



Believe to Achieve

# HEART BEAT

WINTER - 2012



**hfma**

healthcare financial  
management association

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## The Evolution of Hospital Charity Care

*Shanna Hanson, FHFMA, Manager of Business Knowledge, Human Arc*



What constitutes charity care and community benefit has historically had no clear, universal definition. To understand the current state of charity care in the United States, it is both appropriate and insightful to look at the evolution of hospitals. Their humble and charitable beginnings in the 1700's and 1800's were from almshouses at which the poor and homeless received care and shelter. Factors such as the advent of anesthesia and antiseptics, urbanization, economic development, massive immigration, and the need to isolate those affected by a growing number of epidemics, all gave rise in the 19<sup>th</sup> century to establishments in which doctors and nurses gave their time in return for little or no money. Over time, these institutions became symbols of hope. Doctors began to be paid, and nursing and staffing were professionalized. *For the first time, hospitals were fiscally challenged but remained committed to the mission of treating all, and they became ever more vulnerable to marketplace forces.*

Insurance plans emerged in the 1930s, as the non-poor began to demand hospital care. The Hill-Burton Act of 1946, which sought to promote hospital modernization, provided government grants to non-profit hospitals in exchange for charity or discounted care for those who could not afford it. Financing of the hospital industry shifted again in the 1960's with the creation of Medicare and Medicaid. By the end of that decade, about 90 percent of hospital

revenue came either from government programs or private insurance. In 1969, the Internal Revenue Service (IRS) revised the definition of charity care to community benefit. Revenue Ruling 69-545's "Community Benefit Standard," which essentially requires that healthcare organizations "promote health" for a broad cross-section of the community, replaced a 1956 IRS ruling that required healthcare organizations to provide "charity care" (free or low cost healthcare for the indigent) up to the level of their financial ability.<sup>1</sup> In 1986, the Emergency Medical Treatment and Labor Act (EMTALA) became federal law, requiring Medicare and Medicaid participating hospitals to provide a minimum of care to all patients coming to an emergency room regardless of their ability to pay.<sup>2,3</sup>

H.R.3590.AS, better known as the Patient Protection and Affordable Care Act (PPACA), was signed into law on March 23, 2010. Sec. 9007 outlines the "Additional Requirements for Charitable Hospitals."<sup>4</sup> Section 9007(a)(r)(1) states:

In General - A hospital organization to which this subsection applies shall not be treated as described in subsection (c)(3) unless the organization—

*(continued on page 4)*

# President's Corner



**Esteban Ponce**

Saludos!

I am writing this in early December, and it does cause me to think about what I am thankful for in the midst of a time of great uncertainty for our country and our industry.

My hope is that every member of the Heart of America HFMA chapter has a wonderful holiday season with family, friends, and loved ones. The holidays are a great time to reflect on what we are thankful for and our blessings. The chapter programs and networking opportunities are a great way to connect with other members.

Nowdays, we face an almost certain future financial crisis in federally funded health programs that could make our current economic mess in the banking, home mortgage and credit sectors look like good times, and everywhere state budgets are similarly strained as a result of increasing costs and demands for health services among an aging population and now a growing economically distressed population.

So what is there to be thankful for? I think we have to have hope that in times like this courageous leadership will emerge that takes a risk to actually lead through thoughtful, intelligent and decisive action.

Our chapter co-sponsored a very timely panel session in November on what issues a financial team should address to the leadership team. This is a very important topic in order to maintain financially viable healthcare organization in these times. We had over 45 attendees come and listen to key area CEO leaders from the University of Kansas Hospital, Overland Park Regional Medical Center, John Knox Village and Clay-Platte Family Medicine Clinic. The session featured very candid and open discussion of

what it is like to financially run a healthcare organization in these times. We are challenged to find new ways to serve our members and wise in how we manage the chapter's resources. Our goal is to provide you with the types of programming and networking offerings that return value to you.

I'm very excited for the new educational programs coming up in 2012 related to topics such as ICD-10, Recruiting and Retaining Financial Staff, Value Base Purchasing and more! Our next program will be related to AHA and Value Base Purchasing and will be at the Ritz Charles on January 26, 2012. We also have programs slated for February and March as well. April marks our annual installation of new officers and awards banquet...you will not want to miss this!

Thank you to the Heart of America Members that participated in the Member Satisfaction Survey that was sent to members in October. This survey is released annually by National and is used by the officers and board members as we strategically plan the future chapter years. Your feedback is invaluable as the leaders of the chapter strive to make our members very satisfied. I hope we received lots of participation of the members!

I would also like to encourage you to get involved on a committee with the chapter. This is a great way to continue to network with other members and serve the chapter by helping with new members, Planning a program, or helping with the chapter newsletter, website, or social activities. John Maschger, President-Elect, is already starting to actively recruit members to

*(continued on page 7)*

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## hfma

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## HEART OF AMERICA CHAPTER OFFICERS

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## Region 8 Connection



**Teri Reger, FHFMA**  
**Region 8 Regional Executive**

*Greetings HFMA Region 8 Friends and Colleagues!*

In my Fall 2011 newsletter article, I mentioned how exciting that time of year is with the kids going back to school and baseball games to go to . . . well I must say, it was fun being a St. Louis Cardinals fan this year!! It is also fun being a member of HFMA. Your chapter leaders have done a very nice job putting together high quality educational programs and great networking events. If you haven't done so already, please take the time to get to know your chapter leaders, thank them for their dedication to the chapter and get involved in your chapter's activities. Believe in yourself and the skills you could bring to a leadership role. Believe to Achieve! You'll find that by getting involved you'll gain so much more from your membership!

I had the pleasure of meeting with the Region 8 Chapter Presidents and Presidents-Elect, the HFMA Regional Executive Council Chair and an HFMA staff member at our annual HFMA Fall



**Believe to Achieve**

Presidents Meeting in September. We had lively discussions about a variety of topics, all to ensure that the Region 8 chapters have the tools and information they need to be successful. Mike Dewerff, the Region 8 Regional Executive-Elect and I continue to collaborate monthly with the Presidents-Elect and Presidents, providing a forum for ongoing brainstorming and sharing of ideas across the region.

From a National perspective, one of the major initiatives being led by HFMA is the Value Project. "Through HFMA's Value Project, healthcare finance leaders are joining their clinical partners to shape this transformation" of the shift towards value in health care. HFMA has compiled many reports, webinars and tools to help providers respond to their customers' increasing demand for value. More information on the Value Project can be found at <http://www.hfma.org/valueproject/>.

Thank you again for the opportunity to serve Region 8. I welcome your questions and comments, any time! My telephone number is 314-989-6859 and my email address is [Teri\\_Reger@ssmhc.com](mailto:Teri_Reger@ssmhc.com).



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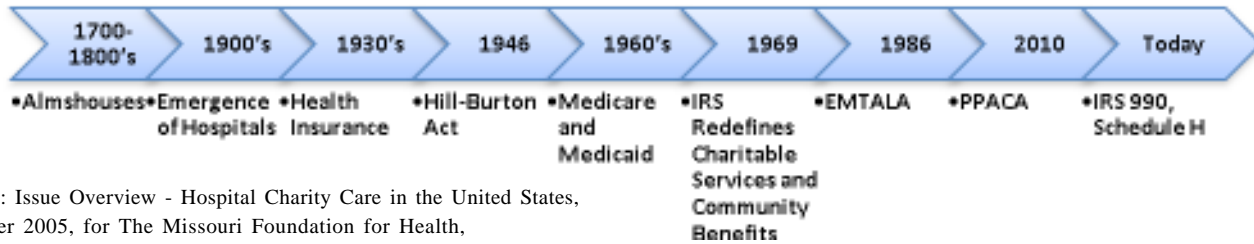
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## Historical Factors that Influenced Charity Care in America <sup>6</sup>



Source: Issue Overview - Hospital Charity Care in the United States, Summer 2005, for The Missouri Foundation for Health, Health Policy Committee, prepared by MFH Health Policy Staff.

- (A) meets the community health needs assessment requirements described in paragraph (3),
- (B) meets the financial assistance policy requirements described in paragraph (4),
- (C) meets the requirements on charges described in paragraph (5), and
- (D) meets the billing and collection requirement described in paragraph (6).

An outcome of the PPACA was the addition of section 501(r) to the Internal Revenue Code, impacting hospital organizations exempt from federal income taxation as described in section 501(c)(3) of the code.<sup>5</sup> A new form, Schedule H to the Internal Revenue Service Form 990, was created for hospitals, required in 2010 for the first time. Schedule H captures hospital disclosures of charity care and community benefit to justify their tax exempt status.

### COMMUNITY BENEFIT “PLUS”

Prior to 1969, non-profit hospitals qualified for tax-exempt status by providing charity care in accordance with the Internal Revenue Service requirement. Hospitals convinced policymakers that charity care would not be needed as much once these patients began to be covered by Medicare and Medicaid.<sup>7</sup>

In 2006, John M. Quirk, an associate attorney in the Portland, Oregon, office of Miller Nash LLP, published a paper titled “Turning Back the Clock on the Healthcare Organization Standard for Federal Tax Exemption” from which I quote verbatim:

The movement toward a new standard for exemption began in the 1960s due to hospital objections that the standard requiring “charity care” to the extent of “financial ability” was no longer relevant following the advent of the new Medicare and Medicaid legislation. In response, a young IRS attorney named Robert Bromberg

began drafting a new ruling based on the misguided notion that Medicare and Medicaid would lead hospitals to experience a substantial drop in demand for charity care. With twenty-twenty hindsight, the present day reality is that Medicare and Medicaid programs do not come close to meeting the massive need for healthcare services for indigent, poor, and elderly patients. Bromberg’s erroneous perception that “charity care” would become obsolete led to the 1969 issuance of Revenue Ruling 69-545 (“Community Benefit Standard”).<sup>8</sup>

Two 2003 federal court cases marked the first time the Tax Court agreed with the IRS’s position regarding the need for something more (**Community Benefit “Plus”**) rather than simply providing healthcare to a broad cross-section of the Community. Beginning in May of 2005, both the Senate Finance Committee, chaired by Representative William Thomas, and the House Ways and Means Committee, chaired by Senator Charles Grassley, actively began to debate whether or not nonprofit healthcare organizations should be afforded tax exemptions and whether these organizations were meeting applicable standards under the law. A Senate Finance Committee hearing entitled “Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals” was held on September 13, 2006. At the hearing, Grassley released the responses he received from ten major nonprofit healthcare systems regarding the “community benefits” they provide and how they measure them. In explaining the responses, Grassley expressed great concern that there were “enormous differences in answers to the same questions” and that “it was rare to get the same answer from even two hospitals.”<sup>9</sup> The IRS Schedule H to the Form 990 began being drafted as an outcome of this hearing in order to create some standardization in defining and reporting community benefit.



### SCHEDULE H: ONE YEAR LATER....

In the making since 2006, the Schedule H (with H standing for Hospital) arrived in 2010 for the 2009 tax year. Part I require hospitals to report “Financial Assistance and Certain Other Community Benefits At Cost” and offers worksheets to assist in the gathering and reporting of such. Part II collects data on “Community Building Activities,” while Part III asks for “Bad Debt, Medicare & Collection Practices.”<sup>10</sup> Policymakers are interested in gathering data that can be used for hospital comparisons in meeting their obligations to the community in exchange for their tax-exempt status.<sup>11</sup>

*Modern Healthcare* gathered Schedule H forms submitted by 156 hospitals and regional systems. An analysis was conducted. It was released in March 2010 and raised concerns about the reporting process and the results.<sup>12</sup> Charity care levels varied widely and nine of ten providers fell below the 5% proposed by Grassley.<sup>13</sup>

Worksheet A of Schedule H (optional) asks for an estimate of bad debt cost providers incurred for patients who likely would have qualified for charity had sufficient information been available.<sup>1</sup> *Bad*

(continued on page 5)

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### The Evolution of Hospital Charity Care (continued from page 4)

*debt* reflects a person's *unwillingness* to pay, while *charity care* is designed to respond to a person's *inability* to pay. According to *Modern Healthcare's* analysis, "many" providers acknowledged writing off potential charity care as bad debt.<sup>15</sup>

### TODAY AND TOMORROW

Economic recovery has been slow. Hospitals struggle for reimbursement dollars and their very survival. Health reform's major provisions don't take effect until 2014 and are being challenged in the courts, and the legislature is attempting to withhold funding.

It stands to reason, if the past is truly a predictor of the future, that the following could hold true:

1. The Patient Protection and Affordable Care Act will not provide health coverage for all.
2. There will always be uninsured people.
3. Charity care and community benefit will not go away.

Providers have options available to distinguish between uninsured patients who may be eligible for Medicaid, charity care or bad debt. Consultants, vendors and in-

formation technology are readily available to meet providers' unique situations and needs. Hospitals have been under a tax-exempt microscope since 2003, and scrutiny is not likely to end. Documented compliance must become a standard practice. ■

#### <sup>1</sup>(Endnotes)

<sup>1</sup>Turning Back the Clock on the Healthcare Organization Standard for Federal Tax Exemption," Quirk, John M., WLR43 1\_QUIR\_EIC\_FINAL\_VH\_11-3-06 11/25/2006 4:41:14 PM. Retrieved May 4, 2011, from <http://www.willamette.edu/wucl/pdf/review/43-1/quirk.pdf>

<sup>2</sup>History of Public Hospitals in the United States," National Association of Public Hospitals and Health Systems website. Retrieved April 20, 2011, from <http://www.naph.org/Homepage-Sections/Explore/History.aspx>

<sup>3</sup>Issue Overview: Hospital Charity Care in the United States" Summer 2005, for The Missouri Foundation for Health, Health Policy Committee, prepared by MFH Health Policy Staff. Retrieved April 19, 2011, from <http://www.mffh.org/mm/files/HospitalCharityCareIssueBrief.pdf>

<sup>4</sup>SEC. 9007, Additional Requirements for Charitable Hospitals," bill text, 111th Congress (2009-2010), H.R.3590.AS, Thomas (The Library of Congress) website. Retrieved July 7, 2011, from <http://thomas.loc.gov/home/thomas.php>

<sup>5</sup>Request for Comments Regarding Additional Requirements for Tax-Exempt Hospitals,"

Notice 2010-39, Internal Revenue Service, May 27, 2010. Retrieved April 28, 2011, from <http://www.irs.gov/pub/irs-drop/n-10-39.pdf>

<sup>6</sup> Ob. cit., "Issue Overview: Hospital Charity Care in the United States"

<sup>7</sup>"Charity disclosures will draw unwelcome attention to hospital tax breaks," In the spotlight, McLaughlin, Neil, Modern Health-care.com posting of March 28, 2011, 12:01 ET. Retrieved April 20, 2011, from <http://www.modernhealthcare.com/article/20110328/MAGAZINE/110329971/>

<sup>8</sup> Ob. cit., "Turning Back the Clock on the Healthcare Organization Standard for Federal Tax Exemption"

<sup>9</sup> Ibid.

<sup>10</sup> "2010 Instructions for Schedule H (Form 990)," Department of the Treasury, Internal Revenue Service. Retrieved June 29, 2011, from <http://www.irs.gov/pub/irs-pdf/i990sh.pdf>

<sup>11</sup> "Ahead of the Crowd," Of Interest, Evans, Melanie, ModernHealthcare.com posting of October 27, 2010. Link to article: <http://www.modernhealthcare.com/article/20101027/BLOGS01/310279965>

<sup>12</sup> "1% to charity care," Carlson, Joe, and Evans, Melanie, ModernHealthcare.com posting of March 21, 2011, 12:01 ET. Link to article: <http://www.modernhealthcare.com/article/20110321/MAGAZINE/303219979/>

<sup>13</sup> "Short of the Mark," Carlson, Joe, and Evans, Melanie, ModernHealthcare.com posting of March 21, 2011, 12:01 ET. Link to article: <http://www.modernhealthcare.com/article/20110321/MAGAZINE/303219980/>

<sup>14</sup> Ob. cit., "Ahead of the Crowd"

<sup>15</sup> Ob. cit., "Short of the Mark"

# **Kansas City Area Leaders Provide Thoughts on Health Care Financial Issues**

On November 29, 2011, four Kansas City area executives participated in a CEO Panel Discussion presented by the Heart of America Chapter and facilitated by Tammy Shepherd. Each executive provided a unique insight into how today's economy impacted their corner of healthcare; a privately owned primary care physician medical group practice, an urban academic medical center, a for-profit acute care hospital and a continuing care/long-term care facility.

The following executives participated in the event and provided their written responses. The Heart of America Chapter extends our gratitude for their perspectives as it affords our members a rare opportunity to glean what financial issues executives address today.

- Jamie Stevens, Administrator: Clay-Platte Family Medicine Clinic
- Bob Page, President & CEO: University of Kansas Hospital Authority
- Damond Boatwright, CEO: Overland Park Regional Medical Center
- Dan Rexroth, President & CEO: John Knox Village

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## **Health Care Reform's Impact to Primary Care Providers**



**Jamie Stevens, Administrator:**  
*Clay-Platte Family Medicine Clinic*

**Q.: What are the drivers behind reform initiatives?**

**A.:** Health care spending is not sustainable. The Congressional Budget Office projects health care spending as a share of GDP to grow from 17% in 2012 to 46% in 2075. There is a poor economic outlook with high unemployment and massive government budget deficits. The burden of rising cost of providing health care benefits to employees is eroding business profits.

**Q.: What are the biggest issues facing primary care providers in the Kansas City market?**

**A.:** Under the Affordable Care Act, more than 32 million uninsured will gain access by 2014, while a short-fall of 125,000 primary care physicians is projected by 2025. Initiatives in both the public and private sectors have aimed to change the incentives embedded in fee-for-service payment which rewards overuse and duplication of services. Fee for service payment models fail to reward providers for keeping patients from being hospitalized, re-hospitalized, or for helping patients control and monitor a chronic condition.

**Q.: What is being done about it?**

**A.:** My group is supporting the creation of the Kansas City Metropolitan Physician Association, which is a primary care led Independent Practice Association (IPA) with 100 initial provider members that was incorporated in October 2011. The IPA is supporting large scale quality improvement initiatives (PCMH, implementation of clinical protocols, leverage HIT, and intensive care management. The desire is to capitalize on physician leaders in the community to connect fragmented care system. Ultimately the goal is to improve care for the community at a lower cost while preserving the viability of primary care practices.

**Q.: Can this IPA model make a difference?**

**A.:** This type of initiative represents significant opportunities for payers and employers to reduce health care costs. A similar program, the Greater Rochester IPA Connect Clinical Integration Program, showed improvements in every chronic condition such as a 17% improvement in cholesterol levels. It takes highly-engaged leadership and alignment of reward models. ■

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## **Human Impact: Finance and Operations Working Together**

**Bob Page, President & CEO:** *University of Kansas Hospital Authority*

**Q.: Describe your ideal Finance person.**

**A.:** I want Finance people who are engaged with our mission, who understand how Finance impacts patient care, who can give me what I need to make good decisions, who are consistent and reliable, have strong negotiating skills and can manage healthy tension. Finance people must be able to balance between being fiscally conservative and meeting the operational needs of the organization. I want someone who tells me how I can achieve what we need to achieve, not why we can't.



**Q.: How do you help Finance professionals communicate with Operations professionals?**

**A.:** The finance world can be very black and white. The operations world is 90% grey. We must figure out how to live in each other's worlds in order for the organization to succeed. Finance people can best help me by using skills, knowledge and experience to identify ways to better meet our patients' needs. Finance people need to get out of their office and see the clinical operations by rounding on patients or observing patient care. I also believe finance professionals should invite operations people into their world. ■

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## **Economic Crisis Impacts: Recognizing Economic Vulnerabilities and Building Strengths**

**Damond Boatwright, CEO:**  
*Overland Park Regional Medical Center*



**Q.: What are the immediate implications of the current economic crisis?**

**A.:** Capital availability has been constrained, forcing prioritization of financial outlays. We've seen a substantial drop in bond issuance to tax-exempt institutions. We must now plan for what capital outlays can wait and what cannot.

*(continued on page 8)*

## New Members

**Kathleen Ahlenius**  
Manager of Business Development  
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WORK: (512) 220-7225  
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**Stephanie Bell** - Specialist Leader  
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**Nate Blackford** - Vice President,  
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**Rochelle E Deardorff** - Corporate Controller  
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**Jeff B Gilbert** - Abbott Labs  
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**Megan Krickle** Account Executive  
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**Elise C Martin**  
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**Cristie M Skeen**  
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**James K. Van Hoet** - CHFP  
WORK: (928) 208.2200 - Email: [jimvanhoet@kc.rr.com](mailto:jimvanhoet@kc.rr.com)

## President's Corner (continued from page 2)

assist in the upcoming fiscal year. Drop him an e-mail at [john.maschger@libertyhospital.org](mailto:john.maschger@libertyhospital.org) to let him know how you can help the chapter next year.

We will continue to work to make sure we bring you the best programming offerings and speakers that we can to make sure what you get from us is relevant to your day to day job. If there is anything that I can do for you, please feel free to send me a note at [eponce@saint-lukes.org](mailto:eponce@saint-lukes.org) or give me a call anytime at 816-932-5450. I look forward to hearing from you soon. It is always a pleasure to serve you. ■

Esteban Ponce

## HFMA Chapter Calendar of Events

**Thursday, January 26th**

### **AHA Update and Value Based Purchasing**

7:30 AM – 11:30 am ♦ Breakfast 7:30 am

Program Fee: \$65 per participant

*Location: Ritz Charles*

**Wednesday, February 22nd**

### **Payor Workshop & Health**

#### **Insurance Exchange**

12:00 PM – 4:30 pm ♦ Lunch 12:00 pm

Program Fee: \$45 per participant

*Location: St. Joseph Medical Center*

**Tuesday, March 27th**

### **ICD – 10**

7:30 AM – 12:00 pm ♦ Breakfast 7:30 am

Program Fee: \$45 per participant

*Location: TBD*

**Thursday, April 26th**

### **Awards Banquet & Leadership**

#### **Organizational Skills**

12:00 PM – 4:00 pm ♦ Lunch 12:00 pm

Program Fee: \$65 per participant

*Location: Ritz Charles*

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*(continued from page 6)*

Additionally, the cushion of non-operating income has been swiftly deflated, which has caused pressure on discretionary spending. Our industry will need to seriously analyze philanthropic support.

**Q.: What are the long-term implications of the current economic crisis?**

**A.:** Elective inpatient and ambulatory volumes are likely to soften even further as the population has less discretionary spending. Decreased ambulatory volumes drive hospital margins down.

Collecting cash will become more difficult as patient obligations are growing, which will create new revenue cycle challenges.

The downward pressure on reimbursement will continue to intensify as our industry is likely to see less favorable pricing from payers, reduced Medicaid reimbursement, and Federal budget shortfalls because of bailout pressures. Payers are likely to make more aggressive moves to link payment to quality.

Our physicians will feel even more economic pressure, delaying retirement and seeking employment shelters. Volume weakness and reimbursement constraints will worsen declining practice economics.

**Q.: So how do we move forward?**

**A.:** The economic situation intensifies our imperative to put in place best-in-class cost containment, LEAN participation, improved quality, and exceptional service. ■

## ***Become Part of the Solution to Make an Impact***



**Dan Rexroth, President & CEO:**  
*John Knox Village*

**Q.: What are the four things every CEO wants their Finance team to do?**

**A.:** 1. Understand Healthcare Reform: Our industry is facing an 11% reduction in Medicare reimbursement for Skilled Nursing, along with frequent and significant reductions in home health

care. I need my Finance team to understand the regulations so that we can make good decisions on how to react.

2. Identify efficiencies in the organization: We need to understand our cost per diagnoses better than we currently do. I want Finance people to come up with solutions.

3. Improve relationships: We need better linkages between financial people and clinicians, as well as more integration with Information Technology.

4. Be transparent: Health Care is the only industry that is not transparent in the areas of quality and pricing, so it is difficult to compete on those two critical components of health care. Health Care makes up 17% of Gross Domestic Product now, which makes it the biggest business in the nation.

**Q.: What do you see as the role for Continuing Care Retirement Communities (CCRC) with regard to Accountable Care Organizations (ACO's)?**

**A.:** Long-term care institutions can help reduce hospital re-admission rates. We look to partner with hospitals and physicians to establish protocols that would follow the patient out of the

hospital and into the community. This will require a significant amount of electronic data sharing.

**Q.: We know that health care spending is not sustainable. Who has the answer?**

**A.:** I don't think the Federal Government has the answers to our health care spending problems, and insurance companies. I think we as health care providers need to develop transformational ideas to solve the problem, and not rely on the government. That is my challenge to each one of you: Be part of the solution, not part of the problem. ■



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# Member Highlights

## Get to Know...

**Nate Blackford**  
VP of Finance and HR  
Northwest Medical Center



### Why did you join HOA-HFMA?

I joined Northwest Medical Center on October 3, 2011 as the VP of Finance and HR and felt strongly that joining HFMA would be of great benefit to me and NMC.

**How long and why do you work in healthcare?** I have worked in healthcare for over 10 years now and am passionate about the healthcare industry and the people we serve.

**What do you like most about your job?** I enjoy working in a community-based medical center that understands its role both as a healthcare provider and employer in the region.

**Marital status? Children?** Married with 2 young children

**Do you have a funny/embarrassing event that has happened on the job you can share?** Not yet, but I am sure it will come!!

**What is your personal or professional motto?** "He is no fool who gives what he cannot keep to gain that which he cannot lose." Jim Elliot

**Please describe some of your favorite accomplishments or biggest challenges met:** I was born with a congenital heart defect and, as such, was a regular patient for the first 20 years of my life. The perspectives gained from those experiences have served me well in my healthcare career.

**What advice would you give to someone entering the healthcare field?** From a hospital administration perspective, we are a "service to a service" and need to work with our care providers to provide an outstanding patient experience throughout the care continuum. ■

## Publication Committee

Brigitte Palmer Doleshal- Co Chair	816-943-5990
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### We could use some help!

If you are interested in joining the Publication Committee or would be interested in writing an article, please contact one of the above committee members.

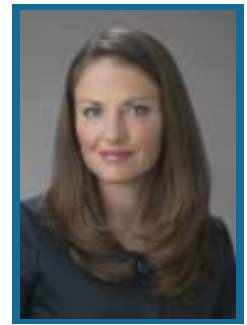
Deadline for submission of articles for the next newsletter is February 15, 2012. ■



**Believe to Achieve**

## ICD-10 and the Rubik's Cube: Complicated But Not Impossible

Rachel V. Rose, JD, MBA<sup>A</sup>



The Rubik's Cube puzzle has six different colored faces comprised of 26 miniature cubes and boasts over billions of possible positions. The goal is to move the cube and have each face front in a single color. Despite the challenge, millions of people have successfully "solved" the puzzle. Likewise, the implementation of ICD-10 on October 1, 2013 can be viewed as complicated, but not impossible.

Part of the Health Information Portability and Accountability Act (HIPAA), the final regulations for the adoption of ICD-10-CM and ICD-10-PCS were set forth by the Department of Health and Human Services in January 2009.<sup>1</sup> On October 1, 2013, the United States will transition from the International Classification of Diseases ninth revision (ICD-9-CM) to the tenth revision (ICD-10). ICD-9 is comprised of three volumes. ICD-10, however, has two distinct categories: ICD-10-CM (clinical modification to report diagnosis data across all sites of service) and ICD-10-PCS (reports inpatient procedure data). ICD-10-CM replaces Vols. 1&2 of ICD-9-CM and ICD-10-PCS replaces Vol. 3.<sup>2</sup>

ICD-10 will require that the clinical detail that is captured in the medical record and reported significantly increases. This is

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**CEO Forum** On November 29, 2011, four Kansas City area executives participated in a CEO Panel Discussion presented by the Heart of America Chapter and facilitated by Tammy Shepherd at the Ritz Charles in Overland Park, Kansas.



▲ (speaker) Jamie Stevens, Administrator, Clay-Platte Family Medicine Clinic



◀ (L to R) Mary Knollmeyer, Janis Richardson and Terrie Bradley taking a break!



▲ Enjoying the luncheon before the CEO Panel Discussion (L to R) Amy Dolan, Kalinda Marfisi, Karrie Pence, Diane Watkins

Enjoying the luncheon before the CEO Panel Discussion (L to R) Doug Brandt, Jerry Plagge, Janis Richardson, Mary Knollmeyer ▶



▲ Taking time to network!



▲ Having Fun at Happy Hour!



The evening happy hour was at Nick and Jakes in Overland Park.



▲ Heath Leuck and Jeff Vanek



◀ John Maschger and Jim Franklin



▲ Tammy Shepherd, Carrie Fangman, Jerry Plagge

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membership number and name on their application. You can locate your membership number within the online membership directory at [www.hfma.org](http://www.hfma.org) or on the address label of the latest HFM magazine. Also, be sure they write "Chapter 22 – Heart of America" on the application.

In addition to this local Chapter opportunity, HFMA National is currently promoting their Member-Get-A-Member program that has some great rewards. Recruit one or two members and receive your choice of an HFMA apparel item with an approximate retail value of \$25 or a \$25 Visa prepaid card good

anywhere Visa debit cards are accepted worldwide. Recruit three or four members and receive a \$100 Visa prepaid card good anywhere Visa debit cards are accepted worldwide and an entry into a drawing (among those recruiting three or four members) to receive a \$1,000 cash prize. Recruit five or more members and receive a \$150 Visa prepaid card good anywhere Visa debit cards are accepted worldwide and an entry into a drawing (among those recruiting five or more members) to receive a \$2,500 cash prize. Additionally, for every member you recruit you will receive one entry into a drawing for a brand new iPad 2. Finally, for every member you recruit, you will receive one entry into the drawing for the Grand Prize worth \$5,000. You will receive \$3,000 in cash for yourself and a \$2,000 donation in your name to the charity of your choice.

This opportunity ends March 31, 2012 for the HOA Chapter drawing and April 31, 2012 for HFMA National. Start thinking about whom within your organization or other organizations, including vendors, that would benefit from joining the Heart of America Chapter of HFMA. Applications are available at [www.hfma.org](http://www.hfma.org) or you may contact the Membership Committee Co-Chairs, Sharon Fiene ([Sharon.Fiene@nkch.org](mailto:Sharon.Fiene@nkch.org)) or Becky Grupe ([rgrupe@bkd.com](mailto:rgrupe@bkd.com)). ■

## **ICD-10 and the Rubik's Cube: Complicated But Not Impossible**

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highlighted with the increase from 17,000 ICD-9 codes to nearly 155,000 ICD-10 codes.

Just like the Rubik's Cube, which requires multiple sides to be considered, providers need to assess everything from clinical documentation to HIM to the revenue cycle. Therefore, everyone should understand the general changes and the heightened burden placed on coders and physicians.

### **The Codes and Documentation**

There are several new features with both ICD-10-CM and ICD-10-PCS. With ICD-10-CM, the structure includes 3-7 characters. There is always a decimal after the first three characters, which can be broken down so that the first three characters represent the category, etiology, anatomic site or severity are reflected in the next three characters, and the extension is represented in the last character.

<b>ICD-10-CM Change</b>	<b>Example</b>
Combination codes for conditions and common symptoms	E10.21 <i>Type 1 Diabetes Mellitus with Diabetic Nephropathy</i>
Combination codes for poisonings and external causes	T42.4x5A <i>Adverse effect of benzodiazepines, initial encounter</i>
Laterality	M94.211 <i>Chondromalacia, right shoulder</i>

ICD-10-PCS poses even more possible permutations. The chart illustrates some of significant changes.

<b>ICD-9-CM (Vol.3)</b>	<b>ICD-10-PCS</b>
<b>Min. characters: 3</b>	<b>Min. characters: 7</b>
<b>Max characters: 4</b>	<b>Max characters: 7</b>
<b>Numeric format (+V code)</b>	<b>Alphanumeric format</b>
<b>Decimal Point (after 3 characters)</b>	<b>No decimal point</b>
<b>Code 92.27 (Implementation and Insertion of Radioactive Element)</b>	<b>Equates to 263 possible anatomic site alternatives in ICD-10</b>

With the terminology differences found between ICD-9 and ICD-10, a common question is whether or not a physician must write the exact new term in order to capture the ICD-10 code. According to CMS,

"Many of the terms used to construct PCS codes are defined within the system. It is the coder's responsibility to determine what the documentation in the medical record equates to in the PCS definitions. The physician is not expected to use the terms used in PCS code descriptions, nor is the coder required to query the physician when the correlation between the documentation and the defined PCS terms is clear."<sup>3</sup>

For example, when the physician documents "partial resection" the coder can independently correlate "partial resection" to the root operation "excision" without querying the physician for clarification.<sup>4</sup>

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To learn more about becoming certified, visit [www.hfma.org/certification](http://www.hfma.org/certification).

To review FAQs about the program changes, visit [www.hfma.org/certificationFAQ](http://www.hfma.org/certificationFAQ).

\*The two year HFMA membership requirement has been dropped.



Just because precise terminology is not required, does not mean less of an emphasis on clinical documentation. To the contrary, SOAP (Subjective, Objective, Assessment, Plan) notes are a key component of the medical record that can be improved now. Greater detail on screening test results, expanded socioeconomic and lifestyle indicators, and future expansion of organ specificity are other areas that will impact accurate coding and ultimately accurate reimbursement. The more accurate the documentation, the more precise the coder can be, and the less potential for an adverse impact on the revenue cycle. Implementing a clinical documentation program and utilizing a physician-to-physician approach now can reduce queries by coders and make the transition to ICD-10 easier. Four steps that healthcare providers can take now include:

1. Audit the top ICD-9-CM codes and map to ICD-10 codes;
2. Begin documenting now to meet ICD-10 standards;
3. Train coders on anatomy and physiology;
4. Form a multi-departmental transition team.

By taking proactive steps, providers will be in a better position to adapt to the additional requirements imposed by ICD-10 and mitigate productivity loss during the initial transition.

### **Conclusion**

ICD-10 implementation, like the Rubik's Cube, has many moving parts. A number of factors need to be considered. By starting with

*(continued on page 13)*



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**ICD-10 and the Rubik’s Cube: Complicated But Not Impossible**

*(continued from page 12)*

clinical documentation and coder education, providers can begin to take manageable steps to make the October 1, 2013 transition less daunting. The revenue cycle, compliance, cost projections and initial decrease in reimbursement must all be considered when assessing the ICD-10 puzzle. Nonetheless, while a smooth transition is complicated, it is not impossible. ■

**(Endnotes)**

<sup>A</sup> Rachel V. Rose, JD, MBA, Assistant General Counsel/Director of Business Development, BCE Healthcare Advisors.

[www.bcehealthcareadvisors.com](http://www.bcehealthcareadvisors.com)

<sup>1</sup> Department of Health and Human Services, 45 CFR Part 162 (Jan. 16, 2009); *HIPAA Administrative Simplification: Modifications to Medical Data Code Set Standards to Adopt ICD-10-CM and ICD-10-PCS* Federal Register, Vol. 74, No. 11.

<sup>2</sup> *Ibid*

<sup>3</sup> Centers for Medicare and Medicaid, *ICD-10-PCS Coding Guidelines* [https://www.cms.gov/ICD10/Downloads/PCS\\_2012\\_guidelines.pdf](https://www.cms.gov/ICD10/Downloads/PCS_2012_guidelines.pdf) (last visited November 19, 2011).

<sup>4</sup>

*Ibid*



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