MN HFMA

Vikingland Viewpoint

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About the background photo
Photo journalist, Joan Brandwein captures Minnesota winter beauty at Como Park in St. Paul. More MN Winter photos on page 4

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Are Operating Leases Dead?

By: George Boyadjis, CPA, FHFMA

Potential changes in lease accounting are likely to have huge consequences for the balance sheets of most hospitals and other companies. Operating leases will become capital leases, resulting in the shift of trillions of dollars onto the balance sheets. With all leases for commercial real estate and other property being capitalized in this way, the assets and debt of many organizations will increase dramatically. In addition, EBITDA measurements (Earnings Before Interest, Taxes, Depreciation, and Amortization) will increase as rent expense will disappear, to be replaced by higher leased asset amortization and interest expenses.

With so much change in the offing, HFMA members need to understand the proposed new accounting standards and plan now. Why is this so important? Because all leases that exist as of the official change will have to conform to the new standards and current operating lease treatment will not be grandfathered. And, a recent survey indicated that 83% of companies were unfamiliar with the proposed changes.

Why Are Proposed Changes Moving Forward?

The Financial Accounting Standards Board (FASB) and the International Accounting Standards Board (IASB) recently issued a joint Discussion Paper that details the changes introduced above. The impetus for the proposed changes dates back to the accounting scandals which raised concerns about off-balance sheet accounting. Concerns about the current rules include:

- Undisclosed liabilities in the form of lease obligations.
- Lack of transparency and comparability.

"Form over substance" transaction structures.

While balance sheets are adjusted by bankers and analysts to approximate the debt implied by operating leases, critics claim the adjustments are inconsistent and frequently understate the lease obligations.

What Are the Specifics of the New Proposal?

Continued on Page 2

Early, Transparent Financial Communications

A PATIENT FRIENDLY BILLING® Project Recommended Practice

This statement specifically addresses patients' rights to understand and prepare for their financial obligation at the earliest point possible in the care experience. It does not address the lack of sustainable health insurance for all, which is a grave shortcoming that destabilizes our healthcare system and our economy.

The issue: consumer expectations and engagement

Patients want to know what they will be expected to pay for healthcare services before they incur the costs. Financial discussions that occur after services are delivered deprive patients of the ability to make informed choices about their treatment options.

Patients who may have difficulty paying their medical bills will want access to Medicaid, charity care, or other financial assistance programs. Delaying financial discussions with these patients will reduce their ability to access these programs and will often result in additional billing and collecting costs for charges that providers are unlikely to collect. This is painful for both the patient and the provider alike.

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Cover Story Continued: Operating Leases

The proposed standards presume that all leases give rise to assets (the "right to use" the leased assets) and liabilities (future rental payments).

The proposed new principles for lessee accounting are:

- All leases (including existing leases at the cutover date) will be treated as capital leases.
- Leases will be capitalized based on the present value of the lease obligation, using the entity's incremental borrowing rate.
- Capitalized lease values will include base rent, residual payments, obligated renewals, and contingent rents.
- Rent expense will cease to exist; instead, interest expense and leasehold amortization expenses will "replace" rent expense in the income statement.

Balance sheets will include a category for leased assets separate from other fixed assets.

How Will this Affect Me?

Based on comment letter trends, the proposed changes seem inevitable, and repercussions will be considerable. Virtually every organization will be affected, since most businesses have leases for real estate, computers, office equipment, vehicles, etc. This change will likely affect numerous metrics—including debt covenants, financial performance assessments, management compensation, etc.—meaning extra work will be needed to adapt.

Other challenges include:

Corporate balance sheets will inflate significantly. Many organizations will appear much more highly leveraged, potentially changing their characteristics as desirable investments.

Expenses related to leased properties will no longer be straight lined; rather, occupancy costs (i.e. amounts formerly treated as operating rent expense) will be higher in the earlier years (as much as 15%) and lower in later years.

Metrics such as Debt to Equity, Interest Coverage, EBITDA, and Return on Assets will change, and comparability to prior periods will be affected.

For many entities, EBITDA (a proxy for cash flow) will increase due to a reduction in recorded rent expense and increases in recorded amortization expenses and interest expenses under the new rules.

Organizations with significant operating leases will face a heavy one-time administrative burden since they will have to collect and input substantial data and perform new calculations to determine the amounts to be capitalized. They will need to plan for new processes and software solutions to facilitate the necessary changes.

So… What Should I Do Now?

While operating leases are not yet "dead", it's fair to say that their prognosis is not good, and hospice care may be in the offing. So, HFMA members should begin today to understand the issues and implications of the proposed new rules.

The first step is to meet internally or with business advisors who specialize in these matters. The initial focus should be on updating your lease administration database so you can analyze and understand the impact of the proposed changes, then review alternatives and strategic options.

"While operating leases are not yet "dead", it's fair to say that their prognosis is not good, and hospice care may be in the offing."

About the Author

George Boyadjis, CPA, FHFMA, is a member of the Minnesota Chapter of HFMA, and is a recipient of HFMA's Muncie Gold Merit Award. He is Executive Director for CresaPartners, a corporate real estate advisory firm, and the largest such firm in North America that exclusively represents corporate users of space. For more information, he can be reached at 612-373-0298 or gboyadjis@cresapartners.com

Cover Story Continued: A PATIENT FRIENDLY BILLING® Project Recommended Practice

Patient Friendly Billing Recommended Practice

Early, transparent financial communications are the cornerstone of the Patient Friendly Billing project's vision for truly patient-focused financial services. As patients become responsible for a larger portion of their hospital bills, it becomes increasingly important that they understand their expected out-of-pocket costs and resolve how they will handle their medical bills before they incur the costs of services (except in emergency situations, of course). This offers them the opportunity to comparison shop for services, learn about payment alternatives (including financial assistance), and explore other alternatives with their own physicians.

This recommendation is based on patient focus group research conducted for the Patient Friendly Billing project, and experiences related by patient financial service professionals. Professionals who work in hospitals that provide early, transparent financial communications tell us that patients who know what their payment obligations and arrangements are before they have the service are usually significantly less anxious about their healthcare bills.

"Early, transparent financial communications are the cornerstone of the Patient Friendly Billing project's vision for truly patient-focused financial services."

Gathering pre-service financial information

Pre-service healthcare financial communications can use a variety of methods to try to assess patients' ability to pay their medical bills. These methods range from paper applications to sophisticated on-line credit analysis software. Some consumers and advocates are concerned that such tools will be used to deny services to patients who cannot afford them. At least one state legislature has sought to bar these tools.

HFMA believes that these tools have great potential to benefit consumers. They:

- Allow consumers to make informed decisions about their care by helping patients understand their financial options and work out agreed upon and reasonable payment plans before costs are incurred
- Simplify and expedite the process of enrolling in financial assistance programs

Avoid collection efforts for patients when it has been determined that they do not have the means to pay their bills.

Easing financial assistance applications

Determining the amount of financial assistance for which a patient is eligible is based largely on information supplied by the patient or someone acting on the patient's behalf.

Unfortunately, for many reasons, patients are frequently unwilling or unable to provide sufficient information for the hospital staff to reliably determine eligibility. These reasons can range from literacy issues to fear of denial to lack of understanding of healthcare payments and sources of assistance that may be available. Many hospitals use data similar to credit reports, Medicaid enrollment information, and other automated tools to reduce the application burden on patients seeking financial assistance. In addition to reducing stress on patients, these tools also help make providers more efficient and reduce their healthcare administration costs.

Conclusion: A vision for patients' financial experiences

Based on the Patient Friendly Billing project's research and dialogue over the past eight years, we believe patients' optimal financial experience for non-emergency services should be based on the following steps:

1. Providers gather detailed information before and at the time of service to prospectively estimate patients' expected out-of-pocket costs.
2. Providers use tools to help estimate the amounts and terms of payment that patients can afford. The resulting information allows providers to: --Identify and aid patients who need financial assistance, either through in-house programs, Medicaid, or other assistance programs. --Efficiently reach an agreement on payment amounts and terms for patients who are able to pay all or a portion of their bills.

Providers communicate earlier, so that patients understand their financial obligation before they undergo treatment.

If urgent care needs prevent these steps from being taken before services are delivered, providers complete these steps as soon as appropriate after service.

Under this scenario, the billing and collection process becomes a verification of what the patient already expects. Each patient's personal payments will be related to what they can afford to pay, and providers are more likely to receive sufficient payment from all appropriate payment sources so that they can continue to provide quality healthcare services.

HFMA's Patient Friendly Billing Newsletter

Improving the patient financial experience

Patient Friendly Billing provides practical how-to strategies for improving patient financial communications and creating a more patient-friendly revenue cycle. Plus, the newsletter helps identify business opportunities in the consumerism movement.

The electronic (html) *Patient Friendly Billing* newsletter is an HFMA member benefit publication. HFMA members must login to view articles. Are you not yet a HFMA member? Join HFMA

Health Care Trends and Issues for 2010

By Davis Fansler, Director, Wipfli LLP

As the New Year nears, it's time for the Wipfli Health Care Practice to provide its view of major trends and issues for the coming year. As you may recall, our theme last year was the economic meltdown in the fall of 2008 and the resulting need for clear strategic financial planning, effective leadership, measuring and demonstrating quality and solid hospital-physician alignment strategies. Many believe, as we do, those same issues will need to be addressed in 2010, along with the added elephant in the room—health care reform—although any reform that may get through Congress will likely not take effect until at least 2013. And the way it appears at present, any passage of a reform bill will be a watered-down version and exclude any public option or Medicare buy-in. It will not cover everyone, it will not control costs, and it will likely increase budget deficits and raise taxes. In sum, it will fall far short of the expectations when the reform initiative began over a year ago. In our view, meaningful reform can only occur when: (1) providers are, indeed, paid according to their performance (i.e., appropriate outcome with the most efficient use of resources); and (2) previously "taboo" issues such as means testing for Medicare, pricing health risk into employees' insurance premiums, and substantive tort reform, to name a few, are put on the table.

We believe the economy will continue to exert significant influence and keep many a hospital executive awake at night. But we also believe there are other dynamics that have slowly been percolating in the background which may emerge with more strength, largely as a result of the recent health reform debate.

"We believe there will be a continuing emphasis on the basics, the blocking and tackling, making sure operations are lean and mean"

The Economy

The economy will remain a looming issue. Most believe the recovery will be the longer "U" at best. It will take time. Balance sheets and nonoperating income have eroded over the last 15 months, which has adversely affected capital budgets. Moreover, the near collapse of the financial industry has made borrowing very difficult for even those who have the financial strength to do so. Many a solid business has been forced to close because of doors to debt being shut. Finally, state budget deficits have sharply increased, further stressing providers dependent on Medicaid reimbursement. In sum, health care has proven it is no longer recession-proof.

The Response

We believe there will be a continuing emphasis on the basics, the blocking and tackling, making sure operations are lean and mean. Accordingly, there will be stronger scrutiny on service line performance and profitability. Cost controls and better matching expenses to volumes will be emphasized. Reimbursement and revenue cycle management will be fiercely monitored for improvements. Significant efforts will be also undertaken to improve provider productivity and the efficiencies of operational and clinical processes. Finally, many believe that there will, indeed, be a resurgence of capital spending, particularly on capital equipment for new technologies. We don't share that view. We believe hospitals and health systems will be much more cautious with their capital until the economic recovery is on firmer ground and the prospective effects of health reform legislation are understood, which at best, will not occur until after the 2010 mid-term elections.

The Increasing Loss of Financial "Oxygen"

Among the effects of the recent health care reform debate has been the increased visibility of key issues affecting the long-term sustainability of our present health delivery system. With an aging population that is consuming an ever-increasing percentage of health care resources, ballooning budget deficits that are further ratcheting down Medicare and Medicaid reimbursement, physician and nursing shortages that are driving up recruitment costs and limiting access, and payer and tort systems that continue to reward perverse behaviors that push utilization, most agree that there is little financial "oxygen" left to breathe. And while pay-for-performance reimbursement systems are beginning to take hold, the fact remains that value (i.e., keeping a population healthy with the least amount of resources consumed) is still not being adequately acknowledged. The only way to create more "oxygen" is to encourage value and, frankly, punish those that don't deliver it. So the question is, "Will value become adequately rewarded and sought before the 'oxygen' runs out?"

Moreover, as patients pay more and more for their care, they will become more informed consumers and more demanding customers. Therefore, health care providers will have to pay more attention to assuring their needs are met. The patient wants a return to their normal health status the first time and every time; the consumer is looking for value in terms of cost versus perceived benefit (outcome); and the customer wants a seamless delivery system that is easily accessed.

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Continued from page 4 — Health Care Trends

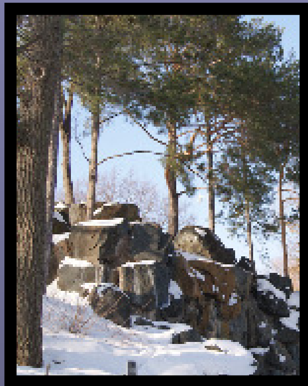
The Response

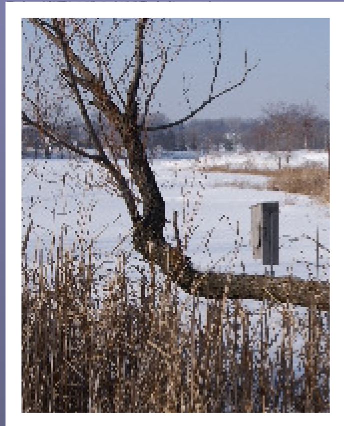
One interesting response we are seeing, and what we believe will continue to emerge, is the notion of an explicit compact between physicians and their local hospitals/systems, much along the lines of what Virginia Mason Medical Center and its CEO, Gary Kaplan, M.D. did with its physicians earlier this decade. Such a compact forces a new culture to emerge, one that requires physicians and their hospital to work together to achieve new goals that focus on the patient and embrace change—from autonomy to interdependence among providers in deployment of evidenced-based protocols.

The fact is that to be successful and sustainable, providers must create indispensability in the minds of the patient, consumer, and customer. This, we believe, is leading to the emergence and evolution of an additional compact, one that's increasingly implicit between the patient/consumer/customer and their health care providers. The compact requires providers to implement the necessary operational and clinical practices to deliver the promise of improved health status, value, and seamless access each and every time. As a result, we believe the accelerated pace of hospital and hospital/health system affiliations, along with hospital-physician alignment, will continue to flourish because, in our view, it is the only way to effectively deliver that promise—each and every time.

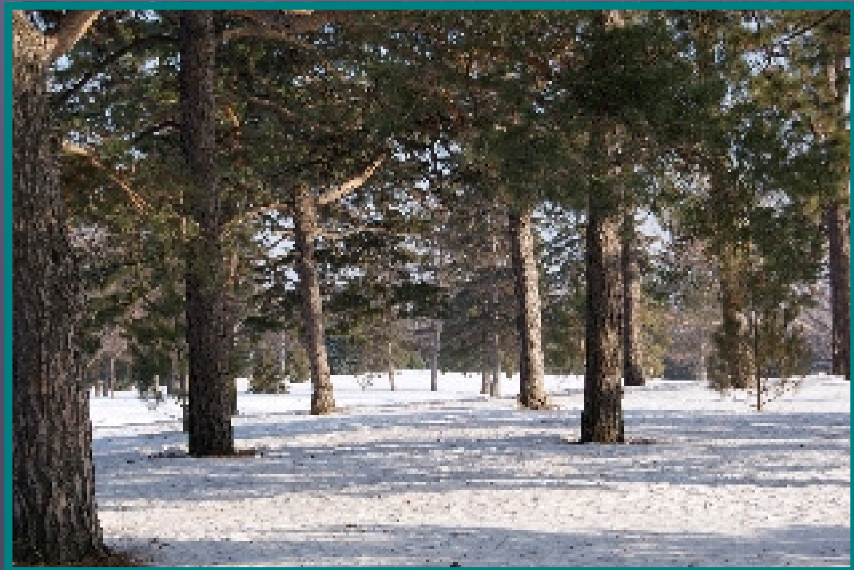
About the Author

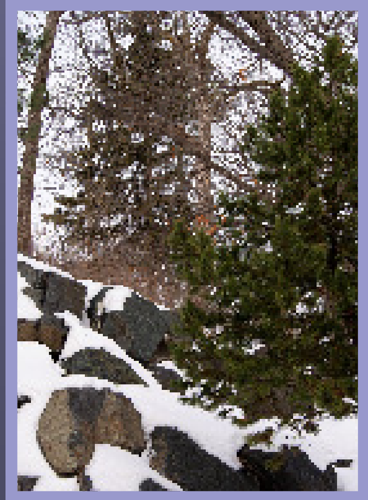
Davis Fansler has over 25 years of health care industry experience. His involvement in health care management helps him understand its financing, operations, and investment sides. Davis brings an unusual blend of experiences, including commercial banking, medical group administration, HMO development, and venture capital, which are distinctively helpful to his clients. His critical listening skills enable him to get to his clients' core issues quickly; his strategic and tactical planning abilities help him to provide proactive and practical solutions to those issues. To learn more, please contact Davis at dfansler@wipfli.com.





Minnesota Winter Beauty — Como Park, Saint Paul





Joan Brandwein, photo journalist

The Latest on USDA Lending

By Kelly Arduino, Director of Financial Advisory Services, Wipfli LLP

As part of the continuing series on capital access for health care organizations, this month's spotlight is on United States Department of Agriculture (USDA) loans. The USDA has certainly filled a void in the credit market this past year with the disappearance of the tax- exempt bond market for nonrated organizations. In this article, we will review the relevant programs and some statistics on amount of available dollars and then discuss key features of these loans.

USDA Rural Development Loan Programs for Health Care Organizations

There are two types of USDA financing that are most applicable to nonprofit health care organizations. These loans are administered through Rural Development's Community Facilities Program and are:

1) the Direct Loan Program, which is a loan made by the USDA and paid directly to the borrower; the current loan rate is 4.25% fixed for up to 40 years

2) the Guaranteed Loan Program, which is essentially insurance (i.e., the "guarantee") applied to 90% of a taxable bank loan or bond issue after construction is complete; rate varies by lender and terms

"This means that another approximately $932 million in ARRA Direct Loan funds are left to be obligated by the end of FY 2010"

To qualify for a Community Facilities USDA loan, the project must be owned by a nonprofit entity located in a rural area or town with up to 20,000 in population. *Note: The USDA Business & Industry Loan Program, which can be utilized by for-profit entities, is not discussed in this article.* The categories of project types and specific examples funded by community facility loans include:

- Health Care (e.g., nursing home, assisted living center, critical access & acute care hospital building & equipment, physicians clinic, medical office building, home health care, etc.)
- Fire, Rescue, & Public Safety (e.g., ambulance service equipment & building, mobile communications center, police station, police car, fire trucks & protection equipment, etc.)
- Cultural & Educational (e.g., public school distance learning, charter schools, college dorms, libraries, museums, child care center, etc.)
- Recreational Activities (e.g., football stadium, campgrounds, ballpark, community park, beach area, swimming pool, etc.)
- Energy Transmission & Distribution (e.g., electrical service, electrical equipment, hydroelectric, natural gas distribution)
- Public Building & Improvements (e.g., health department building, city hall, county courthouse, street maintenance equipment, youth center, school buses, etc.)
- Industrial Development (e.g., water & sewer improvements, drainage & levee districts, industrial parks, etc.)
- Other – Changes yearly (e.g., farmer's market, animal shelter, agricultural fairgrounds, cemetery)

The American Recovery and Reinvestment Act (ARRA) allocated money to the USDA Direct Loan and Grant programs; specifically, $1.136 billion in direct loans and $32.836 million in grants. The $1.45 billion in ARRA funds is in addition to the annual allocations these programs typically receive. The Guaranteed Loan Program, which did not receive ARRA funds, is another $700 million. In short, that's a lot of capital to be distributed.

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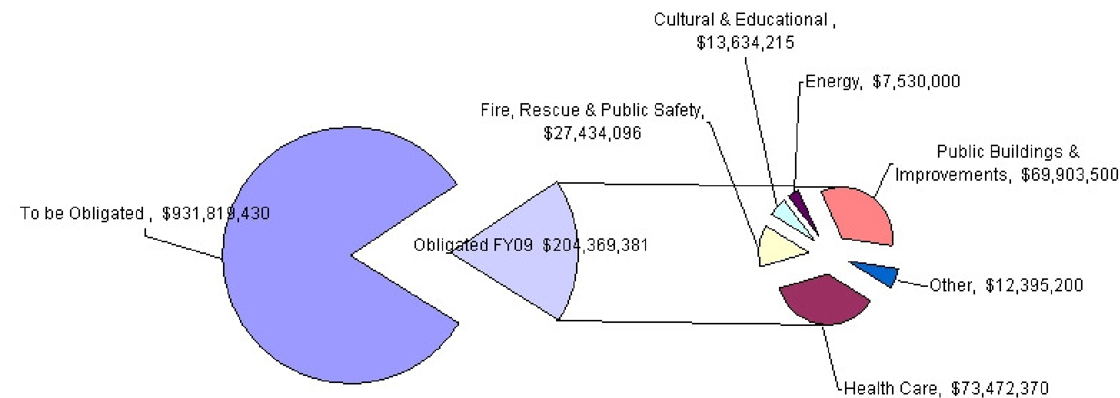

Continued from page 6 — USDA Lending

As of the end of FY 2009, $204.3 million, or 18%, of the Direct Loan ARRA money had been obligated to 230 projects. Health care received 36%, or $73.472 million, of the obligations, which funded 35 separate projects. In terms of grants, 60 health care projects received $3.685 million, or 12%, of the ARRA USDA grant money spent to date, with the average grant just over $60,000. Grant money is available, in part on the basis of income in the area.

This means that another approximately $932 million in ARRA Direct Loan funds are left to be obligated by the end of FY 2010. If the percentage of dollars allotted to health care holds true, then 36% of the total approximately $335 million in capital at the current rate of 4.25% fixed for up to 40 years is still available. Again, this is over and above the amounts available through the Guaranteed Loan Program.

Although there is opportunity to obtain a direct loan from the USDA, for larger projects, there is usually a need to pair the direct loan with a guaranteed loan, and for that you need a bank. The bank will serve as the "lender of record" on the guaranteed loan and generally sets the terms and covenants for both the direct and guaranteed loans. Finding a bank that is comfortable with larger USDA borrowings and the construction risk, as well as getting your architect/construction manager to fill out the required forms and comply with USDA regulations, can be a challenge. The ARRA money requirements to "buy American" and pay prevailing wages further complicate planning, but the bottom line is that in today's market with few alternatives available, who can turn down the opportunity to lock in 40-year money at such a low rate?

In working across the country, we have seen organizations considering the USDA loan program for financing struggle with the logistics of applying for these loans, especially for larger projects. Also, there are a number of ways to structure the combined direct and guaranteed loans to minimize capitalized interest that accrues during construction, of which the borrower or even local USDA representatives are not aware.

We can help you navigate through the USDA loan process and offer services in USDA feasibility studies and financial advisory services.

About the Author

Kelly Arduino has over 15 years of experience in health care, with an emphasis in health care finance and strategy. As an unbiased financial advisor for clients that include critical access hospitals, independent community hospitals, and senior living facilities, her work centers on planning for and securing capital to finance large renovation/replacement projects. She also works with clients on an "as needed" basis to evaluate financing proposals and to provide advice on debt-related decisions. To learn more, please contact Kelly at karduino@wipfli.com

Mission Impossible…Made Possible

Read This Before You Launch Your Billing System Conversion

By Eric Greenberg and Wendy Young. ARC Group Associates

Hospital financial executives are asked to do the impossible every day. Ongoing economic pressures of declining volumes, reduced business margins and tightened credit markets intensify the challenge. For hospitals currently undertaking a system conversion, there is the added strain of an average 10 to 12 month spike in accounts receivable. Executives are taking on a nearly impossible mission.

Like Agent Phelps in the 1960s television series *Mission Impossible* or Tom Cruise's Agent Hunt in the 1996 film, your role as a hospital executive during a system conversion can seem like the next installment of *Mission Impossible*. Your mission: Convert your system without further affecting the organization's financial position. Your challenge is filled with tension; you can feel the pressure building. In the background, you can hear the clock ticking.

There is help at hand. Take a few minutes and review with us some of the lessons learned in working with hospitals going through these challenges. We will provide you with tips and tools learned over the years from dozens of conversions to help avoid some of the tight spots we have seen hospitals get into during this challenging time period.

Aspects of the original *Mission Impossible* that we can learn from include:

- Understanding the Challenge in Total
- Managing and Organizing Your Team
- Handling and Planning for the Unexpected
- Achieving the Impossible

Concluding the Mission

Understanding Your Challenge in Total

You have become the agent in charge of the latest challenge at your hospital: The implementation of a new billing system that the executive and revenue cycle teams have wanted for a long time. Your team has spent a great deal of time defining the hospital's needs, identifying vendors and evaluating their functionality. You may even have selected and negotiated the contract with your preferred vendor. But do you really understand the challenges ahead of you? This conversion may not be like others you have done in your career.

We have developed a Mission-Critical Countdown to help you think through the issues and time commitments that arise with today's 4th generation hospital billing systems. In your transition to the new system, you will have to address clinical integration, workflow management functionality, automation of previously manual processes, new capabilities, additional data reporting features, more complex security configuration and a system that demands answers to questions from billers before it will even drop a bill.* The ARC Group Mission-Critical Countdown can help give surety that your work plan includes new aspects that must be addressed, critical steps and adequate time so that you are ready to make the impossible, possible.

Managing and Organizing Your Team

In *Mission Impossible*, the agent in charge has unlimited resources, a dedicated team and wide discretion in selecting team members to assist him.

You have your team of extraordinary experts for the billing system conversion. But unlike the Impossible Missions Force, you do not have unlimited resources. And generally, the experts assigned to your project are not exclusively assigned to it. In fact, your project team experts must focus on other needs in the organization. They may also be responsible for overseeing changes that occur to your legacy system before it is shut down. And to add to your team's already full workload, they must continue to address changes from the external environment of payor contract requirements and the external economic environment at large.

As the executive in charge, you need to be sure that your team has the knowledge to identify issues before it is too late. We have developed a Pre-Planning Checklist to help your team answer some critical questions before the project begins. By reviewing answers to these questions before moving forward you can reduce the chance that your critical mission will fail.

Handling and Planning for the Unexpected

Each episode of *Mission Impossible* includes unexpected events that force the team to improvise before they can accomplish their mission and make their escape. As the lead on this project, you cannot afford to underestimate or oversimplify the unexpected twists that lie ahead.

Most executives recall prior system conversions and some of the unexpected bumps along the way. With the automation of previously manual processes, today's system conversions increase the potential severity of any unexpected twist in the plot. Current systems with their technical and business complexities add to the twists and turns in the road ahead even with a well thought out project plan.

To help you minimize the road bumps ahead and their effect, ARC Group has developed a summary of Key Revenue Cycle Metrics and best practices to use in maintaining your organization's course. No hospital today can afford unexpected problems that reduce cash flow, impact staff productivity or affect the quality of patient bills produced.

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Continued from page 8 — Mission Impossible. . . Made Possible

Achieving the Impossible

Before you can achieve the benefits of the new system, you must fully implement its functionality. This requires more than a short term burst of extra work from existing staff. It requires the ability to dedicate experienced resources to the task ahead while maintaining cash flow from legacy systems.

It is easy to short change the installation of the new system due to lack of resources, competing priorities or underestimating the complexity of installing today's systems. Providing skilled sufficient resources to the conversion comes at the cost of not working current open accounts. How much risk are you willing to take in completing your mission? Can your organization risk a yearlong spike in accounts receivable?

The ARC Group tool Conversion Options compares the pros and cons of four options to address the run out of old accounts receivable from your legacy system. There are two fundamentally different approaches to working down your old, open accounts-receivable balance from the legacy system. Each of these approaches has two alternatives that can be pursued. Our tool can serve as the foundation for your own detailed assessment of the best alternative for your organization in addressing the old accounts receivable. By carefully thinking through your alternatives, you will identify where your existing resources will need to be deployed and/or supplemented.

Concluding the Mission

Every episode of *Mission Impossible* concludes with success. The agents safely escape and are ready for their next mission, but that is Hollywood, not healthcare.

Adequate planning and expert resources are needed to achieve the vision and value of the new billing system you have purchased. Make sure your expectations are realistic. Use the ARC Group Mission Possible Toolkit to support the success of your mission impossible. Your mission, should you choose to accept it, involves more challenges and loops than any episode of *Mission Impossible.* By preparing for the demands and unexpected twists of your new system, you, too, can conclude your mission safely for you, your team and your hospital.

The Authors

Eric Greenberg is the Founder and CEO of ARC Group Associates, a national firm specializing in revenue cycle management. Eric has more than 18 years experience in the healthcare industry and is a current member of HFMA.

Wendy Young is a healthcare consultant and executive with more than 20 years of experience in revenue cycle operations, claims management systems and business office outsourcing solutions. Wendy has held Revenue Cycle and Patient Financial Services Director roles with responsibility for all aspects of the business office. Currently, Wendy is the Vice President of Operations for ARC Group Associates, Inc. She is also an active member of HFMA and AAHAM.

Options

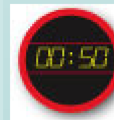
Discover the best conversion option to capture old A/R.

http://www.arcgroup.net/missionpossible/options.pdf

Checklist

Investigate and solve these questions prior to conversion.

http://www.arcgroup.net/missionpossible/checklist.pdf



Countdown

Review the mission-critical countdown to conversion success.

http://www.arcgroup.net/missionpossible/countdown.pdf

Scorecard

Rate your readiness to conclude the mission.

http://www.arcgroup.net/missionpossible/scorecard.pdf

PRESIDENT'S MESSAGE

MAKING IT Count

Happy New Year to you all!

I hope you are staying warm so far this January. I am about to leave on a vacation to Cancun, so I am counting down the hours.

It is hard to believe that we are starting the 2nd decade of the millennium. Wasn't it just yesterday that we all worrying about the year 2000 and what would happen to our computer systems; and here it is, 10 years later and no problems- right? Now all we have to worry about is the economy and healthcare reform.

I hope that you have been able to attend some of the HFMA Regional webinars hosted by Region 8 every month to help keep up on current healthcare issues. Recent topics includ the RAC audits, Healthcare reform, and the Medicaid Integrity Program. These webinars are only $30 per location, for unlimited attendees. The February webinar topic is "RAC Updates and Panel Discussion". The panel includes providers who have already gone through a RAC audit. Information on the webinars is distributed by email and is also available on our Chapter website www.mnhfma.org.

Our Chapter also offers webinars co-sponsored by CPA firms and other organizations, so as an HFMA member you have many educational opportunities.

If you will miss our Winter Institute, the Concordia Institute, co-sponsored by the North Dakota Chapter and Concordia College, is scheduled for April 8th-10th 2010 in Fargo, barring any floods. Debra Kuchka-Craig, the HFMA National Chairman-Elect is the keynote speaker.

If you are interested in becoming a certified member of HFMA, please contact Bill Fenske. He has information on the certification process, and has certification exam study guides available for members to borrow.

If you have any questions regarding HFMA, please don't hesitate to call me or one of the other Chapter officers. Also, if you have any suggestions for programs or improvements on current Chapter events, we are open to ideas. And we are always looking for members who would like to become more involved; an ideal way to get the most out of your membership.

Happy New Year!

Candy

hfma minnesota
healthcare financial management association

hfma minnesota
healthcare financial management association

Committee Updates

Regulatory Committee

The meetings continue between the MN Department of Human Services (DHS) who administers the Medicaid program in Minnesota, the Minnesota Hospital Association (MHA) and the hospitals related to the Medicaid Disproportionate Share (DSH) payments and the changes mandated by the Centers for Medicare and Medicaid Services (CMS). There was a discussion in October 2009 to further discuss the audit procedures to be utilized in the data verification. Noridian Administrative Services (NAS), who is leading the audit, will provide additional guidance once they have an opportunity to further analyze their audit requirements and the issues identified by members of the regulatory committee and DHS.

The regulatory committee hosted a New Medicare Cost Report Form Set seminar on November 11, 2009 that covered the new cost reporting forms. The featured speaker was Becky Dolin, President of Health Financial Systems, one of the leading Medicare cost report software companies in the country. Additional key reimbursement topics facing prospective payment hospitals were discussed in the afternoon sessions.

The Administrative Uniformity Committee (AUC) has approved the formation of a committee to implement a change in data that is submitted back to the hospitals from the PMAP plans. The hospitals are proposing that the PMAP plans submit back the 2-digit program code so the facilities can identify which specific PMAP plan the member is on, essentially eliminating an additional step the facilities are currently having to take. All PMAP plans will be participating. They are looking for provider members with technical expertise in this area to join the committee. If you have someone who is interested in participating on the committee, contact Trisha Schirmers at Trisha.Schirmers@allina.com or Amy Tepp at Amy.Tepp@hcmed.org.

The Regulatory committee continues to meet bi-monthly on the third Thursday of the month. Our next meeting is scheduled for Thursday, January 21, 2009 at Hennepin County Medical Center. Anyone wishing to participate is encouraged to attend. For those outstate practitioners who are unable to travel to the meeting, in most cases we have call-in capabilities which allows participation remotely via the telephone. Any suggestions for agenda topics at upcoming meetings are always welcome.

If you have a suggested agenda topic or would like more information about the regulatory committee, please contact Jackie Hinderks at 320-231-4425 or jhinderks@rice.willmar.mn.us or Mark Davis at 612-397-4298 or markdavis@deloitte.com.

Certification Committee

Certification Webcast:

Please consider stepping up and give yourself a career gift by obtaining your certification in HFMA. There are endless benefits to Certification and the MN Chapter encourages you to consider this gift to yourself. The MN Chapter will be hosting a free webcast on February 19 at 12:00 noon. Please contact Bill Fenske @ 320-231-4009 or fenskeb@rice.willmar.mn.us for further information or visit the website at www.mnhfma.org

Committee Updates

Winter Institute Committee

JANUARY 28TH WINTER INSTITUTE PROMISES TO BE GREAT!

Start the New Year off with a great learning and networking opportunity! The Winter Institute Committee is excited about the line-up of topics and speakers that have been secured for the upcoming event!

The theme of this year's Institute is ***"Financial and Market Sustainability During Changing Times".*** It will be held at Radisson Hotel and Conference Center Minneapolis, 3131 Campus Drive, Plymouth, MN on **January 28th, 2010.**

Topics include:

- Leadership – Are you worth following? Follow the Leader!
- An Integrated Electronic Medical Record - Your Clinical System Sneezes and your Revenue Cycle gets a Cold
- Healthcare Payment Reform
- Chief Financial Officer Panel: Examples and solutions on how some healthcare systems are maintaining and improving financial performance.

Capital Access: Options Available to the Healthcare Industry

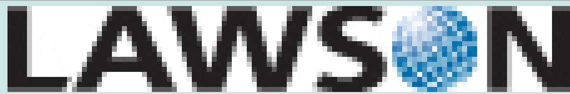
The brochure is on the website with more detail and registration can also be done on-line at: http://www.hfma.org/events/chapter/MNChapter012810.htm.

Hope to see you there!

Committee Updates

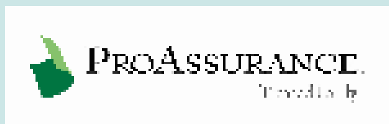
THANK YOU CORPORATE SPONSORS !

PLATNUM LEVEL SPONSPRS - $4,000



GOLD LEVEL SPONSPRS - $2,000

SILVER LEVEL SPONSPRS - $900



CORPORATE SPONSOR COMMITTEE

Corporate Sponsors Make Your Chapter Stronger

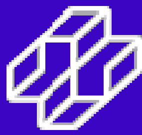
I recently took over the Corporate Sponsor committee for the Minnesota Chapter of HFMA. I did this once before for a different association and I realized once again that there are Companies that support the industry they gain clients from and there are Companies that are surprisingly absent. I'm not here to criticize those that do not because often you'll hear good reasons why they might not participate.

I am here though to draw attention to the Companies that have traditionally supported HFMA at the local Chapter level. We are asked by National not to appear to endorse any Company that becomes a Sponsor but we can draw your attention to them. In this publication you'll find a listing for those Companies. On our local website you'll also see a section with their logos and links to their websites, and at seminars we will have a sheet in the meeting material that will have contact information as well as signage somewhere in proximity to the meeting.

I would encourage you to do one of two things. First, acknowledge to any Company representative that you may currently know or work with that you appreciate their involvement and support of HFMA, and secondly if you do not currently work with them, that you would consider their product or service the next time you or your department heads seek the services they may offer.

Those interested in becoming a Sponsor can reach me at 800-487-3888 or rayc@colltechinc.com. And, let me be the first to say "THANK YOU" to all of our Sponsors.

Ray Costello



UPCOMING EVENTS

HFMA 2010 Winter Institute

Thursday, January 28, 2010

Plymouth, MN

HFMA's Virtual Healthcare Finance Conference & Career Fair

On-Demand Event January 14 - April 13, 2010

Cost Reduction Strategies for Health Care Organizations Webcast

Tuesday, February 2, 2010

12 noon - 1:30 pm CST

Pre-registration required, go to:
http://events.rsmmcgladrey.com/forms/HCCostReductionStrategiesUpdates2210?elq=e64124853c2541fb9a00f9a75c167f8d

RAC Updates and Panel Discussion

Tuesday, February 9, 12:00 Noon - 1:30 pm CST

Certification Webcast

Friday, February 19, 12:00 Noon

Concordia Institute

Thursday April 8 – Saturday, April 10, 2010

Fargo, ND

WELCOME NEW MEMBERS!

August 2009

Katelyn Person

October 2009

Earl Buck, Vice President
Chi Solutions, Inc

Paul Lefebvre, Credit Risk Manager
US Bank

Lawrence Foster, VP Healthcare Payment Solutions
US Bank

Michael P Severson, Manager
Physician Comp and Business Analysis
SMDC Health Systems

November 2009

Jeanne Chapdelaine, Director
Wipfli LLP

John Sheldon, President
Teton Asset Management, LLC

November 2009 continued

Andrew M Edmunds, Manager Financial Reporting
Essential Health

Fred Flemig, Senior Vice President
Lockton Companies

December 2009

Ty Larson, BS, RT, Revenue Cycle Consultant
Emdeon

Timothy Schmidt, Partner, CPA
Lurie Besik of Lapdus & CO LLP

Stacie Usem, Partner, CPA
Lurie Besik of Lapidus & Co LLP

Mark Butler, Regional Sales Manager-Healthcare
First Financial

Andrew Mellin, Vice President
McKesson

HFMA National's On-line Membership Directory

Have you visited HFMA National's On-line Membership Directory lately? Here's the link: http://www.hfma.org/login/index.cfm. When you select "HFMA Directory", not only can you search for members of our chapter, you can also search for all of your HFMA colleagues by name, company, and location - regardless of chapter! Using an on-line directory instead of a printed directory ensures that you always have the most up-to-date contact information.

While accessing HFMA National's On-line Membership Directory, you may view your current contact information and make edits to your profile. You can also view any products you have ordered, events you have registered for, your CPE credits, your Founders points, and more!

It is vital that HFMA has your correct information, so please take a moment to review your record now. By doing so, you will ensure that HFMA continues to provide you with valuable information and insights that further your success.

Experience the Value. Value the Experience.

Chapter Contacts

Chapter Officers	
Candy Peterson, CPA	President
Jeff Gendreau, CPA	President Elect
JoAnna Justiniano	Secretary
Thomas Hogan, CPA	Treasurer
Candy Peterson, CPA Ken Cornish,FHFMA	Interim VP Communications
Bill Fenske, FHFMA, CPA	VP Education
Ken Cornish,FHFMA	Past President

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Trisha Schirmers	Randy Patton
Stacy Barstad	Lissa Benson
Greg Brock, CPA	Elaine Leonard
Gregg Redfield, (ex-officio)	Terry Currie

Committee Chairs	
Vera Schumann	Newsletter
Tom Wang	Concordia
Lee Batulis	Membership
Ray Costello	Networking & Sponsorship
Gregg Redfield	Fall Institute
Terry Currie Kara Carpenter	Winter Institute
Sue Ankeny	Rural Health
Jackie Hinderks Mark Davis	Regulatory
Tom Hogan	Tax
Bill Fenske, FHFMA, CPA	Certification
Greg Brock	Website

Our objectives are to provide members with information about chapter and national HFMA activities and to provide a forum for reporting state and national issues relating to the healthcare industry.

Vikingland Viewpoint is published two-four times annually for the members of the Minnesota Chapter of the Healthcare Financial Management Association as part of the communication series including Month End Entries. No part of Vikingland Viewpoint may be reprinted without receiving prior consent from the Editor. Responsibility for the content of Vikingland Viewpoint lies solely with the Chapter's Communications Committee. The Editor welcomes and encourages the submission of material for publication. Articles should be e-mailed in Microsoft Word and may include a short biography of the author.

The Communications Committee reserves the right to edit material and to accept or reject contributions, whether solicited or not.

Opinions expressed in Vikingland Viewpoint are those of the authors, and do not necessarily reflect the view of the Communications Committee, HFMA Minnesota Chapter Leadership, or the members of the Minnesota Chapter. Any questions or comments may be directed to the VP of Communications.

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The Vikingland Viewpoint is the official newsletter of the Minnesota Chapter of the Healthcare Financial Management Association.