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IN THIS ISSUE

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Successful pre-services result of innovation and technology

Innovative system decreases denials and increases upfront collections

Carolinas HealthCare System in Charlotte, NC, regularly preregisters between 96% and 98% of its scheduled patients — while reducing denials and accounts receivable (AR) days — thanks to an innovative and ambitious pre-services department that serves four acute-care facilities.

In addition to handling preregistration, insurance verification, and nonclinical authorization for inpatients and a large outpatient population, the pre-services unit — located in an off-site office building — also does upfront cash collections, reports **Lisa Grodevant**, CAM, assistant vice president of patient registration.

After verifying insurance for the patient who has just been preregistered, pre-services staff call the person back, explains Grodevant, who oversees registration for Carolinas Medical Center, the health system's 795-bed flagship facility. "They say, 'We verified your information, and your copay is this amount. How would you like to pay?'"

Patients may give their credit card number or use an on-line check system, she says. For five of the first six months of 2004, monthly upfront collections by the pre-services staff have exceeded $120,000, Grodevant adds.

Annual upfront collections — including cash collected at all the system's points of service — totaled just under $6 million in 2003, up from some $70,000 annually when the collections effort began 4½ years ago, notes **Katie Davis**, CAM, who also is vice president of patient registration, and has responsibility for the pre-services area and the system's other three acute-care facilities.

While the pre-services staff have a goal of having preregistered at least 94% of the patients scheduled for a procedure the next day, she says, "we have been exceeding that. We're usually at 96%, 97%, or 98%."

Managers monitor the percentage of scheduled patients preregistered for days one through five (before the service), and then for those preregistered on days six through 10, Davis adds. **(See preregistered**

charts for five days out and next day, p. 99.)

"The schedules are very dynamic," she explains. "Any schedule is subject to add-ons. Registration staff at the [four hospitals] depend on the pre-services department to get the work done for them. We don't have staff at the facilities to handle preregistration."

Staff pull schedules frequently to make sure add-ons are caught in a timely fashion, Grodevant points out. "We check the schedule today for [add-on] patients coming in later this afternoon, and for the next day. That has helped our percentages go up in the past month."

While the goal is to have at least 50% of registrations done in week two before the procedure, she adds, "We're usually running above that — at between 70% and 80%. A lot of streamlining with reports and processes has helped."

Dramatic improvements in the system's revenue cycle in the past four years, particularly the increase in upfront cash and an 86% decrease in net denials, are largely due to the efficiencies of the pre-services department, Grodevant notes. **(See Revenue Cycle chart, p. 100.)**

"When we started our pre-services department four years ago, as with any new process, we ramped up staff," Davis says. "At one point, we had close to 70 people in pre-services. We also were doing a lot of things manually — making a lot of calls to insurance companies, then turning around and making another call for clinical authorization."

Over time, the unit — which now has 56 employees, including two managers — has gained efficiencies, benefiting from, among other things, an online eligibility system that connects with seven different insurance companies, she reports. "For those that are not on that system, we get a lot of information from web sites."

In another timesaving move, the pre-services department worked with Carolinas HealthCare's managed care department, which negotiates payer contracts, to have a list of services that require authorization put on the health system's intranet, Davis adds.

Because of the resulting increase in accuracy and efficiency on the front end, there is less work on the back end, she points out.

"Patient accounting has been able to reduce or reassign staff," Davis says. "They've brought some of the things they had outsourced, such as working returned mail, back in-house."

It's hard to do a before-and-after comparison on the number of accounts preregistered, Grodevant notes. Before the establishment of the pre-services department, she adds, there was some preregistration activity and some authorization of high-dollar surgeries, but it was spread out and was done by different groups of people at each facility.

"We took the preregistration [function] from each facility, centralized it, and pulled it into one freestanding building that is totally separate from our other facilities," she says. Centralizing the process, Grodevant notes, has made possible a very refined level of specialization. An employee who has extensive experience in getting radiology procedures authorized, for example, can do that for all the hospitals, she adds, rather than

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Surgery Preregistrations — Five Days Out

Area	Number Scheduled	Number Preregistered	Number Not Preregistered	% Complete
CSDR	41	37	4	90
CORD	43	42	1	98
MORD	32	29	3	91
SOCL	4	4		100
SEND	9	9		100
UORD	40	40		100
TOTAL	169	161	8	96.5

Surgery Preregistrations — Next Day

Area	Number Scheduled	Number Preregistered	Number Not Preregistered	% Complete
CSDR	43	43		100
CORD	55	54	1	98
MORD	55	55	3	100
SOCL	6	6		100
SEND	21	21		100
UORD	46	46		100
TOTAL	226	225	1	99.7

Source for both charts: Carolinas HealthCare System, Charlotte, NC.

having one person at each facility who must have that expertise.

While moving staff from four different facilities to one big building in an office park posed an initial hurdle, Davis says, "the staff who are out here really like the office environment where their only contact with patients is by phone. When we hire, we try to find somebody who fits the job. Some people really enjoy the pace [of the hospital setting]."

In September 2003, she adds, three of the pre-services employees agreed to move even farther from the typical work setting by becoming part of a telecommuting project that continues to expand. **(For more details, see the October 2004 issue of *Hospital Access Management.)***

One of the technological innovations that has been particularly effective for the pre-services department, Davis says, is an on-line "admission log," or work list, that is used to communicate with other areas of the health system.

"We work hand-in-hand with clinical care management [CCM], which is what we call our case managers," she points out. "When we make that first nonclinical authorization call, and the insurance company [representative] says, 'I can give you a reference number, but we need this clinical information.'"

To get those answers, Davis explains, pre-services staff communicate directly with CCM staff by putting the patient's information on the on-line admission log, which can be viewed on the computer screen. "We say, 'Here's the clinical [issue], and here's the number you can call,' and they work that in real time."

"If they send us something back, we get on it quickly," she adds. A color-coded system helps indicate the priority that should be given to each item. "We can put in 'stat' if we need it right away."

Because the on-line admission log can be customized, pre-services staff also use it to communicate with the health system's financial counselors, Davis notes. If, for example, outdated insurance

Revenue Cycle Improvement from 2000 to 2004

Net Denials	86% Reduction
Total AR Days	28% Reduction
Upfront Collections	800% Increase
Gross Bad Debt	18% Reduction
Total Open Accounts	23% Reduction
Patient Accounting FTEs	6% Reduction

Source: Carolinas HealthCare System, Charlotte, NC.

information was given at the time of a patient's admission, she says, the financial counselor may discover the account actually will be self-pay after going to the patient's room to do an interview.

"When the financial counselor gets that information, she puts it onto the admission log and shoots it over to us," Davis adds. Conversely, if the financial counselor provides information that the pre-services staff determines to be inaccurate or outdated, they communicate that back to the financial counselor via the same log.

"We send a message saying, 'This insurance is not effective. Can you talk with the patient?' It's a real good communication tool."

While this back-and-forth communication could be done in the past by email, the beauty of the online admission log is that it is not dependent on one person checking his or her messages, Grodevant points out. "Everybody has access to the same list, so the next person available can take that message. It's just getting it done that much faster."

The department's managers have access to all the different logs — whether for care management, financial counseling, or insurance follow-up — so they can monitor them to make sure issues are being resolved in a timely manner, Davis adds.

The on-line admission log originally was developed by the information systems staff for use at the system's individual hospitals so that nursing units could communicate with the admissions department without picking up the phone, she says. "Then somebody out here said, 'Why can't we use that as a tool for pre-services as well?'"

At the smaller hospitals, Davis notes, if there is a patient in observation who needs to be admitted, a nurse enters that information on the log, which eliminates the need for a phone call. A registrar then pulls the account and changes the patient's status from observation to inpatient.

"It's also a good tracking mechanism," she says. "Carolinas Medical Center is a big facility. Patients will come in and say, 'I had to wait three hours.' We can look and see where the breakdown was. We can see what time the registrar went in and took that task, and what time she completed it."

Similarly, Grodevant notes, the hospital admitting departments can use the log to track productivity — how many tasks a person did on a given day — in the inpatient area.

Rescheduling procedures

Another important function performed by the pre-services department is the rescheduling of procedures for which authorization cannot be obtained, Davis says.

"If we haven't gotten an authorization 72 hours before the service, we send that patient's name, account number, and information [to the appropriate department]," she explains. "For example, if the patient is scheduled for surgery, we send [the information] to the operating room scheduling area. They call the physician's office and say, 'We don't have an authorization at this time."

The physician's staff may say they're in the process of getting the authorization, or have just gotten it and will send it over, or that they're having trouble getting it, Davis adds. What happens next is always the physician's decision, she emphasizes.

"We may ask, 'Do you want to reschedule until we have the opportunity to get the authorization?' If it's urgent, we do it — no questions asked — but if we can wait till next week, we do."

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Admitting area redesigned for hospital's QI project

Effort targets accountability, customer service

When it came time to reinvent the admissions process at St. Helena Hospital in Deer Park, CA, admitting director **Peggy O'Neill** faced tasks ranging from a complete overhaul of the staffing structure to a redesign of the department's physical space.

When O'Neill came to work at St. Helena in October 2001, changes already had been initiated, she says, thanks to a hospitalwide effort by senior management to determine "what single process needed to be improved for the good of all."

With the Malcolm Baldrige National Quality Award Criteria as a guiding force, team leaders from all the hospital's departments were broken into four groups and held roundtable discussions to determine what that process would be, O'Neill explains. "They were looking for the one thing that would improve customer service and the hospital as a whole."

When the brainstorming was over, she says, the area to be targeted was clear: "They all unanimously came up with admitting."

As part of a patient-focused care initiative, O'Neill notes, the hospital's admission process had been completely decentralized and was taking place on the nursing units. What had drawn the censure of the team leaders, however, was not so much decentralization, she says, as it was the lack of accountability.

"Training was poor at best, and the registrations were problematic," O'Neill adds. "Patients were not getting to their appointments on time, and there were inaccuracies in billing that slowed down reimbursement. Denials and write-offs were high, and the hospital was getting multiple customer complaints."

By the time O'Neill joined the team, she says, the health system's corporate patient financial services (PFS) director — who had selected St. Helena as the hospital to establish best practice for admitting — had laid the groundwork for the departmental redesign.

"[The PFS director] was instrumental in taking the temperature of the end users of the [admitting] products, getting the state of affairs and the areas that could improve, and developing a template," O'Neill explains. Those end users included the directors of hospital departments, physicians, and even members of the facility's board of directors, she adds. "They frequent our hospital and certainly could see that improvements were needed."

The PFS director also worked with the director of case management — who had oversight for what at that time was a very decentralized admitting process — and the chief financial officer, O'Neill adds, to determine the number of full-time equivalents (FTEs) that would be needed and to figure out the job classifications for the new staff.

At that point, in October 2001, O'Neill was hired, "and they turned it over to me to make all this happen," she says. "I wrote the last of the job descriptions, decided where the existing staff would be placed, and did the hiring, which took place over the next six months."

Designing the space

A big part of creating the new admitting department had to do with "redesigning the workstation environment from the ground up," O'Neill says. Her experience designing registration areas at three previous facilities came in handy, she notes, as she worked on the project with an outside architectural firm.

After a couple of drawings in which the architect could fit only eight workstations in the main admitting area, O'Neill says, she redrew the plan and made space for 11 workstations, drawing on her knowledge of where people and equipment needed to be placed.

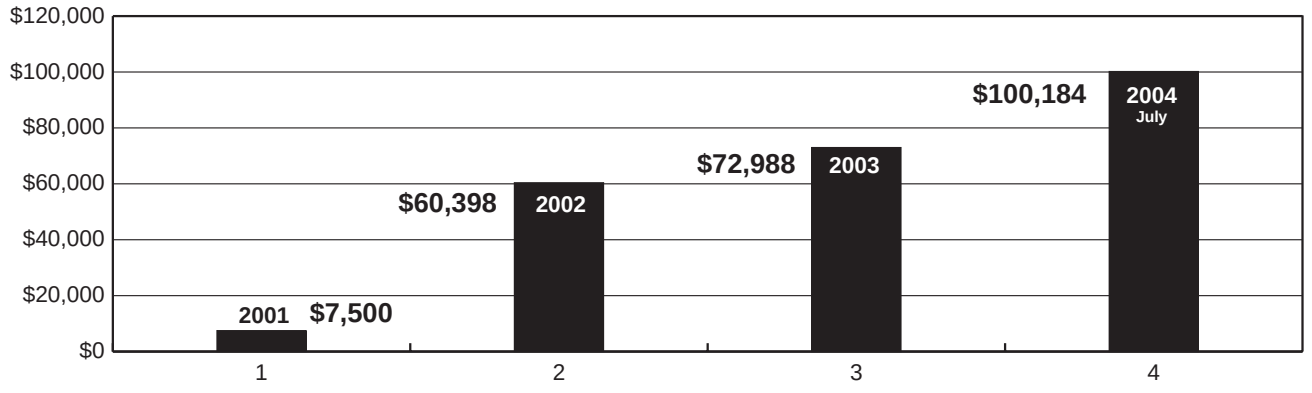
About 85% of the admitting process is centralized now, she notes, albeit with a physical presence in outpatient registration, which is about 100 feet down the hall, and the emergency department (ED), which is about 150 feet in the other direction.

"Some [of the process] is decentralized by location only," O'Neill adds, including in the behavioral health center, the women's center, the hospital's physical therapy sites, and a job care clinic. Registration staff in those areas, she says, have "dotted-line accountability" to admitting.

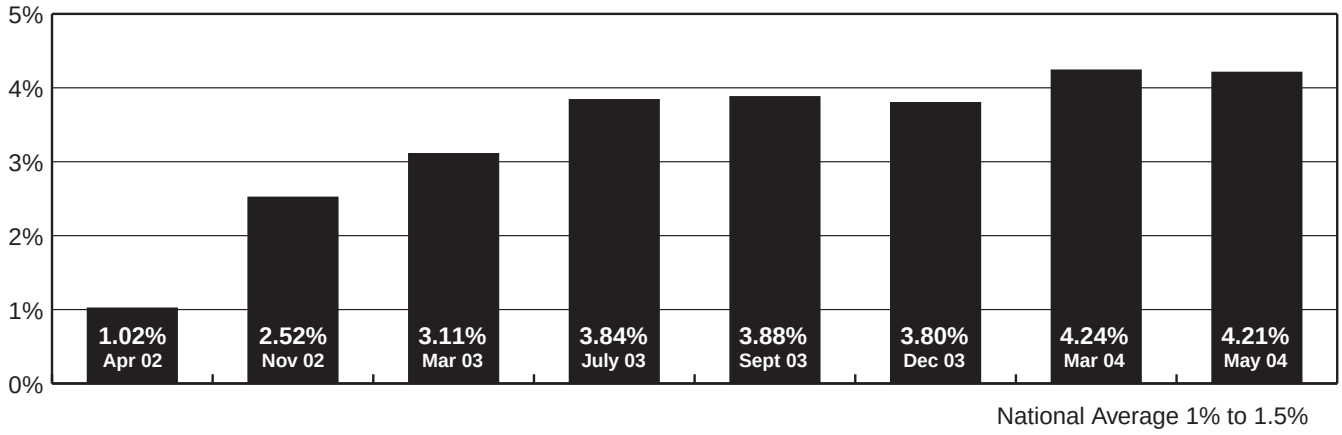
The next task O'Neill tackled was interviewing the existing staff members, she says, "finding out what each one really liked to do and was good at. We weren't laying off people, but were determining who had the skill set, temperament, and demeanor for certain jobs."

For example, O'Neill explains, one employee

Average Monthly Upfront Collections



Upfront Collections Percent Contribution to Total Hospital Collections



Source of both charts: St. Helena Hospital, Deer Park, CA.

felt stressed in her job of doing bed control, which came out in her voice as she dealt with people over the telephone. That person, she says, was reassigned to an insurance verifier position, where she could determine her workflow.

"That was the type of decision I made," O'Neill adds. "There was a little bit of psychology involved. We wanted to help those people who had been reporting up through other cost centers — such as the ED, outpatient surgery, or the nursing units — fit into the new state of admissions."

That left her with the knowledge of what positions remained to be filled, she notes. "I worked closely with human resources, and from November 2001 to June 2002, we were very heavy on hiring."

When she came to St. Helena, O'Neill says, there were 11.5 FTEs to cover central admission and outpatient registration, 24 hours a day, seven days a week. When the hiring process was completed, she adds, there were 22.7 FTEs.

"Some came in as a result of transfers from other cost centers, and some I had to advertise for," O'Neill explains. "We added staff in the ED and in the main admitting area, and then we had to layer in several more positions, including

another financial counselor, preregistration staff, and a [designated] bed control person.

Several key positions — most notably the outpatient financial counselor and the pre-registrars — added the time and expertise needed to facilitate the hospital's dramatic increase in over-the-counter (OTC) cash collections, she notes.

In the admitting area alone, monthly upfront collections have gone from $7,500 to $100,184. **(See Average Upfront Monthly Collections chart, p. 102.)** St. Helena now leads the 20-hospital Adventist Health system in OTC collections. **(See *Hospital Access Management*, August 2004, p. 88.)**

The idea behind the admitting initiative at St. Helena, she notes, was to provide the other Adventist Health hospitals with a model not only for cash collections, but also for registration accuracy and efficiency, customer service, and reducing denials and bad debt.

In addition to using general industry standards, goals for the various registration practices are set for each facility by the system's corporate office in conjunction with the hospital's senior leadership, she notes. Customer service scores are not to drop below "4" on the hospital's 1 to 5 rating system, for example. And the industry standard is that OTC collections should total at least 1.5% of total hospital collections, O'Neill adds, a goal the hospital exceeded by mid-2000. **(See Upfront Collections chart, p. 102.)**

Before implementing some of the changes in the admitting process, St. Helena was preregistering between 4% and 5% of patients, she says. Now the figure is 96% of scheduled cases.

Accounts receivable days have been reduced from 77.4 in January 2000 to 48.5 in June 2004, O'Neill notes.

In recognition of its improvements in the admitting process, St. Helena received Honorable Mention for the Best Practice Admission Model in 2003 from the California Council for Excellence, she adds.

The support — both financial and psychological — of the hospital's senior leadership team was a very big part of the department's success, she points out.

"The hospital leadership was very enthusiastic about taking on this role and lobbied for it," O'Neill says. "Once the decision was made, the money to fund this kind of redesign was there. They were committed to putting the department together the right way."

"It was so nice to get brand-new PCs and other equipment," she adds. "If they had said, 'Make do with old technology and with having staff scattered throughout the hospital, these changes wouldn't have been possible. We made a complete 180-degree turn."

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Frontline people are at top of the career ladder

'You're supporting those above you'

The most interesting thing about the "leadership ladder" for access employees at Children's Healthcare of Atlanta is that the frontline employee position is located at the top.

"It's labeled that way," says **Millie Brown**, senior director of the revenue cycle, "specifically because you're not really going up the ladder. You're going down the ladder, supporting the weight of what's above you. Usually, people think they climb up the ladder [as they get promotions], but I tell them, 'No, you're really climbing down.'

"Our concept," she adds, "is that those people are on top because they interact with the patients, and all of us below that are there to support them, rather than them supporting us."

The career ladder fits the concept of a five-point star — with the frontline employees represented by the top point — that the hospital uses to symbolize its mission, Brown notes. "We understand that it's those people in our organization who will drive everything else."

The access career ladder has been in place about two years, Brown says, and in following it she has done almost all of the promotions in her department, which has a staff of more than 120, from within. A crucial requirement for being promoted — level by level — to the next position has to do with demonstrating the characteristics of that job, she adds.

For example, Brown says, she might ask a registrar who is interested in becoming a lead registrar, which is like an assistant supervisor, whether other staff members come to her for help. "I'll say, 'When the lead isn't there and employees have questions, do they come to you? Or is there somebody else they're more likely to ask?'"

Brown has gone back to employees who have unsuccessfully applied for a supervisor job, she

notes, and said, ""Let's look at what a supervisor does. Can you say that people are looking at you like that?' If I ask staff, 'Who symbolizes this [position]? Is it you? If not, you've got some work ahead of you, don't you'?"

Tracy Wilson, a five-year employee of Children's who now is the hospital's interim manager of the central access verification team, has taken several steps on the career ladder — moving from emergency department (ED) registrar to team leader, to supervisor, to her current position, Brown says. But Wilson also has applied for a position and not gotten it, she points out.

When she first went after the job of ED supervisor, Wilson explains, she thought she was the obvious choice because of her experience as an ED registrar.

"When Tracy was interviewed," Brown recalls, "she really botched the interview because she thought she had it in the bag. There were other people applying who were equally skilled and, while she was in the running, it was obvious she didn't prepare. Her attitude was, 'Why am I even interviewing?' She was not giving credit to those who had come to the department since she left."

A panel did the interview — as usually is the case — and when it came time to vote, the panel members picked someone else, Brown notes.

"When I have someone come to me and apply for a job who doesn't get it," she adds, "I always offer them the opportunity to debrief me as to why [she or he] didn't get it, and what can increase their chances of being the top candidate next time."

Wilson's coaching, Brown says, "was on how to present yourself and sell yourself, and how important an interview is, no matter how much you think you know the position."

After the interview, Wilson continues, "she told me how it went and that she thought I could do some things differently. She gave me a book to read. The next time I interviewed, I laid out all my qualifications, and gave them a copy. I acted like I was interviewing with somebody I didn't know."

The fact that she got the job that time, she adds, "was due to all that feedback and coaching and that book."

If an access employee expresses the desire for career advancement, Brown notes, "We give pretty much constant coaching."

"If there's a scenario I need help with," Wilson adds, "she gives me her perspective — practical advice on how to handle a situation, and what she might do differently than what I'm thinking. Many times I'm not looking at the big picture."

In the case of an employee who needs to be disciplined, Wilson might give her the circumstances and describe the action she's planning to take, Brown explains. "Then we role-play. I play devil's advocate, giving every objection I can think of that the employee might come up with."

Before the leadership ladder was established, Wilson notes, "people didn't understand what they needed to do to move up. You could interview from wherever — you didn't need to be a team leader to interview for supervisor. Jobs were almost always opened up to outside [applicants]."

When she needs to fill a position, Brown says, she looks outside the hospital only if she doesn't have a viable candidate within. "If I do go outside, I feel there is a failure on our part. We have either failed to hire appropriately or failed to teach appropriately."

"Even now, Tracy knows that her role includes teaching my team leads how to be supervisor," Brown adds. "If you move up, you need to have somebody to replace you. Last year, there were 11 internal promotions within our department."

Dealing with qualified candidates

The leadership ladder did not affect departmental salaries, she says. "What has changed is that staff now know there are opportunities [for advancement] if they do a good job. All they have to do is ask, and the path — the steps they need to take to personally advance — will be given to them."

Her own recent promotion, from director of access to senior director of the revenue cycle, is a natural outgrowth of the process, Brown points out. "I know that my success comes from my team. If everyone feels they can move up, it helps me move up and it creates more opportunities for them. It really works that way."

If there are too many qualified candidates looking for leadership opportunities, she notes, "We look for other places in the system where there are openings. We had a lead who was ready to be a supervisor, and I recommended her for a job in the transplant unit. She got a supervisor job over there, based on my recommendation."

Kim Wagner, interim manager of the case management unit — which reports to access — says that moving an employee to another area in the hospital directly benefits the access department. "We have a great advocate on the other department's team."

"This is the first place I've worked where the leadership team encourages us to move up," Wagner adds. "It's obvious they want to invest in us for our benefit, not just for theirs. When people know that is how we're going to handle promotions, it adds a lot of trust with staff."

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Proactive approach leads to revenue job

'I tried to be the best'

Throughout a couple of different access careers — interrupted by a brief stint as an elementary school guidance counselor — the thing that stood out for **Millie Brown** was how much more impact she could have on the front end of the health care financial process than on the back end.

Recently named senior director of the revenue cycle at Children's Healthcare of Atlanta, Brown also has some advice for those who feel stuck in a dead-end job but don't want to take a step backward in order to take another one forward: "Sometimes, that's the right thing to do."

And she adds, "Whatever I was doing, I tried to be the best at it, to be excellent, even if it was something I didn't love."

Those times of not loving the job appear to be even farther in the past as Brown moves from a successful tenure as director of patient access to her new position, where her role will be examining the various parts of the revenue cycle and coming up with appropriate quality processes. First on the list, she says, will be outpatient clinics, the organization's cancer center, rehabilitation services, and other areas where access functions were not directly under her supervision as patient access director.

"I will go into the area and perform a 'SWOT' [strengths, weaknesses, opportunities, threats] analysis, look at strengths and weaknesses, what the opportunities are, what the threats are, and then help put [improvements] in place," Brown says.

Before, she explains, the managers in those areas were invited to attend meetings aimed at enhancing their effectiveness, "but sometimes they would come, and other times they didn't." While the main access area was running efficiently, Brown adds, there were pockets of these outlying access operations that weren't doing well at all.

"I'm going in to make sure everybody is equal in terms of expertise," she says, noting that she will be "almost like an internal consultant, except that I will be helping with implementation. Hopefully, I will take what I've done [as patient access director] and mirror it in different places."

Moving up the access ladder

Before coming to work for Children's about five years ago, Brown notes, she had worked as a financial counselor and later managed a billing office at another health care organization. She left that job to become an elementary school guidance counselor, she says, because she was attracted to the shorter commute and earlier quitting time. After meeting someone who worked at Children's, she was drawn back into the access field, Brown says, when she was offered a financial counseling job that allowed her to keep the same work hours she had at the elementary school.

"One day the billing director brought me some bills and said, 'All these bills were denied,'" Brown adds. "She asked me to check to see if I had entered something wrong."

Knowing she wasn't at fault, Brown nevertheless corrected the bills, took them back to the director, and explained that the errors had to do with how the claims were processed. "I said, 'I'd be happy to show [the billers] what went wrong and how I would have handled the claims."

That conversation eventually led to Brown being offered the job of billing manager, which she accepted — despite the return to longer hours. As financial counselor, she adds, "I found it frustrating not to be able to effect change."

After a little more than a year as Medicaid billing manager — during which Brown implemented a new system that led to a substantial decrease in accounts receivable (AR) days — she was asked to become access director.

"They originally offered me the director of patient accounts position, but then changed [the offer] to director of access," notes Brown, who says she was pleased with the change in plan. "I felt [access director] was a job in which I could have the greatest effect on the system. We had good managers in billing and so I knew that being able to marry the two [areas] would make us successful."

A proactive approach

As the newly hired access director, Brown focused immediately on the quality of registration data — specifically the proper identification of patients' insurance plans — which resulted in more than 75% of claims being paid the first time out. The positive financial impact on the health system was approximately $20 million less in annual denials. **(See the July 2003 issue of *Hospital Access Management*, p. 76.)**

A proactive approach has always been her hallmark, she explains. Working as a financial counselor at her previous organization, Brown notes, she could only get credit for her successes in finding coverage for patients if they resulted in the account actually being paid. Those accounts, however, often were written off for lack of timeliness or other billing mistakes.

"I finally said, 'Why don't you let me bill my own accounts?' So they did — it was more or less on a dare." The challenge paid off for that facility, which resulted in a drop in AR days from 140 to 56 over a three-month period, she adds.

Looking back over her career, to date, Brown notes that she left management positions twice, started over as a financial counselor, and then worked her way up to get even higher on the access ladder. Hence, her advice about not being afraid to take a step backward if it seems appropriate.

Brown has a few other pieces of advice that she shares with her team: "No 1: Always look and act like the leader you want to be. No. 2: Find a mentor — preferably more than one, because not everybody does everything well — that is the

best at what you want to improve."

And, she adds, perhaps most importantly, "Be the one that is always there to help others — whether they're your staff or your peers — because when push comes to shove, they'll be there for you." ■

Nonprofit hospital settles suit for $150 million

A large Mississippi-based hospital has reached a landmark agreement, valued at $150 million, with a group of lawyers. Under the agreement, the system will provide free and discounted care for patients without health insurance.

This agreement sets a precedent that could put pressure on at least 40 other nonprofit hospital systems included in class-action suits for allegedly overcharging uninsured patients and then using aggressive tactics to seek payment. These hospitals have been accused of breaching their charitable obligations in their financial dealings with the uninsured.

North Mississippi Health Services (NMHS) announced on Aug. 5 that it agreed to the new billing practices for the uninsured to avoid protracted litigation and avoid getting tangled up in a lawsuit that would distract the system from addressing other important issues.

The NMHS system includes the 650-bed North Mississippi Medical Center in Tupelo and five smaller hospitals in north Mississippi and western Alabama. The Tupelo facility is the largest hospital in Mississippi and is thought to be the nation's largest nonmetropolitan hospital.

Richard Scruggs, who leads the plaintiff's attorney group, sees this settlement as a "template" for other nonprofit hospital systems to change their treatment of the uninsured. He further states that about a dozen other hospital systems, including some that have not been sued, are currently discussing settlements with his group.

The Mississippi agreement, which begins Oct. 1, includes the following terms:

- Anyone who is uninsured with household income of up to 200% of the federal poverty level (about $37,000 for a family of four) will receive free medical care.
- The uninsured with household income of up to 400% of the federal poverty level (up to about $74,000 for a family of four) would receive discounted rates for care.
- Overall, uninsured people would face collections of no more than 10% of their income per year.

The Mississippi health system also agreed to refund uninsured patients who have received services over the past three years and who would have qualified under the new revised policy. NMHS also agreed to stop aggressive bill collection practices.

Scruggs states that, if the agreement spreads to other hospitals, it would go a long way toward solving the problems of the uninsured. The lawsuits state that nonprofit hospitals have enjoyed tax-exempt status while they accrued millions of dollars in cash and securities. In the process, the lawsuits allege, the hospitals have broken their promise to the government to operate as a charity provider by charging the uninsured at rates that are far higher than those billed to patients with insurance. ▼

COMING IN FUTURE MONTHS

- Staff embrace telecommuting project
- 'Access Career Path' reaches VP level
- Strategies for staff training
- A look at the 'Hospital Report Card Act'
- Financial counseling initiative pays off

CMS: Reimbursement for immigrant care proposed

The Centers for Medicare & Medicaid Services (CMS) has proposed an approach for reimbursing hospitals and other health care providers for emergency health services provided to undocumented immigrants.

The Medicare Modernization Act earmarked $250 million a year in fiscal years 2005 to 2008 to help hospitals and certain other emergency care providers recoup a portion of the costs associated with providing such emergency services.

A paper describing CMS' proposed implementation approach can be found at www.cms.hhs.gov/providers/mma1011.pdf

The American Hospital Association has said it was disappointed the proposal would, in many cases, still require hospitals to ask patients' immigration status. ▼

AHRQ outlines alternate health care sites

A tool to help state and local officials quickly locate alternate health care sites if hospitals are overwhelmed by patients because of a bioterrorism attack or other public health emergency has been released by the Agency for Healthcare Research and Quality (AHRQ), part of the federal Health and Human Services Department.

The tool allows regional planners to locate and rank potential alternative sites such as stadiums, schools, and recreation centers based on whether they have adequate ventilation, plumbing, food supply, kitchen facilities, and other factors.

Produced by Denver Health, a partner in ARHQ's Integrated Delivery System Research Network, the tool was shared with emergency response planners at the 2004 Summer Olympics in Athens, Greece. It can be found in a new ARHQ report, "Rocky Mountain Regional Care Model for Bioterrorist Events." ■