

President's Message



Did you know OHFMA has a vision statement and a five year plan? One of the greatest aspects of being an officer or director of HFMA is benefiting from National's direction, organizational skills, and resources.

Our chapter's "VISION" is 'to be an indispensable professional resource for healthcare financial managers.' We desire to help members and other finance-related healthcare professionals excel thereby improving the business performance of organizations operating in or serving the healthcare industry. We do this by being supportive of National's goals while we infuse our own objectives to address the specific needs of our chapter and members.

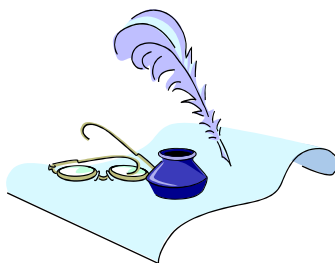
We have adopted three basic objectives:

- Programming – We will increase educational contact hours by offering national educational content and top-notch speakers, increased networking opportunities and more frequent educational opportunities.
- Participation – We will create incentives intended to result in greater participation of chapter members in all chapter activities and increase the knowledge value in the Oklahoma chapter of HFMA.
- Leadership – We will continually identify, develop, motivate, and support a five-year leadership chain of command.

(Continued on page 2)

Congress Passes Medicare Reform

As many of you know, Congress passed late Monday/early Tuesday evening the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Although the bill certainly did not please all parties, there are some provisions in the Bill that are expected to benefit the rural providers. The analysis of this massive document will continue for several months to come, but we have included a three page article from the U.S. Department of Health and Human Services that highlight some of the provisions expected to impact our rural areas. This article is included after page ten of our newsletter.



President's Message (continued)

In terms of programming, in August 2003 we kicked off the 2003-04 fiscal year by teaming with Medical Group Management Association, for the first time, for our annual summer conference at Shangri La. We followed that with our initial CEO/CFO Forum held at the Oklahoma Hospital Association (OHA) offices in October 2003. We then sponsored a speaker at the November 2003 OHA convention. In December 2003, HFMA Region 9 (consisting of Arkansas, Louisiana, Mississippi, Oklahoma, and three Texas chapters) will host our first collaborative efforts in New Orleans called 'Revenue and All That Jazz.' So with the year almost half over, we are off to a great start.

In addition to our focus on programming, strategies for improving participation include continuing our highly popular chapter leadership training conferences (LTC) which were initiated in fiscal year 2002-03. The purpose of the mini-LTCs is to improve the quality of our chapter activities, providing a venue to plan chapter events more comprehensively, and (our third goal above) identify, develop, motivate, and support our future leaders for the organization.

At each of the two Oklahoma LTC meetings this year, the chapter leaders will meet to review the plan and conduct an assessment. This plan will be considered a work-in-progress and therefore may be modified as the year progresses. Volunteerism is a blessing and a challenge, and while the best intent may exist, once we get back into our everyday work environment, it is difficult to achieve the goals we have established for our volunteer organization. For this reason, the Oklahoma LTC meetings will be conducted as true working sessions where not only plans and strategy will be discussed, but we will actually conduct committee work sessions. The expected deliverable from these work sessions will be to complete 50 percent of the committee tasks while our existing leaders, committee members, and our leadership class members are gathered together.

Our first LTC meeting this year focused on three aspects of our chapter: membership, sponsorship, and programs.

- **Membership:** We made phone calls to former members, identified prospective members, and planned several activities for increasing membership, including our member-get-a-member campaigns. We awarded round trip airfare, two night's hotel, and registration to the New Orleans' Region 9 meeting to a member whose name was drawn from a group of members who sponsored a new member. The current member-get-a-member campaign will be awarded a registration at the Annual National Institute in Nashville in June 2004. This drawing will be held in April 2004.
- **Sponsorship:** We retooled our sponsorship program to provide more benefits to our annual sponsors. The new program will be rolled out starting with the 2004 calendar year. We are excited about some of the new offerings and anticipate members and prospective members will also benefit from the changes.
- **Programs:** Our programs for January 23, 2004 and April 1-2, 2004 have substantially been planned and you should be receiving notification about the details of these programs soon.

We will monitor throughout the year how we compare to our goals, some of which include the following:

- Earning the Charles R. Mehler Gold Award for excellence for education by providing greater than 18.88 registered educational hours per member.
- Earning the Henry Hottum Award for Education Performance Improvement by providing greater than 9.7 percent increase in total registrant education hours.
- Earning the Gold Award of Excellence for Membership Growth by obtaining greater than 6.13 percent growth in members for the year.
- Earning the Gold Award of Excellence for Certification by passing more than 7 certification exams during the 2003-04 year.
- Offer four to six educational opportunities during the plan year.
- Record 10% of members spending 25 or more hours per year attending chapter/committee activities.
- Achieve attendance by 30 percent of the chapter members at the Annual Program.
- Increase provider participation by 25 percent by 2005 over the 2002 base at a rate of five percent over the base year each year.
- Retain 80 percent of eligible members each year.
- Increase vendor support (financial and participation) by 45 percent by 2005 over the base year at a rate of 15 percent over the base year each year.
- Increase overall membership by 15 percent by 2005 over 2002 base year.
- Achieve 50 percent participation by OKLTC class members in OHFMA committee activities after one year.
- Have 50 percent of OKLTC class members in leadership roles after three years.
- Have 5-6 officers/board members attend the 2004 LTC under OHFMA sponsorship.
- Provide at least two leadership development opportunities during the 2003-04 plan year.

We look forward to reporting to you at the end of the year how we measured against our goals. Please contact any HFMA Officer or Director with comments or questions you have.



Shift to Consumer-Driven Health Plans Could Strain Hospitals' Billing and Collections Efforts

The Health Care Advisory Board as published in the 10/23/03 issue of Finance Watch

Contributed by Linda Short

The growing popularity of consumer-driven health plans could increase hospital costs associated with accounts receivable and collections, as many institutions face the difficult prospect of collecting a significantly greater proportion of payments directly from patients, *Managed Care Week* (10/13/03) reports. Although the number of individuals enrolled in consumer-driven plans currently represents a relatively small share of the market, many health care experts expect the number of enrollees to grow exponentially in coming years as employers explore ways to stem steadily increasing insurance costs. According to health care finance experts, the shift toward consumer-driven plans will require hospitals to restructure some aspects of their revenue cycles, consider alternatives to traditional bill-collection policies, and invest in increased customer-service capabilities.

On the Path to Consumerism

Intended to keep costs down, consumer-driven health plans – or defined-contribution plans – fund health care cost via special employee-savings accounts that require employees to pay high deductibles partially subsidized by the employer. An article on CFO.com (McCafferty, 8/1/03) reports that since the Internal Revenue Service issued regulations last summer encouraging use of defined-contribution plans, their popularity has increased among employers. Although currently less than 1% of employees are enrolled in consumer-driven plans, *Health Affairs'* Market Watch projects that consumer-directed health plans will account for 20% of the insurance market by 2005 and as much as 50% by 2007 (*Managed Care Weekly Digest*, 10/20/03).

Because patients typically shoulder more of the cost of health care under these types of plans, a widespread shift would likely put even more strain on hospital bill-collection efforts, as hospitals will be forced to track down payments from individual patients, rather than insurers. "Hospitals immediately get into that ugly, ugly collection business," said Michael Taylor, a consultant with Towers Perrin. In addition, a trend toward customized plans with myriad benefit structures, reimbursement arrangements, and flexible-spending accounts is also likely to complicate hospitals' collection efforts, according to *Managed Care Weekly Digest*.

Experts Emphasize Front-End Collections

Most experts agree that if consumer-driven health plans become more widespread, hospitals will not be able to

continue using traditional collection techniques to capture overdue patient payments. Some hospitals have already come under fire for what critics allege are overly harsh collection methods, prompting lawmakers in some states to propose legislation that places strict limitations on the methods hospitals can use to collect payment from uninsured patients (Becker, *Modern Healthcare*, 9/22/03; Page, *Modern Physicians*, 8/1/03). For example, a new law in Connecticut lowers the maximum interest rates hospitals can charge on patient bills from 10% to 5%. The law also prohibits hospitals from garnishing wages, seizing bank accounts, or putting liens on homes without additional court orders, techniques used by some hospitals in extreme circumstances.

To manage the complications associated with consumer-driven health plans, many health care revenue-cycle experts recommend that hospitals "re-engineer" their collection processes, particularly by clarifying payment obligations while the patient is still in the hospital. Some of the largest for-profit hospital systems have already begun this re-engineering process, according to *Managed Care Week* (10/13/03). Beverly Wallace, president of the patient financial services group at Nashville-based HCA, said that HCA has reorganized its collection protocols in response to a 10.9% increase in co-pay and deductible amounts per patient over the last year. Wallace said that the company first attempted a technological solution but was stymied by the complexities of gathering the necessary information from multiple patients, payers, and employers. Instead, the health system refocused its efforts on creating front-end patient protocols. When a patient checks into a hospital, HCA computes a best estimate of the patient's payment obligations, which it shares with the patient during an insurance-clarification process that is completed during pre-registration. This allows the health system to initiate collection efforts almost immediately, Wallace said.

Attracting Patients with Superior Customer Service

In addition to creating new front-end collection policies, some health care revenue-cycle experts believe that hospitals can maximize revenue opportunities associated with consumer-driven plans by investing in customer-service improvements in their patient financial services (PFS) departments. Writing in a recent issue of *Healthcare Financial Management* (9/1/03), Bobette Gustafson, president of Michigan-based health care consulting firm Gustafson & Associates, contends that

patients will increasingly “shop around” to find the most value for their health care dollar, meaning that the speed and quality of hospital cost and pricing information may influence a potential patient’s decision on where to seek

treatment. Gustafson writes that hospitals offering the best customer service stand to benefit the most from the consumer-driven health care movement. ♦

Oklahoma Chapter of HFMA Mourns the Loss of Tom Giaudrone

Tom Giaudrone, CFO at McAlester Regional Health Center, died Sunday, October 26, 2003. Funeral services were held October 30, 2003, at First Presbyterian Church of McAlester. Tom was a 34-year member of the Oklahoma chapter and served the chapter in many capacities, including President.

Tom began his career in healthcare in 1968 with an accounting position with McAlester General Hospital. With the opening of the McAlester Regional Health Center he became the head of the accounting department, was advanced to the position of comptroller and eventually to the position of chief financial officer.

Tom was an active member of the chapter and participated each year in the Bob Junger Scholarship Golf Tournament. His team this past August, made up of Scot Marshall, Frosty Turpin, Rick Wagner and Tom, placed second in a very competitive tournament. His last appearance at an HFMA function was the initial CEO/CFO Forum in Oklahoma City on October 3rd.

Our sympathy goes out to Tom’s family, including his wife Sherry, daughters Cathy and Christy, son Charlie and six grandchildren. Memorials can be made to the First Presbyterian Church, Box 1550, McAlester, OK 74502 or the Alderson United Methodist Church, Box 72, Alderson, OK 74522.



A True Leader Generates Commitment...

Whether you are hospital CFO, department senior manager, or head of a specific project within your group, your leadership only works to the degree of your team's commitment. To be an effective leader, you must generate true commitment throughout your team.

Let's distinguish between *compliance* and *commitment*. We are not speaking of "compliance" in its healthcare usage: Medicare compliance, HIPAA compliance, billing & reimbursement compliance, and such. We are referring to an individual's compliance with a team's, department's, or organization's goals, objectives, direction, and motivation. In this context, "compliance" means doing what is expected, going along with the requirements. A compliant team member obediently cooperates. A compliant person may not do more than that.

Commitment means a good deal more. The team member who demonstrates commitment actively pledges or engages herself to the objectives. Rather than going along, this player "goes ahead." The committed team member channels her time, energy, efforts, and creativity—in full force—to achieve those goals and objectives.

Your objective is to can move individuals on your team from mere compliance to true commitment. Below are six actions that, taken with care and attention, heighten commitment within your team. Such commitment produces efficient and effective results, thanks to your leadership.

Educate about goals and objectives. You should provide information—in an educational format—to everyone who in anyway can impact your team's progress. The player who understands the expected results and the reasons for targeting is much more ready to commit his skills and motivations to working toward those results.

Delegate possession. Do not simply delegate the assignment; delegate *ownership* of the assignment. Merely handing out task responsibility only tells someone what to do. If you help a person understand what is to be done, what it will lead to, and why that is beneficial, you help her accept full ownership of her assignment.

Appreciate process and progress. By consistently observing and discussing an ongoing project, you preserve momentum toward the desired ends. No need to micro-manage. By demonstrating your active care about what is being done, you contribute to your team's commitment to succeed.

Evaluate the work being performed. Here you want to appraise the quality of the work being performed and the qualities of the work. The difference? Qualities are the separate but related steps that make up the work. Quality is the value, the worth, and the success measure of that work. Both formal and informal evaluation tools help you know degree of progress toward goal attainment.

Elaborate changes as necessary. When changes in the plan, the project, the process, the strategy, or the players occur, be certain you provide sufficient detail of the changes. You also want to provide the reasons for the changes. Review "Educate" and "Delegate" above to reinforce that respect for the "why" contributes to full ownership of responsibility.

Celebrate success. But do not wait to celebrate only the ultimate success. Give affirmative recognition to actions that lead to achievement and then the final achievement itself. Both types of recognition (and it need not be in the form of money!) cement commitment for this and subsequent projects.

Your success in generating true commitment among those on your team will go well beyond six ordinary verbs. Such success will be determined by your putting those verbs' actions to work.

**WELCOME NEW & REINSTATED OR TRANSFERRED MEMBERS
SINCE JULY 2003 NEWSLETTER**



Melody Fish	Deaconess Hospital
Pam Stone	Saint Francis Health System
Darin Dammann	Hillcrest Health System
Kiamichi Davidson	The Physicians Group
Sandra Lamle	Okeene Municipal Hospital
Peter Pitchford	Collections, Incorporated
Pam Van Meter	Blue Cross Blue Shield of Oklahoma
Judy Kay Hanks	
Stacey Wolfe	
Verla Holguin	St. Mary's Medical Center
Loren Rials	Henryetta Medical Center
Morris Brown	Southwestern Regional Medical Center
Randall Miller	Accounting Principals
Lisa Wedel	Saint Francis Hospital
Shasta Manuel	Hillcrest Specialty Hospital
Phillip Barnoski	Southwestern Regional Medical Center
Amy Harmon	Woodward Regional Hospital
Richard Ervin	Cushing Regional Hospital

In the News...

Congratulations to Stan Hupfeld, president and CEO *INTEGRIS Health*, who was recently elected to the American Hospital Association Board of Directors. Stan will also serve as the chairman of AHA Regional Policy Board 7. His term begins January 1, 2004 and will run through December 31, 2006.

Congratulations to Karen Hendren and Bryan Bodnar for completing the requirements to receive recognition as Certified Healthcare Financial Professionals (CHFP), the first step in becoming Fellows of Healthcare Financial Management Association (FHFMA). Congratulations also go out to Becky Speight for meeting the requirements for FHFMA in September. For information on how you can become certified, contact our certification chair, Art Mires.

Hope you have received your new 2003-2004 Membership Directory. Thanks to Bryan Bodnar for coordinating this massive undertaking. If your information is incorrect or has changed recently, please go on to the HFMA website and update your information. If you are a member of the Oklahoma chapter and have not received your directory, please contact Lloyd Haggard to get one.

HOW DO VENDORS GET IN YOUR DOOR?

By Connie Proctor

When a vendor calls, do you recognize their company? Chances are you do if they're an OHFMA sponsor! Our Sponsorship Chairwoman, Louise Littlejohn, has done a wonderful job increasing the number and variety of sponsors associated with our chapter. This growth in sponsorship has enabled the chapter to improve meetings by providing innovative speakers and informative, educational sessions to our members.

We are asking our members to help the chapter continue this growth and here are a few simple ways you can help – we'll call it the **AASSK** process:

A **ATTEND:** Attend the chapter meetings and take advantage of new innovative ways to manage your operations, network with fellow healthcare professionals and meet our great sponsors.

A **ASK:** When a vendor calls, ask if they sponsor OHFMA. If not, ASK them to become a sponsor and have a sponsorship committee member contact them.

S **SHARE:** Do you have a vendor who does an exceptional job or provides a unique service? Please share their name with the sponsorship committee and we will contact them or have them contact one of us.

S **SUPPORT:** Support the OHFMA vendors! Unlike vendors who make “cold calls”, the OHFMA vendors have committed to you by making an investment in your chapter and our future.

K **KEEP LOOKING:** Keep looking and recommending new sponsors AND new members!

You might wonder what OHFMA has to offer new vendors. What a timely question! The OHFMA Board has approved a new sponsorship package for 2004 that includes some exciting benefits for our sponsors. One of the most exciting benefits of the higher level sponsorship is customer coupons. The vendor will receive coupons to give their customers for free attendance to a meeting. We hope this will encourage new member attendance and new vendor sponsorship! Look in the newsletter for a complete listing of the sponsorship levels and benefits and **please** make copies to give your vendors.

So, how do vendors get in your door? By being an **OHFMA Sponsor!**

Thanks to our 2003 Corporate Sponsors!

We have had a very successful year increasing participation from our corporate sponsors. Louise Littlejohn, Corporate Sponsors committee chair, has done an outstanding job in helping OHFMA articulate the benefits of participating to the sponsors listed below, and the chapter appreciates their support. This list includes paid sponsors as of July 18, 2003. If you or your organization is interested in becoming a corporate sponsor for OHFMA, please contact Louise Littlejohn at (405) 682-8088, ext. 121.

Platinum

Administrative Consultant Service, Inc.
PO Box 3368
Shawnee, OK 74802

Jeff N. Clark
405-878-0118
405-878-0411
jlark@acsteam.net

BKD, LLP
6120 South Yale Avenue, Suite 1400
Tulsa, OK 74136
www.bkd.com

Lloyd Haggard
918-584-2900
918-584-2931 Fax
lhaggard@bkd.com

Cap Gemini Ernst & Young U.S. LLC
7701 Las Colinas Ridge, #600
Irving, TX 75063

David Miller
972-556-7181
214-665-5104 Fax
972-768-9366 Cell
david.miller@cgey.com

HCFS, Inc.
14285 Midway Rd., Ste. 280
Addison, TX 75001
www.hcfsinc.com

Don McCown
800-394-4237
972-720-0381 Fax
dmccown@hcfsinc.com

JPR & Associates, Inc.
2120 S. Broadway
Edmond, OK 73013

Jim Wilson
405-715-4000
405-715-4015 Fax
877-883-8767
jim@jprai.com

Madole, Wagner, PLLC
6226 E. 101st St., Ste. 200
Tulsa, OK 74137
www.mwhc.com

Rick Wagner
918-299-8833
918-299-8835
rwagner@mwhc.com

MASH
1227 West Magnolia Ave., Ste. 450
Fort Worth, TX 76104
www.mashinc.com

Sharon Leach
800-880-6274
817-923-8900 ext. 415
817-923-3953 Fax
sleach@mashinc.com

Med Data Management, Inc.
P.O. Box 8946
Mandeville, LA 70471

Charlotte Piontek
800-434-5142 ext. 247
972-393-0867
985-674-2217
cpiontek@meddata-inc.com

Spectron
5416 S. Yale, Ste. 650
Tulsa, OK 74135

Charles Young
918-488-8031
918-488-9433 Fax
charlesyoung@spectronco.com

The Midland Group
5020 W. 15th St., Ste. C
Lawrence, KS 66049

Ryan O'Hara
785-840-9676
785-840-9677
ryan@midlandgroup.com

Gold

Cardon Healthcare Network, Inc.
25231 Grogans Mill Rd., Ste. 100
The Woodlands, TX 77380

Scott Willey
281-296-8911
281-296-0246 Fax
swilley@cardonhealthcare.com

HealthWorks Alliance, Inc.
3523 McKinney, Ste. 401
Dallas, TX 75204

Greg Hightower
214-520-3883
ghightower@hworks.com (??)

Zimmerman & Associates
207 E. Buffalo Street, Ste. 400
Milwaukee, WI 53202

Sandi Speranza
414-224-9424
414-224-9432 Fax
sandi@ebadvertising.com

Silver

Works & Lentz, Inc.
3030 NW Expressway, Ste. 225
Oklahoma City, OK 73112-5434

Deborah Miller
405-942-2211
405-942-2370 Fax
dmiller@worksandlentz.com

Que Financial Serviceware Technologies
8948 W. Barnes Street
Boise, ID 83709

George Finefrock
208-672-7228

Woodland Outsourcing, LLC
123 W. 7 St., Ste. 300
Stillwater, OK 74074

Géne Heinrich
405-707-3441
gene@collectpro.com

Bronze

American Collection Services, Inc.
3100 SW 59th Street
Oklahoma City, OK 73119

Louise Littlejohn
405-682-8088
405-682-8044 Fax
louise@americancollectionservices.com

CAC Financial Corp
2601 NW Expressway, Ste. 1000E
Okla. City, OK 73112-7238

Jim Peters, Bob Golden
405-425-1590
jpeters@cacfinancial.com

Central States Recovery
PO Box 3130
Hutchinson, KS 67504-3130

Chuck Lyon
800-779-0419
620-663-3116 Fax
Jkp-csr@swbell.net

Credit Bureau Services Association
123 West 7th, Ste. 300
Stillwater, OK 74074-4068
www.cbsasolutions.com

Teresa Axton
405-372-1693
405-707-3440 Fax
teresa@collectpro.com

Credit Services, Inc.
2519 NW 23rd, Ste. 204
Oklahoma City, OK 73107
www.e-csigroup.com

Mike Yerkes
405-943-9608
405-947-8185

D-Med Corporation
5520 W. Plano Parkway, Ste. 200
Plano, TX 75093
www.d-medcorp.com

Dudley Medlock
800-695-2404
972-733-6901 Fax
dmedlock@d-medcorp.com

FMA Alliance, Ltd.
11811 N. Freeway, Ste. 900
Houston, TX
www.FMAAlliance.com

Phil Lane
972-475-7159 Fax
972-345-4685 Cell
rshallfma@earthlink.net

Transworld Systems Inc.
5400 N. Grand Blvd., Ste. 500
Oklahoma City, OK 73112
www.transworldsystems.com

Joby Brown
405-943-5272
405-943-1169 Fax
jobro222@earthlink.net

**OHFMA Leadership
2002-2003**

OFFICERS

President
Lloyd Haggard
(918) 584-2900

President Elect
Rick Kelly
(918) 494-9297

Vice President &
Newsletter Editor
Becky Speight
(918) 584-2900

Secretary
Vicki Lacy
(405) 297-7159

Treasurer
Thom Biby
(918) 758-3102

DIRECTORS

Bryan Bodnar
(918) 584-2900

Kevin Cox
(918) 787-3405

Karen Hendren
(405) 742-5729

Anita Lollar
(580) 421-1413

Connie Proctor
(918) 787-3630

Linda Short
(405) 307-4442

HFMA & THE INFORMATION AGE

Are you currently receiving "HFMA Wants You to Know," a weekly email for HFMA members? If not, and you would like to receive a free subscription, send an email to memberservices@hfma.org.

The Oklahoma Chapter has implemented email distribution of the chapter newsletter and other updates. We will continue to mail newsletters to those members for which we have no email address. If you do not receive the email version and would like us to have your email address on file, please email Becky Speight at rspeight@bkd.com.

If you need to change your member demographic information, including your email address, contact memberservices@hfma.org.

WE WANT YOUR FEEDBACK!

Do you have ideas on topics for upcoming educational programs? Are there ways we can serve you better either through networking opportunities or educational initiatives? Other comments or suggestions?

Call or e-mail:

Rick Kelly ● (918) 494-9297
rkelly@saintfrancis.com

Lloyd Haggard ● (918) 584-2900
lhaggard@bkd.com

OHFMA Committee Chairpersons

Membership	Meegan Carter	(405) 440-8875
Programs	Rick Kelly	(918) 494-9297
Certification	Art Mires	(580) 762-6219
Davis Management	Vicki Lacy	(405) 297-7159
Management Practices	Ken Simpson	(918) 579-1059
Corporate Sponsors	Louise Littlejohn	(405) 682-8088, ext. 121
Scholarship	Regan Calhoun	(918) 494-7359
Managed Care	Ann Paul	(918) 624-4619
Medical Group Practice	Andrea Rizer	(918) 497-3333
Job Placement	Ed Casteel	(918) 481-4626
Golf Tournament	Rick Kelly	(918) 494-9297



EDITORIAL POLICY

The statements and opinions appearing in articles are those of the author and do not necessarily reflect the view of the Oklahoma Chapter, the Healthcare Financial Management Association, or the editor. The editor reserves the right to edit material and accept or reject contributions whether solicited or not. All correspondences are assumed to be released for publication unless otherwise indicated.

© 2003 OHFMA

ADDRESS COMMUNICATIONS TO:

Becky Speight, FHFMA, CPA
BKD, LLP
Two Warren Place
6120 S. Yale Ave., Suite 1400
Tulsa, Oklahoma 74136-4223
Phone: (918) 584-2900 • Fax: (918) 584-2931
E-mail: rspeight@bkd.com

21st Century Medicare: More Choices — Better Benefits
RURAL PROVIDERS RECEIVE NEEDED RELIEF

The bipartisan agreement includes several provisions to enhance beneficiary access to quality health care services and improve provider payments in rural areas.

Hospitals:

- **Standardized amount.** The bipartisan agreement equalizes the urban and rural “standardized amounts” under Medicare’s prospective payment system for inpatient hospital services. Currently, Medicare has two different operating base payments for inpatient hospital services—one for hospitals located in large urban areas and another, smaller payment for hospitals located in rural and small urban areas. This provision establishes a single base payment, or standardized amount, for hospitals in all areas in the 50 states, the District of Columbia, and Puerto Rico, starting in FY 2004.
- **Labor-Share.** The bipartisan agreement revises the labor-related share of the wage index used in Medicare’s prospective payment system for inpatient hospital services. It reduces the labor-related share of the wage index to 62 percent (currently it is 71.1 percent), unless such revision would result in lower payments. The labor share is an estimate of the national average proportion of hospitals’ costs associated with inputs that are directly or indirectly affected by local wage levels. Many rural hospitals argue that, because their local wage levels are low, they are adversely affected by a high labor-related share.
- **Disproportionate Share.** The bipartisan agreement modifies Medicare’s payments for those hospitals that furnish care to a disproportionate share of low-income and uninsured patients. Currently, the disproportionate share hospital adjustment paid to rural and small urban hospitals is capped at 5.25 percent. The bipartisan agreement increases the rural and small urban cap to 12 percent.
- **Outpatient PPS.** The bipartisan agreement allows sole community hospitals and small rural hospitals to be held harmless under the outpatient hospital prospective payment system for 2 years.
- **Low Volume Hospitals.** The bipartisan agreement establishes a graduated adjustment/add-on payment for low-volume hospitals. Eligible hospitals are those that are located more than 25 miles away from another hospital and have less than 800 discharges in a given year. The maximum total adjustment is 25 percent of the otherwise applicable prospective payment rate.
- **Residencies.** The bipartisan agreement redistributes resident positions from hospitals that have not met their resident cap over a defined period of time. Hospitals located in rural areas are given top priority for receiving these redistributed resident positions.

- **Medicaid DSH.** The bipartisan agreement includes a provision for 10 extremely low Medicaid DSH states (Arkansas, Idaho, Iowa, Montana, Nebraska, North Dakota, South Dakota, Utah, Virginia, Wisconsin) that will receive an enhanced allotment under the agreement. Allotments for these 10 states would be increased by 16% for each of five years (FY 2004 - FY 2008) at which point allotment levels would be those for the previous year increased by the CPI-U.

Physicians:

- **Bonus Payments.** The bipartisan agreement modifies the Medicare Incentive Payment Program, which provides 10 percent bonus payments to physicians in Health Professional Shortage Areas. The bipartisan agreement builds upon this existing program, and adds a new program for physicians serving beneficiaries in physician scarcity counties. Under this new program, physicians would receive a 5 percent bonus payment for providing services in newly defined shortage areas.
- **Geographic Adjustment.** The bipartisan agreement modifies the geographic adjustment for physician payments. The geographic adjustment is in place to reflect the regional differences in the costs of the various inputs necessary to furnish a physician service. These inputs are physician work, practice expense, and malpractice. The bipartisan agreement establishes a floor on one of the three geographic adjustments—the work component. In so doing, it increases the payments to physicians in rural areas by raising their adjustment to the newly established floor.

Critical Access Hospitals:

- **Payment.** The bipartisan agreement makes several modifications to the Critical Access Hospital Program. This program, created by Congress in the Balanced Budget Act of 1997, is designed to support limited-service hospitals located in rural areas. Medicare pays critical access hospitals on the basis of their current Medicare-allowable costs. The Bipartisan agreement increases critical access hospital payments to 101 percent of reasonable costs and extends cost-based reimbursement to additional on-call emergency care providers, providing additional dollars to these rural hospitals. The bipartisan agreement also reauthorizes the Medicare Hospital Flexibility (FLEX) Program, expanding this important source of grant funding for small rural hospitals.
- **Status.** The bipartisan agreement removes barriers for hospitals that are seeking critical access hospital status, while easing some of the requirements that are in place for existing critical access hospitals. The bipartisan agreement allows critical access hospitals to use up to 25 beds for acute care (currently, it is limited to 15 beds). This allows greater flexibility to critical access hospitals. The bipartisan agreement also authorizes periodic interim payments, allowing critical access hospitals to receive payments every 2 weeks, as is currently the case for eligible hospitals, skilled nursing facilities, and hospices. In addition, the bipartisan agreement allows critical access hospitals to establish psychiatric and rehabilitation distinct part units.

Other Provisions:

- **Home Health.** The bipartisan agreement increases payments to home health agencies by 5 percent for services furnished in rural areas.
- **Telemedicine.** The bipartisan agreement extends the current telemedicine demonstration by 4 additional years, and authorizes an additional \$30 million in funding.
- **Ambulance.** The bipartisan agreement increases payment to ambulance providers and suppliers furnishing services in rural areas, directing the Secretary to increase mileage payments for ambulance trips that originate in rural areas with a low population density of Medicare beneficiaries. The bipartisan agreement also increases payments by 2 percent for rural ground ambulance services and 1 percent for non-rural ground ambulance services. In addition, the bipartisan agreement phases-in a floor for ambulance payments based on a blend of the national fee schedule and regional fee schedule, to ease the current transition to the national fee schedule. The bipartisan agreement also increases payment for ground ambulance trips that are longer than 50 miles. The bipartisan agreement also establishes a presumption of medical necessity for certain air ambulance services.
- **Hospice.** The bipartisan agreement allows nurse practitioners to act as the attending physician for a beneficiary that elects hospice. Nurse practitioners often play a central role in furnishing care in rural areas. This provision allows them to continue to serve their patients who elect hospice care.
- **Lab Tests.** The bipartisan agreement establishes reasonable cost payment for clinical laboratory tests furnished by certain rural hospitals as part of their outpatient services, providing additional dollars to these rural hospitals.