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HFMA NORTHEASTERN PENNSYLVANIA
HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

NEWSFLASH

A Newsletter from the Northeast Pennsylvania Chapter of HFMA

A Letter From The President

President's Message,

Chapter President
Loren Stone, MHA, CHE

It is with best wishes that I pass on the presidency of the NEPA HFMA chapter to Diane Roberts and wish her and the officers much success in the upcoming year. This past year has been a time of excitement, success, setback and growth. Excitement in continuing to raise the bar in the quality of education sessions provided to members; success in working with a great team of officers, directors and volunteers of the chapter; setback in not fully meeting all of the goals that one sets; personal and professional growth through presiding over the chapter's operations for the past year.

The NEPA HFMA chapter's core mission is to provide the most pertinent, effective and cost beneficial education to its members and non-members. The past year was no exception with four excellent education sessions provided. I know that the incoming officers and directors will continue to improve upon the past success of the chapter.

It ahs been my privilege to serve as President of the NEPA HFMA Chapter and I thank all of the officers and directors for their guidance, participation and friendship.

Loren Stone, MHA, CHE
Executive Vice President
Endless Mountains Health System

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Physician Group Assessment—Why Subsidize?

By Michael F. Garczynski, CPA
Health Care Services Partner with Carbis Walker LLP

Many hospitals operate certain departments within their organization, such as the emergency department, through agreements with physician groups. Hospital management may develop concerns over these arrangements as subsidies to the physician group increase. To reduce or eliminate the Hospital's financial support to the physician group, management should review the administration and operations of the department. An outside consulting firm may be brought in to alleviate any time constraints or conflicts of interest. When performing a review of this nature, the focus should be on the areas that are most important to the success of the department, three of which are discussed below.

Professional Charges and Payments

An analysis of the department's average monthly totals for charges and payments should be prepared and reviewed for unusual trends and relationships. Any unusual relationship such as charges remaining consistent on a monthly basis while a significant jump in payments occurs would warrant additional investigation. The department's monthly gross collection percentage should also be reviewed. The gross collection percentage indicates how much the department's production is actually deposited into the department's bank account. The rate itself is not as important as the direction the rate is moving from measurement period to measurement period. If the department can increase its gross collection rate, its cash flow will increase accordingly.

Code Utilization and Fees

The CPT codes most utilized by the department should be identified and compared to the Medicare national statistics. Based on this comparison it can be determined if the department utilizes the codes in a more conservative or aggressive manner. Changes regarding medical record documentation and coding would be made based on this analysis.

The fees a department charges for its principal services should be compared to Medicare rates to ensure that fees being charged are high enough to cover any anticipated reimbursements by the department's best paying commercial carriers.

Accounts Receivable

One of the more significant lifelines of any business is its ability to manage its accounts receivable. Hospital departments may have problems maintaining an acceptable aged balance of these accounts. An analysis of accounts receivable should include a calculation of the department's accounts receivable turnover ratio. This ratio measures the time it is taking the department to collect cash from the point of service to the time the collection is deposited into the department's bank account. Using the average monthly charges, this ratio's movement can be compared on a month to month basis and to industry information. Most departments focus on reducing this ratio to 45-60 days.

An evaluation of the aging of accounts receivable should also include reviewing the percent of accounts that are over 90 days old. Depending on payer mixes, the ideal percentage of accounts over 90 days old should not exceed 20%. Nor should the vast majority of this money be due from insurances (versus private pay). Most departments do not allow balances with insurance carriers to exceed 30-45 days (with some exceptions) without some resolution or conversion to self pay. Having insurance balances out this far also creates a problem considering that a portion of these amounts will become self pay responsibility. If these balances are already 90+ days out, getting a patient to pay a balance becomes increasingly difficult resulting in less realized dollars.

The three areas discussed above which are primarily related to the cash flow of the physician practice operations are only a sampling of the areas that a review should focus on. Findings during these reviews usually indicate that there are definite areas of management that departments need to evaluate and change to improve their cash flow. This could include the utilization of full-time physicians and extenders, the use and coordination of administrative costs and time, management and review of the billing and collection process, the payment for independent contracted services, and the utilization of proper coding levels. These possible cost cutting measures should reduce, if not eliminate, the Hospital's financial support of the physician group operating the department.

Michael Garczynski is a Partner with the Health Care Services Team of Carbis Walker LLP, Certified Public Accountants & Consultants. He has over 16 years of experience and his background includes providing assurance and advisory services to clients within the health care and not-for-profit industries. He is a member of the American Institute of Certified Public Accountants, the Pennsylvania Institute of Certified Public Accountants, the Health Care Financial Management Association, and the Hospital Council of Western PA.

Hospital Based Skilled Nursing Facilities—Don't Overlook the Opportunities
By K. James Hunt, CPA—Partner, Coordinator of Health Care Services
Carbis Walker LLP, Certified Public Accountants & Consultants

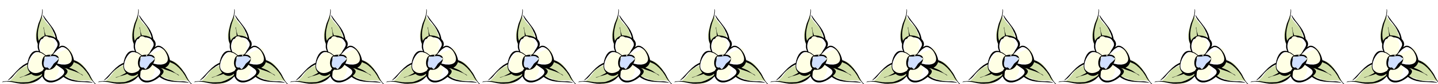
Over the past several years, we have had opportunities to work with several Pennsylvania hospitals that included a hospital based skilled nursing facility (SNF). The individual characteristics of these hospital based skilled nursing facilities varied in that some participated in the Pennsylvania Medicaid program while others did not; some were set up as separate legal entities while others were included with the hospital's employer identification number; and some included 25 beds while others included 125 beds, etc. While there were differences in the individual characteristics of the hospital based skilled nursing facilities, in most cases, there were opportunities to improve the financial performance that had previously been overlooked. Because of the complexity of many health systems and the fact that the skilled nursing facility component is, typically, a relatively small component of the entire system, the skilled nursing facility often does not receive the attention of the larger components of the system resulting in lost opportunities.

The first step in conducting a financial operation review of a hospital based skilled nursing facility is to determine the profitability of this particular operating component. This sounds like a relatively simple and straightforward process. However, because of the extensive integration between the hospital based skilled nursing facility and the other components of the health system, determining the profitability is not as simple as it sounds. Obviously you have the system overhead departments that are "stepped-down" to the skilled nursing facility. The process of reviewing the overhead costs that are stepped down to the SNF and determining the hospital overhead that is "consumed" by the SNF is not that difficult. However, there are other departments within the system for which the determination is not as simple. An example of one of these departments would be the system's pharmacy. This department is more difficult because most of the pharmacy costs that are provided to the SNF residents are billed directly to the resident by the pharmacy as opposed to being allocated to the SNF. Therefore, the profitability of the pharmacy services provided to the SNF residents must be considered in evaluating the overall profitability of the SNF. There are other areas, beyond pharmacy, within a health system that are impacted by the SNF that need to be considered in determining the impact the SNF has on the system's profitability.

Once profitability is determined, the process of profit enhancement can become the focus. There are several areas that we have encountered as it relates to maximizing the profitability of a hospital based SNF and we will touch on a few of those in this article. However, based on our experience, one of the opportunities with the most potential for improvement often involves the medical coding. Health systems often spend a significant amount of resources on medical coding of hospital inpatients and outpatients. This focus is an obvious necessity because of the large dollars involved and risk involved as it relates to the overall system. However, when it comes to coding the hospital based SNF residents into the Resource Utilization Groups (RUG's), often times there is a significant amount of undercoding. This undercoding results in lost reimbursement and can result in quality issues as it relates to care planning.

Another area where opportunity may exist within a hospital based SNF would include staffing levels. Stand alone SNFs have to address staffing levels in every department: nursing, dietary, laundry, etc. However, in most hospital based SNFs, these overhead departments are often allocated from the hospital, so the major area in which staffing levels can be an issue within a hospital based SNF is in the nursing department. Nursing salaries and benefits are the largest single expense within any hospital based SNF. The Pennsylvania state minimum for hands-on nursing care per day is 2.7 hours per resident day. However, the actual benchmark for Pennsylvania providers ranges from 3.1 to 3.5. Minor fluctuations in this ratio can have a very large impact on profitability. As with the coding issue mentioned in the previous paragraph, because of the other challenges that exist within a health system and the size of the hospital based SNF, aggressive monitoring of the nurse staffing ratio in a hospital based SNF often does not occur.

In terms of maximizing the profitability of a hospital based SNF, there are several issues that can be reviewed beyond the coding and staffing issues outlined above. Those issues would include Pennsylvania Medicaid participation, integration of the SNF with the other components of the system (such as home health agencies), Pennsylvania reimbursement for Major Movable Equipment, maximizing census in terms of volume and payor mix, Medicare reimbursable bad debts, tax exemption issues, etc. In most health systems there are a limited amount of resources to be allocated to a multitude of profit improvement initiatives, and management teams are forced to prioritize the allocation of those resources. However, as health system management teams analyze each component of their systems for opportunities for profit improvement, it is important to remember that the hospital based SNFs can include significant opportunities to maximize profit.



Mitigating Risk with Price Transparency
By Karl Kimball

Health care historically never thought of itself as an industry. However, the pressures that traditional U.S. health care providers are feeling is industrial in nature i.e., competition, quality of service, price competition, and consumer (patient) value.

Hospitals are challenged to be competitive but find it extremely difficult to both comprehend and also take actionable steps to thwart the competition. Perhaps the first and most important step for hospitals is to provide price transparency. Consumers must know what the price is for health services. Hospitals will be forced to follow the same course all other industries have been forced to follow i.e. price transparency. Consumers do not accept a continuous chain of discovery and follow-on charges. Consumers demand fixed prices. However, price transparency carries risks for hospitals. These risks are especially high because hospitals don't know their true costs for services and therefore are reluctant to give fixed prices. The simple task of providing prices for services is difficult for a hospital because the traditional way hospitals determined costs is based upon estimation algorithms of RCCs and RVUs. Both methodologies fail because they are based upon averages and are so inaccurate it puts the hospital at very high risk. Further, quality initiatives to improve services and provide price transparency are all but impossible with RCCs and RVUs because the incremental cost changes of a quality program are small compared to the error introduced by averaging based methodologies.

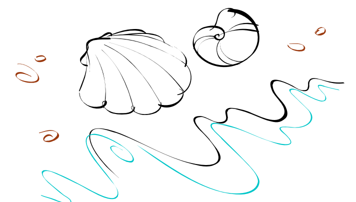
Scientifically, hospitals have not followed the science of quality (Edwards Deming model) and Activity Based Costing used to determine true costs and hence provide a solid scientific foundation for pricing. Hospitals must adopt these methodologies that will allow them to understand costs, which leads to profitability, and finally price transparency. Deming put forward a definition of quality as "meets requirements". This defined quality as set of metrics rather than a subjective evaluation. The early Volkswagen Beetle represented a low end car that was highly reliable because of a low maintenance air cooled engine. The Volkswagen Beetle was manufactured with very few flaws and met the criteria that set the standard for "economy car". The consumer got exactly what they expected when they purchased a Beetle, low price, low maintenance, and high reliability. Activity Based Costing is primarily a methodology of measuring the consumption of resources for a specific activity. This methodology is the heart of modern day supply chain and manufacturing that every successful company in every industry uses to insure that costs are known and pricing can be transparent. Without known costs all other metrics are meaningless, i.e. profit, price, and quality.

Price transparency is an extremely important topic for all hospitals. The ease and low cost of international travel has created more than just vacation time abroad, it has created access to markets that now cater to consumers. Dubbed "medical tourism", the attraction of low cost health care on par with the best of U.S. health care combined with the luxury and services of a vacation resort is increasingly the choice for major clinical procedures. Soon, even routine procedures will become routine for the consumer to seek outside the U.S., because they can be combined with a vacation or business trip. Consumers will opt for treatment where the convenience, cost, and quality combination makes it their best choice. The bottom line is that there is now competition for traditional health care.

The driver for this competition is not the chance for the consumer to have their hip replaced in exotic location. The driver is cost. The continuing rise in U.S. health care costs is the driver that is creating choice for the consumer. Competition is also coming from the bottom i.e. retail health care from Walmart and others who provide affordability. Walmart leverages their low overhead to provide specific, high profit, high volume procedures. Again, low cost health care providers target and commoditize procedures that provide a combination of convenience, cost, and quality attractive to the consumer. Eventually they will dig deep into the mainstream health care market cherry picking and commoditizing more and more procedures.

The path to price transparency for hospitals is a path to industrialization for health care. Hospitals must transition because their competitors are taking their market away. For Hospitals to be successful they must provide price transparency and insure that the profit and quality they provide is competitive to stave off competition. Price transparency is the goal for hospitals to be competitive, however the price hospitals must pay is the cost to transition to scientifically sound methodologies such as the Deming model and Activity Based Costing.

About the Author: Karl Kimball is Vice President of North America for Cortell Health and a member of the Texas Lone Star HFMA Chapter. Kimball holds a BS in Mathematics from University of Texas at Arlington. Karl has been a major contributor to the development of computer and communications standards and has been an ANSI Advisory Board member, a POSIX contributor, JTC 1 Delegate, workgroup leader for the ISO transaction processing standards. He has held various executive and leadership roles for IBM, Apple, Datapoint, and was a founding member of Corporation for Open Systems. Karl can be reached at karl.kimball@cortellhealth.com.

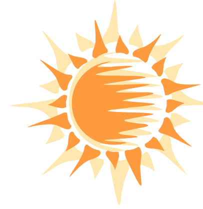


HFAM NEPA CHAPTER
Educational Session Dates & Upcoming Events 2008-2009 Year

Thursday, June 12th—HFMA NEPA Summer Education Session

- Accounting, Audit and Tax Update
- CPEs — 5 Hours A&A, 1 Hour Tax

Monday, June 30th — Annual NEPA HFMA Golf Outing



Please Plan On Attending!

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