



first illinois *speaks*

A Newsletter from HFMA's First Illinois Chapter

January 2010

MAKING IT Count

INSIDE:
Highlights and Recap
First Illinois Chapter Events
begins on page 7

Treasury Program

**Healthcare Finance:
the Next Generation**

Top Five Issues for Physician Organizations

BY ELIZABETH SIMPKIN, VICE PRESIDENT, VALENCE HEALTH

As physician and hospital leaders look ahead to 2010, it's easy to see only challenges – threatened cuts to reimbursement, pressure to adopt Health IT, and the unknown implications of healthcare reform. But new opportunities also exist, and physician organizations that



seize those opportunities can differentiate themselves from those who wait. Looking ahead to 2010, we see growing interest in integration between hospitals and physicians, and the recognition of the critical role of Health IT adoption.

1 Physician Reimbursement

While the Medicare physician fee schedule and Sustainable Growth Rate are major concerns, new reimbursement models offer challenges and

opportunities. Bundled payments, Patient Centered Medical Home models, and Accountable Care Organizations require greater ability to track and measure population outcomes. A clinically integrated physician organization that can enable sophisticated measurement, while demonstrating value to payers and community, is in the best position to protect or enhance today's physician reimbursement while participating in new models for the future.

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Top Five Issues for Physician Organizations

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2 Clinical Integration

More than ever, physicians who want to remain independent and not enter into employed relationships need strong affiliations to share data, improve quality, measure performance and, on the basis of those activities, have the legal ability to negotiate collectively.

3 Health Information Technology (HIT) Adoption

Physicians must ramp up use of information technology with exchange of data among providers. The goal is not simply implementing an EHR – it is sharing patient information to lower administrative costs, reduce repeat testing, and provide providers point-of-care medical management tools. IPAs and PHOs that help their member physicians adopt and use technology will have an advantage in meeting requirements and achieving incentives from both government and commercial payers.

4 Hospital/Physician Integration

Achieving quality and patient safety goals requires collaboration between hospitals and physicians. While some hospitals are focusing on physician employment, for most it will be imperative to align with independent physicians. An integrated delivery system that has a clear strategy for how to effectively work with all physicians will be best positioned to achieve quality improvement goals and be prepared for new reimbursement models.

5 Healthcare Reform Implications for Providers

The debate continues and much is still unknown, but it is clear that healthcare reform will provide insurance coverage for more Americans and place new demands on providers. Physician organizations must be thinking ahead for:


■ Expanded Coverage and Greater Demand for Services

Whether through expansion of current coverage, expansion in Medicaid and/or a public option, more Americans will have access to health insurance in the future, and that will create greater demand for services, particularly primary care. Integrated systems must be planning ahead to expand capacity and meet demand.

■ Measurement and Public Reporting

Measuring and reporting on care processes and outcomes will be a major feature of healthcare reform. Expect to see expansion in existing programs and new demonstration programs, placing greater demands on providers to adopt and use Health IT.

■ Accountable Care Organizations

Managing and maintaining the health of populations will require a new level of collaboration among healthcare providers, supported by a robust IT and delivery infrastructure. Organizations that can successfully provide high quality care for populations will have the opportunity to share in the reward through these new reimbursement models. 



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Letter from the President: “Top Ten for Twenty-Ten”



On behalf of the officers and Board of Directors of your chapter, I'd like to wish you and your families the Best of Health, Happiness and Success for this New Year. Many will be glad to see 2009 end, but don't we say that every year? At this time of year, we often embark on establishing resolutions (wishful thinking) designed to improve our quality of life. In that spirit, I'd like you to consider these top ten HFMA ideas for 2010.

Make Great Choices

We have many great programs scheduled for 2010. Make a great choice to attend one or more of these programs. January will feature the Physicians and Emerging Issues program. February will feature the Managed Care program. Spring will be sprung with the March program, which is the second half of the joint Accounting and Reimbursement and Revenue Cycle program. If you've ever attended these programs in the past, you'll agree your choice will be a good one, this year as well!

Meet New People

As a chapter we are very fortunate to have nearly 1,300 members. You should ask yourself, "How many people do I really know through HFMA?" and more importantly, "How can I enrich my life by getting to know some new people?" A great way to do this is through active participation by either attending one of our fine programs or volunteering

to help out with not only some of the actual program committees, but also our operational committees such as newsletter, program planning, registration, or even membership.

Accept New Challenges

The New Year is a great time to enrich your life with a new challenge or two. It's a great time to consider certification in one or more of the specialties such as Accounting and Finance, Managed Care, Financial Management of Physician Practices or PFS. Certification is a great way to differentiate your background from others seeking the same positions in the work place. Along the way, you may learn some new skills to use in your own job.

Share a Good Idea

If you have a great idea about how to improve your HFMA experience, we'd love to hear about it. Our planning process for next year is already in progress, so it's never too early to share. Another way to share is through submitting an article for the newsletter.

Ask Good Questions

The solution to all your problems is at the other end of every good question you ask. You may need help in identifying resources for a project or opportunities to explore. I am confident your answer is as close as your membership directory.

Count Your HFMA Blessings

A good problem to have is too many blessings to count. Our chapter is rich in terms of the number of members representing diverse interests and backgrounds. We have been blessed with abundant financial resources through the stewardship of our previous leaders. We will continue to offer great programs and social events (golf outing June 16, 2010). We have dedicated officers and board members who are mindful of our legacy and their desire to plan for the chapter's future. You can

multiply your blessings by becoming actively involved in your chapter.

Embrace the Contributions of Others

If you've benefitted from your HFMA experience, it's important to acknowledge that it is only possible through the contributions of time, treasure and talent necessary to sustain our chapter. Thank the volunteers that give their time to ensure successful programs. Support chapter sponsors as they continue to provide financial resources for important activities such as the newsletter and membership directory. Acknowledge the speakers and newsletter authors who choose to share their ideas for your benefit.

Read the Newsletter

OK, so the president's letter isn't your favorite part of the newsletter. No problem. Enjoy the rest. Learn about new members and upcoming events. Set aside time to read an article outside your sphere of knowledge. Speaking from personal experience, I know that the editorial team commits significant resources to provide this award winning publication for your education and enjoyment. There's a lot of good stuff here!

Acknowledge Volunteerism

We all have day jobs. That said, many of us have chosen to volunteer because it makes us feel good. It's a generational thing! You can help the volunteers in two very important ways. First, choose to get involved. Even if you think you only can contribute in a small way, that may be just what another volunteer needs to balance out what they're able to do. Second, beyond the basic courtesy of thanking the volunteers, it's important to be patient and not too demanding.

Don't Fix it if it isn't Broken

As a chapter, we do more things right than we don't. Let's not focus on change for the sake of change. Let's fo-

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Letter from the President Continued

cus on improving what works well. Through the upcoming strategic planning process, we'll have an opportunity to assess what is and isn't working well. Once again, all good ideas are welcome. In fact, the chapter leaders may be calling on you to get involved in the process. Our goal is to improve the member experience.

I'd like to share a quotation from Herman Melville. I first discovered this quote in a health system community benefit report. I think it embodies both our HFMA experience, as well as that of the organizations we serve in our activities of daily living.

We cannot live only for ourselves.
A thousand fibers connect us with our
fellow men;
And among those fibers, as sympathetic
threads,
Our actions run as causes, and
come back to us as effects"

Herman Melville

I hope that you enjoy this issue of your newsletter and that you are making the most of your membership in the First Illinois HFMA chapter. We have many great events planned and I look forward to meeting you very soon. Of course, if there is anything you need, "Just Ask!" 📧

Best Regards,



Mike Nichols
2009 – 2010
Chapter President, HFMA

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The Human Capital Black Box

Why Hiring the Right People and Creating Team Diversity is Important to Your Balance Sheet

BY DAN YUNKER, VP & CFO, METROPOLITAN CHICAGO HEALTHCARE COUNCIL

A critical, valued skill of leadership has always been the ability to hire the right person the first time. Because economic, regulatory and legislative pressure is so severe today, this teachable skill is particularly relevant. Simply put, organizations do not have the time to waste dealing with a staff that does not function well. A non-team player, or an individual with all the talent in the world but who does not mesh with an organization's culture, is the weakest link. It is this flaw in a company that distracts us from spending our time on leading and accomplishing our organization's goals. As important, it also impacts all levels of how the organization functions.

As financial leaders we tend to follow a factual and structured approach to our daily routine. We tend to be hungry for details and the critical thinking that guide daily decisions. We want things to operate like a well-oiled machine, consuming as few resources as possible while delivering the best outcomes that can be achieved. In so doing, we may lose perspective.

At a recent CFO Committee meeting, our educational topic was organizational leadership. Our speaker for the morning was Kenneth R. Cohen, Ph.D., President, The Synergy Organization. Dr. Cohen has spent several years studying why the right continuum of talent translates to sustainable business performance and why succession planning is important. In the weeks following the CFO meeting, I had the pleasure of additional conversation with Dr. Cohen about his insights and wanted to share a few of the highlights with you.

In his presentation, Dr. Cohen spent a good amount of time talking about the importance of hiring the right people using the concept of a behavioral interview approach. A behavioral interview is a highly structured process involving a two way exchange of

relevant information that enables both the interviewer and applicant to make accurate and informed decisions for their mutual benefit. Dr. Cohen emphasized that an effective behavioral interview helps us tease out what matters most to both parties. These discussions are called "behavioral interviews" because they focus on demonstrated overt behaviors. There are three key elements of a behavioral interview: they are highly structured to ensure the interviewer is able to form an accurate assessment of the person's appropriateness for the position, conditions for the interview must be set so both parties share accurate information with each other, and finally, the discussion should never be an interrogation nor should it be an informal chat.



Dr. Cohen also talked about the subject of diversity in the workforce – an objective reflected as important in many of our strategic plans and stated corporate values. Dr. Cohen mentioned that over the years, many people have told him that when they think of the term "diversity" what usually comes to mind are more traditional factors such as age, sex, race, and religion. What we tend to forget is the importance of diversity in approaches to thinking and problem solving. I am sure we would all agree that the primary goal of meeting with others is to exchange accurate information, make good decisions, and

ensure that these decisions are implemented properly. Having an environment that encourages not only the free flow of different reasoned opinions but also generates intelligent challenges to the way things have always been done is critical to the success of any organization.

This then led to a discussion of what Dr. Cohen refers to as the "Management Paradox." Very simply put, the paradox of leadership is that the most effective leaders realize they cannot do everything by themselves even though in the short run, for a particular task, it might be faster. Because of this, the most effective leaders actually delegate more to their subordinates than do their less productive counterparts. As we discussed this concept, it made me think through delegation,

its real value and whether I am giving sufficient thought to this activity. On the surface, when I think about delegation, I value the opportunity to get something off of my desk, quickly. But then I thought of specific examples of delegation over the past 90 days and asked myself if those delegated tasks helped those to whom I delegated the task develop their own skill set. After going through this thought process, I concluded that to be effective, we cannot go it alone. If we do things in a way that enables talented professionals working with us to grow, we also

continue to increase our own effectiveness. A wonderful outcome is that we gain different or fresh perspectives and approaches to what needs to be accomplished. Dr. Cohen agreed and stressed the importance of making sure that our interviewing practices help us hire a diverse pool of talented people who are our complements, not our clones. In order to make the best decisions, we need a divergence of experiences and perspectives from people who act differently than we do, who see things from another perspective, and who have the courage and the ability to share these different perspectives with the team in

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The Human Capital Black Box...

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a factual and honest fashion. Accordingly, we need to surround ourselves with others who see and respond to things differently than we do.

To summarize, we need to have excellent interviewing practices that allow us to hire the right people with ability to bring different views and experiences to the table. It sounds simple but it just is not the norm, probably because we may subconsciously think less resistance means we will be able to accomplish more. As you read through this, you may be saying, "So what? What's at stake?" Dr. Cohen's estimate of the direct cost of hiring the wrong person at the leadership level can be at least 6-10 times that person's annual earnings. The indirect costs are even more when the emotional toll on the organization is taken into consideration. The total cost associated with poor managers who cause turnover among their productive employees is actually much greater than we might think. The Gallup Organization, among others, states that people do not quit their jobs, they quit their managers. That is why the quality of the relationships we enjoy with our direct reports is highly predictive of their productivity and longevity with the organization.

In both his research and in his daily work, Dr. Cohen has also found most effective leaders of the highest quality organizations recognize that it always costs far less to do things right the first time. This lesson applies equally well to hiring the right people as it does to getting a patient's information right on the front end. What contributes to the significant expense of a bad hire is how long it usually takes us to identify them and then act on our findings. In the vast majority of cases, most leaders tend to hold onto poor performers much longer than they should and come to realize, with experience, what he/she learned a long time ago, that a bad hire rarely gets any better. In the presentation Dr. Cohen referred to this as, "A leopard doesn't change his spots."

With these concepts, there are no accounting systems involved; it has nothing to do with issuing a bond, building a budget, or ensuring that the revenue cycle is operating at peak performance. There is no technology that will give us the golden answer, but these concepts are at the heart of who we are as leaders and what we can do to effectively position our organizations to meet their missions. With the right team and the right leadership, we can successfully achieve everything else more effectively. The higher up we move in an organization, the less important our technical knowledge becomes. What becomes critical at higher levels of responsibility is our interpersonal skills and overall leadership style. This we can control and practice, and it all starts with hiring and developing the right people. 

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First Illinois Chapter News, Upcoming Chapter Events and Committee Updates

■ Golf Committee

Anyone Up for a Round of Golf?

Dave Golom, FHFMA, a long-standing First Illinois HFMA member and 2007 First Illinois HFMA Medal of Honor Recipient, shared this joke with us as a reminder that we're only about four months away from golf season.

A businessman was attending a conference in Africa. He had a free day and wanted to play a round of golf. He was directed to a golf course in the nearby jungle.

After a short journey, he arrived at the course and asked the pro if he could get on. "Sure," said the pro, "What's your handicap?" Not wanting to admit that he had an 18 handicap, he decided to cut it a bit. "Well, it's 16," said the businessman, "but what's the relevance since I'll be playing alone?" "It's very important for us to know," said the pro, who then called a caddy. "Go out with this gentleman," said the pro. "His handicap is 16."

The businessman was very surprised at this constant reference to his handicap. The caddy picked up the businessman's bag and a large rifle; again the businessman was surprised but decided not to ask any questions.

They arrived on the 1st hole, a par 4. "Please avoid those trees on the left," said the caddy. Needless to say, the businessman duck-hooked his ball into the trees. He found his ball and was about to punch it out when he heard the loud crack of the rifle and a large snake fell dead from a tree above his head. The caddy stood next to him with the rifle smoking in his hand. "That's the mamba, the most poisonous snake in all Africa. You're lucky I was here with you."

After taking a bogey, they moved to the 2nd hole, a par 5. "Avoid those bushes on the right," said the caddy. Of course, the businessman's ball went straight into the bushes. As he went to pick up his ball, he heard the loud crack of the caddy's rifle once more and a huge lion fell dead at his feet. "I've saved your life again," said the caddy.

The 3rd hole was a par 3 with a lake in front of the green. The businessman's ball came up just short of the green and rolled back to the edge of the water. To take a shot, he had to stand with one foot in the lake. As he was about to swing, a large crocodile emerged from the water and bit off much of his right leg. As he fell to the ground bleeding and in great pain, he saw the caddy with the rifle propped at his side, looking on unconcerned. "Why didn't you kill it?" asked the man incredulously.

"I'm sorry, sir," said the caddy. "This is the 17th handicap hole; you don't get a shot here."

That's why you never lie about your handicap!

Dave Golom, FHFMA

■ Supply Chain/Operational Improvement

Be on the lookout for information regarding a new program on Supply Chain/Operational Improvement to be held April 21, 2010 at MCHC.

■ Certification Committee


The Value of HFMA Certification

When I had the privilege to serve as HFMA's President/CEO in the mid-'80s, I encouraged all our members to strive for professional certification. Today, 25 years later, I still believe in the importance and value of that certification.


Those of us in the healthcare field expect and assume that clinicians – physicians, nurses, other providers – will achieve and maintain professional certification. We expect that those who treat us will be up to date and current in their profession. Why should we expect anything less from ourselves and other healthcare executives?

In my current role as a healthcare executive recruiter, I look for and value a candidate's professional certification because it shows me that individual places importance on their continued education and development. It is another indication that the individual understands the meaning of being a true professional.

Michael F. Doody
Senior Vice President, Witt/Keiffer



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HFMA Events

First Illinois HFMA Treasury Program

BY PAT MORAN

First Illinois HFMA held its first permanent Treasury Program on Thursday, December 17 at the MCHC Conference Center in Chicago. This program, which was sold out two weeks before the program began, was attended by 115 professionals. We had attendees from Illinois, Wisconsin, Indiana, Ohio, Missouri, Philadelphia, Michigan, New Jersey and New York HFMA chapters. We had a record 20 CFOs registered, as well as 20 treasury members from Metro Chicago and a few hospital board members – responsible for treasury.

The program was organized by “Debit” related topics in the morning session (Asset Allocation, Alternative Investments, Accounting Implications of Alternative Investments, Defined Contributions and Cash Management/Fraud Avoidance) and the “Credit” related topics in the afternoon session (The New Reality of Debt, Tax Exempt Finance – Post Closing Compliance Issues, Update from the Illinois Finance Authority and Rating Agency Update from Fitch, Moody’s and Standard & Poor’s). We were also treated to a luncheon presentation on the topic of

“Are Not for Profit Hospitals Over Depreciating their Assets?” Kevin Scanlon, president of MCHC, also stopped by to give a market update to member hospitals.

Most of the presentations were “co-presented” by First Illinois HFMA CFOs/treasurers, in conjunction with speakers from the financial community. These CFOs/treasurers represented Academic Medical Centers, Integrated Healthcare Systems (IDNs) and Stand Alone Community Hospital’s views on the topics, to bring relevance to the other CFOs/treasurers in attendance by utilizing their organization as a “case study” on the topic being presented.

Many thanks to all who attended, the First Illinois Treasury Committee, our speakers and our sponsors of the event – JP Morgan Chase Asset Management & Chase Commercial Banking, Stratford Advisory Group, Fifth Third Bank and Kaufman, Hall & Associates, as well as our exhibitors – Dell Perot Systems, On Target Staffing, Harris & Harris and PNC Bank. 



Cathy Jacobson, HFMA National Chair



Matt Flynn and Terri Wareham



Jim Turco and Patty O’Neil



Clarence Atwood and Milton Santiago

HFMA Events

Healthcare Finance: The Next Generation

BY MICHELLE HOTZMAN, BRIAN KATZ AND PAT MORAN

On Thursday, October 15 2009, First Illinois HFMA conducted its tenth dual-track Accounting/Reimbursement and Revenue Cycle Educational Program at the Holiday Inn in Naperville. The morning general session was started off by John Bomher, SVP for Health Policy from the Illinois Hospital Association. John's update gave a great perspective on what is happening in Springfield with pending legislation and gave his perspective on the current status of healthcare reform in Washington DC. We were then treated to an update on the Recovery Audit Contractor (RAC) program by Sandy Newstein from IMA Consulting and Sharon Young from Perot Systems. They provided great insight into what the RAC auditors will be looking for, how to assess which areas will be at the greatest risk and what steps hospitals will need to take in their appeal process. Finally, we were treated to a dynamic presentation by Cindy Maxey, president of Maxey Creative, on the power and importance of presentation skills. Cindy's energetic and interactive program had the attendees "on their feet" for almost two hours.



Cindy Maxey, President, Maxey Creative

As the afternoon individual tracks progressed, the revenue cycle specific program dealt with key issues of the "season," beginning with the goal of seamless patient access – but seen from the patient's perspective. A rousing interactive session was headed by speaker Elise Lauer, director patient accounts for Northwestern Memorial Hospital, and as she pointed out, one of many healthcare consumers in the room. The theme then moved to the quagmire healthcare providers face in dealing with ERISA plans versus the self-insured employer based plans – what's to be followed legally and practically in enforcing reimbursement and payer contracts. This presentation by Ron Hennings, Esq. offered details, recommendations and case studies for evalua-



Chuck Lund

tion. Charles Lund of Accenture then treated us to details of the latest government challenge – the Medicaid Integrity Program – adding another layer to MAC, RAC, MIC, etc. And finally, a last minute game substitution Chuck Behl, vice president Revenue Cycle Services of Rush University Medical Center, offered his perspective on a revenue generating program to deal with a key aspect of the growing self pay problem. Chuck, in tandem with Fred Graessle of Chamberlin Edmonds, showcased the Social Security Disability enrollment program that has been in place at Rush University Medical Center for the past several years, with memorable results. The program has not only generated increased reimbursement, but has provided patients in need of care the umbrella of coverage so they did not avoid needed health care services to the point of emergency.

On the accounting/reimbursement side, the afternoon began with a bang and a large audience for the healthcare reform presentation. An aide to Congressman Mike Quigley of Illinois 5th District provided an overview of key discussions surrounding healthcare reform in Congress. Afterwards, Larry Goldberg, se-

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Larry Goldberg and Kim Waltz

HFMA Events

Healthcare Finance: The Next Generation

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nior advisor for Health Care Legislative and Regulatory Matters at Grant Thornton LLP, provided a very insightful presentation on the potential impact of health care reform on healthcare providers. Larry's in-depth knowledge of health care legislative matters and his straight-forward commentary captivated the attendees. Chris Hoffman, partner, PricewaterhouseCoopers LLP, provided a very comprehensive presentation on RAC reserves. Joe Becht, partner, Claire Herring, senior manager, and Brian Katz, manager of Deloitte & Touche LLP, provided a thorough discussion and presentation on recent developments in the Supplemental Security Income (SSI) ratio. Finally, Maria Stephan, senior manager and Brian Pavona, manager of Ernst & Young LLP, provided an excellent Financial Accounting Standards Board (FASB) update. ☞



Joe Becht, Claire Herring and Brian Katz



Founders Awards were presented to: Silver Award: Michelle Holtzman, Bronze Award: Pat Moran, Silver Award: Paula Dillon, Gold Award: Janet Blue

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Credit Implications in Uncertain Times — Paging Dr. House

BY ANTHONY A. HOUSTON, SENIOR DIRECTOR, PUBLIC FINANCE HEALTHCARE GROUP, FITCHRATINGS

Chicago — In the hit TV drama **HOUSE** — an irreverent physician leads an elite team of young diagnosticians on a journey to solve mystifying medical riddles. In most episodes Dr. House's genius or the collective brilliance of the team isn't revealed quickly nor is the solution often found in obvious places. Mostly through trial and error and in some cases luck, the team happens upon the diagnosis and treatment plan after expending much effort on meager hunches and perilous searches for some exotic environmental origin. At other times, Dr. House purposely puts his team on the wrong trail in the hopes of stimulating "out-of-the box" thinking; a bit of tail-wag-dog that can lead to answers. Often, the patients are subjected to intense and in certain cases painful therapies for causes that are later proved wrong. Given the uncertainties in our industry, some reading this might relate well to the surreal world of Dr. House and his team or others might relate to his patients who place their lives into the hands and minds of "experts" who at times seem to be without empathy or devoid of proper therapeutics.

Somewhat analogous is the current fury over health reform that has many feeling "unwell". Compounded by the current recession, these daunting times challenge many health leaders with similar puzzles and riddles that confront the House team. Without a crystal ball, although Dr. House is often depicted cajoling a plush tennis ball as a stimulant, it becomes improbable to conjure a plan of action that is full-proof in the face of such uncertainty in the industry. Similar to Dr. House and his young experts who often start with a detailed history and physical (H&P), the leaders of today's health-care organization should begin with a thorough and honest inventory of the organization's core strengths and weaknesses with a focus on the controllable ex-

ternal and internal influences which may impact an institution's overall health. This gathering of the facts, measured against expected outcomes and the questioning of assumptions is no different than Dr. House forcing his team to use the scientific method to find the correct diagnosis and therapy.

Given today's uncertain economic and political environment, keeping your organization healthy is challenging. The industry has weathered cyclical turns in the past; the advent of managed care, the BBA of 1997, along with various recessionary economic cycles. The recent turmoil in the global financial markets negatively impacted the industry's collective balance sheets in a way not seen in the past and forced a rethinking of risk / reward assumptions. Furthermore, the resulting job losses and the specter of health reform are threatening many providers' income statements. When evaluating credit implications of the current environment and the post reform future, analysts at Fitch remain focused on three areas where management is

believed to have the greatest effectiveness: core operations, asset liability management and resultant financial cushion, and strategic positioning.

Fundamentals of management like matching costs with activity and ensuring proper revenue capture will be imperatives for success. Further, a keen focus on quality, although not yet directly rewarded with increased revenues, should result in lower operating costs and greater strategic opportunities going forward. The maintenance of cash flow and operating profitability remain job one and will continue to be differentiating credit factors. As with Dr. House's team, solving the riddle is merely the beginning; it's the ability to learn from the challenge and sustain, repeat and scale the solutions or improvements that will likely be the secret to long-term success.

In past down cycles, the panacea to cure the ails of operating weaknesses was often robust and consistent investment returns. Increased debt issuance

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Credit Implications in Uncertain Times — Paging Dr. House

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throughout the industry was in most part a response to aging plants; however since tax exempt hospitals often borrow at low, tax exempt rates, many boards and management teams decided to retain their earnings and invest them at a higher rate than the cost of borrowing. Variable rate products that provided borrowers a way to increase their “spread” became increasingly popular over the last several years. However, the potential risks were perhaps not fully appreciated by many and have now been brought to bear in the market. In particular, debt structures that expose borrowers to excessive put, term-out, or interest rate risk have triggered some negative rating actions and have caused many to reevaluate their debt profile or transfer the risk to the market via fixed-rate mode conversions. Although a higher interest rate environment is taking hold, interest expense as a percentage of net revenue remains low (2.5% median in 2009 for Fitch’s ‘A’ rated hospitals) and will likely not be a major credit concern for most borrowers. However, for some, the resulting expense increase and coverage decline could pressure ratings, especially if profitability is already depressed.

Now more than ever, providers will be pressured to ensure they have the ability to fully finance their strategic plans; recent events have exposed those organizations without internal resources to weather the storm. Active management of both the asset and liability side of the balance sheet in conjunction with a prudent long-term financial plan is essential. A plan that limits exposure and matches the organization’s capital needs with its debt capacity are viewed as best management practices. Overall, given that management teams and boards will be severely tested and under intense pressure over the near term, those that have already taken that detailed H&P

and have implemented management best practices during the period of good operating times will likely be best positioned to respond and act more effectively in these more uncertain and difficult times.

A provider’s strategic position, which encompasses market presence, recent capital investment history, and demonstrated value of the services it provides, is an essential element to creditworthiness. A prudent strategic assessment aims to answer the question, “In five years, in this service area, with these competitors, what will be the condition of this enterprise and why?” Much like when Dr. House’s team derives its diagnosis and resultant therapies, answers to this question are likely the essential pathway to long-term success. Providers with a leading market share, those that offer specialized services, or those that operate in a limited competitive area should be in a stronger operating position going forward. In turn, these providers should be better positioned to hire and retain physicians, provide high quality outcomes at the lowest cost, and adapt to a lower reimbursement environment post reform. Transparency, physician

alignment, access, quality, safety, patient satisfaction, and expense control are all important elements of the value proposition. Regardless of healthcare reform’s precise configuration and timeline, those providers with favorable performance in each of these elements are expected to be well positioned to thrive as the industry evolves.

Whether you feel part of Dr. House’s team or like one of his patients, the successful remedies for post reform success are not likely found without some level of trial, error and anguish. However, given an honest inventory of an organization’s core strengths and opportunities, management teams who stick to the basics are likely to successfully lead their organizations through these uncertain times, even if it means going through some extreme therapies along the way. 

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On The Front Lines

Inside Criminal Minds, Part I

BY ALLAN P. DEKAYE, MBA, FHFMA

Fraud! Settlements! Restitution! Jail time! All headlines ripped from industry trade journals and newsletters. The unsettling fact is that these same headlines have appeared with regularity over the last 15 years, or at least since Health Care Fraud has become a target of investigation at the federal, state and local levels.

Inside Criminal Minds, presented in two parts, takes a closer look at those who have committed fraud, and examines the characteristics that may have led to this criminal behavior. It also will look to define varying degrees of greed, as behavioral traits common to the criminal mind. In addition, the article will examine: (1) the way many compliance structures work to detect and prevent fraudulent activities to see if it provides sufficient safeguards, (2) the more sophisticated data models used to guard against identity theft and record breaches, and (3) the way we screen new hires and reevaluate existing staff to see if lapses or loopholes exist that threaten to exploit vulnerable areas. Finally, the article will present related perspectives and vantage points to address compliance concerns.

The Hierarchy of Need

History has a way of repeating itself: climate, war, disease, crimes and behavior, to mention a few illustrations. In 1954, Dr. Abraham Maslow introduced the “Hierarchy of Needs.”¹

In this classic work, Maslow identifies five needs: physiological, safety, social, esteem, and self-actualization. In its purest sense, Maslow’s approach contends “...Humanists do not believe that human beings are pushed by mechanical forces, either of stimuli and reinforcements (behaviorism), or of unconscious instinctual impulses (psychoanalysis). Humanists focus upon potentials. They believe that humans strive for an upper level of capabilities...”²

Over the years, Maslow’s “needs” theory has been expanded and adapted. For example, the need for “safety” can be translated to include “...our urges to have a home in a safe neighborhood, a little job security, and a nest egg ...and so on.”³ With this in mind, another adaptation states: “If Maslow’s theory is true, there are some very important leadership implications to enhance workplace motivation.” To allow workers to reach Maslow’s self-actualization level, “...[the workplace needs to] offer challenging and meaningful work assignments which enable innovation, creativity and progress according to long-term goals.”⁴

“Maslow’s concept of self-actualization relates directly to the present day challenges and opportunities for employers and organizations – to provide real meaning, purpose and true personal development for their employees. For life – not just for work.”⁵ While Maslow provides one model for understanding what individuals need, then we need to examine where in the workplace either needs are not being met, or additional behavioral characteristics can be identified to determine if an early warning to predisposition to criminal behavior is possible.

While a psychosocial profile might define a potential criminal from an accounting profile, other characteristics also might be identified. In the Accounting Department at Louisiana State University (LSU), students of Professor D. Larry Crumbly, CPA, Cr.FA, CFFA, FCPA,

have compiled a series of papers that address these characteristics as part of their studies in Forensic Accounting.

In Lisa Eversole’s paper, “Profile of a Fraudster,” “egotistical, risk taker, rule breaker, under stress, financial need and pressured to perform” were among the characteristics identified. In a review of criminally prosecuted health care fraud cases, these same conditions similarly were mentioned. She went on to observe: “The gains from the fraud can be direct (receipt of money or property) or indirect (reward or promotions, bonuses, power or influence).”⁶ In the next section, a system to classify these behaviors will be introduced.

The Hierarchy of Greed

Maslow’s Hierarchy of Need is often represented as a pyramid, with physiological needs at the bottom and self-actualization at the top. In researching this topic, five levels of greed have been used to similarly classify health care’s “Hierarchy of Greeds.”⁷ Using a pyramid, these five types of greed are: undisciplined, opportunistic, corporate, scheme and organized. A definition and discussion of each follows.

Undisciplined Greed – is typified by an individual(s) whose inquisitive mind(s) lead them to “sneak a peek” at celebrity-medical records — more out of curiosity than for profit; but nonetheless, a serious breach of medical data security.

Opportunistic Greed – adds an “opportunity” factor to undisciplined greed and parlays it into a motive by selling that information for personal gain. This category also includes individuals who commit fraud against insurance companies.

Corporate Greed – raises the bar from the staff levels usually found in undisciplined and opportunistic greed, and involves organizational leadership. The notion of “loophole exploitation” is introduced to see how much of a factor it plays when corporate greed is examined in the context of not-for-profit vs. for profit entities.

Scheme Greed – The very sound of the word connotes evil wrongdoing, and is most often exemplified by an outright plan to steal information to profit by its use in defrauding governmental insurance plans.

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Organized Greed – Yes, it can involve organized crime; but more often provides an expansive base from which schemes are hatched, expanded from within a familial circle, and copycatted by others looking to profit from ill gotten gains.

When taken together, these five factors cover a wide-range of health care fraud and abuse. While not necessarily a perfect classification system, it allows for type casting the bad actors that have been disciplined, fined, or incarcerated; and provides some insight into the factors that influenced these bad behaviors. As a result, some additional safeguards can be considered. These discussions follow.

Crimes and Punishment

“Don’t do the crime, if you can’t do the time!”⁸ In cases of health care fraud and abuse, penalties can range from payment restitution to criminal incarceration. In instances in which internal hospital medical records are breached, punishment ranges from reprimands to dismissal, with civil and criminal proceedings possibly based upon the extent of the infraction, and consequential damages caused by the actions.

The EMR isn’t Facebook

“Friend me; tweets, and text messaging” have become commonplace; but all too often that commonplace activity also occurs in the workplace. After a recent mass transit accident in Boston, a trolley driver admitted to “texting while operating the vehicle” while rear-ending another trolley in front of it.⁹ While the case will no doubt look to place future sanctions and prohibitions on carrying and using cell phones, personal digital assistants (PDAs) and the like by transit employees, you need only look around any hospital setting (or for that matter, any office setting) to see this common occurrence.

Surprisingly, after reading two Internet postings (there are probably more), the health care industry will need to brace for the impact of “Twitter Surgery — In the Operating Room,”¹⁰ and the “4 Things You Shouldn’t Do While Texting” including circumcision and surgery),¹¹ which may portend an even greater risk than celebrity data breaches.

The sanctity of the medical record, whether the traditional hardcopy variety, or the newer electronic medical record (EMR) that is dotting the landscape in ever increasing numbers, is vulnerable to the “sneak a peak,” also known as celebrity data breaches. “Our society’s insatiable desire to know everything about celebrities, especially the private details of their lives, has reached a new low with recent news out of Los Angeles. Also at a new low here: patient confidentiality. The UCLA Medical Center is moving to fire 13 employees and disciplining 12 others, for peaking at the confidential patient history of pop star Britney Spears, the Los Angeles Times reports.”¹²

These are not isolated events, although they may have a geographic locus on the East and West coasts. “When a famous Hollywood actor is suddenly admitted to your hospital, some employees will likely be tempted to take a peek at the heartthrob’s medical records. But when the hospital in question later suspends more than two dozen employees without pay for allegedly violating privacy rules, those involved

are bound to question whether ‘the punishment fits the crime,’ and to what extent the hospital could have better protected its celebrity patient.”¹³

These instances of “undisciplined” behavior may be rooted in celebrity viewing, but in another episode at UCLA Medical Center in which celebrity breaches of such notables as Farrah Fawcett and California’s First Lady, Maria Shriver, have occurred, the same individual who viewed Fawcett’s records, also viewed 61 other patient records—including those of noncelebrities.¹⁴ While undisciplined actions seem to attract attention and notoriety associated with celebrities, the impact tends to be localized, as long as the data breach is contained and not exploited for profit and gain, as shown in the next section.

Identity Crisis

Whether watching television or surfing online, the airwaves and cyberspace are filled with offers and advertisements to check your credit report, and prevent financial identity theft. Far less evident in the literature, and almost certainly absent from the media glare is the matter of medical identity theft. Though the two types of theft are rooted in the same premise that something personal has been stolen, the extent of the impact, the detection timeframe and the consequences and prevention techniques are in need of tightening in the health care industry.

The “undisciplined” persona noted above turns greedier when it becomes “opportunistic,” and it is no longer a voyeuristic event, but one where data is stolen and sold. For example, while medical data breaches at UCLA Medical Center were discussed above, an employee at the same facility pleaded guilty to selling patient medical information to tabloid publications in 2007.¹⁵

While tabloids are one avenue to entice the opportunistic individual, another more sinister plot unfolds when staff with access to data can be compromised to sell patient information to unknown third parties. In the incident involving New York-Presbyterian Hospital/Weill Cornell Medical Center, a staff member was arrested for selling data to persons who approached the individual offering money for information. The reported payments of \$750 and \$600 for at least two sets of 1,000 patient data files seems small compared to the risk of losing one’s job and likely facing criminal prosecution. The potential damage resulting from the misuse of this data, however, could cause financial and medical identity theft affecting very large patient populations.¹⁶

Financial identity theft seeks to impersonate an individual by accessing their credit cards, bank accounts and personal data. Medical identity theft, while borrowing some of the same key demographics that make up one’s “protected health information,” results when another individual improperly poses as the patient, or one’s insurance identification is improperly used. These errant entries in the medical record may go undetected for long periods of time and become difficult to correct.

“Medical identity theft is a crime that can cause great harm to its

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victims. It also is the most difficult to fix after the fact because victims have limited rights and recourses. Medical identity theft typically leaves a trail of falsified information in medical records that can plague victims' medical and financial lives for years."¹⁷ Medical identity theft is caused in large part by the type of schemes that involve theft of patient and physician information resulting in billing fraud that will be discussed in more detail. Because of its striking similarity to financial identity theft, however, these two problem areas are grouped together and classified as opportunistic greed.

While a good portion of the undisciplined and opportunistic health care fraud is associated within the framework of organizational entities, individuals commit health care fraud against their own insurance companies. This may take the form of submitting personal claims that are false or erroneous. In instances in which these individuals are caught, their defenses range from ignorance to everyone is doing it, to the insurance company won't miss a few dollars."¹⁸ Prosecutors often cite nongovernmental health insurers in having better systems and resources to detect and prevent claim fraud than do the federal government's Medicare and Medicaid programs.

"Someone Always Playing Corporation Games" ¹⁹

"Corporate Greed" is listed third on the hierarchy of greed. In the first two categories: undisciplined and opportunistic, the individual tends to be a staffer and not a department head or executive. In corporate greed, we start the climb that may take us into the "C-suite." The perplexing question is why?

Many "not-for-profit" organizations find themselves with large settlements, corporate integrity agreements, and in some cases incarceration for fraudulent acts. On the surface, it may appear more obvious that in the "for profit" health care sector there might be more corporate greed, given higher salaries, bonuses, and stock options that serve as the motivating factors. Those successful in the not-for-profit sector, however, often use their accomplishments as a springboard to the more lucrative for profit sector. Then again, the increasing levels of executive compensation in the not-for-profit sector have risen to such heights that congressional investigations have taken a closer look, especially as the voluntary not-for-profit organizations struggle to deliver services and meet the community benefit needs during increasingly difficult reimbursement and regulatory periods.

With these conditions as a backdrop, three other factors warrant consideration as possible precursors to criminal activities: ego, misguided altruism, and loophole exploitation.

(1) Ego – Bragging rights may have something to do with this. Hospitals are ranked in national publications, and even have mortality and other measures becoming commonplace on state health department websites. Additionally, in "Profit of a Fraudster," Eversole said "the perpetrator may be scornful of obvious control flaws...and beating the organization [or system] is a challenge and not a matter of economic gain alone."²

(2) Misguided Altruism – By most accounts, hospitals nationwide have been operating on razor thin margins — with those in New York State (NYS) often on no margin at all. This makes the case of the seven NYS hospitals named in a \$50 million lawsuit alleging kickbacks, billing for unnecessary services, and providing treatment without a license,²¹ a possible case of misguided altruism gone badly. Interestingly, in another article it was reported that "No criminal actions are alleged in the complaint. But the attorney general had harsh words for those named in the complaint."²²

(3) Loophole Exploitation – In a good many instances, the use of civil remedies tend to be applied to what is here termed, "loophole exploitation." While it may be called "gaming the system" or "pushing the envelope," cases for erroneous billing whether associated with outliers, diagnosis-related group (DRG) code assignment, cost reporting, kickback, or various types of billing therapies, these cases generate considerable negative publicity, and often result in steep fines and penalties being levied.

While inexcusable in the eyes of the law, the motives behind these vehicles seem more rooted in misguided altruism, rather than the egregious behavior that is discussed in the next two behavioral levels of greed. Although the types of corporate greed discussed above were centered in the hospital and health system and physician arenas, corporate greed has new frontiers in the pharmaceutical and pharmacy segments, with many cases being brought both civilly and criminally.

Some prosecutors see less behavioral causation, and instead believe its economic risk that weighs as a more significant contributing factor. They emphasize that it is the choices that management often makes in deciding in favor of one project or another determines whether management evaluates economic gains vs. risks. Citing more recent examples of hospital settings vs. pharmaceuticals, they conclude that "pharma" has become more "risk aware and risk averse" after years of being penalized significantly and substantially. Additionally, there has been more restraint as a result of having the overall number of companies reduced in size, and specifically because the companies' boards will directly hire and fire the chief executive officers. In contrast, hospitals and health systems will (still) get it wrong when competing projects pit the general good of the hospital vs. the good of individual and competing departments. Too often, the "actors" don't have the full frame of reference and incomplete knowledge from which to make objective and legally correct recommendations.

When Strategies Becomes Schemes

The literature talks about "schemes," particularly as they relate to those individual(s) who steal Medicare and Medicaid identification numbers and unique physician identification numbers to bill fraudulently. The most prominent schemes are found today in the Durable Medical Equipment (DME) and infusion therapy services.

Surprisingly, many of these crimes are perpetrated by individuals or small groups of people often related to each other. In dissecting the backgrounds of these schemes, prosecutors report that ethnicity and

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barriers to workforce entry of those in lower socio-economic rankings make for a recipe to enter criminal enterprises. So rampant has this phenomenon become that federal task forces have been formed in an all-out effort to dismantle these illegal activities and prosecute the guilty parties. Medicare is a trust-based system, and prosecutors have found over the years that schemers have found ways to take advantage of its thinly reinforced protective barriers. Now with this all-out effort to add manpower and data and analytic prowess, prosecutors hope to derail these current schemes; although they are wary that further vulnerabilities are simply one schemer away from starting over again.


The Sopranos Meet Health Care

At the top of the Hierarchy of Greed pyramid is “organized greed.” “Health care fraud is not just committed by dishonest health care providers. So enticing an invitation is our nation’s ever-growing pool of health care money that in certain areas - Florida, for example - law enforcement agencies and health insurers have witnessed in recent years the migration of some criminals from illegal drug trafficking into the safer and far more lucrative business of perpetrating fraud schemes against Medicare, Medicaid, and private health insurance companies.”²³

It may not be too difficult to see how the opportunistic behavior associated with financial and medical identity theft, and the individual scheming characterized by ethnicity and lower economic standing has led to organized crime seeking a foothold in health care fraud. Pam Dixon, Executive Director, World Privacy Forum, said: “...there have been cases involving Russian organized crime and identity theft rings that are buying health clinics and billing the government for services.”²⁴

While it’s been noted that organized crime may find health care fraud less likely to be detected, and that its penalties less harsh, a review of more recent convictions and penalties suggests otherwise. The joint strike forces that are now operating in Miami and Los Angeles bring all of the power of the federal government to bear. This is particularly noticeable when the convictions appear on the Internal Revenue Services web site where penalties appear to increase exponentially for the added charges of tax evasion and money laundering. When mail fraud also is evident, penalties also increase. The government is trying to combat the problem with an increasingly large arsenal of weapons at its disposal.

Conclusion

Part I of this article has examined those who have committed fraud and the characteristics that may have led to their criminal behavior. It also has defined varying degrees of greed, as behavioral traits common to the criminal mind. Part II will examine the way many compliance structures work to detect and prevent fraudulent activities, sophisticated data models used to guard against identify theft and record breaches, the screening of new hires and the reevaluation of existing staff to see if lapses exist that threaten to exploit vulnerable areas, and related perspectives and vantage points to address compliance concerns. 

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The statements and opinions appearing in articles are those of the authors and not necessarily those of the First Illinois Chapter HFMA. The staff believes that the contents of *First Illinois Speaks* are interesting and thought-provoking but the staff has no authority to speak for the Officers or Board of Directors of the First Illinois Chapter HFMA. Readers are invited to comment on the opinions the authors express. Letters to the editor are invited, subject to condensation and editing. All rights reserved. *First Illinois Speaks* does not promote commercial services, products, or organizations in its editorial content. Materials submitted for consideration should not mention or promote specific commercial services, proprietary products or organizations.

Style

Articles for *First Illinois Speaks* should be written in a clear, concise style. Scholarly formats and styles should be avoided. Footnotes may be used when appropriate, but should be used sparingly. Preferred articles present strong examples, case studies, current facts and figures, and problem-solving or "how-to" approaches to issues in healthcare finance. The primary audience is First Illinois HFMA membership: chief financial officers, vice presidents of finance, controllers, patient financial services managers, business office managers, and other individuals responsible for all facets of the financial management of healthcare organizations in the Greater Chicago and Northern Illinois area.

A broad topical article may be 1000-1500 words in length. Shorter, "how-to" or single subject articles of 500-800 words are also welcome. Authors should suggest titles for their articles. Graphs, charts, and tables (PDF or JPG only) should be provided when appropriate. Footnotes should be placed at the end of the article. Authors should provide their full names, academic or professional titles, academic degrees, professional credentials, complete addresses, telephone and fax numbers, and e-mail addresses. Manuscripts should be submitted electronically, on computer disk or by e-mail as a Microsoft Word or ASCII document.

Founders Points

In recognition of your efforts, HFMA members who have articles published will receive 2 points toward earning the HFMA Founders Merit Award.

Publication Scheduling

Publication Date

April 2010
July 2010
October 2010
January 2011

Articles Received By

March 10, 2010
June 10, 2010
September 10, 2010
December 10, 2010

JUST ASK!

2010 Scholarship Application

Did your child apply yet for the FIHFMA Chapter Scholarship?

The 2010 scholarship application is now online. Please visit the FIHFMA website (www.firstillinoisHFMA.org) to download the application.

The application deadline is March 1, 2010.

Healthcare Financial Management Association First Illinois Chapter

Chapter Events Calendar 2009/2010

For a current listing of all upcoming First Illinois HFMA Chapter events, please visit: <http://www.firstillinoisHFMA.org/calendar.htm>

Tuesday, February 2, 2010

RSM McGladrey Webcast
Online

Wednesday, February 10, 2010

Webinar - IMA
Online

Thursday, February 18, 2010

Managed Care
Chicago, IL

Friday, February 26, 2010

CFO Breakfast
Elmhurst Center for Health, Elmhurst, IL

Thursday, March 11, 2010

alPAM
Chicago, IL

Thursday, March 18, 2010

Accounting/Reimbursement/Revenue Cycle
Chicago, IL

Friday, March 26, 2010

CFO Breakfast
Elmhurst Center for Health, Elmhurst, IL



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