HFMA Today

Official Newsletter of the North Dakota Chapter of the Healthcare Financial Management Association

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Presidents Message

by Doug Okland

November is closing and December is on its way! Our November meeting in Grand Forks was a success thanks to all the attendees. The round tables that were held on Friday generated a lot of discussion. While hearing from national speakers and looking at what is happening in health care provides value to our members, the discussions related to what our members have implemented successfully provides real tools that can be implemented within the state.

I would also like to congratulate the award winners from this year's awards banquet. Tim Blasl, Judy Farkas and Kim Rau received the Follmer Bronze Award. Jodi Atkinson received the Reeves Silver Award, and Steve Ilse and Ron Whetter received the Muncie Gold Award. These awards recognize a combination of length of service in HFMA and active participation in the chapter. CONGRATULATIONS!

As winter doldrums move in, there is no better time to curl up next to the fireplace and study a HFMA certification course. HFMA certification was the topic of our Thursday lunch at the Grand Forks meeting, and I would like to again encourage you to consider studying for the exams. To become certified, you must take both a core exam and a specialty exam. The specialties offered include Accounting and Finance, Patient Financial Services, Management of Physician Practices and Managed Care. While it is nice to receive the acknowledgement of being certified, I also found the courses to be an excellent way to learn more about the business of health care finance. As I studied, I learned about areas that I am not directly involved in. A general understanding of all areas of healthcare finance makes us all better at what we do. The chapter has purchased a copy of the core exam study guide to assist anyone interested in completing the certification exam. Let me know if you would like to begin the process to become a Certified Healthcare Financial Professional.

Let's remember the theme for this year, It's Personal! As we prepare for the changes in rules and payment levels for the upcoming year, remember the knowledge we have in the state. I encourage all of you to use the membership directory to contact other members for assistance if you are unsure how to handle a specific change, and I encourage all members to readily give assistance to each other.

I wish all of you a Merry Christmas and a Happy New Year!

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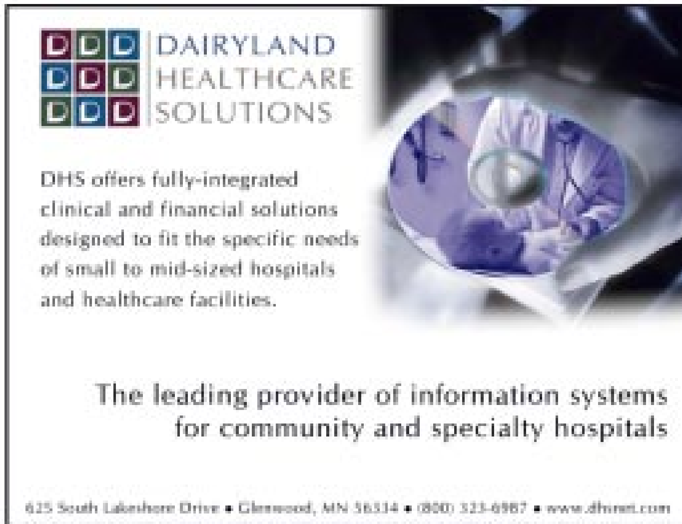

CMS TO USE COST REPORTS TO TRACK SNF PAYMENT INCREASE

CMS wants to know how expenditures on direct patient care changed as a result of the increased resource utilization group (RUG) payments produced by the forecast errors correction. The increase was announced in the final FY04 PPS rule for skilled nursing facilities (SNFs) published in the August 4, 2003, Federal Register.

When completing the cost report statistical page (S-2), SNFs will have to state, for cost report periods beginning on or after October 1, 2003, how the increased RUG payments received for services October 1, 2003, and after, were applied. A breakdown by dollar amounts is not requested, CMS staff said, just explanation of how the increased payments were spent on patient care.

See http://www.cms.gov/manuals/pm_trans/R13P235.pdf

HEALTHCARE FRAUD PROGRAM BOASTS RECORD RETURNS TO GOVERNMENT

The national Health Care Fraud and Abuse Control Program (HCFAC), established as part of HIPAA, reported its FY02 returns to the government are the largest since the program's inception. The federal government won or negotiated more than $1.8 billion in judgments, settlements, and administrative impositions in healthcare fraud cases and proceedings. As a consequence of these activities, as well as prior year judgments, settlements, and administrative impositions, the federal government collected $1.6 billion in cases resulting from healthcare fraud and abuse, of which approximately $1.4 billion was returned to the Medicare Trust Fund, and $59 million was recovered as the federal share of Medicaid restitution. It should be emphasized that some of the judgments, settlements, and administrative impositions in 2002 will result in collections in future years, just as some of the collections in 2002 are attributable to actions from prior years.

In addition, 361 criminal indictments were filed in healthcare fraud cases in FY02 and a total of 480 defendants were convicted for healthcare fraud-related crimes during the year.

TRAFFIC IS HEAVY ON NURSING HOME COMPARE WEB SITE

The CMS Nursing Home Quality Initiative, which has expanded and enhanced the nursing home quality data available to the public, has turned Nursing Home Compare into one of CMS's most frequently visited web sites. As the initiative approaches its first anniversary, the web site home page will utilize tabs for navigation similar in look to Amazon.com, a popular commercial site, CMS advised October 14.

The new site will go live in December with the 14 measures recommended by the National Quality Forum. CMS is continuing to work on consumer-oriented language as the number of visits to Nursing Home Compare exceeds 20,000 per day. The nursing home quality reporting initiative is paving the way for the home

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health initiative to be rolled out across the country in the coming weeks. A nationwide hospital quality program is currently being developed through voluntary participation.
Read more about at http://www.cms.gov/quality/

To visit Nursing Home Compare goto http://www.medicare.gov/Nhcompare/Home.asp

MEDICARE PREMIUM AND DEDUCTIBLE RATES FOR 2004 RELEASED

HHS has announced the Medicare premium, deductible, and coinsurance amounts to be paid by Medicare beneficiaries in 2004. The Part B premium goes up 13.5 percent to $66.60 (the amount needed to cover 25 percent of estimated program costs for the aged 65 and older). The Part A deductible increases $36 to $876. See the HHS announcement for hospital and nursing home coinsurance. If more information is needed call 1-800-MEDICARE (1-800-633-4227); assistance for the hearing and speech impaired is at TTY/TDD: 1-877-486-2048.

CONGRESS PASSES MEDICARE BILL

The Senate approved the final version of a bill containing the broadest expansion of the Medicare program since its inception 38 years ago. The president earlier praised the compromise bill as a "good piece of legislation" and plans to sign the bill. The House passed the measure on November 22.
The most visible provision of the "Medicare Prescription Drug and Modernization Act of 2003'' (S.1) is a voluntary prescription drug benefit to seniors beginning in 2006, with additional federal subsidies for drug coverage offered to certain low-income Medicare beneficiaries. Under the bill, seniors would be able to purchase a Medicare-backed discount drug card to help obtain medications in 2004 and 2005.
The bill also provides for a limited experiment in competition between private plans and the traditional Medicare program and a host of provider payment revisions, such as eliminating reductions in payments to teaching hospitals, relief for rural hospitals, and increases in physician payments.
Get summaries and background on the bill at http://waysandmeans.house.gov

IRS PUBLISHES BROCHURES TO EXPLAN TAX-EXEMPT STATUS

To prepare for increased enforcement efforts toward tax-exempt organizations, the IRS has issued two brochures to help organizations understand the laws and regulations of tax-exempt status and compliance guidelines. One brochure is designed to help organizations apply for tax exemption. The other brochure explains compliance guidelines for recordkeeping, tax return filing, and disclosure rules. The brochures also reference a host of other important IRS publications and forms, with contact information for organizations with specific questions on complex issues.

See http://www.irs.gov/pub/irs-pdf/p4220.pdf (Publication 4220).

See Compliance Guide for 501(c) (3) Tax Exempt Organizations at http://www.irs.gov/pub/irs-pdf/p4221.pdf

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FCC ADJUSTS RURAL HEALTHCARE RULES

On November 13, the Federal Communications Commission (FCC) adopted new rules to improve the universal service program for rural healthcare providers. The six-year-old program provides discounted telecommunications services to rural healthcare providers at rates equal to the rates charged for similar services in urban areas. The FCC seeks to increase participation in the rural healthcare support program (capped at $400 million annually) by expanding the eligibility for rural healthcare providers, providing discounted support to obtain Internet access, and modifying calculations of discounted services to offer more flexibility to the providers.

Read the FCC proposed rule at http://hraunfoss.fcc.gov/edocs_public/attachmatch/DOC-241210A1.pdf

CHARITABLE GIVING TO HOSPITALS DOWN 31 PERCENT IN 2002

Charitable giving to U.S. hospitals and health systems declined 31 percent in 2002 to $5.53 million from $8.01 billion in 2001, according to the Association for Healthcare Philanthropy's 2002 annual "Report on Giving." The report attributed the dramatic drop primarily to the economic downturn, which has caused return on investments, gifts of appreciated property (such as stocks), and interest on endowments to fall. The survey of 282 hospitals and health systems was conducted in the first quarter of 2003. The majority of respondents were community hospitals (59.6 percent), health systems (13.1 percent), or academic medical centers (7.6 percent).

CMS ESTIMATES $11.6 BILLION IN ERRONEOUS PAYMENTS

CMS estimates that $11.6 billion in Medicare payments-or 5.8 percent of payments-were made in error in FY03, about the same as last year's rate.

The CMS analysis identifies error rates by contractor, provider type, and service type. CMS will continue working with claims payers and quality-improvement organizations to lower the error rate by improving education and outreach efforts to providers and by simplifying document submission, the agency stated in the report.

Read the CMS error-rate report at http://www.cms.gov/providers/psc/Medicare-Error-Rate-Short-Report.pdf

CMS PROVIDES EMTALA GUIDANCE TO SURVEYORS AND REGIONAL OFFICES

In a November 7 letter, CMS provided interim guidance to regional office staff and state survey agencies concerning enforcement of the Emergency Medical Treatment and Active Labor Act (EMTALA). The CMS letter directs surveyors to use the interim guidance and current CMS Interpretive Guidelines for EMTALA to assess hospital compliance with the final rule.

Additional CMS letters clarifying CMS policies on EMTALA are on the CMS web site under Medicaid Survey and Certification. They address:

- On-call requirements
- Certification of false labor
- Policy clarification on hospital-owned and -operated ambulances participating in emergency medical services

The CMS interim guidance summarizes the EMTALA rule published September 9, offers additional clarification regarding when a patient is stabilized and the hospital's obligation to inpatients. The guidance notes that the enforcement of EMTALA remains a complaint-driven process with investigation of a hospital's policies and processes, and any subsequent sanctions to be initiated only by a complaint.

GAO: NUMBER OF PHYSICIANS INCREASED BY 26 PERCENT

The number of physicians in the country increased by about 26 percent from 1991 to 2001-twice the overall population growth of the nation during the same period, according to a report by the General Accounting Office (GAO). The average number of physicians per 100,000 people increased from 214 to 239 and the mix of generalists and specialists in the national physician workforce remained about one-third and two-thirds, respectively. According to the report, in nonmetropolitan areas the number of physicians per 100,000 people increased by 23 percent from 1991 to 2001, while the number of physicians in metropolitan areas increased by 10 percent.

While the proportional growth in physicians was higher in nonmetropolitan areas than metropolitan areas, the disparity in the supply of physicians in both areas persisted. Metropolitan areas continue to have about 145 more physicians per 100,000 people than nonmetropolitan areas, the GAO found. In addition, nonmetropolitan counties with a large town had the biggest increase in physicians per 100,000 people of all county categories, but their numbers were still less than those for large and small metropolitan counties in 1991 and 2001.

OUTPATIENT PPS PAYMENTS TO INCREASE 4.5 PERCENT

CMS will increase aggregate Medicare payments to hospital outpatient departments by 4.5 percent in 2004, according to a final rule issued October 31. This increase is an improvement on the 3.7 percent increase for 2003. The change does not include effects of hold-harmless provisions, outlier payments, or transitional pass-through payments.

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The estimated net effects of the final outpatient PPS updates are:
Urban hospitals: 4.3 percent increase
Large urban: 4.2 percent increase
Rural hospitals: 4.9 percent increase

The 2004 payment rates are based on actual hospital costs derived from 2002 claims for outpatient services. In addition to the new payment rates for 2004, the final rule includes:

1. A determination that pass-through spending in 2004 should not exceed the cap, and there will be no across-the-board reduction.

2. A decision to package the cost of drugs with daily median costs below $50 and the cost of all implantable devices into the payment rate for the primary procedure with which the products are usually furnished. The proposed rule, as well as the 2003 final rule, had set the threshold for packaging drugs at $150.
3. Restructuring of new technology APCs to enable Medicare to "pay more accurately for services assigned to these APCs."
4. Setting the threshold for outlier payments at 2.60 times the APC payment rate, but with a separate outlier threshold (3.65 times the APC payment rate) for community mental health centers.

Proud to be part of HFMA!

We salute the professional development and educational efforts of the *Healthcare Financial Management Association of North Dakota* and are pleased to be part of your statewide program.

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North Dakota Chapter
HealthCare Financial Management Association
2003/2004 Strategic Plan
Executive Summary

Each Year during our planning meeting in April, the Board of Directors and Chairpersons of the chapter develop a strategic plan for the upcoming year. The following information is a summary of the Strategic Plan for the North Dakota Chapter.

Mission Statement: North Dakota HFMA will serve as the statewide organization carrying out the mission of HFMA by:

- providing *local* professional development through education, information, certification, peer interaction, and leadership training
- influencing *local* healthcare financial management and accounting policy decisions, principles, and practices through advocacy and dissemination of information
- establishing and promoting the highest standards of professional and ethical conduct; and
- serving as the primary service opportunity for individual members of HFMA.

The North Dakota Chapter self assessment indicated the following strengths and weaknesses:

Area	Strengths	Weakness
Services	Good financial base of reserves. Chapter Sponsors a variety of meaningful programs to its members. Chapter has an effective membership assessment tool. Tradition of success; ND members are used to having an active and successful chapter organization. Strong culture. High quality publications at chapter level in newsletter, membership directory and website. Provide cost effective educational programs.	Large diversity of members not attending any meetings. Unpredictable weather in winter months. Advocacy efforts not well organized at the state level. Geographical dispersion of members across the state. Constraints on provider budgets to support member participation.
Quality	Member assessment of programs extremely high. Recognized as successful chapter at national level. Diversity of leadership. High quality of newsletters.	Lack of written documentation of standards or operating procedures. Member involvement in writing articles for newsletters.
Growth	Stable membership base; many long term members. Strong membership committee. Overall low turnover of members. Membership from majority of providers in the state. Increase of members from other associations.	New members are not actively sought out for immediate involvement in chapter activities. Long-term members of the association are not involved.

Based on this assessment, the following strategic initiatives were set for the upcoming year:

- Develop a statewide listserv for the specialties of Financial, Business Office, and Rural Health.
- Develop a policy and procedure manual for the five elected chair positions.
- Conduct Certification Training.
- Hold a Videoconference Meeting in September to increase attendance for a non-management focused educational session.

These initiatives will be implemented throughout the year.

A Look Back. . .

Grand Forks A/R Management Conference

November 2003

Thanks to our 2004 NDHFMA Sponsors

2003 Award Recipients

Attendees at the Grand Forks Meeting

2004 HFMA Meetings

January 29-30
Reimbursement Institute, Bismarck

March 15-16
Cost Report 101, Bismarck

April, 2004
Concordia Institute

June, 2004
Eide Bailly Healthcare Symposium

For more information or if you have suggestions for conference topics, please call Ron Whetter at (701) 738-2000

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2003-2004 SPONSORS

The North Dakota Chapter would like to thank the following sponsors for their donations. These donations are used to assist us in providing high quality educational programs for our members at a reasonable cost. During the year, each sponsor is recognized in a variety of ways, including program announcements, sponsorship boards at meeting activities, chapter newsletters, social events and in the membership directory.

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