



hfma™

healthcare financial management association

Volume 21 Number 4
April / May / June 2009

gulf coast lines



HFMA Texas Gulf Coast Chapter 2009 Annual Meeting & Conference *The Healthcare Roller Coaster...*



May 14-15

**Marriott Westchase Hotel
2900 Briarpark at Westheimer**

12 CPE Hours

Topics Include:

National Legislative Update: Healthcare in the Obama Administration

Jeanne Scott

Texas Legislative & Regulatory Update

Susan Feigin Harris - Baker Hostetler

Surviving the Hurricane of Change

B.J. Huffman - Learning Interventions

How to Make Yourself an Indispensable Resource

Todd Dixon & Ted French - Acclivity Healthcare

Education, Training & Expectations: Understanding Workforce Diversity

Suzanne Lestina - Healthcare Financial Management Association (HFMA)

Pay for Performance

Suzanne Lestina

Business Continuity Planning

Terry Cooper, FACHE, MBA - U.T. M.D. Anderson Cancer Center

Registration & Details

Printable Brochure

June 12 Program

The Crisis in Healthcare and its Impact on You in 2009

Attend the June Luncheon to hear a multifaceted discussion of the current crisis in healthcare as well as thought provoking conclusions regarding the implications of this crisis from several important disciplines. Perspectives include:

- **A Political Perspective: The Obama Plan** - John Boettiger, Jr., Deloitte Financial Advisory Services
- **A Provider Perspective: The Impact on Care** - James G. Springfield, President JGS Consulting, LLC, Former CEO Valley Baptist Health System
- **An Insurance Perspective: The Impact on Availability and Cost** - Lorraine N. Lewis – Alliant Insurance Services
- **A Financiers Perspective: The Impact on Healthcare Financing** - Dan Cain, Cain Brothers & Company

See "June Program" page 2

Conference Location

Marriott Westchase Hotel - Houston
2900 Briarpark Dr.
Houston, Texas

[Map & Directions](#)

Complimentary self parking

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Message from the President

By Cindy Price, FHFAM, Chief Operating Officer
HCA – Shared Services



Cindy Price, FHFAM is Chief Operating Officer for HCA-Shared Services. She also serves as the 2008-2009 President for the HFMA Texas Gulf Coast Chapter.

As unbelievable as it seems, we have almost completed another Chapter year!

I have just returned from our HFMA Texas Statewide Conference in Austin, which was an overwhelming success. All three of the Texas Chapter memberships and healthcare communities participated in the two day education session validating the value of our mission, which is to be an indispensable resource for healthcare finance. In today's challenging economic environment, our ability to provide professional development opportunities locally, in a cost effective venue, continues to increase HFMA's membership value.

As we look forward, be sure to mark your calendars for our Annual Symposium on May 14th and 15th, at the Houston Marriot Westchase Hotel. "The Healthcare Roller Coaster...Surviving the Ride" is the theme of this year's conference. The formal installation of our new Board Members and officers will take place during this conference.

As we near the end of my year as President, I want to thank our Chapter leaders and Officers who have served you this past year. They have contributed well beyond expectations and made considerable career and personal sacrifices to help build a foundation that will allow our Chapter to progress during the most challenging of economic times. It has truly been rewarding to serve with such committed leaders. Additionally our Chapter could not have provided the quality programs without the generous support of our Sponsors.

Thank you for the opportunity and support you have given me during my year as President. We have such an exciting and rewarding year ahead of us!

Sincerely,
Cindy Price, FHMA 

June Program

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About the Speakers



John Boettiger, Jr.

John is a principal with Deloitte Financial Advisory Services, LLP. He has served clients in all sectors in the healthcare industry, their boards, officers and legal advisors. John will share with us insights from the Washington, D.C.-based Deloitte Center for Health Solutions. The organization was founded in 2004, to further research and develop solutions to some of the nation's most pressing healthcare and public health-related challenges. Tommy G. Thompson, former Secretary of Health and Human Services and

former Governor of Wisconsin, is the Independent Chairman of the Center.

John has more than 12 years of experience in consulting work including business valuation, purchase price allocation, litigation support, and regulatory compliance. He has been engaged by attorneys as a consulting and testifying expert in a number of cases. He has a Bachelor's of Business Administration and a Master's of Business Administration from the McCombs School of Business, The University of Texas at Austin.

[See "June Program" page 3](#)

Save the Date Calendar of Events

May 14-15

Annual Meeting

The Healthcare Roller Coaster...Surviving the Ride
Marriott Westchase Hotel

June 12

Monthly Luncheon

11:30a – 1p
The Crisis in Healthcare and its Impact on You in 2009
John Boettiger, Jr.
James G. Springfield
Lorraine N. Lewis
Dan Cain

July 17

Monthly Luncheon

11:30a – 1p
TBA

August 21

Monthly Luncheon

11:30a – 1p
TBA

Regular Luncheon meetings are generally held on the 3rd Friday of each month at 11:30 am. However, please confirm dates/times in advance.

Our regular meeting

location is:

Methodist Hospital
6565 Fannin
Dunn Rio Grande
Conference Room

Topics and Speakers subject to change.
Credit Cards accepted.

RAC'd with Uncertainty

by Scott McBride, Partner, Baker & Hostetler and Summer Swallow, Associate, Baker & Hostetler



Scott McBride is a partner with the law firm Baker & Hostetler LLP. He also served as the 2006-2007 President for the HFMA Texas Gulf Coast Chapter.

As providers nationwide prepare for the impact of the March 1, 2009, rollout of the Medicare recovery audit contractor (RAC) permanent program, they should study the experiences of those that have been wading in its murky waters for the past three years. Congress authorized the RAC demonstration in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) for the purpose of identifying past inaccurate payments under the Medicare fee-for-service program.¹ Over the course of the three-year demonstration, the RACs identified more than \$1.03 billion in improper payments.² The RAC demonstration program began in California, Florida and New York in 2005 and expanded to include Arizona, Massachusetts and South Carolina in the summer of 2007. Although providers in these states consistently raised concerns regarding the program's structure, scope and direction, Congress required the program to be a permanent part of Medicare in the Tax Relief and Healthcare Act of 2006.³

Initially, the RAC permanent program was primed to be implemented gradually, rolling out in the four geographic regions of the United States in three stages, beginning in selected states in late 2008, and continuing with full national expansion in place by January 10, 2010. However, this rollout was revised following the delay resulting from the protest filed by two unsuccessful RAC bidders for the permanent program. Following the Centers for Medicare and Medicaid Services (CMS) announcement identifying the four RACs chosen for the RAC permanent program, two unsuccessful bidders, Viant Inc. and PRG-Schultz, USA, Inc., filed a protest with the Government Accountability Office (GAO).⁴ PRG-Schultz, the RAC for the troubled California jurisdiction during the demonstration program, publicly stated that although it received one of the highest technical scores, it was not awarded a contract because it ultimately did not have the lowest contingency fee bid in any region. As a result of

[See "RACs" page 5](#)

June Program

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Jim Springfield, FACHE

Jim is President of JGS Consulting, LLC, a consultancy intended to work with hospitals and health plans on operational and strategic matters. Prior to establishing JGS Consulting, Jim was the President and Chief Executive Officer of the Valley Baptist Health System, the largest provider of healthcare services in south Texas. Valley Baptist is a not-for-profit organization that includes two acute care hospitals, one in Harlingen and another in Brownsville, Texas, health clinics, a health maintenance organization (HMO), a preferred provider organization (PPO), an ambulatory surgery center, a continuing care retirement community, a wellness center, and other outpatient facilities. He assumed this role in January of 2003. He came to Harlingen from Houston where he spent almost 13 years with the Memorial Hermann Healthcare System. While at Memorial Hermann, he held several leadership positions including serving as the Chief Operating Officer of Hermann Hospital. In addition Jim served as the Chief Executive Officer of the Hermann Children's Hospital.

Jim serves on numerous boards of professional organizations including the Texas Association of Voluntary Hospitals, the Voluntary Hospitals of America Southwest,

[See "June Program" page 6](#)

New Chapter Members

Julius Adeniy
BKD LLP

Prender Alderson
Coventry Healthcare

Jorge Arcilla
Methodist Hospital

Anthony Bristol
Metropolitan Neurology

Pamela Brooks
Methodist Hospital

Krystal Carter
St. Luke's Sugar Land Hospital

Sharla Clark
Baylor Health Care System

Marcus Coyle
Baylor College Of Medicine

Pam Dwyer
Methodist Hospital

Brad Gibson
U.T. - M.D. Anderson Cancer Center

Michael Gordon
CHRISTUS - St. John

Lynette Hunter, RN, CMAS
Methodist Hospital System

Adeola Ibrahim
Kelsey-Seybold Medical Group PA

Janika Johnson
East Houston Regional Medical Center

Jared Johnson
Sullins & Johnston, Rohrbach & Magers

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Access to the Capital Markets

By Jordan Melick, Managing Director, Morgan Keegan & Company Inc.

Access to the capital markets has changed drastically over the last year, particularly for healthcare systems and hospitals. Certain financing mechanisms (some of which were used extensively over the last ten years) are either no longer available or are available, but with much less favorable features, compared to what had been the case the last several years. However, even with these unfavorable changes, healthcare systems and hospitals still have access to capital, but at interest rates that are higher than in the past and with more restrictive conditions.

To analyze the last year, it makes most sense to take a historical perspective on the capital markets since 1990. The 1990's and the time period through 2006 were generally a time of very easy money as fixed rates were at or near all-times lows for most of this time period. Hedge funds became significant investors; 'AAA'-rated bond insurers broadened market access; credit spreads were extremely narrow; and the yield curve was very flat. Additionally, numerous other products, such as auction rate securities, variable rate demand notes, and interest rate swaps gained significant traction. While these products created some additional risks, they lowered borrowing costs even further. In 2007, conditions became a little tougher, but the capital markets were still generally very favorable. Rates increased slightly but were still low from a longer-term perspective, and newer, more complex debt products were still being used frequently. However, certain problems were beginning to develop, as subprime lending increased and default rates on mortgages increased. In 2008, the markets experienced many unprecedented events, most, if not, all of which had negative repercussions on access to capital. These included the downgrading of the 'AAA'-rated bond insurers and the subsequent collapse of the auction rate securities market, the nationalization of AIG, Freddie Mac, and Fannie Mae, the bankruptcy filing of Lehman Brothers, and the fire sales of Merrill Lynch and Wachovia, among others. All of these events triggered a massive "flight to safety" to three-month treasury bills. This extraordinarily large shift in investor appetite to treasury bills and away from stocks and bonds made access to capital extremely difficult, if not impossible, for the last quarter of 2008. So far in 2009, the capital markets have rebounded but remain quite different from how they were in the 1990's.

Therefore, at this point in time, there are basically only two debt products that are available to healthcare systems and hospitals, and these are fixed rate bonds and variable rate bonds with bank letters of credit. While both of these are viable, they are both less attractive than they were, even as short as one year ago. More specifically, availability and cost of fixed rate bonds favor stronger credits as many weaker credits have very little access to the fixed rate bond market at this time. Transactions that are completed are being executed at spreads to 'AAA' rates that are significantly greater than in the past. With respect to variable rate bonds with bank letters of credit, this product is actually working very well as the weekly or daily reset rates are extraordinarily low. However, the challenge is obtaining a letter of credit as banks have substantially reduced their interest in offering this product. Further complicating the process is the fact that banks have significantly more clout than in the past given the much reduced supply of letters of credit and are using this clout to demand non-credit revenues, increased pricing, shorter terms, and more stringent covenants.

...at this point in time, there are basically only two debt products that are available to healthcare systems and hospitals, and these are fixed rate bonds and variable rate bonds with bank letters of credit.

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New Chapter Members

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Joy Korth

Methodist Hospital System

Pamela Kutner

The Alexander Group

Karin Larson-Pollock, MD, MBA

The Methodist Hospital

Brian Liebknecht

Guardian Home Care, Inc.

Patrick Mathews

St. Joseph Medical Center

Carol Mitchell

Methodist Hospital

Michael Moriarty

Information Builders

Mary Oetken

Memorial Hermann Hospital

Donna Rumley

Methodist Hospital

Thomas Sanchez

Baylor College of Medicine

Franco Sieras

Methodist Hospital

Tamara Sword

U.T. - M.D. Anderson Cancer Center

Serpil Uludat

Baylor College of Medicine

RACs

from page 3

the protest, CMS was forced to impose an automatic stay in the contract work of the four permanent RACs. On February 6, 2009, CMS announced that the bid protests to the permanent RAC program had been settled.⁵ CMS released a revised map reflecting the amended two-stage RAC expansion schedule and showing the projected implementation date for each state.⁶ The RAC permanent program began in Texas on March 1, 2009. In March and April, CMS, the RACs and the state hospital associations will host RAC education sessions with RAC audit activity then expected to begin in May.

Target Areas

In the demonstration program, CMS allowed the RACs to unilaterally decide the types of claims they wished to target. Since the RACs are paid on a contingency fee basis, they stand to make the most return on their investment by structuring their claim review strategies on high-dollar improper payments, like inpatient hospital claims. As a result, hospitals accounted for 95 percent of overpayments collected by the RACs during the demonstration program, with 85 percent from inpatient services, 4 percent from outpatient services and 6 percent from inpatient rehabilitation facilities.⁷ In the RAC permanent program, CMS will have more oversight of the types of audits selected by the new permanent RACs. CMS has contracted with Provider Resources, Inc., to work as the RAC Validation Contractor (RVC). The RVC will work with CMS and the RACs to approve new issues the RACs want to pursue for improper payments, as well as perform accuracy reviews on a sample of randomly-selected claims on which the RACs have already collected overpayments. The look-back period will be counted starting from the initial determination date and ending with the date a RAC issues a medical record request (for complex reviews) or the date of the overpayment notification letter (for automated reviews). The initial determination date will be the claim paid date. However, RACs may not review claims with paid dates earlier than October 1, 2007. Although CMS will have more oversight under the RAC permanent program, providers should be aware of past RAC target areas in order to review and strengthen compliance in these specific areas. A report, released by CMS in July 2008, and updated twice since, details the outcomes and lessons learned from the RAC three-year demonstration program (Report). The Report reveals that most

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Capital Markets

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So, as we move forward, healthcare systems and hospitals should expect certain changes with respect to their debt. More specifically, fixed rate bonds will very likely have higher interest rates, require more security, and have tighter covenants. Variable rate bonds will be much more difficult to obtain and will have higher fees, decreased terms, and tighter covenants. Additionally, banks will demand a full relationship rather than just the letter of credit. Auction rate securities (which were used very frequently by healthcare systems and hospitals) have been eliminated as products to gain access to the capital markets due to the downgrading of the bond insurers. Interest rate swaps are still available and can offer significant advantages. In fact, swap rates are currently near all-time lows, which can translate to substantial savings. As with any product, their risks, as well as their benefits, need to be evaluated.

In conclusion, the events of 2008 dramatically changed access to capital for healthcare systems and hospitals as many unprecedented events occurred. As we move forward in this "new world", healthcare systems and hospitals still have access to capital through a reduced spectrum of products and with conditions that, in most cases, are less favorable than they were over the last fifteen years.



Certification News

**Next Exam Date
Friday,
September 11
at 9:00 a.m.**

Offices of Deloitte &
Touche, LLP
Three Allen Center
333 Clay, Suite 2300

Please contact Victoria
Nikitin at 713.566.4342
or e-mail at
Victoria_Nikitin@hchd.tmc.edu
if you are interested in
additional exam
information.

RACs - Target Areas

from page 5

common errors detected by the RACs include medically unnecessary (40 percent), incorrectly coded (35 percent), and no/insufficient documentation (8 percent).⁸

The RACs attempt to identify improper payments resulting from: incorrect payment amounts; non-covered services; incorrectly coded services; and duplicate services issues through use of software programs that analyze claims data (automated review) and through medical chart reviews (complex review). An automated review would highlight clearly improper payments such as duplicate surgical procedures. The RAC would then contact the provider to disclose the claim information and request payment. The RAC could perform automated review only when the improper payment was obvious or a written Medicare policy, Medicare article or Medicare-sanctioned coding guideline existed and precisely described the coverage conditions. On the other hand, in a complex review, a claim may not be clearly erroneous but rather identified as likely containing errors. In that case, the RAC could request medical records from the provider to further review the claim. Although the RACs were bound by Medicare policies, regulations, national coverage determinations, local coverage determinations, and manual instructions when conducting these complex claim reviews, concerns were raised during the demonstration program regarding the RACs' ability to adhere consistently to these guidelines.

The American Hospital Association ("AHA") has identified specific areas that the RACs targeted, including: (1) debridement (excisional versus nonexcisional); (2) incorrect selection of principal diagnosis (respiratory failure versus sepsis); (3) wrong diagnosis

[See "RACs - Target Areas" page 9](#)

June Program

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and the Texas Institute for Health Policy and Research. He is also active in numerous community and philanthropic organizations and holds a Paul Harris Fellowship with Rotary Club International and was appointed by Governor Rick Perry to serve on the Texas State Health Services Council. Jim is a recipient of the 2004 Robert S. Hudgens Award from the American College of Healthcare Executives as the Outstanding Young Healthcare Executive in the country and also that same year, Jim was named an Outstanding Young Alumnus of Baylor University. He is also a Fellow in the American College of Healthcare Executives (FACHE).

Jim has a Bachelor's of Business Administration from Baylor University in Waco, Texas and a Master's in Healthcare Administration from the University of Houston -Clear Lake.



Lorraine Lewis

Lorraine is a senior vice president of Alliant Insurance Services Houston LLC's Healthcare Division focusing on client development and service with emphasis on healthcare organizations. She has over 19 years of insurance brokerage and risk management consulting experience and five years experience with Alliant and/or its predecessor firms.

Lorraine's brokerage career includes nine years with Arthur J. Gallagher and five years with Aon Risk Services having specialized in healthcare and alternative risk financing techniques. Her background includes work with single parent, group and association captives, captive implementation, planning and strategy. She is a member of RIMS, GHSHRM, and ASHRM and has taught several insurance-related courses. Lorraine has been a

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Community Services Corner

by Lisa Dixon, Client Services Director
Cardon Healthcare Network



Lisa Dixon is a Client Services Director for Cardon Healthcare Network. She serves as the HFMA Gulf Coast Chapter's 2008-09 Community Service Co-Chair, Programs Co-Chair, and as a Director on the Board

Shriners Hospital for Children An Incredible Outpouring of Donations in Time and Money from our Chapter!

We kicked off our Community Service Project for Shriners Hospital on January 16 and collected \$615 in checks payable to Shriners Hospital. We also received a \$500 Target gift card that was used to purchase Bingo prizes and candy, and \$357 in monetary donations that was, in part, used to purchase Valentine Bingo Set, decorations, food, goodie bags and more candy for the party (detailed in the sidebar). The remaining monetary amount was donated to Shriners.

Thirteen HFMA members volunteered to host a Valentine's Party for the children at Shriners Hospital on February 18. We played Valentine Bingo and gave away prizes to the 9 children who attended. They enjoyed the cupcakes, drinks and goodie bags as well. LaKeisha, the Child Life Assistant, delivered gifts, goodie bags and cupcakes to the patients who were unable to leave their rooms.

Great fun was had by the children and our volunteers. My personal thanks to everyone who made donations to this project and to the volunteers who participated in the Valentine Party. I want to also say a special thanks to all the members of the Community Service Committee. You ladies are AWESOME!

Valentine's Party Prizes & Supplies

- Plates
- Napkins
- Gift bags
- Candy for tables, gift bags
- Table cloths
- Juice boxes
- Cupcakes
- Valentine Bingo Game
- Bingo game chips
- 2 MP3 players
- 2 Hannah Montana make up sets
- 3 CDS
- 1 Decorating kit for a birdhouse
- 1 Decorating kit for picture frames
- 1 Camp Rock Art Set
- 1 Remote control car
- 1 Star Wars Lego set
- 3 TV plug in games
 - 1 Transformer
 - 1 Yahtzee game
- 1 Battleship game
- 1 Clue game
- 1 Connect Four game
- 1 Magnext set
- 1 Scrabble game
- 1 Creator Legos
- 1 Chess, Checkers and Chinese checkers set



Shriners Hospitals
for Children™

Lisa Dixon
Cardon Healthcare Network
25231 Grogans Mill Rd., St. 100
Woodlands, TX 77380

Houston
Pediatric Specialty Care
Orthopaedic

LaKeisha R. Holmes
Child Life Assistant

February 26, 2009

Dear Ms. Dixon

On behalf of all of us here at Shriners Hospital for Children, we want to thank you for your very special contribution to our kids and families. The Bingo night was awesome! The patients and their families talked about the party all week. They kept going on and on about the great prizes and the delicious treats you all provided. They had a wonderful time.

When people like you reach out to our patients, it communicates love and support to our families, which in turn helps them through their hospitalization process. We realize that you gave not only of yourselves through your smiles and kind words to our patients, but also of your time and resources. We look forward to "partying" with you all again. Do not hesitate to give us a call so that we may schedule something in the future. We cannot thank you enough.

With Sincere Thanks,


LaKeisha R. Holmes



Extreme Ad Makeover – 3 Keys to Increasing the Effectiveness of your Next Job Posting

By Scott Sette, CPC, President, Kensington Group



Scott Sette, CPC, is the President and founder of Kensington Group, a search firm specializing in leadership positions for the healthcare industry.

Congratulations! You just found out that you have gotten approval for an additional FTE in your department. You immediately start thinking about all the benefits of having an additional employee – less overtime, more efficiency, better morale. Now, all you have to do is get that new person on board. So, you write a job posting for the position and it gets posted on your company website and a couple of job boards. Within a few days, you have hundreds of resumes. At this point, you're pumped up because you have lots of candidates to choose from! However, after spending several hours sifting through the applicants, you realize that *none* of them are who you want. For some of them, you don't even know why they applied because they have no experience relative to your new position. What went wrong? How can you attract your ideal candidate in a job posting?

I'm sure that most of us can relate to this situation. How can we attract ideal candidates to our job postings? The biggest problem that a hiring manager faces is that their job posting looks exactly like everyone else's. To attract the "A players" to your ad, you need to differentiate your posting from all the others. Here are 3 keys to improve the effectiveness of your job postings:

1. Start with a compelling title and introduction sentence

You want to grab an applicant's attention right away. Most job postings will have the title of the position and that's it. Boring. Every ad lists the title. In order to grab the attention of an "A player", you should make the title and first line of the ad captivating. Instead of saying, "Revenue Cycle Director" or "Accounting Manager", spice up the title and use "Revenue Cycle Royalty" or "Accounting Authority with GAAP Greatness."

2. Describe the position, not the person

The biggest problem with standard job postings is that they describe a person and not the position. The majority of the posting deals with the kind of experience the ideal candidate should have: years of experience, education, software knowledge, certifications, etc. This is used to screen out the unwanted candidates. However, it can also screen out some candidates that you want. For example, instead of mandating 10 years experience, ask yourself, "What can someone with 10 years experience do that someone with 8 years experience can't do?" If the answer is "nothing," then don't mandate 10 years because you will screen out some candidates who would otherwise be qualified. You can repeat this exercise for every "must have" in your job posting.

In addition to describing a person, the traditional job posting also lists a standard set of responsibilities. This list will talk about number of direct reports and some generic description of routine duties. This approach will never attract the top talent from the marketplace. In order to attract the "A players", you need to *engage* them. Include SMART objectives to describe what you want this person to accomplish (SMART stands for Specific, Measurable, Achievable, Realistic, and Time-bound).

You should create enthusiasm with your language. If you get these potential candidates to visualize what you want them to accomplish, then you will get their juices flowing and they will apply. Let's not forget who these people are. They are the employees who are excelling in their current positions. They don't regularly think about making a job change because they are successful in their current roles. They will be motivated to consider a new opportunity based upon the impact they can have on your organization, long-term career development, and increasing their knowledge base. So, to attract this type of person, your job posting should focus on those things.

3. Sell the sizzle

What is exciting about your company or this position? The question I always ask of a hiring manager is, "If I am a person who works for your competitor in this same

Has Your Contact Info Changed?

If you are relocating, changing jobs, changing e-mail addresses or phone numbers, don't forget to update your information on the National HFMA website at www.hfma.org, or e-mail your new contact info to memberservices@hfma.org

Also, please notify the Chapter office of your changes at 713.776.1314 or info@htmatxgc.org

[See "Ad Makeover" page 9](#)

RACs - Target Areas

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code (sepsis, septicemia versus urosepsis); (4) diagnosis-related groups designated as complicated or having comorbidity with only one secondary diagnosis; and (5) unit of service (multiple colonoscopies for the same beneficiary on the same day).⁹ Additionally, a number of medically unnecessary target areas have been identified including, such inpatient acute services as short-stay claims and outpatient versus inpatient surgeries. Short-stay claims were specifically targeted in Florida and New York. Large numbers of one-day stays were denied based on RAC determinations that the cases should not have been admitted for inpatient care because they were clinically appropriate for outpatient observation or other less-intensive care. A number of three-day stay claims were also denied because the RACs found the stay was inappropriately extended in order to qualify a beneficiary for Medicare Part A coverage of post-acute skilled nursing care. Specifically, medical back problems were commonly denied, finding the service medically unnecessary if they determined the care could be provided on an outpatient basis and the patient was primarily admitted for three days in order to qualify for skilled nursing coverage. Outpatient versus inpatient surgeries proved to be another target area. Procedures not found on Medicare's "inpatient-only list", must be well documented and provide a medical reason for performing the procedure on an inpatient basis. In addition, providers, when examining potential target areas, should look to the most frequent medically unnecessary errors, including chest pain (17.9 percent), medical back (17 percent), esophageal, gastroenterological and miscellaneous digestive disorders (10.3 percent), nutritional and miscellaneous metabolic disorders (10.3 percent), and blood glucose/reagent strips (10.1 percent).¹⁰

Objections to RAC Program


One of the most controversial aspects of the demonstration program, which remains in the permanent program, is the RAC contingency payment for detecting overpayments and underpayments. CMS selected three Claim RACs and two Medicare Secondary Payer (MSP) RACs for the demonstration. Through March 27, 2008, the RACs collected \$187.2 million in contingency fees for identifying improper payments.¹¹ According to the Report, this was the first time the Medicare program paid a contractor on a contingency fee basis. When CMS announced its selection of the four permanent RACs it stated that "selection of the new contractors was based on a best value determination for the Federal government that included a sound technical approach for the level and quality of claim analysis and detail to exceptional customer service, conflict of interest reviews and lowest contingency fee."¹² However, when two unsuccessful bidders under this selection process, PRG-Schultz, Inc. and Viant Payment Systems, Inc., protested the process, they were both awarded subcontractors positions.¹³ In an effort toward more transparency in the permanent program, CMS released the contingency fees to be paid to the permanent RACs, Region A - Diversified Collection Services, Inc. 12.45%; Region B - CGI Technologies

[See "RACs - Objections" page 10](#)

Ad Makeover

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exact position, then what would make me want to resign from my current position and come to work for you?" This could be something unique about the position (e.g. work with new technology, specific promotion track, create something from scratch) or the company (e.g. Best Places to Work awards, financial stability, stellar reputation in the industry). Whatever makes you stand out from the competition – SELL IT!

If you have any questions about improving the effectiveness of your next job posting, or if you would like some examples of postings that work, then contact me at 713-629-6161 or scotts@kengroup.com. I would be happy to help! 

HFMA Texas Gulf Coast Chapter Job Bank

Contact Dianne Love, PhD at love@cl.uh.edu to post job opportunities and/or to be added to the HFMA e-mail distribution group for future job opportunities.

HFMA National Job Bank

http://www.hfma.org/careers/job_bank_new.cfm

Arden and Richard
Rodriguez, 2005-06 HFMA
National President

RACs - Objections

from page 4

and Solutions, Inc. 12.50%; Region C - Connolly Consulting Associates, Inc. 9%; Region D - HealthDataInsights, Inc 9.49%.¹⁴ Two of the four RACs chosen for the permanent program, Connolly Consulting Associates, Inc. in Region C and HealthDataInsights, Inc. in Region D, participated in the three-year demonstration and have significantly lower contingency fees than the new RACs.

Critics of the RAC program claim these “bounty hunter-style” payments encourage the RACs’ aggressive claim denial practices as well as disproportionate focus on overpayments. From 2005 through March 27, 2008, RACs succeeded in finding more than \$1.03 billion in Medicare improper payments. Of the \$1.03 billion in Medicare improper payments the RACs identified, approximately 96 percent were overpayments collected from providers. This sharply one-sided recovery has caused some to question CMS’s claim that capturing underpayments is a goal of the program. Adding to the controversy was the fact that the RACs would collect these contingency fees even if their determination was overturned at the second level of appeal. CMS agreed with providers who loudly proclaimed that paying RACs for making incorrect claims denials

does not make good practice. As such, in the permanent program CMS has removed the contingency payment when a provider overturns a denial at any level.

From 2005 through March 27, 2008, RACs succeeded in finding more than \$1.03 billion in Medicare improper payments. Of the \$1.03 billion in Medicare improper payments the RACs identified, approximately 96 percent were overpayments collected from providers.

One of the major concerns consistently echoed by hospitals during the demonstration was the performance of medical necessity determinations performed by “unqualified personnel, and review practices ... inconsistent with Medicare policies.”¹⁵ During the demonstration, CMS did not mandate that the RACs employ a physician medical director to

oversee the programs. Interestingly, in the permanent program the RACs are not required to involve physicians in the medical record review process, instead registered nurses or therapists can make determinations regarding medical necessity. Specifically, a number of providers in California were successful in shedding light on errors and inconsistencies in the RACs’ medical necessity criteria for rehabilitation claims. The problems in California were so widespread that in September 2007 CMS instituted a “pause” in all inpatient rehabilitation facility (IRF) reviews to allow for an independent review of a sample of denied claims and further discussion the other Medicare contractors on IRF medical record review.¹⁶ It became clear that with respect to IRF reviews in California, CMS contractors were not consistently applying Medicare policy for IRF services. CMS provided training to contractors reviewing IRF claims in California, and then instructed the RAC for that jurisdiction to re-review all previously denied IRF claims using the medical review methodology described in the training. Although the RAC refunded \$14 million to IRF providers for improperly reviewed claims, for many providers who suffered financial hardships requiring them to scale back services, the damage had already been done.

Response to Concerns

In response to comments from the AHA and others regarding the concerns and issues discussed above, CMS released a revised Statement of Work in November 2007 that contained several refinements to the national RAC program.¹⁷ More recently, CMS identified additional changes that will be included in the permanent program as it is rolled out. These changes include: (1) requiring that RACs have a medical director; (2) setting a monthly cap on the number of medical records that a RAC can request from a provider (For example, RACs may request from hospitals a maximum of 200 medical records per NPI in a 45 day period, further limited to no more than 10 percent

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RACs - Response to Concerns

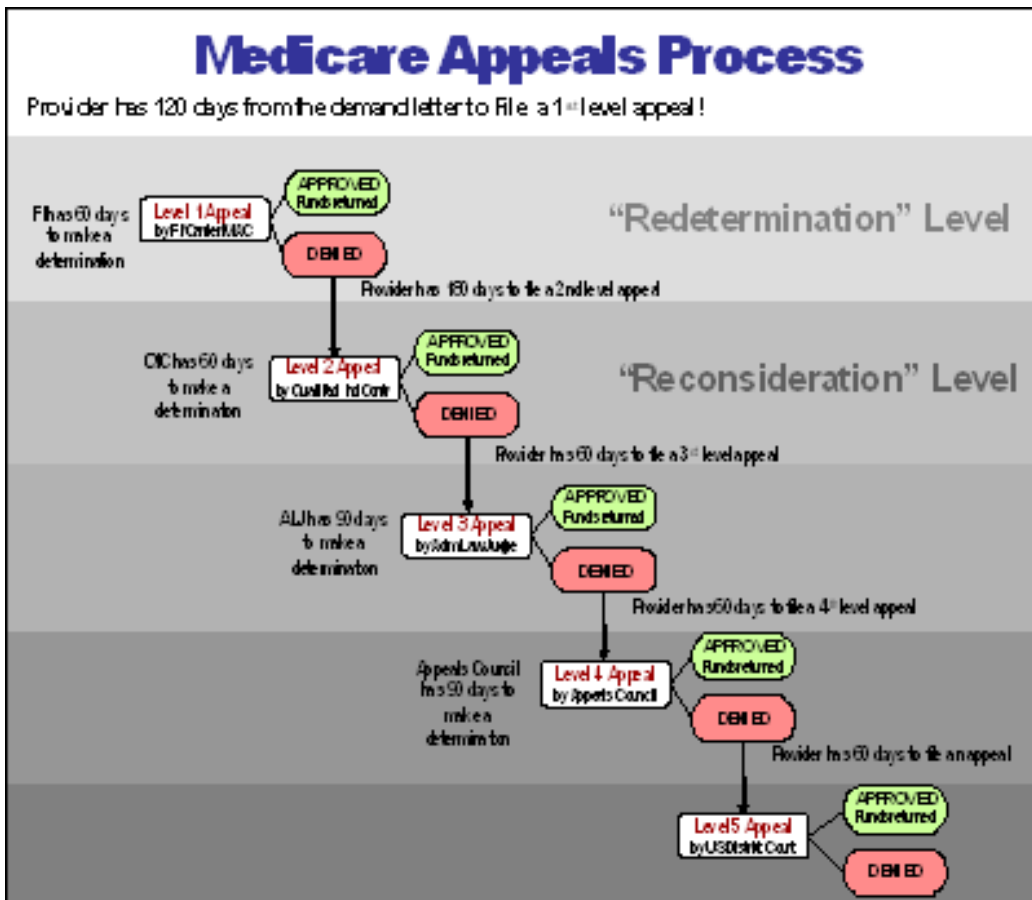
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of average monthly Medicare paid claims in the 45 day period); (3) shortening the look-back period for claims review from four to three years; (4) providing that no claims with dates of service prior to October 1, 2007 will be reviewed; (5) allowing review of claims during the current fiscal year; (6) requiring mandatory use of certified coders; and (7) independently auditing RAC denials for accuracy. CMS will require new areas targeted by RACs to be approved by CMS in advance and will announce the expanded target areas on RAC websites prior to widespread review. In addition to these modifications, AHA is advocating for other changes including (1) an expanded role for physicians, especially with regard to medical necessity reviews; (2) the establishment of a reliable process for re-billing denied claims; (3) a 12-month look-back period instead of three years; (4) a more balanced approach on overpayments versus underpayments and (5) audits targeted across provider types.

In response to concerns about the RAC program, the Medicare Recovery Audit Contractor Program Moratorium Act (H.R. 4105) was introduced in the House and backed by the AHA.¹⁸ The bill, which died in committee last session, would have placed a one-year moratorium on the RAC program in an effort to provide CMS with sufficient time to "thoroughly examine the practices of private Recovery Audit Contractors to ensure they are properly interpreting and applying Medicare criteria and using qualified personnel to review claims." With no action on the requested moratorium, the RACs are currently moving forward.

Appeals Process

All RAC findings are subject to the Medicare appeals process. The January 5, 2009, update to the Report includes appeals statistics through August 31, 2008. According to the second update, providers appealed 22.5 percent (118,051) of RAC determinations, and of those, 34 percent (40,115) were overturned in favor of providers. CMS is still unable to determine the number of appeals at the first level



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and will continue to update the report until all appeals have completed the Medicare appeals system. It is important to note also that although CMS counts the pending claims as part of overall program savings, some of these pending claims ultimately may be overturned in the providers' favor. The CMS chart on the previous page reflects the Medicare appeals process.

Of the \$1.03 billion in improper payments found by the RACs from the inception of the demonstration through March 27, 2008, approximately 4 percent occurred in FY 2006, 34 percent in FY 2007, and 62 percent in the first half of FY 2008. As evidenced by this steep incline, the permanent RACs increasingly efficient detection of possible improper payments will soon demonstrate that the financial impacts felt by providers during the demonstration program was just the tip of the iceberg.

Also, last year, CMS issued guidance preventing the recoupment of funds during the first two stages of the five-stage appeals process (as shown above).¹⁹ The guidance addresses the appeals process available to healthcare providers who wish to contest overpayment determinations by a RAC. Currently, Medicare begins the overpayment recovery process from a provider as soon as the overpayment is identified. Under the guidance, which was adopted to conform to the statutory requirements of Section 935(a) of the MMA, providers will have 30 days to submit an appeal for redetermination before Medicare contractors may begin recouping an overpayment. If the appeal is submitted within the 30-day period, the recoupment will be further delayed until a redetermination decision is issued. If the overpayment determination is affirmed at the first level of the appeal process, Medicare contractors may begin recoupment 60 days after the decision is affirmed unless the provider appeals to a Qualified Independent Contractor ("QIC") for reconsideration. If the provider requests reconsideration, recoupment is again delayed while the second level of the appeal process is underway. If the QIC denies the provider's appeal for reconsideration, recoupment may begin immediately after the QIC issues its decision, even if the provider appeals to an administrative law judge (the third level of the appeal process.) The delays in recoupment will create greater incentives for providers to quickly appeal overpayment determination and examine the accuracy and appropriateness of such

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guest lecturer at several insurance and risk management workshops and functions, including ASHRM 2005 and Cayman Captive Conference 2005.

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Dan Cain

Dan is chairman of Cain Brothers & Company LLC. The company, founded in 1982, is a healthcare investment banking firm and a general partner of its private equity affiliates, CB Health Venture I and II, and Health Enterprise Partners. Prior professional experience includes 10 years in corporate and real estate finance with Merrill Lynch, Blyth Eastman Dillon and Salomon Brothers.

Dan is a current director of several companies, including Sheridan Healthcare, Brim Healthcare and NATIXIS-Loomis Sayles Mutual Funds. He is chairman of the Norman Rockwell Museum and a board member of American Heart Association and Brown University School of Medicine.

Dan has a degree in American Civilization from Brown University and a Master's of Business Administration from Columbia School of Business, where he serves on its Board of Overseers. 

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April & May Project to benefit Eye Care for KIDS



During the months of April & May, we will be raising donations for Eye Care for KIDS. This organization provides eye screening and glasses to children in order to give them an equal opportunity to succeed in school. The mission of Eye Care for KIDS Foundation is to empower children to reach their full educational and social potential through vision. All contributions will be used to purchase an item (or items) for donation to the Eye Care for KIDS Silent Auction on May 27, 2009. If you'd like more information about this organization, please visit www.eyecareforkids.org.

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determination. However, providers should note that while the recoupment may be delayed during the first two appeal levels, interest will accrue on any overpayments that are ultimately affirmed. Providers should consider the cost associated with an appeal, and the availability of the necessary resources to appeal, including the quality of the medical records and charts.

Conclusion - Prepare Now

Although there is uncertainty surrounding the permanent RAC program, providers should take notice of the new developments to the program and how these changes will affect their preparation as the permanent RAC program rolls out. Providers should consider establishing an interdisciplinary taskforce including representatives from finance, medical records, utilization management, compliance and others to meet regularly to establish communication channels and loops to review RAC requests, findings and appeals as well as to monitor CMS updates. Providers' interdisciplinary taskforce should consider conducting internal audits in the target areas and providing additional education to staff regarding documentation and coding concerns in those areas. Providers need to monitor all RAC activities, including timeframes, verify that claims are eligible for review, and review all cases targeted for repayment. Based on these reviews, the task force can implement internal corrective actions where appropriate. In addition, Providers should implement a process for reviewing the validity of RAC denials and where indicated, pursuing an appeal of the denials. In sum, providers need to be prepared now to handle and monitor the RAC audits and appeals.

Endnotes

¹ Medicare Prescription Drug Improvement and Modernization Act of 2003, Pub. L. 108-173, 117 Stat. 2066 (2003).

² Centers For Medicare & Medicaid Services, The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration, (June 2008).

³ Tax Relief and Healthcare Act of 2006, Pub. L. 109-432, 120 Stat. 2922 (2006).

⁴ Centers For Medicare & Medicaid Services, Overview Recovery Audit Contractors available at <http://www.cms.hhs.gov/RAC/>.

⁵ *Id*

⁶ A map of the RAC rollout is available at <http://www.cms.hhs.gov/RAC/Downloads/RAC%20Expansion%20Schedule%20Web.pdf>

[See "RACs - Conclusion" page 14](#)

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⁷ Centers For Medicare & Medicaid Services, The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration, (June 2008) as updated by Appeal Update through 8/31/08.

⁸ *Id*

⁹ American Hospital Association, Recovery Audit Contractors (RACs): Preparing for RAC Audits (March 3, 2008).

¹⁰ Centers For Medicare & Medicaid Services, CMS Improper Medicare FFS Payments Report (May 2008) available at http://www.cms.hhs.gov/apps/er_report/preview_er_report_print.asp?from=public&which=long&reportID=

¹¹ Centers For Medicare & Medicaid Services, *supra* note 2.

¹² Press Release, CMS Enhances Program Integrity Efforts To Fight Fraud, Waste and Abuse in Medicare, (October 6, 2008) (available at <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3291&intNumPerPa>).

¹³ PRG-Schultz, Inc. will be a subcontractor to HealthDataInsights, Inc., Diversified Collection Services, Inc. and CGI Technologies and Solutions, Inc. in regions A, B and D; Viant Payment Systems, Inc. will be a subcontractor to Connolly Consulting Associates, Inc. in region C.

¹⁴ Centers For Medicare & Medicaid Services, Final RFP (and Statement of Work) for four new permanent RACs available at http://www.cms.hhs.gov/RAC/01_Overview.asp.

¹⁵ Press Release, Stark, Rangel, Dingell, Pallone, and Capps Request GAO Study of Medicare RAC Program (July 11, 2008) (available at <http://www.house.gov/stark/news/110th/pressreleases/2008-07/11-rac.htm>).

¹⁶ Centers For Medicare & Medicaid Services, *supra* note 2.

¹⁷ Centers For Medicare & Medicaid Services, *supra* note 14.

¹⁸ Medicare Recovery Audit Contractor Program Moratorium Act, H.R. 4105, 110th Cong. (2008).



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