hfma western new york chapter
healthcare financial management association

Spring 2013

FINE PRINT

LEADERSHIP MATTERS

INSIDE THIS ISSUE:

PRESIDENT'S MESSAGE

KRISTEN CHAPMAN
2012-2013 CHAPTER PRESIDENT

My presidential year is winding down. In a couple of weeks HFMA national will begin to tally each chapter's Chapter Balance Scorecard (CBSC) and already we are gearing up for a new slate of directors, officers, and committee chairs. I am happy to report that the Western New York chapter will receive a passing CBSC score this year. The chapter is anticipated to receive a total score of 80/100. We successfully meet our goals in education, member satisfaction, certification, days cash on hand requirements, on-time reporting, and we only missed our membership goal by 5 members. That passing score was not easily earned which it makes it all the sweeter! THANK YOU to each and every one of our members who helped us achieve those goals!

Other accomplishments this year include the second annual Long Term Care Institute as well as the chapter's SWOT analysis, which was facilitated by HFMA's Chapter Advancement Team (CAT). The LTC Institute was held September 24th and was well attended and liked. The event is spearheaded by Kristin Anderson, who does an excellent job of providing targeted, quality education to an important demographic of our membership. The chapter's SWOT analysis was held on a stormy winter day in February. In fact the day was so stormy that our CAT facilitator's plan was delayed in Philly and he never made it! Western New Yorkers are not afraid of some winter weather, however, and chapter leaders met in spite of the weather to complete the self-evaluation. The meeting's end deliverable, the chapter's strategic plan, is still under review and is hoped to be re-evaluated each year forward.

I am truly proud to have served the chapter as president for the 2012 - 2013 year. I am confident that my successor, Jeffrey Jacobs, will serve the chapter well in his upcoming 2013-2014 term. Again, I thank each and every one of the members, directors, chairpersons, and officers, for the opportunity to serve them and for their support and efforts throughout the year. I hope to see each and every one of you at our upcoming annual awards banquet so I can thank you personally.

2012-2013 CHAPTER LEADERS

Officers
Kristen Chapman
President

Jeffrey Jacobs
President – Elect

Robert Levesque
Secretary

Paul Vinkle
Treasurer

Board of Directors Class of 2013
Debbie Cudzilo
Christopher Eckert
Jessica Landers
Peggy McDonough

Board of Directors Class of 2014
Susan Brown
Ryan Caster
Michael Cournyea
Mary Ann Miccichi

Committees

Membership:
Christopher Eckert
Mary Ann Miccichi

Education:
Jeffrey Jacobs
Mary Mahaney

Certification:
John Eichner
Robert Levesque

Social Events:
Ryan Caster
Bruce Liebel

THE REGIONAL FRONT

BRUCE LIEBEL, REGIONAL EXECUTIVE 2013-2014

Bruce Liebel, REE

REGIONAL EXECUTIVE ROLE:

As I was preparing for the Leadership Training Conference (LTC) in California recently, I thought about my upcoming role as Regional Executive for Region 2. A daunting task, but one nonetheless that I feel I'm ready for because of the people who got me here.

Like the soon-to-be Chapter Presidents, you realize the importance of your fellow chapter leaders – in my case, those from Western New York, that have been instrumental in supporting me and accepting changes I've made along the way. "It takes a Village" or in this case, the entire HFMA chapter to provide the support to push you to greater heights and success. Likewise, without the support of National HFMA and the Chapter Relations staff, many of us would not have succeeded in our leadership roles. They provide you the materials to run your chapter or region, and the tools to succeed. They are there to support you along the way, and failure is just not an option!

Lastly, there has been a great succession of past Region 2 RE's that I have learned from over the years, most recently Bob Masi from Hudson Valley, Liz Carnevale from Metro and the current RE from Rochester, Tom Crilly. From each I have watched them in action, guiding the Region through a range of events, issues and problems, while picking up tips on the numerous conference calls I've been part of. They have all been instrumental in the Region 2 Chapters success in meeting CBCS goals and garnering awards, and in bringing to the forefront, issues that needed to be addressed on a National level.

MINI-LTC

Coming up soon is the Region 2 Mini-LTC, a smaller version of the training involved at the National LTC, but tailored to meet our own Region's needs. Besides Chapter Officers & Board Members, it allows chairs and co-chairs to interact amongst their peers and pick up tips to facilitate their committees. The planning for this year's event on May 19th & 20th at the historic Otesaga Hotel in Cooperstown, NY is almost complete, and I must say this year's host chapters, Central NY, Metro NY & Puerto Rico, have done a great job. I must thank Karen Carter, Michele Mecomonaco, David Evangelista & Julio Colon for their dedication and efforts, for what should prove to be a great Mini-LTC. My job as RE, is to oversee their work and guide them, along with the assistance of the upcoming REE, Teresa Figueroa from Puerto Rico, and I must say, they will make the Region look good.

THE REGIONAL FRONT

CONTINUED

REGION 2 CONFERENCE:

Another event for the Region, our largest, and the event that supports most of our regional activities, is the Annual Region 2 Conference held in the fall. Work begins around the end of the year, within months of the one just completed, as much time is involved to insure its success. A coordinator is selected from each chapter, most often a past president, as they have the experience running sessions and conferences. Recently we have had a few great volunteers from those who have not served that leadership role. Some coordinators serve a one-year term, while others continue the role over 2-3 years, dependent on each chapter's selection process. The coordinators that Teresa and I are fortunate to work with this year are Chris Etsler (Rochester), Christine Blidy (WNY), Cindy Strain (Metro), Karen Richards (Northeastern), Scott Rau (Central NY), Raphael Rodriguez (Puerto Rico), and Will Scheuermann (Hudson Valley). Each brings something to the table, not only in the planning stages, but during the event as well.

The team is currently working on completing the program, listing not only a myriad of keynote and breakout education sessions, but also several networking events. Please Save-the-Dates of October 9th – 11th, for this year's conference at the Turning Stone Resort Casino, noting the following sessions being offered:

- **KEYNOTE SPEAKERS:** 2013-14 National HFMA Chair, Steve Rose, Inspirational Speaker, Lauren Manning, National Health Care Policy Expert, David Merritt, & Dr. Jonathan Niloff, for a session on Analytics
- **BREAKOUT TOPICS:** Accounting, ACO's, Insurance Exchanges, ICD-10, Revenue Cycle Best Practices, DSH, Long Term Care, Pre-payment Audits, Legal & Compliance, Beacon Project, Denial Management & Mergers & Acquisitions

In closing, I'd like to encourage everyone to take advantage of all HFMA has to offer, especially Region 2 and its upcoming Fall Conference. Through its leaders, coordinators, and all other chapter volunteers, education programs are provided to bring back tools to use in your job, and networking opportunities, to enjoy the ride along the way!

2012-2013 CHAPTER LEADERS

Committees

Patient Financial Services:
Susan Brown
John Galley

Patient Access:
Susan Brown
Peggy McDonough

Chargemaster:
Jessica Landers
Cheryl Loverdi

Reimbursement:
Russell Previte
Paul Sweet

Sponsorship:
Deborah Cudzilo
Larry Nowak

Newsletter:
Stephanie Bottomley
Jill Johnson

Davis Chapter Management:
Rachel Davis

Founders:
Susan Dybas

Past Presidents:
Jennifer Dunn

**If you are interested in becoming involved in the Chapter, contact Jennifer Dunn, Chapter Volunteer Coordinator at jdunn@kaleidahealth.org.

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A YEAR IN REVIEW

MARY MAHANEY, EDUCATION CO-CHAIR

You are probably wondering what's with this title? We are only nearing the end of April! Well, our chapter year actually starts June 1st and ends May 31st in the next year, so really we are winding down.

The questions I pose now are these:

- Did we meet your needs in education this year (2012-2013)?
- Is there a topic we should have addressed with an education session and did not?
- What are the topics you absolutely need to see for 2013-2014?
- What topics are interesting to you on a personal development level?

It is essential that we know what you are interested in, so that we can plan for the next education year. It is our goal to ensure that our chapter provides the education that is important for you and your organization.

Please do not remain silent and let the larger organizations be your voice. All organizations of every size are our customers! Although some topics are germane to all, there may be some services or processes that are specific to your organization or are limited to only a few hospitals.

What about physician billing topics? There are physician billing groups and there are organizations that bill physician services as well as acute services.

What about personal development classes such as Excel, PowerPoint etc?

If you were not aware, we have wonderful sponsors that provide money each year to help us provide education sessions that are relevant, accurate and most importantly cost effective. We acknowledge their generosity always and appreciate their commitment to our chapter.

So no, it is not Christmas where I am asking you to make a list for presents, but please do make a list of education topics that you would like to see and send them to the Education Co-Chairs.

Your education co-chairs for 2013-2014:

Robert Levesque-Blevesque2@Verizon.Net

Mary Mahaney-MMahaney@Kaleidahealth.Org

Thank you

2013 Annual Cost Report Briefing and Workshop

Russ Previte, Reimbursement Committee Co-Chair

On Monday, April 8, 2013, the Annual Cost Report Briefing and Workshop was held at the Terry Hills Golf Club in Batavia, NY. Jointly sponsored by the Rochester Regional and Western New York Chapters of HFMA, this all day session dealt with the changes and filing requirements for the Hospital Institutional Cost Report (ICR) in the morning session, and the Nursing Home cost reports in the afternoon session.

The day started off with a presentation from Jane Casale of the New York State Health Dept. regarding cost report changes for 2012, and filing procedures. Then Don Fry and Joe Sellars of KPMG demonstrated certain aspects of the ICR software, and presented changes and special items to watch out for.

This was followed by a presentation by individuals from National Government Services (NGS), who discussed items specific to Medicare. Angie Tyson, Sandy O'Connor, and Christine Chamberlain, discussed several items of importance such as staffing changes at NGS, the status of SSI reopenings, a new portal for submission of documents called Connex, filing requirements and an update on reimbursement issues.

Both the Medicare CMS -2552 and Medicaid ICR cost reports for 2012 are due on May 31, 2013.

The Long Term care session in the afternoon began with a presentation of regulatory updates from Pat Cicinelli, of LeadingAge New York (formerly NYAHSA).

This was followed by a session on the changes in the Medicaid RHCF-2 and RHCF-4 presented by Matthew Boswell, followed by changes and preparation tips from Janine Mangione, both of The Bonadio group.

The Medicare CMS-2540 is due on May 31, 2013 but the RHCF reports are not due until July 31, 2013.

Once the Hospital ICR software is released, the Reimbursement Committee will begin weekly Friday morning meetings at 8:00 at the Western NY Healthcare Association offices to discuss issues and problems with the current year reports. All individuals are invited to attend or call in if more convenient.

For further information on the Reimbursement Committee of the Western NY Chapter of HFMA, contact Committee Co-Chairs Russ Previte at 298-2770 or russell.previte@msmh.org, or Paul Sweet at 512-7106 or PSweet@wnyha.com.

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Thank you to all Chapter sponsors for their support.

Welcome New WNY Chapter Members:

Ashley Bauer
KMPG LLP

Carol Cassell
Principal - Strategy & Performance Improvement
Freed Maxick

Justin Cuviello
Senior Account Representative
CCAB Medical

Frederick DiStefano
Chargemaster Manager
Erie County Medical Center

HFMA Revised Maintenance Requirements

Robert P. Levesque, Certification Co-Chair

Effective December 2012, the HFMA Board of Examiners revised the certification maintenance requirements. This applies to members who have earned either the CHFP or Fellow of HFMA designation.

To retain certified status with HFMA, certified members are required to remain an active member in good standing annually as well as maintain their designation every three years through participation in relevant professional development activities. The revisions relate to these activities.

Previous requirements:

- Complete 90 contact hours in eligible education programs every three years. At least half of these contact hours must be in healthcare finance-related topics and at least 20 contact hours must be completed in each of the three years.
- A contact hour is 50 minutes of continuous programming, excluding meals, breaks, or social activities.

Revised requirements:

- 90 contact hours of eligible education activity has been reduced to 60 hours across the three year maintenance cycle.
- Clearly defined list of eligible education activities covering specific content domains.

The reason for the revisions is that maintenance activity will be more clearly tied to current defined practice standards.

HFMA recommends that all certified members review the revised education activities, the online reporting tool and certification maintenance web page. Doing so will help familiarize the certified member with the maintenance process.

Eligible Certification Maintenance Activities

Continuing education eligible for certified maintenance includes but not limited to: seminars or conferences, workshops, educational offerings sponsored by your employer, webinars and e-learning self-study courses. All activities must be related to one of the following topic areas: Revenue Cycle, Disbursement, Budgeting/Forecasting, Internal Control, Financial Reporting or Contract Management functions. These competency topics are very broad. A specific topic you have that is not listed here might fit in one of these areas.

A more detailed listing of Certification Maintenance Information is available at www.hfma.org. If you have any questions, contact the Career Services Department at 1-800-252-4362 or email certification@hfma.org.

HFMA Revised Maintenance Requirements

Continued

Certified members must show evidence of maintaining their CHFP or FHFMA designation every three years. The three-year reporting period ends on May 31 of the "good through" year shown in each member record and begins on June 1 three years prior to their "good through" year.

Failure to meet the maintenance requirements by May 31 of the "good through" year will result in removal of the member's designation on September 1 of the "good through' year. The designation must then be re-earned by successfully completing the required certification exams and meeting the other requirements for certification. Also note that failure to renew the member's HFMA membership can also lead to removal of their designation.

It is the member's responsibility to self-report their education activities using the online reporting tool. The only activities that do not need to be self-reported are activities sponsored by HFMA National for which the member has received CPE credit.

Maintaining HFMA certification:

- Demonstrates commitment to the highest standards of professional practice and a dedication to quality healthcare;
- Provides value to the employer and the public through continued refinement of professional skills and expertise;
- Positions the member to assume increased leadership within their organization and the profession.

The WNY Chapter presently has twenty-three members who have obtained and maintained CHFP and/or FHFMA designation, which represents 12% of the membership and exceeds the National average. If you are currently certified, do not let your certified designation lapse. There are many eligible activities available to help maintain certification. The Certification Committee will continue to offer assistance to certified members as well as those who wish to become certified.

Certification Committee:

Robert P. Levesque, FHFMA, CPA – blevesque2@verizon.net

John P. Eichner, FHFMA, CPA - jeichner@ecmc.edu

Welcome New WNY Chapter Members:

Betty Gillespie
Senior Manager
Accenture

David Palumbo
Accountant
Niagara Falls Memorial Medical Center

Shari Salemi
Billing Clerk
Brooks Memorial Hospital

Annual Spring Institute

Kristin M. Anderson

Kristin M. Anderson

The western New York chapter of HFMA presented its annual spring institute to an audience of 47 on March 21, 2013. Vendors and attendees had the opportunity to learn about recent developments in the healthcare industry during a day of education. Jeffrey Jacobs, chair of the education committee, welcomed everyone to the Millennium Hotel. Christine Blidy then introduced the first speaker, Don Ingalls, Vice President of State and Federal Regulations for Blue Cross Blue Shield. Don built on last year's presentation by reviewing the impending health care reform mandates. Some of the more important changes include a 90 day limit on waiting periods, elimination of pre-existing condition exclusions and employers shared responsibility. These changes begin January 1, 2014. Also beginning January 1, 2014 will be new taxes to fund various elements of the Affordable Care Act. The comparative effectiveness fee will add $1 per member per month in 2014, and $2 thereafter. This fee will fund a federal Patient-Centered Outcomes Research Institute. The Reinsurance Tax will add approximately $5.25 per member per month. The level of risk in the state pools is an unknown cost. This fee is intended to cover the reinsurance pool of the state pools. The final tax is a tax that will add approximately 2.3% to premiums in 2014. Don noted that "the industry is afraid this is driving up costs in an era when we are trying to make it more affordable." He briefly reviewed the Pay or Play penalties for groups over 50 full time employees who do not offer qualified, affordable coverage. Future changes include discrimination rules for insured plans that will be similar to those that apply to self-insured plans, automatic enrollment for companies with more than 200 employees, and an excise tax on "Cadillac" plans. He closed with decisions that businesses must assess as they enter 2014. Employers of all sizes are analyzing whether they should drop coverage and pay the penalty, adopt or continue high deductible plans, or adopt or continue traditional or self-insured plans. The impact of these new regulations will only be known as they are implemented.

Melanie Strange, Project Coordinator, External Affairs, Outreach and Marketing for the NYS Department of Health followed Don Ingalls with an introduction to the New York Health Benefit Exchange. The Exchange will allow individuals, families, and small businesses to shop

and enroll in qualified health plans including Child Health Plus and Medicaid. The Exchange is expected to be available in October 2013, with coverage effective January 1, 2014. Anyone will be able to use the Exchange, but those who are between 138 and 400 percent of the federal poverty level will receive a premium tax credit, and those who are between 100 and 400 percent of the federal poverty level and enrolled at the silver plan level will be eligible for a cost-sharing subsidy. Melanie stressed that the Exchange is meant to walk people "through the process in 'Turbo-tax' fashion." The Exchange will contain enrollment and other information and a toll-free telephone hotline will be available. It will calculate tax credits and cost sharing, determine eligibility, allow people in public plans to enroll, and help people choose the plan that is best for them. The Exchange is mandated to offer qualified health plans that meet the 10 ACO required benefit categories. New York State has selected Oxford EPO as its benchmark plan. Details are available at www.healthbenefitexchange.ny.gov. The website also provides information on the coverage levels that will be available, the 10 mandated essential health benefits as well as historical information on the development of the Exchange. New York State has received $368.9 million federal dollars to date to develop and implement the Exchange. Open enrollment begins in October 2013. The first year, open enrollment will span six months in order to accommodate the expected influx of new enrollees. The Exchange will phase in to accommodate larger employers by 2017. The Urban Institute was engaged to study the expected effect of the Exchange on New York's uninsured population. The study concluded that approximately 1 million of the current 2.7 uninsured New Yorker's will opt to purchase coverage through the Exchange. The study also concluded that premiums will decline in the small group and individual market. This, along with $2.6 billion in federal tax credits per year for individuals and small businesses are projected to reduce the burden of cost of coverage. To facilitate enrollment, New York will provide enrollment assistance in person, online and through phone and mail. The IT platform is in development, and expected to be available for use by open enrollment later this year. This spring, the Exchange will develop an outreach strategy, plan its media and education campaign, continue surveys and focus group testing and create a name, brand and logo strategy. The summer will see a roll out of marketing materials and large outreach campaigns. As we enter fall and open enrollment season, a large advertising campaign will be launched using TV, radio, online, print, bill boards, and awareness events. During the question and answer period, Jennifer Dunn inquired if the method of enrollment mattered for Medicaid recipients. According to Melanie, it does not. Regardless of how a patient enrolls in Medicaid, whether via the Exchange or traditional methods, they will still be considered a straight Medicaid patient. It is expected the Exchange will function as a clearing house. A provider will still receive reimbursement from the insurer, and premium payments will flow through the Exchange to the insurer.

ANNUAL SPRING INSTITUTE

CONTINUED

Another participant asked how the Exchange will function once the federal subsidy ends at the end of 2014. New York State is studying that now. Another question asked was what happens to the remaining uninsured population, and the expectation is that people will still remain uninsured, but they will be "taking their chances." Further questions can be directed to exchange@health.state.ny.us.

Participants enjoyed a short break between the morning sessions when they could visit the vendors who help make the Spring Institute possible each year. Vendors included Passport Health, PNC, Xtendhealthcare.net, REV Spring, Inc., Client Financial Services of MI and The White Stone Group, Inc. Participants enjoyed the information on health care reform and on the Exchange. Bruce Liebel said "Information on the insurance exchange was comprehensive and informative. The Question and Answer period was very good." Christine Blidy commented the "information on the exchange was extremely timely, and gives us a better idea of what to expect and how it will impact our industry."

The final group session revealed ways to strengthen communication in the revenue cycle. Rebecca T. Black, Vice President of Revenue Cycle at Southern Regional Medical Center in Riverdale, GA spoke about the cost of "communication chaos." According to studies, $12.6 billion a year, or about 2% of hospital revenues can be gained by creating better communications systems. Rebecca put this in perspective with numbers. At a hospital system whose gross revenues are $1 billion, approximately $4.5 million is lost to denials, and most of this can be avoided with better communication. Other causes of lost revenue include delayed accounts receivables, rework, wasted time, frustrated customers, wasted materials and physician dissatisfaction. "Revenue is a team sport" said Rebecca, and it starts with Patient Access. Obtaining the correct information to schedule a procedure, handling information between the patient and the provider and between the insurer and provider are all key aspects to getting it right from the beginning. It is important to "document any and all conversations with patients so you can refer to it if the patient experience turns sour" recommends Rebecca. To make sure the conversation is documented accurately, Rebecca advocated recording all calls. She said the benefits extend beyond merely documenting a conversation in real time. It is also a "great QA tool" because it allows the staff to hear themselves. She said it "hits the person between the eyes" and they immediately experience how they come across to customers. Often times, the only education an employee will need is to hear their own voice. Recording conversations with insurance companies and physicians are as important as with patients.

Rebecca emphasized that "the 'norm' can no longer suffice" and a common platform must be used to capture all data and communication. She painted a picture of a biller's desk with sticky notes that pertain to a patient, but that contradict sticky notes at patient access for the same patient. "A central repository is needed so the information is all in one place and cohesive," said Rebecca. St. Joseph's Hospital of Atlanta, a 410-bed acute care facility, implemented just such technology in all areas of the revenue cycle. Rebecca recounted two experiences which proved her point. In one case, an insurance company denied two procedures stating they had never been authorized. A review of the conversation revealed they indeed had been authorized. After sharing the memorialized conversation with a manager at the insurance company, the denial was reversed. In another instance, a physician was convinced the hospital staff was incompetent and rude to his secretary. When he listened to recorded calls, the truth was revealed. He immediately apologized to the hospital manager, complimented her staff on their patience and tact, and started referring more patients to the hospital. He is now one of the hospital's champions. Memorialized conversations and documentation remove the "he said-she said" scenario and contribute toward solutions rather than finger-pointing. Rebecca concluded by listing the benefits of using a cohesive system for documenting communications. In her experience, it allows staff to prove they are doing a good job. It is a quality assurance and training tool for staff, which leads to better customer service and increased patient satisfaction. Finally, it leads to improved relationships with physicians and between different departments.

After lunch, attendees had the option of attending one of two breakout sessions, and could choose between investment strategy or an update on bad debt and charity care. The investment strategy focused on looking at an entity as a whole. Chris Seidl, Director for SEI's Institutional Group related that organizations too often take a fragmented view of their investment portfolio, segregating funds for investment according to each fund's purpose. He advocated evaluating risk on an enterprise-wide basis and provided an example of a children's hospital that had investments at both the hospital and a related foundation. The hospital and the foundation had traditionally evaluated their investment allocations separately. By taking a global view of the entire organization, evaluating risk for both entities and analyzing future spending plans for both organizations, the investments were re-allocated and earnings for both entities increased.

Stewart Presser of the Greater New York Healthcare Association presented changes the Affordable Care Act (ACA) will have on Disproportionate Share Payments (DSH), updated the audience on the IRS proposed Financial Aid rule, relayed state budget changes to the Indigent Care Pool, and provided an overview on a recent CMS Administrator's Rule and NPRM on Inpatient Part B billing. Under the ACA, hospitals will keep 25% of their DSH funding under the current formula.

ANNUAL SPRING INSTITUTE

CONTINUED

The remaining 75% will be redirected to a national uncompensated care pool, and those pool funds will be distributed under new criteria. The Pool will be undergo a projected phase down from $11 billion to $4 billion. In theory, the reduction in DSH payments will be offset by the increase in new revenue from expansion of insurance coverage to previously uninsured individuals. New York State finds it necessary to change its DSH distribution method to comply with the ACA's priorities. A Medicaid Redesign Team workgroup revised the Indigent Care Pool distribution formula by removing bad debt and adding Medicaid inpatient volume. The new formula will be phased in with losses capped at 2.5% in 2013, 5.0% in 2014, and 7.5% in 2015. The MRT Workgroup will revisit the policy in 2016 and beyond. Stewart ended his presentation with a recap of the new CMS rule that would allow hospitals to bill inpatient Part B services when an inpatient admission is denied for medical necessity and ends the Part A to Part B demonstration project that began in 2012. The Rule is a reaction to the overloaded Medicare appeal system that is backlogged with thousands of appeals.

The final speakers of the day discussed managing risk in defined benefit pension plans and Medicare compliance/ medical necessity. John Waite, Chief Actuary of SEI's Institutional Group, gave an outlook on, and strategies for managing, defined benefit plans. He expects rates will come down, but liability losses may increase in the short term. It is generally thought that the Feds will keep rates low until 2015. The asset outlook is unclear, but it seems we can expect long-term growth, but short-term growth will be slower than in recent history. John explained that the current market could be beneficial to offering lump sum payouts to participants. The benefits include the opportunity to offer payouts below current market value because of the low interest rates, reducing the accounting funded shortfall, reducing future administrative costs by reducing participant population, and removing investment interest rate and longevity risks for those who accept the lump sum payout. Many considerations are inherent in the decision. The complexity and size of the plan and the amount of the service plus interest costs are among those considerations.

Those who attended John Zelem's presentation regarding compliance challenges learned best practices for audit success and the target areas of the Medicare auditors. It seems that audits are revealing increased improper payments, yet neither regulations nor procedures have changed. What has changed is the contractors interpretation of the regulations. According to John, "if providers don't challenge them, the new interpretations become the new rules."

It is little wonder that denials and improper payments have increased with the increase in oversight from the Department of Justice, the Office of the Inspector General, Recovery Auditors, MAC, and CERT audits, and that is just on the federal level! The DOJ is currently focusing on defibrillators, NCDs, kyphoplasty, referrals from other government contractors and qui tam, or whistleblower, cases. The OIG is looking at coding/implications, short stay procedures, canceled surgeries, readmission, high-cost cases, technical issues and patterns of fraud. Recovery auditors are reviewing cardiovascular procedures for medical necessity and minor surgeries that are billed as an inpatient stay. The recovery audit firms have received $81.9 million in contingency fees on $488.2 million they returned to the Medicare trust fund. The MAC contractors are auditing hospitals and physicians, doing prepayment reviews and focusing on medical necessity. It appears that the guidance provided is inconsistent with statutes, regulations and manuals. According to John, in today's audit environment, an audit is likely imminent. He stressed that if providers do not appeal, the contractor's interpretations become the new standard. Inappropriate denials must be appealed! When a notice of an audit is received, it is important to ask three key questions: Who does the audit involve? Do the charts need to be reviewed? Is legal representation needed? Communicate quickly and engage all relevant parties. Up front and consistent preparation will reduce the likelihood of a higher recovery amount. Ensure that medical staff understand the importance of proper documentation procedures, be prepared to defend the decisions made by clinical staff and to advocate for their rights. It is critical to detail why the care provided was deemed medically necessary in the inpatient setting. The judgment of the admitting physician, reference to CMS manuals, and citation of relevant standards, clinical guidelines and national best practices should be noted. The strongest defense against inappropriate denials is a consistent front end process. Make sure admissions decisions are based on clinical and regulatory evidence and best practices, and those decisions must be documented accurately and with enough detail to support the admitting physician's decision when reviewed after time has passed.

On The Social Side...

Bruce K. Liebel, Social Co-Chair

WNY HFMA held its 6th Annual Euchre Tournament on Saturday, March 9th, at the Forestview Restaurant. A rotation of players, both winning and losing partners during the seven games, allowed for a great night of networking and fun!

Tournament Winners (l - r): Jill Johnson (3rd place), Andy Johnson (1st place), John Haberstro (2nd place), Katie Biggie (4th place)

Steve, Erica and Emily

Editorial Policy: Opinions expressed in signed articles are those of the authors and not necessarily those of the WNY Chapter of the newsletter committee. The committee believes the contents of *Fine Print* are interesting and thought provoking, the staff has no authority to speak for the Officers or Board of Directors of the WNY Chapter of HFMA.

Evelyn and Daria

Steve Chizuk's Group

Kristen Chapman & Bill Lang

Asset Price Inflation: Contributors and Consequences

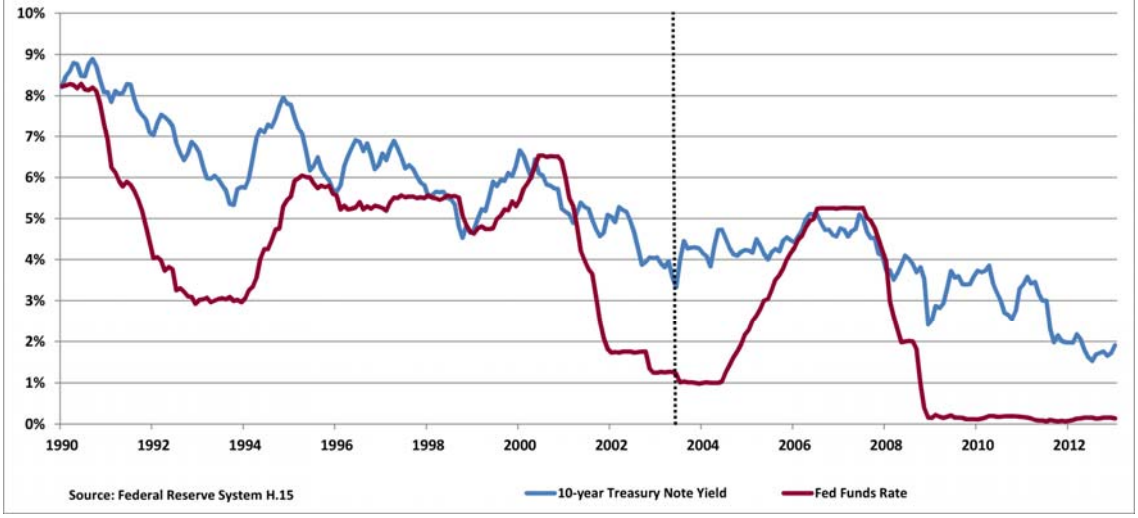
Conventional wisdom has that looking back to the past often is the best way to prepare for the future. If that's the case, let's take a look back at recent history in regards to the Federal Reserve Board (the Fed) in regards to asset prices.

The U.S. equity markets were recovering from the bursting of the tech bubble in 2000 as the economy slipped into recession in 2001. The desire of the Fed at that time was to reduce market interest rates in order to stimulate economic activity largely through increasing expenditures on capital goods by reducing financing costs.

After touching a low of 3.13% in June 2003 (as noted by the dashed line in Figure 1), the yield on the 10-year Treasury note began to move upward, even as the Fed had pushed the target federal funds rate to 1%. Rising 150 basis points to over 4.6% in less than three months, the 10-year Treasury note continued to move higher, reaching a cyclical peak of 5.25% in June 2006.

Throughout this period, the Fed also sought to improve bank balance sheets by reducing short-term interest rates as a way to reduce a bank's cost of funds. Coupled with stable and somewhat higher long-term (i.e., lending) rates, bank net interest margins (NIM) began to improve. Net interest margin is the difference between the lending rate and the banks' cost of funds. A higher NIM generally results in improved profitability and stronger balance sheet. A stronger balance sheet, in turn, increases the banks' capacity to lend, injecting liquidity into the capital markets. However, an increased capacity to lend does not automatically result in an increase in loan volume. This was especially true for the period after the credit market freeze of 2008.

Figure 1: U.S. Interest Rates 1990-2012



According to the Federal Reserve Bank of St. Louis in October 2012, between the fourth quarter of 2008, when the Federal Open Market Committee reduced its federal funds target rate to virtually zero, and the first quarter of 2010, the net interest margin increased by 21%, its highest level in more than seven years. The bank's report concluded that the amount of commercial and industrial loans on bank balance sheets declined by nearly 25% from its peak in October 2008 to June 2010.

The dearth of lending was an extreme reaction to an overheated real estate market, driven in part by easy money of the previous period. Although there were few professionals who could foresee the extent of the credit market freeze, some market observers believed that the low interest rates of 2003 and 2004 may have contributed to excessively high asset prices.

In April 2006, after a sustained period of low interest rates, former Federal Reserve Chairman Alan Greenspan warned of an overabundance of liquidity that would result in an asset price decline. Speaking to the Asian Financial Centers Summit in Seoul, Korea, Greenspan noted that the market value of assets had been rising faster than gross domestic product growth, as a result of a "decline in real equity premiums" and the decline in real long-term interest rates. He went on to say "that cannot go on indefinitely."

Asset Prices and Interest Rate Sensitivity

Although housing investments tend to be more interest rate sensitive, equity investments also tend to react to a low interest rate environment. Greenspan considered the value of this very liquid and widely dispersed asset to be at risk as well. The Dow Jones industrial average was at 11,000 at the time as the United States was nearing the end of the housing boom.

The increase in short-term interest rates shown in 2005 and 2006 (Figure 1) was intended to stave off unwarranted asset price increases while addressing the possibility of an increase in inflation. The short-term rate increases did nothing to mitigate the upward momentum of the stock market as the Dow continued its ascent until October 2007, when it exceeded 14,000. Nor did the market perceive a significant inflationary threat.

A year later the Dow had fallen below 8,400, on its way to an inter-day low of 6,469 in March 2009. in less than 18 months, the euphoria of ever-increasing stock prices had turned into panic. Just as equity investors saw in the 1987 crash, pundits compared the stock market decline to that which precipitated the Great Depression. Concurrent with the stock market decline and to encourage the availability of credit, the Fed responded by quickly reducing short-term interest rates from 5.25% in October 2007 to nearly zero in December 2008.

Back to the Future?

Well into the recovery period after the Great Recession, the Fed has maintained a low interest rate posture and has even provided market participants specific triggers before deciding to modify its existing interest rate guidance, such as

(continued next page)

inflation and unemployment targets. In existence for over four years, the cycle of low short-term interest rates continues today as the Fed Funds target rate remains near zero. Over the same period, the 10-year treasury yield has fallen from 5.25% to about 2% today.

The current low interest rate environment has affirmed its contribution to an increase in asset prices, as the Dow has again traded above 14,000 (Figure 2) and housing markets are showing signs of recovery.

The Fed Response

The Federal Reserve Bank has access to financial tools not available to any other market participant. In addition to open market activities, including repurchase agreements and the issuance of treasury bills, notes and bonds, the Fed has expanded powers to include the purchase and sale of federal agency debt and mortgage-backed securities. Use of these tools has contributed to a significant reduction in both short-term and long-term interest rates.

In spite of these tools and the advantage of employing some of the greatest economic minds of our time, recent history has shown that the Federal Reserve Board cannot sufficiently anticipate and seemingly cannot prevent a substantial decline in asset prices, most notably equity and real estate markets, even when the Fed ostensibly caused the asset price increase through a sustained low interest rate environment. The response from the Fed is reactive at best.

Logically, investors should not rely on the Fed for guidance through its open market activities as a leading indicator of future asset values. Nor should investors become distracted by the euphoria of ever increasing asset prices. Rather, disciplined investors should review their unique risk profile and adjust asset allocations accordingly, being mindful of new market risks while being a student of history.

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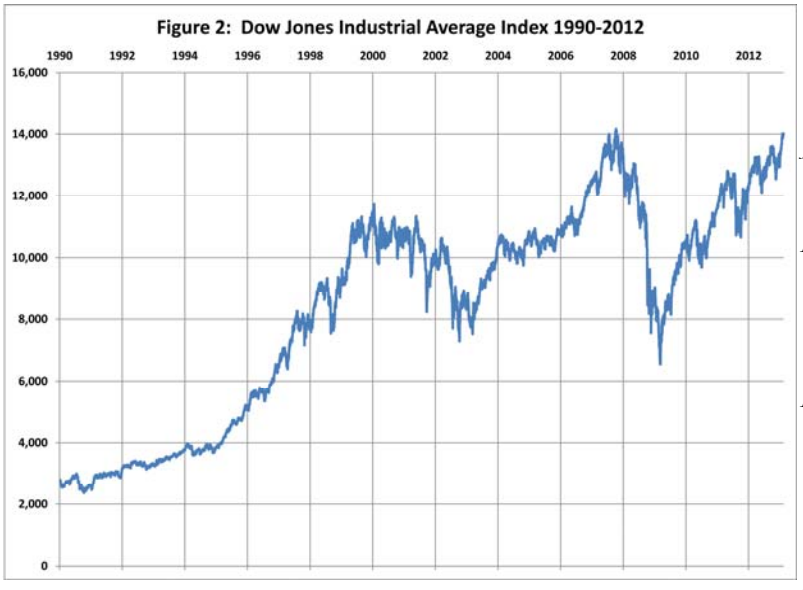

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