CT SCANNER

hfma connecticut chapter
healthcare financial management association

October 2008

making connections

Strategic Planning for Recovery Audit Contractors (RAC)

By Cassandra Mitchell

As the Centers for Medicare and Medicaid Services (CMS) wrap up their three-year pilot program with the "recovery audit contractors" (RAC), there are a multitude of opinions regarding the success of the program. Proponents say that the RAC program has recovered more than 1 billion dollars in overpayments to providers by detecting and correcting improper reimbursements, therefore protecting all taxpayers. Opponents say that the tactics utilized by the auditors can be aggressive, vague and that they often times interrupt patient care. Both sides can agree, however, that the best defense is an organized strategy of preparation and response.

Slated to roll out nationally no later than January of 2010, the RAC auditors have recovered a majority of provider overpayments primarily from hospitals (see below). The typical provider post-audit response is a multi-layered appeal process that can be arduous and burdensome, further supporting that the best offense will be defense.

RAC Recovery Report	(Source: AMA Amednews)
Provider Type	%
IP Hospital	84%
OP Hospital/ IP Rehab/ SNF	14%
Physician/ Ambulance/ Lab	1.5%
Durable Medical Equipment (DME)	<1%

The RACs conduct claims data mining through information available from the Office of the Inspector General (OIG), MedPar, and the General Accounting Office (GAO) to target areas of interest, including but not limited to:

- One Day Stays
- Inpatient Coding and DRG Assignment
- Observation Services
- Improper Drug Units
- Radiation Oncology Services
- Discharge Dispositions
- Other ancillary services that defy logic like incongruent charge to payment comparisons, procedure codes that do not match diagnosis codes, and procedure codes indicating inappropriate sites of service

RAC Audit Overpayment Classifications	% (Source: AMA Amednews)
Medically Unnecessary Service	40%
Incorrect Coding	35%
Insufficient Documentation	8%
All Other	17%

When the RAC completes an audit, currently there are two options for followup – submitting a *rebuttal* directly to the RAC or filing an *appeal* directly with the FI (Fiscal Intermediary). Since the time period for rebuttal to the RAC is a short, 15-30 day window, providers need to strategically choose how efficiently and effectively they can make their case dependent upon the type of "finding." Since there has been limited success refuting the RACs with one day stays and DRG assignments, it may be in the best interest of the provider to seek rebuttal only when new information is made available and choose appeal to the FI in many of the other areas of dispute. Since resources are limited, and time is money, effective strategies for defense will help lead both physicians and facilities to success.

Effective management of the Revenue Cycle Process, monitoring of denials and prepay reviews, implemented strong compliance programs, effective auditing of the chargemaster and monitoring of the Medicare Suspense files can assist in identifying issues for

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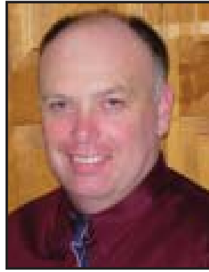
President's Corner

By Jim Harris, Chapter President



I hope you had a wonderful summer and that you were able to spend quality time with friends and family.

Now that the fall season is upon us with children going back to school, the leaves starting to turn into magnificent colors and of course scraping car windows from the morning frost, it reminds us that fall is the "season of change." But in healthcare finance we feel that we are in a constant season of change. The healthcare industry is changing, particularly on October 1 with the changes from CMS that will impact providers' reimbursement. HFMA provides the resources to meet these changes through education, analysis and guidance to its members. The HFM magazine comprehensively addresses many issues. Visit the HFMA Web site or attend one of our chapter's educational programs. I encourage you to take advantage of your membership and use these resources.

On a personal note, I believe that one of the ways that HFMA can enrich your life is to personally get to know other HFMA members. So I decided that I would use this forum to tell you about some of my experiences outside of HFMA. Since this is the fall and football season I thought that you might be interested in a recent experience I had. My wife and I are season ticket holders for UConn football and have been to both of their bowl games. For the past couple of years UConn has run a promotional contest where they pick one seat out of 40,000 and if UConn returns the opening kickoff for a touchdown that lucky ticket holder wins a new car. Before the kickoff of the first game this year one of our seats was picked to win a 2008 Toyota Highlander. Everyone in the stadium was cheering wildly, especially us, when the kickoff was returned for a touchdown. As the roar of stadium started to quiet down, we heard over the public address system the dreaded words of "holding on the play." This nullified the touchdown, no seven points for UConn and no 2008 Toyota Highlander. So we thought just our luck no new car. As the game was winding down at the end of the fourth quarter I approached one of our Connecticut state troopers showing him my ticket stub and asked him if he could do me a favor, "Would you arrest that official for stealing my car." Then Saturday after the game we read several newspaper articles and learned that the head coach of UConn sent game tapes to the Big East league office on two plays that the game officials had called holding penalties that negated UConn touchdowns. The Big East league office responded that one of the plays should not have been called for holding, the kickoff return was one of the two plays. The newspapers then stated that UConn head coach wouldn't elaborate on which penalty should not have been called for holding. Just our luck!

I would like to send out my best wishes for everyone to have a happy, safe and enjoyable holiday season. I look forward to having the opportunity to see you at one of our chapter events.

Connecticut Chapter — Healthcare Financial Management Association

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Web Site Information

Chapter – www.cthfma.org

Sue Stanley, Chair

stankel43@aol.com

National – www.hfma.org

CT HFMA is Cosponsoring the Following Educational Sessions with CHA

All meetings are at CHA in Wallingford, CT.

OPPS Proposed Rule for 2009
October 22, 2008
8:30 a.m.-3:00 p.m.

OPPS Final Rule for 2009
January 12, 2009
8:30 a.m.-12:00 p.m.

Changes in CPT/HCPCS for 2009
February 11, 2009
8:30 a.m.-12:00 p.m.

CT Chapter at Work

New Membership Communication Committee

A new Communication Committee has been formed. Survey results indicated that members feel they are not receiving all communications. The committee is responsible for recommending a policy, process and action steps to the full board for their consideration. Joe Pajor chairs the committee. Below is a synopsis of the Committee's first meeting. The committee welcomes your suggestions.

Membership Communication Policy

The Connecticut HFMA Chapter will communicate chapter activities on a routine basis to its membership using an array of communication vehicles, which include, but are not limited to, the Chapter Web site, the Chapter Newsletter, and email and postal mailings.

Specific Recommendations:

[1] All postal mailings will be on CT Chapter letterhead and envelopes.

[2] A moving 12-month calendar listing all CT chapter and Region 1 conference activities is maintained and available on the Web site.

[3] All email announcements to be standardized as to subject, no matter who prepares and distributes the email, using the following standard.

Subject: Connecticut HFMA Chapter- {xxxxxxxxxxxxxxxxx}

[4] One vendor is contracted for all membership support. Newsletter production may be separated if appropriate.

[5] Current vendor be given the required 6-month notice of contract termination with indication they will be receiving RFP for new scope of services.

[6] Create RFP type process to firms expressing interest [minimum of CHA and Admin. Resources]

[7] Request membership chair to report at Board meetings that membership listing is accurate and up to date and if not, define steps being taken to stay current.

Fellow Connecticut HFMA Members,

Within the next few weeks the membership committee will begin compiling the 2008-2009 Membership Directory.

Please log on to HFMA to verify and update your personal information. The Web address is: http://www.hfma.org/login/index.cfm

Your username is normally your email address or your membership identification number and your password is whatever you set it up to be. If you have any problems you can follow the prompts on the Web page and get HFMA to send you this information.

Summary of Connecticut Chapter HFMA Board of Directors Meeting
September 12, 2008

Awards
Founder's Awards were presented to Janet Roemer (Silver) and Jacqui Gorin (Bronze).

Fall President's Meeting
The meeting was held in Brewster, MA. Jim Harris and Joe Pajor attended. It was a two-day event: the first day focused on National HFMA; the second day focused on the chapters.

Balanced Score Card/Program Committee
Member education hours went down from the previous year, driving our overall score below 50. As a result, National has asked us to do a Chapter Advancement plan.

Communications Committee
The Committee had a conference call at the end of July and made recommendations to the Board.

Financials
Lou D'Auria reviewed the highlights of the financial reports.

Regional
Connecticut needs to nominate a Regional-elect; it needs to be a past-president who is still an active member of the chapter. Kathy will provide a list of the active past presidents to the Board for consideration.

Sponsorship
The Chapter needs to identify opportunities to attract sponsors. It is important that we articulate the value of sponsorship.

Next meeting November 14, 2008.

Balance Sheet of CT HFMA as of May 31, 2008

Assets	
Current Assets	
Checking/Savings	$95,221
Accounts Receivable	2,132
Other Assets	
Prepaid Expenses	718
Total Assets	$98,071
Liabilities & Equity	
Current Liabilities	
Deferred Revenue	4,650
Total Liabilities	$4,650
Equity	
Beg Balance	$55,330
Retained Earnings	29,902
Net Income	8,189
Total Equity	$93,421
Total Liabilities & Equity	$98,071

HFMA Region 1 Eighth Annual Healthcare Conference May 12-13, 2009

Get ready for the 2009 HFMA Region 1 Eighth Annual Healthcare Conference! Member survey results for 2008, once again, wanted the 2009 conference at Mohegan Sun, a world class resort and casino in Uncasville, CT. These exciting one-and-a-half days of education, scheduled for May 12-13, 2009 is being presented by the Region 1 Chapters: Connecticut, Maine, Massachusetts/Rhode Island and New Hampshire/Vermont.

More than 30 national and local speakers will address participants. The conference will kick off with a keynote speaker who will launch us off into four dynamic tracks: The Financial Executive Track; The Revenue Management Track; The Reimbursement Track and The Peer-Reviewed Product Track.

If you are looking to become involved in this year's event there are many opportunities for participating in the production of the Region 1 Conference. One way that provides a good introduction is joining the Registration and Hall Monitor team.

Registration Volunteers are individuals willing to volunteer time at the registration table on the evening before the conference and the morning of the first day of the conference. Volunteers are not scheduled during conference sessions because our paid administrative personnel cover those time periods. There are approximately 12 one-hour time slots for registration volunteers. Some individuals volunteer for more than one time slot.

Hall Monitors are individuals willing to volunteer time greeting guests and directing them to the registration table or to sessions. Hall monitors arrive at their designated area 10 minutes before the session or registration period begins and stay at their post for approximately 20 minutes. Usually individuals ask to be scheduled for the session they are attending so they can join the session as soon as most of the attendees have arrived. There are approximately 26 time slots for hall monitors.

Volunteer Incentive Plan (for Registration Volunteers). An individual who works the registration desk for three hours or more will receive a reduction of $100 in conference tuition and reimbursement of mileage costs.

These two jobs are a lot of fun. You get to greet old friends, meet new ones, and you feel good about keeping the conference running smoothly.

Sign up now! Please email marie.mcgee@valley.net. Further details will be provided as the conference draws nearer.

Strategic Planning for Recovery Audit Contractors (RAC)

Continued from page 1

cleanup prior to RAC identification. Additionally, a strategic plan, defined early and developed quickly, can be essential in deploying the appropriate amount of multidisciplinary skills and resources to be sure that every RAC request is fulfilled timely. Preparation elements could include but are not limited to the following:

1. Creating a multidisciplinary team composed of key members of the Revenue Cycle to strategize workflows and determine corrective actions.
2. Implement a process with written policies and procedures with corrective actions plans to inventory RAC planning approach.
3. Design, develop and flow the internal process of who will receive, log, distribute and respond to the RAC requests timely.
4. Create a claims database to track RAC requests, request status, repeated trends, and claims that are permanently excluded from RAC review because they have been reviewed by some other carrier or contractor.
5. Evaluate billing processes, pre-claims edits and resolutions to scrubber software edits to evaluate areas of risk and opportunities for improvement.
6. Train Patient Access Staff on MSP (Medicare Secondary Payer) processes and test competency.
7. Educate Case Managers, Physician Advisors and Residents stationed at the hospital portals of entry regarding the pitfalls of insufficient documentation and suggestions for improvement.
8. Properly use ABNs (Advance Beneficiary Notices) for noncovered services to limit those claims susceptible to RAC review.
9. Develop methods of identifying and extracting data, by DRG, to develop a dashboard of metrics that can be used to track and measure RAC activity.
10. Conduct random chart sampling to identify issues not already defined by internal or external reviewers.
11. Develop physician and hospital report cards to evaluate utilization patterns and to pre-identify problematic trends.
12. Conduct "mock" RAC audits to determine how effective and efficient current processes will be and to ensure post-correction auditing is implemented.

Upon implementation of the above planning steps, the processes should lead to enhanced compliance, stronger and more complete documentation, better revenue cycle processes and, therefore, less risk for current and future RAC findings.

Fall President's Meeting

By Jim Harris, President CT HFMA

One of the benefits of becoming more involved in your local HFMA Chapter and in leadership of that chapter is the annual Fall President's Meeting. This year, Joe Pajor (current president-elect) and I had the opportunity to go to Ocean Edge Resort and Club on Cape Cod on September 4 and 5. Presidents and presidents-elect from each New England chapter attended; regional executives (Dan Phillips regional executive; Kasey Davila regional executive-elect; Reggie Albert regional executive-elect elect; Mary Griswold regional treasurer) and representatives from HFMA National (Eileen Crow and Debora Kuchka-Craig).

Background

The Fall President's meeting is an opportunity for chapter leaders to represent their members, making their views known and gain knowledge of HFMA national initiatives. It is an important mechanism for involving chapter leaders in the governance of the Association.

The purposes of the Fall President's Meeting are to:

- Solicit and gather input from chapter leaders on important policy and program issues under consideration by the national volunteer and staff leadership.
- Provide an opportunity for idea exchange through the sharing of successful practices.
- Conduct regional business.

The input received from the Fall President's Meeting is then summarized, compiled and shared with chapter leaders. The regional executive will keep chapter leaders informed of the progress of any issues that require follow up.

Meeting

Eileen Crow, HFMA National chapter relations, provided an overview of the products and services available to HFMA chapter leaders. She also mentioned that HFMA is planning to make revisions to its Web site. Debora Kuchka-Craig, HFMA National secretary gave an update on what happened at the national board of directors meeting. She mentioned that Dick Clark, President and CEO of National HFMA, was named to *Modern Healthcare* magazine's 100 Most Powerful People in Healthcare. Dr. Clarke is one of only 17 individuals who have been recognized in this distinguished list each year since its inception.

A significant amount of the meeting was devoted to best chapter practices and discussion of common issues that each of our chapters are facing. This was a great experience as both Joe and I were able to share our accomplishments and concerns regarding the issues facing our chapter. We were all able to learn from one another about social / fun events, sponsorship and providing value to our members. We also reviewed the chapter balanced scorecard, which shows member educational hours, membership retention and member satisfaction.

Lastly, we spent time on regional business. The Region 1 2009 conference will be held at the Mohegan Sun on May 12 and 13.

This is a summary of what transpired during the meeting. As a member you should know that the leaders of this chapter, along with national staff, are making every effort to ensure that you get the most out of your membership in HFMA.

Chapter Balanced Scorecard

By Joe Pajor, President-Elect

Similar to key financial metrics, the Connecticut HFMA Chapter has its own scorecard to help measure its performance. National HFMA has developed a "balanced scorecard" to provide a consistent measurement tool for its 79 regional chapters which comprise HFMA.

Annually, each chapter commits to fulfillment of specific performance goals for each metric appearing on the Chapter Balanced Score Card by June 1. This helps provide a clear, unified vision to guide each chapter's activities and committees. It encourages consistency of chapter activities and provides a clear set of goals to work toward.

The balanced scorecard measures 9 key chapter indicators which are applied to each chapter. These are: [1] education hours [2] membership retention [3] financial executive membership [4] membership overall satisfaction [5] % of board composed of providers [6] quality of service delivery [7] days cash on hand [8] chapter reporting compliance and [9] chapter achievement

The Connecticut Chapter Board utilizes the scorecard to guide its activity throughout the year. Last year the chapter performed well in membership retention, % board composition, quality of service delivery, days cash on hand, and chapter reporting. Renewed focus this year will be on education hours as the chapter will try to strengthen its educational offerings for the membership.

The scorecard is a valued tool utilized by all chapters and helps guide much of the board's activity.

Mark Your Calendars!

HFMA Region 1
Eighth Annual Healthcare Conference

Educational Sessions –
Tuesday, May 12 and Wednesday, May 13, 2009
Mohegan Sun, Uncasville, Connecticut

Four tracks will be offered:

1. Revenue Management
2. Senior Executive
3. Reimbursement
4. Peer Reviewed Products

Past Presidents Dinner will be held
the evening of Tuesday, May 12, 2009

CT Chapter Golf Tournament **— Will precede the conference**
Monday, May 11, 2009
Fox Hopyard, East Haddam, Connecticut

Stay Tuned for More Details!

Mediation: A Welcome Alternative to a Formal PRRB Appeal

By John P. Ruocco, Consultant Third-Party Reimbursement and Appeals

When the Provider Reimbursement Review Board (PRRB) opened its doors in late 1974, our appeals staff at Blue Cross and Blue Shield Association (BCBSA) had identified 53 of our 700+ Medicare reimbursement appeal cases as being under the jurisdiction of that newly-appointed adjudicative body. Over thirty years have now passed since I sent Art Owens, the first Chairman of the PRRB, his initial 53-case backlog of appeals. That backlog sits at over 8,000 cases as of this writing. In their most productive year (1984), the Board managed to issue 180 decisions. Their current annual production, in terms of formal decisions, is less than 90.

> ***Mediation emphasizes informal, on-the-spot problem solving as a practical alternative to gearing up for protracted and formal adversarial proceedings such as a "formal" PRRB hearing.***

This ponderous administrative process continues to be a necessary step in challenging an adverse action on the part of a Medicare Intermediary affecting certain aspects of program reimbursement. In order to protect its right to bring certain actions in court, a healthcare provider must first "exhaust its administrative remedies," and for certain aspects of Medicare reimbursement those remedies still involve filing an appeal with the PRRB. That means that if a provider does not protect its right to bring an administrative action by filing an appeal within the time frames set by the regulations, it may very well lose that right. For example, I am currently involved in settlement discussions in a large PRRB group appeal involving the provider members of a national healthcare chain. In that case, certain individual providers in that chain organization neglected to file their individual appeals on time and, because of that inadvertence, are now left out of the current action.

The Board has instituted certain procedures to expedite its administrative process, especially where providers are challenging Program actions that the Board has no choice but to follow. A provider may request that it be allowed an "expedited judicial review" and essentially skip the step of having to present a case at a formal appeal hearing. The Medicare program has issued regulations addressing this process and the Board has covered it in their general instructions. Furthering the spirit of expedited dispute resolution, the Board has adopted procedures that accelerate the hearing process and continues to encourage actions that bypass the process entirely such as informal pre-hearing settlement negotiations among the parties and the conduct of mediation sessions presided over by Board staffers.

The latter has proven to be quite successful since it was instituted in 1998 largely through the efforts of Kathleen Scully-Hayes, Esq., Director of Hearings and Appeals, and continuing through the current fiscal year under Mr. Paul Crofton, the Board's current Director. This process elevates the ad-hoc and informal "out-of-court" pre-hearing meetings between the appealing provider and its Medicare fiscal intermediary to a more formal and controlled level.

Mediation emphasizes informal, on-the-spot problem solving as a practical alternative to gearing up for protracted and formal adversarial proceedings such as a "formal" PRRB hearing. According to the Board, approximately 90% of all cases filed are settled or are withdrawn at some point before the scheduled hearing date, and of that figure approximately 85% settle within days before the scheduled hearing. Especially with regard to the latter, considerable resources have already been expended by the Board, its staff, the Provider, and the Intermediary when a settlement announcement is made at the eleventh hour.

The mediation process encourages the diversion of resources to meaningful informal settlement negotiations earlier in the process before (sometimes years before) these resources are committed to the pursuit of a formal adjudicative resolution. The Board has indicated that it believes that if the parties engage in mediated settlement discussions early in the process, the time necessary to resolve these disputes and the parties' expenses in pursuing the appeal would be considerably reduced.

As to the PRRB's mediation process itself, the Mediator (unlike the Board in its formal proceedings) does not "decide" the case. Under the mediation process, the Board's Mediators have no power to make and issue decisions but instead will use their knowledge of negotiation and consensus building and their persuasion skills to help all parties reach their respective objectives. The Board points out in its material on the subject that its mediation alternative is a voluntary, informal process and that formal rules of evidence that may come into play in an actual Board hearing are not critical to this process. In this informal procedure, for example, formal testimony is not taken and recorded by a stenographer, witnesses are not formally sworn, and interrogatories, depositions, and transcripts are not required. Also, the parties involved are encouraged, but not forced, to reach agreement, i.e. the mediator is there to facilitate the process but is not going to issue a "decision" that everyone must adhere to.

While the process is informal and fairly off-the-cuff, the Board staff conducting the mediation will establish certain basic requirements, a primary one being that both parties agree as to the issues to be mediated. Also, while formal position papers submitted in multiple copies and bound together with all exhibits are not necessary for a mediation as they are in a PRRB hearing, summary position statements of one or two pages from both parties on each issue are submitted to the Mediator and are exchanged between the parties a few weeks in advance of the date set for mediation discussions. Finally, prior to the commencement of mediation discussions, the parties will be asked to sign a Statement of Understanding regarding

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CT HFMA New Members

We extend a sincere welcome to the following individuals who have chosen to join the Connecticut Chapter of HFMA. We hope our new members will contact one of the Chapter Officers or Directors with any questions they may have and also let us know if they have an interest in becoming involved or participating on one of our Committees.

Patrick W. Brosnan
Director, Business Ventures
Health Net

Dana D. D'elia
Director, Hospital Contracting
Yale-New Haven Health System

Sarah M. Gaignat
Strategic Planning

Ann D. Gineo
SVP & Actuary
The Segal Company

Daniel Henderson
Student

Alan G. Mayhew
Manager, Revenue Analysis
Planned Parenthood of Connecticut

Robert Nelb
Student

Julie Stanford
Business System Analyst
University of Connecticut Health Center

Arif Toor
Chief Executive Officer
Kabot International Inc.

Rick Zitkus
Director, Provider Solutions
Optumhealth Financial Services

Certification — Make It Happen for You

By Bill Wollman, Chairperson, Certification

The Certified Healthcare Financial Professional (CHFP) designation is earned by successfully completing HFMA's certification program. This is the first step in achieving the designation of Fellow of the Healthcare Financial Management Association (FHFMA).

The certification program is designed to prepare individuals for increasingly responsible positions in the healthcare finance industry. Being HFMA certified indicates that certified members have demonstrated comprehensive understanding and proficiency of HFMA's defined body of knowledge in healthcare financial management overall and in the specialty areas.

Survey results have shown a strong relationship between certification and career advancement. Certified members of HFMA tend to earn a higher annual salary and are more likely to be hired for upper-level positions in healthcare finance. They are respected members of the healthcare leadership team.

For a copy of the HFMA Certification Brochure call Bill Wollman at (860) 646-6383. This brochure summarizes information about program requirements, includes application and order forms, and contains information about the HFMA Certification Maintenance requirements.

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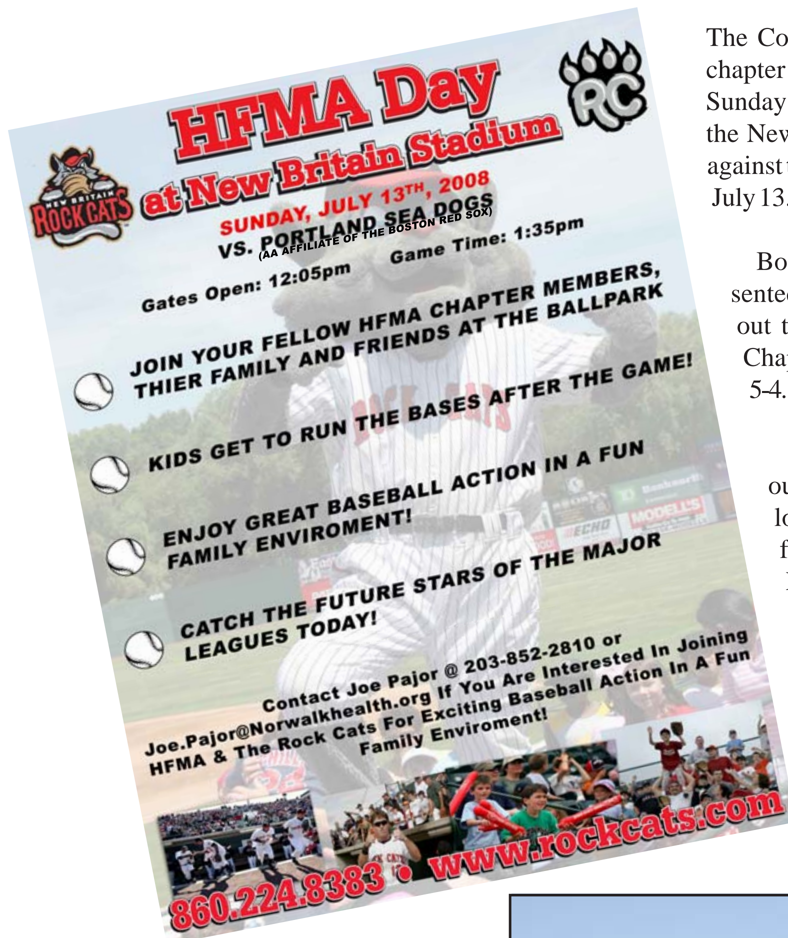
- Medicare Eligible Days
- SSI Proxy
- GA Days
- Other Medicaid Proxy Issues
• Medicare Bad Debt Analysis
• Capital Cost Reimbursment Review
www.qualityreimbursement.com

CT HFMA Summer Outing at the New Britain Rock Cats

By Joe Pajor



The Connecticut HFMA Chapter was well represented as chapter members, their families and friends enjoyed a sunny Sunday afternoon Double AA minor league game featuring the New Britain Rock Cats, the Minnesota Twins affiliate, against the Portland Sea Dogs, the Boston Red Sox affiliate on July 13.

Board member and Past President Lou D'Auria represented the chapter in opening game ceremonies throwing out the first pitch. The 73 individuals representing the Chapter saw an exciting game with the Rock Cats winning 5-4.

This marked the chapter's first attempt to sponsor an outing at a minor league game. Based on its success, it looks to be a yearly event. Next year's game will try to feature the Rock Cats playing the Trenton Thunder, the New York Yankees AA Minor League affiliate.

Hospital Pricing — A Complex Payment System Equals Complex Pricing

By Janet F. Roemer FHFMA

Defensible pricing is one of the "hot topics" in the healthcare industry. In fact the topic has generated so much interest that HFMA (Healthcare Financial Management Association) in conjunction with AHA (American Hospital Association) published a report named "Reconstructing Hospital Pricing Systems."

What's causing such interest in hospital prices?
There are several factors driving this interest. First is the shift of a greater percentage of healthcare cost from companies to employees. As employees, the consumer becomes responsible for more out-of-pocket expenses. Interest in the price they are paying for a particular service grows. Also consumers now have the ability to shop around to find out what hospitals charge for a particular service. Price transparency in the industry has opened a new door.

A hospital provides a service just like other companies, so it should be pretty easy to set prices. Right?
Well to a consumer that makes sense. But those of us in the hospital industry know it's not that simple.

Let's look at the similarities and differences between how hospitals and, let's keep it simple, a local diner, set prices and get paid. Like the local diner, hospitals buy products; they have overhead expenses and set prices accordingly with the expectation of making a profit margin sufficient to meet their financial needs. Consumers understand that. When a consumer goes to "Joe's Diner" for a steak dinner they expect to pay the same price on Joe's menu that anyone else that visits the diner will pay. Well that's true for the diner, but as we in healthcare know, that is not true in our industry.

So why doesn't a hospital set a price just like Joe's Diner?
When hospitals set a price, they rarely receive that price. Outside forces, beyond the hospital's control, complicate the process. Hospitals have to negotiate rates with insurance companies that are unique to an individual insurance plan in order to get paid. Hospitals also provide services to patients insured by the government (Medicare and Medicaid). In order to provide services to these consumers a hospital accepts what Medicare and Medicaid pay. The rates hospitals receive from these government agencies usually don't cover hospitals costs, creating shortfalls. Hospitals also provide services to consumers who are underinsured, don't have insurance and to the indigent.

How can a hospital possibly set defensible prices when all these variables come into play?
It's not easy. We need to keep the hospital pricing model simple and rational so that we can explain our prices to consumers.

So what factors affect how a hospital sets a price? Let's examine some elements that go into defensible pricing.
Market Forces – Hospitals need to compare their rates with their competitors. It's important to know your competitors. Hospitals compete for business with other hospitals, physicians and specialty companies such as independent laboratories. A second market force is the rate paid by health plan payers. A hospital also needs to understand the number of patients who receive services at the hospital from each payer, that is, payer mix. And finally most hospitals, unlike other businesses, have a mission to provide community benefits through reduced cost and free care.

Cost – It's important that hospitals know the fully loaded cost to provide a service. What is the true cost of providing a particular service?

Quality – What makes the quality of service at one hospital so much better than the hospital down the street? There is added cost associated with excellent quality and it needs to be factored in when setting a price.

Financial Requirements – A hospital needs to set a reasonable profit margin to ensure stability. The price of hospital services must be sufficient to meet all the hospital's financial requirements.

Just for an example, let's pretend that one of the services a hospital provides is a steak dinner just like Joe's Diner.
A steak dinner on Joe's Diner's menu is $40. Every customer who orders that steak dinner will pay Joe $40 for the dinner. Now Joe's competitor Green Leaf Hospital would like to set the price at $40, but every customer who comes through their door won't pay $40, like Joe's customers. Green Leaf Hospital has determined if they were paid the same amount from all their customers they could match Joe's price. Due to market forces, the quality of their steak dinner and their commitment to provide free steak dinners to those in need, Green Leaf Hospital will need to charge $60. If Greenleaf does not charge the higher price, Green Leaf Hospital will not meet their financial requirements and will be out of business.

It's not surprising that hospitals receive complaints from consumers. The complexity of the payment system has made it impossible to price hospital services in a way that consumers can easily understand.

So what is a hospital to do?
We need to educate consumers. Hospitals need to let consumers know the factors that go into setting prices.

What pricing methods are used throughout the industry?
Gross charges, the price a hospital charges, may be based on a combination of factors, including the highest allowable charge in a contract, and cost and marketplace consideration, such as being in a particular percentile of the marketplace.

Prices go up every year. How do hospitals adjust charges annually?
Prices are increased across the board.

Some hospitals adjust prices on departmental cost-to-charge ratios.

Some hospitals set prices using market rate information.

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National HFMA Education Opportunities

Revenue Cycle Strategies Conference
Las Vegas, October 27-29, 2008

HFMA Web Casts – Strapped for Cash Hospitals and Physicians Joint Ventures
October 27, 2008

Regional Chapters:
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Hospital Pricing

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Some hospitals selectively increase prices based on pricing sensitivity.

But **most hospitals** use a **combination** of the above.

A model of Market-Based Strategic Pricing is a more explainable pricing methodology that hospitals are using today. It is common for a hospital to hire consultants to compare hospital prices to industry-wide accepted benchmarks. This method appears to be more defensible to the consumer. Pricing is never easy, but the healthcare industry needs to find methods of pricing that help them achieve financial stability and offer prices that can be explained to patients.

Notes from the Editor

I think I'll call my column this issue "Double V" – Vote and Volunteer.

In a few weeks we will be electing a new President. It's very important that we get out and vote. Our healthcare system is broken and we can't continue to survive with a bandaid approach. Every one of us has an obligation to look at each candidate's position. We need to look at the candidate and stop voting along party lines. Our country is suffering because so many of us over the years have not voted their conscience but taken the position of a follower and voted either Democratic or Republican. I am guilty of this too.

Our country is in such distress that we must discard party lines and vote for the person we each believe will do the best for our country. Familiarize yourself with each candidate's positions; understand each person's plans for the future. Look at the quality of the candidate. Does the candidate have the country's best interest at heart? Does the candidate have the ability to lead our country in our troubled times? I urge you to take the time and study the positions of each candidate. Let your voice be heard and cast your ballot in the November election!

I hope all of you joined HFMA because of the great programs and networking opportunities. HFMA is a great organization because of its members' involvement in the organization. There is a call to volunteer in this publication. Please consider volunteering your time to help with next year's Region 1 meeting. HFMA will benefit from your time and you will benefit from the experience.

Please email me with your comments: roemerjf@att.net

Janet F. Roemer FHFMA

Editorial Policy

The statements and opinions appearing in the articles are those of the authors and not necessarily those of CT HFMA Chapter, or the editor. The editor reserves the right to edit material and accept or reject contributions whether solicited or not. All correspondence is assumed to be a release for publication unless otherwise indicated.

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Mediation: A Welcome Alternative to a Formal PRRB Appeal

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the mediation that sets the parameters for the process. Essentially, in that agreement the parties stipulate as to the confidentiality of the process and that settlement pursuant to the mediation will be binding on all participants.

Once the agreement is executed, the parties will then meet with the Mediator, generally for several hours at the intermediary's offices, and attempt to reach a consensus on a resolution of the issues. If the parties are able to fully resolve the case as a result of the mediation, the parties will prepare and sign a "Settlement Agreement" at the conclusion of the mediation and the case will be closed. If the parties are unable to resolve all issues under appeal, the case will be scheduled for hearing and the PRRB appeal will proceed as a normal, formal appeal.

While the ideal outcome is to settle all issues in the appeal and close the case, the mediation process is not an "all-or-nothing" process. The parties, for example, may agree on the resolution of only some of the issues leaving the remaining issues to be adjudicated by the Board. If that is the result, the parties will be advised of a new briefing schedule for the remaining issues and a date for the hearing will be set as in a normal appeal.

In reaching a decision as to whether a particular dispute is a candidate for mediation there are a number of factors to consider. It is important to identify the nature of the problem that is preventing a resolution of the dispute, for example a lack of communication between the parties may be the principal stumbling block and a face-to-face meeting in the presence of an informed neutral party may serve to overcome that problem. Also, there may be technical or complex factual issues or legal issues that need to be fully explored to facilitate a reasonable settlement.

A semi-formal mediation discussion may be all that is needed to break a negotiation stalemate. The intervention of a neutral party may serve to defuse the hostile atmosphere that prevented meaningful discussions in the past. The mediation itself allows the evaluation by a neutral party of dispositive factual, legal or settlement issues. A presentation of its case by the parties on each side to decision makers on the other side aids in allowing each to understand the position of the other.

Both parties must be willing to engage in mediation, and it helps if the parties or their representatives are experienced in mediation techniques. Of course, not every case or situation is appropriate for the use of mediation and there are a variety of factors that can be considered as either supporting the use of mediation or making the use of mediation less likely in a particular case. Generally where the parties expect to have continuing relationships, such as a provider and its intermediary, a cooperative, informal negotiation is preferable to a formal adversarial proceeding. The nature of the case should be compatible with a need for problem solving or the development of creative alternatives. Possibilities of settlement may be improved by the neutral mediator's ability to conduct frank, private discussions among the parties.

Where the provider and intermediary have attempted traditional settlement negotiations (e.g. reopening requests or proposals for administrative resolution) without success or an impasse has been reached and the parties believe that the involvement of a third-party neutral will facilitate further progress and/or final resolution, the mediation alternative presents a forum that could accommodate such a resolution. In some cases, the parties need to hear an evaluation of the case from someone other than their own representatives, such as a Mediator.

Before mediation can commence, the facts should be sufficiently developed to permit the parties to make informed decisions concerning the ultimate disposition of the dispute. A provider should not request a mediation if it has yet to get its facts straight. Also, both parties must be prepared to discuss settlement and be willing to resolve the case short of a formal PRRB hearing. Individuals who are convinced that "their way is the only way" or tend to hold personal grudges should be left at home. If such individuals are necessary to the presentation of the case, the better course would probably be a formal hearing with direct and cross examination.

Before mediation can commence, the facts should be sufficiently developed to permit the parties to make informed decisions concerning the ultimate disposition of the dispute. A provider should not request a mediation if it has yet to get its facts straight.

Any case involving the provider's dispute with adjustments stemming from clearly stated program regulations or general instructions are not candidates for mediation as a rule. Also, if the Medicare reimbursement dispute results from an adjustment that is clearly in error or if a disallowance can be cured by simply submitting additional documentation that was not available at the time of the audit, the intermediary should be willing to revisit its initial audit determination and reopen and revise the cost report on its own rather than involving the intervention of a "neutral."

On balance, the mediation alternative has a great deal of potential and should be considered by most providers with cases currently pending before the PRRB, either individually or through group representation by their parent chain organization. Having been involved in the successful mediation of several PRRB cases over the years, my experience with the process has been quite encouraging. A final thought weighing on the side of this alternative is that a resolution by mediation, similar to any pre-hearing administrative resolution that results in a reversal or modification of an intermediary's determination to the satisfaction of both parties, is informally made. It therefore does not become a matter of "public record" as does a PRRB decision. Once made, the settlement is truly "final" in the sense that there is no post-resolution time period wherein an appealing provider must worry about an overturn of the "decision" by higher administrative authority followed by protracted and costly litigation. If successfully negotiated, everybody truly wins.

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