

Presidents Message

BY RON WHETTER



One of our objectives for the year was to get more members involved in the planning of our chapter meetings. Nancy Schulz from Altru successfully applied this strategy to the planning of the Grand Forks Meeting on Dec 1st and 2nd. She invited me to one of her planning meetings for the December conference and I was really excited about walking into a room where there were 10 -12 HFMA members from Altru sitting around a

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table discussing the speakers, the brochure, and the other components that go into putting together a successful meeting.

The HFMA members from Altru participating were Nancy Schulz, Cherri Ellis , Stan Salwei , Tony Aymond., James Novak, Dwight Thompson, Jim Feldman, Tom Tweeten, Jerry Peeler, Sue Olson, Julie Klein, Cindy Braseth , Dave Zimmerman and Al Sorenson,

In the past, a majority of us have tried to put the meeting together with 1 or 2 of us pulling all the components together. It has worked out but there are HFMA members out there who want to get involved in our chapter and working with a committee on planning a meeting would be one of the best ways to get involved. I also think bringing more ideas to the table is going to make our meetings even better than they have been in the past which is saying a lot because our attendees have rated our meetings highly.

If you did not make it to our Grand Forks meeting, we hope to see you at our Bismarck Meeting on January 26th and 27th.

I still believe the most important part of HFMA is the networking opportunities for our members. I ran across a couple of paragraphs on networking in the Eastern Michigan Chapter Newsletter from the president that I would like to share with you.

“Networking is getting to know people who are interested in the same things you are. We can make new friends and acquaintances whom you can feel comfortable in calling to talk over a problem or a situation. Networking increases your visibility, helping you find people and people find you. (Did you know that 5-10% of all new jobs are actually posted in the classified or on the internet? The rest are filled by word of mouth.)”.

“Networking is a strategic investment of your time. Strive to network with those you have the most to learn from, but make sure you make the contact rewarding for them as well.” Be a good listener, empathetic and supportive.“

In conclusion, just like I had noted in my last message in August, there is so much to get out of HFMA by just coming to our meetings and sitting down and talking to your peers. Don't miss this opportunity. It will benefit the organization you work for and also will help you to pave a successful path for your career.

All the chapter's goals and objectives are listed on the NDHFMA website. Visit the website to review these and other NDHFMA info (www.ndhfma.org).



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OIG APPROVES DAY TREATMENT FACILITY JOINT VENTURE

A joint venture relationship that would establish a day treatment facility to provide pediatric psychiatric services does not violate regulations on referrals, according to an HHS Office of Inspector General advisory opinion. Under the proposed terms of this joint venture, each psychiatrist will invest one-third of the capital necessary to establish the facility and hold a one-third ownership interest. The vast majority of patients will be referred to the facility by clinicians who are not affiliated with the facility. The facility will treat self-pay patients, those covered by certain private health insurance plans, and patients enrolled in Medicaid health maintenance organizations. No beneficiaries in any of the other federal healthcare programs will be treated at the proposed facility.

The OIG concluded that it appears unlikely that the proposed arrangement is being established to serve as a mechanism to compensate or reward the psychiatrists for referrals of patients enrolled in the Medicaid HMOs, or by the investors to one another. In addition, the OIG stated that the risk of overutilization of items or services reimbursed by Medicaid is "minimal." While the proposed arrangement could potentially generate prohibited compensation under the anti-kickback statute, the OIG said, it would not impose administrative sanctions on the requestor in connection with the proposed arrangement.

CMS UPDATES 2006 CLINICAL LAB FEE SCHEDULE

CMS released the 2006 update for Medicare's clinical laboratory fee schedule and laboratory services subject to reasonable charge payments. According to the November 10 transmittal, the fees for laboratory travel - code P9603 will be set at \$0.935 per mile and code P9604 will be set at \$9.35 per flat-rate trip for dates of service beginning September 1, 2005. In accordance with the Medicare Modernization Act of 2003, there is no change in the update to the local clinical laboratory fees.

In addition, carriers will determine the charge for codes identified as payable under the reasonable charge basis. For customary and prevailing charges, carriers will use data from July 1, 2004, through June 30, 2005, updated by the 2006 inflation index of 2.5 percent. However, when these services are performed for hospital-based renal dialysis facility patients, intermediaries will determine payment on a reasonable cost basis. The effective date for this transmittal, number 750, is January 1, 2006.

WISCONSIN SEEKS ORDER ON HOSPITALS' UNINSURED PRICING PRACTICES

The Wisconsin attorney general announced action to seek special orders prohibiting two Milwaukee-area hospitals from charging excessive prices to uninsured patients.






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According to the complaints, St. Joseph Regional Medical Center, which is a member of the not-for-profit Covenant Healthcare System, and the Wisconsin Heart Hospital, which is a joint venture affiliate with Covenant Healthcare, have unfairly charged uninsured patients prices that far exceed the discounted prices the hospitals regularly charge the vast majority of insured patients.

PHYSICIAN FEE SCHEDULE REVISES ESRD, IMAGING, INHALATION DRUG POLICIES

The final Medicare physician fee schedule update for 2006, makes several changes to end-stage renal disease (ESRD) treatment payments. Under the new methodology, the payment rate for separately billable ESRD drugs and biologicals will be set at the average sales price (ASP) plus 6 percent, consistent with the Medicare Part B payment rates for most other drugs. At the same time, the rule increases the drug

add-on adjustment to the composite rate. The final rule also revises geographic designations and wage index adjustments with respect to ESRD payment, but provides for a four-year transition.

In addition, the final rule implements payment reductions for certain diagnostic imaging procedures when performed on contiguous body parts in the same session. However, the changes will be implemented over two years, with a 25 percent reduction in 2006 and 50 percent reduction in 2007.

The final rule also modifies Medicare payment for dispensing inhalation therapy drugs using nebulizers, which are covered by Medicare Part B. In 2005, CMS established an interim dispensing fee of \$57 for a 30-day supply and \$80 for a 90-day supply of these inhalation drugs. The rule goes into effect January 1, 2006.

OUTPATIENT PPS UPDATE SIGNIFICANTLY REDISTRIBUTES PAYMENTS

The average calendar year 2006 Medicare outpatient PPS update across all hospitals will be 2.2 percent, even with the full market basket adjustment of 3.7 percent, CMS has projected. However, large urban hospitals should average a 1.2 percent increase, while sole community hospitals will see a 7.6 percent increase. Low-volume hospitals' outpatient PPS payments are expected to drop by 1 percent in urban areas, 2.2 percent in rural areas.

The redistribution in the 2006 update comes from changes in the policy for drug payments, the ambulatory payment classification (APC) weights, and the wage indices, as well as the Medicare Modernization Act's 7.1 percent payment adjustment for rural sole community hospitals--all changes that must be budget neutral.

The outlier payment pool drops from 2 percent of total payments under the outpatient PPS to 1 percent. The outpatient PPS conversion factor goes to \$59.11 from \$56.983, while the outlier fixed dollar threshold will be \$1,250, up from \$1,175 for 2005. As a result of changes in beneficiary liability for copayments (see last week's coverage of the rule), CMS expects the copayments, as a percentage of total payments, to drop from 33 percent in 2005 to 29 percent in 2006, a \$400 million decrease.

2006 UPDATE TO MEDICARE DEDUCTIBLE AND COINSURANCE

CMS has updated its standard systems with the new 2006 Medicare deductible, coinsurance and premium rates. The deductible for Part A is \$952

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per benefit period, and for Part B is \$124 per year. The Part A coinsurance rate is \$238 a day for days 61-90, \$476 a day for days 91-150 for each "lifetime reserve" day used. The Part B coinsurance rate is 20 percent. The rates go into effect January 1, 2006.

HFMA SUPPORTS SIMPLIFIED PHYSICIAN CREDENTIALING SYSTEM

HFMA has signed a coalition letter urging CMS acting medical director Barry Straube, MD, to adopt the Council for Affordable Quality Healthcare (CAQH) Universal Credentialing DataSource® (UCD) for the Medicare program. UCD enables healthcare providers, at no charge, to complete a single, standardized, online application that fulfills most payers' provider data requirements, rather than completing multiple credentialing applications for different organizations. Widespread adoption of a standardized credentialing system would result in a dramatic reduction in paperwork, which is a significant source of dissatisfaction and cost among both physicians and the participating organizations.

The goal of the Healthcare Administrative Simplification Coalition, convened by the American Academy of Family Physicians, the American Health Information Management Association and the Medical Group Management Association, is for CMS to integrate the Medicare physician enrollment process into the CAQH service, thereby further reducing a significant physician credentialing burden.

IRS TO SHINE COMPLIANCE SPOTLIGHT ON EXEMPT HOSPITALS

Tax-exempt hospitals will be the focus of a new compliance and enforcement initiative, according to IRS FY06 Exempt Organizations Implementing Guidelines released this week. The guidelines state that the Exempt Organizations Compliance Unit (EOCU) is considering a compliance project to determine how hospitals set and pay executive compensation and how they meet the community benefit standards for purposes of section 501(c)(3). The EOCU would send compliance check letters to "a significant number" of hospitals asking them about these and possibly other issues.

Enforcement will be the IRS Exempt Organizations (EO) division's primary focus in the coming fiscal year, noted Martha Sullivan, director of the division, in the guidelines' cover letter. She noted that "the overwhelming majority of tax-exempt organizations try hard to comply with the letter and spirit of the law, and the tax-exempt community, itself, recognizes the need to protect the reputation of the sector."

Other initiatives for FY06 will address abuses in façade and conservation easements, charitable trusts, and charities that facilitate abusive transactions.

MARGINS FOR MEDICAL GROUPS DROPPED IN 2004

Margins for medical group practices decreased in 2004, according to a new 2005 cost survey by the Medical Group Management Association (MGMA). According to the survey, margins for internal medicine single specialty groups decreased by 5.5 percent to \$201,896 and primary care multispecialty groups not owned by hospitals saw a decrease of 3.9 percent to \$217,315. Overall, multispecialty groups' median total operating margin increased by 1.7 percent. For specialty practices, the median total medical revenue after operating costs per FTE physician grew by 5.6 percent to \$387,341.

For specialty practices, the median total medical revenue after operating costs per FTE physician grew by 5.6 percent to \$387,341. Among other factors, MGMA attributes the decrease in margins for single specialty groups to the 5.7 increase in median total operating costs per physician and a 4.6 percent increase in average support-staff costs. In addition, professional liability coverage continues to increase at a consistent level for all specialties, with obstetrics and gynecology leading the pack at 5.91 percent of total medical revenue, according to the survey. Since 2003, professional liability costs per full time physician have increased from 13 percent to 19 percent, MGMA noted.

Hospital-owned multispecialty practices seemed to do better at controlling costs, while not-hospital-owned multispecialty practices seemed to better revenue-generators, MGMA observed. Hospital-owned multispecialty practices' total operating costs per FTE physician dropped 9.9 percent (to \$283,191) while not-hospital-owned multispecialty practices saw theirs grow 3.5 percent (to \$392,108). Hospital-owned multispecialty practices' total medical revenue per FTE physician dropped 5.8 percent (to \$439,672) while not-hospital-owned multispecialty practices saw theirs grow 6.3 percent (to \$673,258).

STUDY FINDS ALTERED BILLING AND COLLECTION PRACTICES

The Center for Studying Health System Change (HSC) has found many hospitals have adopted more generous charity-care guidelines for uninsured patients in the aftermath of publicity about aggressive hospital billing and collection practices and several dozen lawsuits alleging hospitals overcharged uninsured patients. The findings are reported in a new HSC Issue Brief, "Balancing Margin and Mission: Hospitals Alter Billing and Collection Practices for Uninsured Patients." The study is the result of site visits to 12 nationally representative communities: Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y.

Other key findings of the study include:

- ✘ It is now common for hospitals to provide charity care to uninsured people with incomes under 200 percent of the federal poverty level, or \$38,700 for a family of four in 2005, and
- ✘ offer sliding-scale discounts beyond this income threshold, in some cases up to 400 percent or 500 percent of the poverty level;
- ✘ Some hospitals have restricted access to care for some uninsured—for example, some public hospitals limit non-emergency care for uninsured out-of-county residents; and,
- ✘ Most changes in billing and collection policies have had negligible impact on hospital finances to date.

OIG COUNSEL STRESSES CAUTION ON GAINSHARING VENTURES

Gainsharing arrangements may violate the civil monetary penalty (CMP) rule and pose a substantial risk of violating the federal antikickback statute, concluded Lewis Morris, chief counsel of the Office of the Inspector General, in testimony to the House Ways and Means health subcommittee. However, he did state that when properly structured, gainsharing arrangements offer ways for hospitals to reduce costs without causing inappropriate reductions in medical services or rewarding referrals of federal healthcare program patients.

**NEW HFMA MEMBERS
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Kari L Anderson
Reimbursement Analyst
Meritcare Health System - Fargo

Ramona Edwards
Chief Financial Officer
Mountrail County Medical Center - Stanley

Lindy Davison
Decision Support Analyst
St. Alexius Medical Center - Bismarck

Kim Zink
Chief Financial Officer
Jacobson Memorial - Elgin

Robin Murphy
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Sarah Gustafson
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Casey Ryan Johnson
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According to Morris, gainsharing between hospitals and physicians should occur only with strict safeguards that stress accountability, quality controls, and the prevention of direct payment for referrals. A major concern, Morris said is the impact of gainsharing on the quality of care provided to Medicare and Medicaid beneficiaries.

Morris cited congressional concerns that under the inpatient PPS, hospitals would have an economic incentive to pay physicians to discharge patients too soon or truncate patient care. Any hospital gainsharing plan that encourages physicians, through direct or indirect payments, to reduce or limit clinical services violates the CMP, Morris said. Hospitals that have obtained favorable advisory opinions, Morris added, established baseline thresholds based on historic utilization and national data to protect against inappropriate reductions in services and to ensure that physicians would not receive any money for savings that accrued beyond the baseline thresholds.

Also, arrangements intended to encourage physicians to "cherry pick" healthier patients for hospitals offering gainsharing while sending the sicker, more costly patients to other hospitals not offering gainsharing could potentially implicate the federal antikickback statutes, according to Morris.

IRS POSTS DRAFT FORM 990 FOR COMMENT

The draft Form 990 for 2005, recently posted for comment by the IRS, puts a new focus on current and former officers, directors, trustees, and key employees. Whereas Part V of the 2004 form was primarily a list of officers, directors, trustees, and key employees, with hours, compensation, benefits, and expense accounts/allowances, the proposed form

for 2005 follows that listing with additional questions at line 75 about those individuals' relationships with one another and related organizations. At line 75d, the IRS asks if the organization has a written conflict of interest policy.

New Part V-B asks for a list of former officers, directors, trustees, and key employees receiving payments during the year, and whether there were loans and advances or benefits and expenses attributable to them.

The form will apply to the 2005 calendar year returns, as well as those for tax years (or periods) beginning in 2005. The IRS has requested comments on the proposed form.

CURRENT ASC RATES WILL REMAIN IN EFFECT FOR 2006

The current ambulatory surgical center (ASC) payment rates and wage index values will remain in effect for FY06, CMS has announced. The Medicare Modernization Act delayed the implementation of new FY06 wage index values until CMS can determine the impact of changes in the FY06 inpatient hospital wage index on payment amounts for individual ASCs.

Medicare contractors will continue to use the FY04 wage index to calculate payments to ASCs and the payment rates that were effective for services furnished beginning April 1, 2004. Payment for ASCs will remain at the following rates:

The FY06 ASC payment rates are:

Group 1 \$333, Group 2 \$446, Group 3 \$510, Group 4 \$630, Group 5 \$717, Group 6 \$826 (\$676+\$150 for intraocular lenses), Group 7 \$995, Group 8 \$973 (\$823+\$150 for intraocular lenses), Group 9 \$1,339

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What is your current job/position? Provider Contractor for Blue Cross Blue Shield of North Dakota

What are the responsibilities of your position? Negotiate and service participation and managed care contracts with providers; work with providers and managed care networks to resolve issues, share utilization and financial performance information; and maintain and enhance the relationship between BCBSND and providers.

How long have you been at your current position? Six years

What was your very first job in healthcare? Hospital accountant at Sioux Valley Vermillion Medical Center in Vermillion, SD

What other healthcare-related positions have you held? CFO at two different hospitals and interim CFO at a sister facility while still working full-time at my own facility.

What do you like best about your current job? The nearly-daily opportunity to positively impact providers and members.

What are your hobbies? Reading (primarily science fiction) and playing online computer games.

What has been your proudest moment (personally or professionally)? My proudest (and happiest!) moment was when my wife said "yes" to my "will you marry me?"

What has been the best advice you have ever received? Stay credible. It's tempting in today's sensationalist journalism atmosphere to make numbers more exciting – and sometimes they should be. But your 'normal' day-to-day operations don't need to be exciting; it's more important that they be reported accurately.

Why did you join HFMA? I originally joined HFMA as a new CFO so I could meet others in similar positions and learn from them.

What are your favorite foods? Tex-Mex, spicy Chinese, and good barbeque.

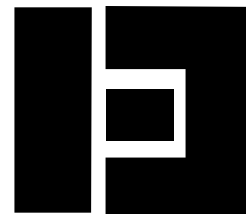
Share with us one of your favorite quotes. "Communication – key to success"

How did you first become involved with HFMA? Committee? Director? Officer? I first became involved in HFMA while I was a new CFO – the CFO of a sister facility convinced me to give it a try. I

became interested in joining the North Dakota board when Don Schott, a coworker, finished his year as Past President – I wanted to follow in his footsteps. Don also impacted my decision to become an Officer and work through the chairs – plus I feel that if you are going to belong to an organization, you need to give back what you get (and I've gotten a lot out of HFMA).

What is your current role with the North Dakota Chapter of HFMA? Treasurer; Webmaster / Chair of the Website Committee; Chair of the Constitution and Bylaws Committee; member on the Planning and Founders Points Committees.

What have been the personal and/or professional benefits you've realized from your HFMA involvement? The biggest benefit would have to be the relationships – both on a professional and a personal level. HFMA's certification process has also been a plus, as it shows that you "know your stuff." And North Dakota HFMA's educational programs are an incredible value – I've been to very few national conferences that match the content in our local programs, and those are usually much more expensive.



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