The Patient Access Issue

issue highlights:

**Financial Triage:**
Point of Service Collections and EMTALA

**Patient Access at Westchester Medical Center:** Ensuring Revenue Recovery & Patient Satisfaction

**Physician/Hospital Integration:**
White Plains Hospital Makes the Transition
**President’s Message**

**William L. Scheuermann, MBA, Director of Managed Care Contracting, Orange Regional Medical Center**

*Happy Holidays.* I want to wish you and yours a safe and Happy New Year and outstanding 2012! I am very excited about the upcoming year for a number of reasons.

For starters, I want to thank everyone who took the time to participate in our Hudson Valley membership survey. We look forward to hearing more on how we are meeting your needs as well as suggestions for ways we can better serve you. We promise to use the feedback to help best meet your organizational, and personal professional, needs. Keep posted for details on the final results.

I also encourage you to please reach out to me, or any member of our leadership team, to discuss how we can be of assistance in getting you the most out of your HFMA membership.

In order to provide further opportunities to help with your growth and professional development, the Hudson Valley NY Chapter HFMA provides many resources. One group that has been extremely engaged in recent months in reinventing itself and looking for ways to better serve chapter members is our Certification committee, headed up by Marianne Muise, FHFMA, Barbara Piascik, CHFP, Perry Santullo, FHFMA, Bob Davison, CHFP and Immediate Past Chapter President Jason MacDonald. The committee has begun to identify opportunities to serve membership, including being available and visible at all chapter educational programs to provide information on certification. Additionally, they are looking for members interested in developing an active study group; identifying ways to offer chapter members cost savings for on-line study materials; and reviewing benefits offered to members who successfully achieve certification. To that end, I am very excited and proud to recognize both Scott Edelmann, FHFMA of Burke Rehabilitation Hospital and Bob Davison, CHFP of Catskill Regional Medical Center for achieving HFMA Certification.

One of the keys to our mission and serving our members’ needs is providing timely and valuable educational opportunities. On December 15th the Chapter hosted our annual OPPS Update program. The program included presentations from Navigant Consulting, HANYS and Kirschmann & Associates, who presented on Charge Master Keys to Success. This nuts and bolts program offered important information to bring back and share.

The next session will be our Annual Holiday and Awards Program on January 19th at the wonderful Tappan Hill Mansion in Tarrytown, New York, and featuring HFMA National Chair, Greg Adams, as the morning keynote speaker. The program will also feature presentations on patient access, and the relationship between quality, finance and payment innovations. The day will wrap up with an afternoon keynote presentation from Michael Irwin of Citigroup Health Investment Banking who will discuss trends in hospital organizational structure and designation.

Next on the calendar is our highly anticipated Annual Institute on March 29th. This year’s theme is “The Value Based Transformation: Healthcare’s Path to the Future.” Keynote speakers include Emily Friedman, Dr. Robert Galvin and David Hammer. A panel discussion with industry experts,
break-outs on ICD10, Calculating the Impact of Payment and Delivery System Changes, and Developing a Patient-Centric Experience round out the day. I promise that this is a program you do not want to miss!

A final exciting update I want to share relates to a new committee we’re developing and expect to kick-off in early 2012. The chapter, with support from the Northern Metropolitan Hospital Association (“NORMET”), is formalizing an active “Revenue Cycle Roundtable”. The driver behind this idea is the Hudson Valley HFMA’s very own Bob Shaw, Vice President of Revenue Cycle at Westchester Medical Center. The focus of these two hour meetings will be to discuss “successes, challenges and opportunities across the revenue cycle spectrum.” The meetings will be held bi-monthly, and topics will be defined by the group. The participants will share their thoughts on organizational and individual solutions to problems, opportunities and lessons learned. The goal will be to attack the key challenges surrounding Patient Financial Services, Patient Access, Charge Master, Managed Care / Reimbursement and Coding / Medical Records that keep us up at night, and to offer actionable ideas to apply back at the office. Some topic examples offered by Bob Shaw include charge capture, bill holds, external appeal processes, one-day stays, DRG validation, audits (RAC, OMIG, etc.), point of service collections, insurance company concerns, and cost outliers processes.

In closing, I want to again wish you and your families a safe and lovely holiday season. Please stay tuned for additional updates on all of the above happenings.

As always, please let me know if there is anything I can do to help.

Respectfully yours,

William L. Scheuermann
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Hospitals in communities throughout New York are taking note of the proliferation of for-profit investors literally “rescuing” not-for-profit hospitals in surrounding states. These investor-owned chains have the money to fund the clinical and technological investments needed to compete in the evolving health care marketplace. However, many question whether these investors, who answer to shareholders, can also adhere to the original charitable mission embodied by not-for-profit hospitals.

It was not long ago that New York State hospitals and policy makers entertained the idea of a proprietary hospital marketplace. In the late 1990s, we saw similar struggles with the economy and hospitals' finances. Resorting to layoffs and facing mounting bills, hospital administrators and even the New York State Health Department began to think the unthinkable — turning to public, profit-making companies to own and run hospitals. The de-regulation of hospital rates in 1996, under Governor George Pataki, led many to believe for-profit hospitals were not far behind.

But time elapsed and the economy improved and to this day New York State remains the only state in the nation that bars publicly-traded, for-profit hospitals. Once again, a weak economy, dearth of capital, and soaring expenses make investor-owned and operated hospitals an attractive option. At the October 2011 meeting of the Medicaid Redesign Team Brooklyn Task Force, chair Stephen Berger stated he is open to “any and all proposals to help the capital worries that hospitals in Brooklyn are facing. This includes for profit operators who can inject capital into providers.”

Many remain concerned, however, that investor-owned hospitals will put profits before patients, undermining the very premise of hospitals’ desire to care for any and all patients. Less profitable service lines, such as trauma centers, burn units, psychiatric services, and even emergency room services, might be a drag on the bottom line. And since supply has historically driven demand in health care, for-profits may look to capitalize on the more profitable service lines such as cardiac catheterization or orthopedics, leaving some communities without proximal emergency services.

Performance-based reimbursement and quality improvement efforts are also driving the for-profit trend. Last year, the head of Moody’s health care bond rating unit argued that better quality control can improve hospitals’ financial performance. Moody’s now looks closely at hospital clinical measures when rating debt offerings. A recent Forbes survey of America’s most profitable hospitals found that patient satisfaction scores from Medicare’s Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey correlate meaningfully with profitability. The rationale is that when hospital consumers are happier and hospitals work diligently to deliver high quality care hospitals become more profitable.

Yet, for all the financial pressures facing not-for-profit hospitals, many continue to thrive and prove their worth, both economically and charitably. Perhaps that is why HealthGrades America’s 50 Best Hospitals for 2011, published this past February, found 86 percent are not-for-profit or local entities. Indeed, many NorMet member hospitals are now taking a hard look at their operations and business models in the face of health care reforms. Consolidations, physician hospital organizations, and similar arrangements hold potential for sustainability and profitability, as our health care delivery system transforms. The challenge to not-for-profits and for-profits will certainly intensify, as we move further into reform and the economy sputters to recover.

Register to attend!

**2012 Holiday Session**

**Thursday, January 19**

**Tappan Hill Mansion**  Tarrytown, New York

Visit www.hfmahudsonvalleyny.org to learn more about all of our Chapter events & to register.

NYS CPE Credits 5.0
As health care reform moves care delivery away from fee-for-service payment and toward coordinated models of care and reimbursement, HANYS has been a vocal advocate for ensuring that hospitals and health systems can access the resources they need to serve patients as they make this transition.

Although the familiar uphill battle for adequate fee-for-service payment is less exciting than the innovative possibilities we see emerging from health care reform, it is every bit as important to New York’s hospitals and health systems.

Fee-for-service is still the dominant payment paradigm, and it is critical that we ensure that it is not dismantled in a manner that harms providers and patients as we transition to new payment and care delivery models. However, at times, government seems to willfully undermine the transition by chipping away at the fee-for-service payments providers need to restructure.

HANYS and our members embrace the need to innovate to reduce costs and improve care. As champions of reform, we are helping reshape the health care system to make it more patient-centered and efficient. Yet, our efforts have been hobbled as we have witnessed repeated rounds of legislative cuts, and the threat of more to come. Equally insidious is the “death by a thousand cuts” providers face as state and federal government agencies diminish existing payment streams.

For example, the Centers for Medicare and Medicaid Services (CMS) continues to implement “coding adjustments” to the Medicare Prospective Payment Systems (PPSs), ostensibly to offset provider behavior in billing Medicare for more expensive procedure codes (“upcoding”). CMS apparently refuses to acknowledge some cost increases are linked to actual changes in patient characteristics and treatment patterns, not upcoding.

The most egregious example was CMS’ decision to implement prospective and retrospective inpatient PPS coding adjustments in the current fiscal year, despite our strong arguments against this, in which we detailed well-known, documented factors that explain a steady, gradual increase in the severity of Medicare patients that are treated in the hospital inpatient setting.

In a recent twist on this trend, the 2012 Home Health PPS final rule will reduce Home Health (HH) PPS rates to account for what CMS says are improvements in the coding and classification of home health patients. But CMS went further: it recalibrated the HH case-mix weights by reducing the relative weights for episodes with “high therapy” and increasing the weights for episodes with little or no therapy. The idea is to remove what CMS sees as an incentive for HH agencies to provide more visits to patients to receive the increased “high therapy” payment. But the reality is that some patients really do need more visits—and HH agencies must now provide them at lower reimbursement rates.

These CMS actions come in tandem with a series of state HH cuts aimed at reducing utilization and costs.

Both the federal and state governments’ approaches to reducing readmissions are examples of a good quality improvement principle that has been distorted by the desire to reduce costs, failing to differentiate between avoidable and unavoidable readmissions, and using a punitive approach instead of rewarding improvement.

In addition, HANYS has voiced strong objections to recent efforts to tie payment to quality in ways that would penalize providers multiple times for the same case, or would use unproven methodologies.

These kinds of adjustments and “incentives” do not advance patient-centered care; they just further constrain the resources providers need to innovate.

New York’s health care provider organizations are struggling to make the transition to new care models, but are saddled with extremely low, and in some cases, negative operating margins. Providers are trying to step from the dock to the boat, but government is too aggressively whittling away the supports under the dock. It may save the government money now, but it will only lead to higher costs in the long run as perverse incentives and nonsensical cuts confound and delay reform.

Mark your calendars

The Hudson Valley NY Chapter Annual Institute
March 29, 2012
Tarrytown, NY
Medical Necessity: Minimizing exposure to financial, compliance, audit risks
Mary Guarino, VP, Regulatory, Craneware InSight

Medical necessity is one of the leading reasons payors deny claims, but these denials can often be prevented by improving training and communication between physicians and the revenue cycle team. Ensuring services are medically necessary is not simple. National coverage determinations (NCDs) and location coverage determinations (LCDs) change frequently, which makes matching related CPT/HCPCS codes and ICD-9 codes especially challenging. In fact, the overwhelming majority of medical necessity denials are caused by ICD-9 codes that don’t match procedural CPT codes. With CMS and payors converting to ICD-10, this process will become even more complicated. Healthcare organizations should be prepared to handle additional medical necessity denials and address ICD-10 requirements to support prior authorization.

Validating medical necessity at the exact time services are requested is the best defense for reducing medical necessity denials and ensuring compliance with Advance Beneficiary Notice (ABN) requirements for Medicare as well as requirements for Commercial Notices of Non-coverage (NONCs).

Medical necessity software allows healthcare organizations to determine, in real time, whether diagnoses support the medical necessity of the procedures ordered, or if they require prior authorization. Flagging services with medical necessity issues before the services are rendered ensures accuracy of coding and compliance with ABN guidelines. Medical necessity software also helps structure communication and supports the education of physicians, clinical staff and the revenue cycle team on medical necessity rules and payor requirements.

To evaluate the effectiveness of medical necessity software, consider the following:

- Are LCD/Medical Necessity requirements maintained for every contractor, including all Medicare Administrative Contractors (MACs), fiscal intermediaries (FIs) and commercial payors?
- Do the LCDs contain not only CPT to ICD-9 verification, but also check for frequency, gender and age criteria as well as primary and secondary diagnosis coding?
- Is coding available for LCDs that have a probability for future RAC medical necessity audits?
- Are qualified individuals reading and interpreting difficult LCDs to ensure accurate results?
- Are prior authorization warnings available for all payors?
- Are proprietary edits available?
- Is medical necessity for Medicaid provided?
- Are CMS and MAC/FI/Carrier websites monitored weekly to keep every policy updated?
- Is direct access provided to current policies to validate services?
- Are ABNs or NONCs issued before providing services that do not meet “medical necessity” guidelines?
- Is there a review of payor medical necessity denials to create front-end warnings?
- What preparations are being made for ICD-10 codes?

Up-front monitoring of all medical necessity and prior-authorization policies issued by CMS, Medicare contractors and commercial payors is fundamental to ensuring total earnings are not at risk and that healthcare organizations are not exposed to post-payment audits and potential compliance issues with ABNs. The proper medical necessity tools and processes can help healthcare organizations establish and sustain revenue integrity, including mitigating compliance risks, improving staff efficiency and optimizing reimbursement.

Mary Guarino, Vice President of Regulatory at Craneware InSight, has more than 28 years of professional healthcare experience. Her expertise includes revenue cycle management, managed care contracting, physician practice management, uncompensated care reimbursement, Medicare regulations and extensive chargemaster knowledge. Her achievements at several hospitals include reducing outpatient denials by 40% and increasing net revenue by millions of dollars for services previously not identified. Mary holds a B.A. from UMass and has completed business courses towards an MBA at Northeastern University. Mary is an active member of both HFMA and MAPAM.

visit us online www.hfmahudsonvalleyny.com
Patient Access at Westchester Medical Center:
Ensuring Revenue Recovery & Patient Satisfaction

Brian Shea, Vice President, MES, Collection Bureau of the Hudson Valley, Inc.
Robert Shaw, Vice President of Revenue Cycle, Westchester Medical Center

Westchester Medical Center (WMC) is a 643 bed tertiary and quaternary acute care hospital located in Valhalla, N.Y. serving residents of the Hudson Valley, Northern New Jersey and Southern Connecticut. Previously operated by the County of Westchester, the hospital separated from the County in 1998 and was re-organized as a New York State Public Benefit Corporation and continues to operate today as a free-standing entity.

Like many hospitals, WMC experienced difficult financial times, losing million of dollars annually from 1998 through 2004. It was clear that things had to change from an operational and financial perspective in order to preserve its safety net status for Hudson Valley residents.

Among many changes that occurred beginning in 2005 at WMC was new senior management leadership in clinical operations and finance including the Patient Access (PA), Patient Financial Services (PFS) and Finance Departments. What is clear today to all hospitals was evident then to WMC management - WMC needed to implement an integrated Revenue Cycle System to ensure maximum recovery of revenue while providing excellent customer service.

WMC formerly operated under the flat-rate reimbursement system and had to transition to fee-for-service billing – not an easy accomplishment when their chargemaster development was still in its infancy. It was also evident that in order to maximize revenue recovery on the back end of the revenue cycle, it was imperative that comprehensive changes be made to the fundamental role of the Patient Access Department.

Mr. Robert Shaw (VP, Revenue Cycle) and Ms. Marie Caprio (Director, Patient Financial Services and Patient Access) led a management team that sought to rebuild the revenue cycle system at WMC to meet the financial needs of the institution. The focus on PA led to better efforts on the part of staff to collect, verify and react to information and events that would have a direct impact on revenue recovery.

Shaw and his management team developed a PA staff that is detail oriented, personable, coachable, and open to the many changes that would come about to the traditional role of PA staff: “It was a major culture change for many of the staff members who have been with the Medical Center for many years,” says Shaw, “yet they all understood that change was necessary to effect the financial turnaround of the facility.” With the constant and ongoing efforts of management to educate and collaborate with staff, many critical changes in the role of Patient Access were successfully implemented.

Shaw is proud to say that if 30 patients are scheduled for elective procedures tomorrow, he has 30 authorizations in hand; and if not, management knows why and decisions have already been made as to whether or not the case will proceed. Whether an elective procedure is booked as inpatient or outpatient, his PA staff has verified insurance, confirmed authorization and determined out-of-pocket responsibilities of the patients. An appointment “reminder” call is made to the patient the night before with a reminder of the patient’s responsibility and payment methods available.

Shaw notes that his departments are often challenged by late bookings, yet his staff rises to the occasion to get the cases cleared as quickly as possible, sometimes only hours before a procedure. “It is our job to support our physicians and provide a quality experience for the patients,” says Shaw. While last-minute bookings are often necessary for clinical reasons, Shaw is continuing to work with his team and the practice managers of the various physician offices to encourage early bookings whenever possible. Shaw gives credit to his PA staff for establishing and maintaining excellent working relationships with the practice managers - relationships that have made so many improvements possible. He is also proud to say that “no authorization” denials are virtually non-existent. Should a denial occur, their managed care contracts incorporate “no technical denial” language that will not result in lost reimbursement.

In the case of unscheduled visits (emergency department and emergent direct admissions), every registration hits a PA work group queue in real time to ensure that demographic and insurance information is reviewed and verified. Notifications are made to the various insurance plans and Case Management is notified electronically so utilization review processes can begin.

Every patient classified as self pay at the time of admission receives a visit from a financial counselor the next day. Any insurance information that may not have been available at the time of admission is obtained and verified. Patients who are determined to be truly self pay are interviewed and offered the opportunity to complete a Medicaid application along with the hospital’s financial assistance application. WMC utilizes the services of a third-party agency to assist patients and their families in the Medicaid application process once the patient has left the hospital. The agency has staff members in the field who visit the patients at home to obtain the required documents and signatures. WMC is also fortunate to have a County Department of Social Services unit on site to expedite completed Medicaid applications.

Continued on page 8
Shaw stated that WMC, like other facilities, has seen a significant increase in “high deductible” and/or “high co-pay” insurance plans. Often times these are “catastrophic” plans that come with lower premiums that are affordable to the consumer who must pay for a greater share of his or her own insurance. Quite often, the patient is completely unaware of the out-of-pocket expense until notified by the WMC PA staff. Add this to the ever-growing self-pay population and it becomes critical for hospitals to understand that the recovery of those self-pay dollars begins with the earliest encounter with the patient.

Prior to 2007, Shaw states that point of service (POS) collection of patient responsibility amounts was virtually non-existent at WMC. Staff had to be trained and educated to embrace their front line role in the hospital’s efforts to maximize the recovery of self-pay dollars. While being sensitive to Emergency Medical Treatment and Active Labor Act (“EMTALA”) regulations which may affect financial discussions with patients in the Emergency Department, Shaw and his management team developed tight, compliant processes to ensure that registrars collect amounts due whenever possible. Management provides continuing education, feedback and recognition of the efforts to collect POS payments, not only in the emergency department but across the many points of entry over a sprawling medical campus. A cultural shift in the mindset, not only on the part of PA staff, but also the community, was necessary over time to achieve his POS collection goals.

Shaw feels that the concerted efforts of his management team to not only mandate changes in the PA departments but to also educate and collaborate with employees was critical to the PA staff embracing their role in the revenue cycle process. Informational newsletters and emails are utilized to educate and encourage staff by providing them with the results of their efforts and linking the changes they have successfully effectuated at the front end to improved recovery at the back end of the cycle.

Furthermore, good financial screening leads to good customer service. It is a time of anxiety when a patient arrives at a hospital for medical treatment. When the PA employee is efficient, professional and personable in carrying out his/her responsibilities, the patient can be expeditiously processed through to clinical treatment more quickly. The first impression on that patient goes a long way to making the entire medical encounter more positive. With a clear understanding of what the insurance will cover and what the out of pocket responsibilities are, the patient has less uncertainty to deal with during the clinical treatment to follow.

Technology continues to play an important role in improving the capabilities of the PA department. Software has been purchased and integrated seamlessly into the WMC system that allows the various components of the revenue cycle to “speak” to each other relative to patient responsibilities, past due accounts etc. Programs are in place to clock the time it takes to register a patient and that data is reviewed in a monthly multi-disciplinary meeting. Work lists and “expert rules” are utilized extensively to ensure that the right people are working the right cases in a timely manner. WMC has also rolled out software to verify demographic information with national third-party firms, a process that has resulted in 80% less returned mail. Further, with the advent of electronic medical records it is critical that a patient is properly identified and registered under only one medical record number. Additional software was recently rolled out to assist the registrars in that process by using electronic algorithms to search for potential duplicates in real-time.

Shaw never hesitates to give credit to his management team for working with him to develop the vision for an enhanced PA department at WMC capable of providing the entire revenue cycle with the best chance to maximize revenue recovery. Furthermore, management has maintained the vision with consistent leadership, training and collaboration with staff to ensure the collective success and transformation of the Patient Access Department of Westchester Medical Center. This transformation has enabled the PA department to play a prominent role on the hospital’s Accounts Receivable Oversight Committee, which also includes Case Management / Utilization Review, Medical Records, Patient Accounts, Managed Care and Chargemaster staff. This committee has the responsibility to meet monthly to assess progress, establish goals and, most importantly, share the everyday successes which lead to a healthier bottom line and a happier patient population.
Teaching Healthcare Finance: Mastering The Acronyms
Scott Edelman, MBA, CPA, FHFMA, CFE
Controller, Burke Rehabilitation Hospital

I have just finished teaching the first course in the new Healthcare Sector Management Program at Long Island University’s Hudson Graduate Center in Westchester.

First, it was a big relief, after grading all the student papers, to find that everyone passed the course. Our students, drawn from a variety of fields, were largely unfamiliar with the language of healthcare finance.

We started out with the basics – types of Health Care Organizations and the users of those statements – and no one fell asleep. We then moved into billing and coding for health services. Again the students were engrossed, and soon the class was reciting acronyms like it was their first language (NFP, 501c3, ICD-9, Case Mix, DRG, CMG, RUG, etc).

Students especially liked the material on regulatory issues; they now know what the Corporate Compliance officer’s job entails. Community benefit and Charity care was another topic we covered at length, pulling the 990’s of some area hospitals and comparing them.

To prepare for their final project, students formed teams to analyze a fictitious hospital. Even though this was a new challenge, all of the teams did an impressive job, producing a full blown analysis of an HCO.

A final note: Long Island University has extended a special tuition discount of 25% to all HFMA members, whether they enroll in the Advanced Certificate (four graduate courses) or the MBA with a Healthcare Sector Management concentration. I would strongly recommend that HFMA members and their staffs take advantage of this great opportunity.
Best Practices: Obtaining Authorizations and Preventing Denials

Victor Marcinik, Vice President, Product Management, Recondo Technology

“A hospital with $300 million in revenue typically writes off $7.7 million annually to denied claims.” — The Advisory Board Company

“The U.S. Healthcare Efficiency Index© (USHEI) is a forum for raising awareness and monitoring business efficiency in healthcare. The USHEI seeks to provide a national reference to track and measure the transition from a paper-based healthcare system to an electronic one” (source: http://www.ushhealthcareindex.com). The USHEI shows the adoption rate and costs for various electronic transactions between providers and payers; eligibility and benefits; authorization and referral; claims and remittance; and claims status and payment posting.

Many organizations are attempting to leverage these standards of communication, but first, many processes and workflow changes must also be implemented. This starts with moving authorization and denial management to the front of the revenue cycle. This yields savings by reducing the number of denied claims and re-allocating staff from managing authorizations full-time to other areas of the facility.

Creating a plan to reduce authorization related denials starts with understanding what your baseline is. How do the denials breakout in terms of total dollars, payer, patient type and service area. Next the key stakeholders should be identified.

Stakeholders and Influencers for Authorization

- Physicians
- Patient Access
- Case Management/Ancillary Depts.
- Business Office
- Administration/Managed Care
- Payer Network

Relationship with the physician community is vital.

This is the front line of authorization activity for scheduled services. Hospital staff should be diligent in requesting and documenting insurance information, specific services and diagnosis information, and request authorization numbers that have been obtained.

From a payer compliance perspective, physicians are contractually obligated to provide clinical data to the patient’s insurance(s) to ensure the payer has adequate information to determine if precertification criteria have been met. Best-performing facilities have proactive relationships with the physician community to discuss payer requirements and share exception reports when requirements were not achieved.

Facility Scheduling

Whether your organization scheduling services are centralized or decentralized, best-performing facilities initiate authorization activities at time of scheduling. Along with clinical procedures and diagnosis, schedulers need to capture the insurance data and assist with coordination of benefits when multiple insurance(s) are present. The facility scheduling system at minimum should be able to house the insurance data, precertification number, patient type of the authorization, and claim status and payment posting.

Patient Access

Scheduled:

As part of preregistration, the Patient Access team should monitor authorization exception reports from the scheduling and/or HIS system. This will provide enough time to address any exceptions before the patient arrives for services. Exception handling will uncover any constraints with payer timeframes and the ability to discuss the need to reschedule services in order for patient benefits to apply. In some circumstances, the hospital should have available a notice of non-coverage to present to patients if they choose to proceed in having services without securing the authorization approval from the payer(s).

Unscheduled: Daily, the Patient Access team should monitor patient type changes and direct admits. Patients admitted through the emergency room should be promptly reviewed and payer(s) notified when insurance is known. Any delays in obtaining patient demographic and insurance data should be concurrently documented to assist in timely notification appeals.

Patient Type changes/Maternity

Best-performing facilities also have strong controls to monitor daily other patient type changes and maternity and newborn length of stays. The ability to document the patient type with the authorization allows for quick identification of a mismatch. Patients that convert from outpatient surgery to observation or even inpatient are easily identified as an exception and prioritized for processing.

Maternity cases are a little more challenging, but the Patient Access teams that monitor length of stays, service transfers, and have regular communication with the labor deck team as to delivery type (C-Section versus vaginal) benefit the most with very few authorization exceptions with this service.
Case Management

Case Management is the second line of defense for scheduled and unscheduled authorization activity. This team should take the initiative to communicate patient type changes to other teams within the organization in a timely manner. CM must take ownership of observation and inpatient statuses and make the appropriate departments aware of changes to ensure Patient Access and HIS systems are updated with current status. CM should have a worklist to monitor accounts for concurrent review activity and proactively communicate with payers on continued stays and document additional days approved.

During concurrent review, CM should communicate, document and take the initiative to resolve any denied days. Case Management must take action and provide clinical information on weekend discharges, short LOS visits, and other retroactive encounters. Best-performing facilities have policies and procedures to address variances in service levels, patient types, or delays in service denials.

Business Office

The Business Office must have the ability to track payment denials for every encounter. This team needs to communicate the payer activity on every registration to the organization. High-performing facilities have the ability to timely assign unique denial codes and/or unique $0 payment codes to pull reports to track and trend payer activity by patient type, service, and department.

The Business Office should be appropriately staffed to identify and appeal unauthorized services. Organizations that don’t have available staff or skills sets have successfully contracted with vendors who perform this activity on contingencies. This department should have access to legal advice and avenues for payment demands.

Best-performing facilities have an active Denial Committee, which is often attended by patient access, business office, case management, and managed care. The Business Office Patient Accounting System generated the data for the committee. Denial data should be tracked and trended by payer and separated between technical, clinical, and administrative denials. The committee chair should identify action items by respective departments to minimize future denials.

Managed Care/Administration

Managed Care communication and feedback is another attribute of a best-performing facility. Managed Care should solicit input from multiple departments within the facility to address any exposures before a contract is signed. Several departments manage a patient throughout the life cycle of the encounter, and each department must understand respective obligations to secure proper payment. Managed Care should work with other departments to promote and find efficient ways for entities to communicate and interact.

Payer

Authorization requirements should be published and made accessible. The requirements must be clearly defined as to patient type, CPT, and clinical description for inpatient services. Payer’s provider relations or marketing department should be visiting the physician community to assist with training and to educate them on their responsibilities for authorization activity.

Encourage payers to adopt family CPT ranges for authorization versus specific CPT which you often experience in radiology. The radiologist has the discretion to change, augment or add to the order for providing the best care of the patient. Adding additional overhead expense for the change in CPT order is costly and burdensome to both the payer and providers.

Finally, payers should promote and embrace electronic communication of patient information and activity with the provider and HIS vendor community.

Conclusion and Next Steps

- Determine your baseline, this will make it easier to measure a program’s success
- Engage your stakeholders
- Develop a plan, including milestones and responsibilities
- Assess and leverage technology…it’s out there
- Leverage existing resources — trade associations, state hospital association, CORE, WEDI, etc.

Victor Marcinik is the Vice President, Product Management at Recondo Technology, and the former Chief Operating Officer for HCA Revenue Cycle Operations in Denver, which encompasses seven acute care facilities.

Want to get involved?

Our chapter is looking for new members of our Website Committee! Email sarahb@bluemark.net to learn more.

Interested in another committee? Click on “Committees” on our website or contact anyone on the leadership team to learn more.
Putnam Hospital Center

As I drove across the scenic reservoir causeway, I envisioned my impending visit to the quaint 164 bed community hospital lying several twisty turns ahead. For a moment, I had forgotten that Putnam Hospital Center ("PHC") has been part of the Health Quest System since 2001, thinking only of its fine reputation as the largest employer in the community and the care it provides to the residents in the Northern Westchester / Putnam County area that it serves.

As a nearby resident with two active children, I have had several opportunities to visit PHC’s emergency room, and have been grateful for the proximity, and the prompt attention we received. However, as I stepped into the main lobby of the hospital for the first time in at least five years, my impression, one I’m sure is shared by any patient or visitor walking through the doors, was that I had stepped into a facility that had taken great care to be welcoming. New wood floors, gracious, comfortable furniture and a player piano caught my eye. A bright hallway led into the Camarda Care Center, PHC’s $34M expansion, which was completed in 2008. I was curious to hear what else was being done at the facility beyond the inviting cosmetics.

Donna McGregor, Putnam Hospital’s Chief Executive Officer, has been at the helm of the hospital for nearly five years, having transitioned here from her role as Chief Financial Officer of Health Quest. Since joining PHC, her focus has been on quality of care, and quality of the patient experience. When McGregor first joined PHC, the hospital was ranked in the 27th percentile for inpatient satisfaction. This was something she wanted to improve upon. She pulled together managers from every department, and set up a group she calls “Voice of the Patient.” Voice of the Patient meets every two weeks to review every comment made by patients, good and bad. The comments are distributed to every manager, hospitalists and nurses, and they are each assigned patients to call to address concerns, and to ask “what should be changed; what can we do to improve our service?” The group adds new comments and suggestion to a list, and then works down the list to implement positive changes. Patient Satisfaction scores are shared with the physicians and the group works with the doctors to help them deliver service in a manner that will be perceived favorably by patients. Teams are formed to compete for the highest patient satisfaction ratings, and winners get a party.

McGregor is also implementing a program for training the environmental staff on how best to interact with patients and help make their visit more comfortable. As a result of these efforts, Putnam Hospital was recognized by HealthGrades with an “Outstanding Patient Experience Award” for 2010/2011 – one of only eight hospitals in New York State to make the top 10% in patient satisfaction. “I’m really proud of the teamwork that was involved in improving patient satisfaction,” McGregor explained. “I love the way people feel about Putnam Hospital in the community. I love reading the letters telling me what a great job the staff has done. I always share these letters with the team.” If an employee is mentioned by name in a letter, they are given movie tickets in appreciation.

Patient satisfaction is only one of “three legs of the stool” – the things that are critical to the success of a healthcare facility and/or system. The other two are quality and financials. While some feel that it is a difficult balancing act to provide quality and patient satisfaction while meeting aggressive financial goals, McGregor believes that improving patient satisfaction and quality helps achieve the financial goals. For PHC, accomplishing this balancing act is greatly facilitated by being a member of the Health Quest System.
Health Quest

As a Chief Financial Officer, Donna McGregor’s role was mostly “technical.” Decisions could be made quickly, based on budgets, numbers and facts. As a Chief Executive Officer, she learned to move beyond her reliance on purely technical proficiency to developing trust- and relationship-building skills. Before she makes a decision, she listens to input from all the stakeholders; works with the physicians; and asks questions such as “who have you spoken to about this?” As a CFO, McGregor didn’t have a great deal of contact with patients. In the hospital clinical setting, that changed. As Putnam Hospital’s CEO, the most important lesson she learned is that if you do384(18,28),(995,994)
Introducing HFMA HV Chapter Member, Sarah Brainard

Frank B. Giraldi, Manager, Contract Compliance / Reimbursement, Orange Regional Medical Center

It isn’t every day that one has the opportunity to write about their successor so I am grateful for the opportunity to do so here. Chapter member Sarah Brainard has succeeded me as Co-chair of the Chapter’s Newsletter Committee. Sarah brings her ten years of experience in graphic arts and design to Managing Health Today, where it is clearly visible in the newsletter’s new layout. Having been involved with the publishing and proofing of Managing Health Today for the past ten years, I was impressed with the ideas Sarah proposed as we proofed a draft on the March 2011 issue. Sarah rearranged the flow of the newsletter, and redesigned the graphics to be consistent with those presented by HFMA National. I commented that the print appeared off center and questioned whether that was accidental. Sarah enlightened me that the formatting was indeed intentional, and was a technique used to draw the reader’s eyes to the next page. Upon hearing Sarah’s description of the graphical style she had employed, I suspected that we were in the hands of a professional. When she showed us how to distribute the newsletter through Constant Contact, and how to upload it onto the website with embedded links to each article, I knew we weren’t in Kansas anymore. In addition to jumping into a leadership position on the Newsletter Committee, Sarah is also active on the Website Committee and Education Committee.

Sarah’s interest in graphic design began in high school where she worked on the school newspaper. She thought she’d like to be a journalist, but didn’t think she’d enjoy the investigation part of the work. She then realized it was the design of the paper that she really loved. She attended Broome County Community College where she published the student newspaper, and received her Associates degree in Communications & Media. She also holds a Bachelor of Fine Arts degree in Studio Arts with a focus in Graphic Design from the State University of New York at New Paltz. As part of her college program, Sarah had the opportunity to work at Walt Disney Corporation.

From the first moment you meet Sarah, you realize that she is not a person who idles the time away. Professionally, Sarah is the Director of Client Relations for Bluemark, LLC, a software company based out of New Paltz, New York that develops programs to assist providers with improving workflow efficiencies within the revenue cycle. She serves as the project manager and lead trainer for many software platforms and manages all customer support team relationships. She is also pursuing her Master in Business Administration during the evenings and weekends. That would be enough to fill many individuals’ calendars, but not Sarah’s. In addition to her volunteer work with HFMA, Sarah does the web design for, and sits on the Board of, the Catskill Ballet Theatre. She also provides her graphic design services, pro bono, to many organizations, and is on the Advisory Committee for Big Brothers/Big Sisters.

When Sarah isn’t working, studying or volunteering, she loves to hike, camp, and play with her basset hound mix, Maggie. You may also see Sarah out on one of New Paltz’ softball fields, playing in the New Paltz Women’s League. If you can get her to slow down long enough to chat, please be sure to introduce yourself to Sarah and welcome her to the Chapter.

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Medicare/Medicaid Update:
Now You Know Everything
Joanna Schaffer, Editor

Medicaid and potentially preventable Negative Outcomes, New York State Issues!, Medicaid Rate Sheets, Medicaid RAC, Medicare Fraud and Abuse - all of these issues and more were addressed at our October 27 Medicare/Medicaid Update program at the Ramada in Fishkill. The Chapter provided our attendees with a terrific line-up of speakers including Todd Ball and Bob McLeod from HANYS, John Gahan from the New York Department of Health, Jeff Flora from the Office of the Medicaid Inspector General, and Jean Stone from the Centers for Medicare and Medicaid.

The survey results were outstanding. Jean Stone was “Fabulous! Fantastic! Terrific!” John Gahan was a “great speaker with great insight! So Knowledgeable!” and our other speakers received equally glowing comments. Overall, the program was described by attendees as “excellent.”

Our goal as a Chapter is to bring you relevant, useful, timely and interesting education programs. Please reach out me or to anyone in leadership if there is a topic that you would like to hear more about, or a speaker that you think we should engage.

New Members

We would like to welcome our new members:

Chaim Chaimowitz
Lindsey Gioster
Reimbursement Analyst
St. Luke’s Cornwall Hospital

Rajendra Pithadia
Manager Revenue Analytics & Managed Care
Somnia, Inc

Know anyone who might be interested in becoming a member?
Send them to our website hfmahudsonvalleyny.org

Marianne Muise, John Gahan and Bonnie Armoia
Financial Triage:
Point of Service Collections & EMTALA
Barbara D. Knothe - Partner, Garfunkel Wild, P.C.'s
Health Care Practice Group

Many healthcare providers have instituted point-of-service collection procedures, which have been accepted by most consumers. Patients with insurance coverage are now accustomed to paying copayments and deductibles before receiving services from their physicians and dentists, and even scheduled inpatient admissions. Consumers actually prefer to know how much their out-of-pocket expenses will be. But hospital emergency departments are subject to the Emergency Medical Treatment and Active Labor Act (42 USC § 1395dd et. seq.) (“EMTALA”), which restricts not only the collection of copayments and deductibles before services are rendered, but also prohibits the hospital from obtaining preauthorization of services. Can hospitals maximize collections and still comply with EMTALA? Yes; if point-of-service collection procedures are implemented in observance of EMTALA guidelines, they can be done in the emergency department (“ED”).

EMTALA

The purpose of EMTALA is to ensure non-discriminatory access to emergency medical care and appropriate inter-hospital transfers, and to prevent “patient dumping” and the disparate treatment of patients (whether as a result of the existence, non-existence or type of insurance, or for any other reason). EMTALA contains 2 basic requirements:

1. For any person who comes to a hospital emergency department, “the hospital must provide for an appropriate medical screening examination . . . to determine whether or not an emergency medical condition exists” (see 42 USC § 1395dd[a]).

2. If the screening examination reveals an emergency medical condition, the hospital must “stabilize the medical condition” before transferring or discharging the patient. (see 42 USC § 1395dd[b])

Thus, hospitals are required to provide screening and stabilizing services to everyone, regardless of payor source or ability to pay. Frequently, the hospital ends up providing free care to the uninsured and underinsured, and hospitals are feeling the financial strain. In the face of decreasing reimbursement, improving registration procedures and maximizing collections in the emergency department is critical.

Special Advisory Bulletin

Hospitals may follow reasonable registration processes so long as they do not delay screening or treatment or unduly discourage patients from remaining at the Hospital for further evaluation. On November 10, 1999 the Office of Inspector General (“OIG”) and the Health Care Financing Administration (now called the Centers for Medicare and Medicaid Services (“CMS”)) issued a Special Advisory Bulletin which identified certain prohibited practices and “best practices” for EMTALA compliance with respect to registration procedures. The Special Advisory Bulletin stated that:

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“It normally is permissible to ask an individual for general registration information prior to performing an appropriate medical screening examination. The hospital may not, however, condition such screening or further treatment upon the individual’s completion of a financial responsibility form or provision of a co-payment for any services.”

Moreover, the Special Advisory Bulletin stated a “best practice” would be for a hospital not to provide financial responsibility forms or notices to an individual, or otherwise attempt to obtain the individual’s agreement to pay for services before the individual is stabilized. A hospital may continue to follow reasonable registration processes for individuals presenting for evaluation and treatment of a medical condition. Reasonable registration processes may include asking whether an individual is insured and, if so, what that insurance is, as long as this inquiry does not delay screening or treatment. However, reasonable registration requirements should not unduly discourage patients from remaining for further evaluation. The Special Advisory Bulletin also stated that a hospital may not condition care upon a patient signing a financial responsibility form or making a co-pay, as this would deter patients from staying for care.

The Special Advisory Bulletin noted that it is not appropriate for a hospital to seek, or direct a patient to seek, authorization to provide screening or stabilizing services to an individual from the individual’s health plan or insurance company until after the hospital has provided (i) an appropriate medical screening examination to determine the presence or absence of an emergency medical condition, and (ii) any further medical examination and treatment necessary to commence stabilization of an emergency medical condition. The hospital may seek authorization for payment for all services after providing a medical screening examination and the patient is stabilized.

Final Regulation

In September 2003, CMS issued a final regulation which codified a hospital’s EMTALA obligations when treating individuals with emergency medical conditions who present to the hospital, usually at the emergency department. The regulation codified much of the Special Advisory Bulletin and reiterated that while a hospital may not delay appropriate medical screening examination or treatment in order to inquire about an individual’s method of payment or insurance status, it is acceptable for hospitals to follow reasonable registration processes for individuals presenting to the emergency department. In particular, the regulation, 42 CFR 489.24(d), states: (i) reasonable registration processes may include asking whether an individual is insured and what that insurance is, as long as no delay in screening or treatment occurs; (ii) the registration process may not unduly discourage individuals from remaining for further evaluation; and (iii) the hospital may not seek, or direct the individual to seek, prior authorization until after the hospital has provided an appropriate medical screening examination and initiated any further medical examination and treatment required to stabilize the emergency medical condition.

Accordingly, hospitals may follow reasonable registration procedures for individuals presenting to the emergency department so long as there is no delay in screening. The individual may be asked to provide basic demographic and insurance information, but hospital staff should not: (i) seek or direct the individual to seek prior authorization, or (ii) ask the individual to pay a co-pay or sign a financial responsibility or Medicare Advance Beneficiary Notice (ABN) form during the registration procedure. Once the individual has been evaluated and any necessary stabilizing treatment has been started, hospital staff may request co-pays and insurance authorization may be obtained. The registrar may obtain the information necessary to perform a routine registration from the individual or from a source other than the individual (e.g., authorized next of kin), provided such request does not delay the screening exam or any necessary stabilizing treatment. Otherwise, this financial information should be obtained after the individual has received a screening exam and any necessary stabilization treatment has at least been commenced. The individual may be informed of his/her potential financial liability after the determination that the individual does not have an EMC or the provision of any necessary stabilization treatment. The hospital’s policies and procedures regarding registration and evaluation of individuals should provide clear guidance on the permissible scope of the initial registration process.

Practical Issues

The emergency department staff is frequently so focused on providing care that patient contact and insurance information is not recorded, and copays are not even requested. After services are provided, some patients simply walk out the door without paying, and the hospital is left without contact information for sending a bill or setting up a payment plan. If the hospital cannot seek payment or authorization until the patient has been fully screened and any necessary stabilizing treatment has been at least started, how can they maximize collections at the time of the ED visit? Here are some methods that hospitals have instituted to enhance collections in the ED:

- Verify patient identity and contact information at the outset – Collecting adequate and accurate patient demographic data, including insurance coverage, on the front end can help eliminate fraud (e.g., people using multiple identities), and enhance prompt access to available charity care and government assistance programs. Such information may be obtained before services are rendered, as long as it does not delay screening or stabilization services.

- Ensure patients see a business office representative prior to leaving the facility – All patients should exit through the business office, or such staff could come to the patient in the emergency department. Screen for the patient’s ability to pay, and eligibility to enroll in medical assistance programs and/or charity care as soon as possible, and assist the patient in the enrollment process.

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Allan D. Rosenberg Receives Distinguished Service Award from the Westchester Public/Private Partnership for Aging Services

Joanna Schaffer, Editor

On October 6, 2011, the Westchester Public/Private Partnership for Aging Services honored Allan D. Rosenberg, a past President of the Hudson Valley NY Chapter HFMA, with a Distinguished Service Award at its Annual Golden Harvest Awards Breakfast. Rosenberg, a Partner at O'Connor, Davies Munns & Dobbins, LLP, has been very active in our chapter and we were thrilled to see him receive this well-deserved recognition.

In addition to all of his support of the chapter as both a leader and as a frequent speaker, Allan has chaired the Board of Directors for the Westchester Public/Private Partnership for Aging Services. He is an associate member of the American Health Lawyers Association and the American College of Health Care Administrators.

Other winners included William M. Mooney, Jr., the President of The Westchester County Association and a good friend of our chapter who received the Jim Curran Leadership Award, and White Plains Hospital/Jon B. Schandler, President and CEO, who was presented with the Golden Harvest Corporate Award. Congratulations to Allan, Bill and Jon on your awards, and thank you for all you do for the healthcare community.

Barbara D. Knothe, a Partner in Garfinkel Wild, P.C.’s Health Care Practice Group and a registered nurse with critical care experience, has over 20 years of experience in the health care field. Ms. Knothe has particular experience in compliance and regulatory programs and has been a frequent speaker on various federal and state regulatory issues, including EMTALA, 340B, Joint Commission, and office-based surgery, as well as treatment issues. Her clients include hospitals, physicians, home health agencies and other health industry providers.

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• Ask for payment in, or on the way out of, the emergency department, once services have been provided – If the bill is ready, patients may be offered various options for payment, including cash, check, and credit card on the spot, reducing uncollected copays and deductibles.

• Offer financial counseling and payment plan terms, and have the patient sign a payment agreement before they leave – For patients who need to pay over time, having staff in place who can structure a payment plan around the patient’s financial needs before they leave can improve compliance with the payment plan and speed up payments. Having payment forms ready to be printed and signed by the patient while the patient is still in the facility will enhance the process.

• IT tools – Portable laptops and notebooks can speed registration in the emergency department. Some hospitals are using self-pay “management systems” to verify patient name and address in real time, while the patient is being assessed and treated. Information systems can also help determine payment responsibility at the point of service, and identify eligibility for emergency Medicaid, discounting and charity care options when applicable. Collection of copays, deductibles, and co-insurance, as well as settlement of accounts, can be done through the system. Some hospitals have instituted registration “kiosks” that patients who are triaged as non-urgent use to register themselves, saving staff time for other tasks.

Conclusion

EMTALA imposes constraints, but hospitals can work around these constraints to enhance collections. Getting staff and patients accustomed to new procedures can be challenging. Staff training in EMTALA is key, as is having staff who can implement the new techniques with efficiency, tact and sensitivity to patient needs. With guidance, training and persistence, there are several ways to improve emergency department collections and still comply with EMTALA.
Physician/Hospital Integration:
White Plains Hospital Makes the Transition

Jonathan Friedman, Chief Operating Officer, Somnia, Inc.

In the September issue of Managing Health Today, I found myself at a CVS Minute Clinic. In this issue, however, I find myself at one of the most prominent hospitals in Westchester. I am here to find out more about the physician-employment alignment strategy at White Plains Hospital. Since 2009, 65% of established physicians have taken ownership with hospital-owned practices, and 49% of physicians hired out of residency or fellowship have been placed in a hospital-owned practice, according to the Medical Group Management Association.

After reading about the White Plains Hospital and one of a number of their initiatives, the formation of White Plains Hospital Physician Associates, I gave a call to Michael Bookchin, Vice President of Ambulatory & Physician Services at White Plains Hospital. After serving as the Senior Director of Operations for Montefiore Medical Group for eight years, Michael joined White Plains Hospital in March of this year to lead the effort in managing the integrated physician enterprise, as a key component of an overall physician/hospital alignment strategy.

My first question for Bookchin, who was involved with physician practice acquisitions in the 1990s was “what makes today’s physician integration different from the fad of the 1990s when hospitals were buying physician practices?” “The difference,” Bookchin told me, “is that in the 1990s large organizations would buy a practice for a multiple of net earnings, provide a guaranteed compensation, and then move on to the next acquisition. Now the goal is to create sustainable partnerships that offer long term value to both the physician practice and the hospital; co-design a plan for operational and financial success; and incorporate financial incentives (similar to a private practice) for physicians to remain productive and provide a high quality of care.”

“Physicians are entrepreneurial, so how do you ensure culturally that the integration will succeed?” I asked Bookchin. “For physicians, it can be a challenge to transition from being a business owner to becoming an employee of a larger organization. We spend a lot of time with the physicians during the practice integration to assure that they adapt well to the change. Our goal is to retain and nourish the physician’s entrepreneurial spirit even though they are no longer the business owner, and continue to have them be involved in the practice’s evolution.”

White Plains Hospital has so far aligned with 3 prominent medical practices, each already known for providing high quality care in the community. Surgical Specialists, comprised of 4 surgeons specializing in colorectal, bariatric, endocrine and general surgery became the first group to join. They were followed by OB/GYN-Obstetrics and Gynecology Partners, a group with 2 offices comprised of 5 physicians and 1 mid-wife. The third group to align was Westchester Orthopedic Associates, a 2.5 physician practice.

One of the challenges of alignment will be the introduction and implementation of an electronic medical record (EMR), a challenge that Bookchin has already experienced at Montefiore. “It can be very challenging to transition a physician practice from paper to electronic records, regardless of whether it is one of our integrated practices or for a private medical group. There are financial incentives to utilize an EMR now as well as financial disincentives for not adopting EMRs in the future. For most of the defined physician practice initiatives being developed by federal and managed care payors (i.e. PCMH to ACO), electronic clinical records are at the heart of improving patient care and outcomes. The benefit for one of our integrated practices is that we can alleviate some of the capital investment burden that physicians would otherwise incur, and we bring in the requisite management expertise and resources, which will ultimately allow our physician partners to focus on the practice of medicine.”

Now that the hospital was committed to the physician-hospital alignment strategy what strategy did White Plains Hospital implement? “The Hospital chose to invest in the infrastructure for White Plains Hospital Physician Associates as something of a ‘build it and they will come’ model. While we have not been actively soliciting physicians in the community, we are inviting physician practices to consider this as one of their available options. As a solution to the challenges of managing solo or small group practices in this challenging environment, physicians have been approaching the Hospital for viable alternatives. There are several prestigious medical groups in the community who will choose to remain independent, and of course our objective is to continue to align strategically and synergistically with those practices as well.”

As a reader of many of the articles on these relationships I wondered what kind of governance structure lay behind their walls. “It is vital to collaborate with physician leaders regarding all aspects of managing a growing medical practice,” Bookchin explained. “In our current organization, physician leaders retain significant decision making within their respective practices, and we will continue to bring physician leaders together into a more unified governance structure as the number of practices grows.”

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“In addition, there is a very strong senior leadership group and highly engaged Board of Directors within White Plains Hospital, all of whom are working towards having the physician/hospital integration strategy succeed.

Are there any projects encompassing standardization of care, using evidence based medicine? “Our first challenge as mentioned earlier will be the adoption of EMR technology. That will allow us in the future to focus on evidence based medicine and develop appropriate clinical measures and tracking. We of course expect to work closely with our physicians towards continuously improving both clinical outcomes and non-clinical patient services.

Will the White Plains Physicians Associates form their own ACO? Do you currently have plans to be part of a pilot? “While we do not expect to be one of the early pilot programs for the federal ACO implementation project, we do expect to adopt those ACO criteria that make sense for our physician practices. There are several components of an ACO development that represent good clinical practice and patient services. As we shape our physician practices along with the implementation of an EMR, we expect to utilize the ACO criteria as something of a roadmap and develop that type of infrastructure as we grow. Further, as many consider an ACO strategy to evolve from a large primary care base, the Hospital does expect to partner with those large, regional medical groups that are pursuing ACO accreditation themselves.”

What is the relationship between the hospital and the physician? “During the due diligence process, the management team of WP Hospital Physician Associates works with practice leadership to review and understand all aspects of practice operations and finance. During the practice integration stages, the physicians and staff become employees of White Plains Hospital. As all of the integration steps are completed, we retain a high level of contact and partnership with both physicians and administrative staff to assure a successful transition and ongoing success for the practice.”

Finally I wanted to know how White Plains Hospital feels about the future of Westchester and the Hudson Valley. “It’s a very interesting time for both hospitals and physician practices through the country, as well as in the local region of Westchester County and the Hudson Valley. Community and academic medical centers are bringing physician practices under their organizational structure. Physician practices continue to merge and grow. I expect that we’ll continue to be in the midst of a changing landscape in the local healthcare marketplace. Our intention is to work closely with physician practices, whether they are private group practices in the community or those employed within the hospital, towards continuing to thrive in a future of healthcare reform. Our collective goal is to continue to provide the highest quality of clinical care and patient services, and remain in the position of being the destination medical facility of choice in the community.

A major goal in developing White Plains Hospital Physician Associates is to keep the local healthcare marketplace intact and thriving, provide an option for physician practices seeking organizational change, and to remain synergistic with other medical practices in the area. And all of the above with a focus on providing high quality care and excellent patient services to the communities in and around Westchester.

On December 16th, the chapter presented “OPPS Final Rule: APC Destinations for 2011.” The session was held at the Westchester Medical Center in Valhalla, New York. Attendees learned about the 2012 APC Payment rate changes and Charge Master basics in the morning sessions. The afternoon was highlighted by the return of HANYS’ Steve Harwell, who delivered a well-received presentation on Medicare Payment Updates, Payment Delivery Reform and Outpatient Quality Measures. Thank you to chapter members Bob Shaw, Kristen Zebrowski and Lillian Gamble for putting the program together.
Look hard at the healthcare industry, and you’ll see a growing number of business transactions between hospitals and physicians. These can range from simple employment agreements to complex co-management agreements to compensation agreements tied to acquisition transactions. The common denominator is the need for a fair market valuation (FMV) by a qualified advisor.

Standards for FMV in a healthcare transaction have been well-defined by both valuation industry standards and governmental codification. However, many pitfalls await the inexperienced. This article offers guidance on identifying and avoiding ten common problems in determining physician compensation FMV.

PITFALL 1: TRYING TO PAY SUPERMAN
To support highly compensated physicians, compensation agreements may define an effort level that Superman or Wonder Woman would be challenged to provide. Requiring 60 hours per week over a full work year invites skepticism, particularly if a physician holds multiple roles. Stacking jobs that total excessive hours in total is bound to draw regulatory attention. Excess effort requirements also invite inaccurate effort reporting by the physician, resulting in records that will not withstand audit.

PITFALL 2: THERE’S A GHOST IN THE HOUSE
Hospital-physician employment agreements and professional services arrangements normally contain a specific list of duties. Clinical services are easy to define, but administrative, supervisory and teaching tasks are often defined too broadly or vaguely, raising questions about the physician’s role.

To remove the “specter” of a padded scope of work, define duties and responsibilities to be consistent with organizational needs and expectations and to be measurable for performance evaluation.

PITFALL 3: FRUITLESS “CHERRY-PICKING”
Valuation advisors are required to apply three methodologies—income, market and cost—when determining the FMV of a transaction. They rarely yield the same result. The FMV usually is determined by considering the applicability of each methodology and then applying judgment as to which best reflects FMV.

When the “best” outcome is used to justify a compensation level, the result can be a biased or indefensible value. Like kids picking unripe cherries, leaders that pursue this strategy are setting themselves up for a belly ache.

PITFALL 4: TRYING TO BUY A CADILLAC AT A CHEVROLET PRICE
Physicians may decline to take on administrative, teaching or supervisory (AS&T) roles because they are offered less compensation than they would be for equivalent time in clinical practice. FMV standards may allow a more appealing compensation level.

Often, when the AS&T role is less than 50% of a physician’s standard defined work week (40 hours), the FMV can be based on clinical payment benchmarks which are higher than administrative benchmarks. This is equitable for the physician and allows the hospital to match physician skills and experience to the position’s requirements.

PITFALL 5: ONE SIZE DOES NOT FIT ALL SITUATIONS
Compensation for on-call services is both a political and financial issue for hospitals and medical staff. The FMV rate methodology most commonly applied for on-call physicians (carrying beepers at home) is 10% to 25% of the full hourly rate (derived from published data) for the physician’s clinical specialty.

The discounted rate selected should consider the importance of the call coverage to the hospital’s operations, frequency of required response and the physician’s ability to generate fee income when called in to provide services.

PITFALL 6: TREATING QUALITY DIFFERENTLY FROM QUANTITY
Compensating physicians for productivity has become standard practice. Productivity measures using wRVU’s (work Relative Value Units) are commonly used to measure a physician’s work effort and can support FMV remuneration—especially the base component of a compensation package.

Metrics for quality are more limited and must be selected carefully for the FMV process, especially when quality is to serve as the basis for a performance-based incentive.

In determining the FMV of compensation for quality-based performance, consider:

- Are the measures clearly and separately identified?

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- Do they use an objective, verifiable methodology supported by credible medical evidence?
- Are they reasonably related to the hospital’s practice and do they consider the patient population?
- Do they use historical baseline data with targets based on national benchmarks?

PITFALL 7: FAIR BUT UNREASONABLE!

Compensation FMV determinations often overlook the separate, but interrelated, concepts of which it is composed:

- Fair market value is compensation in an arrangement that results from bona fide bargaining between well-informed parties who are not otherwise in a position to generate business for each other.
- Commercial reasonableness requires that the arrangement would make business sense if entered into by other reasonable parties of similar size and scope of interests.

Compensation paid by a hospital to a physician(s) must meet both of these tests.

As an example: A hospital may offer to compensate a cardiologist $200 per hour to serve as medical director of a heart station (FMV), but it is not necessarily commercially reasonable to hire three medical directors for this role.

PITFALL 8: FLYING TOO CLOSE TO THE SUN

The published data used to support physician compensation FMV analyses is stratified by percentiles. As a rule of thumb, compensation paid to a physician should fall between the 25th and 75th percentile of the market. Compensation between the 75th and 90th percentile can be supported if one or more of the following are met:

- The position and its requirements are unique to the market place
- The physician under consideration has qualifications, credentials and experience that can support use of this standard
- There is a limited pool of qualified candidates available to fill the position

Setting a compensation level above the 90th percentile is ill-advised. It poses a significant risk of external review with the attendant justification issues. When extremely high compensation levels are required to obtain the services of a physician, the best approach is to structure compensation with a base and an incentive component, both of which, if properly set, can be supported under FMV.

PITFALL 9: TREATING A ‘ROCK STAR’ LIKE AN OPENING ACT

Medical ‘rock stars’ are high profile physicians with extraordinary performance levels and diverse responsibilities. They are unique to a regional or national marketplace and can command a compensation package that far exceeds usual and customary FMV considerations. It is impossible to establish the FMV of such a rock star by using standard market data.

FMV efforts for these physicians are usually based on anecdotal information that has been sourced and thoroughly vetted by an independent party knowledgeable about physician compensation within the industry.

Since these physicians typically wear multiple hats, the FMV evaluation can be strengthened by dividing their roles or functions and valuing each component separately. By aggregating the individual results, a composite can be used as a proxy for the FMV.

PITFALL 10: PUTTING THE CART BEFORE THE HORSE

The most frequent mistake hospitals make with regard to FMV is consummating a physician transaction before conducting an FMV analysis of the remuneration. If a compensation package fails to meet FMV tests, the hospital may have to revise, renegotiate or even renege on a deal, which can destroy important business relationships. A proposed transaction term sheet should be conditioned upon obtaining a satisfactory FMV opinion.

Avoiding these ten pitfalls can take an organization a long way towards minimizing the risks associated with physician compensation and fair market value.

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Is Your Brand Ready for Healthcare Reform?

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No matter what happens in the courts, Congress, or at the state level, healthcare as we know it is changing. The industry is becoming more competitive. Consumers are demanding transparency. Providers are consolidating and integrating, while insurers continue to face cost pressures.

Is your brand ready?

While we may not know exactly what the future entails, we can separate the known from the unknown, acting on the certain and hedging our bets on the less certain.

We see that in all scenarios, healthcare will become more retail. Consumers—not just employers—will weigh benefit levels with pricing to make their own decisions. With this new transparency will come the risk of confusion about all the tradeoffs to be made. Many choices will be determined on rational criteria. But clearly, when it comes to an individual’s health, choices will also be based on emotion.

Together, all signs indicate that brand will become a key decision driver. And yet, research shows that most healthcare brands tell neither a great story, nor deliver a compelling experience—two key measures of brand health.

We also know that these new retail consumers will have different wants and needs. From those looking for insurance purely as a hedge against illness to those looking for a true advisor to help with health decisions, each will seek a brand that speaks to him/her.

Now is the time to assess the health of your brand and prepare for the paradigm shift.

Here are five key questions to ask about your brand:

1. Does your brand reflect your role in healthcare, now and in the future? Delivering healthcare as consumers know it today requires a cast of characters—from caregivers and insurers to hospitals and drug companies. Each of these companies plays a distinct role now, but successful ones will develop a much more integrated delivery system. If you’re positioned around being a caregiver today, you need to ask yourself if that positioning will still be relevant in the future? Your brand needs to reflect who you are today, but also where you’ll play in the future. Medical Mutual of Ohio is just one example of an insurer embracing the role of health coordinator. They’ve partnered with Health4, a healthcare delivery model consisting of The Medical Group of Ohio and Ohio Health, to actively manage care for patients because they understand that successful insurers will need to be more than just bill payers.

2. Does your brand resonate with everyone in your target audience? While the fundamental shift in healthcare will empower consumers in new ways and require a new found focus on them, traditional healthcare partners should not be ignored. Many of them will actually become more important. Your brand will be intrinsically tied to a host of other companies that all ultimately deliver healthcare to consumers. This network will evolve to become a reflection of your brand. As hospitals and providers decide which networks to join, how well the brands all align to deliver complete healthcare solutions will become increasingly important. We can all easily understand how a hospital that is focused on service would likely have little interest in aligning with an insurer emphasizing efficiency.

3. Are you building a brand that fits with a long-term perspective? As much as we all talk about consumerism and the new “retail” market for healthcare, decisions will never be made like that of laundry detergent. Healthcare will end up being more like a durables purchase—similar to how you think about your next car. Many consumers will spend hours researching, but in the end it could be just too much to comprehend. Brand will become a shortcut to narrowing the field. And your brand will become a proxy for a (hopefully) long and important relationship. Decisions will be influenced by emotional considerations—such as comfort and security—more so than specific benefit levels or price points.

4. Does your brand attract the right customers? Of course your brand should attract your target consumers. But your brand also needs to help consumers self-select out of your brand. If you’re an insurer, you want to attract as many healthy and health-conscious consumers (and try to avoid those who aren’t interested in their own well-being). On its surface the idea may seem controversial, but using brands to encourage consumer self-selection is pervasive. Take SeeChange Health, a new insurer started in California by a former Aetna and United Healthcare executive. The brand clearly targets individuals who want to take control of their own health, with an emphasis on preventative treatment and incentives for following doctor’s orders.

5. Does your brand help inform a unique consumer experience? In today’s world, a brand is as much the sum of individual and collective experiences as it is the story that is told. And how healthcare brands deliver is becoming even more important as consumers share their experiences directly with one another through social media. Saying who you are is no longer sufficient. Companies need to deliver their story through a unique experience. Given the majority of interactions with the healthcare system involve a negative event, creating a positive experience is difficult—but if you’re able to succeed, you’ve won a customer for life. Look at Regence and their focus on creating a differentiating online customer experience.

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They've created an award-winning website, myRegence.com, to better inform consumers about their health and wellness options and to more effectively navigate the health care system.

If you answered no to any of the questions above, you should ask yourself why.

The best brands craft authentic stories and memorable experiences that transform perception and drive change. Your brand is not just a representation of who you are and what you stand for, but also a guide for where your business is going. Getting your brand right in a changing industry is not a “nice to have”; it is critical to your success.

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