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Washington / Alaska Chapter
Healthcare Financial Management Association

NW Outlook

April 2002

President's Message. . .

by Anne Stallard

It's hard to believe this is my final "President's Message." Unless I want to be like Nevada and do it again! Not! The year has just flown by and it hardly seems possible. I would like to thank everyone for all their hard work and especially to Tom, as I know how much work he has done this year.

We've survived earthquakes, September 11, and a year of change. We have all learned to take our shoes off at airports and not to carry fingernail files in our purses. As we move forward with ANI just around the corner, we have a wonderful opportunity to capitalize at the national level. Certification testing will be offered along with a myriad of educational opportunities and networking with other states.

We hope Tom, Gregg, Bob and Eric have fun in Puerto Rico and bring back tons of ideas for the coming year. Last year's theme of "Leading at the Speed of Light" seems to be true as the year is done. I wish you all well and you haven't seen the last of me yet! Now I can go fishing… ■

HFMA Comments on Regulatory Reform

- Notes from National

On March 4, 2002, HFMA submitted recommendations to HHS Secretary Tommy Thompson on what HFMA members believe are the most important regulatory reforms that the agency should pursue.

Results of a February 2002 survey of HFMA members were instrumental in forming HFMA's recommendations.

On June 8, 2001, Thompson announced a department-wide initiative to reduce regulatory burdens in health care and respond faster to the concerns of healthcare providers, state and local governments, and individual Americans who are affected by HHS rules. In January, Thompson appointed 27 consumers, physicians, and other healthcare professionals to the Secretary's Advisory Committee on Regulatory Reform. The committee, which is chaired by a Mayo Clinic cardiologist, will

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Jim Heilsberg
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THANK YOU!!!

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scrutinize all HHS agencies but will focus particular attention on CMS and FDA—the two HHS agencies with the heaviest regulatory duties.

In its letter, HFMA recommended CMS should:

• Eliminate, or significantly simplify, the Medicare cost report so that only those data elements critical to the development of appropriate payment and cost analysis are collected.
• Make Medicare truly a nationwide program without local variations in policy and regulations.
• Give providers a way to obtain clarification and guidance in the application of unclear regulations or processes. Make those decisions applicable to all regions of the federal government and to all contractors.
• Work in partnership with providers to address the confidentiality and security of electronic data and timetables for compliance with law and regulations.
• Before the enactment of regulations, develop a cost/benefit analysis of the cost of implementation and compliance. Providers should receive federal funding to cover the additional costs. Similarly, CMS should have a system to ensure the timely elimination of obsolete regulations.
• Establish a system to facilitate participation of interested parties in regulation development. The system would seek input on assumptions, cost estimates, and implementation issues before the promulgation of the regulations.

Results of a February 2002 survey of HFMA members were instrumental in forming HFMA's recommendations. The survey asked members to prioritize the urgency of specific reform issues and requested comments on additional topics that the committee should address. Thank you to all who responded.

Excessive regulation, of course, is a crushing burden to all of us in the healthcare industry, and HFMA intends to do everything it can to support this important initiative.

This comment letter is only the earliest step. As the work of Secretary Thompson's reform committee progresses, HFMA will be coming to you again for more detailed information to clarify issues and evaluate the effects of proposed solutions. However, there's no need to wait for a formal request.

If you have information or observations about this broad issue of regulatory reform, please share it with HFMA's technical staff. The more information you can share, the more effective we can be in focusing Federal attention on the right issues. Contact HFMA technical director Jim Alexander, at (800) 252-4362, ext. 604, or jalexander@hfma.org.

According to the call for comments, which was published in the January 4 issue of the Federal Register, HHS will post comments, along with information about the committee's activities and related efforts, on the Regulation Reform Web site, at http://www.regreform.hhs.gov The complete comment letter is available under the "HFMA Positions and Activities" section of HFMA's on-line Resource Center at http://www.hfma.org/resource/ ■

Would you like to check your progress toward a Founders Merit Award.

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Tom Muller

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Hospital Data Reporting Improvements Planned

by Bill Mackey, Department of Health, CHARS Project Lead

The Department of Health (DOH) is taking steps to improve the quality and timeliness of hospital inpatient discharge data. In May we will begin modernizing our collection system – the Comprehensive Hospital Abstract Reporting System (CHARS) – with a secure, Internet-based application. Secure Web technology will provide a place to get CHARS data online while protecting confidential information by limiting access and encrypting data. This efficiency move will reduce reporting costs for hospitals and cut ongoing operating costs for the state.

Financial Analyst Tom Muller reviews indicators. File Photo.

State law requires hospitals to report to the DOH certain information about patient stays in their facilities. The Center for Health Statistics collects the information in CHARS and uses this information to support a variety of vital public health functions including evaluating the cost, quality, and access to health care.

CHARS processes over 500,000 inpatient reports each year from 95 acute care facilities in Washington. Currently, DOH contracts with a vendor for processing, compiling, editing, and releasing data, as well as producing reports. Hospitals correct data errors through a paper process in which error reports and corrections are mailed or faxed between DOH, hospitals, and the vendor. This labor-intensive process is largely unchanged since it began in the 1980s.

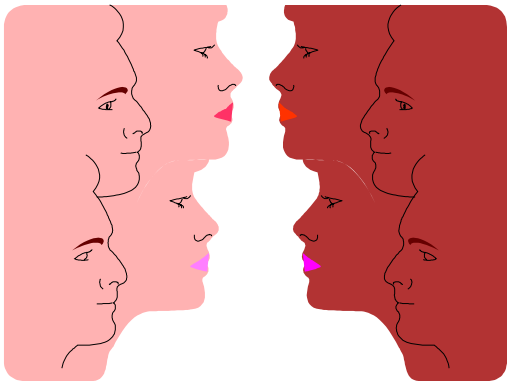
CHARS Manager Jeanette Neibert (R) and CHARS Processing Representative Kim Dunlap (L) maintain CHARS. File Photo

Hospital Patient Data Systems Manager Larry Hettick checking accuracy of CHARS data. File Photo.

The new improved CHARS will allow hospitals to submit data easily and securely over the Internet. Data will be evaluated and errors promptly reported back to the hospitals online so corrections can be made. The data will be processed and turned around in reports quickly – within hours instead of weeks. The new process is expected to reduce the workload and related costs at the hospitals while improving the overall quality of CHARS information. The planned efficiencies are projected to reduce net operating costs to the state by about $840,000 over a 10-year period.

An Emotional Economy

by Randy Morgan



Organizations are realigned and reorganized, shuffling people like cards in a deck.

We just returned from a trip to Ireland and as usual whenever I slow down enough to pay attention, I learn something. We were treated to a presentation (and several pints of Guinness) by the Irish Tourist Board while we were there. Ireland's tourism industry has enjoyed unprecedented growth in the last several years resulting in near 0% unemployment. For the first time in recent history they have begun to import workers. Their greatest challenge in the process was finding people who create the same kind of connection the natives of Ireland are known for.

Their research has shown that although people may come to Ireland for the beauty and history, what they invariably remember are the people. Before we left I remember someone saying, "You will never meet a stranger." Even in Dublin, a city of well over a million people, they always seem to put people before product. I believe the growth in their industry (50% of which is fueled by US travelers) is driven partially by this need to connect with others.

We are electronically connected by cell phones, email, faxes and PDA's but the same things that provide a technological interconnect result in a psychological disconnect. When we returned from our trip we found that "Our Post Office Lady," Doddy, had gone to sleep one night and never woke up. We were surprised at how much this impacted us emotionally. We weren't social friends, we didn't know her family, but she was one of our life's connections.

Jim Collins talked about the importance of these connections in his book Good To Great. Out of 1457 companies evaluated, only 11 were determined to have gone from just being average companies to being great. One of the characteristics was the importance of putting "who" before "where." The "where" is the product or service, which is out of necessity always changing and therefore described not as an end but a journey. Their point was that if people become part of a team based on where that team is going many would leave if the destination changes or worse "retire on the job." But if people become part of a team not because of the destination, but whom they are traveling with, the destination becomes unimportant. People are flexible, productive and resourceful, not because of the goal, but because of their responsibility to each other. This is not a positional, professional or organization responsibility, but a personal one and as such is always voluntary.

> *Change tears us away from the "Real People" we have come to know, and new relationships often take time to develop.*

Jim Collins' message was about the importance of hiring the right people, but the importance of these "personal connections" should be applied everywhere, yet they are often given little consideration.

Organizations are realigned and reorganized, shuffling people like cards in a deck. New connections are created as easily as dotted lines on an organizational chart, but little time is spent on the psychological connections that make those connections work. People are not committed to the process because they are not committed to each other.

We create cross-functional teams of dysfunctional people. If we want people to adapt quickly to new and changing responsibilities, we have to invest not just in the interconnection of systems, but the personal connections of people. Who would be more effective, a group of paid strangers, or a group of volunteer friends?

In the prologue of Executive EQ by Robert Cooper, PhD and Ayman Sawaf, Cooper told of climbing a mountain in Tibet and upon reaching the summit was told a horrifying story by his Tibetan guide. In describing why he told the story the guide

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explained "Could you trust me, or share a purpose with me simply because someone...commanded you to? No. But now if you choose to, you can begin to know me, and work with me and trust me. Now I am real, I am not just a name. I have a heart, a voice, a life story."

Change tears us away from the "Real People" we have come to know, and new relationships often take time to develop. We must invest the same energy and effort in creating not just organizational connections, but REAL connections. Create environments, activities and events where the purpose is not on knowing the job, responsibility or process, but the person. Teams change exactly the same way people do. People do not change from the outside in; they change from the inside out. When positions become people, commitments become personal.

While waiting for my first appointment with the cancer surgeon in the lobby of the cancer hospital, my brother-in-law Bill walked in. We had no idea how he knew we were going to be there and he didn't want to come in with us. After the examination, Dr. Lung commented to my wife about the family resemblance and how much he appreciated Bill coaching his daughter's basketball team. I was no longer a patient, I was a person. What do you do to make people more than positions? To make real connections, not just paper connections. The most valuable resource for any organization is the emotional commitment of its people. The Tibetan greeting "Tashi deley" means "I honor the greatness in you." Help your team get to know each other. There is greatness in all of us.

We hope Doddy left this world feeling connected and you will let all of your life's connections know how important they are to you.

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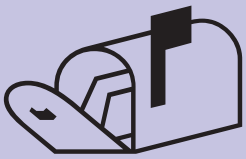

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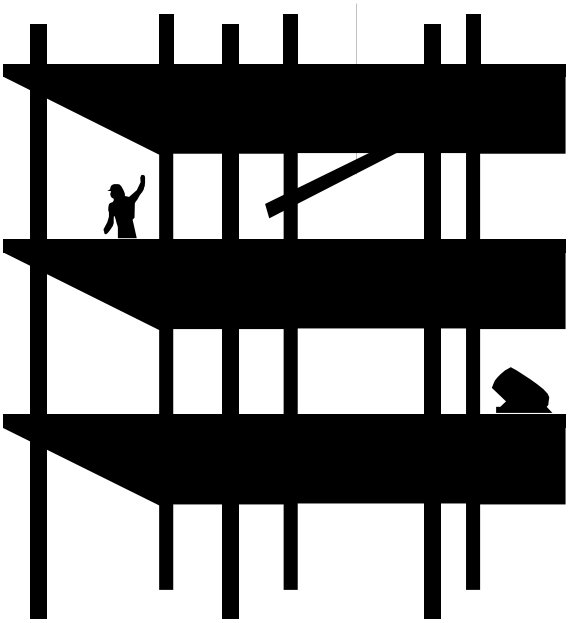

To Build or Not to Build – That is the Question

by Jim Heilsberg
Whitman Hospital & Medical Center

To even think about building in our current reimbursement and expense environment may drive fear into the most courageous CFO. Many hospitals in Washington State and other states are looking at building projects on the drawing board or are building.

As with any businesses, Healthcare institutions need to look at the current situation, what they expect for the future and how all factors fit together to allow for building. If you go through this process you may know intuitively or will find that several pieces of data are needed to make a good decision.

I will try to highlight several data points that should or could be looked at in the process.

Two main questions to be asked at the beginning are how will you fund the building project and how will you pay to operate it. When replacing space, the operations portion is less significant but should not be overlooked.

Building Construction Costs

When looking at the building costs, the first assumption to be made is it will cost more than you think to build it. This is not always true but often is the case. In order to determine if you can afford to build the project you need to know a number of things including the following:

- Cash and investments available
- Debt capacity available
- Cost of the building
- Political justification
- Operational justification

Cash/investments available can be determined if you know the total amount you need on hand to run the operation and what total amount you have available in total. Cash for operations varies based on how conservative you are. If you are less conservative you may want only one months expenses on hand and plan to rely on a line of credit if things go bad. More conservative may say you need to have 3 months cash on hand or more. It depends on the institution and board on where you fit on the continuum.

Debt Capacity can be determined by looking at standard ratios and talking to your auditor to see where they see appropriate limits to be. You must also consider your ability to pay back what you owe. I don't think this can be overlooked. Many people (including some financial individuals) assume you can pay it. Board, doctor and institution feelings on how much is too much are also very relevant. Most financial people are less tolerant of debt than others.

Cost of the building is one of the most difficult pieces to get a hold of in the process because the building costs are like trying to hit a moving target on the wall with a dart. The financial person may have a perspective on how much they think can be spent but people keep looking at the plans and say, how about adding this or it does not flow well clinically, what if we add this. End result is that building costs grow and before you know it, there is a political issue that does not always make logical sense but can cause the potential cost to go up.

Architects are also difficult to get a hard number out of, when it comes to total cost. You may have to get round numbers and do some of your own estimating with some help of the Architect. An alternative once you do

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get information from the architect is to consider having a separate party review the estimate or do your own internal estimate to determine how accurate the Architect is. One other thing not often thought of is the cost of the parking and cost of equipment to put in the building that is not part of the bid. A final note is to make sure you add around 16% to all costs to account for architect fees and sales tax. This one can be costly to forget.

Political Justification is often the normal justification process. If a doctor or clinical staff want certain things and can paint a partially credible or completely credible justification around patient safety, all the discussion in the world about cost can take a back seat and before you know it, you may be the one holding back the train of progress. Being aware of this can help you know who your audience is and how you need to present information so that all parties can be on the same page and you are not seen as the bad guy/gal. Good luck.

If you plan to fund the project with taxes, you may have other political considerations to account for. Other entities running building levies, voter moods on taxes in general and how your hospital is viewed can also be something that should be considered.

Operational Justification is also not always thought of. There are many areas where justification relating to volumes and reduction in operating expenses should be researched. Research will allow you to better guess at the predictability of the volumes materializing and the potential dollars saving potential being realized. These along with actual operation expense increases that result from adding space are big pieces of the puzzle.

Operational Impact

The operational impact of a project can be overlooked or underestimated. The larger the project, the more important it is to understand how much it will cost to run the building once it is up and going. There are several pieces that need to be included at a minimum. They are listed below.

- Net Revenue Increases from extra volume
- Housekeeping Staff Increases
- Plant Staff Increases
- Utility Cost Increases

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- Interest on Debt
- Line Staff Increases or Decreases
- Depreciation

Revenue increases are hard to determine but critical to the equation. One thing to keep in mind when calculating this is to make sure you understand what will potentially increase, what the predictability of increase is along with what the amount of net reimbursement is for adding one extra case or visit.

The potential of increase and predictability should be obtained from the data on the books in conjunction with what people can reasonably predict will happen. Most people believe "If they build it, they will come." While this makes a great line, failure for it to happen may have you left holding the bag. It pays to go through the pain of identifying that will come and what will they have done.

Knowing the marginal increase of each additional procedure is a critical process that takes a fair amount of digging in the detail to find out the answer. You can use some sampling techniques along with extrapolation to the whole but you must take care you have a representative sample and put the appropriate level of reliance on guesstimates. Unfortunately the majority of this is a guess. You just want to make it as educated as possible.

Housekeeping/Plant/Utility costs can be calculated by taking square footage costs for these departments and taking it time the amount of increased square footage. This can be an overkill depending on how much actual physical plant is in the plan. If you have a big plan with lots of infrastructure like boilers, HVAC etc. the plant may be correct but the housekeeping may be high.

Interest is all a function of whether you take out any debt. On the other side if you use cash you should put in an amount for decrease in interest income at some point in the analysis.

Line staff is often difficult to estimate but should be reviewed by interested parties and some level of commitment should be obtained from the departments that they will not go beyond the amounts identified. It is easy to say it will only take 1 FTE and then find out it takes 4. This is easy to implement as long as you have the money. If you don't this may be an operation breaker, depending on your margin.

Depreciation on the new building is an obvious one but often forgotten.

The onslaught of APC's and other reductions in payment rates have caused us to take more care as we look to build. Many non-financial people still believe everything is profitable to the hospital and if something is not profitable, it could not possibly be related to their department or procedure. As a result education is a key and some people may not want to hear it.

One must believe that data is king in the end. Obtain valid data, analyze it appropriately and prepare it for your audience and you will be ahead of the game or at least in a position to play the game out and not lose completely in the end.

Boy what a list. If you are not tired after reading all of this, you will be if you get to go through the building process. It is our job however and may help others avoid or at least make an informed decision. It may even save your job if it all goes south. We all hope for the best and plan for the worst. Hopefully these thoughts will help you along the way. ■

The next LCC meeting will be Thursday, May 23rd, at 5:00PM at the Embassy Suites at SeaTac. Plan on being there.

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Are you ready to take the HFMA certification test?

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Hospital Financial Highlights

by Tom Muller

Since calendar year 1992 total patient service revenue for hospitals in the State of Washington has increased by 133.4%, which is a compound rate of 9.9% per year. Over this time period outpatient revenue grew much more rapidly (13.9% per year compounded) than inpatient revenue (7.6% per year compounded). As a result, outpatient revenue expanded from 31.0% of total patient service revenue in calendar year 1992 to 42.8% of total patient service revenue in calendar year 2001. Contractual adjustments in calendar year 2001 were over four times the calendar year 1992 level. This represents an annual compound growth rate of 17.0%.

Net patient service revenue grew 10.3% over the year earlier level, which was the largest percentage increase recorded since calendar year 1992. Since this exceeded the 9.3% growth from calendar year 2000 in operating expenses, net operating income was able to leap 76.1% over the year earlier level to $171 million. This was the highest level of net operating income achieved since the four quarter period ended September 1998.

Since calendar year 1992 inpatient discharges have grown by 8.9%, while patient days have declined by 5.6%, resulting in a 13.3% drop in average length of stay. As a result of the significant growth in the proportion of outpatient revenue over the period, adjusted discharges expanded by 31.8%.

Days in accounts receivable plunged 10.1 days, or 13.0% from the year earlier level to 67.3 days, which was the lowest since the four quarter period ended June 1994.

HOSPITAL PERFORMANCE	Calendar Year 1992	Calendar Year 2001	Nine Year Change Total	Nine Year Percent Change Total	Nine Year Percent Change Annualized
Total Patient Revenue					
Inpatient	3,751,309,752	7,249,204,824	3,497,895,072	93.24%	7.59%
Outpatient	1,682,010,693	5,433,269,835	3,751,259,142	223.02%	13.92%
Total	5,433,320,445	12,682,474,659	7,249,154,214	133.42%	9.88%
Deductions From Revenue					
Contractual Adjustments					
Medicare	642,675,354	1,988,303,041	1,345,627,687	209.38%	13.37%
Medicaid	357,666,036	858,932,766	501,266,730	140.15%	10.22%
Other	326,101,616	2,597,511,879	2,271,410,263	696.53%	25.93%
Total	1,326,443,006	5,444,747,686	4,118,304,680	310.48%	16.99%
Charity	107,821,109	153,994,264	46,173,155	42.82%	4.04%
Total	1,434,264,115	5,598,741,950	4,164,477,835	290.36%	16.34%
Net Patient Revenue	3,999,056,330	7,083,732,709	3,084,676,379	77.14%	6.56%
Total Operating Expenses	3,834,279,047	6,913,139,564	3,078,860,517	80.30%	6.77%
Net Operating Income	164,777,283	170,593,145	5,815,862	3.53%	0.39%
Utilization					
Discharges	471,010	512,778	41,768	8.87%	0.95%
Patient Days	2,355,681	2,223,851	(131,830)	-5.60%	-0.64%
Length of Stay	5.00	4.34	(0.66)	-13.29%	-1.57%
Adjusted Discharges	688,599	907,865	219,266	31.84%	3.12%
Rates					
Tot Rev Per Adj Disch	7,890.40	13,969.56	6,079.16	77.05%	6.55%
Deductions Per Adj Disch	2,082.87	6,166.93	4,084.06	196.08%	12.82%
Net Revenue Per Adj Disch	5,807.53	7,802.63	1,995.10	34.35%	3.34%
Oper Expense Per Adj Disch	5,568.23	7,614.72	2,046.49	36.75%	3.54%
Net Income Per Adj Disch	239.29	187.91	(51.39)	-21.47%	-2.65%
Financial Ratios			-		
Operating Margin-Gross	3.03%	1.35%	-1.69%	-55.65%	-8.64%
Operating Margin-Net	3.96%	2.28%	-1.68%	-42.50%	-5.96%
Deductible Proportion	26.40%	44.15%	17.75%	67.23%	5.88%
Contractual Proportion - Total	24.41%	42.93%	18.52%	75.85%	6.47%
Contractual Proportion - Medicare	33.22%	46.52%	13.30%	40.03%	3.81%
Contractual Proportion - Medicaid	37.81%	46.70%	8.89%	23.52%	2.37%
Contractual Proportion - Other	12.77%	39.54%	26.77%	209.54%	13.38%
Charity Proportion	1.98%	1.21%	-0.77%	-38.81%	-5.31%
Outpat Rev Percent	30.96%	42.84%	11.88%	38.39%	3.68%

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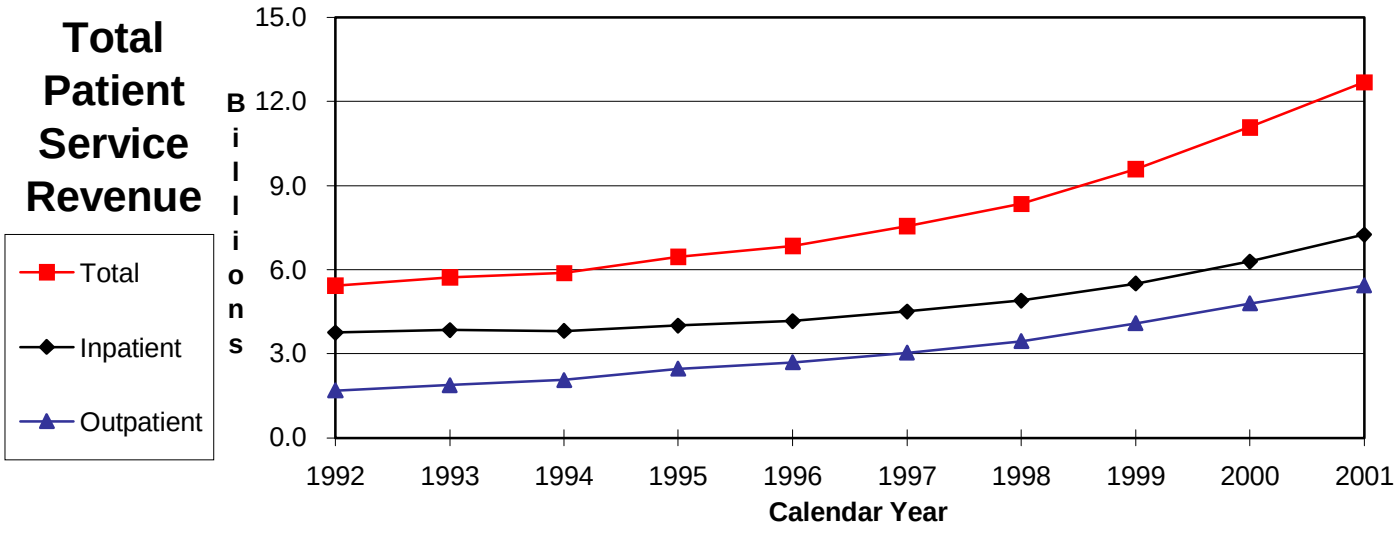
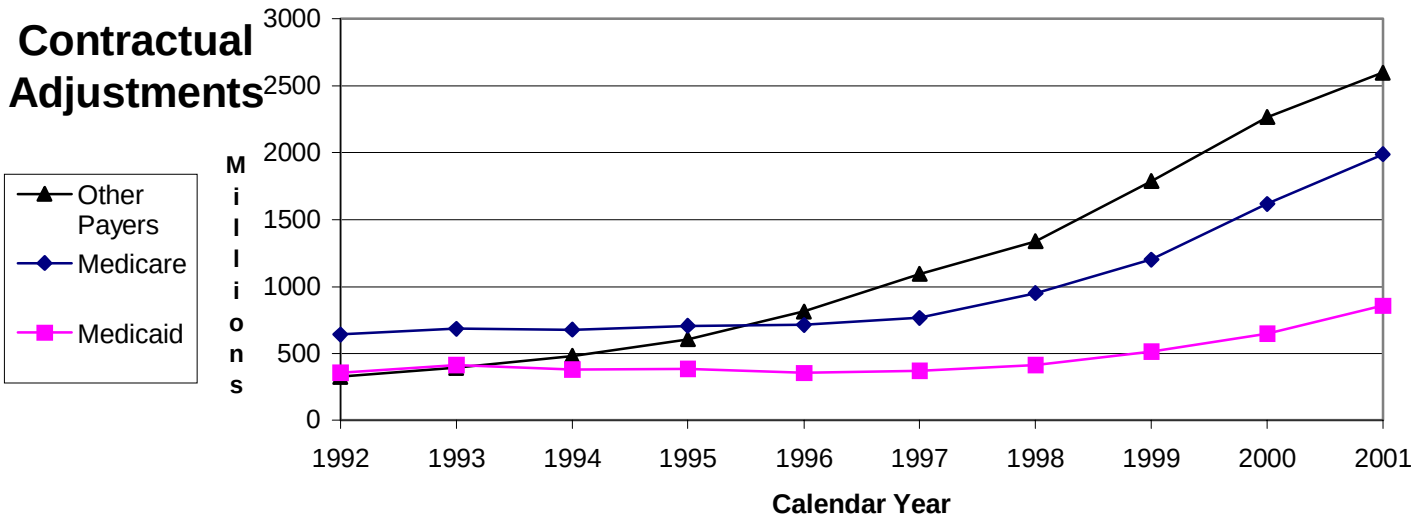
HOSPITAL PERFORMANCE	Calendar Year 2000	Calendar Year 2001	Total Change	Percent Change
Total Patient Revenue	11,078,833,958	12,682,474,659	1,603,640,701	14.47%
Deductions From Revenue	4,655,619,606	5,598,741,950	943,122,344	20.26%
Net Patient Revenue	6,423,214,352	7,083,732,709	660,518,357	10.28%
Total Operating Expenses	6,326,363,238	6,913,139,564	586,776,326	9.28%
Net Operating Income	96,851,114	170,593,145	73,742,031	76.14%
Days in Accounts Receivable				
Medicare	61.0	51.1	(9.8)	-16.14%
Medicaid	75.7	72.2	(3.5)	-4.65%
Other Payers	87.8	76.5	(11.3)	-12.90%
Statewide Total	77.4	67.3	(10.1)	-13.00%
Financial Ratios				
Operating Margin-Gross	0.87%	1.35%	0.47%	53.87%
Operating Margin-Net	1.41%	2.28%	0.86%	61.02%





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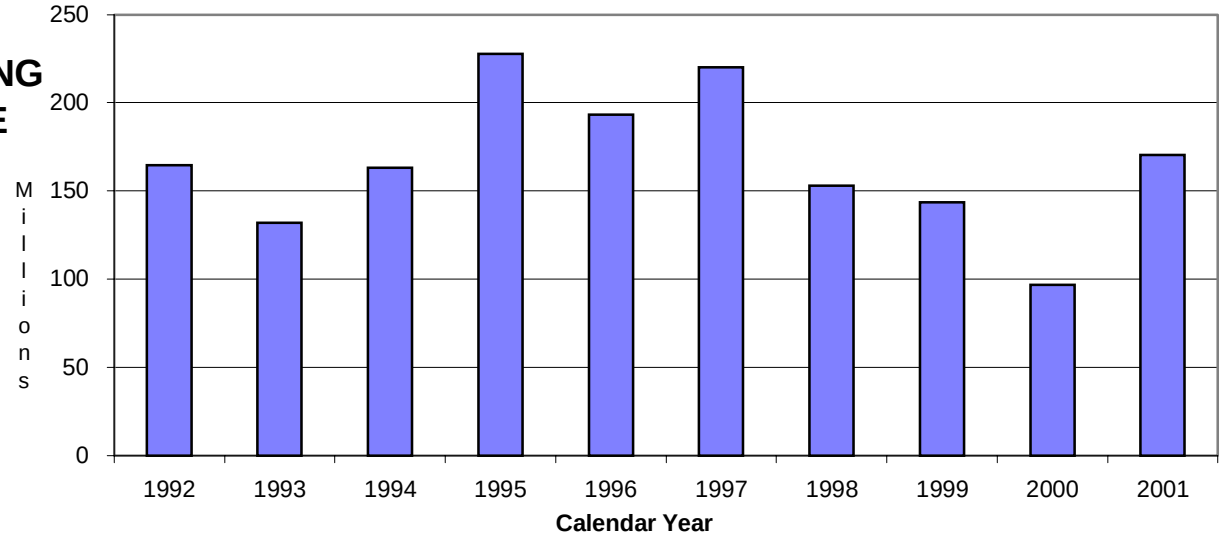
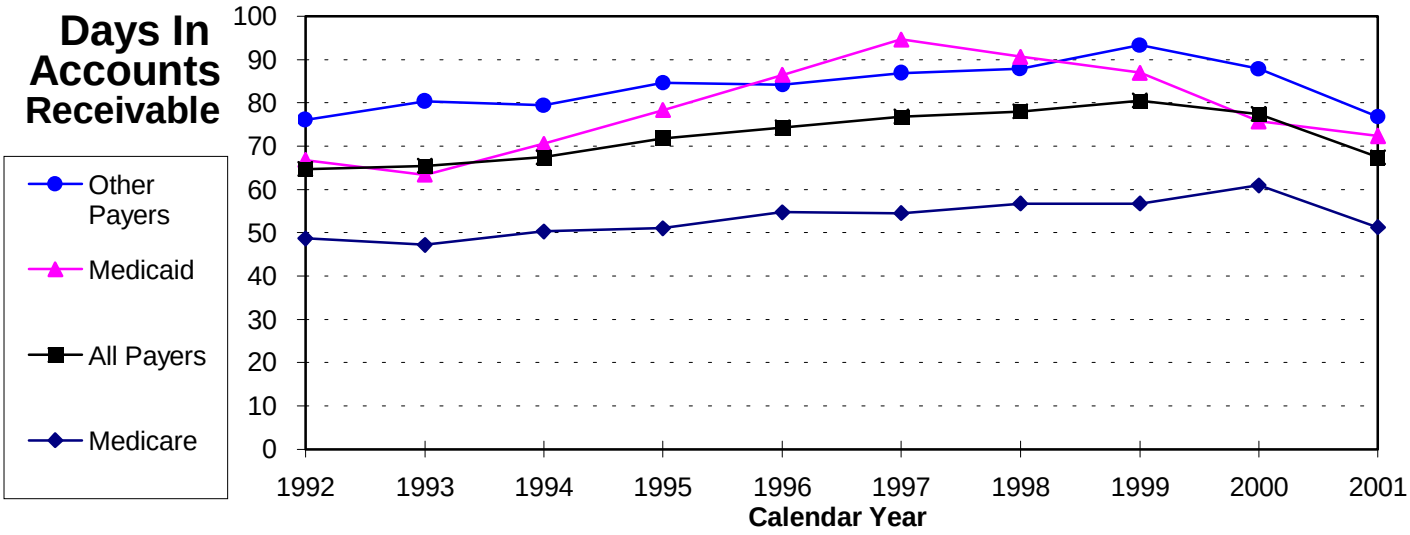
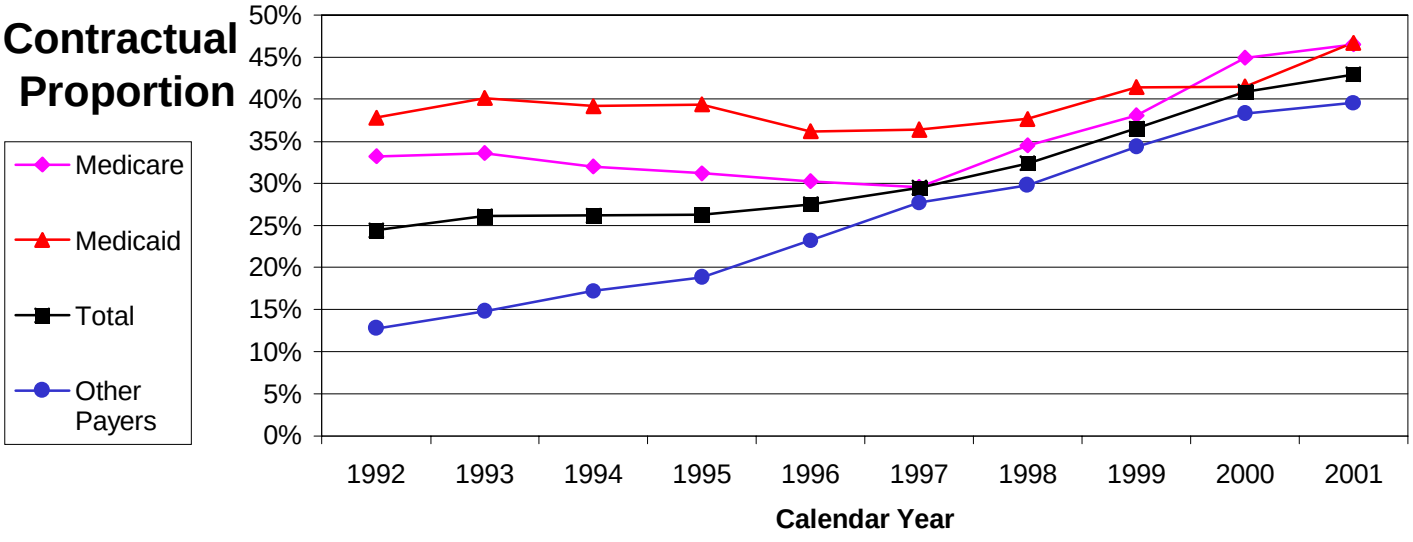
NET OPERATING INCOME



Days In Accounts Receivable



Contractual Proportion



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Chief Financial Officer	Sitka Community Hospital	Sitka, AK (S.E. Alaska)
Chief Financial Officer	Mount San Rafael Hospital	Trinidad, CO
Chief Financial Officer	Good Samaritan Community Healthcare	Puyallup, WA
Chief Financial Officer	North Sonoma County Hospital District	Healdsburg, CA
Contract Manager	Redwood Regional Medical Group, Inc.	Santa Rosa, CA
Controller	Jefferson General Hospital	Port Townsend, WA
Decision Support/Revenue Cycle Analyst	Hospital in high desert	One hour north of LA, CA
Director of Finance	Northwest Healthcare	Kalispell, MT
Director of Finance Operations	Large medical center	Los Angeles, CA
Director of Finance/Controller	Hospital organization	Central coast region, CA
Director of Internal Audit	Washoe Health System	Reno/Tahoe, NV
Director of Patient Financial Serv./Business Serv	Large healthcare system	Nevada
Director, Contracting and Network Development	United HEALTH NETWORK	Portland, OR
Director, Registration Services	Enloe Medical Center	Chico, CA
Financial Analyst III	Washoe Health System	Reno/Tahoe, NV
Health Finance and Operations Officer	Health department	Benton County, OR
Manager of Strategic Planning & Bus. Analysis	Lucile Packard Children's Hospital, etc.	Palo Alto, CA
Patient Financial Services Operations Manager	Large Medical Center	Los Angeles, CA
PFS Project Coordinator	Lucile Packard Children's Hospital, etc.	Palo Alto, CA
Regional Director Operations	Kaiser Permanente	Oakland, CA
Reimbursement Manager	Providence Services-Eastern Washington	Spokane, WA

FOR MORE INFORMATION...

...on these listings or to include a listing, please contact

Julie Meek, (509) 942-2708 or meekj@kadlecmed.org

See also National HFMA's website (www.hfma.org) for additional job listings.

Quality, Cost & *Critical* Access

by Sean Douglas, St. Joseph's Hospital/Deer Park Hospital

Financial executives are an integral part of the delicate dance between the triad of quality, cost and access in healthcare facilities. We tend to align ourselves with the issues of cost, show a muted interest in quality, and salivate at the idea of increased access to our facilities. For many rural hospitals in the United States and the State of Washington, these components of healthcare recently received a boost from the U.S. Congress in the form of the Critical Access Hospital (CAH) Program.

The Balanced Budget Act of 1997 created the CAH Program as a component of the Rural Hospital Flexibility Program. The CAH Program is an investment in America's rural hospitals, ensuring access to healthcare for the Medicare beneficiary, promoting quality of care, and accomplishing this through increased reimbursement. Congress made this investment because many rural hospitals were struggling financially and were providing care to a large number of Medicare beneficiaries.

The CAH Program is an investment in rural hospitals but not all rural hospitals. Eligible hospitals are limited in size to fifteen acute beds. However, an additional ten beds may be set-up as swing beds (SNF level care). While all twenty-five beds can be used as swing beds, only fifteen of the twenty-five can be used for acute care. Therefore, Congress focused the additional resources on the smallest of rural facilities. Other requirements of the CAH program include around the clock emergency care services, an annual average per-person length-of-stay of ninety-six hours (4 days) or less, and an agreement with a network hospital or peer review organization for credentialing and quality assurance.

Eligible rural facilities must also be located no more than thirty-five miles from another short-term general hospital or CAH. The mileage criterion is reduced to fifteen miles in mountainous terrain or in areas with only secondary roads. Of the hospitals in the State of Washington, forty-three qualify for CAH under these eligibility rules. As of April 1, 2002, seventeen of these facilities have converted to CAH, one is currently undergoing the survey process, and eight more are analyzing the impact conversion would have on their facility. Nationally there are 511 Critical Access Hospitals as of January 2002.

The increased reimbursement for CAH's is achieved through reasonable cost based reimbursement. Therefore, CAH's are exempted from the prospective payment system reimbursement for inpatient (DRG) and outpatient (APC) services. The mean first year impact for CAH's was an increase in Medicare reimbursement of $286,000 nationally. For many hospitals this was enough to move from operating losses to positive operating margins. The CAH Program was not intended to be a panacea for rural hospitals but it has provided a much-needed infusion of capital for these facilities.

The Balanced Budget Act of 1997 created the CAH Program as a component of the Rural Hospital Flexibility Program.

The largest increase in Medicare reimbursement within the CAH is laboratory, which moved from fee schedule reimbursement to reasonable cost. Lab reimbursement under reasonable cost was not part of the CAH program but was implemented by the Benefits Improvement and Protection Act (BIPA) of 2000. Additional reimbursement differences for CAH's include payment for emergency room on-call physicians, payment for swing beds on cost-based reimbursement, the ability for all-inclusive billing for physician services at 115% of the fee schedule, and cost-based reimbursement for ambulance services that are owned and operated by CAH's.

Many states, including the State of Washington, have converted their Medicaid reimbursement to cost-based for CAH's as well. This is a significant increase in Medicaid reimbursement. It also means that many CAH's are reimbursed on reasonable cost for a large portion of their payer mix. The operating margin must therefore be generated from the limited number of commercial payers and private pay patients. According to the Rural Policy Research Institute (RUPRI), the average operating

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margin of CAH's prior to conversion was a fifteen percent operating loss. The same study states that many CAH's are generating breakeven or small positive operating margins after the second year in the program.

The CAH Program has increased reimbursement to rural hospitals in order to ensure access to care for Medicare beneficiaries and to promote quality of care. Evidence suggests that the program is reenergizing many rural facilities and reversing the trend of struggling hospitals. Even though these reimbursement mechanisms have been authorized by Congress to continue indefinitely, only time will tell how long the increased investment will last. One thing that we do know is that the struggle between quality, cost and access will continue in healthcare indefinitely, even if one of the components is listed as *critical*.

Sean Douglas, CPA is the Chief Financial Officer of Deer Park Hospital, a CAH in Deer Park, Washington, and St. Joseph's Hospital in Chewelah, Washington, a CAH and forty-bed nursing home. ■

Mark Your Calendar

June 16-20 , 2002

National ANI Conference

Convention Center

Seattle

- Guest Speakers
- LCC Meeting

SEE YOU THERE!

REAP THE BENEFITS OF LCC PARTICIPATION

by Tom Muller, Membership Services Chairman

Since WA-AK chapter is a volunteer run organization, it is the members like you that make things happen in the chapter. By participating in the chapter LCC you have a voice in determining the topics that will be on the agenda for future chapter meetings, where and when those meetings will be held, the future goals of the chapter, and the types of recognition the chapter will give to members. In addition, participation in LCC provides an excellent opportunity for networking with other chapter members who are actively involved in the operation of the chapter.

As a token of appreciation, the chapter provides dinner for all members who attend LCC meetings. As an additional incentive, all members attending, except officers and directors, are entered into a drawing. The winner of this drawing receives a prize of $50. The most recent winner was John Nutter from Olympic Medical Center. Previous winners during the 2001-2002 chapter year were Del Nord from Quality Reimburse-ment Services and Pat Green from Overlake Hospital Medical Center. You could be the next winner. But, you must be present to win. The next LCC meeting will be Thursday, May 23rd at 5:00 PM, directly after the May 2002 chapter meeting.

The May meeting is an ideal time to start participation in an LCC committee or council. At this time each committee and council is outlining its activities for the coming year. However, all of the LCC councils and committees welcome new members at any time of the year. A description of each LCC council and committee and its functions is available on the chapter website at http://www.waakhfma.org ■

Welcome New Members

The Washington/Alaska Chapter is pleased to announce the following new members

Paul L. Dini
Vice President
Wells Fargo Bank
Bellevue, WA

Bomi M. Bharucha
Chief Finance Officer
North Valley Hospital
Tonasket, WA

Toni L. Qunell
Medical Record and Compliance Manager
Enumclaw Community Hospital
Enumclaw, WA

Michael Sager
Financial Analyst
Olympic Memoroal Hospital
Port Angeles, WA

Roald Helgesen
Director Adminstrative Services
South East Alaska Regional Health Consortium
Sitka, AK

Angela M. Marlow
Reimbursement Analyst
Franciscan Health System
Tacoma, WA

Daniel A. Evans
Director of Reimbursement Projects
DaVita, Inc.
Tacoma, WA

Robert L. Van Winkle
Accounting Manager
Providence Washington Service Center
Seattle, WA

Dee Ann Aust
Director
Swedish Medical Ctr / 1ST Hill
Redmond, WA

Dawn Cemulini
PeaceHealth
Longview, WA

Steven Schramm
Manager Audit / Consulting Services
Catholic Healthcare Auditors Network
Tacoma, WA

Cynthia Lynn Jones
Chargemaster Coordinator
University of Washington Medical Center
Auburn, WA

Gena F. McLain
Senior Accountant
Moss Adams LLP
Yakima, WA

Michael J. Haggerty
Controller
Central Peninsula General Hospital
Soldotna, AK

Holly C. Thomsen
Manager Patient Accounts
Good Samaritan Community Healthcare
Puyallup, WA

Kirk Ruddell
Chief Compliance Officer
Island Hospital
Anacortes, WA

Bryan E. Anderson
Columbia Ultimate
Vancouver, WA

Upcoming Chapter Meetings

EVENT	DATE	LOCATION
HFMA Workshop	May 23, 2002	Embassy Suites - Seatac
HFMA National ANI Conference	June 16-20, 2002	Convention Center - Seattle
HFMA Workshop & Meeting	September 25-27, 2002	Campbells - Chelan
HFMA Workshop	December 5, 2002	Facility - TBD - Seatac
HFMA Region 11 Symposium	January, 2003	Caesers PalaceLas Vegas
HFMA Workshop, Meeting, & Vendor Fair	February, 2003	Sheraton - Tacoma
HFMA Workshop & Meeting	May, 2003	Davenport Hotel - Spokane
HFMA Workshop & Meeting	September, 2003	Joint Mtg w / OR - Portland
HFMA Workshop	December, 2003	Facility - TBD - Seatac

www.waakhfma.org

NW Outlook

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