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VIKINGLAND VIEWPOINT

Minnesota Chapter of HFMA

VOLUME 59, ISSUE 1

JULY 2008

IRS Form 990 Scrutinizes Charity Care Programs

By Bruce Nelson, Vice President of Sales & Marketing, SearchAmerica
and Jordan Levitt, Vice President of Strategic Relationships, SearchAmerica

On December 20, 2007, the Internal Revenue Service (IRS) unveiled its updated Form 990 for tax-exempt organizations, with a new schedule designed specifically for hospitals (Schedule H). While the IRS is phasing in Schedule H for the 2008 tax year, only Part V requires obtaining identifying information. However, the entire schedule will be mandatory in the 2009 tax year.

In short, hospitals must use the

2008 tax year to ready themselves by assessing their charity processes and related reporting in order to meet the upcoming IRS requirement for 2009

Closer Charity Monitoring is Imminent

The evolution of the Form 990 began in 2006 when the IRS sent "compliance check questionnaires" to more than 550 tax-exempt hos-

pitals, seeking detailed information about their operations and billing practices and the compensation of top hospital executives. While only auditing 5% of non-profit hospitals in the past 10 years, the IRS is clearly looking for new ways to monitor the non-profit healthcare industry with more scrutiny.

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Reversing the Trend of Bad Debt

Revenue Cycle Management and Hospital Financiers Must Confront This Trend Together in Order to Reap its Rewards.

By Bruce Nelson, Vice President of Sales & Marketing, SearchAmerica

Yes, bad debt is on the rise everywhere including hospitals. However, you still have the power to decide how to react to this trend. At a high-level, there are two strategies:

A. Wait to see if international healthcare will be adopted by the United States; or

B. Take action to streamline and improve the processes that impacts your hospital's bad debt.

Most of us would opt to control our destiny, and adopt strategy B. After all, with industry

analysts such as Lehman Brothers reporting that bad debt expenses for hospitals could reach as much as 17%, now is not a good time to sit back and wait.

Unfortunately, there is a stalemate.

Executive Leadership; Limited Purse

In recent years, the direction from many hospital board rooms on how to minimize bad debt was to add more visibility and high-level attention to the revenue cycle side of the organization.

A new position, the Vice President or Director of Revenue Cycle, was created. This executive was tasked with improving the hospital's bottom line by implementing changes and minimizing bad debt by improving collections and patient payment communications, and streamlining its charity care programs – but given a meager budget to do so until s/he demonstrated savings. Unfortunately, changes cannot be achieved with a budget to purchase new systems, enlist alternative collection agencies, train internal staff and more.

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Patient Identity—A Hospital's Clinical Responsibility

By Christopher Linder, Senior Client Executive, SearchAmerica



It's Sunday afternoon in the ER of an outlying hospital in the Midwest. The radiologist arrived and completed his review of some X-rays from a car accident victim admitted the night before. He identified several blood clots which needed to be treated or a massive stroke may result. However, as no injuries were found the patient was released earlier that morning.

No problem.

The physician calls the phone number on the patient's record only to find it disconnected. A day nurse offers to drive by the address on her way home and ask the patient to call her physician immediately. Unfortunately, the address is a vacant lot.

Due to inaccurate demographic information, the patient will never know of her condition, perhaps until it is too late. There is no way to know whether she willingly provided errant information, was too confused by the accident to recall details correctly, or the hospital's registrar keyed in the information wrong.

Now some may regret the hospital's inability to recover the costs of her treatment, but most of us would feel most affected by the knowledge that someone out there needed medical help right away and they couldn't be reached.

Clinically, the hospital did not serve the patient to the best of its ability.

During my decades in healthcare systems throughout the country, I have seen this scenario or similar ones repeated too many times. Too often hospital personnel assume that knowing a patient's identity is needed only for billing, insurance and other administrative purposes, and forget the clinical importance of this data.

Identity Is Part of Patient Care

Patient identity is a critical piece of the patient's care and community service, and the most effective and accurate means of providing this information is through automated demographic validation solutions.

Often, medical staff sees automation as a means of minimizing one-on-one interaction with the patient. After all, technology and computers don't have a pulse so they must be the opposite of caring. In the case of validating a patient's identity, this mindset couldn't be more wrong.

Automating how a hospital identifies a patient shows it is interested in the patient's long-term health.

Accurate information ensures that information for all visits from the patient are included in a single patient record. X-ray and lab results received after discharge can be forwarded to them and/or their doctor as needed, and any associated hospital communications can reach them without delay.

Civically, it is a hospital's duty to use appropriate measures to locate a patient after discharge if medically necessary, or contact next of kin if needed.

The following real-life example demonstrates how important to the patient and their family proper identification can be:

"Due to inaccurate demographic information, the patient will never know of her condition, perhaps until it is too late."

The police brought a homeless man to the ER who was found in a coma under a bridge where he appeared to have been living for several weeks. After 10 days in the hospital and still in a coma, an aide found an old Social Security card in the man's backpack. Utilizing this information, the hospital was able to use their demographic and address checking system to uncover the last known address for this individual. The address was on the opposite coast, and when the hospital tried the phone number, a woman answered. It was the patient's daughter, who hadn't seen her father in more than eight years. Using digital photos, she immediately identified her father and was able to have him moved to a hospital near her for future treatment.

Using just one piece of information, in this case a Social Security Number, could identify a patient and reunite him with his family. While I don't know if the patient ever woke up from his coma, at least his daughter could see him again and not live the rest of her life wondering about his whereabouts.

For those financially minded, the daughter was also aware of her father's Medicare benefits and provided the needed documentation to recover some of his medical costs from his hospital stay.

The patient and his family benefited much from the hospital's automated capabilities, which provided an accurate address match from just a single piece of information. Without it, the reunion and subsequent care would not have followed the same path and the man would have passed on alone. Automation improved this patient's care and future.

Stop Fraud Before Care Starts

Identity theft is increasing, and hospitals need to be smart about the credence they give to documents provided directly by a patient. While most patients are honorable and represent themselves accurately, there are those who try to cheat our healthcare systems.

A third-party solution can be used to quickly and accurately validate the information provided by the patient – their name, address, SS#, Date of Birth (DOB), etc. The following example, the technology would have provided the accurate DOB, showing the patient would be in his 80s, not his 30s as his paperwork claimed. The registrar would have been alerted to the discrepancy and able to address the situation prior to providing any medical services.

A 30-something year old disabled truck driver was admitted to the hospital for elective back surgery to minimize his pain due to chronic back issues. After surgery, he recov-

ered as an in-patient for 2 ½ weeks, running up a hospital bill well over \$200K. Since he had provided appropriate documentation, the hospital was able to submit his bill to Medicare and receive payment for his stay.

Nine months later, a phone call came into the billing department. A man in the southern part of the state (approximately 300 miles away) had received a Medicare statement showing they had paid for his back surgery and related hospitalization at our facility. The man had never been to our city, let alone the hospital.

The patient had falsified documents and received elective care using fraudulent means.

The hospital had to reimburse Medicare for the expenses, and never recovered the cost of the surgery or hospital stay. The patient had committed a crime, but the hospital found out too late to minimize any impact and/or stop him from doing it again.

In reviewing the case, the hospital discovered that the man's Social Security Number hadn't been validated. If it had, it would have shown that the man going into surgery should have been 89, not 39.

Every patient who enters a hospital through the ER or regular admittance must have their identification validated by a third party system. Hospitals such as the ones in this article have learned hard lessons – ones that should be learned from, not repeated.

Every patient, no matter how urgent their medical need, how complete their paperwork, how incapacitated, should be screened to verify their basic information. *It is the hospitals clinical and civic responsibility.*

B. Christopher Linder is a Senior Client Executive at SearchAmerica, and has worked in healthcare for over 25 years. Mr. Linder graduated from The Ohio State University and his expertise is in banking finance in the healthcare industry.

Reimbursement Update

Rule Season:

We are now into full swing with the CMS Rule season with the release in July of the Physician RVRBS Rule and the Outpatient Prospective Payment Rule. The comment period for these rules will be in September 2008.

The Inpatient Prospective Payment Rule had its comment period close in June 2008 and we are waiting for the final rule to be published prior to August 1, 2008.

All the rules released have exhibited a greater emphasis on being a value based purchaser with the proposed increase in quality measure continuing to expand, although much controversy from the industry remains over certain of the proposed measures.

Revised Medicare PRRB Appeals –

Revised Provider Reimbursement Review Board (PRRB) appeals procedures were published in the May 23, 2008 Federal Register, Volume 73, #101. The new procedures are effective for all appeals pending as of

(with some exceptions) or filed on or after August 21, 2008. There are a number of substantive changes that may affect current pending appeals in addition to the filing of all future appeals. Providers are encouraged to read the new procedures to ensure compliance with the new rules.

Education Opportunities:

The MN Chapter of HFMA is presenting a day long conference on September 12, 2008 on the revised Cost Report Schedules that are under development and due to be released prior to the conference. The conference format is for a day long presentation priced at \$150 or 100 for FI/MAC's or governmental agencies although there are two half day sessions available that are priced at \$80 or 60 for FI/MAC's or governmental agencies. All options include a lunch.

Topic and presenting for the morning session:

The new Medicare changes to the formset and discussion:
Presented by: Becky Dolin, Vice President, Health Financial Systems

Topics and presenting for the afternoon sessions are:

Understanding MS-DRGs and associated opportunities
Presented by: Maureen Drach-Murphy is a Director in Health Care Regulatory practice for Deloitte & Touche LLP

The impact the proposed changes to the cost report will have on the MS-DRGs as well as the first year impact of the MS-DRGs
Presented by: Gregg Brock is a Senior Manager in the Health Care Regulatory practice for Deloitte & Touche LLP

This is an opportunity to be on the front end of the change to understand and begin to training and preparation for the next cost report preparation.

For additional information on any of these topics please contact Joe Heidkamp at 612-262-4725 or Mark Davis at 612- 397 4298

Cover Story - *IRS Form 990 Scrutinizes Charity Care Programs.*

The timing of the new schedule is not surprising. Hospitals have come under more and more scrutiny by the IRS and the Senate Finance Committee to justify their tax-exempt status by demonstrating how they benefit their community. Many legislatures and government officials are lobbying for tighter standards for hospitals to keep their tax-exempt status. These senators do not want to recognize the community benefits such as health fairs, cancer screenings, and medical research, as replacements for charity care.

The IRS does not outline how it will use the information collected in the 990, but IRS Exempt Organizations Director Lois G. Lerner was quoted in a December news conference as saying, "We want to look at what the hospitals are doing. We think having broader information will better inform us on any decisions we would like to make in the future."

Meet the 5% or Be Scrutinized?

Senate Finance Committee Chairman Max Baucus, D-Mont and Sen. Charles Grassley, R-Iowa, have both expressed concern over the overcharging of uninsured patients, the allocation of too few resources to charity care, and overstatements of the amount of free care provided.

Senator Baucus' opinion on this topic is well known. He believes that hospitals should allocate at least 5 percent of their annual revenues or expenses to free care for those unable to pay.

The revised Form 990 asks new questions about a non-profit hospitals' charity care program. While no legislation exists today to back the 5% rate proposed by Baucus, the new 990 will clearly identify hospitals that need to increase their charity care enrollment.

Readying Your Charity Program

Form 990 is forcing hospitals to reassess their charity care programs, if they haven't already. The evaluation should be two-fold, examining the process itself and the measurement of a successful program.

1. Process: Is the correct charity care process in place? Is it non-discriminatory and defensible?

Non-discriminatory. A charity program cannot discriminate by age, race, sex or any other personal characteristic. Unfortunately, people are human and biases do exist, even under the best of circumstances. Hospitals need to demonstrate that their process identifies every patient who would qualify for charity care under their specific guidelines. Only by automating the screening process using technology, *without human intervention and natural subjectivity*, can the process be truly objective.

Defensible. The process of identifying a qualified charity patient must be defensible. Screening must be performed on every patient who could potentially qualify for a charity discount based on the hospital's specific guidelines at the point of registration using a third-party or neutral service. The independent service's audit trail validates that the screenings took place and that the patient was directed to the appropriate financial arrangement based on the data provided.

2. Measurement: Is the hospital near the recommended 5%? Should some bad debt be reclassified?

Too often bad debt accounts should have been enrolled in the charity care program from the beginning. In Part III of the Form 990, bad debt can be included but smart hospitals realize there is more benefit to reclassifying them to charity.

When re-classified, many hospitals determine that they are providing more charity care than first reported. Correcting this

error could improve a hospital's standing with their community and the IRS.

Automation is the Only Option

Hospitals need to be ready for a new era in their relationship with the IRS.

There is only one way to improve compliance and minimize the risk of an IRS audit or possible loss of tax exempt status -- by automating the process using a third party provider of patient information such as demographics and credit scores.

Governed by the unique rules of the hospital's charity care program, the automated screening service can objectively determine whether or not a patient is qualified based on data not appearances. If the patient qualifies, it can also aid in the enrollment phase with pre-populated forms for patient signature.

Before the IRS Form 990 was unveiled, many hospitals had proactively automated their charity care screening and achieved tremendous results. Lesa Klepper at Novant Health explained that, "For every self pay patient, we have SearchAmerica automatically run a credit and financial profile. If this information indicates that their income level matches the criteria of Novant's charity care program, the patient is immediately enrolled. Since implementing this new process, we have more than tripled our number of charity cases and delivered a 50% decline in bad debt."

IRS Form 990 is a wake-up call for tax-exempt hospitals to bring their processes and charity expenses to appropriate levels. With less than 12 months until tax year 2009, time is of the essence and solutions from SearchAmerica are available to solve the most burdensome aspects of the 990.

Cover Story - Reversing the Trend of Bad Debt

When these Vice Presidents approached the board to secure the actual amount of funds necessary to launch the needed changes, the response was most often, 'show us the savings first, and then we'll invest in the plan.' However, without sufficient budget, significant savings couldn't be demonstrated.

Unfortunately, this game of what comes first – savings or budget – has kept many hospitals at an impasse and prevented them from achieving the cost savings they all desired.

Breaking the Impasse

As bad debt increases, the cost of doing nothing is high and getting higher. Instead progressive hospitals are breaking this cycle and wisely invest in automating process that will provide payback in **6-12 months**.

The following are two strategies that deliver rapid return-on-investment (ROI) and can cut bad debt by 50% or more:

Strategy #1: All Bad Debt Isn't Bad Debt

Too often accounts that are tagged as bad debt, should never have been in the hospital's billing system in the first place. Often 25-50% of bad debt accounts qualify for government programs, such as Medicaid, or the hospital's charity care program but were not screened properly at registration.

This misclassification can cost hospital hundreds of thousands of dollars, if not millions, over time. Not only do they negatively impact a hospital's financial health, they also incur collection costs on accounts with little or no chance of payment. This is simply throwing good money away.

By using an automated screening system, hospitals can easily verify whether or not a patient's income and demographics qualifies them for government programs or charity. If done consistently with every patient and at the point of registration, a hospital should never expend resources to collect from these accounts. Instead, those resources can be used to improve collections on the remaining accounts that are collectable.

By removing qualifying charity and government aid accounts from bad debt, a hospital has a healthier balance sheet. By reclassifying bad debt using an automated system to screen for charity accounts, many hospitals can shift 1.7% or more of bad debt to charity by enrolling all qualified patients in their charity care program.

Real-Life Example – Novant Health:

Since automating its screening process, Novant has more than tripled its number of charity cases and experienced a 50% decline in bad debt. For accounts sent out to collections, there is also a greater expectancy for payment as we have validated all contact information and provided the initial income screening for determining the patient's ability to pay.

Lesson 2: Validate Each Patient's Identity & Address

Identify theft is on the rise, especially in healthcare as patients are paying more and more of their hospital expenses. In 2007, Good Morning America did a feature on the apprehension of a Texas ring of individuals who had used false identities to secure hundreds of thousands of dollars of healthcare services from local hospitals. Unfortunately, this case isn't unique.

Every patient entering the hospital must have their identity validated by a third-party service, regardless of their appearance or paperwork. By doing so the hospital can further repel fraud, remain unbiased in their operations, and validate the address to be used for billing purposes.

In 2007, we saw several hospitals use simple identity and address verification to reduce their returned mail by 50% or more. The financial gains were significant and also resulted in lower aging of accounts.

Real-Life Example – Mercy Hospital & Medical Center:

As an urban healthcare provider, Mercy's self-pay patient community is significant. Despite a recent push to have every patient present a valid ID, many patients arrive with-

out proper identification. Mercy knew that with accurate demographics, they could eliminate some of their bad debt that resulted from inaccurate information.

Using a third-party solution, Mercy is able to validate the identity of their self-pay patients by making sure that a patient's date of birth (DOB), Social Security Number (SSN) and the patient's name match. Registrars are able to immediately confirm or correct this patient information within seconds using accurate demographic data.

An increase in accurate patient demographics has led to a reduction in return mail and increased patient satisfaction at Mercy.

Positioned for Greater Tangible Results

Revenue cycle executives and board members are often surprised by the savings their organizations can reap in a short period of time, with some investment in the above strategies. After reclassifying bad debt, and uncovering those accounts that should be allocated to a government aid or the charity care program, they reduce bad debt AND:

- Reduce processing time per charity account by automating the identification and enrollment process.
- Improve collection rates as charity accounts are no longer included.
- Produce more compliant IRS filings (e.g., 501(C)3) to prevent audits.
- Deliver better revenue cycle metrics and ratios:
 - Lower bad debt as a % of revenue
 - % of charity accounts may rise or remain stable, but all charity accounts are assured to fit defined criteria
 - Reduced aging or days in Accounts Receivable, as accounts are moved to charity at the beginning of the process and never reach collections

As bad debt rises, the reasons for inaction, and the current stalemates, need to be resolved. This trend is being reversed by hundreds of hospitals across the United States, who have chosen to change instead of wait for change.

Gaining Visibility and Control over Your Collection Agencies

By Steve Levin, president, Connance, Inc. slevin@connance.com

How to adequately compare your collection agencies' performance

Hospitals increasingly rely on third-party collection agencies to work patient accounts. Today, day-to-day management of these relationships is cumbersome and unproductive as hospital resource time is consumed with auditing and reconciling vendor invoices and files. Limited visibility into vendor activity and inconsistent reporting make performance reviews across vendors virtually impossible.

As patients today are directly shouldering a greater share of healthcare costs than ever before, hospitals need to gain visibility and control over their self-pay collections in order to maximize cash flow. By better managing agencies, hospitals can realize more cash with greater oversight while substantially reducing administrative burdens. In addition, hospitals need to make sure they continue building stronger relationships with their patients by being able to supervise agencies' daily activities.

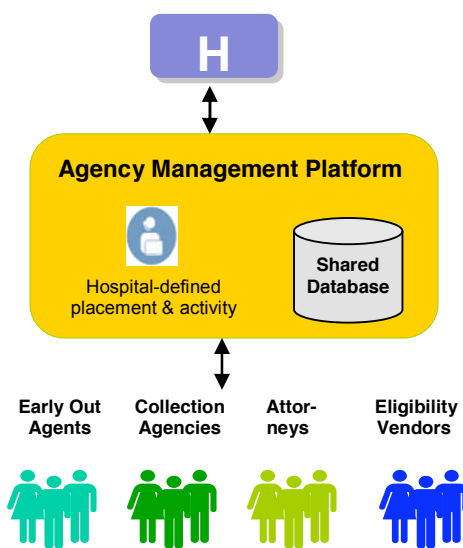
Step 1: Consider New Approach

Innovative companies in other industries, such as telecommunication companies and multiline financial institutions, have embraced technology to improve collection agency management. Using three or more primary and secondary collection agencies, these companies don't rely on alpha splits and account balance size to simply place accounts. Instead, they use technology to manage the placement, reconciliation, and auditing activities – all activities that tax scarce internal resources. These creditors have realized consistently increased cash yields from any single agency, reduced clerical costs, improved handling of exceptions in the collections process, enhanced customer satisfaction with their agencies, and the ability to optimize their portfolio of agencies. Their agencies also experi-

ence improvements including less clerical activity, fewer administrative calls and better creditor engagement.

The technology solution for collection agency management establishes a single placement platform that sits between the hospital and its agencies and collection resources. The best platforms include a database and a rules engine that captures the hospital's work requirements. The database maintains an inventory of accounts being worked by all vendors and receives daily updates on recent activity by the hospital and the vendor. As a result, the central database has all the information needed by hospitals to analyze performance. The rules engine continually analyzes the database to find activity that should be flagged for review.

Agency Management Platform Exhibit



Step 2: Evaluate Your Options

When choosing agency management technology, hospitals should evaluate their current agency management issues and then

compare the features and benefits that existing solutions can offer. Some factors to consider follow.

A single platform for all of the hospital's agencies. All agency activity (including early out and late stage collection agencies, attorneys, and debt buyers) should be centralized to compare agency performance consistently.

A full reporting suite. A framework for consistent reporting across all collection agencies is necessary to support account audit and reconciliation requirements and to conduct agency performance comparisons. Daily reports of agency activities can provide insight into the number of letters sent, calls made, and "promises to pay" taken, which allows hospitals to respond quickly to changing agency dynamics and performance.

Ability to execute the hospital's business rules. A system that offers automatic rules-based workflow allows hospitals to monitor and control compliance to their business rules.

Ability to change agencies quickly. A more robust, comprehensive system enables users to change vendors quickly and with minimal business disruption.

Quick and easy installation. Implementation of an agency management system can be done on a small scale. Many web-based solutions don't require investment in hardware and software upgrades, have reasonable installation fees, and are predominantly pay-as-you-go.

Limited maintenance. Web-based systems simplify maintenance and software upgrades. They have limited requirements for internal resources.

Regulatory compliant. The system should ensure full regulatory compliance with the Health Insurance Portability and Accountability Act.

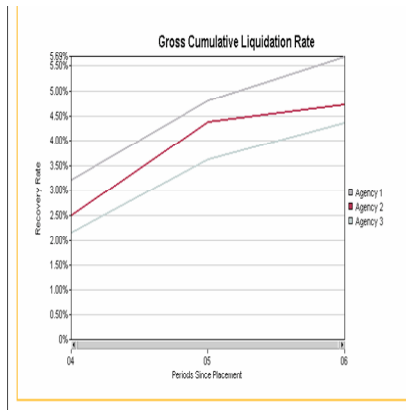
A platform for future analytics. The system should be able to accommodate analytics to achieve maximum financial performance. Analytics ensures that each account is sent to the collection agency most likely to maximize collections on that type of account.

Step 3: Implement and Compare

Once you have selected the technology that is right for your organization, ensure executives and managers are taking control of patient revenue by better managing the collection agencies.

The hospital CFO should monitor and compare current and trend line performance of the collection agencies and evaluate performance on gross and net liquidation rates to get a complete view of the true relative value of each vendor.

How do my agencies liquidation rates compare?



The revenue cycle executive should access information necessary to manage the vendors, not just audit them. The executive can find the collection sweet spots for each of the collection agencies by comparing performance on different classes of accounts. The revenue cycle executive should make more informed decisions with respect to assignment timing and recall decisions, optimizing internal resource costs against vendor demonstrated performance. Over time, the

executive should quickly identify true underperformers and replace with a new proven vendor, already connected to the agency management network, who has a demonstrated strength in the desired area.

The day-to-day manager of a hospital's vendors should monitor service level agreements, rapidly reconcile invoices and inventory, and broadcast new information to all vendors at once.

Providers that are adopting new agency management technologies will be more efficient and effective, know where performance is slipping and be able to respond quickly. Their personnel will sleep better at night knowing what the agencies are and are not doing with their patients.

What in the World is a "BOOM" Project?

By Tim Foley

Healthcare is one of the many industries today that is faced with both financial challenges and the need to manage rapid change. A popular strategy for confronting these issues has been to focus on "core businesses" where an organization can capitalize on its strengths (i.e. add value) and "outsource" to the extent practical, those items which are outside of that core competency to an organization that has a core focus on the segment to be outsourced. Outsourcing is being utilized in wide variety of business sectors as a means to save money and focus on where your organization can generate revenues and profit.

Energy costs are continuing to rise, causing unpredictable spikes in operating budgets. Capital is limited for plant overhauls or expansions. Yet your patients still need comfort and you need a predictable budget.

"Energy cost are continuing to rise, causing unpredictable spikes in operating budgets."

BOOM stands for build-own-operate-maintain. Essentially, it is outsourcing the construction, ownership, operation, and maintenance of a central heating and cooling system to an organization that has that as its "core business". Advantages of this approach include:

- Predictable long-term budgets
- Reduce the risk associated with a rise in energy costs
- Eliminate the need for capital outlay for central facility upgrades
- Offload the financial risk associated with unexpected downtime
- Guaranteed performance

While engaging in a BOOM project is not a good fit for all hospitals, it should be considered when any of the following conditions arise:

- Your systems are in need of optimization to reduce operating costs
- The central systems are nearing the end of their expected life
- The hospital is considering major expansion or new construction
- Redundancy in the system has eroded due to increases in cooling requirements, causing financial risk of unexpected downtime
- Your energy costs are over budget and need to be made predictable

Tim Foley is with the Strategic Partnerships Group of Carrier Corporation, a division of United Technologies Corporation. He works with executives at hospitals and other large facilities with reducing operating costs and with major facility upgrades. He is newsletter editor and an active member of the Healthcare Financial Managers Association of Northeastern New York. He can be reached at tim.foley@carrier.utc.com.

Making a Difference...

By Keith Truax, Senior Revenue Cycle Strategist, SearchAmerica



As I meet and work with healthcare organizations around the country, I am often reminded of how important what we do on the business side of

healthcare is. When I think back in time to my first financial position in healthcare, I quickly realized that we are truly blessed. We don't have the skills and talents to provide direct health care to a patient, that has been reserved for those with that calling, but we do have the business skills and talents to ensure that physicians, nurses and all direct care professionals can continue to focus on providing the level of care that is needed.

Early in my healthcare career I realized when organizational decisions are contemplated that purely focus exclusively on either the medical or the business aspects, the outcome most often misses the mark. Balancing both sides of the equation is what works best. It requires business and medical professionals to consistently work together.

A Balancing Act of Teamwork

Another balance that is equally important in our line of work is between mission and margin. Healthcare organizations have a unique mission, different than any other industry in our economy. This is even more apparent with the degree of not-for-profit and faith-based healthcare organizations, as they are the largest segment within the hospital and clinical industry. Serving their communities in a compassionate manner with a higher calling is a good summation of the mission statements I have run across. But this compassion would quickly disappear if the bottom line was ignored or not paid its appropriate due. In my humble opinion, those organizations that have found that right balance

are the ones truly **living up to the mission and optimizing the margin.**

Unfortunately, many healthcare organizations have not been able to strike this balance. Why? Well, it goes back to perspective. Those that have achieved the mission/margin balance have deliberately chosen to align their actions with their missions.

Charity Programs Change Lives – My Tale

From my personal experience (and many of you reading this have stories that come to

“By providing charity care for your respective communities, you are making a difference in more lives than most probably ever realize.”

mind as well), this mission aspect of our business makes a difference in numerous lives each and every day. In all of my engagements with healthcare organizations across the country, I've heard a variety of reasons for providing or not providing charity care respective to an organization's mission. These reasons range from “well they're ” to “they didn't comply with our policy, so they were declined” to “we give enough charity”. Well, I was one of those people at one time. For those that have never been humbled to that degree, I can tell you it is an experience I would not wish upon anyone. But it also taught me a valuable life lesson. No matter how successful, we are not exempt from significant personal and professional challenges in our lives.

I was and still am appreciative for those in healthcare that showed compassion. They had an impact on my life that I will never forget. Based on that experience, I have intentionally turned my gratitude into a lifelong calling to financially support those organizations. Today, my job is to help healthcare organizations live up to their missions and still improve the bottom line.

How could I ask for anything better?

It Has Never Been Easier

By providing charity care for your respective communities, you are making a difference in more lives than most probably ever realize. A Chief of Medical Staff once told me that more than seventy percent of health issues are psychosomatically related. If this is true, just imagine the associated health benefits with letting patients know they have been approved for charity, if they qualify, at the point of service (POS) or even before.

Today's financial clearing solutions are designed to help you achieve your mission and margin goals. For example, they can automate the charity screening process to make “fast-track charity” a reality for your organization and permit you to live up to your *mission*. On the margin side, focused collection can also become a reality for your organization and permit you to optimize your *margin*.

As you can probably tell, I just call it like I see it. I've seen the mission/margin balance become a reality in a number of healthcare organizations; but even more importantly, I've seen it first hand. That's all the proof I need to know it works and makes a difference.

If you'd like to learn more about how your hospital can make a difference, please feel free to contact me. Please join me and we can make some great things come to reality – sooner than later.

Finally, don't forget to thank your staff today; it's their day-to-day efforts that make it happen.

Commentary: Non-Profit Hospitals Need to Toot Their Own Charity Horn

By Tina Eller, Senior Revenue Cycle Strategist, SearchAmerica

In 2008 you are hearing much about healthcare's failures from the politicians, media, and others. In their minds, the healthcare community is doing a poor job and needs to be dramatically reformed. I couldn't agree more. We have failed, but not where Americans may think we have.

Our 'F' belongs in our lack of public relations showing Americans the billions spent in charity care programs, and the associated belief that even non-profit hospitals are more focused on margin than mission.

Hospitals today do an outstanding job serving all of their patients. Most people don't realize how exceptional our healthcare is until they receive medical care outside of the United States. These experiences, even in the most civilized nations, usually include lengthy waits for services (sometimes more than a year!), unclean or archaic facilities, and almost always bureaucratic staff with no hint of a smile.

We need to remind the United States that we should be proud of our independent healthcare services. In 2008, don't just watch the news and let the politicians speak on healthcare. We have a responsibility to join in the discussion.

Who should the leading spokesperson be? Surprisingly, it may not be the hospital president or award-winning doctor, but its CFO and their revenue cycle staff. For who else could speak authoritatively on the dollar value of uncompensated care given by the hospital in recent years?

Charity Program – Huh?

If you ask the average American if non-profit hospitals in their area provide services at no charge to the indigent population, they would most often look confused at the question and certainly lay all credit for serving the uninsured/underinsured community at the foot of government – 'isn't that what Medicaid is for?' Unfortunately, few people know about the billions of dollars that hospitals, especially non-profits, give back each year to their community in the form of free or discounted services.

It is like the saying if a tree falls in the forest with no one around, did it actually happen. If hospitals provide care on their own dime, and no one hears about it....did it actually happen?

Thus, in this year where healthcare and Iraq will dominate most discussions and debates, I urge you and your colleagues to make the billions spent on hospitals' charity care programs a point a topic of discussion at your next social gathering, kids' soccer match or class reunion.

Rumblings from Congress & the IRS

You are no doubt aware of the increased scrutiny rising from Washington. The updated IRS Form 990 and public statements by members of the Senate Finance Committee are just several examples of the government's increasing monitoring of the nation's healthcare providers. For the past year or more Senate Finance Committee Chairman Max Baucus, D-Mont and Sen. Charles Grassley, R-Iowa have spoken of the 'magical' 5% of annual revenues that non-profit hospitals should be required to allocate to free care for those unable to pay.

The bottom line is that the government is following poor public perception of healthcare and adding fuel to it with its current activities. Unfortunately, good news doesn't sell...so we must do our part to comply with their new regulations but not lose focus of the bigger issue -- public opinion.

Choose More Than One

Just as doctors take a oath to serve those in need, healthcare organizations have a shared passion, or mission, to deliver quality care to its patients, to make a difference in their lives.

For non-profits, it's not just about margin. Unfortunately the public, and to be honest sometimes our staff, forget that it is not the balance sheet alone that steers the organization.

More than ever, hospital CFOs need to picture themselves at a buffet not a wedding reception. They can freely choose multiple desserts in whatever quantity, not just a single piece of cake.

This is how they should view their hospital's margins and charity programs. Hospitals can place both on their plate side-by-side, and neither is of more or less importance. In fact, just like ice cream and apple pie, both are better when served together.

How, you ask? When non-profit hospitals focus their collections on only those patients who are able to pay (removing those who qualify for charity and Medicaid in advance), their collections rates and margins dramatically improve while their bad debt decreases.

The revenue cycle is an important way to support a non-profit hospital's mission. It needs to develop processes and use technology to identify and enroll all qualified patients for charity care, and focus 100% of its collection efforts on patients with the means to pay for services. Tax-exempt hospitals are not asked to give away the "farm" but to simply serve those who need assistance.

The bottom line is that hospitals need to be proud of the services they bring to everyone, whether they can afford them or not. In 2008, I challenge you to be more vocal about the positive aspects of our healthcare systems. After all, if we don't toot our own horns it is clear that the politicians and media won't.

Tina Eller is a Senior Revenue Cycle Strategist, SearchAmerica, and has worked in healthcare, both physician and provider spaces, for 15 years. Ms. Eller's expertise is in helping organizations drive initiatives within the Revenue Cycle focusing on the self pay population and Consumer Driven Healthcare. She is a frequent speaker at healthcare forums as well as contributor to a number of healthcare publications on the topics of Revenue Cycle best practice, challenges in the industry, etc.

A Message from President Ken



Welcome to another year in the life of MN HFMA. Our National President has set the theme for this 2008-2009 year as "Making Connections". I would challenge each of you to take this to heart and use

HFMA to make some very important connections in your professional lives. We can use HFMA to make those networking connections that help us out during time of opportunity on our jobs. We can use these connections to have a good time as some of us did at the Spring Fling this past May. We can also use our HFMA connections to become a certified member and build our resumes for career advancement.

Getting connected with HFMA is easy and right now we have some opportunities for a few of you to get more involved with HFMA than just going to the institutes. There are a few openings for volunteer on our board and some committees. This could be your chance to get involved and learn how your chapter works (and occasionally doesn't work). I'm not talking about a huge time commitment here but a chance to become a chapter leader, and have some fun along the way. We are planning some great educational and fun events this coming year; don't miss out by just sitting on the side lines. If you would like to get more involved, please drop me an email at kcornish@stpeterhealth.org.



Membership



The Minnesota Chapter membership count stood at 587 at April 30, 2008, the end of the chapter's year for membership counting purposes. This total was down slightly from the beginning of year when the count stood at 592. The committee chair for the current fiscal year will be

Lee Batulis of SearchAmerica, Inc. If you are looking for an opportunity to volunteer and are interested in helping to maintain and grow the Chapter membership, the membership committee can use your help. The committee coordinates surveys, mailings and events throughout the year to recruit and welcome new members and to

help new and existing members get the most out of HFMA membership. If you have any questions concerning membership, or would like to volunteer to help out on this important committee, please call or email Lee at (763) 416-1057 or lee.batulis@searchamerica.com.

New Members

June 2008

Pam J Bednar, VP Marketing
Visionshare

Blake G Iverson, JD, Tax Consultant
Grant Thornton, LLP

Nivedita C Girotra, Student
Nive

July 2008

Adam H. Schmidt, Lead Operations Analyst
Ingenix/ Unitedhealth Group

Christopher S. Imm, Director of National
Healthcare Alliances
ADP Inc

Welcome!

Job Postings

Financial Analyst

St. Luke's

Duluth, MN

St. Luke's has an excellent opportunity for an experienced individual to join our team. Responsibilities for this position include performing financial and value analysis to support decision making while maintaining the cost accounting system, productivity reporting systems and assisting in preparation with the annual budget. Qualified candidates must have a bachelor's degree in accounting and 5 years of professional level experience.

St. Luke's consists of a 267 bed hospital, primary and specialty care clinics, home care, several physician joint ventures and a Foundation. The system generates 280M in net revenues.

St. Luke's offers an excellent benefits package, health, dental, 401(k), pension, educational reimbursement.

Interested applicants should apply online at:

www.slhduluth.com

Financial Analyst II

Fairview Ridges Hospital

Fairview Ridges Hospital, located in Burnsville, MN, is currently seeking a full-time Financial Analyst. You will be supporting hospital and clinic operations through financial reporting, data analysis, financial planning and pro forma development to improve the operational and financial effectiveness of the assigned operating units. The Financial Analyst II extracts and validates data from various information sources and provides relevant information and recommendations to assist management in business decisions. Qualified candidates will possess a bachelor's degree in accounting or finance and 3 years related experience. Strong accounting, financial analysis and computer/database skills required. Learn more and apply online at fairview.org referencing requisition #08-24678. EEO/AA Employer

Reimbursement & Reporting Manager

Rice Memorial Hospital

This position provides vision and leadership for the hospital's reimbursement & external financial reporting functions. The right candidate must be a self motivated team player who demonstrates Rice's values of respect, integrity, compassion and excellence. Qualified candidates will have a Bachelor's degree in finance/ accounting or a healthcare related field and a minimum 5 years experience in health care management or related field. Reports to Rice Hospital's CFO.

Rice is located in the lakes region 2 hours west of the Twin Cities, and is the state's largest municipal hospital. It provides services to the residents of west central Minnesota including inpatient/outpatient surgery, rehabilitation, high-tech diagnostics, radiation oncology, DME, mental health, dialysis, long-term care and hospice services. In 2007 Rice completed a \$52 million building and renovation project.

Submit resumes to Human Resources, Rice Memorial Hospital, 301 Becker Ave SW, Willmar, MN 56201. For more information, visit www.ricehospital.com or contact Nancy at nski@rice.willmar.mn.us

Up Coming Events

August 25th—HFMA Golf Outing, Bent Creek

For more information please see our website www.mnhfma.org



September 12th—Medicare Cost Reporting Seminar @ Allina

September 22nd - 25th—National HFMA Education Conference in Minneapolis (Radisson Plaza Mpls)

October 2nd - 3rd—Autumn Institute (Radisson Plymouth)

January 29th—Winter Institute (Sheraton Mpls)

April 2nd - 3rd—Concordia Institute (Fargo)

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Thank You!

For your continued support and involvement.

**Minnesota Chapter of HFMA—
Volume 59, Issue I**

JoAnna Justiniano, Director of Corporate Development
Outreach Services
4294 Dahlberg Drive
Golden Valley, MN 55422
Phone: (800) 544-9925
E-mail: jjustinianno@outreachservices.com

Darla Anderson, Director of Finance
Sibley Medical Center
601 West Chandler Street
Arlington, MN 55307
Phone: (507) 964-8424
E-mail: darla.anderson@sibleymedical.org



Other Valuable Web Sites

HFMA—www.hfma.org

AAHAM—www.aaham.org

HCCA—www.hcca-info.org

AHA—www.aha.org

NMHCC—www.nmhcc.org

ACHE—www.ache.org

MHA—www.mnhospitals.org

AHIAM—www.ahiam.org

VHA—www.vha.com

AHLA—www.healthlawyers.org

AHIP—www.ahip.com

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

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.

JoAnna Justinianno, VP of Communications

jjustinianno@outreachservices.com or call (612) 332-6773

Darla Anderson, Newsletter Editor

darla.anderson@sibleymedical.org