approaching aging and financial risk thresholds. They also cleaned up and monitored old or unused financial classes (some that are auto assigned by their host system), thereby eliminating potential write offs.

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Upcoming Seminar:

Survivor: The Reimbursement Challenge

January 23, 2003 at the Carlisle, Oakbrook, IL

The First Illinois HFMA Accounting & Reimbursement Committee is very excited about this year's seminar. Come hear about the latest reimbursement, accounting and finance issues impacting our business from our area's leading experts. This is a great opportunity to learn some new things, network with your peers and enjoy a day away from the office. We look forward to a great turn out as always.

Overview

Learn the survival tactics your organization will need to be successful for the Finance/Reimbursement Challenge in 2003. Useful and timely topics such as tax exempt issues facing healthcare, an update of the Sarbanes-Oxley Act, a health care environmental assessment, a discussion of PRRB issues, a legislative update and APC update as well as a discussion of Blue Cross UPP will be presented.

Agenda

Tax issues facing healthcare

Zack Fortsch, Partner, McGladrey & Pullen, LLP

This program will explore the implications of significant events in the area of taxation for health relation organizations. Topics covered include Intermediate Sanctions, Conflict of Interest Policies, Charity Care Policies, Hospital Joint Ventures, Unrelated Business Income among others.

Balance Sheet Risk Reduction through Asset and Liability Management

Carsten Beith, Principal, Cain Brothers & Company, LLC

Asset and liability ("A&L") management is the proactive management of financial assets and liabilities in light of the underlying risks associated these balance sheet classes. Not-for-profit organizations, often with significant investment portfolios and substantial debt, have balance sheet characteristics similar to financial institutions. However, the industry has been slow to adopt the tools used by the financial services industry to manage and reduce the risks in their balance sheets. This presentation will provide and introduction to A&L management including:

- Measuring and managing risk
- Assessing risk and volatility
- Recognizing barriers to A&L management
- First steps to A&L liability management
- Case Study
- Practical tools

Update of Sarbanes-Oxley Act of 2002 and Health Care Environmental Assessment

Matthew Kates, Partner, Deloitte & Touche, LLP

This program will provide an update on the Sarbanes-Oxley Act of 2002 and its impact on management, audit committees and the public accounting profession. In addition, we will share insights from research and surveys recently released in the following publications.

- *Health Care 2002 - a Strategic Assessment of the Health Care Environment in the United States* (Deloitte & Touche, VHA)
- *Employer Health Care Strategy Survey 2001* (conducted by the Human Capital Advisory Services practices of Deloitte & Touche and Business & Health magazine)

Medicare Update: Provider-Based Status, Fraud & Abuse Issues, PRRB Developments

Larry Manson, Law Office of Lawrence A. Manson

This program will discuss new developments in Medicare, beginning with the changes in August to the Provider-Based Status regulations for outpatient departments, which require action for all units by the next cost year beginning on or after July 1. Also included are Fraud & Abuse, False Claims Act, and OIG work plan developments, a review of Medicare rulings from the PRRB, and the strict CMS and PRRB requirements on timely data submissions by providers.

Legislative update

Rick Hamilton, Senior Vice President of Finance, Illinois Hospital Association

This program will update providers on current and upcoming legislative issues facing the industry.

What's UPP?

Rex Pipher, Manager, Blue Cross Blue Shield of Illinois
John Evans, Manager, Blue Cross Blue Shield of Illinois

This program will discuss the aspects of the Blue Cross Uniform Periodic Payment (UPP) system. The program will discuss how UPP is administered and will track a claim to show how the UPP check is determined.

APC update

Barbara Shurna, Director Midwest Health Care Advisory Services Practice, KPMG LLP

This program will provide an overview of significant changes to APC reimbursement resulting from the 2003 Outpatient PPS Final Rule. It will also review significant changes in APC payment amounts including pass-through drugs and devices and highlight charge capture issues and best practices.

Biographies

Zack Fortsch is a CPA and Partner with McGladrey & Pullen, LLP, and a leader of the Illinois Health Care tax practice and the Chicagoland Nonprofit Industry group for McGladrey & Pullen, LLP. He is currently based in the firm's suburban Schaumburg, Illinois office. He is also one of the firm's lead specialists in the area of taxation for non-profit organizations and is responsible for advising tax professionals within the firm on issues affecting exempt organizations. Mr. Fortsch also frequently authors a tax column for the firm's industry newsletter – Fundamentals. Mr. Fortsch received his Master in Tax from De Paul University. He is also currently a member of the Finance Committee and board of Directors for the Illinois Division of the American Cancer Society, a member of HFMA and the non-profit tax committee of the Illinois CPA Society.

Carsten Beith is a Principal with Cain Brothers & Company, LLC. Since joining Cain Brothers in 1993 to establish its Chicago Office, Mr. Beith has been active in strategic advisory, mergers and acquisitions and capital planning and capital formation work for hospitals, medical group practices, and managed care organizations. Among recent Chicago area transactions represented by Mr. Beith include the sales of MacNeal Hospital and Louis A, Weiss Memorial Hospital to Vanguard Health Systems, and the creation of a Hospital/Physician Cardiac Cath Lab joint venture for Silver Cross Hospital and Health Center. Nationally, Mr. Beith is currently active in assisting hospitals and managed care organizations in repositioning assets and raising capital through sales, joint ventures and other affiliation arrangements.

Prior to joining Cain Brothers, Mr. Beith was director of health care with the New York office of Unibank, a Copenhagen-based bank with a broad international health care finance presence. At Unibank, Mr. Beith established Unibank's U.S. health care lending and investment group to finance a range of health care transactions including hospital acquisitions and recapitalizations, physician acquisitions, leveraged buy-outs and ESOP acquisitions. Mr. Beith also represented a number of Danish pharmaceutical, biotechnology and devise manufacturing companies. Prior to Unibank, Mr. Beith was a manager with Arthur Andersen & Co. where his health care work included hospital audits, feasibility studies, contract compliance reviews and merger and acquisition advisory services.

Mr. Beith is a CPA and received his Master's degree in finance from New York University and Bachelor's degree in accounting from Michigan State University.

Matthew Kates is a partner in the Deloitte & Touche health care and life science practice with over 20 years experience providing services to hospitals, physicians, managed care organizations, and other providers. Matt has broad based experience in health care regulatory, reimbursement and revenue cycle issues and leads the Deloitte & Touche health care regulatory and revenue management practice in the Midwest. He has led engagements in such areas as revenue cycle improvement, hospital charge description master services, billing/coding assessments, third party reimbursement, merger and acquisition due diligence, compliance risk assessments, investigations, regulatory impact studies and other financial management issues.

Matt is a Certified Public Accountant and is a member of the Healthcare Financial Management Association, American Institute of Certified Public Accountants, the Illinois CPA Society and the American Association of Health Plans. He received his Bachelors degree in accountancy from Southern Illinois University. He is a frequent speaker for various trade associations, clients and Deloitte & Touche internal training and seminars on health care regulatory issues.

Larry Mason, Esq. is in the private practice of health law in Highland Park, IL and has represented hospitals, nursing homes and other providers in health care regulatory, litigation, and corporate matters. He is a past president of the Illinois Healthcare Attorneys Association, a former chair of the now Health Law Section of the American Bar Association, and a past board member of First Illinois, HFMA. He has represented many hospitals in reimbursement appeals before the PRRB and in the federal courts. He is a graduate of the law school of Columbia University.

Rick Hamilton is Senior Vice President of Finance for the Illinois Hospital Association, Naperville, a position he has occupied since 1990. His responsibilities include strategic planning, representing Illinois hospitals in discussions and negotiations concerning financing and payment activities, particularly those issues affecting Medicaid. Prior to joining IHA, Mr. Hamilton was Michigan Hospital Association Vice President of Data and Policy Services and President of the Michigan health Data Corporation, the voluntary statewide repository for health data evaluation in Michigan. He received his Bachelor's degree in engineering, his Master's degree in Engineering and his Doctorate in industrial and operations engineering from the University of Michigan. He has also conducted post-doctoral work in health services administration at the University of Michigan.

Rex Pipher has been with Blue Cross Blue Shield of Illinois for over twelve years. As a manager, his responsibilities include the calculation of HMOI and Blue Cross contractual allowances for contracted providers. Rex is a CPA and has a Bachelor's degree from Indiana State University and a MBA from Xavier University.

John Evans is the manager of Provider Relations at BCBSIL. He joined the company in 1984 as a supervisor in a claim adjudication department. In 1987, he became a Hospital and Provider Affair Representative for the Chicago/Metro area. Since assuming the manager's role in 2001, he is responsible for the statewide operation of all Provider Relations.

Barbara Shurna is Director in the Midwest Health Care Advisory Services Practice of KPMG LLP. She manages the chargemaster practice in the Midwest and her focus also includes regulatory and compliance assessment related to Medicare coding and billing, physician coding and business process analysis. Barbara's experience includes conducting chargemaster and Ambulatory Payment Classification analyses; evaluating health care delivery operations systems and charging processes in acute care hospitals; and overseeing all aspects of patient care delivery in the acute care setting in the role of Vice President of Patient Care Services. Barbara received a Bachelor of Science in Nursing from Mount Saint Joseph College in Cincinnati and a Master of Science in Nursing from Rush University in Chicago. She has nearly 30 years of experience in the health car field as a clinician, administrator and consultant.

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First Illinois Welcomes New and Transferring Members

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New Members Share FOOD & FELLOWSHIP at New Member Breakfast

New members and Chapter leadership share food and fellowship at New Member Breakfast

Jean Roberts

Cathy Pastorek introduces October Program

New members and Chapter leadership share food and fellowship at New Member Breakfast

The following new members attended the October New Member Breakfast:

John Salka
Robert York
Douglas McCoy
Brian Groves
Russ Gardner
Richard Meyer
Mariann Strabe
Donna Rende
Ryan Dusek
Linda Thomas
Pat Bracken
Maria Del Ray Walsh
Laura Goodman
Bernie Hollicky

Phyllis Cowling and Suzanne Lestina

Phyllis Cowling, National HFMA Chair

October Program Feature — Denials Management: A Provider Prospective

October Meeting Presenters: Marcus Padget, Katherine Murphy, Julie Rodke and Kathy Babcock

Enriched Business Intelligence Stimulates Revenue

... *continued from page 8*

Conclusion

Of course, improved results come not from BI technology, but from an organizations ability to use accurate, timely information to improve processes, reduce costs, and increase productivity. The effort to establish excellence and sustained revenue cycle improvement is a process, not an endgame. Executives must invest in tools and technologies that provide clarity and simplicity. They also must strike a balance between in-house and outsourced services, between hosted and ASP applications, between dollars spent on training, consultants and technology. Business Intelligence can provide a platform to make revenue cycle operations and performance easy to understand, coordinate and improve.

To grow revenue and improve the efficiency of operations, healthcare providers must recognize the strategic importance and role of business intelligence (and information technology in general) in the overall scheme of the organizations corporate strategy.

Consider the following items:

- Are you ready to create value from information you already have?
- Are you ready to use this information to advance the capabilities you already have?
- Are you ready to face the competition that already has?

About the author...

Kyle Kalinich

Kyle Kalinich is the Director of Business Development for Aon Healthcare Alliance, a branch of Aon offering financial risk solutions for health care providers and payers. Kyle has been in health care management for 15 years. Kyle has a Masters of Science degree from Northwestern University and a Bachelors of Science degree from the University of Illinois Urbana Champaign. Kyle is a member of the First Illinois Chapter of HFMA.

Kyle welcomes any questions or comments to this article at kyle_kalinich@aon.com or call 630.434.2402.

Education Committee 2002 Program Calendar • First Illinois Chapter

Month	Committee	Format	Date	Location
January	Accounting and Reimbursement	Full Day	Thursday 1/23/2003	The Carlisle Lombard, IL
February	Medical Group Practice	Full Day	Thursday 2/20/2003	Maggiano's Oakbrook, IL
March	Managed Care	Full Day	Thursday 3/13/2003	The Carlisle Lombard, IL
April	Classroom Education	Half Day	Thursday 4/17/2003	The Carlisle Lombard, IL
May	CFO	Full Day	TBD	To be announced
May	Annual Golf Outing	Full Day	5/23/2003	To be announced

First Illinois Speaks

A Newsletter from HFMA's First Illinois Chapter

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healthcare financial management association

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In This Issue

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