News & Profiles

September/October 2010 Vol. XXIX No. 2

hfma

Wisconsin Chapter

The official newsletter of the Healthcare Financial Management Association - Wisconsin Chapter

Increasing Educational Opportunities

Can Healthcare Reform Impact Your Tax-Exempt Status?

Membership & Marketing • Coming Attractions

Wise Words from Wisconsin • July Board Meeting

Squeezing Blood from a Stone • New Members

The Increasing Value of the Patient Statement, and more!

Increasing Educational Opportunities

Thanks to all the volunteers that make the Wisconsin Chapter so Great! We continue to make big strides and we work to serve our membership. A few notables are below:

I just got my Sept 22-24 WI Chapter Conference brochure in the mail and we were in for yet another thought-provoking round of education – not to mention some exercise as you all show off your baseball skills. We always reserve Thursday night for entertainment and this softball game should prove to be entertaining. Congratulations to Denise Olsen, Program Chair, and the entire program committee for putting together the action packed event.

One of our strategic goals this year is to increase the educational opportunities for members. I've been very proud of the work that Diane Lunde and Shawn Gretz have been doing on the webinars. The two webinars they've already provided were timely topics with very good attendance. We've got another webinar in the works to bring members up to speed on Meaningful Use and the impact it will have on their organizations. Stay tuned for an e-mail with the details.

Aaron Biebert and his crew on the Electronic Communications Committee are revamping the Chapter's website. Once completed the website will house the webinars for members to "check out" and still get educational credit. We are looking forward to the new features and functionality. Aaron will give the Fall meeting attendees a preview of the new website.

Another group deserving a Kudo is the Certification Committee lead by Leslie Claas and Eric Summers. They've spearheaded an online study course for HFMA certification that involves 30+ participants from 4 different Chapters. All these participants plan to sit for the certification exams this Fall. Congratulations to Leslie and Eric and to the participants on a very successful program. Being certified is a good feeling!

We learned that God is not a Vikings or Cowboy fan as our President-Elect's house got struck by lightning on August 20. Luckily for Art Mertig this was just a warning and there is time for him to get his Packer gear lined up for this season. Seriously, Art and his family were lucky to have escaped their house as lightening struck its roof at 6am. There had to be some surreal moments as Art watched firefighters enter his house as flames shot from the roof. The house sustained considerable fire, smoke and water damage. Early indicators are that half the house will need to be demolished and rebuilt. Keep Art and his family in your thoughts.

Art and I will be attending the Fall Presidents meeting in San Francisco at the end of August. This is an opportunity for us to connect up with other Chapter Presidents and learn what is on the horizon for HFMA. We will report back to you in the next newsletter and thru minutes of board meetings.

Looking forward to seeing you in Neenah in September.❖

Upcoming Educational and Networking Events

Shawn Gretz, VP of Programs

September 22-24, 2010, Fall HFMA Conference

Our WI HFMA Fall Meeting is shaping up to be a great educational, professional and networking event! The meeting will take place Wednesday September 22 through Friday September 24, 2010, at the Bridgewood Hotel in Neenah, WI. Denise Olsen from Agnesian HealthCare is the chair for this conference and has been doing a terrific job putting together a great lineup of speakers that will discuss:

- Certification Cram Session and Test: If you have thought about becoming certified, then now is the time to start studying. At our fall conference Christoph Stauder, one of the original writers of the HFMA Study guide, will be leading a Cram Session in the morning that will conclude with the HFMA test in the afternoon.
- ACO: Accountable Care Organizations
- Data Analytics in HealthCare
- Healthcare Reform
- Managing Balance Sheet Risk

Thursday evening will be especially entertaining as HFMA Wisconsin will travel to the Home of the Wisconsin Timber Rattlers (Brewers baseball minor league team) and play a softball game on the field. President of Wisconsin HMFA, Jim Nelson, and VP Art Mertig will be captains of the teams (more information to come). On Wednesday there will be a golf outing at Westridge Golf Course in Neenah, WI, and at night, more networking along with a campfire.
Register Online today at: http://www.acteva.com/go/wihfma

60 Years Young!

HFMA Wisconsin is turning 60 Years Young in 2011. Todd Nova will be chairing our 60th Anniversary celebration at the Hilton Milwaukee City Center. Mark your calendars now so you can be a part of this historic event January 12th through 14th, 2011. Todd has already lined-up Debra Kuchka-Craig, the HFMA National Chairman-Elect, to be the keynote speaker.

Webinars

HFMA Wisconsin will continue to provide free webinars to its members throughout 2010 and 2011. Watch your emails for these upcoming educational opportunities. If you have suggestions for webinars, please contact Diane Lunde at diane.lunde@forthc.com.❖

Can Healthcare Reform Impact Your Tax-Exempt Status?

By Stephen M. Chrapla

(Yes, based on new requirements regarding patient billing and financial assistance)

Public Law 111-148, Patient Protection and Affordable Care Act (PPACA) establishes new compliance requirements relating to billing practices and financial assistance that must be satisfied in order for a hospital to retain its tax-exempt status. In addition to provisions calling for periodic assessments of community health needs, hospital executives also need to be concerned about the detailed operational processes and procedures for patient billing that will be required to be implemented on the front lines. This article addresses the implications for hospitals of the patient billing and financial assistance requirements of PPACA.
Section 9007 of PPACA establishes a new Internal Revenue Code section 501(r) which imposes the following new operational requirements on the billing practices of tax-exempt hospitals:

- Development, implementation and communication of a Financial Assistance Policy
- Limitations on charges for services
- Billing and collection requirements related to patients

Hospitals will need to comply with these requirements by the start of their next fiscal year after March 23, 2010. This may create some challenges, since regulations governing this legislation have not yet been developed by the Secretary of Treasury and may not be finalized prior to the required implementation date.

Here are the specific requirements that will need to be met:

Financial Assistance Policy that must include:

- Eligibility criteria to qualify for assistance
- The basis for calculating amounts to charge patients
- The method for applying for financial assistance
- Measures established to widely publicize the policy within the hospital's service area

Limitations on Charges:

- Cap on amounts charged for emergency or medically necessary care to patients eligible for financial assistance to no more than the amounts generally billed to individuals with insurance coverage
- Prohibition on the use of gross charges, regardless of a patient's eligibility for financial assistance

Billings and Collection Requirements:

- Prohibition against extraordinary collection efforts until reasonable efforts have been made to determine if a patient is eligible for financial assistance

The legislation constitutes an amendment to the Internal Revenue Code and will be administered by the Department of Treasury. Reviews are required to be conducted not less frequently than once every third year.

The Secretary of Treasury is authorized to issue regulations and guidance as may be necessary to carry out the provisions of the legislation. The Secretary is specifically directed to provide guidance as to what constitutes "reasonable efforts" for a hospital in determining the eligibility of a patient under a financial assistance policy. The timing of any such regulations and guidance, however, remains uncertain. As a first step, the Internal Revenue Service has issued a Notice seeking public input on the application of the requirements of Section 501(r), with a submission deadline of July 22, 2010. In a typical process, regulations would then be issued in preliminary form, followed by a further comment period in which interested parties have an opportunity to provide written submissions raising issues, concerns or questions about the proposed language, after which final regulations are promulgated. This process can sometimes be very lengthy and can even take years. Nonetheless Congress specified that new code section 501(r) applies starting with a hospital's next fiscal year following the of whether definitive regulations and guidance have been issued by such date.

See ***Can Healthcare Reform*** page 4.

State Collection Service, Inc.

Steve Beard,
Director of Revenue Cycle,
State Collection Service, Inc.

Meet our Director of Revenue Cycle!

- Former VP of Ontario Systems' Healthcare Division (creators of Artiva Healthcare)
- Experience working with some of America's largest healthcare providers including Healthcare Corporation of America and Catholic Healthcare West
- Featured speaker at numerous national seminars and conferences
- Expert panelist for HFMA's Revenue Cycle Forum

With over 25 years of experience in the receivables management industry, Steve Beard has the solutions to meet your outsourcing needs.

As State Collection Service's new Director of Revenue Cycle, let Steve's extensive knowledge of the entire revenue cycle – including first-hand experience with Artiva Healthcare, our newest technology offering – work for you!

Contact us at 800.477.7474
Service. Integrity. *Results.*

Can Healthcare Reform from page 3.

What does new IRC Section 501(r) mean to hospitals?

Hospitals must meet the requirements of new IRC Section 501(r) in order to maintain 501(c)(3) tax-exempt status. While many hospitals may already operate in a manner largely consistent with the intent of this new legislation, it is critical that the detailed operational aspects of the legislation as well as the related regulations are met. Compliance will be ruled on very specific criteria that differ from previous tax-exemption criteria and state chartered charity designations.

Financial Assistance Policies. Financial Assistance Policies will need to be reviewed and revised as appropriate to include specific criteria for eligibility as well as how amounts will be calculated and the method for a patient to apply for financial assistance. Hospitals will also need to specify, either in the Financial Assistance Policy or in a separate billing and collections policy, the actions they may take in the event of non-payment, including collections action and reporting to credit agencies. The method for communication will also be more extensive than what was customary in the past for many hospitals, in order to satisfy the requirement to "widely publicize" the Financial Assistance Policy within the community.

Limitations on Charges. *Gross Charges.* Any hospital whose current practice is to impose "gross charges" for services rendered to patients who are not otherwise entitled to a contractual allowance with an insurance company or other third-party payor will need to adopt a new pricing approach in order to take into consideration the blanket prohibition on that practice. Since the legislation is silent as to the amount of allowance necessary to satisfy the new requirement, it will be important to monitor guidance from the Secretary of Treasury regarding acceptable levels. Irrespective of whether any such guidance is provided, hospitals must eliminate "gross charges" before the start of their next fiscal year.

Patients Eligible for Financial Assistance. A second limitation relates to amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the hospital's Financial Assistance Policy. In these cases, the hospital may charge only "amounts generally billed to individuals with insurance coverage." The determination of "amounts generally billed" is not further clarified in the legislation. However, the Technical Explanation attached by Congress to PPACA states that "[i]t is intended that amounts billed to those who qualify for financial assistance may be based on either the best, or an average of the three best, negotiated commercial rates, or Medicare rates." Whether the Internal Revenue Service adopts a standard reflecting the language of the Technical Explanation or a more flexible standard remains unclear. The Secretary of Treasury may (but is not required to) provide further guidance on this calculation.

In order to comply with this additional rule affecting eligible patients, a hospital must either (1) unilaterally adjust all patient bills receiving emergency or medically necessary care to reflect amounts which satisfy the "generally billed" test, regardless of financial need, or (2) affirmatively determine patient eligibility for financial assistance and adjust the bills only of those patients. If the latter, an open question remains as to the actual mechanism for making the adjustments. For example, must a hospital contact all patients prior to sending out any statements in order to ensure that no eligible patient receives a bill showing more than the "generally billed" amount? Or is it sufficient to include a blanket disclaimer in all patient statements advising them of their right to a further discount if they meet eligibility requirements for financial assistance, and to then make adjustments only on those statements where eligibility has been determined by subsequent communications initiated by the patient? While the latter interpretation might seem reasonable, the legislation is not clear on this point. Again, the Secretary of Treasury may (but is not required to) provide further such guidance.

Extraordinary Collection Efforts. A hospital must make "reasonable efforts" to determine whether a patient is eligible for financial assistance before it engages in "extraordinary collection actions." Once again the language of the statute alone leaves room for interpretation, although the Secretary of Treasury is specifically mandated to define the phrase "reasonable efforts." Along these lines, the Technical Explanation accompanying PPACA states that "[i]t is intended for this purpose, 'reasonable efforts' include notification by the hospital of its financial assistance policy upon admission and in written and oral communications with the patient regarding the patient's bill, including invoices and telephone calls, before collection action or reporting to credit agencies is initiated." The Technical Explanation also states that "extraordinary collections include lawsuits, liens on residences, arrests, body attachments or other similar collection processes." It is possible that the Secretary of Treasury may define "extraordinary collection actions" to encompass other collection practices as well, such as reporting to consumer credit agencies, threats of legal action or credit reporting, or referring delinquent accounts to an outside collection agency. What is clear is that traditional billing and collection protocols that place the burden on the patient to request or avail themselves of financial assistance will no longer be allowed. Simply sending a patient a series of statements and thereafter commencing aggressive collection efforts is likely to violate the statute. Instead hospitals will need to demonstrate that they have tried in good faith to make a determination of financial assistance eligibility prior to resorting to extraordinary collection efforts. Satisfactory documentation of these efforts will also be well-advised, if not required.

What steps do hospitals need to take?

1. Review current policies for financial assistance, billing and collection and make necessary revisions to comply with the new regulations.
2. Establish Financial Assistance Policy communication protocols for wide publication.
3. If gross charges are currently used, establish a discount policy applicable to patients without insurance or other third-party coverage.
4. Determine what amounts will be charged to patients qualifying for financial assistance.
5. Establish protocols and procedures for screening patients for eligibility for financial assistance, including a documented process meeting the "reasonable efforts" test.
6. Review staffing levels and quality metrics in patient billing area, adding internal or external resources as necessary to ensure compliance.

[For further information regarding the billing and collection implications of new IRC Section 501(r) for your institution, please contact Stephen M. Chrapla (phone number: 847-395-7655. E-mail: schrapla@revenuecyclepartners.com).]

About Revenue Cycle Partners

Revenue Cycle Partners LLC (www.revenuecyclepartners.com) provides a comprehensive suite of account resolution management services to hospital clients throughout the United States, focusing particularly on non-delinquent patient accounts and third-party follow-up.❖

News from Membership & Marketing

Tom Tanel, Committee Chair

With the start of a new chapter year now in full swing, I wanted to take the time to thank our membership and those individuals who have helped our chapter grow and flourish during a most difficult economic period in our history. And, it is for that reason that we as members keep that connection going forward as we are sure to experience many changes in our Healthcare professions. With all the impending changes, we can tap into the many resources that are available to us from the National level, as well as our own local experts, to gain the knowledge that we need to continue to adapt, grow, and advance in our association, and in our own organizations. This staying connected over the years has helped us retain our position within the HFMA as one of the leading chapters that other chapters look to.

Attending the recent Leadership Training Conferences with other chairs from the 68 HFMA Chapters has given me an insight that we are doing many of the progressive things that other chapters are just starting to do to grow and be more successful. As hard as it can be for many of us to renew, or consider renewing our memberships, it is for many of these reasons and more that we need to stay connected and network with our peers. There is much to learn whether you are a new member, bringing new ideas to the table to share in our rapidly changing technological era, or a longtime loyal member with a history of adapting to all the changes that we have gone through to get to this point.

A testimony to this is the fact that we have over 280 members that have renewed their memberships repeatedly, and have been members for 10 years or more.

The following will be celebrating milestone anniversaries worthy of mention:

Over 40 years

Rolland Hippe (46), Neil Rittershaus (46), Tom Gazzana (43), Alex Soltesz (43), Dolores Winkler (40), Dan Blask (40), and Bill Buelow (40).
(Most, but not all of them retired as of yet, but still connected)

Over 35 years

Les Whiteaker (39), Bill Bestor 37), Robert Hankes (37), Chris Penney (37), Dale Volkman (37), Ron Betz (36), James Pinger (36), Bob DeFelice (36), Karl Appleton (35), Gerry Demmer (35), Rich Donkle (35), Charlie Roeder (35).

I would need quite a few more pages to name others reaching other milestones, but I'll save that for the next issue, as I have a limited amount of space and time to do so. We often don't get many chances to honor and thank those members that have Made-a-Difference. Next time you see one of them you can thank them for helping make a difference in shaping our Wisconsin Chapter. It's also a great segue, as we will be celebrating our 60th Anniversary early next year.

If you know of someone who may be interested in becoming a member, and attend our next conference, there is still time for them to join before October 1st . The new member can take advantage of a National promotional discount on dues, and for you being mentioned as a sponsor, would get credit for 1 of many local and National contest prize drawings to be awarded by the end of the Association fiscal year through April, 2011. Just have them go to HFMA National's website at www.hfma.org. Hope to see many of you at a future function.❖

Coming Attractions

HFMA Wisconsin:

September 22-24, 2010
HFMA Fall Meeting
Denise Olson, Chair
Bridgewood Resort & Convention Center
Neenah, WI

Janary 12-14, 2011
60th Anniversary Celebration
Hilton Milwaukee City Center
Milwaukee, WI

Date TBA
2011 CFO Forum
Nick Bauer, Chair
Location TBA

May 25-27, 2011
HFMA Annual (Spring) Meeting
Eric Summers, Chair
Stoney Creek Inn, Wausau, WI
Hotel Rate Only $77/Call 800-659-2220
by April 25, 2011 for Reservations

For more information go to
http://www.hfma.org/events/conferences/html

Wise Words from Wisconsin *Compiled By David Cartier*

For our second installment we turn to Green Bay... Donna Hutchinson is the Chief Financial Officer at St Mary's Hospital Medical Center in Green Bay and at St Nicholas Hospital in Sheboygan. She has been with Hospital Sisters Health System for 25 years and worked in not for profit healthcare most of her career. She has held a variety of financial roles in hospitals in Missouri, Maine and Wisconsin. She has an MBA from University of Wisconsin – Oshkosh and has Fellowships in both the Healthcare Financial Management Association (FHFMA) and the American College of Healthcare Executives (FACHE).

She presently serves on the HFMA National Board of Examiners and she just completed the National HFMA Regional Executive role for Region 7 which consists of the Wisconsin, Illinois and Indiana chapters. Donna has served as a past President of the Wisconsin chapter of HFMA (2003-2004). She completed a two year term on the HFMA National Advisory Council (2006-2008). Donna is a HFMA Medal of Honor winner.

1. Q: Can you comment about your experience as an HFMA member? Are there unique features to HFMA membership that especially helped you during your career?

A: The WI chapter has been my home for most of my career. It has provided me with a wealth of education hours and networking opportunities. I would also say that some of my closest friends have come from relationships with fellow chapter members.

2. Tell us a little about your organization and its mission?

A: My organization is Hospital systems Health system with our corporate office based in Springfield IL. We have 8 hospitals in IL and 5 in WI which include' St Mary's Green Bay, St Vincent Green Bay, St Nicholas Sheboygan, Sacred Heart in Eau Claire and St Joseph's in Chippewa Falls. As our name implies, we are a healing ministry guided by the historic mission of the Hospital Sisters of St. Francis. At the same time, we are firmly grounded in modern best practices.

- We use progressive physician partnerships and the latest technology to provide personal, integrated health care across our entire system.
- We demonstrate commitment to our communities and to our Franciscan traditions by providing quality, caring and compassionate health care to all—including the sick, needy, uninsured and underinsured.
- We continue to grow deliberately, through our commitment to professional lay leadership. Stewardship of resources and strategic investments help ensure the highest standards of clinical quality and service as well as the long-term viability of the system.

3. From your current perspective, what do you view as the 2-3 most significant challenges in today's healthcare environment?

A: Preparing for the challenges in the Affordable Care Act passed in March, continuing pressure on healthcare reimbursement, and using information technology to the fullest extent possible for maximum benefits.

4. How do these challenges affect the industry and your facility in particular? How are your challenges similar and different from other WI hospitals?

A: We will be moving through a major IT system conversion over the next two years. We are embracing LEAN to streamline our processes and eliminate waste in our hospitals. We will be closely examining the specifics in the reform act to see what demonstration projects and or ACO opportunities we might pursue.

5. How has your organization changed since your arrival? How has your focus changed as a result of the current economic crisis?

A: I have worked at St Mary's in Green Bay for over 25 years. We have grown from a small west side facility to a major healthcare facility including building our Center for Digestive Health, Cardiac Cath Lab, regional Cancer Center with St Vincent Hospital, new Emergency Center and Surgical suites. Our changes as a result of the economic crisis include reductions in our labor force, aggressive productive hour targets by department and cost reductions in non-labor expenses. We are being to see a trend in utilization which we call "pre" and "post" deduction seasons, shifting greater volumes to the latter half of the calendar year.

6. Tell us about your management and staff structure? How do you keep your staff and leadership apprised of the key performance issues? Are there specific tools you use to ensure good communication among your leaders?

A: We have divisionalized many leadership positions across our three eastern WI hospitals including revenue cycle, supply chain, IT, finance, HIM, and within many clinical services lines. Each facility has weekly leadership forum with conferencing capabilities and we use email and divisional newsletters to promote good communication. We are also using more video conferencing capabilities throughout our system.

7. What is your prediction for the next few years in terms of the strength and health of your organization? What will help you remain strong?

A: Our division and system's balance sheets are very strong. I believe this will help us weather the storm that is coming along with forward thinking strategies and accepting constant change as the new norm.

8. How is your current CFO role different from other similar positions you've held and how have other institutions differed from your current organization?

A: I currently serve two hospitals as CFO in the Eastern WI division. Splitting my time appropriately has been my biggest personal challenge over the past year. Fortunately, I have strong site leaders and staff at both organizations.

9. What suggestions do you have for HFMA members who may wish to follow a career path to hospital CFO and how would you suggest they take advantage of their HFMA membership?

A: My advice is to first work on the basics as far as certifications and education (I am living proof that you can get your MBA while working 40 hours plus per week). I am not a CPA but do have the FHFMA and FACHE certifications. There are many chapter members that can serve as mentors, take advantage of them and their insight. I really believe that good things that come to those who work hard and are passionate about their business.❖

Donna Hutchinson

July Board Meeting On The Lake

Submitted by Editor Philip Rohs

The July board meeting took place July 9th in Madison. The group convened aboard a Betty Lou Cruise on beautiful Lake Mendota. The meeting was productive and everyone stayed dry.

Shawn Gretz boarding the Betty Lou Cruise

Jim Nelson kicking the meeting off

Bruce Lorenz, Roger Rego and Sonja Weiland enjoying the meeting. . .or maybe they were enjoying the lake!

Eric Summers and Diane Lunde

Thomas Krystowiak and Dave Meister

Squeezing Blood from a Stone – ThedaCare Discusses Its Success Cutting Telecom Expenses

By Lacinda Athen from Valicom

In today's economy, any way to trim fat from the bottom line is a welcome activity. As clinic and hospital professionals, the focus is often concentrated on the health care side of spending, not the technology end. But as technology needs become more and more complex, there can be great opportunity for savings through better management of telecommunication costs. Problems like overpayments, errors, or poor inventory tracking of your land lines, circuits, pagers, "smart" phones, and data plans could be wasting a lot of your annual budget.

ThedaCare in Appleton has long known this to be a key expense control area. By implementing a strong telecom expense management (TEM) program, they have seen over a 400% return on investment over seven years. To find out more about how ThedaCare approaches TEM, and how other clinics can work to access such savings, we spoke to Joe Van Dehy, Director of eHealth and former IT Manager.

What first brought you to the realization that managing telecom costs was a priority?

"A little over eight years ago, we saw that while managing expenses had always been a priority, IT/Telecom costs were advancing more quickly than expected, and we needed new ways to manage that. We recognized that more and more of our spend was going towards communications as our network was developing and our organization was growing. We had been struggling for a long time with the staggering amount of cryptic detail that accompanied our telecommunications invoices, and we recognized that we weren't doing a good job of staying on top of that. It was clear that we either needed an army of people, or a partner who was an expert and had the systems to do this well, quickly, and at a fraction of the cost of an internal solution. Thus we sought out our partnership with Valicom. "

What do you feel are the key things involved in a good telecom expense management program?

"For ThedaCare there were a number of components we took into consideration, including technological automation, customer service (including access to my support team, ability to get reports that I need when I need them, and scheduled interactions), and the ability to measure results. "
"But perhaps no attribute was more important in our minds than relationship. Early on in the relationship the expectation was set that our TEM partner would act as an extension of ThedaCare's staff. This set the stage with our telecommunications vendors and laid the foundation for the relationship. From that point on, they involved my team when appropriate, provided regular updates on status and opportunities, and took the daily load of managing this expense while giving me the tools and opportunities to own the responsibility."

What area of savings did you find the most surprising?

"There were a number of items that surfaced that surprised me. The first was the realization that what we were being billed for was not what we were getting. We were being charged for lines that were no longer in service, for locations that we no longer owned, for taxes that we should not be paying, and for duplicates. These were all opportunities that were uncovered once we could see what the bills were saying to us.

"Another surprise came with the renegotiation of our wireless agreement, and the realization that there was quite a bit of room for cost reduction. We worked with our partner on the development of an RFP, and they fronted the process so I didn't deal directly with the vendors. We were able to leverage their experience and twenty years of benchmarking data as an extension of the ThedaCare team, and come up with a much better result."

What is the top challenge currently facing ThedaCare with regards to telecom costs?

"With the recent health care reform legislation we expect there to be increasing pressure to do more with less. While it is understood that this is no different than what everybody else, regardless of industry, has been trying to do for quite some time, this paradigm change has significantly ratcheted up the pressure. This pressure, and the idea that mobility and communications will be key contributors to our ability to be successful, means that we can expect our telecommunications costs to continue to increase at a greater rate than other expenses. We therefore must not only be effective in our use of these tools, but we must be more diligent than ever before at making sure that we are managing this significant expense."

If you could tell other healthcare providers the best thing they could do to cut their telecom expenses, what would it be?

"Develop a telecommunications expense management strategy, and set it up in such a way that it can be successful. Staff it appropriately, or find a partner who has experience and a wide range of services to support your organization. Then, give it 6 months to show a return...and make sure that you track the return. If you choose to partner with a vendor, negotiate a no-risk clause into your agreement ."

As shown by the successes at ThedaCare, telecom expense management can really be the "best money you never spent".

If you're interested in learning more about ways to control your telecom expenses, feel free to contact Sandy Thompson, ThedaCare's Project Manager and long time collaborator for an overview. www.valicomcorp.com or 608.227-0612.❖

On the Cover

Shawn Gretz, Eric Summers, Diane Lunde, Roger Rego, Sonja Weiland, Julie Wiki, Jim Brick, Thomas Krystowiak, David Meister, Brian Potter and Art Mertig.

HFMA Wisconsin Chapter New Members

We extend a warm welcome to the following individuals who joined the HFMA Wisconsin Chapter through July 2010.

Eric Wilson, Delafield, WI, (262) 646-8001

Vicki Mueller, Health Care Manager, Wipfli LLP
Bonduel, WI, (920) 662-2890

Barbara Allen, VP of Account Management, MedQuist
Mequon, WI, (262) 385-1736

Pam Ott, Accounting Manager, Meriter Health Services Inc
Verona, WI, (608) 417-5820

Susan Anderson, Contract Specialist, Gunderson Lutheran Health System, La Crosse, WI, (608) 775-8061

Austin Moore, Greenfield, WI, (414) 379-1506

Tim Ferrier, Accounting Manager, Gunderson Lutheran
La Crosse, WI, (507) 895-8799

Susan Rochholz, Director Managed Care & Provider Network Mgmt., Gunderson Lutheran, La Crosse, WI, (608) 775-0531

Andrea Hatcher, Sr. Vice President, Marshall & Ilsley Bank
Milwaukee, WI, (414) 287-7319

Scott Alger, Business Consultant, Medical Pay Solutions
Thorp, WI, (715) 512-0934

Sean Stevermer, Business Office Lead
Osceola Medical Center, Osceola, WI, (715) 2945657

Jenny Rasner, Systems Manager/PI Analyst, Bay Area Medical Center, Marinette, WI, (715) 735-6621 x1783

Barb Hoffman, Staff Accountant, Southwest Health Center
Platteville, WI, (608) 342-5078

Stephanie Chedid, President, MBO Cleary Advisors, Inc.
Milwaukee, WI, (414) 270-2276

Randy Lubahn, Division Finance Director, Gundersen Lutheran Health Systems, La Crosse, WI, (608) 775-0170

Jim Reuter, Account Manager, Wisconsin Medical Society Insurance, Madison, WI, (608) 442-3727

David Jirovec, Ministry Health Care, Merrill, WI
(715) 539-5010

Steven Johnson, Enterprise Solutions Executive, GHX
Sister Bay, WI, (920) 854-3238

Timothy Haag, Sales & Service Executive, State Collection Service, Madison, WI, (608) 661-3000 x318

Mike Kangas, Director Clinical Materials & Services, Ministry Health Care, Stevens Point, WI, (715) 295-5961

Mark Butler, Sr. Financial Analyst, Marshfield Clinic
Marshfield, WI, (715) 389-7439

Suzanne Denzine, Kolb & Co, Brookfield, WI, (262) 754-9400

Dean Puzon, Senior Vice President, ALPHA Healthcare
Madison, WI, (877) 689-4756

Pamela Bradley, Accountant, Aspirus Wausau Hospital,
Fenwood, WI, (715) 847-2000 ext 51419

Kevin Murray, Associate Vice President, Johnson Insurance Services, Madison, WI, (608) 203-3928

Kirsten Roy, Audit Manager, CHAN Healthcare Auditors
Madison, WI, (608) 259-3477

Michelle Gwin, Internal Audit Director, Ministry Health Care
Milwaukee, WI, (414) 359-3192

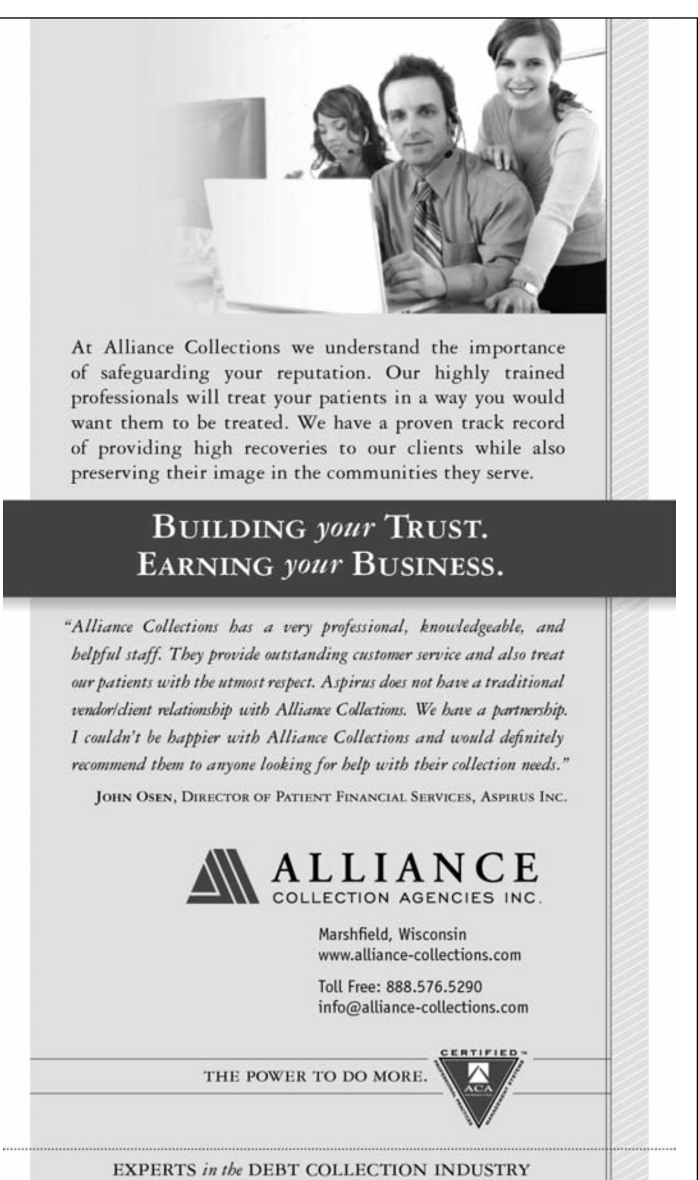
Penny Fuller, Accountant, Wausau Hospital, Inc.
Wausau, WI, (715) 847-2042

Jeremy Rickert, Sales Consultant, Credit Bureau Data, Inc.
La Crosse, WI, (608) 791-2170

Scott Kniprath, Division Finance Director, Gundersen Lutheran Health System, La Crosse, WI, (608) 775-9486

Stephen Mandel, Regional Vice President, Gardner & White, Madison, WI, (608) 287-6186

See ***New Members*** page 10.



The Inceasing Value of the Patient Statement

By Nels Peterson of APEX

Business offices for hospitals and healthcare systems focus on coding and compliance for good reason. Public and private payer requirements make receiving a timely and correct reimbursement for their patients a challenge. Add the prospect of penalties or even criminal allegations from either payers or regulatory agencies and the reason is clear. However, with the current shift in today's healthcare environment from a reimbursement model based on government and insurance company reimbursement to self-pay patients, a business office's traditional emphasis on coding and compliance ignores the main patient communication vehicle for the revenue cycle – the patient statement.

Catastrophic insurance policies with high deductibles and the uninsured have combined to increase the number of self-pay patients. HFMA's November 2009 Research Findings regarding the shift to self-payment found that 97% of provider respondents experienced an increase in self-pay accounts receivables from the prior year. In a third of the respondents, this self-pay account receivable growth resulted in receivable balances growing faster than patient revenue. Revenues derived directly from the patient are increasing. These numbers highlight the increasing value of the patient statement to healthcare business offices.

The statement is the final "patient touch" in their experience with your organization. It gives the patient an opportunity to make a first-hand impression of your revenue cycle. How good is the financial communications vehicle you send to your patients? The HFMA Patient Friendly Billing Project exposed patient billing as a significant problem for patients and providers. This project is based on the ideal that the patient statement should be easily understood by the average reader.

Is your statement intuitive from a patient's perspective? Who's it from? How much do I owe? What's my account number? What's that code mean? I need my readers - this font's too small. These are all examples of patient frustration with the bill received. Healthcare terminology can be an unknown. Codes and acronyms that professional billers take for granted mean nothing to others.

Is your statement an effective collections vehicle? Is the amount owed obvious? Is there a due date for payment? Do aging buckets help collection efforts by demonstrating days overdue or hinder those efforts by demonstrating probable lack of action for 90 or 120 days? Can you expect the same prompt payment that credit card companies do? Healthcare organizations are forced to ask questions like these to become more aggressive in their collection efforts.

When's the last time you really looked at the patient statement your organization's providing? An efficient statement design can affect important metrics. Both the number and length of inbound calls to your financial services call center staff can be decreased, the number of statement complaints and patient correspondence received can be reduced and the amount of self-pay receivables can be lowered. Are you tracking these metrics today?

Patient focus groups help in identifying current issues with your statement. How is your statement viewed from their perspective? What are your most common statement complaints? This group can be made up entirely of patients. However, a patient focus group made up of employees who are also patients may prove to be easier and faster to assemble.

Most healthcare administrative professionals are not looking for one more project requiring an investment of their time today. However, these issues can be addressed without involving changes to your medical billing software. At the very least it would take an investment of time - time that demonstrates your commitment to revenue cycle improvement that our changing healthcare environment requires. The increasing value of the patient statement today demands it.

Nels Peterson is a statement design consultant at APEX.❖

New Members from page 9.

Tammy Greene, Osceola Medical Center, Osceola, WI (715) 294-5722

Kenneth Stastny, Director of Decision Support, Columbia St. Mary's, Glendale, WI 53212, (414) 326-2239

Thomas Kelley, III, VP Finance and Strategic Planning United Hospital System, Kenosha, WI, (262) 577-8113

Tujama Kameeta, Manager, Menasha, WI, (920) 968-4192

Shari Tieman, Contracts/Payor Relations Rep, Marshfield Clinic, Marshfield, WI, (715) 389-3636

Luke Check, PO Box 1566, Manitowoc, WI, (800) 838-0100

Matt Hoffman, Cerner, Kansas City, MO, (816) 885-5696

Annette Wallace, Director Business Operations, ProHealth Care, Waukesha, WI, (262) 928-4120

Mark Lieberthal, VP Business Development, Revenex Inc., Bayside, WI, (414) 352-4448❖

Your Government at Work: Recent Medicare Final and Proposed Rules

By: Kirsten Wild, RN, MBA, CHC

Final Rule

2011 Hospital Inpatient Prospective Payment System ("IPPS") Final Rule

On July 30, 2010, the Centers for Medicare & Medicaid Services (CMS) issued a final rule establishing payment rates and policies for inpatient services in acute care hospitals under for fiscal year 2011. The final rule also establishes payment rates and policy changes for inpatient stays in long-term care hospitals (LTCHs) under the LTCH Prospective Payment System (LTCH PPS). In addition, CMS is applying a "documentation and coding" adjustment to recoup a portion of excess aggregate payments in FY 2008 and FY 2009 that do not reflect actual increases in patients' severity of illness. This reduction, coupled with other adjustments, is estimated to reduce total payments for operating expenses to IPPS hospitals in FY 2011 by 0.4 percent or $440 million.

Further, the rule strengthens the relationship between payment and quality of service by expanding the quality measures that hospitals must report in order to receive the full market basket update in fiscal year 2012. Under the Medicare law hospitals that choose not to participate in the voluntary reporting program or do not participate successfully will receive an inflation update less two percentage points. This update is reduced by 0.25 percentage points – to 2.35 percent – in accordance with the Affordable Care Act, and, therefore, hospitals that do not successfully report the quality measures will receive updates currently projected to be 0.35 percent.

New Law

Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010

On June 25, 2010, President Obama signed into law the above act. Among other provisions, this law clarifies Medicare's policy for payment of services provided in hospital outpatient departments on either the day of or during the three days prior to an inpatient admission (known as the 3-day payment window).

The new law clarifies Medicare's policy to be consistent with how hospitals have largely been billing the program as far back as 1991. Under this policy, a hospital includes, in its charges for the inpatient hospital stay, charges for all diagnostic services and non-diagnostic services "related" to the inpatient stay that are provided during the 3 day payment window.

The new statute clarifies that the term "other services related to the admission" includes "all services that are not diagnostic services for which payment may be made by" Medicare that are provided by a hospital to a patient on the date of the patient's inpatient admission, or during the 3 days during the 1 day immediately preceding the date of admission unless "the hospital demonstrates that such services are not related to such admission." The statute makes no changes to the billing of diagnostic services. The provision is effective for services furnished on or after June 25, 2010.

In the very near future, CMS expects to provide instructions to the hospital community through its contractors advising them how to bill for related therapeutic services provided during the 3- or 1-day payment window.

Proposed Rule

On, July 2, 2010, CMS issued a proposed rule that would update payment policies and rates for both hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs) for calendar year (CY) 2011. For ASCs, CY 2011 will be the first year of full payment rates under the revised ASC payment system methodology following a four-year transition. The proposed rule proposes to implement several provisions of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 that are effective Jan. 1, 2011. The proposed rule also seeks to promote higher quality, efficient services for Medicare beneficiaries by adopting improvements to the Hospital Outpatient Quality Data Reporting Program (HOP QDRP), which makes data about the quality of outpatient hospital services publicly available.

Fact sheets on the above changes can be found at: http://www.cms.gov/apps/media/fact_sheets.asp❖

"*We've been working with AMERICOLLECT for more than 20 years* and have no reason to switch to another agency."

In fact, they have reason to stay, says Adria Pekarek of Holy Family Memorial. That's because *AMERICOLLECT* has consistently collected more for the Manitowoc health care provider than their two previous collection agencies.

AMERICOLLECT's success is based on its Win-Win Collection Concept, a sales approach that creates goodwill and gives consumers payment options. The result: More money for your business.

To learn how *AMERICOLLECT* can help, call 1-800-838-0100 or go to www.americollect.com.

Do You Make it Easy for Patients to Pay?

By Karen Hauer

For over a decade now, high deductible health insurance plans have significantly changed the relationship between patient and health care provider. While patients have been pressed to become saavy consumers of health care, clinics and hospitals have experienced a dramatic increase in their accounts receivable and bad debt. What can you do to reverse this growing trend? Have you considered how easy it is for your patients to pay you? Here are some tips to consider.

Understanding the cost of service and your payment policy:

Health care is a unique industry where consumers often receive a service without knowing or understanding what their cost will be. Several weeks later the bill arrives and if it is not clear or includes surprises, this will delay payment. Many businesses are adopting some or all of the following solutions:

- Provide a good-faith estimate of services in advance when possible. This is not only prudent and worth the time and effort, but many states are requiring this by law when patients ask. The challenge can be the availability of accurate cost information at the points in your business where it would be needed to produce an estimate. There are a number of services and online tools typically for a per-use fee to assist in implementing this process.
- In conjunction with a good-faith estimate, obtain a signed authorization to process a one-time payment from the patient's designated financial account such as a health savings account, credit card or bank account once the claim has been adjudicated. This will not only guarantee payment up to the estimated amount, but may also save on repeated mailing of statements and collection efforts. To implement this process, be sure to use a PCI Compliant service provider to provide a secure card-on-file service to store payment account information and tools to process payments at a later date. Never store credit card or bank account information in desktop software, paper form or a 'tickler file!'
- Are your statements easy to read and understand? If you are not certain, check with your business office about how many calls they take from patients with questions about their statement. Invest in a redesign of your statement from a statement vendor who specializes in making health care statements easier for patients to understand.
- Use all available methods for informing patients of your payment policy, acceptable payment methods and payment terms before and after service; at registration, clearly on statements, and within one click on your web site.

Online Bill Pay:

Nearly two-thirds of Americans desire to pay medical bills online, according to a 2009 Deloitte survey of health care consumers. About 75% of households with Internet access are paying an average of 11 bills per month online. The principal driver for the high demand for online bill pay cited by consumers is convenience. So, while health care providers are offering online patient portals with login access to many secure tools, be sure to offer your online bill pay without the barrier of logging in. Couple this service with online bill presentment to satisfy consumers' concern for the environment and you save on statement mailing costs as well.

Automated Payment Plans:

If a patient owes a high balance, your business may offer a payment plan as a last effort before the account goes to collections. But if your current plan requires sending repeated statements and the patient promises to pay each month, that is not a good plan! Your patients will appreciate the convenience of setting up an automated payment plan to process their authorized payments. Typically, the same PCI Compliant service provider with the card-on-file security mentioned above, will have tools to automatically process recurring payments. The process should include a written authorization confirming the payment plan terms. Some services also include an online payment plan authorization form as well. This will save even more staff time when patients can complete the initial information themselves.

Accept all Payment Types:

Not withstanding the recent squawking about "trading chickens for healthcare" (Google and Bing search for 'Chickens for Checkups - April 2010), health care providers concerned with reducing their A/R should accept all forms of 'acceptable' payment types. By this, I mean all credit cards, checks, and ACH (or electronic funds transfer). Most health care providers do accept credit cards, but a smaller number are able to process an electronic funds transfer or ACH payment direct from a patient's bank or savings account. With the cost of processing an ACH payment at one-third the cost of processing the same payment by credit card, be sure that the tools you employ for processing payments especially by phone or online have the capability for ACH.

If your organization is faced with a growing A/R or bad debt issue, are you doing all that you can to make it easy for your patients to pay?❖

About the author: Karen Hauer is CEO of Secure Bill Pay (www.securebillpay.net), a software-as-a-service company offering a comprehensive suite of payment processing and revenue cycle management tools specific to health care. She is co-founder of MedCare Compare, an online service assisting health care providers to connect with patients in the growing consumer-driven health care marketplace. Ms. Hauer is also a new member of HFMA Wisconsin.

Legislative Study Committee on Health Reform Launches

By Barbara J. Zabawa, JD, MPH, FACHE
Whyte Hirschboeck Dudek S.C.

On August 19, 2010, I had the honor of participating in what will be the first of many meetings of the Wisconsin Legislative Council Study Committee on Health Reform. The Committee is Chaired by Senator Jon Erpenbach and Representative Jon Richards. Appointed members range from executives of health plans, providers, employer groups, community advocates and me, as Chair of the State Bar Health Law Section and practicing health lawyer. Needless to say, the Committee is comprised of very knowledgeable, experienced people all who are passionate about the future of our health care system. A full list of members and documents provided to the Committee can be found at http://www.legis.state.wi.us/lc/committees/study/2010/REFORM/index.html.

The Committee's charge is to decide over the next few months what legislation Wisconsin needs to implement the federal health reform bill, the Patient Protection and Affordable Care Act (PPACA), which President Obama signed into law in March of this year. PPACA's changes are many and the Committee's objective to sift through all the provisions and requirements is daunting to say the least. However, after our first meeting, the Committee seems to have settled on finding an appropriate governance structure for the health information exchanges, which need to be operational by January 1, 2014.

The exchange serves as the heart of health reform, at least from a coverage perspective. It is through the exchange that many of the current small group and individual insurance purchasers will receive health insurance coverage. It is the hope of Wisconsin's Office of Health Care Reform, according to the testimony provided by Department of Health Services Secretary Karen Timberlake, to fully integrate Wisconsin's exchange with Medicaid. According to Secretary Timberlake, full integration will assist consumers to know whether they are eligible for Medicaid or the exchange.

Integrating the exchange with Medicaid is understandable from a consumer standpoint, but health care providers will have to pay careful attention to the proposals to integrate. Integration between the exchange and Medicaid will create increased leverage in achieving payment reform. Some payment reform changes may be welcome, such as value-based insurance designs where payment is based on higher-value services. These designs may be in the form of Accountable Care Organizations, Medical Homes or payment bundling, for example.

However, payment reform through a Medicaid-based system has the potential of significantly reducing health care payments overall. It is no secret that Medicaid rates are lower than most payers. With increased leverage by a Medicaid-based system, payment rates for all services may decrease. This leverage will be further enhanced to the extent that the exchange partners also with the Medicare program, the State Employee Trust Funds program and other large players. Secretary Timberlake characterized such partnership as an opportunity.

Creating leverage at the payer level will no doubt force further consolidation of providers. There is already a trend in creating larger health systems. Physicians are looking for

Wisconsin Chapter HFMA Salutes its Sponsors for 2009 - 2010

Platinum
The MMIC Group
ProAssurance

Gold
CBE Group
Hall Render
Harris and Harris
McGladrey
Rycan
Quarles and Brady
WHEFA

Silver
Amphion Medical Solutions
Eide Bailly
HRS Erase
Larson Allen
MBO Cleary Advisors
Von Briesen and Roper
Wipfi
Ziegler Capital Markets

Bronze
Alliance Collection Agencies
Americollect
Credit Management Control
FinCor Solutions
IMA Consulting
Marsh USA
Outreach Services
State Collection Service
Tri-State Adjustments

Legislative Study from page 13.

See *Legislative Study* page 14.

health system employment rather than establishing or maintaining separate clinics. Creating integrated health systems will likely facilitate efforts establish Accountable Care Organizations or Medical Homes, efforts encouraged by PPACA.

In addition, coverage of more persons through the exchange and Medicaid will increase demands on primary care. Health care providers will have to step up their efforts in attracting more primary care practitioners, including physician extenders such as physician assistants and nurse practitioners. Expanding coverage will not be of any help to the United States health care system if there are not enough providers to deliver the increased demand for care.

How should Health Care Financial Managers respond?

The changes on the horizon are monumental. As a financial specialist in your health care organization, you need to stay on top of the proposed changes so that your organization can remain successful. One of the best ways to stay on top of the changes is to have a trusted legal advisor who is aware of what is happening on the state and federal level. It is imperative that as any changes occur, those changes comply with the law. For example, although leveraging buying power among payers may be able to drive down health care prices, payers must be careful not to run afoul of antitrust laws. In addition, value-based purchasing initiatives are currently subject to Stark requirements. Consolidation of providers will also likely create compliance challenges with reimbursement rules, perhaps exposing providers to more audits and government inquiry. Relying more upon physician extenders will also likely call into question scope of practice issues.

Change is coming. Over the next few years it may be redefined, but the status quo will no longer exist. The good news is that you are not alone. To successfully wade through this change, you must create and leverage your own partnerships with knowledgeable professionals. Experiencing the change together will make the transition much smoother.❖

The Growing Charity Challenge Form 990 and Health Reform

Providers have made great progress in expanding and developing financial counseling processes over the past several years. Unfortunately, a large number of patients are continuing to fall through the cracks. Many patients meriting financial assistance fail to participate in financial counseling and are instead declared to be bad-debt and sent to collections.

This situation, while disappointing, is taking on new concern with Form 990 filing obligations, in which hospital executives are required to declare the amount of charity they believe they missed by current processes and which ended up as bad-debt. This admission of process breakdown is in addition to documenting the various types of financial assistance delivered and scale of community benefit spending.

It is likely that community groups and consumer advocates will closely study the new information disclosed on the Form 990. They will use this information to form opinions with respect to how well not-for-profit hospitals are delivering on their community responsibilities.

Recently passed health reform legislation is also picking up on this issue, setting expectations for comprehensive financial assistance effort prior to any extraordinary collection activity. How this component of the legislation ultimately is converted into guidelines and operating standards remains to be seen; however, it is hard to imagine that the results will lessen the current anxieties. Similarly, it remains unclear what limits or restrictions the new Consumer Financial Protection Agency will impose.

Size of the Opportunity

Based on research done by Connance and PARO, it is common to find that 20-30% of a provider's bad-debt is from guarantors that would qualify for charity, but slipped through the cracks in the process. This is a meaningful percentage and is sure to attract attention when reported on Form 990.

Of course, the amount of missed charity for any individual hospital varies based on the local market, their specific financial assistance policies, and the financial counseling process in place. Poverty is a local phenomenon.

Root Causes of Missed Charity

Simply working harder under today's standard patient access and financial counseling processes is unlikely to overcome the missed charity issue. Structural challenges stand between many poor people participating in counseling and properly documenting their eligibility.

Consumers living in poverty have less education and higher illiteracy than the average household. While statistics on illiteracy and poverty are limited, the U.S. Department of Education estimates that, on average, 1 in 5 Americans are functionally illiterate. With this national average, a sizable share of the poor are very likely unable to fill in a basic charity application or even read a charity sign in the emergency room.

People living in poverty often lack stable addresses, are immigrants, or are embarrassed by their situation and prefer to not participate in application processes and announce their plight.

The Federal Reserve estimated that as many as 25% of those living in poverty lack access to traditional "banking" resources such as a savings or checking account. This means they are unable to provide financial documentation and databases of such information will not have their information.

Poverty and Credit Scores

The relationship between poverty and credit scores is an interesting one.

It stands to reason that if people living in poverty lack traditional banking relationships they will also lack a credit score. However, the corollary is not true – just because one lacks a credit score does not mean they are poor. There are many reasons other than income that will cause an individual to lack a credit score. Consider the situations of students who are just entering the workforce, someone who is newly widowed or divorced, or recent immigrants.

Next, consider that credit scores are really not an income measure but a delinquency measure. They answer the question "is this person likely to repay a new credit obligation?" Poverty is not a question of being overextended or spending more than you make. It is simply a question of income and household structure.

A common example of the difference between credit scores and poverty is an elderly patient living on a fixed income without any property. This patient will often have a bank

See *Growing Charity* page 15.

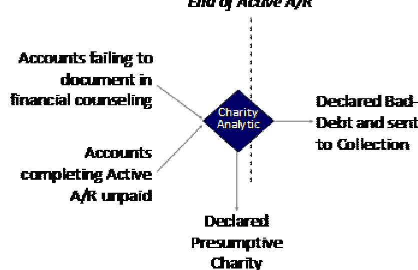
Growing Charity from page 14.

account and a credit card, which they use sparingly or under tight control so as to never run up a bill they cannot afford. This patient will likely have a solid credit score, but also be eligible for poverty classification based on income. One can contrast this with a middle income consumer who has racked up large bills buying the latest electronics or being overextended on their mortgage. They probably have poor credit scores, but would not meet the charity test for low income.

Presumptive Charity Analytics Leading Solution

Presumptive charity analytics are the leading approach to addressing both day-to-day operational issues of missed charity and Form 990 disclosures. They are a type of predictive model built specifically for identifying accounts eligible for poverty classification. Presumptive charity analytics use publicly available information to predict whether or not that guarantor would have been approved for financial assistance had they participated in the process.

Providers are using predictive analytics to evaluate accounts that fail to document through standard financial counseling processes. Accounts are scored just prior to bad-debt assignment. Those qualifying for presumptive charity are reclassified as such and removed from the bad-debt placement file. Those failing to qualify are declared bad-debt and handled as such.



Using a presumptive charity analytic in this fashion complements the existing financial counseling and patient access processes by addressing recognized breakdowns and barriers. Every account, including those that were missed by or failed to participate in financial counseling, are reviewed using a proactive, consistent and repeatable process.

This approach also provides a clear pathway for Form 990 submissions. Hospitals are able to reclassify significant bad-debts as presumptive charity, demonstrating a truer view of their community benefit. The estimate of missed charity ending up in bad- debt is reduced to the error rate of the model applied against bad-debt placements. In total, the institution is communicating a comprehensive and proactive effort to identify and aid needy patients, even those unable to speak up. This is clearly on point with newly passed federal health reform legislation.

In order to implement this approach, charity policies need to explicitly note that presumptive charity can be conferred based on a third-party analytic. Similarly, auditors should be apprised of the decision to implement a presumptive analytic. Their input should be incorporated into the process and policies.

Picking a Presumptive Charity Analytic

There are a range of presumptive charity analytics available to identify missed charity eligible accounts. In picking a model, consider the following elements:

- **Local calibration.** Poverty is heavily weighted to local economic circumstances and socio-economic attributes. Better predictive models will be calibrated during implementation to the hospital's specific community.
- **How the model handles households without bank accounts and credit files.** Credit based models may have challenges with this population. Socio-demographic models are often better able to handle households living in the cash economy.
- **Information required.** Some models require a current address and guarantor social security number for scoring. Understanding differences in data requirements is important as it can have significant impact on Patient Access activities.
- **Portion of accounts a model cannot evaluate.** Better models will have broader coverage, e.g. fewer accounts that are not able to be predicted or assessed. Some models cannot evaluate as many as 30% of self-pay accounts, while others will have issues with as few as 1-2%.
- **Sliding Scale Calibration.** Models differ in the extent to which they can be tuned to a hospital's sliding-scale discount, e.g. the discount offered at different income thresholds.
- **Acceptance by IRS, Regulators and Other Organizations.** With many different vendors offering models, understand the extent to which the model in question has been used in previous filings or been recommended as an effective solution.

Few Simple Steps Solve Growing Issue

Analytics are commonly accessed through simple web-based applications and can be connected to a patient account system through secure file transfer. The system generates a file for scoring and sends it to the scoring website, much the same way patient accounting systems generate bad-debt placement files today. The web-based scoring system picks up the file, scores each account and sends back a response file. Your patient account system grabs the file and automatically reclassifies accounts based on the score.

Within just a few weeks of selecting a charity analytic an organization can be automatically reviewing accounts as they age out to bad-debt. In some instances it is also possible to review, at initiation, existing bad-debt inventory and execute a one-time financial adjustment for those identified as presumptive charity eligible.

Adopting a presumptive charity analytic is a straightforward, cost effective solution to a problem of significant public concern. It is additive to a great financial counseling and patient access program, closing the loop on patients missed in current routines, incapable of participating, or reluctant to make themselves visible. Your patients win and so does your organization.❖

About the Author. Steve Levin is CEO and co-founder of Connance, whose products help hospitals and third-party revenue cycle vendors improve patient collections and satisfaction. Connance products increase a provider's self-pay cash, reduce costs and improve the patient experience throughout the collection process. Contact him at slevin@connance.com or visit www.connance.com.

News & Profiles
Wisconsin Chapter HFMA
5405 Pheasant Hill Road
Monona, WI 53716

PRESORT STANDARD
U.S. POSTAGE
PAID
MILWAUKEE, WI
PERMIT #5654

HFMA National's On-line Membership Directory

Have you visited HFMA National's On-Line Membership Directory lately? Here's the link: www.hfma.org/membership/. When you select "Membership Directory", not only can you search for members of our chapter, you can also search for all of you 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 assessing HFMA 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.

Editorial Statement

NEWS & PROFILES is the Official newsletter of the Healthcare Financial Management Association – Wisconsin Chapter. Published six times per year, the newsletter is sent to more than 750 individuals in the health care management field. Our objective is to provide members with information about chapter and national HFMA activities, as well as timely reporting of local, state and national issues and developments.

LETTERS TO THE EDITOR and other materials for publication should be sent to Philip J. Rohs, Apex Print Technologies, 5405 Pheasant Hill Rd., Monona, WI 53716. Direct Dial: 608-240-9488, Fax: 608-554-0003, E-mail: philr@apexprint.com

NEWS & PROFILES STAFF: Philip Rohs and David Cartier.

ADVERTISING INQUIRIES: Martha Henes, (262) 354-2237 or at mhanes@intellimed.com