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Negative press of hospital pricing policies becomes movement to reshape industry practices

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REVENUE & CAPITAL MANAGEMENT

Website marketing strategies help hospitals attract 'medical tourists,' boost revenue

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Announcement

Register now for the upcoming Financial Leadership Council teleconference, "Member Case Study: 'The Art of the Deal' – Implementing Physician Partnerships," to be held Friday, Dec. 2 at 3:00 p.m. EST. Council member Lydia Jumonville, Baylor Health Care System's chief financial officer, will share specific lessons drawing from Baylor's experience with employment, joint ventures, and specialty hospital development. To register, please visit Advisory.com or contact Jennifer Henderson at 202-266-5346 or hendersj@advisory.com.

POLITICS, RULES, & REGULATIONS

Negative press of hospital pricing policies becomes movement to reshape industry practices

Not-for-profit hospitals have contended with public relations pressures on their pricing, billing, and charity care policies since early 2003, when allegations portraying their operating practices in a negative light were first raised nationwide (*Healthcare Financial Management*, November 2005). Although hospitals have acceded to expanded charity care policies and won the dismissal of potentially damaging lawsuits, these PR challenges have evolved into long-running concerns that threaten to reshape how hospitals operate and will likely fuel the industry's move toward pricing transparency (*AHA News Now*, 11/8/05).

Aggressive news stories foment, spread

The first cycle of negative hospital coverage began in early 2003 with stories alleging that hospitals were violating the spirit of their not-for-profit tax-exempt status by overcharging uninsured patients and aggressively pursuing collections; in some cases, hospitals rebutted the claims by explaining that the stories were fed to newspapers by unions "[seeking] to mislead...and [pressure] union targets" and force hospitals to accept new contractual agreements (Bass, *New Haven Advocate*, 5/8/03). Regardless of their origins, however, these issues quickly grabbed political attention and forced an examination of hospital operating practices.

Negative media coverage leads to full-blown concerns for many hospitals

First national story condemning hospital pricing policies breaks in early 2003...


THE WALL STREET JOURNAL.

March 2003: "HEARTLESS HOSPITAL" overcharges poor, relies on collection agencies, misuses charity-care funds; state sues hospital

...generating scrutiny of key hospital operating practices and guidelines

	Billing and collections	*Community benefit*	*Property-tax exemption*
2003-2004	Allegations of overcharging of uninsured spawn lawsuits, Congressional investigation	Union-sponsored reports argue that hospitals spend too little on community benefit	Combination of billing, charity care concerns lead one Illinois hospital to lose its property-tax exemption
2004-2005	Hospitals back off aggressive collection tactics, increase patient eligibility for charity care	Hospitals clarify how they classify community benefit, promote figures to community	Five hospital groups file a court briefing to support efforts to reclaim property tax-exempt status
Late 2005	First lawsuit settled but most already dismissed; state attorneys general raising same concerns	Chicago, Sacramento city councils considering vetting expansion projects for community benefit	Calif., Cleveland hospitals scrutinized for possible violation of property tax-exempt status

Source: Lagnado, *Wall Street Journal*, 3/13/03; Vogt, *AMNews*, 3/14/05; Colliver, *San Francisco Chronicle*, 8/2/05; *Sacramento Bee*, 10/23/05; Boulton, *Milwaukee Journal Sentinel*, 11/8/05.

Since the media first raised allegations, hospitals have staved off some criticism and won plaudits by expanding their charity care policies and more clearly documenting community benefit. However, the varied points of dispute and hospital responses do not obscure that, fundamentally, hospitals' complex and confusing pricing practices leave them especially vulnerable to negative media coverage and continued scrutiny.

Hospitals easy targets for lawsuits, 'political opportunism'

Most significantly, hospitals' inability to easily communicate why uninsured patients are charged at a higher rate than covered patients has left them, if not legally culpable, guilty in the court of public opinion and exposed to pressure to change pricing policies. Although many of the over 50 class-action lawsuits that allege aggressive hospital collection practices and systemic overcharging of the uninsured have since been dismissed, one health system's decision to settle this month proves that the "threat...still has teeth" (*Watch* interview, 11/15/05). According to administrators at Portland, Ore.-based Providence Health System—the first hospital in the nation to settle a class-action lawsuit—the high cost of potential litigation overrode their "disagreement" with many of the allegations and forced a deal (McCall, Associated Press, 11/1/05).

Moreover, with many of these lawsuits in traction, state attorneys general (AGs) increasingly are picking up the argument. In June, Minnesota's AG used the threat of litigation to pressure over 50 hospitals into accepting pricing discounts for uninsured patients; Wisconsin's AG filed charges this month against two hospitals for "price gouging" of the uninsured (Evans, *Modern Healthcare*, 11/14/05). However, while Minnesota's AG was perceived as pursuing "an industry standard" and health care reforms, critics allege that the Wisconsin AG's move is "basically...a stunt" aimed at strengthening the AG's bid for reelection (Boulton, *Milwaukee Journal Sentinel*, 11/8/05).

Pricing transparency next logical step

With politicians increasingly interested in legislating hospital pricing practices, experts believe that this wave of scrutiny will ultimately culminate in a shift for the industry; specifically, hospitals should prepare for an "imminent and irreversible move to pricing transparency," according to Preston Gee, managing director of Austin, Texas-based Phase2 Consulting (*HFM*, November 2005). Ironically, this shift is not fueled by patients—seemingly the group most affected by a change in practice—as they so far have seemed ambivalent to transparent prices; in California, few patients have sought out hospital chargemasters despite a state mandate making them available, largely because understanding the complex terminology is difficult for the average patient (*HealthLeaders*, November 2005).

Instead, other forces will likely drive the growing movement; a number of AGs and state legislatures are investigating avenues to make chargemasters both "public...and comprehensible," and non-hospital players increasingly are employing methods to steer patients to the least-costly providers. The insurer Cigna, for example, has introduced a three-star rating system that ranks hospital by their contracted rates for specific services, with one star being the least expensive and three stars the most (Benko, *Modern Healthcare*, 11/14/05). According to a Cigna spokesperson, the insurer plans to replace the stars with actual price ranges in December "to give members a truer feel for what things cost."

Fittingly, Gee believes that hospitals can best prepare for this potential sea change in industry practice by setting up "clear communication channels" to avoid negative press (*HFM*, November 2005). Finance staff should understand how an organization's prices compare with those of regional competitors, reconfigure charge lists if prices are not comparable, and work to help the rest of the hospital's staff in grasping the organization's pricing policies. According to Gee, a hospital must present a "unified communication message" and strategy to external groups that review price data in order to avoid drawing unnecessary media scrutiny of pricing policies.

For more information

The Financial Leadership Council is organizing a roundtable of leading members interested in sharing best practices to simplify pricing and the billing process. This roundtable will convene via teleconference with Council staff support to collectively address pricing transparency and push on creation of a new model for the industry. Members who would be interested in participating are invited to contact Aneesh Chopra, managing director, at 202-266-6891 or chopraa@advisory.com.

POLITICS, RULES, & REGULATIONS

On Our Watch

Tougher bankruptcy laws spike bad debt, hamper consolidations

Strict regulations on bankruptcy filings that went into effect last month will cause a "momentary" rise in bad debt and challenge how for-profit hospitals acquire not-for-profit providers, *Modern Healthcare* reports. The regulations, which were signed into law by President Bush last April, make it more difficult for debtors to erase their financial obligations after filing for bankruptcy, leading some hospitals to report a spike in patient bankruptcy notices as the deadline neared; New York-based St. Vincent Catholic Medical Centers, for example, had averaged six notices per week but received 29 notices in the week prior to the change. An attorney for the law firm McDermott, Will & Emery predicted this rise in hospital bad debt will be a one-time event in the third quarter of FY 2005; however, the laws will likely hinder hospitals' ability to file for bankruptcy to erase debt as filings and negotiations will be "more expensive and…difficult." The regulations also will complicate the sale of assets from not-for-profit organizations to for-profit organizations during consolidation; the new regulations defer the handling of such assets to state law, whereas the previous application of state law was "ambiguous." Industry experts surmise that these standards may damper for-profit hospitals' "appetite" for acquiring less profitable not-for-profit facilities (Becker, 11/21/05; Pickler, Associated Press, 4/20/05).

Medicare cracks down on payment errors, saves $9.5 billion

CMS officials this month announced that Medicare saved an estimated $9.5 billion during the last fiscal year by cutting the number of payment errors in half after it increased the number of claims "routinely reviewed" for accuracy, the Associated Press reports. Of the one billion claims submitted by providers to Medicare each year, the error rate in fiscal year 2005 was 5.2%, compared with 10.1% in FY 2004. CMS Administrator Mark McClellan says computer databases and new independent contractors are responsible for the decrease in errors, which can include Medicare paying for a "medically unnecessary service," providers submitting incorrect billing information, or providers submitting insufficient documentation to validate the need for a particular service. He notes that when the agency first began determining error rates it reviewed only 6,000 claims but now reviews 160,000 claims. Although he noted that there was "no one magic bullet" for identifying where "improper payments arise," he cited examples of glucose monitors being ordered for patients who did not meet program stipulations or back pain being treated in the hospital setting when it "was not a medical necessity or could have been done in a less expensive outpatient setting." The Associated Press notes that McClellan plans to expand the improved monitoring practices to the Medicaid program and will monitor states "for the first time to determine their error rate when reimbursing health care providers" (AP/*Wall Street Journal*, 11/10/05).

CMS reports success of pay-for-performance program

CMS last week announced that hospitals participating in the Premier Hospital Quality Incentive program, a three-year pay-for-performance demonstration project, "significantly improve[d]" their quality of care in the first year of the program, with the average scores for 33 national treatment indicators improving by nearly 7%, the *New York Times* reports. The "groundbreaking" project, which marks the first time CMS has paid hospitals "actual monetary bonuses," awarded participating hospitals that "showed measurable improvements" a combined total of $8.85 million. According to CMS Administrator Mark McClellan, "both the top and bottom hospitals showed very impressive gains" and the demonstration project's results indicate that "pay for performance works" and that "increased quality of care for patients…will mean fewer costly complications [which is] exactly what we should be paying for in Medicare." However, hospital executives contend that the current system for reimbursing providers needs to be reformed "to foster further improvement." While one hospital administrator "praised" the demonstration's results, he noted that even with the quality bonus his hospital received, the institution will see a net decline in revenue because Medicare "continues to pay less when patients have fewer complications and require less extensive care." He calls on future programs "to rely more on the government's directly sharing with hospitals the cost savings from the quality improvements" (Abelson, *Times*, 11/15/05; CMS release, 11/14/05).

REVENUE & CAPITAL MANAGEMENT

Website marketing strategies help hospitals attract 'medical tourists,' boost revenue

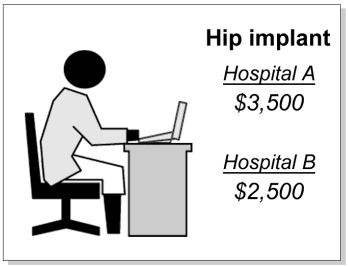
A number of forward-thinking hospitals are redesigning their websites to attract Internet-savvy "medical tourists" who are willing to travel or pay higher prices for what they perceive to be superior health care, the Associated Press reports (11/12/05). Although Anthony Cirillo, a Huntersville, N.C.-based health care consultant, notes that many community hospitals may not have the budget or capability to leverage the Internet to reach a broader audience and extend their brand, all hospitals have a "strategy opportunity" to do so (*Watch* interview, 11/18/05). For some hospitals, these efforts have reaped hundreds of thousands of dollars in revenue from out-of-town patients "who may never have come in" without the website's prompting.

Tech-savvy patients create online marketing opportunity

Patients increasingly view health care as a global, rather than local, service and are more inclined to "seek out alternatives…and travel" to see specialists for second opinions, says Andrea Reynolds, manager of multimedia services for Ohio-based Akron Children's Hospital (*Watch* interview, 11/18/05). With consumers using the Internet to vet potential providers, hospitals are realizing that a minimal investment compared with that required by traditional advertising can position them to solicit new volumes.

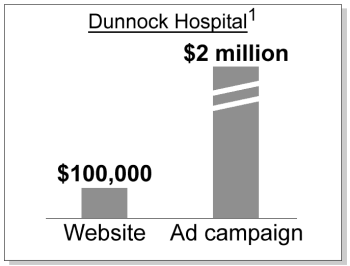
Building a Web to catch more patients

With patients going online and getting involved in selection...



Over 84 million adults use the Internet for health care information; rising trend of patients shouldering costs of own care

...and hospitals investing in the Web to get "bang for the buck"...



Hospital invests in website at fraction of ad campaign's cost; investment includes design and hosting, content management system, third-party content

..the Internet is becoming the "new front door" for more patients

Many facilities reporting 1,000% or more increase in website traffic over past two years, with yield of "online-only" patients growing at same or higher rate

[1] Pseudonym

Source: *Watch* interview, 11/17/05, 11/18/05; Keough, Cleveland *Plain Dealer*, 11/12/05.

Both Reynolds and Cirillo advise that, as with any marketing effort, the website marketing strategy should identify, attract, and retain the target audience by highlighting how the facility can meet that audience's needs (*Watch* interviews, 11/17/05; 11/18/05).

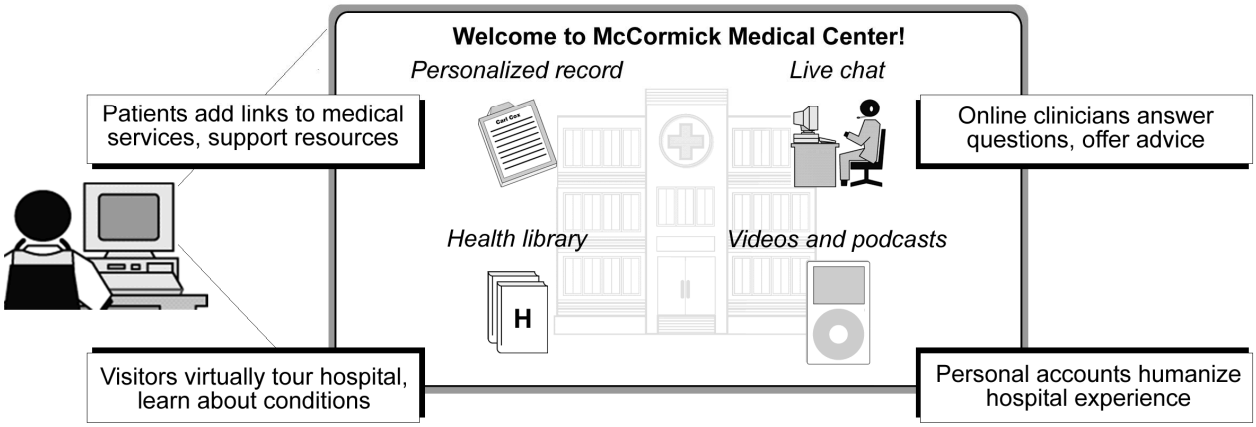
Increasing online visibility first step

However, to lure medical tourists, hospitals must understand how advertising channels differ on the Internet, says Jack Moore, chief marketing officer for the Arlington Heights, Ill.-based Cancer Treatment Centers of America (CTCA) (*Watch* interview, 11/18/05). According to Moore, providers must be "readily accessible in the online search world" so potential patients can quickly discover the hospital's services; moreover, as an Internet consultant points out, many patients believe "that the top three listings that pop up on Google are the best" (Cleveland *Plain Dealer*, 11/12/05). To ensure that Internet users are made aware of CTCA, regardless of the type of cancer they are investigating, the organization hired a consultant who "guarantee[d] high placement" on search engine query results; today, Moore would "bet money" that CTCA is one of the top three results when searching for 'cancer treatment' (*Watch* interview, 11/18/05).

Interactive sites offer 'snapshot' of patient-friendly services

Having attracted medical tourists to the website, an equally important component to winning their business is developing a website that offers interactive, informative, and unique features, rather than "brochureware," or reproduced promotional materials. According to Reynolds, Akron Children's new website will "anticipate the user's next actions" by enabling quick transitions between learning about a condition and scheduling an appointment; administrators at other facilities have added features that improve responsiveness to user queries and "demonstrate the service level" a patient would experience at their institutions (*Watch* interviews, 11/17/05; 11/18/05).

Best practice websites lure medical tourists with interactive, patient-friendly features



Source: *Watch* interviews, 11/17/05, 11/18/05; Keough, Cleveland *Plain Dealer*, 11/12/05.

Hospitals with visible and appealing websites have attracted new patients from around the world. Akron Children's website profiled several patient success stories, which in turn drew families who were researching their children's conditions online; according to Reynolds, these profiles eventually attracted six out-of-state patients who were responsible for $250,000 in revenue in the last year (*Watch* interview, 11/18/05). On CTCA's website, the "Click to Chat" feature, which offers real-time conversation between patients and medical professionals, has grown to 3,000 sessions monthly; between 10% and 15% of those "chatters" become patients who generate nearly half of the facility's new revenue, which is growing by 25% annually (*Watch* interview, 11/18/05). CTCA's Moore says that the website is so successful that it has turned the traditional physician referral model "on its head" by generating referrals online rather than by word-of-mouth.

Leverage website to assure patients of high quality

The Cleveland *Plain Dealer* notes that patients may worry whether a hospital savvy enough to leverage technology to create an interactive and informative website "is the best choice to treat a condition or just the one with the best website" (11/12/05). Cirillo says that a hospital's website can be used to alleviate these concerns; because the deciding factor for many medical tourists is "the patient experience," he recommends that hospital websites link to personal web logs, or "blogs," and recorded conversations, known as "podcasts," in which patients share accounts of their care (*Watch* interview, 11/17/05). These independent and "real" reviews connect online visitors to the hospital's physical environment, hopefully highlighting its service quality in the process, and serve as surrogates for word-of-mouth recommendations.

REVENUE & CAPITAL MANAGEMENT

On Our Watch

New York hospitals function with 'unhealthy' bottom lines

New York state hospitals lost a combined $127 million in 2004—the seventh consecutive year they posted combined operating losses, according to a report released by the Healthcare Association of New York State (HANYS). The state's hospitals had an average negative 0.3% operating margin last year, compared to the average national operating margin of 3.7%; the hospitals' cumulative seven-year loss now stands at $2.3 billion. Although economists recommend that a 4% operating margin is the necessary threshold for capital reinvestment and service line expansion, 90% of New York hospitals fell significantly below the level; about two-thirds of state hospitals are "losing money, breaking even, or operating with a margin of less than 1%." The president of HANYS said that the findings demonstrate the need for "fundamental changes" in New York's hospital community, and the state has formed the Commission on Health Care Facilities in the 21st Century, which in January will begin ranking hospitals to determine if any should be closed to improve the industry's overall viability (*Business First of Buffalo*, 11/15/05; *Albany Business Review*, 11/15/05).

Moody's report discusses for-profit rating factors

In a recent report, Moody's Investors Services highlights the factors it uses to rate for-profit hospital companies, such as operations and competitive strength, and addresses potential concerns for these organizations. According to Moody's, which rates 10 for-profit hospital companies in the U.S.—representing $25 billion in rated debt—organizations in the sector share similar challenges as not-for-profit hospitals, the most pressing of which is how to respond to "constrained" payer budgets. Like not-for-profits, falling reimbursement rates have led many for-profit hospitals to focus on reducing LOS and boosting clinical efficiency; the higher-rated for-profit hospitals generally boast higher throughput and productivity. For-profit providers also are concerned over the effect of the 2003 Medicare Prescription Drug, Improvement, and Modernization Act's new drug benefit, which will likely strain federal funding and may affect ratings in the long-term by forcing cutbacks in Medicare reimbursement. Unlike the not-for-profit sector, however, many for-profit companies focus on an acquisition strategy to increase shareholder value; many of the potentially available, smaller facilities have already been purchased, leading for-profit companies to focus on larger hospital acquisitions and repurchasing shares, which present greater credit rating risks (Moody's release, 11/16/05).

Fewer hospital 'financial secrets' boosting bond income

After calls to improve their financial disclosure, not-for-profit hospital CFOs have generally become more sophisticated in the frequency and quality of their reports, positioning their organizations to reap increased bond investments, *HealthLeaders* reports. Lisa Goldstein, senior vice president and health care team leader for Moody's Investors Service notes that, led by larger not-for-profit systems, the entire industry has shown marked improvement in financial reporting following a wave of corporate accounting scandals and increased regulatory scrutiny;. As a result, some hospitals have used improved disclosure to help spur a financial turnaround or boost the price of a bond offering. Camden, N.J.-based Cooper Health System relied on monthly executive summaries and "regular, timely disclosure" of financial reports to lure bond investors and reverse its fiscal health; as recently as 1999, the hospital had "three to four days of cash on hand," a cash position of negative $11 million, and was bordering on bankruptcy, but the open communication strategy has brought a wave of new investment, helping to oversubscribe Cooper's $80 million dollar debt issuance last year by a three-to-one ratio. The current low-interest rate market should serve as further incentive for financially struggling facilities to improve reporting; although investors eye lower-grade credits in such environments for potentially lucrative returns, analysts warn that they are only attracted to financially "transparent" facilities (Betbeze, 11/16/05).

Fitch updates Florida hospital ratings in wake of Hurricane Wilma

Although Hurricane Wilma temporarily disrupted Florida hospitals, hospitals quickly "resumed normal operations," and an update from Fitch Ratings reflects stable ratings overall, the *South Florida Business Journal* reports. The post-hurricane situation in Florida significantly differs from the fallout of Hurricane Katrina; many Gulf Coast hospitals continue to be affected by patient and staff dispersal, and ratings agencies have subsequently issued negative outlooks for these facilities or downgraded their credit status. In the South Florida region, however, Boca Raton Community Hospital and Miami Children's Hospital maintained A ratings for outstanding bonds, with stable and positive outlooks, respectively. In addition, Fitch rated bonds for the Mount Sinai Medical Center of Greater Miami in the B-positive category, with a positive outlook, and rated bonds for the North Broward Hospital District in the A-minus category, with a stable outlook (11/14/05).

COST MANAGEMENT

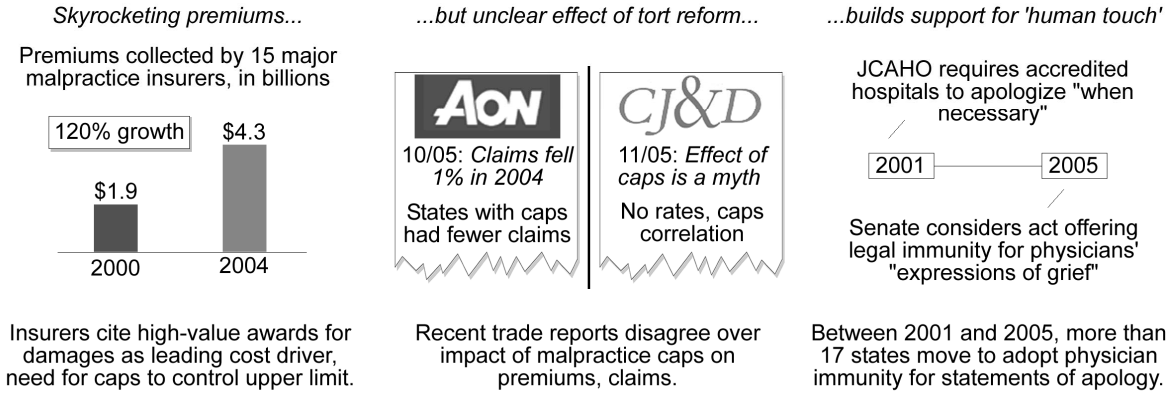
Apologies receive growing support for malpractice crisis relief

With rising malpractice premiums continuing to plague the health care industry and the effectiveness of caps on financial damages being questioned, hospitals increasingly are adopting policies that mandate apologizing for medical errors in an effort to prevent litigation and lower premiums (*US Fed News*, 9/28/05; Eisenberg, *TIME*, 8/15/05). Because the policies are backed by growing legal protections and the benefits have been quantified by several organizations, experts predict that hospital apologies for errors will soon become an industrywide standard (Sorry Works! website, accessed 11/11/05; *Watch* interview, 11/14/05).

'I'm sorry' championed over malpractice caps

While support for formal apologies has existed for several years, many experts made a stronger push for tort reform, arguing that malpractice caps would help control rising premiums (Center for Justice & Democracy, 11/5/05). However, with malpractice costs still mounting and the debate over the effectiveness of caps increasing, sentiment has again surged for the value of admitting errors.

Can kind words cut malpractice costs? Policymakers starting to believe they can



Source: *US Fed News*, 9/28/05; Anderson, *New York Times*, 7/7/05; CJ&D website, accessed 11/17/05; Aon website, accessed 11/17/05.

Although critics allege that apologies may incite more patients to sue or that a culture of apologies could backfire and "usher in an epidemic of playacting," there has been no evidence of either outcome at hospitals that have adopted the strategy (*TIME*, 8/15/05). Instead, because many patients report that they file malpractice claims out of anger that their physicians were not adequately informative or communicative, or simply to learn the facts about how the error occurred, experts predict that a more open policy will dampen the total number of claims.

Straightforward policies, physician education essential for hospital adoption

Hospital apology policies are often simple and replicable, according to Rick Kidwell, associate counsel and director of risk management for Pittsburgh-based UPMC Health System and former managing attorney for legal claims and litigation at Baltimore-based Johns Hopkins Health System—two organizations with formal disclosure policies that include apologies (*Watch* interview, 11/14/05). Kidwell says that an apology policy includes three components: An apology to the patient in the wake of an error; an explanation, if possible; and assurance that the provider will ensure the mistake is not repeated.

Hospitals also must explain to physicians—many of whom have long been advised by legal counsel to deny error or halt communication in the aftermath of an adverse event—that they have growing legal protection to make these apologies (*US Fed News*, 9/28/05). Under the act currently being considered by the U.S. Senate, which is already under law in 17 states, statements made by providers in the wake of a mistake would not be admissible in a court case.

Policies improve work environment, cut cost of litigation

While hospitals find it difficult to track whether an apology policy will lead a "patient to say 'I'm not going to sue you now'," says Kidwell, he believes that honest disclosure policies offer additional benefits beyond "being the right thing to do" (*Watch* interview, 11/14/05). Frank discussions of errors create an environment focused on quality improvement and improve the patient-family-provider relationship; in addition, they boost professional morale by addressing the guilt and regret that can often burden providers.

Moreover, Kidwell points to several hospitals that have quantified the benefit of their apology policies by focusing on the cost of litigation and claims. Both the Lexington, Ky.-based Veterans Administration Medical Center (VAMC) and the Ann Arbor-based University of Michigan Health System offer apologies, explanations, and assurances to patients following an error.

VAMC, University of Michigan control malpractice claims with apology policies

How it works

- Providers identify potentially compensable situations
- Staff, counsel review case to decide if a standard of care was violated, if a medical error occured, and if a patient was injured as a result
- Staff, counsel decide whether situation meets disclosure requirements
- Providers meet with patient, family to disclose; apology and explanation offered. Patient, family informed of right to litigate; compensation and other avenues to make amends offered.
- Facility shares plan for preventing future incidents

	Results
VAMC-Lexington, 1987-2000	• Settled 170 claims, went to trial three times • In 2000, average claims payment was $16,000, compared with $98,000 for the entire VA health system
University of Michigan, 2001-2004	• Annual malpractice claims, lawsuits dropped 50%, from 260 to 140 • Average legal expense per case fell at similar rate, from $65,000 to $35,000 • Total annual savings: $2 million

Source: Sorry Works! website, accessed 11/11/05; Eisenberg, *TIME*, 8/15/05.

For more information

Members of the Financial Leadership Council can learn more about strategies to control rising premiums in the brief *Managing Health Care Malpractice Costs: 2004 Update.* To obtain a copy of the brief, please visit the Council's homepage on Advisory.com or contact Jennifer Henderson at 202-266-5346 or via e-mail at hendersj@advisory.com.

COST MANAGEMENT

Hospitals concerned over cost, prevalence of premature infants

A recent study quantifies the "staggering" cost of premature births on the nation's hospitals, even as the number of babies born prematurely continues to rise, the *Los Angeles Times* reports. Hospital costs for premature births totaled $18.1 billion in 2003; while a full-term birth represents average charges of $1,700 and an average hospital stay of two days, a premature birth costs approximately $77,000 and has an average hospital stay of 24.2 days. The rate of premature births has risen 30% since 1983, totaling over 500,000 premature births last year; however, the largely successful medical treatment of premature babies has "pacified" the need to investigate why the number of premature births has risen, according to the medical director at the March of Dimes (Roan, 11/21/05).

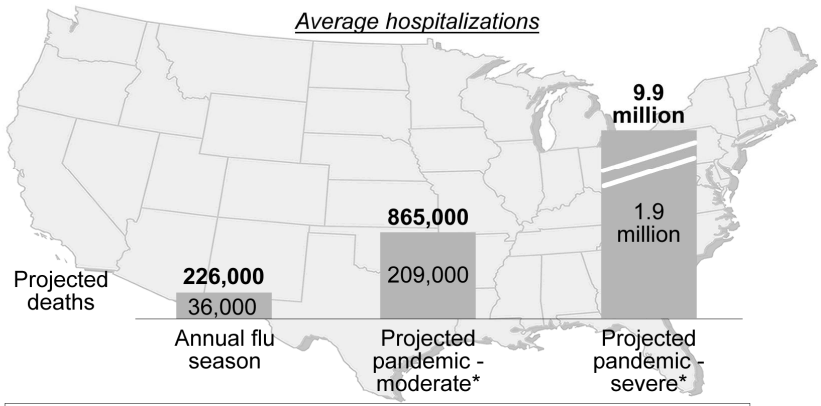
FAST FACT

Providers debate effect, anticipate high costs of potential flu pandemic

Experts are concerned that an improperly managed avian flu pandemic could unravel "an already overstretched and unprepared health care system," *Modern Healthcare* reports (Becker, 11/7/05; Mantone, 11/7/05). Although some have raised concerns that avian flu represents another "health scare" following projected epidemics such as SARS and Mad Cow disease, others say that the history of repeated flu pandemics—three in the last century—leaves the world "long overdue" for another. Although the U.S. government has earmarked $6.1 billion to support vaccine development, production, and stockpiling as part of a national response to a pandemic, a recent report from the HHS indicates that the financial effects of an avian flu pandemic would likely be crippling for the industry.

HHS: Pandemic would incur high cost and patient toll

- Standard flu seasons predominantly affect the very young or elderly patients; a pandemic would target the entire population
- Standard flu seasons boost admissions and hospital profits; a well-managed pandemic could do the same
- However, facilities may not have the surge capacity to treat pandemic, which could complicate cases and extend stays



* Based on data from severe pandemic of 1918 and moderate pandemics of 1958 and 1968; assumes 30% of population would fall ill from pandemic today

Source: *Modern Healthcare*, Becker, 11/7/05; Mantone, 11/7/05; HHS website, accessed 11/21/05.

FROM THE FINANCIAL LEADERSHIP COUNCIL

ONLINE IMPLEMENTATION KIT

Revenue Cycle Best Practice Compendium

Top 10 downloaded practices, as of 11/23

1. Revenue Capture Accountability Grid
2. Frontline Performance Tracking
3. Charge Audit and Reconciliation
4. Standardized Scheduling
5. Patient Segmentation Protocols
6. Denial Management Database
7. Copay Collection Initiative
8. Frontloaded Outpatient Collections
9. Inpatient Documentation Support Tools
10. Comprehensive Denials Report

TELECONFERENCE SERIES

Friday, Dec. 2, 3:00 p.m. EST

Member Case Study: "The Art of the Deal" – Implementing Physician Partnerships

Council member Lydia Jumonville, the CFO of Baylor Health Care System, will present a case study on her organization's approach to physician partnerships. This presentation will feature Baylor's historical strategy favoring physician economic alignment, its corporate policies that "hardwire" finance's role, and specific lessons drawing from Baylor's experience with employment, joint ventures, and specialty hospital development. Council Managing Director, Aneesh Chopra, will share highlights from the research and interview Ms. Jumonville live for the hour. Council Members are strongly encouraged to pose questions during a Q&A session reserved at the end of formal remarks.

For more information

To register for "The Art of the Deal," please visit www.advisory.com or contact Jennifer Henderson at 202-266-5346 or hendersj@advisory.com.

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