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Should your employees be certified? Access training and credentials debated

NAHAM members demand new CHAA exam

Just how meaningful is national certification for access managers and the staff they oversee? Is it possible to design a standardized curriculum that has real relevance for an industry where the devil is in the details?

The answers to these and other questions related to access credentialing vary, depending on which access professional you're asking, and some of the differences in opinion have as much to do with what part of the country they're from as with any particular philosophical stance.

The Washington, DC-based National Association for Healthcare Access Management (NAHAM) has offered the certified health care access management (CHAM) credential (formerly called AAM for accredited access manager) since shortly after the organization's inception in 1974, notes president-elect **Nancy Farrington**, MBA, CHAM.

The CHAM examination is in the process of being updated, Farrington says, but currently is in four parts: access management, general management, finance, and medical records. "Our vision is to have it more closely aligned with the NAHAM access model," she adds, which breaks the subject matter into "pre-encounter," "encounter," and "future development."

As of late April, there were 384 NAHAM members — about a third of the membership — with the CHAM credential, Farrington says, not including those who have been CHAMs in the past but have let their certification lapse. (To maintain their status,

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COMING IN FUTURE ISSUES

- The future of managed care
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- How to implement a CRM center
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CHAMs must complete 30 hours of continuing education during a two-year cycle.)

Although she says there is a large untapped market for both NAHAM membership and the CHAM certification, Farrington adds that the credential has increasing importance within the access field. Within the organization, she notes, CHAMs earn about 20% more than their non-CHAM counterparts.

An enthusiastic response

In response to demand from its membership for assistance in staff education, Farrington says, NAHAM instituted the certified health care access associate (CHAA) certification in the fall of 1999. Response to that credentialing opportunity has been enthusiastic, she adds. **(See related story, p. 63.)**

A national certification for frontline access personnel is as much about legitimizing the profession as anything else, suggests **Anthony Bruno**, MPA, corporate director for registration and financial services at Crozer-Keystone Health System in Upland, PA.

"As an industry, we don't do enough to emphasize their importance," he says. "Every hospital is built upon the work done by the folks who do inpatient and outpatient registration. It all has to be accurate and timely, plus all the customer service amenities. Anything we can do to help improve their image and self-respect . . . this is one way of doing that."

Hospitals can no longer afford to look at these front-end employees as secretaries or clerks, Bruno points out. "We need to attract those who can do the job best, and that doesn't come with paying a little more than McDonald's might pay."

It's also important that hospitals can see the value in making the investment in national certification for their employees, says **Jack Duffy**, FHFMA, director and founder of Integrated Revenue Management in Carlsbad, CA. "Right now, the value statement is not very sophisticated. People in a personal training program get personal certification, but the company never measures the impact of that investment."

What would be meaningful, he suggests, is if that self-study effort were reflected in, say, the registration accuracy rate. "Without success stories, without the ability to treat the expenses like an investment, it's [only] the wealthy hospital or the visionary hospital [that will participate].

Jeanne Hughes, CHAM, regional director for

quality assurance and training at Providence Health System in Portland, OR, points out that although the CHAM certification is recognized within NAHAM circles and in the access marketplace, outside that group not everyone knows what a CHAM is. "It doesn't have that wide recognition that, say, CPA has," Hughes notes. "It would be pretty hard to have a [credential] that is widely recognized, especially since in most organizations, there are just one or two managers."

In addition, she says, "we have such a strong curriculum that I don't have a desire for [getting national certification for access employees]. We are so fortunate to have a QA [quality assurance] and training department with six people in it. I might feel differently if we were a stand-alone hospital that didn't have a comprehensive training program."

A national curriculum would be of limited value, Hughes suggests, for access employees at Providence and other organizations in the Northwest, where managed care is pervasive. The training focus there, she says, must be on the differences in health plans and their requirements.

"We could have a high-level discussion [nationally] of what is an HMO, and what is a PPO, but couldn't go much beyond that," she says. "Plus, for us, what I really want to see is outstanding customer service skills, and there's not a test in the world that can show me that. I will take someone from a different industry and train them for access if they have those public relations, customer service skills. I really believe you either have them or you don't, although you can enhance them with good training."

At Providence, Hughes points out, "we don't view registrar as an entry-level position, and we haven't for a while. For those [organizations] that still do, some recognition and national certification might help [those employees] advance."

What she's excited about at present in the world of training, Hughes adds, is web-based delivery, which she is exploring for possible implementation at Providence. **(See related story, p. 64.)**

Farrington points out, however, that while the CHAA certification does not provide any recognition of the skill set related to specific contracts, it acknowledges a more sophisticated understanding of the fundamentals that are common to the vast majority of access departments.

The CHAA exam promotes, for example, the understanding that managed care contracts in general require a copay or require a referral from a primary care physician, she notes, and covers a variety of subjects ranging from JCAHO requirements to customer service to patient rights and responsibilities.

As the privacy and transaction standards called for under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 go into effect, Farrington says, standardization within the access field will increase.

"Two of the things the government wanted to accomplish with HIPAA were portability and accountability, and under the latter came administrative simplification," she adds. "In order to do that, it makes sense to use [electronic communication] and to do that means no deviation from the rules."

One change under HIPAA, Farrington says, is that every insurance plan will have a number, a unique identifier, as will all employers that offer health insurance. "This links back to the idea of a national certification program," she notes. "As more and more [information] is standardized, we will continue to build it into our programs." ■

Hospitals and frontline staff queue up for test

'It's a great morale booster'

The access staff at St. John's Medical Center in Tulsa, OK, were so committed to taking the new certified healthcare access associate (CHAA) exam, says NAHAM regional delegate **Jeanice Van Liew**, CHAM, that "if they didn't have the money, they were charging it on their credit cards."

And their manager at the time was so dedicated to having her staff pass the test, Van Liew adds, that she took out her study guide for the National Association for Healthcare Access Management's certification program for managers and made up a sample exam to help them prepare.

"They had study groups, they had time set aside to study, and they came from all over," she says. "Some registered patients in radiology, some worked in bed control, and some were regular admissions people."

Seventeen of the 21 St. John's staff members that took the exam when NAHAM piloted it in fall of 1999 passed the first time, and the rest were successful on a second try, Van Liew notes. As new access employees are hired, they are applying to take the test, she adds, and the process is

still generating a sense of excitement.

The hospital's administration — which has tied passing the exam to a $1 per hour increase in pay — continues to support the effort, Van Liew says. "That is absolutely key. It makes the staff feel like the administration knows they are important. They all feel a sense of, 'I do know how to do my job, I'm doing it well, and I have the certification to prove it.'"

The traveling proctor

Other hospitals are following suit, and the interest in the exam appears to be intensifying, says Van Liew, who represents the central states region for NAHAM and was temporarily covering the Midwest region. "It's gotten so much interest I've had to put another book together to keep track."

Van Liew, a former access manager who now works for Cerner Corp. in Kansas City, KS, spends many of her weekends traveling to different facilities to serve as proctor for the exam, she notes. So does **Maxine Wilson**, CHAM, the southeast region's NAHAM delegate and director of customer service for physician services at Methodist Medical Center in Oak Ridge, TN. Although the organization's official count was that just under 400 people had passed the exam as of late April, both Van Liew and Wilson said that figure was changing weekly and exponentially.

"The Baptist Health System, which has several facilities in several states, is going to certify 300 people," Wilson says. "It will be a requirement, and [the health system] will give [access personnel] 18 months to do it." Among other organizations promoting the exam for their access employees are Baycare Health System, Clearwater, FL, and Knighton Health System in Shreveport, LA, she adds.

Virtually every hospital and health system that is promoting the CHAA certification "is either paying for the exam or offering an increase in salary for passing," Van Liew says. "Some are doing both. Several are in the process of re-creating their job descriptions. For example, [registrars] will come in at the entry level, and after being there so long, are expected to take the exam. If they pass, they get their increase. Each facility is doing it a little bit differently."

Taking the exam "is having a tremendous effect on staff," Wilson adds. "It's a great morale booster."

It costs $75 to take the CHAA exam, Wilson says, which includes a study guide — it now comes with a sample exam — and the opportunity for one "retake" if the applicant fails the first time.

The format is 100 multiple-choice questions covering admissions, registration, billing, insurance, customer service, laws and regulations, continuous quality improvement, medical terminology, Health Care Financing Administration regulations and compliance, and Joint Commission issues, among other subjects, she adds.

As NAHAM moves forward with the next edition of the test, points out **Nancy Farrington**, MBA, CHAM, president-elect of the organization, more questions on the Health Insurance Portability and Accountability Act of 1996 will be included. "We will continue to look for ways to continue to improve the program and the process," she adds.

The exam for the CHAM (certified healthcare access manager) credential costs $150, Farrington notes, with a study guide available for $50. The exam has four sections, she adds, and applicants who fail a part of the test may retake just that portion.

[Editor's note: For more information on the CHAM and CHAA certifications offered by NAHAM, visit the organization's web site at www.naham.org, or call the national office at (202) 367-1173.] ■

Web training offers flexibility, efficiency

'You can customize it'

Web-based delivery is where the future lies for effective training of access personnel, suggests **Jeanne Hughes**, CHAM, regional quality assurance (QA) and training manager for access services at Providence Health System in Portland, OR.

"What we're really looking at is how can we reach people on alternate shifts and make sure they get the information that they need," says Hughes, who oversees a six-person QA and training department that provides comprehensive, ongoing training support for access personnel. "One of my projects is to investigate web-based [training programs]. That is what I want to see for us."

The trend as she sees it, Hughes explains, is more toward "learner-directed training, rather than always have the trainer standing up talking."

Compliance training is available on the

Medicare web site (www.hcfa.gov), which prompts users through various screens to find areas where they have deficiencies, she notes. "Their technology can then send your test results back to [a designated recipient]."

But while Hughes sees the value of some standardized training at a national level on topics such as confidentiality and Medicare Secondary Payer issues, "the neat thing is when you can customize it," she says.

Providence, for example, would benefit from specialized Intranet training on the HMOs in its area or on the Oregon Health Plan, she says. "The way I see it, there would be an icon on your desktop [computer]," Hughes adds. "When there are no patients around, or [after hours], you come in and click on the icon. It takes you into the program, which leads you through the pre-test, lecture format, post-test, and gives you feedback. If there's a low score, you know you need to do it again."

There would be the option, she points out, of designing a training program for a specific insurance plan, perhaps one that is causing problems for registrars.

An organization called the American Society of Training and Development (ASTD), which has a web site at www.astd.org, Hughes adds, "is on the cutting edge of training and development. That's where I learn a lot about how to take our training to the next level, about presentation skills and how not to do the same old thing."

In Portland, she says, there is a subgroup of ASTD that focuses on nothing but web development.

The piece of her plan for web-based training that she isn't yet sure about, Hughes notes, is whether it can be done with current staff. "That's one of the things I have to investigate this year. Can we take this on? At the idea level, it makes a lot of sense to us."

Mentoring, notary support

Providence's Access Continuing Education, a daylong program designed to provide access staff with the latest information on customer service, compliance issues, and insurance changes, among other topics, began its second year in January 2001, she notes. **(See *Hospital Access Management*, September 2000, p. 102.)**

New this year are two other QA and training initiatives:

- **A mentoring program.**

"When new employees get on-site," Hughes explains, "there is a designated mentor who works with them in addition to the supervisor. It's like the star of the department — someone who can help them on the practical side." Plans are to provide some sort of compensation for the person who does the mentoring, she adds. "We want to do everything we can to help our employees be successful."

- **A support group for the access employees who serve as notaries.**

At Providence Health System, Hughes notes, the access department provides the notaries public that are needed when, for example, a patient needs to sign a financial power of attorney. Providence pays for the training and certification for these individuals and provides the test that is required, she adds.

"It's part of being a registrar, that they may be asked to do this," Hughes says. "Most of the time, it's cut-and-dried — they know the requirements, but there can be a tough situation. Maybe a daughter is pushing her mom to sign [a financial document], and you realize the mom is confused."

Helping these notaries learn how to deal with family members and other providers, and to explain, for example, that they are not able to perform a particular function at that time, is one of the reasons why a support group is important, she says. "It just provides educational opportunities, and a chance to network with other notaries, so that when you get into a sticky situation, you know who the others are." ■

Getting 'self-pays' paid: Hospital seeks solutions

HDX pluses, minuses examined

It's a scenario that can wreak havoc on a hospital's bottom line:

A patient comes to the emergency department (ED) and, in the urgency of the moment, has forgotten his insurance card. Or an accompanying family member says, "I think my mom's on Aetna, but I'm not sure."

ED registrars create an account listing the patient as "self-pay" and may — as is the case with The Ohio State University (OSU) Medical Center in Columbus — notify the patient of that in a letter a few days later that also asks the person to contact

the hospital if he or she has insurance.

In many cases, says **Sue Alden,** RN, MS, director of registration training and quality assurance, the hospital may not paid for the service. At best, payment is delayed, often for months or more.

As OSU Medical Center looked at ways to optimize its use of the SMS registration system, which was installed in January 1999, Alden notes, a key question was, "How can we enhance our ability to bring money in?" With self-pay accounts responsible for a big part of the institution's missing revenue, she says, one of the answers to that question was to implement the electronic insurance verification system from HDX. **(For another kind of solution to insurance verification, see story, p. 67.)**

Win-win situation

Although the hospital also had looked at stand-alone systems, notes **Joseph Denney,** CHAM, lead, patient management system implementation, HDX ultimately made sense because of its partnership with Malvern, PA-based SMS. "When you buy the products together, you get a good deal financially. We made a conscious decision [to go with HDX] because of everything else that came along with it."

With HDX in place, the above ED scenario changes dramatically, Denney says. If the insurance company involved is on the system, it will be queried — through entry of the patient's name, Social Security number, and date of birth — and will provide the registrar with a policy number, group number and whether the coverage is effective for that patient account, he adds. "It's a win-win situation."

In addition to those who simply forget their card, Alden says, "we're frequently finding insurance on people who said they were self-pay."

Another advantage to the system, Denney points out, is that a patient who says he has Medicaid may have forgotten that he subscribed to an HMO. "HDX will go in and search the system, and if the patient is in an HMO, that information will come back."

It's too early in OSU Medical Center's implementation of HDX to know exactly the percentage of patients the system will cover, Alden says, "but even if we can check 40%-60% of the cases, we're better off. It's well worthwhile — anything you can do to improve self-pays is worthwhile."

In general, the HDX coverage rate for central Ohio is about 55%, Denney adds, and the company has promised to work with the hospital on special requests. For example, "one of those I would shoot for is our own health plan," he says. "We take care of our own employees, and that's 25,000 people."

Under the present arrangement, HDX covers about 20 insurers with which OSU Medical Center does business, including Medicare, Medicaid, Medical Mutual of Ohio, and United Healthcare, among others.

"Ultimately, we would like to see a company that covers all [insurances]," Denney notes, "and with some of the Internet-based products, that is closer than we might have thought." The competition provided by the companies that provide the service through the Internet, he suggests, will spur other vendors to increase the number of insurers they cover.

With HDX in place, the insurance verification happens as the registration is being done, which saves the time that financial counselors and precert personnel have spent going into another system to check on insurance status, Alden says. In addition, input errors are eliminated. Besides these more obvious benefits, she notes, the system offers these advantages:

- **Information is more specific.**

"We're finding that by being able to check eligibility on Medicare, we're getting, for example, exactly how a name is spelled," she points out. "We might have had a rejection before because the name didn't identically match what Medicare had."

- **Plan code confusion is decreased.**

Because of confusing insurance cards and patients who are unclear about the coverage they have, registrars sometimes put in one type of Aetna plan when it should be another Aetna product, Alden says. In one case, she points out, the faint watermark of a "C" is the only difference between the cards for two different insurance cards. Use of the HDX system eliminates that issue for the insurance companies it handles.

- **You can correct problems before the bill drops.**

There are real benefits from a quality assurance perspective, she notes. "When you see an account that is missing a number, or doesn't look like the registrar pulled off the right number, you are able to correct that. It allows you to do a lot more upfront fixing."

- **Extra information is sometimes provided.**

Staff increasingly have found that when HDX

makes a Medicare check, the system not only brings back the information on that account. It may say that, according to Medicare records, the patient also may have another third-party insurance, Alden explains. This is important because it alerts the hospital that it should ask the question of whether Medicare, or another company, is the patient's primary insurer, she adds.

There are drawbacks

Although the HDX system has many pluses, there are some drawbacks that potential buyers should keep in mind, Alden notes.

• **Sometimes HDX has access to an insurance company, but not to all of the company's products.**

"You may not be querying all the company's products (when the system goes out to search for a patient's account), but it doesn't tell you this," she says. "You think you've checked all the products, but the HDX contract may be limited to a couple."

That means that if HDX handles Cigna's PPO plan, but not its HMO plan, a query on a patient with the latter will come back with the response that the patient isn't covered, Alden notes. "We don't see a lot of this [problem], but it is a limitation."

• **Some interpretation is required.**

"We have to find out some things for ourselves," Alden points out. "The response comes back from Medicare and we have to do some interpretation. The biggest concern is the staff's ability to [do this]. It takes more of a thought process."

For example, based on the answer that comes back from Medicaid, for example, staff have to determine whether the person has Medicaid or Medicaid disability coverage, she notes. "For us, those are two different plan codes."

With the accounts of inpatients or those having ambulatory surgery, there is a pre-cert area where staff provide "a second-tier verification" to ensure that registrars have identified the right insurance plan.

• **The regions covered are more limited.**

The hospital's previous system for checking Medicare coverage extended the search to all regions of the country, she notes. "With HDX, we had to choose whether we wanted the system pointed to one regions vs. another." That means if patients from Kentucky are included, those from Pennsylvania are not, Alden adds. "If the region you need is not included, it's a longer process. We have to do the follow-up by phone."

Here's some advice

Alden advises access managers helping make the decision on whether to buy an electronic verification system or which one to buy, to choose an option that puts the process into the registration pathway. This way, she says, eligibility is being checked as the registration proceeds.

Denney adds, however, that there are hospitals who batch their accounts at the end of the business day. In such cases, he says, a stand-alone system is the only choice.

Crucial to selecting the right system, Alden points out, is questioning the vendor on how quickly negotiations are conducted with insurance companies it seeks to add to its coverage. "How fast have they added on [in the past] and are they continuing to grow the business?" ■

Better system sparks need for customer PR

Staff script may help

Here's a question you may not have thought of in connection with the use of an electronic insurance verification system:

What do you do if the patient says that he or she has a particular type of insurance, and the registrar gets a direct response saying that this person is not covered?

You might want to have an answer scripted for the registrar who finds herself in a bit of an awkward situation, suggests **Sue Alden**, director of registration, training, and quality assurance at The Ohio State University (OSU) Medical Center.

"We're still figuring out how to handle that," says Alden, who is directing the hospital's implementation of the HDX electronic verification system. "We're trying to prepare [registrars] for people who say, 'But I have United, I know I have United.' What will be the directions to the registrar when they know from the system that [the patient] doesn't have it?"

The hospital that OSU Medical Center staff have consulted with on its use of HDX "takes the approach that the customer is always right, and when the person leaves, they just go ahead and

take it out of the system," she says.

It's important to keep in mind, however, Alden adds, that "there's always the chance that you might be wrong. Maybe there's been a change in insurance, and the company hasn't updated their records. We've had discussions, and we're scripting out what to say." ■

How good is your eligibility verification?

Company says it can do it better

A Cleveland-based company called the COB Clearinghouse Corp. has issued an invitation — and a bit of a challenge — to the nation's health care providers, and the subject matter is something that access managers struggle with every day.

COB Clearinghouse promises to provide "one-stop shopping" for eligibility data on every patient admitted to a hospital through the automation of "coordination of benefits." Coordination of benefits is the process of determining which insurance policy is primary for a particular patient.

The purpose of what is called the National COB Demonstration Project, company officials say, is to bring the national eligibility record together for the first time.

What COB Clearinghouse is offering is "a report card on how we're doing," says **Susan Brock**, regional manager of access services for Providence Health System in Portland, OR, the first health care provider to accept the company's challenge and join the demonstration project. The idea, Brock explains, is "to see what is the quality of the information you're getting, as opposed to what you would get if [insurance eligibility checks] were running through the Clearinghouse.

"Our belief is that we have excellent systems in place," she says. "The plus for us is the opportunity to check the accuracy of what we've done. If it's not what we thought, we know there's an option out there available to us if their system proves to be a tool with greater accuracy."

As part of the project, Providence will share with COB Clearinghouse the insurance eligibility data it received for three days in March, June, and September of 2000 using the systems the health care provider currently has in place, she says.

That data include:

- the insured person's name, Social Security number (SSN), and date of birth (DOB);
- the name, SSN, and DOB of each covered dependent of the insured;
- each person's coverage status;
- each person's effective date;
- each person's termination date;
- the insured's address or residence ZIP code;
- the insurance plan number;
- the identity of the plan sponsor;
- any "other coverage" data known to the Providence system.

Using its proprietary software program, COB Clearinghouse will examine the identities of the individuals in the combined data provided by all the demonstration participants, and will report to Providence:

- "false negatives" in the "other insurance" record provided by Providence, indicating the existence of other insurance for the individual where the Providence record indicates there is no other insurance for that person;
- "false positives" in the "other insurance" record provided by Providence, indicating the absence of other insurance for the individual where the Providence record indicates there is no other insurance for that person;
- the changes in eligibility, double coverage, false-negative and false-positive results over time between March, June, and September;

Also as part of its agreement with Providence — and with other organizations that participate in the project — COB Clearinghouse will distinguish the identity matches that are "unequivocal" from those that are possible, probable, or indefinite.

The Washington, DC-based National Association for Healthcare Access Management (NAHAM) has endorsed the project, and provides information about COB Clearinghouse on its web site at www.naham.org.

"We're hoping to show that an automated system will take out misdirections in coordination of benefits, double payments, [and] all the problems that the hospital network faces in trying to verify eligibility and primacy," says **Jeff Patton**, director of national accounts for COB Clearinghouse.

"The key is getting the plan sponsors to recognize the savings there can be with accurate eligibility information and proper coordination of benefits testing," he adds. "It becomes a direct savings to them, therefore saving throughout the system."

In addition to health care systems, project participants include insurance plan sponsors (employer groups), third-party payers, pharmacy benefit managers, and preferred provider

organizations, Patton notes.

To be a part of the demonstration project, participants pay $1,000. That fee, company president Patrick Lawlor explains in a question-and-answer (Q&A) document on the NAHAM web site, will be used to help cover the cost of merging as many as 10,000 data files to conduct the project. The file will be so large that the programs will have to be run at a Hewlett-Packard Performance Center.

Although the COB Clearinghouse model appears to require the centralization of all the eligibility data in the country, that isn't quite the case, Lawlor explains in the Q&A exchange with NAHAM.

"Actually, the model doesn't require a perfectly centralized database," he says. "HIPAA requires health plans to open an eligibility gateway, and the Clearinghouse can use those gateways to complete a search of all possible payers."

It would be much more economical, however, for a payer to put its eligibility data into the centralized database, Lawlor explains, and making that point is part of the purpose of the demonstration project. The project aims to show payers and their clients, the corporate and governmental health plan sponsors, that it is in their financial interest to maintain eligibility data this way, he adds.

According to information on the NAHAM site, a number of organizations where NAHAM members are employed have postponed buying decisions on electronic eligibility tools pending the results of the demonstration.

[Editor's note: More information on COB Clearinghouse is available at NAHAM's web site, and at the company's own site, www.cobclearinghouse.com, or by calling Jeff Patton at (216) 861-2300.] ■

Tired of consultants? Here's a different twist

Company celebrates hospital staff

The problem with the "consultant model" for revamping a hospital's operation, says **Jack Duffy**, FHFMA, director and founder of Integrated Revenue Management (IRM), Carlsbad, CA, is that the consultant comes in and solves the immediate problem, but doesn't systematically correct the underlying errors.

His company, Duffy adds, "is founded on the principle that the way we can make a significant principle is to train the internal staff to do the sophisticated work that often has been purchased through a consultant."

The training emphasis is on revenue management, he says, and focuses on "the intersection between the bill and the [patient's] chart." That includes registration and coding, charge choosing, contracting, and billing and collections, Duffy notes.

The IRM package, he explains, includes a two-week curriculum at the corporate office in Carlsbad for a team of employees. Those employees return to their home hospital — with an advance practice trainer from IRM — for an additional week of training, Duffy says. **(See related story on the company's chargemaster initiative, p. 70.)**

After three weeks, the team is highly motivated and productive, he adds, but it takes two to three years to get it to the optimum level. For that reason, Duffy says, the IRM trainer — who is recruited from the hospital's own community — is assigned to the hospital virtually full time. In the case of smaller facilities, he notes, one person may travel between two clients.

"We start with the most sophisticated person we can find," Duffy says, "and that person receives weeks of training with the [IRM] core group."

Since IRM doesn't charge contingency fees, he explains, it negotiates a "master fee" with the hospital and enters into a three-year contract.

"We tell them honestly it takes five years to develop skill [at discovering revenue opportunities], and what they're considering buying from us is the ability to accelerate their business to a five-year level," Duffy says.

IRM's first client, he notes, discovered $1 million in additional revenue within 10 days of returning from the Carlsbad training session. That hospital's investment with IRM is around $600,000 a year for three years, Duffy adds, "and their improved performance should be in excess of $36 million."

Consultants with fee-based or contingency services, he says, typically do a project in which they discover the high-dollar, incorrect payments. "They bill [the hospital] $300,000, and save it $1 million," Duffy adds. "For that same $300,000, we train [internal staff] to find the errors, and they find them every day, every year. It's a dramatic difference in mission and approach."

This approach, he says, "celebrates the hospital staff instead of them having a persistent feeling of inadequacy, a feeling that the real brains come from the outside."

Company out to fill gap in chargemaster training

Job is full of bear traps

Managing a hospital's chargemaster — where every service the hospital gets paid for is listed — is a patient financial services job that is rule-oriented, fraught with compliance challenges, and "full of bear traps," says **Jack Duffy**, FHFMA, director and founder of Integrated Revenue Management (IRM), Carlsbad, CA.

But despite extensive research, Duffy notes, he found no training program in the entire country that prepares an individual to be competent in that area. That will change in July, he says, with the introduction of the Chargemaster Institute of America, an enterprise that will be a business partner with IRM.

That situation can be looked at as a microcosm of the state of the art of training in the world of health care revenue management, Duffy suggests. "You can get in so much trouble, so fast, with [inadequate management of] the chargemaster. Every dollar of revenue goes through it," he adds. "In the future, every account will be scrutinized by the Health Care Financing Administration [HCFA], and the intersection between the contract and the chargemaster will determine the success of hospitals."

After interviewing a man who worked for a 932-bed hospital that was a potential IRM client, Duffy notes, he discovered that although the individual had responsibility for the chargemaster, he spent only 20% of his job time on that task. Considering that the organization's chargemaster included 72,000 items, Duffy adds, "We said, 'How can you be effective?' He said, 'I really can't.' We asked, 'How were you trained?' He said, 'I wasn't.' He was very bright, but he had no support, and limited time compared to his responsibilities."

To date, Duffy points out, a hospital's option for cleaning up its chargemaster and bringing it up to date and into compliance has been to hire a consulting firm, which in turn recruits a coder. "That coder will come in and test the chargemaster against some kind of standard [and bring it up to speed]. The fee for that will be $100,000, and on the day they finish, the chargemaster become obsolete."

The Chargemaster Institute's approach, in contrast, will be to train a person from the hospital — during a three-week intensive in Carlsbad — on the sophisticated software associated with the chargemaster, he says. As part of the training, that individual will bring the chargemaster up to the industry standard, and will learn how to keep it up to standard, Duffy adds.

The new CPT (common procedure terminology) codes are published annually, he notes, and all graduates of the Chargemaster Institute will come together to install those codes for their organizations. The cost for the entire training cycle will be $19,500, Duffy says.

"These people [who work with chargemasters] are islands of information," he notes. "There is no professional organization that supports that. Some of what they do will be very routine — add a new code, make a procedure change. Some of it will be highly sophisticated, where you get into multi-tiered discussions with HCFA, [as in], 'The physician wants to do this. How do I do it?' You can find a new opportunity at every turn." ■

Hospital profit margins show negligible increase

Operating profit margins at U.S. hospitals flattened at an annualized average of 3.69% in 2000, indicating only a slim degree of financial health, according to a report by Solucient, a provider of benchmark information on health care.

Hospital operating margins increased 0.41% over 1999 and remained relatively low, a full 36.6% lower than in 1997. Solucient president **Gregg Bennett** says margins of from 3%-4% are not sustainable in the long run, especially given the pressure from increasing drug costs and hospital labor shortages. He also says hospitals are still feeling the sting of the 1997 Balanced Budget Act and its clamp on Medicare payments.

Other key findings from the study, "The Health of Our Nation's Hospitals," include: smaller hospitals finished the year best at 4.84%, their highest operating margin since 1997; larger hospitals produced the slimmest operating margins at 2.83%; regionally, western hospitals posted the weakest operating margins — 3.9%, while northeastern

hospitals fared the best, going from break-even in 1999 to almost 5% in 2000. For more information, visit www.solucient.com. ▼

Teaching hospitals give more than their share

Medical schools and their primary teaching hospitals are providing a disproportionate share of uncompensated care to the poor and uninsured, according to a study released by The Commonwealth Fund.

The study, "A Shared Responsibility: Academic Health Centers (AHC) and the Provision of Care to the Poor and Uninsured," reports that such institutions provide uncompensated care at a rate that is increasing faster than for other types of hospitals.

Partially based on data provided by the "AHA's [American Hospital Association] Annual Survey of Hospitals," the study reports that AHCs are experiencing a substantial increase in the treatment of patients who do not have health insurance and cannot pay for medical services. Other types of hospitals see a decrease in such care, the study shows. AHCs are providing up to 44% of the charity care provided in some communities, and that care is causing a significant negative impact on the AHCs' operating margins. For more, go to www.cmwf. org. ▼

AHA adds group on outpatient coding

The American Hospital Association (AHA) has launched a new division to provide hospitals advice on how to properly code for Medicare outpatient services.

The new division, the Central Office on the Health Care Financing Administration's Common Procedural Classification System (HCPCS), was created to respond to Medicare's new outpatient payment system that requires hospitals and health systems to code for all outpatient procedures or services.

Hospitals that direct HCPCS coding questions to the AHA will receive written advice. Questions can be sent to the AHA's Central Office on HCPCS, One N. Franklin St., 29th Floor, Chicago, IL 60606.

In addition, AHA Coding Clinic on HCPCS provides advice, articles, and regulatory updates in a quarterly newsletter that is available through AHA's order services at (800) 242-2626. A continuing education video program, "Implementing APCs: Best Practices," is available at (888) 999-9242. ▼

HCFA gives direction on cost-to-charge ratios

The Health Care Financing Administration (HCFA) has provided Medicare program

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Editorial Questions

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Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

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intermediaries detailed instructions on how they are to calculate the payments certain hospitals and community health centers are due to make up for some of the losses they suffered in the switch to the outpatient prospective payment system, according to a report in the on-line news service *AHA News Today*.

HCFA's Program Memorandum Transmittal A-01-51 gives instructions on how to calculate payment-to-cost ratios for determining the transitional corridor payments, or transitional outpatient payments. Rural hospitals with fewer than 100 beds, qualifying cancer hospitals, and children's hospitals are to receive the full difference between what they would have gotten under the pre-Balanced Budget Act system and what they would get under the new outpatient prospective payment system. All other hospitals and CMCHs get a portion of that difference.

The new program memorandum also notes that hospitals using subscripted cost centers and providers that changed the types of services they furnish after the cost reporting period HCFA used to calculate the original ratio may request recalculations of their cost-to-charge ratios. ▼

CBO: McCain-Kennedy bill would drive up care costs

The patient's bill of rights co-sponsored by Sens. John McCain (R-AZ), and Edward Kennedy (D-MA), would increase premiums by an additional 4.2%, according to an analysis by the Congressional Budget Office (COB).

Critics say this could cause many employers, already facing a 13% increase in health care costs this year, to drop plans. **Dan Danner**, chairman of the Health Benefits Coalition, says it would be "unconscionable" for Congress to enact any legislation that would make health care more expensive and risk the possibility of millions of more Americans losing their health coverage.

Despite language regarding a "cap" on lawsuit damages to employers, the bill still leaves them open to unlimited, class-action suits, the COB study contends. A recent survey shows that 46% of employers carrying health plans would drop them if they were made vulnerable to expanded health care liability. A copy of the CBO analysis, requested by Sen. Don Nickles (R-OK) of the Budget Committee, can be found at www.cbo.gov/showdoc.cfm?index=2796&sequence=0&from=7. ■

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Confidential Salary Survey

This confidential salary survey is being conducted to gather information for a special report later in the year. Watch in coming months for your issue detailing the results of this salary survey and the overall state of employment in your field.

Instructions: Circle the appropriate answer directly on this form. Please answer each question as accurately as possible. If you are unsure of how to answer any question, use your best judgment. Your responses will be held strictly confidential. Do not put your name or any other identifying information on this survey form.

1. What is your current title?
   A. access manager
   B. director, access management
   C. manager, patient accounts
   D. supervisor
   E. patient accounts representative
   F. other _____

2. Please indicate your highest degree.
   A. ADN (2 yr)
   B. diploma (3 yr)
   C. BSN
   D. MSA
   E. other _____

3. Please indicate which of your certifications best represents your current position. (Choose only one.)
   A. FHFMA
   B. CHAM
   C. RRA
   D. MSA
   E. other _____

4. Including your past and present employers, how long have you worked in positions with the same or similar responsibilities as your current position(s)?
   A. less than 1 year
   B. 1 to 3 years
   C. 4 to 6 years
   D. 7 to 9 years
   E. 10 to 12 years
   F. 13 to 15 years
   G. 16 to 18 years
   H. 19 to 21 years
   I. 22 to 24 years
   J. 25 or more years

5. Including your present and past employers, how long have you worked in the health care field?
   A. less than 1 year
   B. 1 to 3 years
   C. 4 to 6 years
   D. 7 to 9 years
   E. 10 to 12 years
   F. 13 to 15 years
   G. 16 to 18 years
   H. 19 to 21 years
   I. 22 to 24 years
   J. 25 or more years

6. What is your age?
   A. 20 to 25
   B. 26 to 30
   C. 31 to 35
   D. 36 to 40
   E. 41 to 45
   F. 46 to 50
   G. 51 to 55
   H. 56 to 60
   I. 61 to 65
   J. 66 or older

7. What is your sex? A. male B. female

8. What is your annual gross income from your primary health care position. Please exclude additional income from teaching, consulting, bonuses, etc. To answer this question, circle the correct salary.

A. less than $20,000
B. $20,000 to $24,999
C. $25,000 to $29,999
D. $30,000 to $34,999
E. $35,000 to $39,999
F. $40,000 to $44,999
G. $45,000 to $49,999
H. $50,000 to $54,999
I. $55,000 to $59,999
J. $60,000 to $64,999
K. $65,000 to $69,999
L. $70,000 to $74,999
M. $75,000 to $79,999
N. $80,000 to $84,999
O. $85,000 to $89,999
P. $90,000 to $94,999
Q. $95,000 to $99,999
R. $100,000 to $104,999
S. $105,000 to $109,999
T. $110,000 to $114,999
U. $115,000 to $119,999
V. $120,000 to $124,999
W. $125,000 to $129,999
X. $130,000 or more

9. If you or your company charges clients by the hour, please indicate the hourly amount. If you do not charge by the hour, please mark answer I.
   A. less than $30
   B. $31 to $50
   C. $51 to $70
   D. $71 to $90
   E. $91 to $110
   F. $111 to $130
   G. $131 to $150
   H. $151 or more
   I. do not charge by the hour

10. On average, how many hours a week do you actually work? (Regular hours plus overtime, regardless of whether you're paid extra.)
    A. less than 20 hrs/week C. 31 to 40 E. 46 to 50 G. 56 to 60 I. more than 65 hrs/week
    B. 20 to 30 D. 41 to 45 F. 51 to 55 H. 61 to 65

11. In the past 12 months, how has your salary or income increased or decreased?
    A. salary decreased C. 1% to 3% increase E. 7% to 10 % increase G. 16% to 20% increase
    B. no change D. 4% to 6% increase F. 11% to 15% increase H. 21% or more increase

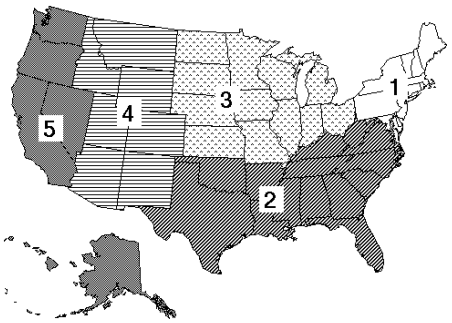
12. In the past 12 months, how has the number of employees in your company or department changed?
    A. increased B. decreased C. no change

Please rate the following benefits according to how important they are in determining your job satisfaction. Use the following scale, and be sure to mark the benefit's importance only if your employer currently provides that benefit to you. If your employer does not currently provide that benefit, or if your company has no benefits, mark 5.

	Extremely important		Somewhat important		Benefit not provided		Extremely important		Somewhat important		Benefit not provided
13. medical coverage	1	2	3	4	5	20. pension plan	1	2	3	4	5
14. dental coverage	1	2	3	4	5	21. profit-sharing plan	1	2	3	4	5
15. eyecare coverage	1	2	3	4	5	22. annual or semi-annual bonus	1	2	3	4	5
16. life insurance	1	2	3	4	5	23. elder care	1	2	3	4	5
17. 401k or other plan	1	2	3	4	5	24. maternal/paternal leave	1	2	3	4	5
18. child care	1	2	3	4	5	25. some freedom to choose work schedule	1	2	3	4	5
19. tuition reimbursement (including CE credits)	1	2	3	4	5	26. exercise facilities or health club membership	1	2	3	4	5

27. Over the last 12 months, has your contribution to the cost of your medical benefits increased, decreased, or stayed the same? (Don't include deductibles or copayments. If you don't contribute to your medical plan or don't receive medical benefits through your job, please mark either D. or E.)
    A. increased C. no change E. I don't contribute to my plan
    B. decreased D. I don't receive medical benefits

28. Using the map provided here, please indicate where your employer is located.
    A. region 1 C. region 3 E. region 5 G. other
    B. region 2 D. region 4 F. Canada



29. Which of the following best describes the location of your work?
    A. urban (within a large city) C. medium-sized community
    B. suburban (in a community within a metropolitan area dominated by large city) D. rural

30. Which best describes the ownership or control of your employer?
    A. college or university D. nonprofit (church-operated, volunteer, etc.)
    B. federal government (VA, military, and federal agencies) E. for profit (individual, private practice, or corporation, etc.)
    C. state, county, or city government

31. Which of the following best categorizes the work environment of your employer? Choose only one answer.
    A. academic C. city or county health department E. college health service G. hospital
    B. agency D. clinic F. consulting H. private practice

32. If you work in a hospital, what is its size? (If you don't work in a hospital, please mark J.)
    A. < 100 beds D. 301 to 400 beds G. 601 to 800 beds J. I don't work in a hospital
    B. 101 to 200 beds E. 401 to 500 beds H. 801 to 1,000 beds
    C. 201 to 300 beds F. 501 to 600 beds I. > 1,000 beds

Deadline for responses: July 15, 2001

Thank you very much for your time. The results of the survey will be reported in an upcoming issue of the newsletter, along with an analysis of the economic state of your field. Please return this form in the enclosed, postage-paid envelope as soon as possible. If the envelope is not available, mail the form to: Salary Survey, American Health Consultants, P.O. Box 740058, Atlanta, GA 30374.