The Future of Rural Health Care Challenges and Solutions

Few topics are as emotional and personal as health care. Imagine your child breaking an arm playing football in the backyard, your mother calling to relay some bad news about your father’s health after a visit to the doctor or your sibling telling you about an upcoming battle with cancer. Fear, anger, sorrow, uncertainty and other emotions flood over you instantly. It’s inevitable that everyone will face health care issues in one form or another.

But rural Americans are suffering unique health care challenges that urban residents typically do not face. Simply accessing health care can be a significant hurdle for many. Even more challenging may be finding affordable care.

Defining Rural

The U.S. Census Bureau identifies two categories of urban areas: the first is an urbanized area of 50,000 or more people, including cities and metropolitan areas; the second is an urban cluster of at least 2,500 and less than 50,000 people, including suburbs and large towns. Rural encompasses all population, housing, and territory not included within either of the designated urban area definitions. According to 2010 census data, approximately 20% to 25% of the U.S. population lives in rural areas. Typical demographic trends of rural areas include lower median incomes, a high proportion of seniors, higher acuity levels and lower life-expectancies. Based on 2010 census data, per capita income is on average $7,417 lower in rural areas than in urban areas, and rural Americans have a higher likelihood of living below the poverty level.

According to the Rural Health Foundation, nearly 24% of children in rural areas live in poverty. And as younger residents leave home to attend colleges and universities, or seek employment in urban centers, the remaining

Continued page 5
Thinking about your business is a big part of ours.

PUT OUR TAILORED INSIGHTS TO WORK FOR YOU.
To make confident decisions about the future, middle market leaders need a different kind of advisor. One who starts by understanding where you want to go and then brings the ideas and insights of an experienced global team to help get you there.

Experience the power of being understood.
Experience RSM.
rsmus.com

THE POWER OF BEING UNDERSTOOD
AUDIT | TAX | CONSULTING

To all members and friends of the Southern Illinois Chapter of HFMA:

Thank you to all who participated in the annual chapter survey. This survey is so important to shaping and growing our chapter. One way that we use the survey results is to plan the chapter educational programs for the next year. The planning is done at the annual Program Planning meeting and I want to personally invite you to attend the meeting on May 25th and get involved. Our chapter couldn’t THRIVE without our volunteers. I want to say big thank you to all the volunteers, from the past to the present, who have given much time and effort to this chapter.

Mark your calendars:

February 16, 2017  Educational Program  Regency Conference Center Shiloh, IL
March 30, 2017  Educational Program  SIH Corporate Office Carbondale, IL
May 17-19, 2017  Joint Spring Conference  River City Casino St Louis MO
May 25, 2017  Program Planning Meeting  Stonewolf Golf Course Fairview Heights, IL
May 25, 2017  Golf Tournament  Stonewolf Golf Course Fairview Heights, IL

Sincerely,

Jennifer Durham

2016-2017 President
Southern Illinois Chapter HFMA

It’s not what happens to you, but how you react to it that matters - Epictetus, ancient Greek philosopher.
24/7 COMMITMENT

What’s your destination? Wherever you’re headed, chances are we’ve been there. BKD National Health Care Group can help you get where you’re going. Experience how BKD’s round-the-clock commitment to your organization and your goals can help you by lighting a path to success.

Fred Helfrich // Partner // bkd.com
fheldrich@bkd.com // 314.231.5544
population in the rural communities they leave behind becomes older. The fastest growing age cohort in rural America are residents 85 years old and above.\textsuperscript{1}

Rural populations typically have high numbers of lower income and aged residents, and there are specific ailments that impact these communities at a higher rate than urban communities. Obesity, lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease are statistically more common in rural areas.

Finally, the gap between urban and rural life expectancies is growing. According to a 2014 study published in \textit{American Journal of Preventive Medicine}, consistent overall increases in U.S. life expectancy was noted during the past 40 years, from 70.8 years in 1970 to 78.7 years in 2010. However, the study reveals the rural-urban gap widening from 0.4 years in 1969 to 1971 to 2 years in 2005 to 2009.

To make matters worse, the providers of rural health care suffer alongside the populations they serve. From reimbursement cuts to a suffocating regulatory environment, smaller facilities located outside urban and suburban population centers have a more difficult path to managing cash flow and scaling fixed costs. This article will focus on two of the primary challenges that both residents and providers face in rural communities.

\textbf{Challenge One: Access to Health Care}

In most U.S. cities, access to physicians and hospitals is a quick drive, a cheap public transit fare, or a taxi ride away. However, people in rural settings are likely to live further away from health care providers, particularly specialist services. Additionally, the deficiency of dependable transportation can be a barrier. Transportation services that exist in urban areas are often lacking or non-existent in rural areas.

Besides the geographical barriers to accessing health care, there are fewer providers. As noted earlier, about 20\% to 25\% of the population is rural; however, only about 10\% of physicians practice in these communities.\textsuperscript{2} Ask any rural hospital or skilled nursing CEO to list the top issues in the industry; most would likely tab finding qualified staff as a key concern. Per \textit{Healthy People 2010: A Companion Document for Rural Areas}, a project funded by the Office of Rural Health Policy, more than 33\% of rural Americans live in “health professional shortage areas,” and nearly 82\% of rural counties are classified as “medically underserved areas.”

Compounding these issues is the rate at which rural health care facilities are shutting down. The National Rural Health Association recently teamed with the University of North Carolina and iVantage, a health analytics firm, to conduct a study that identifies current and potential rural hospital closures. The ultimate goal is to identify potential closings before they occur. The research targeted approximately 2,000 rural hospitals across the country, and labeled 210 as “most vulnerable” with another 463 labeled as "at risk." Those dubbed “most vulnerable” could close any day, while “at risk” ratings are reserved for hospitals that

\textsuperscript{1} “The Demographics of Aging...” \url{http://transgenerational.org/aging/demographics.htm}
\textsuperscript{2} “Primary Care: Current Problems And Proposed Solutions” \url{http://content.healthaffairs.org/content/29/5/799.full}
may only last another few years without adjustment. Ultimately, closing these sites will not only have a negative impact on the access to care in the service area, but also eliminate a top employer in the community.

**Challenge Two: Affordability**

With a new presidential administration on the horizon, the future of the Affordable Care Act (ACA) is unclear. The general purpose of the ACA was to create more affordable health insurance for the uninsured, thereby reducing the drain on the health care system created by caring for uninsured. According to *The Affordable Care Act and Insurance Coverage in Rural Areas*, a 2014 report, rural populations have a larger proportion of low-income residents who could potentially benefit from the ACA to receive health insurance coverage.

However, approximately 66% of uninsured rural individuals live in states that chose not to expand Medicaid. In some states that chose to expand, the enrollment has far exceeded the projections, which has caused strain on the Medicaid funds from the state. Additionally, several national insurers have pulled out of the ACA state exchanges as their losses piled up. In some cases, to offset losses, premiums on employer-provided insurance plans have increased, creating strains on small businesses subsidizing these plans to employees. Limited employment opportunities combined with mounting health care premiums continue to drive costs higher. Ultimately, these factors equate to rural individuals having fewer affordable health insurance choices.

Aside from the ACA complications, Medicare payment systems and reimbursement practices typically do not acknowledge the distinctive situations of small and rural hospitals. These hospitals are disproportionately impacted by the continual cuts to Medicare reimbursements, including the bad-debt program and disproportionate-share hospital payments. At some facilities, the average age of plant for health care and hospital facilities far exceeds acceptable levels. Improvements to the physical plant and the demand for new information systems climbs, yet access to capital financing can be limited. Reinvesting in the facility is difficult with dwindling revenues and limited financing options.

**Solutions and Paths Forward**

Though the landscape seems bleak, not all hope is lost. Many
rural health facilities are using rural clinics, allowing them to open smaller yet impactful health care facilities across their service areas. This model allows for easier access to general care, but still limits the ability to access specialty care, such as cancer treatment centers or heart specialists. Accessibility is also being driven by new delivery methods, like telehealth, online prescription subscriptions and delivery services and 24/7 on-call doctors via the internet. Supplementing hands-on care with technology should allow greater access as long as communities become connected.

Health care organizations must also address affordability in expense reductions. Specialized consulting groups, such as Health Care Resource Group, focus on working with smaller rural facilities to navigate through difficult waters and improve operations. A thoughtful capital structure is a good way for hospitals to address expense reductions through minimizing debt service payments. Several financing programs are available to rural hospitals that can address the need to reinvest their facilities through expansion, acquisition, rehabilitation, or even a modern replacement facility and meet the needs of the community. The USDA Community Facilities Program is reserved for rural nonprofit organizations, including hospitals and skilled nursing facilities, and provides below market fixed-rate, long-term, non-recourse financing for construction and refinance. Other non-recourse financing solutions include the Federal Housing Administration (FHA) Sec. 242 mortgage insurance programs, which also provide agency-insured, long-term, fixed-rate debt at relatively high leverage points.

The aforementioned challenges in rural communities impact a significant portion of the U.S. on a daily basis. Simply accessing affordable health care is something the majority of the nation may take for granted. Without strategic financial action, our rural health care system will continue to face obstacles that severely inhibit community members from receiving necessary care.

Brett Murphy is a vice president with Lancaster Pollard in Chicago. He may be reached at bmurphy@lancasterpollard.com.
GO AHEAD, OBSESS.

That’s right. Obsess. Think more. Work more. More on your life’s passions, that is, and less on the financial hassles that come along with them, because that’s where Anders comes in.

We’re a team of CPAs and industry-focused advisors, and we’re always working to fuel decisions that strengthen your business and improve your life. Decisions that free you to obsess about the things that really matter – the things you really love.

What are you obsessing about today? Call Anders at (314) 655-5500 and see how our team can help.
Healthcare IT Spending on the Rise

Kimberly Moore, First American Healthcare Finance

Survey finds top drivers of healthcare IT investment are improving patient experience and engagement

In an era of digital natives, new technological solutions to healthcare challenges appear almost daily. Not surprisingly, two-thirds of hospitals report increased tech budgets for this fiscal year. Additionally, over a quarter of hospitals have seen more than a 5 percent increase. A recent survey* by First American Healthcare Finance, in partnership with the American Hospital Association, identified this rise in budgeting for hospital and health system information technology.

Where Are Healthcare Organizations Investing?

With endless possibilities, where are providers investing IT? In 2016, First American met with over 700 unique healthcare organizations to learn about their top investment priorities. Out of 900+ projects, top IT investments fell into four buckets:

- **Infrastructure** to run operations and keep data safe with server, software, and wireless infrastructure upgrades.
- **Communication** to make verbal and digital flow of information more efficient, using tablets, iPhone, nurse call systems, EMR upgrades, and telehealth.
- **Patient monitoring devices** to boost preventative care using heart failure prevention devices (necklaces, wristbands, and watches), nutrition tracking devices and apps, and food scanners.
- **Revenue generating** items such as da Vinci robots, hybrid operating rooms, cutting-edge ultrasound and imaging equipment, artificial intelligence in robots, and 3D bio-printing.

In the past, technology in healthcare organizations meant a handful of computers, some digital monitoring equipment, and a few pieces of imaging equipment. In today’s healthcare environment, technology has never been more aligned with every aspect of the patient experience. Additionally, as physicians utilize these devices, it is more important organizations invest in them. Also, every organization has an EMR system and diagnostic results are shared via mobile devices, many times through cloud computing networks. With this shift in the use of technology, providers must also focus on appropriate security measures to ensure the data they are collecting is safe.

Randy McCleese, CIO at St. Claire Regional Medical Center and former member of the CHIME Board of Trustees describes how technology is impacting every aspect of healthcare, not just the IT department.

“Medical equipment is a huge issue for us. In healthcare, we tend to keep pieces of medical equipment for a number of years, sometimes even until it is 15-20 years old. When the equipment was manufactured, the security requirements for that piece of equipment were so different than security requirements today. We must pay attention to devices that are connected to the network and how much data they can share across that network into our EMR. That falls into the security because we have to make sure that they are secure and the data flowing from them are secure, so we don't have ransomware getting into those devices.”

As healthcare organizations invest in new technology, they should consider the overall impact of the equip-
ment to the organization, staff, and patients. Examples of some questions to ask are:

- Will additional training for staff be needed?
- What data will be stored on the device?
- Does the equipment sync with current systems or will additional software be needed?
- Do patients have access to the data?
  - If so, full access or partial?
  - Are our current systems robust enough to keep data safe?

Alternatively, routine questions should be asked about old technology to make sure equipment does not become obsolete. Examples of questions to ask about old technology would be:

- What is the recommended useful life?
- Does the old technology sync with the new?
- Are there gaps in the technology that make data vulnerable to attacks?
- Would new technology create efficiencies that old technology cannot match?

As technology factors more and more into patient care and satisfaction, it is important to stay informed of changes by using peer organizations to find new best practices and receiving guidance from industry associations and key partners.

*To read a report on the full survey results, visit: [http://fahf.com/hit_survey](http://fahf.com/hit_survey)*

**About First American Healthcare Finance:**
First American Healthcare Finance provides leasing and financing solutions for medical and technology equipment, software, expansions, renovations, and services. First American is the equipment financing arm of City National Bank, and on November 2nd, 2015, City National merged with Royal Bank of Canada (RBC) and continues as an independent bank within the RBC family of companies. First American Healthcare Finance is also the first equipment financing service to simultaneously achieve the HFMA Peer Reviewed designation and the AHA exclusive endorsement.

For more information on Healthcare Financing, contact [financing@fahf.com](mailto:financing@fahf.com).
PLAN FOR CHANGE

Shape your future by collaborating with people who understand the financial, operational, and reimbursement needs of hospitals and health systems.
Ms. Macon is a compassionate, empathetic professional with nine combined years in healthcare and law enforcement. She holds a Bachelor of Science in Physical Education and Health from Oakland City University, Oakland City, IN. She is presently pursuing a Masters in Healthcare Administration from Lindenwood University in Belleville, IL with anticipated degree in December, 2017. She maintains an active IL and MO license as an Occupational Therapy Assistant.

Ms. Macon is passionate about the quality and level of care provided to the aging and/or patient population requiring care within skilled nursing facilities. She plans to utilize her knowledge and experiences as a SNF Administrator and pledges to cultivate an environment that places patient safety at the forefront while culminating high morale amongst all employees.

Ms. Macon has worked for multiple environments throughout her career, including assisting classroom teachers with special services, the correctional system, rehabilitation, and occupational therapy. She has completed coursework in the National Incident Management System, which allows her the ability to assist in disaster preparedness.

Ms. Macon is a member of the Healthcare Finance Management Association. She has received several awards and recognition to include the 2015 Illinois Jaycees Outstanding Young Person.

Ms. Macon held the role as the lead singer with Downtime Productions from 2011 to 2015 and continues to sing in her church choir, as well as coordinates children and the Easter programs. She serves on her church board as a trustee and was a previous Sunday school teacher and usher. In her spare time, she enjoys fishing, spending time with family and absorbs every minute possible with her son.
Consumer Collection Management, Inc. is celebrating over 35 years in business. What we do at CCM is not unusual for a full service collection management service - we just strive to do it better than anyone else. We assure the best service and complete resolution of your accounts.
In a health care industry that is transitioning from a fee-for-service model to a value-based reimbursement system, hospitals are selling outcomes, not procedures. This shift has had a substantial impact on health care delivery and treatment, especially in regard to hospitals’ partnerships with post-acute care providers. Although post-acute care providers include long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), and home health agencies (HHAs), the majority of services are rendered by SNFs and HHAs (Figure 1). Developing partnerships with these service providers is of crucial importance to reducing re-admittances to the hospital and improving overall outcomes.

Nearly 42% of Medicare patients are discharged to a post-acute care setting and in order for improvements to be made, the process must first be measured and tracked. This becomes complicated as nearly 50% of hospitals refer patients to 18 or more post-acute care providers. The more post-acute care providers in the network of the hospital, the more resources will be required to manage the care process to ensure quality care is given after discharge. Hospitals that identify and select the correct strategic partners should achieve better outcomes with their patients.

Identifying and Selecting Strategic Partners

There is a plethora of information out there to assist hospital management in screening for potential strategic partners. Big data resources such as Medicare.gov is a good place to start. Here are some important measures of performance to focus on for SNFs and HHAs:

**SNFs:**
- Three out of five-star quality rating minimum
- A three-star quality rating is needed to waive the three-day-stay rule to allow for the transference of patients to a post-acute care setting more quickly for comprehensive joint replacement (CJR) and certain managed care companies and ACO programs. Approximately 64% of SNFs have a rating of three or higher, leaving more than one-third of all SNFs below the requirement.
- Below average re-hospitalization rates
- Number of registered nurses
- Patient and family satisfaction survey information

**HHAs:**
- Star scores at or above the state average
- Recertification rates at the state average
- Patient survey results
Although the five-star system started out as just a tool to measure SNF performance, it has developed into a highly sophisticated payment tool which is closely monitored by post-acute care providers. The ratings in the five-star system are calculated on a state-by-state basis, with the top 10% of facilities receiving five stars, the middle 70% receiving a rating of two, three or four, and the bottom 20% receiving one star. These ratings are based upon health inspection scores, staffing, case mix and quality. Those metrics may vary from year to year, thus it is important to look at the historical ratings of the facilities. Reviewing re-hospitalization rates are also important and although the national average is currently 17.5%, special care should be given to analyze the acuity level of the facility (typically, the higher the acuity of the patient, the higher the chances of readmission are). Additionally, the appropriate number of registered nurses should be analyzed based on the acuity and number of patients at the facility, with careful distinction between registered nurses and licensed practical nurses. Becoming a registered nurse requires additional training that allows for more accurate and timely assessments.

For HHAs, the five-star rating system is not as widely used as it is for SNFs. However, it still provides valuable information and will likely become more widely used as more patients utilize the Home Health Compare function on Medicare.gov. Recertification rates are also useful, as they provide the proportion of non-initial patient episodes to initial episodes, giving an indication as to the incidence of chronic, multi-episode patients. Finally, because home health occurs in the patient’s home, patient surveys are a good source to review as well.

Consideration should be given to the proximity of the patients to the hospital if they are not returning home. Closer facilities present obvious benefits, such as less travel time for a patient should a complication occur and re-admittance prove necessary. Closer facilities also allow for more networking between the post-acute care provider and the hospital. This could prove beneficial in improving the lines of communication, resulting in reduced mistakes and aligning both organizations to improving outcomes of patients.

On-site reviews of the post-acute care facility and interviews of senior management are also key in determining the culture fit and quality of care.

**Investing in People and Technology**

To truly achieve an integrated health care delivery model, post-acute care must act as an extension of the care a patient receives at a hospital. Hospitals need to be able to monitor patients in the post-acute care setting the same way they monitor patients in their own facility. This requires significant investment in technology that is able to communicate effectively with the hospital’s own technology as many of these patients have co-occurring health conditions. Although many hospitals may have sophisticated electronic health records systems, the same cannot always be said of post-acute care providers. Special attention should be paid to the integration of health...

**Credit Control**

Terri DiMaria
Vice President of Sales

Credit Control, LLC
5757 Phantom Drive, Suite 330, St. Louis, MO 63042

Main 314.442.7422
Mobile 314.807.0599
Fax 314.442.7401
tdimaria@credit-control.com
information technology systems to ensure health information is able to be shared in a secure and timely manner. The best health management systems are able to identify and issue alerts on a real-time data exchange to the hospital on patients discharged to post-acute care settings. Post-acute care providers that have implemented these systems may come at a higher price but a reduction in re-admission rates may justify the increased cost.

Similar to inter-departmental meetings at the hospital, best practices denote regular meetings with management of the post-acute care facility to review trends in patient care, discuss readmission causes and identify any weaknesses in the provision of care after discharge from the hospital. Assigning a hospital care coordinator with accountability in the patient outcomes and re-admission rates from a specific post-acute care facility could lead to better results. Additionally, aligning the incentives of the hospital and post-acute care provider by sharing savings if certain quality metrics are met may improve outcomes as well.

Remaining Flexible

The implementation of the Affordable Care Act (ACA) has disrupted the traditional health care delivery model and, no matter what the ACA’s future, it is likely that there will be continued change. Remaining flexibility is vital to hospital operators and post-acute care providers alike. To deal with some of these changes, hospitals and accountable care organizations (ACOs) have been forming post-acute continuing care networks comprised of select post-acute care providers. Although these care networks are still in the developmental phase, they are emerging as a means of ensuring there is a certain quality of care given to patients after discharge from the hospital.

Some hospitals are forming joint ventures with post-acute care providers, building new facilities located on or near the hospital’s main campus. This allows for a streamlined process and uninterrupted care after discharge from the hospital. The joint venture aligns the organizations and leverages experience from both acute care and post-acute care to improve patient outcomes. Other hospitals are choosing to instead lease space to post-acute care providers on their campuses in an effort to bring the organizations closer together.

Although there is no one-size-fits-all solution to building successful partnerships with post-acute care providers, hospitals that allocate resources efficiently and remain open to new care delivery models will be best positioned to provide quality care to their patients.

Conner Girdley is a vice president with Lancaster Pollard in Atlanta. He may be reached at cgirdley@lancasterpollard.com.

Grant Goodman is a vice president with Lancaster Pollard in Newport Beach. He may be reached at ggoodman@lancasterpollard.com.
The (New) Gold Standard

Certified Healthcare Financial Professional

Health care is changing—and so is the Certified Healthcare Financial Professional (CHFP) designation.

The new CHFP from HFMA prepares finance professionals, clinical and nonclinical leaders, and payers to address the continually evolving healthcare business environment. Multidisciplinary courses focus on providing today’s essential skills: business acumen, strategy, collaboration, and leadership.

Course modules include:

The Business of Healthcare
Healthcare finance overview, risk mitigation, evolving payment models, healthcare accounting and cost analysis, strategic finance, and managing financial resources

Operational Excellence
Exercises and case studies on the application of business acumen in healthcare

Business skills for today’s healthcare leaders

Take the next step in your professional development—check out the new CHFP at hfma.org/chfp.
Calling all Writers.....

We are always looking for new articles for our SHARE quarterly newsletter. If you or someone in your organization have the skills and talent to write an article on any of our Hot Topics in Healthcare Finance, please feel free to submit it to the newsletter editor, Nikki Graves at ngraves@touchette.org

Currently, we are looking on articles on
- MACRA
- 503(c) Updates
- 2017 Prospective Payment Changes
- Insurance Exchanges
- Denials Management

The statements and opinions expressed in articles or features are those of the author and do not necessarily reflect the Southern Illinois Chapter, the Healthcare Financial Management Association or the editor. Paid advertising is an informational service for the Southern Illinois Chapter members and does not constitute an endorsement by the editor or HFMA leadership at the chapter or national level. The editor reserves the right to edit material and script, as well as reject contributions.

Nikki Graves, Editor, Southern Illinois Chapter HFMA (ngraves@touchette.org)
November 17-18, 2016 Meeting
Shiloh, Illinois
Trivia Winners
Awards Presentation

JENNIFER DURHAM: ROBERT H. REEVES SILVER AWARD

GREG WRIGHT: MEDAL OF HONOR

ELAINE MATZENBACHER: PRESIDENT’S GAVEL

JENNIFER VENABLE: MEDAL OF HONOR

ABOUT AWARDS:

The William G. Follmer Bronze Award is award after an individual has earned 25 member points.

The Robert H Reeves Silver Award is awarded to an individual who has earned 50 total member points.

The Frederick T. Muncie Gold Award is presented to a member who has earned a total of 75 points.

The Founders Medal of Honor recognizes individuals who have been actively involved in HFMA for at least 3 years after earning the Muncie Gold Award, has provided significant service at the chapter, regional and/or national level in at least two of those years, and remains a member in good standing.
INTRODUCING

HFMA CERTIFIED TECHNICAL SPECIALIST PROGRAMS

TECHNICAL EXPERTISE FOR MANAGERS AND DIRECTORS

Never has technical expertise been more important than in today’s complex healthcare operating environment. With the rapid pace of change, it’s critical to keep skills sharp and stakeholders aligned. So HFMA’s made it easier... with three on-line, self-paced comprehensive certification programs to earn the CTS designation and CPE credit. No prerequisites required.

Get certified. Earn your CTS designation today.

To learn more about these new HFMA certification programs, contact HFMA’s Career Services Dept. at careerservices@hfma.org.

Grow your credibility. Advance your career. Choose from:

Accounting & Finance
Gain critical technical competencies for effective decision support in all areas of healthcare management, compliance, and development. Designed for accounting professionals in healthcare finance. (CPE credits: 15)

Managed Care
Learn the “nuts and bolts” of managed care with a thorough primer on challenges posed by healthcare reform. Designed for managed care professionals as well as hospital or health system-based managers and clinicians. (CPE credits: 12)

Physician Practice Management
Explore best practices for hospital-physician practice alignment to excel in a value-based payment and population health management structure. Designed for financial professionals in both independent or integrated healthcare delivery system group practice settings. (CPE credits: 12)
Our Sponsors for 2016 - 2017

**Platinum**
Anders, Minkler & Diehl, LLP
CliftonLarsonAllen LLP

**Gold**
Accelerated Receivables Solutions/Magnet Solutions
BKD CPAs & Advisors
Consumer Collection Management
Experian Health
Kerber, Eck & Braeckel, LLP
RSM

**Silver**
Eide Bailly
Law Offices of Jay Umansky

**Bronze**
Craneware
Credit Control, LLC
Eagle Recovery Associates
H&R Accounts
HCFS, Inc
Mail Communications Group
Midwest Healthcare Inc
PNC
Wakefield & Associates
Changes to Cost Report Worksheets Affecting Wage Index

By Chad Tysdahl, BKD, LLP

Recent Transmittal 10 Provider Reimbursement Manual (PRM) instructions are included in Publication 15-2, Chapter 40, and affect provider Medicare cost reporting forms. The effective date for these changes are for cost reporting periods ending on or after September 30, 2016. View the complete Centers for Medicare & Medicaid Services (CMS) PRM guidelines for Publication 15-2 and the instructions in Chapter 40.

Changes Specific to Wage Index Reporting Lines

Worksheet S-3, Part II: CMS has added Lines 14.01 and 14.02 to enhance the wage index data collection related to home offices and related organizations. All home office and other related organization salaries, hours and wage-related costs were previously included on Line 14. Line 14.01 will now only include the home office salary and hour data, while Line 14.02 will only include other related organization salary and hour data. As mentioned below, wage-related costs will be reported on separate lines. Line 14 will no longer be used.

Worksheet S-3, Part II: CMS has added Lines 25.50, 25.51, 25.52 and 25.53 to separately report the wage-related costs related to home offices and related organizations. Home office and related organization wage-related costs were previously lumped together with salaries on Line 14. This transmittal now requires the home office wage-related costs to be included on Line 25.50. Related organization wage-related costs will now be included on Line 25.51. In addition, Line 25.52 has been added to include the wage-related costs in regard to any home office Part A physician administrative salaries reported on Line 15. Similarly, Line 25.53 has been added to include the wage-related costs related to any home office contract Part A teaching physicians reported on Line 16. Lines 15 and 16 will now only include the salary component of these categories.

Worksheet S-3, Part IV: Regarding Lines 25.50 through 25.53, Worksheet S-3, Part IV instructions state, “if a wage-related cost associated with the home office is not ‘core’ and is not a category included in ‘other’ wage-related costs on Line 18, the cost must not be included on Line 14, or subscripts.” This isn’t a change, but a clarification that home office wage-related costs follow the same guidance as hospital wage-related costs.

Worksheet S-3, Part IV: CMS has eliminated the wage index pension cost schedule Exhibit 3 and the corresponding instructions from the cost reporting instructions. The transmittal now directs providers to use the latest published wage index pension cost schedule on the CMS website. For hospitals that have historically used their own version of the pension computation, it will be important to use the CMS form going forward.

Worksheet S-3, Part IV: CMS added Lines 8.01, 8.02 and 8.03 to accommodate various categories of health insurance. Line 8.01 will apply if the hospital is self-funded for health insurance without a Third Party Administrator (TPA). Line 8.02 will be completed if the hospital is self-funded with a TPA. Line 8.03 will be completed if the hospital purchased health insurance. Previously, all health insurance expense was included on Line 8, which will no longer be used.

In addition to the reporting line changes, CMS offered additional guidance within the transmittal instructions. Primary changes are detailed below.

Worksheet S-3, Part II, Line 5: The instructions for reporting the salaried Part B physicians were modified to add that not only salaries billed to the Part B program are reported on this line, but also on-call physicians.

Worksheet S-3, Part II, Line 6: The instructions specifically state to include Lines 88 and/or 89 for nonphysician on-call salaries and salaries for any hospital-based Rural Health Clinic and Federally Qualified Health Center included on Worksheet A.

Worksheet S-3, Part II, Contract Labor: The instructions reiterate that only contract labor costs reported on the hospital trial balance on Worksheet A, Column 2 are included with the wage index. In addition, the instructions were modified to add that contract labor not reported in the proper cost center will be disallowed from the wage index calculation. This change could affect the reporting of Administrative & General (A&G) under contract. It will be important such costs are properly grouped on Worksheet A or reclassified on Worksheet A-6 to include the costs on Line 28, A&G under contract.

Furthermore, the changes indicate that “attestations or declarations from the vendor of hospitals are not acceptable in lieu of supporting documentation for wage, hours, wage-related costs and nonlabor costs.” Hospitals that have historically obtained an attestation from a vendor need to work with that vendor to obtain acceptable documentation, including—but not limited to—providing the hours on the invoice.

Finally, the contract labor instructions clarified that on-call wages and hours related to providing Part B services may not be included. Hospitals may still include on-call contract labor if the
regular scheduled dollars and hours meet the definition of contract labor. The on-call hours wouldn’t be included in this instance. We’ve noticed this change primarily relates to the ability to claim contract physician services when the physician’s other duties—besides being on-call—would be excluded as Part B time.

Worksheet S-3, Part II, Hours: When employees or contracts are on-call, the hours aren’t reported if the person is off site. If the provider is only being paid to be on-call and doesn’t work a regular schedule, the contract information wouldn’t be reported as noted above. Furthermore, the instructions clarify that if the employee or contractor is actually called into work, the dollars and hours would be reported.

Worksheet S-3, Policy Section, Pension Plan: For a hospital with a defined benefit pension plan that covers multiple entities, the hospital must report its own three-year average pension cost, i.e., each year the hospital’s allocated share of total plan contributions is calculated. This is a change that was effective this past year, but was added to the current transmittal instructions. The new transmittal provides several examples related to the pension plan computation.

If you have questions or need clarifications regarding guidance from the MAC or would like to discuss further, please contact BKD, LLP. We welcome the opportunity to answer questions or concerns.

This article is only for general information purposes and is not to be considered as legal advice. This information was written by qualified, experienced BKD professionals, but applying this information to your particular situation requires careful consideration of your specific facts and circumstances. Consult your BKD advisor or legal counsel before acting on any matter covered in this update. Article reprinted with permission from BKD, LLP, bkd.com. All rights reserved.
Is Your Self-Pay AR Becoming a Resource Drain?

Magnet Solutions Provides:

- Increased Cash and Cash-Flow
- Reduced Bad Debt Expense
- Improved Patient Satisfaction
- Optimized Communication Consistency
- 501 (r) Compliant Patient Communications

Magnet Solutions works with each client to develop specific solutions to resolve your self-pay account challenges. Our programs, which are tailored to your specific needs, create an efficient, patient-friendly system that delivers measurable results.

Learn how we can help!
308-672-1446
bfunk@ar-solutions.biz
President
Jennifer Durham
Director Patient Financial Services
Harrisburg Medical Center

President– Elect
Nikki Graves
Director of Reimbursement
Touchette Regional Hospital

Secretary
Shannon Tesio
Director of Finance
Touchette Regional Hospital

Treasurer
Greg Wright
Corporate Director of Finance
Southern Illinois Healthcare

Past President
Elaine Matzenbacher
Chief Financial Officer
Washington County Hospital

Visit our Chapter Website at:
http://www.sihfma.org/
Don’t miss out on the Upcoming HFMA Live Webinars. These webinars are free to members, but there are also special rates for new subscribers. Many earn CPEs.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tues Feb 14</td>
<td>2:00—3:30pm</td>
<td>An Overview of the Office of Inspector General’s 2017 Work Plan</td>
</tr>
<tr>
<td>Tues Feb 22</td>
<td>TBD</td>
<td>Healthcare Analytics Design: Smart, Creative, Forward-Thinking</td>
</tr>
<tr>
<td>Tues Feb 28</td>
<td>12:00—1:00pm</td>
<td>Healthcare’s Identity Crisis: Managing Identities and Authentication Pathways in Health Care</td>
</tr>
<tr>
<td>Tues Mar 7</td>
<td>2:00–3:00pm</td>
<td>The Impact of MACRA: Practical Applications and Your Preparation</td>
</tr>
<tr>
<td>Tues Mar 14</td>
<td>2:00–3:00pm</td>
<td>Risk Adjustment Best Practices</td>
</tr>
<tr>
<td>Tues Mar 21</td>
<td>2:00–3:00pm</td>
<td>Driving Organizational Effectiveness Through Data Transparency</td>
</tr>
<tr>
<td>Thur Mar 23</td>
<td>2:00–3:30pm</td>
<td>New Ways to Pinpoint Data and Improve Your Payment and Retention Strategies</td>
</tr>
</tbody>
</table>

It is also not too late to view the webinars available ON-DEMAND. These are also free to HFMA members.

**WEBINARS ARE AVAILABLE ON THE FOLLOWING TOPICS:**

- Accounting & Financial Reporting
- Finance & Business Strategy
- Legal & Regulatory Compliance
- Operations Management
- Payment, Reimbursement & Managed Care
- Revenue Cycle
- Technology
Save the Dates

**Thursday, February 16, 2017**
Chapter Education Meeting
Regency Conference Center
Hilton Garden Inn, O’Fallon, IL

**Thursday, March 30, 2017**
Chapter Education Meeting
SIH System Office
Carbondale, IL

**May 17—May 19, 2017**
Joint Spring Conference
River City Casino, Saint Louis, MO

(Greater St. Louis, Show-Me, and Southern Illinois Chapters)

**Thursday, May 25, 2017**
Chapter Program Planning Meeting and Golf Event
Stonewolf Golf Course, Fairview Heights, IL

Join us on February 15, 2017 at 6:30 at the Regency for Dinner and BINGO.
Contact Lisa Pulley at lisa.pulley@sih.net for RSVP