

Critical Access Hospital GOVERNING BOARD MANUAL

Volume II





“... who in their right mind would agree to serve on a hospital board?”

In the Introduction to the Illinois Critical Access Hospital Network's *Governing Board Manual I*, we asked the question, “... who in their right mind would agree to serve on a hospital board?”

In the case of critical access hospitals in rural Illinois, there can be only one reason: a chance to serve and give back to the community. Our critical access hospitals offer the opportunity for neighbors to help neighbors. It's all about community residents organizing resources to help improve the health care status of the entire community. Governing board members are at the apex of this person-to-person event. They are rarely prepared, yet they arrive and they serve, without pay and, usually, with little thanks. This *Governing Board Manual II* is dedicated to those who serve their communities in this manner.

One thing is certain; board members' responsibilities become increasingly more difficult each year. Few of the problems discussed in the first volume of the manual have gone away. In fact, the list of “hot topics” is now far longer. The distressed economy is the basis for many of the concerns, from increased bad debts to talk in Washington about eliminating the critical access hospital program. The stress builds and the problems loom.

The authors who contributed to this *Governing Board Manual II* have written with governing board members in mind. All of the articles address the very real and pressing issues faced by governing boards. Several of these articles were penned by current governing board members of Illinois critical access hospitals. We especially thank them for their service not only to their communities but also for sharing some of their experiences with their peers.

Hospitals are all about people helping people. The Illinois Critical Access Hospital Network is all about helping you to help others. We welcome your suggestions and thank you for your continued support.

A handwritten signature in dark ink that reads "Sue Campbell". The signature is written in a cursive style.

Sue Campbell, President

Board of Directors

Illinois Critical Access Hospital Network

A handwritten signature in dark ink that reads "Pat Schou". The signature is written in a cursive style.

Pat Schou, Executive Director

Illinois Critical Access Hospital Network

Governing Board Manual Volume II

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Governing for Greatness: Get on the Bus!

By Terry A. Pope and Matt Dickinson, Board of Directors, Memorial Hospital, Carthage, IL

“Do we have members with the necessary experience and knowledge on the board?”

In the truest meaning of the word, governance is the oversight of adherence to the rules and charter of the board of directors of an organization to make sure everything is fully accomplished. However, governance can go beyond that, particularly when it involves self-assessment.

Jim Collins, in his book Good to Great, asks the question, “Are the right people on the bus?” and “Are they in the right seats?” So, for boards, these questions might translate to “Do we have members with the necessary experience and knowledge on the board?” and “Have we maximized use of that experience by aligning it with our board and committee assignments?” Our own board of directors has looked at these questions and taken steps to answer them.

A few years ago, we began using a board matrix (see abbreviated matrix) to identify the areas of expertise and traits our board members possess. This tool has enabled us to objectively consider each director's strengths and determine if they participate on the committees where their skills and expertise can be best used. Our corporate structure allows two community members to serve on each committee. The matrix also helps us identify the right community members to fill those slots because we can focus on the skills and expertise needed. Personalities, life experiences, connections to the community and geographical representation are just a few of the characteristics we map to be sure we have the best coverage possible. When a vacancy becomes available on the board, this matrix can help show us the type of person we should try to recruit.

	Board Member 1	Board Member 2	Board Member 3	Board Member 4	Board Member 5	Average
Years on board	7	9	3	11	9	7.8
Age	57	52	68	51	53	56.2
Gender	M	M	F	F	F	
Ethnicity	W	W	W	W	W	
Residence in prime area?	In	In	In	In	In	
Occupation	Own biz	Tech biz	Senior svcs	Pharmacy	Teacher	
Governance experience	Low	Med	Low	Med	Med	
Industry/market knowledge	Low	Med	Med	Med	Med	
Clinical expertise	Low	Low	Low	Med	Low	
Financial knowledge	Med	Med	Low	Low	Low	
Management experience	Med	Med	High	Med	Med	
M&A experience	Med	Low		Low		
Community/political contacts	Low	Med	High	Med	Med	
Enneagram* personality	1,7	7,1	2,7	1,6	9,1	

*Trademark: www.enneagraminstitute.com

For each board member, leave blank or put 1 (low) through 5 (high)	Board Member 1	Board Member 2	Board Member 3	Board Member 4	Board Member 5	Average
Personality Traits:						
Outgoing		3	4	2	4	2.6
Thoughtful	4	4	5	4	4	4.2
Deliberate	3	4	4	4	4	3.8
Impulsive	2	4		3	3	3.0
Analytical	3	4	4	3	4	3.5
Logical	3	5		4	2	3.6
Argumentative		3		2	1	1.5
Challenging	3	3		3	1	2.5
Quiet	4	4		4	3	3.8
Inquisitive	2	3	5	4	4	3.6

Geographical Traits: Use 5 (in town), 3 (near town), 1 (distant)	Board Member 1	Board Member 2	Board Member 3	Board Member 4	Board Member 5	Average
Carthage		3	5			
LaHarpe		2				
Dallas City						
Nauvoo				4		
Hamilton	5			1		
Warsaw/Sutter						
Bowen					1	
Augusta					3	
Plymouth					1	
For each board member, leave blank or put 1 (low) through 5 (high)						
Business Traits:						
People skills	3	3	3	3	4	3.2
Government	0	1	1	2	1	1.0
Civic connections	0	3	3	1	3	2.0
Leadership	3	3	3	2	3	2.8
Labor/HR	3	0	0	2	1	1.2
Schools	1	1	5	4	5	3.2
Churches	1	1	3	4	5	2.8
Medical	0	0	0	4	3	1.4
Regional connections	0	3	2	3	1	1.8
Fund raising	0	0	0	2	3	1.0
Legal/Corporate regulation	0	1	0	1	1	0.6
Political action	0	2	0	1	2	1.0
Public relations	0	2	3	3	3	2.2
Community relations	1	4	4	4	3	3.2

For each board member, leave blank or put 1 (low) through 5 (high)	Board Member 1	Board Member 2	Board Member 3	Board Member 4	Board Member 5	Average
Skills:						
Financial/Accounting		2	0	1	1	1.0
Construction		1	1	1	0	0.8
Farm business		1	1	2	1	1.3
Entrepreneur	5	5	0	4	0	2.8
Management		4	4	3	3	3.5
Networking		3	2	2	2	2.3
Clinical/Medical		0	0	4	1	1.3
Technical		4	1	3	1	2.3

As an example, the following lists show the make-up of two of the committees, based on areas of expertise:

Finance Committee

Treasurer of a co-op
 Business owner
 Bank CFO
 Statistician (community member)
 Bank loan officer (community member)

Planning Committee

Business owner
 Council on Aging member
 Construction contractor
 Grain elevator owner (community member)
 Engineer/Contractor (community member)

This objective information, with subjective observation, helps select committee leadership. We also can use this information to appoint board members to committees with which they may not be as familiar so everyone gains an understanding of all committees. In our structure, each board member serves on two committees and assignments are rotated every two years.

In October 2011 we started work on a three-year strategic plan to be completed by June 2012. With the plan in place, we will review the membership of the board and assess the community members on our committees, then ask the questions, “Are the right people on the bus?” and “Are they in the right seats?”

Matt Dickenson and Terry A. Pope are members of the board of directors of Memorial Hospital, Carthage, IL. Matt may be reached at 217.357.3100 and Terry may be reached at 217.357.4922.

Health care and the rules that govern it are constantly changing and boards that can adapt efficiently and effectively will be better able to respond to those changes.

Governance Issues Related to Managing Hospital-owned Physician Practices

By Bill Clayton, Principal, Healthcare Group, Clark Schaefer Hackett

Many if not most critical access hospitals in Illinois own and operate medical clinics. The acquisition and operation of these clinics call for an additional set of governance and management considerations. This article offers suggestions about acquiring and managing physician practices.

Key Elements of Managing Physician Practices

Medical Staff Development Plan

Every community should have a physician needs analysis, sometimes referred to in the industry as a “medical staff development plan,” conducted on a periodic basis. Typically, this is a population-based projection of the number of physicians needed for the community. These plans may be compiled by hospital management or by an outside consulting firm. The plan details the ideal number of providers needed to properly service the health care needs of the community. Usually the plan identifies the population by zip code for the service area, the number of required physicians by specialty, and the number of physicians to recruit in the future, based upon the age of existing physicians. This plan provides a framework to identify future physician needs and identifies future funds needed to implement the plan.

Conflict of Interest Policy

When physicians serve on hospital boards, conflicts of interest become an issue, whether or not the physicians are employed by the hospital. Hospital boards are encouraged to seek legal counsel for assistance with the development and implementation of a policy that addresses this issue.

Due Diligence in Purchasing Physician Practices

When a hospital evaluates and moves forward with the intent to buy the practice of and subsequently employ a physician who is already practicing in the community, several due diligence issues must be addressed to ensure a smooth transition from an independent to a hospital-owned medical practice. Although the author’s check-list encompasses over 12 pages, the main issues are as follows:

- **Valuation of the Medical Practice:** Usually the hospital conducts a valuation of the practice when potentially buying a medical practice. This involves a cash-flow projection to determine the value of the business, its “goodwill”. Some hospitals pay for goodwill, and others do not. This process can be conducted internally or supported by the use of an outside consultant who specializes in valuations.

- “Hard Asset” Purchase: The value and purchase price of the “hard assets”, such as the office furniture and exam tables, need to be determined using either one or a combination of methods. Some hospitals employ an outside asset valuation expert who develops an inventory of assets and then determines the market value of each as if sold on the open market. The second method involves employing the “book value” and depreciation schedule for each asset.
- Physician Compensation: Regardless of the type of employment relationship, it is incumbent upon boards to insure that physicians are paid within industry norms.
- Malpractice Liability: When employing physicians, the hospital must provide each physician with insurance that protects both the physician and the hospital. Several types of insurance are available and include: (i) “slot insurance” that insures an unnamed provider who is in a “slot” or position, such as in emergency department coverage; (ii) claims-made coverage where “tail coverage” insurance is needed at the end of the term to cover future claims for past events; or (iii) “occurrence coverage” that covers a physician for incidents that occur while the policy is in effect, regardless of when the incident is reported to the insurer, negating the need for separate “tail coverage.” Regardless of the type of policy, the hospital must be protected from a physician’s “prior acts” that occurred prior to employment. It is reasonable for board members to be interested in the malpractice history of a physician they might employ.
- Record Retention: Employing physicians creates additional record retention issues for the hospital. The record retention policies of the hospital, including hospital-owned clinics, should be reviewed periodically. Generally, such policies should address at a minimum the length of time that patient records are to be retained, and address retention of other documents as well, such as personnel records. These policies should be reviewed by legal counsel, and the board should assure itself that hospital staff is properly educated about the policies and that the policies are observed. Some legal firms provide at no charge white papers that address these issues.
- Compliance: The compliance officer and management team must ensure that physician transitions are in compliance with Stark regulations, antitrust provisions, and other applicable federal and state laws.

Bill Clayton has over 25 years experience in health care management with responsibilities ranging from systems implementation engineer to chief operation officer. He specializes in implementing management accountability improvement programs with numerous healthcare organizations. In the past 16 years, Bill Clayton has focused on implementation of improvement programs in physician practices. He is a principal with the consulting firm of Clark Schaefer Hackett, which focuses on hospital-owned physician practices and independent medical groups.

The content of this article is based on the opinions and experience of the author and is not meant to constitute legal opinions. Hospitals are encouraged to obtain advice from corporate counsel regarding the key elements in this article.

Aligning With a Hospital System – Some Thoughts

By Don Johnson, Chair, Mercer County Hospital Board of Directors, and Bill Spitler, Special Projects Consultant, Illinois Critical Access Hospital Network

“When I retired, I wanted to give back something to the community. I thought serving on the hospital board would be a way for me to give back. I had no idea what lay ahead”.

When Don Johnson retired in 2001 as a pilot for Delta Airlines, he was asked to join eight other community residents to serve on the reassembled Board of Directors of Mercer County Hospital. The hospital is in Aledo, a town of 3,700 located 30 miles south of the Quad Cities. Johnson’s background was in aviation and farming, with no background in health care. Johnson entered a tumultuous situation where various community interests seemingly were pitted against each other. “When I arrived at my second hospital board meeting, there were so many people present that I had to park about a block away. Very few of those present were there to compliment the board.” This encounter with an unhappy community was fueled by a long-time community physician who felt wronged by the hospital’s CEO. It was the first of many board meetings held under fire.

Mercer County Hospital is an integral part of Mercer County government. For many years, members of the county board also served as the hospital’s governing board. They met in the morning to talk about asphalt and bridges, then again in the afternoon to talk about physician credentialing and managed care. In 2001 the county board appointed a separate hospital board that served in a more traditional role. Johnson was appointed to that new board and was elected its first chair. Nevertheless, even with a semi-independent hospital board, the hospital remained the property of the county. One of the challenges of the new hospital board was to share its vision of health care in the community with members of the county board. Interestingly, the county also owns a nursing home that is attached to the hospital but operates under a separate governing board and administration.

Within two years of the new board’s appointment, the board voted to replace the hospital CEO with an interim administrator. Because of the difficulty of recruiting a replacement CEO, the board searched for a firm to provide management services and to conduct a search for a new CEO. Eventually, the management company proved to be unsatisfactory. “They just acted like they weren’t in it for the long term”, Johnson said. Finally, a CEO was hired in 2003 who reorganized both the board and the hospital. “He really brought us out of the dark ages”.

The hospital was plagued by a myriad of serious code compliance problems. “When we tried to fix one thing, three others popped up. Our new CEO wanted to move ahead with a major renovation program to eliminate the life safety problems and to generally upgrade the appearance of the place, but it was difficult.” The board soon realized it was unable to sell bonds on the open market, scaled back its renovation plans, and turned to the Farmers’ Home Administration and local banks for funding.

Johnson lamented that it seemed that everything the hospital did required expensive consultants be brought in. “It was killing us, financially.” One of the hopes for use of a management firm was to eliminate the need for consultants. When the management firm approach was unsuccessful, the board considered the possibility of working with larger health systems in the area.

“We began talking with three major regional hospital systems about what they could do to help us,” Johnson said. It became obvious that for the long-term future of health care in our community we needed a partner who was able and willing to eventually take over ownership of the hospital. There were a lot of meetings in Peoria and the Quad Cities”. The board continued to talk with the hospital systems and eventually was able to focus on one.

Genesis Health System, based in Davenport, Iowa was selected to be Mercer County Hospital’s partner. “The hospital board’s goal was to provide health care to the community. There were never any conflicting or personal agendas.” Johnson said. He is obviously pleased with and grateful for his fellow board members.

Before an agreement about ownership was considered by the county board, an emotional public hearing was held. Presentations were made by hospital officials from both Mercer County Hospital and from Genesis Health System. The main “bones of contention” were fear of job loss and the Illinois Municipal Retirement Fund issue. While some employees were fearful of losing their jobs, time has resolved many of those concerns, according to Johnson.

“One of the greatest stumbling blocks was how to deal with the employees’ pensions. Because Mercer County Hospital is a county facility, hospital employees participate in the Illinois Municipal Retirement Fund. If the hospital’s ownership was transferred out of the county’s hands, then IMRF would cease. Employees who had worked at least seven years and were already vested in IMRF would retain their coverage. Employees who were not vested would be refunded all contributions they already had made, but they would lose the funds the hospital had contributed throughout their employment.

The current hospital CEO is an employee of Genesis Health System. Genesis is paid a monthly management fee and works hard to show-case to the community what it can do. The agreement with Genesis allows the health system to take ownership of the hospital when it feels the time is right. Genesis also manages the nursing home, although no agreement for ownership has been developed.

“The culture of the hospital is gradually changing for the better.”

“The culture of the hospital is gradually changing for the better,” Johnson reported. “Employees are now seeing how the whole is greater than the sum of the parts. There is better cohesion and people are working together better than in the past.” With new management and critical access hospital designation, the hospital is now in the black, financially. Two new surgeons now travel from the Quad Cities to Aledo. Employees are again optimistic that the hospital will survive.

“The first two years of my term were contentious, to say the least”, Johnson said. “There are still some bumps ahead, but we are headed in the right direction”. When asked when he will step down as chair, Johnson said he now can see the light at the end of the tunnel. “I want to make sure the job is complete, and we are close.”

Don Johnson is the Chair of the Board of Directors of Mercer County Hospital, Aledo, Illinois. He can be reached at 309.582.2766. Bill Spitzer is Special Projects Consultant of ICAHN and a retired hospital CEO. He can be reached at 309.463.2906.

Illinois Open Meetings Act Requirements, Revisited

By Lisa Harms Hartzler, Sorling, Northrup, Hanna, Cullen & Cochran, Ltd.

The first volume of the *Governing Board Manual* contained an excellent summary of the Illinois Open Meetings Act¹ as applicable to public hospitals. In 2011, however, the Illinois General Assembly passed a number of amendments to the act. This article focuses on those amendments relevant to public hospitals.

Training

Prior to 2011, public hospitals were required to designate specific officers, employees or members to be trained annually on the provisions of the Open Meetings Act. Now, each elected or appointed member of a public body subject to the act, which includes current public hospital board members, also must complete the online training available on the Illinois Attorney General's website by December 31, 2012. (For further information on the Freedom of Information Act & Open Meetings Act and to access the electronic training portal, please refer to the Illinois Attorney General's website at: http://foia.ilattorneygeneral.net/electronic_foia_training.aspx.) Any new members elected or appointed after January 1, 2012, have 90 days after taking an oath of office or assuming responsibilities of the office to complete the online training. The Attorney General's website is easy to navigate and the step-by-step course can be completed in about an hour². Public officials must register before taking the course and can immediately file a completion certificate online.

Board members do not have to complete the course more than once to serve on the board, any committees, or any other public body. Any person specifically *designated* by a public hospital board to receive training on compliance with the act and who fails to complete the training may be found guilty of a Class C misdemeanor, but such failure will not affect the validity of any board actions. At this time, there is no penalty for any board member who is *not designated* to receive training and who fails to do so. Board members should keep in mind, however, that as public officials they must uphold and implement the law. A serious attitude about the Open Meetings Act and its reflection of public policy that government is the "people's business" will serve all public board members well.

Closed Meetings

The Illinois General Assembly continues to expand the types of meetings and topics excluded from the act's¹ requirements. Added to the list are:

- meetings of independent teams of experts under Brian's Law (involving death of a person with a developmental disability)^{III}.
- meetings between internal or external auditors and governmental audit committees and finance committees when the discussion involves internal control weaknesses, identification of potential fraud risk areas, known or suspected frauds, and fraud interviews conducted in accordance with generally accepted auditing standards
- correspondence and records that may not be disclosed under the Illinois Public Aid Code, Sec. 9 (relating to protection of records) and Sec. 8 (relating to appeals)^{IV}.

Minutes

Minutes of open meetings now must be approved within 30 days after the meeting or at the second subsequent regular meeting, whichever is later. The deadline for when those minutes must be available for inspection by the public was lengthened from seven to 10 days after approval.

Right to Speak

A public hospital board must give every person an opportunity to speak under established and recorded rules. Each board should create and formally adopt procedures for how members of the public will be permitted to speak at an open meeting. The board may place reasonable time limits on individuals, but the Open Meetings Act does not allow the number of persons wishing to speak to be limited. The board's rules may also restrict public comment to subjects on the meeting agenda, may permit the board to cut off a comment if it is irrelevant, repetitious, or disruptive and may set aside a specific time during the meeting for public comments.

Posting Employee Compensation

Effective January 1, 2012 a public hospital participating in the Illinois Municipal Retirement Fund must post, within six days after approving a budget, the total compensation package for each employee having a total compensation package that exceeds \$75,000 per year. The board must post each employee's total compensation package that exceeds \$150,000 at least six days *before* approving the compensation. *Total compensation package* means payment by the hospital to the employee for salary, health insurance, housing allowance, vehicle allowance, clothing allowance, bonuses, loans, vacation days granted, and sick days granted.

Posting must be on the hospital's website, although in lieu of posting the entire compensation package directly on the website, it is permissible to post directions on how to access a physical copy of the package posted at the hospital's principal office. If the hospital does not maintain a website, it must post a physical copy of the information at its principal office.

Conclusion

The Illinois General Assembly may continue to refine the Open Meetings Act. Public hospital board members need to monitor changes to fulfill their responsibilities to the public and to protect their institution, particularly as the General Assembly adds exceptions to the Act.

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ⁱ Illinois Open Meetings Act, 5 ILCS 120/1, et seq.

ⁱⁱ The Attorney General's training site can be accessed at: <http://foia.ilattorneygeneral.net>. The statute and other educational materials on the Open Meetings Act and the Illinois Freedom of Information Act also are available at this site.

ⁱⁱⁱ Brian's Law is codified at 405 ILCS 82/1, et seq.

^{iv} Sec. 8 and 9 of the Public Aid Code can be found at 305 ILCS 5/11-8 and -9.

Sarbanes-Oxley Act of 2002: Implications for Nonprofit Hospitals

By Michelle P. Clatfelter, Sorling, Northrup, Hanna, Cullen & Cochran, Ltd.

The Sarbanes-Oxley Act of 2002 (SOA), formally known as the Public Company Accounting Reform and Investor Protection Act of 2002, was enacted to improve corporate responsibility and accountability. As internal controls, accounting measures, and codes of ethics for directors under SOA are becoming the standards by which corporate governance is judged both legally and professionally, nonprofit health care organizations, while not directly regulated by SOA, have begun implementing SOA-like controls as a form of “best practices.”

The SOA themes of maximizing the independence of the audit function and minimizing conflicts of interest are not new to the health care arena. Among other things, SOA:

- tackles issues related to external auditors, including provisions regarding independence, conflict of interest, procedures to approve auditors, audit partner rotation and auditor reporting requirements
- addresses issues related to corporate responsibility including interaction between audit committees and external auditors, and officer certification of periodic filings
- requires enhanced financial disclosures, including the controversial provisions of Section 404 regarding management and external auditor reports that address internal control over financial reporting
- imposes penalties for fraud by manipulation, destruction or alteration of financial records and other interference with investigations as well as certain protections against job loss for whistleblowers
- increases criminal penalties for certain white collar crimes
- criminalizes certain types of corporate fraud and records tampering

Incorporating some of the key elements of SOA into health care compliance programs can help to increase the efficiency and improve transparency of the organization, including:

- Development of an internal control over financial reporting as a subset of the organization’s disclosure controls and procedures, whereby management would be responsible for establishing and monitoring financial reporting and the framework used to evaluate the effectiveness of such internal controls, and officers would certify as to the efficacy of disclosure controls and procedures. This includes implementing policies and procedures that (i) maintain records in reasonable detail that accurately and fairly reflect the transactions and dispositions of the organization assets; (ii) provide reasonable assurance that transactions are properly recorded; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisitions.

A basic process for documenting and evaluating SOA-like internal controls begins with identifying the key business processes that have an effect on the organization's financial statements, identifying process risks and controls that can reduce the possibility of identified risks, testing and evaluating the controls by determining whether they are operating as designed, performing a deficiency assessment, and evaluating the audit steps that have been performed and determining recommendations for remediation.

For example, failure to collect valid insurance policy information is a frequently cited process risk. Two financial reporting consequences attach to this risk: (1) collectibility of an account affects the amount of receivables reported, and (2) collectibility is a criterion to be met for recognition of revenue. The seriousness of each risk should be evaluated, including how much financial damage the organization could suffer. For example, with respect to incorrect coding for reimbursement of Medicare patients, there is a medium probability that errors will occur in the process because Medicare coding is complex, but there is a high probability of a negative outcome and financial impact depending on the number of Medicare beneficiaries served. A preventive control could involve verifying the patient's coverage prior to completing the admissions process. A detective control would facilitate analysis of the rejected claims for invalid policy numbers.

- Promoting director independence to reduce conflicts of interest, encourage neutrality, and provide an additional layer of oversight on important issues such as auditing, executive compensation, corporate governance, and ethics.
- Implementing a code of ethics that sets standards for honest and ethical conduct, including ethical handling of actual or apparent conflicts of interest, prohibiting non-auditing relationships with auditors, requiring codes for executive officers, requiring mechanisms for anonymous reporting of financial complaints, and closely monitoring executive compensation. Because most health care organizations maintain a code of conduct as part of the corporate compliance program, the implementation of a code of ethics consistent with SOA should be a natural extension of the compliance function.

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Nonprofit health care organizations have a unique opportunity to stay ahead of the regulatory curve with a volunteer approach to providing accountability for financial reporting controls. Working with internal or external legal counsel to align SOA best practices will serve health care organizations well in the evolving environment of corporate accountability, allowing them to set their own pace for compliance and potentially discover room for improvements in their financial reporting process.

¹ Sarbanes–Oxley Act of 2002, Pub. Law 107–204 (July 30, 2002).

² The provisions of SOA only apply to public companies regulated by the Securities Exchange Commission.

³ Exchange Act Rule 13a-15(d) defines "disclosure controls and procedures" to refer to those designed to ensure that information required to be disclosed is recorded, processed, summarized and reported, within the time periods specified in the SEC's rules and forms.

⁴ Sarbanes-Oxley Act § 302(a) and (c); See also Exchange Act Rules 13a-15(e).

⁵ For example, violators of the Anti-Kickback Statute are subject to criminal penalties and/or exclusion from participation in the federal health care programs. 42 U.S.C. 1320a-7b(b)(2) . Under Stark, any person who knowingly submits or causes a bill to be submitted for prohibited services is subject to a civil monetary penalty of up to \$15,000 for each service. 42 U.S.C. 1395nn(g)(3).

⁶ For example, the SOA amended Section 13 of the Exchange Act to prohibit public companies, directly or indirectly, from making personal loans to or for any director or executive officer, subject to certain exceptions.

⁷ Section 406(a) of the Act requires a company to disclose whether it has a code of ethics for its principal executive and financial officers designed to deter wrongdoing and to promote honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships.

⁸ Section 806 of SOA includes whistleblower protections.

The Community Health Needs Assessment

By Terry Madsen, Project Consultant, ICAHN

The Patient Protection and Affordable Care Act* enacted in March 2010 requires that hospital organizations recognized under Section 501(c)(3) of the IRS Code must conduct a community health needs assessment (CHNA) and adopt an implementation strategy to meet the prioritized needs of that assessment for each of its hospital facilities by the last day of its first taxable year beginning after March 23, 2012. Failure to meet this requirement exposes the hospital to a \$50,000 fine that year and each taxable year thereafter that the process is not completed. A new CHNA must be conducted every three years.

Many critical access hospitals lack the time and in-house expertise to address the unusual mix of community development and tax requirements of the CHNA. The Illinois Critical Access Hospital Network developed an understanding of the CHNA requirements to assist member hospitals in this effort. It contracted with a consultant to create a model CHNA and to facilitate the assessment process for ICAHN member hospitals.

The CHNA requirements as specified in the most recent guidelines available from IRS (Notice 2011-52) are outlined in this article. The guidelines eventually will be replaced by regulations but may be relied on until six months after the regulations are in force. Because the Patient Protection and Affordable Care Act focuses on IRS Section 501(c)(3) recognition, it appears that the CHNA requirements under IRS Section 501(r)(3) only affect government hospitals that have been recognized, or that seek recognition, as an organization described in Section 501(c)(3).

Readers are reminded that the information provided in this article is a general overview and summary, is not offered as legal or tax advice, and is not meant to market tax related services to any third party. Hospitals should consult their own legal counsel or accountant with questions about all legal and tax matters.

A CHNA is conducted in the same tax year that the written report of its findings is made widely available to the public. The implementation strategy will be considered adopted on the date it is approved by an authorized governing body of the hospital organization. A hospital organization must adopt by the end of the same tax year in which it conducts the CHNA an implementation strategy to meet the community health needs identified in a CHNA.

Each CHNA must describe:

- the community served by the hospital
- the process and methods used to conduct the assessment
- the hospital organization's approach to seek input from persons who represent the broad interests of the community served by the hospital
- a prioritized list of all of the community health needs identified through the CHNA, as well as the process and criteria used to prioritize such health needs
- the existing health care facilities and other resources within the community available to meet the community health needs identified by the CHNA

A CHNA must, at a minimum, take into account input from the following:

- persons with special knowledge of or expertise in public health
- federal, tribal, regional, state, or local health or other departments or agencies with current data or other information relevant to the health needs of the community served by the hospital facility
- leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs in the community served by the hospital facility

A hospital may also seek input from the following:

- health care consumer advocates
- nonprofit organizations
- academic experts
- local government officials
- community-based organizations, including organizations focused on one or more health issues
- health care providers including community health centers and other providers focusing on medically underserved populations, low income persons, minority groups, or those with chronic disease needs
- private businesses
- health insurance and managed care organizations

The CHNA report format developed by the Illinois Critical Access Hospital Network enables its users to present a brief description of the methodology used to conduct the assessment; to identify potential information gaps; define the community to be assessed, including its geography and its economic and demographic profiles; present health profiles that may exist in local data and other secondary sources; and present the information gathered by the CHNA facilitator from focus groups, key informant interviews and other local contacts and inquiries. The information collected from primary and secondary sources is compared and reconciled, and a summary statement of findings and prioritized recommendations is prepared.

The report concludes with an area-wide health resources inventory that identifies services offered by the hospital and other area health care providers and partners, followed by an appendix of sources of information and participants. This information should include the names and titles of organization representatives, community leaders, persons representing underserved groups and anyone identified as a person with particular knowledge about any aspect of local health needs.

The IRS requires a hospital organization to conduct a CHNA and adopt an implementation strategy for each hospital facility it operates. Although hospital organizations may collaborate with other organizations to conduct CHNAs and develop implementation strategies, a hospital organization that operates multiple hospital facilities must document separately the CHNA and the implementation strategy for each of its hospital facilities.

The CHNA report must be posted to the hospital's Website and distributed through other media options sufficient to meet the "widely-publicized" criteria.

An implementation strategy must be developed to address the health needs identified by the CHNA. The hospital must describe its plans to meet the identified health needs or state the reasons why the hospital does not intend to address the identified health needs. When describing how a hospital facility plans to meet a health need identified through a CHNA, the implementation strategy must tailor the description to the particular hospital facility, taking into account its specific programs, resources, and priorities.

The implementation strategy also might describe planned collaborations with governmental, nonprofit, or other health care organizations, including related organizations to meet the health need.

The Illinois Critical Access Hospital Network will continue to monitor the evolving federal requirements related to the CHNA process and will ensure its members remain up-to-date on this process.

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*The Patient Protection and Affordable Care Act ("Affordable Care Act"), Pub. L. No. 111-148, 124 Stat. 119, § 9007(a) enacted March 23, 2010

What Happens in Board Meetings Stays in Board Meetings: A Hospital Board Member's Responsibility to Protect Confidential Information

By Troy Holland, Attorney, Former CAH Board Member

As a member of a community hospital board of directors, a board member is often presented with information that is not available to the general public. Specific patient medical information should not be - and generally is not - shared with the board. However, in a small community hospital setting, even the sharing of general information about a hospital incident can provide enough information for everyone in the boardroom to identify or speculate about who and what the incident involves.

When presented with such confidential information, board members should keep their overall fiduciary duties in mind. Such fiduciary duties require a board member to act with loyalty to the hospital and in good faith with the care an ordinarily prudent person would exercise under similar circumstances. A hospital board member also should keep in mind that there are extensive state and federal laws preventing the release of patient information including, but not limited to, the Hospital Licensing Act, the Medical Patient Rights Act and HIPAA.¹ For the most part, hospital board members understand their legal duties in regard to specific patient information. However, duties of confidentiality of a board member regarding other matters before a hospital board may not be as clear. Further, disclosure of confidential information by a board member can undermine the ability of the board to govern and can negatively impact the ability of administration to manage the day-to-day operations of the hospital. This article explores various aspects of confidentiality from a hospital board member's perspective and offers some practical guidance for governing boards.

Confidentiality of Public Hospital Boards Versus Private Hospital Boards

Public Hospital Boards

The manner in which hospital boards keep matters confidential varies depending on whether the hospital is a public hospital or a private hospital organized as a nonprofit corporation. Public hospitals are a subdivision of a municipality, county or other unit of government and therefore are governed by the Illinois Open Meetings Act² and the Illinois Freedom of Information Act.³ The Illinois Open Meetings Act provides for general transparency of the public hospital's governing board. Board meeting dates and agendas must be publicly posted in advance and the board meetings themselves are required to be open to the public and the media.⁴ Board minutes must be prepared and later posted on a website if the hospital (the public body) has one.⁵

The ability of the hospital board to meet in executive session and without the presence of the public and media is limited to very specific topics listed in the Open Meetings Act.⁶ Topics legally discussed by hospital boards in executive session include the following: (1) the hiring, termination or discipline of employees, (2) the purchase, sale or lease of real property, (3) pending or imminent litigation, (4) security procedures, and (5) the recruitment, credentialing, discipline and formal peer review of physicians.⁷ The Open Meetings Act requires a verbatim record of the executive session (typically a tape recording) along with preparation of minutes of such executive sessions.⁸ The Open Meetings Act further requires that executive session minutes be reviewed by the board semi-annually to determine whether such minutes can be released to the public or whether such minutes should remain closed because of a continued need for confidentiality.⁹

A hospital board president and board members should not stray from the specific limited topic that the board is legally addressing in executive session. Sometimes board members tend to relax their demeanor outside the presence of the public and press. Board members may begin joking about various topics or begin discussing other matters unrelated to the specific topic that should be discussed in the closed session. This kind of conduct may unwittingly cause the board member to violate the Open Meetings Act.

There are several reasons board members should be very careful to keep their executive session discussions to the specific topic the board legally cites as the exception to the Open Meetings Act. First, the meeting is required to have a verbatim record, typically a tape recording. One of the purposes of the tape recording requirement is to allow the judge of the reviewing court, the county state's attorney or the Illinois Attorney General's Office (through the position of the Public Access Counselor) to review the audio tape to determine if the board was properly in the executive session or if any inappropriate matters outside the scope of the exception cited were discussed. Second, board members of public hospitals should be aware that there are potential criminal and civil penalties for failure to follow the Illinois Open Meetings Act.¹⁰ While the Open Meetings Act provides penalties for discussing matters in executive session that should be discussed in open session, there is no corresponding penalty in the act for revealing confidential information that was discussed in an executive session. As stated previously, there are specific statutes governing confidentiality of patient information. However, the other gray areas of confidentiality for hospital boards must be handled through the board's own orientation of its members and adherence to a code of conduct.

Private Hospital Boards

Private hospital boards operating as nonprofit corporations typically are not subject to the Open Meetings Act. Therefore, private hospital board meetings usually do not have the public or media in attendance. Rather, in addition to the board, one or more hospital executives and supervisors are typically present for all or a portion of the meetings. If necessary, the board meets outside the presence of administration, for example when discussing executive compensation. Many of the matters listed above that provide exceptions for closing a public hospital meeting (personnel, pending litigation issues, real estate contracts and review and hiring of doctors) are the type of topics that private hospital board members should keep confidential.

Private hospital board members have more options than public hospital boards to keep other matters confidential. For example, private hospital board members can, and should, keep sensitive financial information and reports confidential unless the board elects to release such information for reasons that may benefit the hospital. In addition, discussions about potential vendor contracts, construction projects or capital acquisitions with other entities or persons should remain confidential until such time as the board may elect to publicly release information about a purchase or project. Disclosure of such information by a board member could place the hospital at a competitive disadvantage. Quality of care and patient safety issues also present sensitive and confidential information that is required to be reported to supervising authorities and may be required to be released at an appropriate time. Such information generally should be kept confidential by board members until the hospital has been required to disclose the information publicly through mandated reporting requirements.

Reasons for Hospital Board Confidentiality

While hospital boards have many reasons to keep hospital matters confidential, as a community-supported organization in the growing era of transparency, they do not want to be perceived as a secret organization. The distinction between confidentiality and secrecy lies in the motivation.¹¹ The motivation to keep information confidential at the board level is to protect a person or organization, while the motivation to be secret is to hurt someone or achieve a particular outcome that would not be possible with a full and open discussion.¹² Confidentiality in the nonprofit sector prevents unnecessary harm to the organization and its assets, employees, volunteers and board members; can be reconciled with transparency in that the relevant stakeholders are allowed to know enough information; can be reconcilable with accountability when stakeholders have the opportunity to question the process and outcome; and requires trust, but does not strain it.¹³ In contrast, secrecy attempts to protect someone or something from scrutiny; is not reconciled with transparency; seeks to prevent accountability; demands, and then misuses, trust.¹⁴

Practical Issues Affecting Confidentiality

Most members of a hospital board in a small community have had the experience of a hospital employee or member of the community with close ties to the hospital who asks to confidentially tell the member about a major problem or issue at the hospital. This individual claims he/she has not told anyone but that member and makes the member promise not to tell anyone else. This individual will often come to a board member as an informer because “they can’t trust the hospital administration” or it is an issue with a “powerful” doctor. As a practical matter, when this situation arises what should the member do? While each scenario may vary, a member should first remember their fiduciary and loyalty duties as a member of the hospital board and inform that individual that as a board member he/she has to share that

individual's concern with the rest of the board and, unless the matter directly involves a complaint about administration, the member will also share the concern with the administration. Once a board member indicates that he/she will be sharing information with the board and administration, the staff person or community member may simply refuse to tell the member anything. If the situation involves sexual harassment, discrimination or similar employment issues, it may be helpful to direct that individual to the policies and procedures that already are in place at the hospital. Such policies typically provide specific reporting procedures that should be followed. If the individual seems credible, is not concerned with the board member's disclosure to the board and is willing to share detailed information with the board member, then that board member should report the matter to the board. The board can then determine the best course of action. If the matter directly involves administration, the board may need to meet outside the presence of administration. Also, as these types of matters often involve potential legal issues, the board should seek immediate legal counsel. In some instances, if the matter is serious enough, legal counsel may advise the board to conduct an outside investigation.

While the majority of issues and concerns individuals bring to board members are relatively minor or simply the result of personality conflicts between co-workers, there are instances when the board member is informed of serious matters that require disclosure to the full board and subsequent action. The consequences of a hospital board ignoring a matter or simply sweeping a real problem under the rug can be devastating to the hospital. With the recent developments at Penn State University, every board member of institutions, including hospitals, should be prepared to come under closer scrutiny in the handling of internal complaints, investigations and reporting.

Best Practices Regarding Board Confidentiality

Careful and Objective Selection of Board Members

The best community hospital boards include individuals with diverse backgrounds, technical experience, and varied professional skills. In addition, board members should have backgrounds free of legal issues. The careful and objective recruitment and selection of new board members can avoid many confidentiality issues before they occur.

Orientation of New Board Members and Continuing Education Options

Expectations of confidentiality should be explicit and presented in a thorough board member orientation and job description. Some hospital boards use written contracts with board members or have written codes of conduct to reinforce the board's expectation that "what happens in board meetings stays in board meetings." Consequences for violating the code of conduct - including the potential for removal from the board - should be clearly identified. In a small community, convincing a qualified person to serve on your board can be difficult, and there may be a fear that all this paperwork and training may discourage the potential board member. However, if a potential board member seems unwilling to commit the time and effort to go through an orientation, to review a board member job description or to sign a board member code of conduct before becoming a board member, then perhaps the individual may not be a good fit

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for the board. A board that learns such information before the individual takes office can take steps to withdraw the nomination and search for a different member. Such action can be far easier to deal with than a board member who is not committed to the service required.

The continuing education of board members on confidentiality issues is important. In addition to formal training on confidentiality, this continuing education may be as simple as the board president reminding the board of the confidentiality of hospital board matters before the board discusses such matters. This consistent verbal signal from a board president can immediately bring a board to attention and reinforce the importance of keeping the matter confidential.

Confidentiality Should Be a Part of Board Self-evaluations

Hospital boards typically conduct an annual self-evaluation and confidentiality expectations should be part of the self-evaluations. If the board had a breakdown in confidentiality in the past year, the board should take the time to frankly discuss how the breakdown occurred, how the board can learn from it, and determine what steps to take to prevent a future occurrence.

¹ Hospital Licensing Act, 210 ILCS 85/6.17, Medical Patient Rights Act, 410 ILCS 50/0.01, HIPAA, 45 CFR Parts 160, 162 and 164.

² Open Meetings Act (OMA), 5 Illinois Compiled Statutes (ILCS) 120/1 et.seq.

³ Freedom of Information Act (FOIA), 10 ILCS 140/1 et.seq.

⁴ OMA, 5 ILCS 120/2.01, 2.02 and 2.03

⁵ OMA, 5 ILCS 120/2.02

⁶ OMA, 5 ILCS 120/2 (c)(1)-(25)

⁷ OMA, 5 ILCS 120/2 (c)(1), (5), (6), (8), (11), and (17)

⁸ OMA, 5 ILCS 120/2.06

⁹ OMA, 5 ILCS 120/2.06

¹⁰ OMA, 5 ILCS 120/3

¹¹ *In Camera Board Sessions: Securing Confidentiality or Cultivating a Culture of Secrecy*, by E. Grant MacDonald, Dalhousie University College of Continuing Education, page 2. (citing Les Stahlke, author of *Not for Profit Governance Matters: An Introduction of the Relationship Model of Governance (2010)*)

¹² *Id.* at page 2.

¹³ *Id.* (citing *Grassroots Governance: Governance and the Non Profit Sector*, Certified General Accountants Association of Ontario (2008) page 21.

¹⁴ *Id.*

How Medicare Pays Illinois CAHs: A Primer

By Hervey Davis, President and CEO, Franklin Hospital, Benton, Illinois

Medicare is the federal health insurance program for people 65 years of age and over, for people under age 65 who have certain disabilities, and for people of any age who have end-stage renal disease. Medicare expenditures represent approximately 13 percent of the federal budget. Medicare insurance is important for critical access hospitals in Illinois as the payments can represent between 40 and 60 percent of a hospital's annual revenue and approximately 80 percent of inpatient days are accounted for by Medicare insured patients.

Prospective Versus Cost-based Reimbursement

When the Medicare program was developed in 1965, all hospitals were paid on the basis of cost. In 1982, federal law was changed and hospitals were paid for inpatient services on a prospective basis, using expected costs for services within a particular diagnosis category. Additional changes to Medicare payments accompanied the Balanced Budget Act of 1997 and Congress made very large reductions in the Medicare budget. Fortunately, rural advocates and policy makers recognized that many small rural hospitals around the country were in jeopardy of closure because the prospective payment system did not pay them enough to survive. The critical access hospital concept was created and the small rural hospitals in this new category were moved from the prospective payment system to a cost-based reimbursement system.

Hospitals other than critical access hospitals continue to be paid prospectively for services provided to Medicare beneficiaries. Procedures volume is especially important to these hospitals because the amount of Medicare payments received is directly proportional to the volume of procedures performed.

Medicare pays critical access hospitals according to a cost-based formula. Receiving payments that equal the cost of providing the services means that hospitals will be unable to develop any excess revenues, or profit. Consequently, a cost-based system does not provide excess cash to offset losses incurred when caring for patients where financial loss is a certainty, such as individuals whose care is paid by Medicaid as well as uninsured people. The nation's health care system forces hospitals to depend on revenues received from commercially-insured patients to offset the losses on care where less than cost was received.

Medicare Cost Report

Critical access hospitals are paid on the basis of reasonable costs that are calculated from information each hospital submits annually in its Medicare Cost Report. The cost report is very important as approximately 40 percent to 60 percent of a critical access hospital's annual revenue may be based on the information reported in that document.

The typical cost report contains several hundred pages and organizes each cluster of similar and related hospital activities into cost centers. The costs associated with each cost center are calculated. Complicated cost-finding formulas are used for each hospital activity. Indirect costs generated by departments such as housekeeping and accounting are proportionately distributed to the direct costs of departments such as nursing. Most critical access hospitals use a consulting firm or their auditors to complete the Medicare Cost Report. Many also use sophisticated software to generate interim cost reports throughout the year to aid with decision-making and to improve predictions of the amount the hospital eventually will be paid by Medicare.

Regardless of how hospitals are paid for services provided to Medicare beneficiaries, they all are required to complete and file an annual Medicare Cost Report. These reports are audited annually by government employed or contracted auditors, generally known as fiscal intermediaries.

The Cost-based System

The cost-based system works well for hospitals that have low volume, but it must be remembered that these hospitals generally receive no more than cost. For this reason, there is always a limit to potential growth of cash receipts for the cost-based institution.

What does it mean to be paid on the basis of reasonable cost? First, not all of the critical access hospital's activity is reimbursed on the basis of cost. Nursing homes, ambulance departments, home health departments, physician services and, in some cases, anesthesia services are outside the scope of cost-based reimbursement. Expenses associated with all of these services are documented in the Medicare Cost Report, but reimbursement is made on a prospective basis.

How do we define cost? Federal regulations are very specific and fill thousands of pages of guidance for hospitals. Part of the process of preparing the cost report involves keeping statistics related to what costs are included and excluded. For example, costs related to advertising are excluded. Costs related to the rental of space to physicians or others are excluded. Because critical access hospitals are not paid for all costs incurred, it is extremely important that a hospital's finance department staff be knowledgeable about cost report preparation and proper documentation, even if the cost report is prepared by an outside organization.

The Medicare program pays two times in the critical access hospital's annual financial cycle. Individual claims are paid on an interim basis as health care services are provided. At the end of the hospital's fiscal year, after the Medicare audit is complete, a settlement process begins. If the hospital was underpaid by Medicare, it will receive an additional payment. However, if the hospital was overpaid, it must reimburse Medicare the excess amount. The cost report

must be filed within five months following the close of the hospital's fiscal year. Any funds due to Medicare must be paid within 10 business days. If Medicare owes the hospital additional funds, Medicare may withhold between 10 and 20 percent of the settlement amount to cover possible adjustments that might result from a future audit. Audits typically are completed within 12 to 18 months. An authorized signature on the cost report attests to the critical access hospital's acceptance of the accuracy of the report's content. Signing an inaccurate cost report with knowledge of the errors is considered Medicare fraud, a serious illegal act.

Billing for Services

Medicare requires each hospital to submit a bill for services provided to each Medicare beneficiary. If the bill is accepted as accurate, the hospital receives its payment for those services very quickly, usually within 21 days. Payment amounts are determined in different ways. If the service on the bill relates to programs that are paid on a cost basis, then the payment is determined based on ratios and computations related to the most recent cost report filed by the hospital. If the service is paid on a fee schedule, then the payment is calculated on that basis.

To demonstrate the Medicare service payment process, consider the following simplified example:

- A Medicare beneficiary receives services in a critical access hospital emergency department and is charged \$1,000 for services provided during the visit.
- The hospital's most recent cost report determined that the cost-to-charge ratio for the hospital's emergency department is 70 percent. Thus, it costs the hospital 70 cents to produce \$1 of revenue.
- Applying the 70 percent to the \$1,000 emergency department charge results in a \$700 obligation to Medicare.
- Medicare expects the patient to make a 20 percent co-payment based on the charge (\$1,000), thus a \$200 co-payment in this example.
- Medicare pays the hospital the balance of the allowed cost (\$700 minus the \$200 co-payment) or \$500.
- The balance of the charge, \$300, is written off by the hospital as a contractual allowance.

Another example of the Medicare cost reimbursement process and its possible impacts follows:

- Assume that the critical access hospital described above doubles its emergency department volume during its fiscal year but does not increase expenses. Its 70 percent cost-to-charge ratio would decrease to 35 percent (an intentional oversimplification).
- Because the on-file cost report indicates cost-to-charge ratio of 70 percent, the hospital will be overpaid throughout the year.
- If the hospital was not aware of the ongoing overpayments and spent the excess on operations, the year-end reconciliation could be financially painful.

Conclusions

Medicare payments account for a major portion of a critical access hospital's business. The payment process is complicated and requires that board members develop a sound understanding of the nuances of the process. Because of the significant expenditures of federal funds for the Medicare program and the federal efforts to reduce expenditures, it is important that board members and critical access hospital CEOs and CFOs be knowledgeable about Medicare reimbursement issues. Active involvement with professional associations and rural advocacy organizations will help ensure that critical access hospital fiscal issues are accurately presented to state and federal policy makers.

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How Medicaid Pays Illinois CAHs: A Primer

By Hervey Davis, President and CEO, Franklin Hospital, Benton, Illinois

Medicaid is the insurance plan jointly funded by federal and state governments, but administered by each state. It provides health insurance for people with lower incomes as well as for some who are blind, disabled, or elderly. Medicaid is the only insurance coverage that many young people, children and nursing home residents have. Some people may qualify for both Medicaid and Medicare. Costs of Medicaid are shared almost equally between the State of Illinois and the federal government. Medicaid is sometimes referred to as the “public aid” program. Federal expenditures on Medicaid and a companion program, the Children’s Health Insurance Program (CHIP), represent approximately eight percent of the federal budget.

Medicaid: How Does It Work?

Within federal guidelines, the design and administration of the Medicaid program is the responsibility of each state. Each state has its own rules about who can participate in the program and how the bills will be paid for services. Illinois is renowned for having a very complicated Medicaid program and ranks among the worst of states for low and slow payments to providers. Illinois policy makers are engaged in an effort to reform the hospital payment system. The critical access hospital community has been blessed recently with great success in establishing a favorable payment system. The Illinois Critical Access Hospital Network, its member hospitals, and the Illinois Hospital Association worked collaboratively to convince the Illinois General Assembly to pass a law to give critical access hospitals cost-based Medicaid reimbursement for outpatient services using the same methodology used by Medicare. This new reimbursement mechanism could be at risk if the critical access hospital community is not vigilant while the hospital payment reform process unfolds.

Basically, all hospitals in Illinois are paid for each claim filed with the Illinois Department of Healthcare and Family Services. Hospitals also receive substantial lump sum payments to augment their Medicaid payments. At one time, there were 18 different lump sum programs through which hospitals in Illinois received payments. Examples of these lump sum payment programs include:

- rural adjustment payments
- safety net payments to hospitals in inner city areas
- payments for disproportionate share hospitals (DSH) that serve disproportionately high numbers of Medicaid patients
- special payment system for critical access hospitals’ outpatient costs
- hospital assessment program

The hospital assessment program collects a tax from hospitals and uses those funds to contribute to reimbursement. One can easily see why the state needs to undertake rate reform. Overall, after all lump sums and claims payments are received, most critical access hospitals receive a bit less than cost for the services provided to Medicaid-insured patients. The claims portion is generally the smallest portion of the total payment and most hospitals find themselves more dependent on the lump sum payments.

Timing Is Everything

There are two key problems related to Medicaid reimbursement: how much is paid to the hospitals and when these payments are made. Illinois delays claims payments as a means of managing its cash flow. It is not unusual for hospitals to be owed payments for Medicaid claims that are over six months in age. Conversely, lump sum payments traditionally have been paid on time and on a monthly basis. These special payments have become very important to hospitals, allowing them to pay their bills and meet their obligations. One of the concepts being explored by the state in its payment reform efforts is the possibility of rolling the present lump sum payments into the claims system. This concept is being met with resistance but appears to be a concept that likely will be implemented.

Hospital Assessment Program

The federal government reimburses Illinois for one-half of its Medicaid expenditures. This reimbursement proportion varies among states. Because Illinois is financially unable to increase the amount that it pays for the Medicaid program, the hospitals have agreed to pay a special assessment tax, the proceeds of which are contributed directly to the reimbursement program. The hospitals pay this tax to the state to increase the amount the state has available to pay for Medicaid services. In this way, the federal share amount is also increased because of the 50 percent match provided by the federal government. In this manner, the assessment tax dollars paid by the hospitals are applied to the match formula to increase the over-all amount of funds available to hospitals.

This description of the assessment program is overly simplified. Very complicated rules and procedures govern the state's participation in the program. The reader should recognize that this program is of significant importance to the hospitals of Illinois. By agreeing to pay the assessment tax to the state, the hospitals in the state, with the match contributions from the federal government, are providing almost half of the dollars available for the Medicaid program in Illinois.

Conclusions

Critical access hospitals are located in rural communities throughout the state. The economic down-turn has adversely affected the rural population and the providers who serve them. The number of Medicaid-insured patients rises each day. A typical downstate Illinois hospital in 2000 might have expected that between 5 to 10 percent of its patients

would have been Medicaid-insured. Today, that same hospital might have Medicaid-insured rates of 20 to 25 percent of its patients. For many hospitals, Medicaid is no longer a footnote and receipt of timely Medicaid payments is vital to a hospital's survival. The Patient Protection and Affordable Care Act, signed into law in March 2010, will extend federal and state support for health care coverage to roughly 75 percent of the uninsured population in the United States. One can easily see the importance of the Medicaid program to critical access hospitals.

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The Medicaid program contributes between 10 to 30 percent of the business for our critical access hospitals. Because both the State of Illinois and the federal government have problems with their finances, it is important that the Illinois Critical Access Hospital Network and the Illinois Hospital Association monitor the Medicaid program on behalf of all hospitals in the state. It also will be important for hospital board members and hospital CEOs and CFOs to be knowledgeable about Medicaid reimbursement issues. They should be actively involved with professional associations and rural advocacy organizations to help ensure that critical access hospital fiscal issues are accurately presented to state and federal elected officials and to policy makers.

Understanding Charity Care

By Todd Etheridge, CPA, Partner, CliftonLarsonAllen LLP

Many nonprofit hospitals in Illinois are facing challenges to their eligibility for tax exemption from income tax, sales tax and property taxes. The focal point of these challenges is the use of a charity care policy to identify the level of charity care provided at the hospital. Policies that address charity care provisions are a fundamental component of a hospital's operations and provide essential information that is used by patients, staff, and other stakeholders.

Notification of the Existence of a Policy

Charity care policies should be posted for public access on the hospital's website and prominently displayed in the facilities the hospital operates. Most charity care policy statements describe the essential purpose of the policy, the process to be followed to apply for charity care, and a statement of the hospital's commitment to service. A confidentiality clause typically is included as are a detailed description of what constitutes family income to be used to determine eligibility for charity care, a time-line for the hospital to respond to such an application, and the hospital's self-pay collection policy.

Training

Hospital staff must receive training related to (1) the charity care policy, (2) implementation guidelines, (3) how multilingual services will be provided, (4) the responsibilities of various departments and leaders with regard to charity care, and (5) details pertaining to application requests, processing, and patient notification. Time lines for application reviews, patient notification, and collection procedures also must be addressed. Hospital staff must be educated on how to approach and document charity care decisions when insufficient or inaccurate information is provided by patients. The training should address the time frames for provision of care and implementation of the discounts for low-income and uninsured patients.

Federal Guidelines

Charity care decisions typically are based on federal poverty guidelines, which are usually published in late January each year. The guidelines are based on the amount of family income and the number of family members. Family income generally includes earnings, unemployment compensation, worker's compensation, Social Security, supplemental security income, public assistance, veteran's payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Non-cash benefits such as food stamps and housing subsidies do not count. Family income is calculated before taxes and excludes capital gains or losses.

Accounting for Charity Care

Charity care is different than bad debt. Charity care, in its truest form, represents services provided for which the hospital never intended to collect fees for providing such service. Bad debt encompasses fees for services that the provider fully intended to collect but was unable to accomplish. Thus, charity care is identified before the service is provided and collection is never expected from the patient. However, due to the nature of the health care industry, there are many situations where the service is provided before a charity care assessment is completed. It is important for the hospital to complete the charity care assessment as soon as possible. Because the hospital never intended to collect the revenue from the service provided under a charity care policy, revenue is not recorded or it is recorded then netted to zero by a deduction from revenue. The deduction from revenue is typically called *charity care deduction*.

Additional considerations that impact charity care in Illinois hospitals are the Fair Patient Billing Act of Illinois and the new Section 501(r) of the Internal Revenue Code required by the Patient Protection and Affordable Care Act.

The Fair Patient Billing Act of Illinois was enacted to support the prompt and accurate payment of health care services through fair and reasonable billing and collection practices by hospitals. This act directly affects charity care as it requires hospitals to post signs in conspicuous locations that notify patients of its financial assistance policy. Additionally, this act has provisions that address the patient's service bill, how patients should pursue inquiries about a bill, the timing and method of bill collection, and patient responsibilities.

Internal Revenue Code Section 501(r) was added in response to the Patient Protection and Affordable Care Act Section 9007(a). Section 501(r) contains four categories: Financial Assistance Policy, Limitation on Charges, Billing and Collections, and Community Health Needs Assessments.

- Financial Assistance Policy provisions require each tax-exempt hospital to develop, implement, and make widely available written policies regarding financial assistance and emergency medical care.
- Limitation on Charges provisions require each tax-exempt hospital to limit the amount it charges for emergency services or other medically necessary care provided to patients eligible for financial assistance to not more than the lowest amounts charged to insured patients.
- Billing and Collections provisions require that each tax-exempt hospital cannot take "extraordinary collection actions" until it has made "reasonable" efforts to determine whether a patient is eligible for financial assistance.
- Community Health Needs Assessment (CHNA) provisions require that each tax-exempt hospital must conduct a CHNA at least once every three years and adopt an implementation strategy to meet the needs identified by the assessment.

The Financial Assistance Policy, Limitation on Charges and Billing and Collections provisions became effective for taxable years beginning after March 23, 2010. The CHNA provisions are required for taxable years beginning after March 23, 2012.

Charity Care Disclosure

In 2010, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update No. 2010-13, "Measuring Charity Care for Disclosure," for health care entities. The update clarified the measurement basis for the disclosure of charity care as a cost measurement rather than one based on revenues or prices. A single measurement basis makes health care entities' financial statements more consistent and easier to compare. Health care entities are permitted to estimate costs using recognized techniques. For example, an entity may calculate a ratio of cost to gross charges and then multiply the ratio by the gross uncompensated charges for charity care.

Additionally, health care entities are required to disclose the level of charity care provided on a cost basis and provide the methodology used to determine that cost. These disclosures affirm the amount of charity care provided to the community and provide data about the economic environment in which the hospital operates. Potential investors, creditors, donors and other stakeholders may use the disclosures to make decisions regarding investment, credit, and resource allocations.

As noted above, the accounting update requires that cost be identified as the direct and indirect costs of providing the charity care. In acknowledging that various techniques are used to identify direct and indirect costs, the update mandates disclosure of the methods used to identify costs, such as a costing system or estimation techniques.

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A health care entity also is required to disclose separately the funds it receives from grants or gifts that are restricted for charity care.

The new standard became effective for fiscal years beginning after December 15, 2010 and is to be applied to all prior periods presented in the financial statements of the health care entity.

Quality...The Constant Challenge

By Angie Charlet, Director of Quality Services, Illinois Critical Access Hospital Network

Performance improvement, continuous quality improvement, quality assurance, quality assessment, total quality management. Whatever terminology is used, a board member of a critical access hospital always has the moral and legal responsibility to monitor, evaluate, and support efforts to continuously improve the quality of care and services provided to hospital patients. The board must organize itself to effectively perform its oversight role: this responsibility cannot be delegated.

The hospital board must form a dynamic and collaborative partnership with hospital and medical staff leadership. A successful quality management process requires a commitment by the board members to visibly support the quality mission of the hospital and to remain up-to-date on quality issues in health care.

The Institute of Medicine, the health unit of the National Academies, issued a report in 1999, *To Err Is Human: Building a Safer Health System*¹ that estimated that as many as 98,000 patients die each year in hospitals as a result of medical errors, many of which are preventable. A follow-up report in 2001, *Crossing the Quality Chasm: A New Health System for the 21st Century*², served as a catalyst for the patient safety movement by identifying practices that impede quality care and explored how systems approaches could be used to implement change.

In 2006 the Institute of Medicine also reported³ that at least 1.5 million Americans were sickened, injured or killed annually by avoidable errors in prescribing, dispensing, and taking medications. On average, mistakes in dispensing drugs are so prevalent in hospitals that a patient likely will be subjected to a medication error each inpatient day.

These findings have sparked demands from the public, from legislators, the media, and health care providers that hospitals must improve care. The need to document quality measures continues to grow and is increasingly recognized as essential to the improvement of health care.

In 2011 the need for critical access hospitals to focus on quality was highlighted in an article in *JAMA*, (July 6, 2011). Critical access hospitals were criticized for a variety of quality concerns; subsequently, the authors of the article were criticized for erroneous comparisons of rural and urban statistics. In response to the article, the federal Office of Rural Health Policy⁴ developed a proactive and visionary approach to ensure critical access hospitals are well-equipped to meet and document future quality requirements through an initiative titled Medicare Beneficiary Quality Improvement Project or MBQIP⁵.

Also in 2011 the U. S. Department of Health and Human Services created the Partnership for Patients: Better Care, Lower Costs⁶, a public-private initiative to achieve two main goals by 2013:

- keep patients from getting sicker by reducing by 40 percent hospital acquired infections
- help patients heal without complications by reducing by 20 percent hospital readmissions

The drive to improve care demands transparency from hospital providers so stakeholders have access to better information for health care decision making, provider selection, and cost containment. Effective performance improvement results in continuous improvement of patient outcomes and requires hospital-wide interdisciplinary collaboration and involvement of the board of directors.

As part of the new Patient Protection and Affordable Care Act, the U. S. Department of Health and Human Services drafted a national health care quality strategy that was presented to Congress in January 2012. The proposal sets national goals for quality improvement and identifies measures to track progress in achieving the goals.

The National Quality Forum⁷ is developing additional consensus-endorsed measures. The forum is creating its first-ever agenda to prioritize efforts to measure resource utilization and effective care coordination.

The rush to build a new quality of care consensus is driven in part by the upcoming Medicare demonstrations mandated by the Affordable Care Act. Reimbursement will be tied to performance on standardized measures, possibly including outcomes. Medicare intends to change from volume-based health services payments to a value-based payment methodology. At this time, critical access hospitals are not affected by the demonstrations but likely will be in the future.

Requirements and standards of the Joint Commission, Conditions of Participation for Medicare and Medicaid, and the Illinois Hospital Licensure Act Rules and Regulations all require hospitals to have active and effective quality improvement plans that result in demonstrable improvement in patient care and safety. All of these standards charge the hospital board with the ultimate responsibility "to make it happen." Hospitals are hearing demands from the public, the media, policy makers, and payers to improve care --- to meet the level of trust expected from the health care system. These demands will continue to grow as each day passes.

¹ "To Err Is Human: Building A Safer Health System", November, 1999, Institute of Medicine, www.iom.edu

² "Crossing the Quality Chasm: A New Health System for the 21st Century", March, 2001, www.iom.edu

³ "Preventing Medication Errors: Quality Chasm Series," July, 2006, Institute of Medicine, www.iom.edu

⁴ Office of Rural Health Policy, Health Resources and Services Administration, U. S. Department of Health and Human Services, www.hrsa.gov/ruralhealth/

⁵ Medicare Beneficiary Quality Improvement Project, www.hrsa.gov/ruralhealth/

⁶ www.healthcare.gov/compare/partnership-for-patients

⁷ www.qualityforum.org

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Health Information Technology's Importance to Health Care

By Mary Catherine Ring, Project Director, Illinois Critical Access Hospital Network

The collection, analysis, storage, and sharing of health care information have moved to an electronic format at such a rapid pace over the past decade that all hospital employees, physicians and other healthcare professionals, whether employed or in private practices, are directly involved in the change. Patients also are aware of the electronic advances, experienced not only when they visit a health care provider or hospital but also when they hear reports on television or radio, read print media, or view their favorite Internet browser homepage. Hospital board members likewise must be cognizant of these changes and engage in decision making that enables the hospital to achieve all milestones in the migration to digital information systems known collectively as health information technology.

Health IT includes multiple health technologies:

- electronic health records
- secure electronic networks to deliver/exchange patient information among providers
- electronic transmittal of laboratory test results
- confidential access for patients to view their own health information online
- electronic communication between patients and health care providers
- electronic prescribing of medications, treatments, and tests
- decision support systems to provide clinicians with the most up-to-date information on best practices and treatment options
- mobile electronic devices that allow documentation and presentation of information at the point of care

Source: Rural Assistance Center (www.raconline.org)

The federal Office of the National Coordinator of Health IT identifies the following outcomes associated with health IT:

- ready access to accurate and complete patient health information, ensuring health care providers can administer the best care in any setting with reduced potential for errors
- increase patients' knowledge of their health information and participation in their own healthcare
- increase the contribution of health care information to enhance evidence-based medicine and help clinicians improve quality of care and reduce medical errors
- improve health care efficiency to prevent duplication of services and inappropriate or unnecessary expenditures

Electronic health records (EHR) are not a new technology. A rudimentary prototype was developed in the late 1960s and refinement continued throughout subsequent decades. The recognition that health care caused tens of thousands

of deaths annually due to preventable errors was presented in the 1999 Institute of Medicine report, *To Err is Human: Building a Safer Health System*. Lack of comprehensive and coordinated patient information was cited as one of the key contributing factors leading to errors. The 2001 IOM report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, called for fundamental change to prevent the avoidable errors and “to close the quality gap” by promoting evidence-based practice and strengthening clinical information systems through the use of electronic capture and sharing of patient information.

Building on the momentum generated by the two IOM reports, President Bush set a goal in 2004 that most Americans should have an EHR by 2014. To help achieve that goal, President Obama championed the 2009 American Recovery and Reinvestment Act and the Health Information Technology for Economic and Clinical Health (HITECH) Act that authorized \$44.7 billion to be paid by Medicare and Medicaid to help hospitals, physicians, and other selected health care professionals meet the costs related to EHR implementation. Eventually, payment reductions will be instituted by Medicare if hospitals and providers do not fully utilize EHRs.

A three-staged approach to the complete or *meaningful use* of EHRs has been developed and is spread over a five-year period. Ten of the 51 Illinois critical access hospitals attested to Stage 1 meaningful use by the close of the first year of the program, September 30, 2011. An equal number of Illinois critical access hospitals is expected to meet Stage 1 meaningful use requirements within the first six months of the second program year.

Health IT’s Impact on Critical Access Hospitals

Critical access hospitals often have an advantage over their larger counterparts when implementing new programs or processes: Their smaller size can make changes easier to implement due to less complex operating procedures, fewer staff, and more opportunities for staff communication and interaction. However, these characteristics also can contribute to the challenges critical access hospitals face when implementing major functional changes.

Transitioning to EHRs requires that all providers and support staff perform old functions in new ways. Learning to use EHRs and other new software systems must occur on the job. This can be difficult to schedule when staff are limited in number and appropriate staffing levels must be maintained to ensure that the highest quality patient care is uninterrupted. All critical access hospital staff and health care providers must be willing and enthusiastic participants in the migration to the electronic way of doing business. There can be no choice as health care systems worldwide are moving in this direction, or already have in many countries. Nonparticipation can result in business disruption at the critical access hospital, loss of consumer/patient confidence, and jeopardizing patient safety and care outcomes.

Some critical access hospitals must make significant modifications/upgrades to IT infrastructure as well as upgrade any existing EHRs to the most current and nationally-certified versions, and possibly add EHR modules not installed to date. Some have managed to function with a minimum number of IT-devoted staff. The increasing use of unique and innovative technologies likely will require IT department expansions. Recruitment of staff will be difficult; there are an estimated 50,000 health IT vacancies nationwide and rural communities traditionally struggle to recruit new staff.

The necessary upgrades and new purchases of both hardware and software are costly. Hospital capital initially must be used, subsequently the critical access hospital can seek the Medicare and Medicaid incentive payments. Imprecise definitions of allowable expenditures for Medicare EHR incentive payments are worrisome. The newness of the EHR incentive payment programs requires critical access hospitals to be flexible and patient as their Medicare fiscal intermediaries work through the incentive payment process. The Medicaid incentive payment process is much more straight-forward, offering eligible critical access hospitals reasonable financial support. There will be ongoing expenses as the Stage 2 and Stage 3 meaningful use requirements are released by CMS and critical access hospitals work to meet the increasingly stringent expectations.

Special Health IT Considerations Linked to the EHR

As EHRs become ubiquitous, the ability to make the patient health information available to providers anywhere, if the patient consents, is one of the next steps in the continuum of health IT development. The ability to securely share patient information supports the concept of right patient, right information, right time, regardless of where the patient seeks care. This process is health information exchange, or HIE. In Illinois, multiple local HIE networks are developing as is a statewide, state sponsored network, the IL-HIE. Hospitals and health care professionals will engage with one or more of these HIEs, all of which will engage with the IL-HIE, which eventually will be linked to the Nationwide Health Information Network, the NwHIN. Fees will be charged by these HIEs as they all must be self-sustaining.

Collecting and storing health care data in an electronic format require significantly enhanced privacy and security procedures within health care settings. Data privacy and security must be thoroughly addressed in policies and stringently enforced, with no exceptions. Patients must be confident that their data, thus privacy, are protected or they will seek other sources of care.

Cyber security experts report that EHRs can be worth up to \$50 each on the black market, compared to just \$3 for a Social Security number and \$1.50 for credit card information. This value fuels hackers and medical identity thieves. However, data loss reports to the federal Office for Civil Rights indicate that the majority of large-scale (500 or more affected individuals) data breaches occurred due to theft of portable devices (laptops, external storage, and mobile

devices), with the majority unprotected by data encryption. Institutional policies for data management likely were ignored in all of these instances. Penalties for data breaches were increased from \$100 per violation to as much as \$50,000 by the HITECH Act. Security breaches can result in significant and long-term financial consequences for critical access hospitals due not only to the levying of fines but also the loss of confidence by patients and their decisions to seek care elsewhere.

Additional Health IT Implementations on the Horizon

Concomitant with the deployment of EHRs is the rapid expansion, refinement, and adoption of telehealth technologies. Use of remote monitoring is expanding rapidly, prompted by the growth of the elderly population, the increasing prevalence of chronic diseases, and the high cost of care associated with both of these phenomena. The increasing demand for care, the inability of the health professional education system to keep up with demand for physicians and other health care providers, and the increasing sophistication of technology and communications resources all point to telehealth as one of the next major technology challenges/opportunities to be addressed by critical access hospital administrators, their staff and their boards of directors.

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Rural Health Clinics: A Good Option for Critical Access Hospitals

By Pat Schou, Executive Director, Illinois Critical Access Hospital Network

Medicare-certified rural health clinics play an important role in the delivery of primary health care to rural residents. The Rural Health Clinics Act was passed by Congress in 1977 to address two primary purposes. One purpose was to encourage the use of physician assistants and nurse practitioners by authorizing direct reimbursement to these providers for services they provide to Medicare and Medicaid-insured patients, even in the absence of an on-site physician. The second purpose was to create a cost-based reimbursement mechanism for services provided at the rural health clinics. In 2000, Congress passed legislation that allowed state Medicaid programs to pay for rural health clinic services using a fee-for-service methodology instead of the cost-based system, which has caused a less than consistent Medicaid payment system. Reimbursement for Medicare beneficiaries served at the rural health clinics continues to be based on reasonable costs.

Many critical access hospitals have established rural health clinics on the hospital campuses or in neighboring communities as a means of increasing access to primary health care services for residents of a hospital's service area. The use of nurse practitioners and physician assistants is an appropriate alternative when a hospital cannot recruit a physician or has limited funds available to establish a clinic site. A rural health clinic on campus also provides an option for non-emergent patients to receive care quickly and at a lower cost. Commercial insurers and managed care companies recognize rural health clinics and may contract directly with the clinic and/or the parent hospital.

Rural Health Clinic Requirements

Rural health clinics must be located in a federally-designated medically underserved area or health professional shortage area, or in a state-designated physician shortage area that is classified as rural. A rural health clinic may be organized as a public or private entity, as nonprofit or for-profit, and may be owned and operated by an individual such as a physician, a physician assistant, or a nurse practitioner. A rural health clinic in Illinois must be certified by the Illinois Department of Public Health, acting on behalf of the federal Centers for Medicare & Medicaid Services, before it can receive Medicare and Medicaid payments. The most unique requirement for a rural health clinic is that the clinic must employ a physician assistant or nurse practitioner and that provider must be available to treat patients at least 50 percent of the hours the clinic is open for patient visits. A physician must see patients at the clinic at some time every two weeks and also must review a defined number of patient records in the two week period.

A rural health clinic is required to provide basic lab services and emergency medical procedures as a first response to common life threatening injuries and acute illnesses. It is not required to provide pharmacy services, but some do and may have sample medications onsite. It is not required to have radiology, dental services, or specialty care

on site nor is it required to provide transportation, or after hours coverage. A rural health clinic may choose to provide preventive services and mental health services. With the increasing use of electronic health records as the national standard, a rural health clinic will need electronic health records as well as the ability to submit all service claims electronically.

New rural health clinics must be surveyed by the Illinois Department of Public Health prior to providing services and to become certified. Follow-up surveys are conducted approximately every three years. There are specific program guidelines for care and treatment of patients that clinic staff must follow. Hours of operation must be posted. Work schedules of medical providers must be available to surveyors to verify that the clinic has a physician assistant or nurse practitioner available at least 50 percent of the time the clinic is available to patients.

There are two categories of rural health clinics. One is provider-based, which is operated by a critical access hospital, skilled nursing facility, home health agency, or other hospital. The parent organization of a provider-based rural health clinic must demonstrate ownership, administrative oversight, and financial integration of the clinic. Provider-based rural health clinic patient visit rates are based on the total operating and administrative costs of the clinic.

A free standing rural health clinic may be owned and operated by a corporation or individual and must accept the federally-determined payment rate-per-visit. Both categories of clinics complete a Medicare Cost Report each year and are able to receive additional payments through the cost settlement process. Most critical access hospitals operate a provider-based rather than a free standing rural health clinic because of the opportunity to complete a cost report and receive an increased level of reimbursement that encompasses the administrative costs expended to manage the clinic.

Advantages and Disadvantages of the Cost-based Rural Health Clinic Model

The rural health clinic cost-based model, the provider-based option, enables the parent organization to receive reimbursement payments that more closely match operating costs. However, rural health clinic services are to be focused on primary health care. If a critical access hospital has a need for more procedure-oriented specialty services, a fee-for-service clinic model would be a better choice than the Medicare-certified rural health clinic option.

Rural health clinic expenses must be closely monitored throughout the year. If reimbursement amounts and operating costs do not match, a payback situation may result when the Medicare Cost Report is completed at the end of a fiscal year.

The rural health clinic program has been in effect for over 35 years and has been an excellent service model to increase access to primary health care in rural communities when a physician practice is impractical. Critical access hospitals can own and operate a rural health clinic, which allows the hospital to provide services in multiple communities throughout its service area. A rural health clinic also can serve as a physician recruitment incentive, offering a new physician the opportunity to supervise the nurse practitioner or physician assistant in the clinic while building his or her own practice. Hospital boards should explore the benefits of operating a rural health clinic, or clinics, to expand access to primary health care in the hospital's service area.

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A recommended resource for additional information is *Comparison of the Rural Health Clinic and Federally Qualified Health Center Programs*, U.S. Department of Health and Human Services, Health Resources and Services Administration, Revised June 2006. (www.ask.hrsa.gov/downloads/fqhc-rhccomparison.pdf)

Hybrid Hospitalist Services: Straight Talk about a Critical Rural Service

By Randy Simmons, President and CEO, Paris Community Hospital, Paris, Illinois

Let's say...

Your community's population is aging and requires more and more inpatient care.

You have resorted to employing many physicians because of the difficulty of recruiting new or retaining existing active medical staff.

To prevent your existing physicians from leaving, you long ago invested in 24/7 emergency department coverage.

Your costs for emergency department coverage continue to rise and, without some way to retain more of these patients, the budget hole just keeps expanding.

Even with the aging of your patient population, your inpatient volumes drop each year.

Your emergency department physicians transfer more patients to larger hospitals than they admit to your hospital.

As you desperately search for new primary care physicians, most of the candidates are focused on limiting or avoiding both on-call and inpatient responsibilities.

Your physicians are tired. Some are aging, and they no longer want to or are able to assume the same responsibilities for patient care they had when they were in their 30s or 40s.

They look toward the bigger towns with larger populations, bigger hospitals and larger and more diverse medical staffs.

They wonder if they made the right choice in coming to your hospital.

You find it almost impossible to recruit new primary care physicians in a reasonable time frame. When they express interest, they often demand pay and benefits that match those of the most senior physicians, but they are unwilling to accept the on-call or inpatient care responsibilities so vitally needed to pay for the losses generated by their clinic practices.

Without primary care physicians referring to surgeons, one of the hospital's most profitable service lines will fail.

What To Do?

One solution used by critical access hospitals over the past five years is staffing both the emergency department and the medical-surgical inpatient unit of the hospital with specially trained physicians. These physicians treat patients who seek care in the emergency department and, if necessary, admit and care for these same patients when they are hospitalized.

Most models used by critical access hospitals consist of a core group of five or six physicians who staff twenty-four hour shifts as the ED/Hospitalist. This model works when the emergency department and inpatient volumes are manageable by one physician. Simultaneously staffing both the emergency department and inpatient unit creates solutions to the problems of maintaining patient volumes while reducing the responsibilities of the active medical staff for 24/7 patient care. However, this approach is often difficult to initiate and requires constant communication with the active medical staff to foster trust and dependence on the ED/Hospitalists. Once in place and functioning well, this model will alleviate many of the pressures faced by overworked primary care physicians while stabilizing or increasing inpatient volumes.

Acceptance of this model of care is sometimes difficult for rural patients who are accustomed to their primary care physicians admitting them and continuing to care for them while they are in the hospital. If these same patients had been referred to any secondary or tertiary level hospitals within the past decade, they experienced their emergency department care managed by a contracted emergency department physician and their inpatient care managed by a hospitalist. Using the hybrid ED/Hospitalist model, two areas of care are covered by one highly skilled physician who is present in the hospital and is available to patients and nursing staff around the clock. The costs are high but manageable and far better than the alternative of the continuing deterioration of inpatient volumes, and unhappy physicians and staff.

With the addition of this new model of care, rural primary care medical staff often continue to be on-call on their normal rotation to back up the ED/Hospitalist in the event of overwhelming emergencies. The primary care physicians have far fewer responsibilities that require them to take phone calls at night or to come to the hospital to care for a patient. These responsibilities are transferred in whole or in part to the ED/Hospitalist who always is in the hospital. Often, as the program becomes more accepted, recruitment of new physicians becomes easier. The hospital finally is able to attract physicians who previously would not have considered interviewing because of the perceived lifestyle limitations associated with inpatient responsibilities.

Costs to implement this new service vary widely but will exceed the cost of 24/7 emergency department coverage.

Several of the additional benefits of this new service include:

- the ability to retain and possibly extend the practice life of existing physicians
- quicker and more consistent responses to inpatient needs
- improved inpatient medical care of surgical patients
- the ability to more quickly and consistently implement patient care and documentation changes than when dealing with multiple medical staff

Several of the problems encountered when initiating this new service include:

- acceptance by the existing physicians
- difficulty in recruiting qualified physicians as ED/Hospitalists
- lack of initial patient acceptance
- significant time commitments from key hospital staff during the first year of the service
- identifying a physician group business partner that will be able to provide the necessary expertise, resources, and medical direction to make the service successful

This model may not be the best approach for all rural hospitals, but it is a very viable option for critical access hospitals that are experiencing the types of pressures described in this article.

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Health Care Reform: What it Means to Rural Communities and Health Care Providers

By Pat Schou, Executive Director, Illinois Critical Access Hospital Network

The Patient Protection and Affordable Care Act passed Congress and was signed into law in March 2010. Since then, no other federal legislation has created such controversy and, at the same time, excitement about the opportunities for change. Health care professionals have embraced reform because of the growing number of uninsured individuals, the increasing number of health insurance payment denials, and the skyrocketing costs of health care with no limits in sight.

The Patient Protection and Affordable Care Act, usually referred to as the Affordable Care Act, has two key components. First, it significantly increases the health insurance options available to the uninsured. Approximately 93 percent of all Americans would become insured through some form of health care insurance. Second, it authorizes multiple initiatives to both require and to incentivize the transformation of the current health care delivery system to one that focuses on keeping people healthy while reducing health care expenditures.

The Affordable Care Act requires individuals to purchase health care insurance. So-called health insurance exchanges are to be established in each state to offer an alternative insurance marketplace for both individuals and small businesses. Government subsidies would be offered to eligible insureds within both groups. Under the act, companies with 50 or more employees must offer group health insurance or pay a penalty. Medicaid enrollment would be adjusted to provide health care coverage for individuals and families otherwise unable to pay the insurance premiums.

A majority of states and multiple organizations and individuals have challenged the constitutionality of the Affordable Care Act. The Supreme Court will hear oral arguments in March 2012 and is expected to issue its ruling in Summer 2012.

Although many positive outcomes could accrue from the provisions of the Affordable Care Act, there are many fears about its implementation costs. Those costs are to be met by the cost savings that result from the reforms to be implemented. Our nation's health care system is fragmented and expensive, and the health status of Americans is significantly lower than in many other industrialized nations. Many questions remain whether the Affordable Care Act can achieve the desired results with available funds.

What Are Some of the Key Provisions of the Affordable Care Act?

Access to health insurance – children guaranteed coverage through their parents' insurance to age 26; elimination of pre-existing conditions exclusions; creation of state-owned health insurance exchanges as an alternative marketplace for individuals and small businesses; government subsidies to help selected individuals purchase health care insurance

Expanded Medicaid coverage – between 2013 and 2020, expand Medicaid eligibility to include Americans with incomes at 133 percent or less of the federal poverty level

Wellness and prevention – expand wellness and prevention benefits for Medicare beneficiaries; offer multiple health promotion and disease management grants to schools, health departments, and community health centers

Health care workforce – increase funding for primary care physicians and midlevel providers; create health professional training sites in community-based health centers

Medicare reform – eliminate the Medicare prescription drug donut hole for the elderly by 2020; offer incentive bonuses for general surgeons who practice in shortage areas; incentivize Medicare payment system reform, including bundling of payments, to begin to reduce Medicare costs

Compliance improvements, and fraud and abuse reductions – implement standards for electronic claims; initiate use of Medicaid recovery audit contractors; increase efforts to eliminate fraudulent claims and abuse of both Medicare and Medicaid programs to potentially save billions of dollars each year; implement community health needs assessment program for nonprofit hospitals to identify levels of care needed in the community

Quality improvement – expand quality indicator reporting to include outpatient measures; implement reporting of critical access hospital-specific quality measures by 2013; continue use of incentive programs for quality care and add penalties for poor performance; increase use of value-based purchasing and public reporting of physician performance; fund the new Center for Medicare and Medicaid Innovation

Integrated health delivery – communicate, coordinate, cooperate, collaborate and consolidate for care integration; initiate incentive programs for medical shared savings programs and for accountable care organizations to require all providers to work together and share a single payment; develop initiatives to increase the use of the medical home model and encourage coordination of care throughout the health care system

What Do Some of the Provisions of the Affordable Care Act Mean for Rural Hospital Boards?

Even if some of the provisions of the Affordable Care Act, especially the mandate to purchase health care insurance, are repealed, many programs authorized by the act already are underway or nearly so. Change and health care reform are here to stay. Hospital leaders should expect to do more with less. Payers soon will not pay for poor performance and will expect providers to focus on quality of care and collaboration with one another. Already overburdened with regulations, hospitals can expect increased scrutiny of billing and documentation practices. They will need to initiate a very robust revenue cycle management. There will be no room for inefficiencies in management or clinical practice.

Electronic health records and health information exchange eventually will make a significant difference in coordination of care, will reduce costs associated with duplication of tests, and will increase patient care management. Electronic health records will make data collection and analysis occur in real time, enabling health care providers to make quicker adjustments to treatment plans and hospitals to reduce inefficiencies and poor performance.

Critical access hospital boards of directors must re-evaluate their strategic plans and identify how well their local care system is integrated with other health care and social services providers in the area, as well as the level of coordination with their resource hospitals. Coordination and integration and partnerships will become increasingly more important as payment systems change.

Critical access hospital boards must ensure their hospitals are good partners in the delivery of care to the patients served. Boards will need to strengthen relationships with their health care providers. There likely will be more interest shown by physicians and midlevel providers to have the hospital manage their practices due to the complexities of care coordination components of the medical home model. Hospitals will be in the business of managing physician practices. Boards must identify opportunities to improve the overall health status of their service area residents and use local resources to do so. Collaboration with the local health department, behavioral health providers, senior services, and other support services such as hospice and wellness programs will become an essential role of the hospital.

Some of the initiatives authorized by the Affordable Care Act will not be funded. The individual mandate to purchase health care insurance may or may not be ruled unconstitutional but already, health care providers, hospital staff, and payers have begun to envision the nation's health care delivery model differently. There will be no turning back to the system of isolated services and unquestioned reimbursement for care, simply because it was ordered by a provider. Critical access hospital boards are encouraged to be part of the new solutions for better care at lower cost and to preserve the local availability of health care with the hospital as the service area's center of coordinated care.

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Strategies for Governing in Hard Times: When the Cash Runs Out

By Mary Rooney Sheahan, Chair, Midwest Medical Center Board, Galena, Illinois

Perhaps the most difficult decision a board of directors will ever face is whether the leadership team can effectively implement the strategic vision set forth by the board.

Just such a decision was necessary in a rural hospital in northwest Illinois shortly after a replacement hospital facility was completed and opened. The state-of-the-art facility had a price tag that exceeded \$40 million. As the first months of operation passed and revenues were not meeting required levels, both bondholders (investment companies) and the board members became increasingly concerned that the chief executive was not the right person to implement the strategies necessary to sustain the new hospital.

A strong cash position initially masked the need for a plan aimed at preserving that cash. Expenditures on salaries were very high because of the increase in hiring that took place to support planning for and opening of the new facility. Physician compensation often exceeded patient revenues generated by the providers.

The first decision the board made was to replace the CEO. Board members had many in-depth discussions, and not all members agreed. Two board members resigned because of the decision. The second board decision was to engage a turn-around consulting firm recommended by the bondholders to complete an operational analysis and then develop a plan. As this was underway, the bondholders decided that the hospital must seek either a new owner or a merger.

Community residents viewed the new hospital facility as too large and too “fancy.” Many residents simply believed it was not needed. The board chair convened a community forum to answer questions and to communicate next steps. The entire board was engaged in reaching out to the community, working to change perceptions, and asking the community to give the hospital a chance.

The plan prepared by the turn-around firm became the operational road map. An interim CEO, who was a member of the community with many years of executive experience, was hired by the board with the concurrence of the bondholders to lead the turn-around and to work toward the sale of the hospital.

The roles of the board members expanded during this crucial time period. Meetings were held as often as needed, often weekly. A discussion of bankruptcy was very difficult but very necessary. In the event the hospital did not sell, could the doors be kept open?

Drastic cost-saving measures were carefully examined and implemented, many involving employees. Salaries were frozen, a reduction in work force occurred that eliminated many of the new positions, and the employer match for retirement was put “on hold” indefinitely. The highly compensated physician positions were eliminated with little impact on revenues. The business office function was outsourced and “days in accounts receivable” improved almost immediately. Leadership reached out to area legislators to seek their assistance in speeding payment of more than \$1million due from Medicaid.

The interim CEO held monthly meetings that included all staff. Rumors were rampant and much time was spent clarifying and addressing employee concerns. Honest and open communication was the number one goal for both the board members and the executive team. Slowly, trust was rebuilt.

When it became apparent that a sale was not going to occur, the board engaged a strategic planning consultant who led the board and the management team through a process that created a new roadmap, one of growth and expansion. The board took a courageous stand that the hospital would no longer use its cash reserves for operating expenses, thus potentially jeopardizing the ability to make required bond payments. Fortunately, the situation improved, and the relationship with the bondholders grew to one of partnership and understanding.

The strategic plan included the recruitment of local physicians to practice at the hospital, if only twice per month. This effort netted an orthopedic surgeon, a group of three general surgeons, and increased business from two plastic surgeons and a podiatrist. This additional activity substantially increased cash. An internal medicine physician who had previously practiced in the town was recruited back. The number of hospital-supported providers grew to four physicians and one nurse practitioner. Medicare-certified rural health clinic status was achieved as well. Aggressive marketing of all hospital services and physicians sent the message to the community that excellent care was provided locally. Out-migration of patients was very high and the goal was to reduce this pattern. Many local groups were invited to hold their meetings at the hospital, which increased foot traffic.

The role of the board was crucial in this turn-around situation. Assuming fiduciary responsibility and assuring quality are the most important functions of the board. When board members are forced to involve themselves in details, it is easy to slip into an operational mind-set. While the board can and should give suggestions, management must be allowed to perform as a team, as long as outcomes are achieved. Because replacing the CEO created such painful, indelible memories, board members wanted to avoid a recurrence, making the choice of an interim leader very important. The selection process must be done in a thoughtful and unhurried way.

Fortunately, this hospital board of directors and staff seized upon the many opportunities to turn around the poor performance and the negative community perception of the hospital and instead embraced the potential for future growth.

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“Days cash on hand” have increased exponentially, two of the three bond covenants are met, and record numbers of services are provided in all areas. The chief operating officer/ chief financial officer, who was mentored by the interim CEO, was promoted to president after two years of leadership by the interim CEO. The board members and the leadership team recently held another community forum. The tone of the interactions was vastly improved from earlier forums. Members of the community were supportive and recognized the hospital as a resource, both from a health care perspective and as an economic engine.

When the situation was so bleak and overwhelming, the leaders on the board truly stepped up and gave the time and energy necessary to support the hospital staff as they worked to turn operations around. The bankruptcy discussions are in the past and the future looks much brighter. The board of directors continues to lead.

Illinois Critical Access Hospital Network: An Important Resource for Boards of Directors

By Pat Schou, Executive Director, Illinois Critical Access Hospital Network

The Illinois Critical Access Hospital Network was established in 2003 to enable the 51 critical access hospitals in Illinois to identify common issues, concerns, information and education needs, and business and operational needs that would benefit from the shared resources and collaborative efforts of the entire group. The unique characteristics of, and the regulatory requirements placed on critical access hospitals create unique information and advocacy demands. The critical access hospital community must speak with a singular, collective voice. The Illinois Critical Access Hospital Network provides the voice to meet the unique demands of the hospital administration and staff members, and their boards of directors.

The *Governing Board Manual, Volumes I and II* have been developed as information resources for the critical access hospital board members. The Illinois Critical Access Hospital Network again is in a unique position to provide critical access hospital-focused information specific to the needs of the hospital board members and to promote the exchange of information and shared experiences among the members.

One of the services the Illinois Critical Access Hospital Network offers to help hospital staff members identify common issues and share expertise and experiences is the support of user groups organized by numerous hospital departments. Examples include nursing, CFOs, CEOs, business office, health information management, corporate compliance, human resources, pharmacy, rehabilitation services, respiratory, laboratory, radiology, materials management, plant management, infection control, rural health clinics, quality improvement and more. These user groups enable peer-to-peer information sharing and problem solving to help participants most efficiently and effectively address department management issues. The user groups meet quarterly in person or by electronic means, have active LISTSERVs or e-mail groups, and conduct educational programs throughout the year. Hospital department managers and other staff often will query the LISTSERVs to learn of others' procedural approaches and best practices to resolve staffing and training issues.

The Illinois Critical Access Hospital Network offers ongoing training programs for its members that focus on regulatory changes, HIPAA compliance, coding, clinical and evidence-based practices, executive and supervisory leadership courses, meaningful use of electronic health records, and billing requirements, as examples. The network also offers programs on practice management, rural health clinics, annual membership conferences, and special interest programs on diverse topics such as wellness and diabetes management. The topics of the educational programs and training sessions are identified by the needs and interests of hospital staff.

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The Illinois Critical Access Hospital Network provides a number of shared service programs including information technology planning and hardware installation, physician recruitment, managed care contracting, after-hours remote pharmacy coverage, community health needs assessments, group purchasing of products and supplies, and employee health insurance and benefits. The network is able to leverage participation by multiple hospitals to provide better pricing, service and quality. The Illinois Critical Access Hospital Network functions as a clearinghouse for rural health information. It also has developed and supports a critical access hospital-specific benchmarking program for the collection and analysis of quality of care, financial, and productivity indicators.

The 51 members of the Illinois Critical Access Hospital Network collectively account for over \$2.2 billion in annual hospital revenues, provide primary and emergency care to 1.1 million rural Illinois residents, employ over 10,000 people, and have over 500 physicians on their medical staffs. The Illinois Critical Access Hospital Network has a voice that can represent the needs of the smallest rural hospitals and the communities they serve. The network supports a regulatory and legislative committee to ensure its members learn about legislative issues, budget discussions, and new regulations, and to add a critical access hospital voice to discussions on state and national concerns. The network interacts closely with its partners, including the Illinois Hospital Association, the National Rural Health Association and many other groups to deliver its message. It often is the key resource for members when addressing licensing, Medicare and Medicaid issues, connecting hospitals to the right information source or solution for a very broad range of issues.

Members of critical access hospital boards of directors are encouraged to use the resources of the Illinois Critical Access Hospital Network to access thorough and accurate information related to the critical access hospital program. Board members are encouraged to contact the network office at any time at 815.875.2999 or to visit the network's website, www.icahn.org.

End Notes

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Inquiries regarding the contents of this *Governing Board Manual II* should be addressed to ICAHN, 245 Backbone Road East, Princeton, IL 61356 USA; 815.875.2999.

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