



The GemStatement

Volume 16, Issue 2

September 2007

President's Message



Fall has arrived and with it the end of year triathlon that consists of the year-end close, the annual financial statement audit, and the preparation of the Medicare cost report. During this stressful time of year, I thought that a little bit of humor may help to lighten the load

- Q. Why do accountants get excited on Saturdays?
- A. They can wear casual clothes to work.

An accountant and a young CFO are applying for the same job. The boss said, "Boys, you need to take a test before you can get this job." So they took the test and the next day they came back to see who the boss chose. "Well," he said, "Both of you got the same score except I'm going to choose the CFO." The accountant complained, "Don't you think that's prejudice or something?" "Well," the boss said, "Let me tell you what happened. Both of your papers were right all the way through until the last question came up, and the CFO answered 'I don't know,' and then when I looked at your paper, you answered, 'Me either'.

- Q: What's the difference between an auditor and a vampire?
- A: A vampire only sucks blood at night.

- Q. What did they call the accountant who joined the army?
- A. General Ledger

On a serious note, please take advantage of our quarterly HFMA meetings to gain the education and contacts that makes year-end less of a nightmare.

Have a great fall.



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Patient Financial Management: As a Community Benefit

Cory Shank

Hospitals can better articulate the true extent of the community benefit they provide by sharing the ways their medical assistance outreach programs benefit the community.

At a Glance

Steps to take in documenting medical assistance advocacy include:

- Designating the program as a social service, not a collections effort
 - Detailing the program's practices
 - Identifying outcomes
 - Sharing the impact of advocacy efforts with the community
-

When it comes to reporting community benefit, hospitals tend to report charity and bad debt write-offs, losses from Medicaid or state assistance plan contractual adjustments, and perhaps even charitable contributions and education-related expenses. But there is one key component of a hospital's community benefit that typically goes unreported, and it is perhaps the farthest-reaching benefit provided: medical assistance advocacy and outreach, or the management of uncompensated care.

Most likely the reason these data go unreported is because the management of uncompensated care is typically a process of patient financial services, and it is first and foremost designed to prevent revenue loss. Therefore, it may not necessarily be thought of as a community service. However, at a time when challenges of some not-for-profit hospitals' tax-exempt status are gaining momentum, recognizing the community benefit of medical assistance advocacy outreach programs—and highlighting other services that also benefit the community—could prove to be a valuable strategy.

Last year, the Catholic Health Association, a nationally recognized authority on defining community benefit, published *A Guide for Planning and Reporting Community Benefit* for its members and the public. In a reference document for the guide, the CHA lists the following as items that should be counted as community benefit:

- Programs that respond to an identified community need
- Programs and services directed to at-risk persons, such as the uninsured and underinsured, community members representing diverse cultures, and persons who have limited English proficiency
- Programs offered to the broad community designed to improve community health

Every hospital and health system in the country has some mechanism for managing uncompensated care; it may be a team of social workers, an internal department of financial counselors, the use of an outside vendor, hiring state financial workers, or the combination of any of these. When hospitals assist patients in applying for coverage from Medicaid, state and county assistance programs, Consolidated Omnibus Budget Reconciliation Act of 1985, workers' compensation, and more, they are responding to concerns identified in these three items defined by CHA.

To realize the importance of medical assistance advocacy and outreach, and to understand its impact on the community, all one has to do is compare this process directly with hospital charity.- 2 -

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Comparisons with Charity Care

Hospitals give millions of dollars in the form of charity care to patients who are indigent and who have financial hardships. However, charity care does not cover ambulance bills, physicians' visits, and prescriptions, which are medical expenses most patients incur in correlation to hospital stays. Also, hospital financial assistance does not help community providers that may not receive any form of remuneration for the care they provide to indigent patients or for the supplies donated for treatment.

Consider this example: An uninsured woman presents to the hospital for pregnancy-related issues and delivers a low-birth-weight baby. When Medicaid eligibility is facilitated by the hospital's efforts, the patient and her family receive medical benefits. Other community providers that care for the critically ill baby also will benefit from the hospital's patient advocacy by receiving Medicaid payment for services rendered. So, although the process of uncompensated care management may indeed be a financial management process, it is also very important to the community as a whole.

To capitalize on patient advocacy efforts, it is important to do two things: define and exemplify the process, and develop and maintain a data management system to easily report this benefit provision.

Defining the Process

There are three main items to address when defining a medical assistance advocacy program:

- The service should be differentiated from any other collections effort.
- The practices and procedures of the program should be detailed and all potential outcomes identified.
- The way in which the program's efforts support the entire community's healthcare delivery system should be demonstrated.

Differentiate the program from any other collections effort. For an uncompensated care management program to work, it should be designated as a social service. This is fundamental to the success of the program, whether it is going to be cited as a demonstration of community benefit or not. For successful facilitation of this service, it is also important to provide patients and the community with information and education regarding the provision of this social service. Both steps are a necessary part of demonstrating that the program is a community benefit to the public, other providers, and governmental bodies.

The provision of an outreach and advocacy program and the delivery of charity care to the community is a public service, and the process of facilitating such a program should be sensitive to patients' cultural and economic differences. It should not be facilitated in a manner that creates barriers or difficulties in applying for assistance.

Interactions with patients in need of assistance should no longer sound like this: "In order to be eligible for our charity/financial assistance program, you must first apply for medical assistance and/or give proof of no other payment source."

Rather, interactions and policies geared to community service should sound more like this: "We provide a comprehensive service to assist patients in addressing the financial burden of their medical expenses. We not only sponsor charity/financial assistance, but also provide our patients and families with trained advocates who work to identify and facilitate any and all forms of coverage for their hospital bills."

Detail the program's practices and identify outcomes. If for nothing else, it is important to formally define the process so that a document outlining the process may be provided to public overseers. Detailing the program's specifics also allows for the quantification of the process in terms of expenditures for the program as well as reporting the millions of dollars of medical bills covered through the program.

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MEASURING THE IMPACT OF COMMUNITY OUTREACH ON SCREENED DISPOSITIONS, CY05

Status	Patients
Pending as of Aug. 8, 2006	632
Approved	13,775
Incomplete	4,715
Not eligible	16,987
Total	36,124

APPROVED OUTCOMES GENERATED THROUGH COMMUNITY OUTREACH

Outcomes	Patients Helped	Charges Covered
Bank financing	13	\$96,474
CMS 1011	192	\$7,362
COBRA facilitation	67	\$2,276,796
Crime victims' funds	75	\$1,353,105
Discovered insurance	1,189	\$22,269,728
Document retrieval for insurance	633	\$10,779,494
Indian Health Services	289	\$2,953,983
Motor vehicle policies	1,131	\$8,258,355
Other third-party liability	71	\$577,390
Public assistance	10,011	\$115,762,118
Veterans' assistance	59	\$1,422,869
Workers' compensation	45	\$486,638
Total	13,775	\$166,244,311

Real data from a set of hospitals in the Pacific Northwest underscore the impact of a successful patient advocacy program. These exhibits represent 54 hospitals ranging from critical access hospitals to large, urban medical centers. The exhibits reflect the number of patients served. A patient is not counted more than once, even if the patient has multiple accounts; however, the charges of the multiple accounts are included in the total.

Identifying potential outcomes also is important. Although Medicaid is the eligibility program most often applied for, there are many others. When Medicaid is not an option, there are crime victims' funds, Veterans' Assistance, Indian Health Services, and other tertiary payers that are important to identify in order to provide the most comprehensive benefit. What can really make an impact are the efforts to secure funding from payers primary to Medicaid: COBRA, workers' compensation, and third-party liability. By recognizing these possible outcomes, even the Medicaid system benefits from hospitals' medical assistance outreach programs, as the service helps conserve limited Medicaid budgets.

Last, it is also important to identify noneligible outcomes so that when adverse (collection) efforts are made, tracking these outcomes will substantiate these efforts by showing cause. Tracking noncooperation, loss of contact, and even denials for medical assistance due to excess income, resources, or other reasons will improve the hospital's defense of its collection practices. A comprehensive case management practice that focuses on advocacy can clearly show that the last resort in account resolution is collections by ruling out any other benefit or funding source first.

Demonstrate the impact of community benefit on the community. Once patient advocacy is defined as a social service and policies and procedures for its implementation are in place, the community benefit of this program—its impact on the community—can be demonstrated. This piece will be quantified through data management.

The easiest demonstration is the benefit provided to uninsured and underinsured patients and families. By providing an outreach service, health systems facilitate coverage for patients' medical bills in and out of the hospital.

Michael A. Banks, formerly CFO of Sacred Heart Medical Center in Spokane, Wash., describes how Sacred Heart has demonstrated the community benefit of a medical assistance outreach program.

In 2005, Sacred Heart facilitated benefits for 2,583 patients and their families, representing \$60 million in hospital medical bills. The assistance that patients have received from Sacred Heart in qualifying for healthcare benefits also has enabled other providers in the community to receive payment for their treatment of uninsured and underinsured patients.

Banks explains that Sacred Heart’s outreach and advocacy service was developed to do two things: provide much-needed community service to the uninsured population, and track the provision of the service in order to demonstrate the facility’s commitment to meeting the healthcare needs of its community.

“We worked hard to build functions in our IT system to track accounts through this case management process and to have our vendor build and conform its system to document, in detail, the extent of our joint work,” says Banks, now CFO, Alaska Native Medical Center, Anchorage, Alaska. “Using custom indicators, financial action codes, and insurance codes with our partner’s tracking abilities, we are able to report our successes to the most finite detail.

“Hospitals have always provided these types of services to their communities,” Banks says. “Now more than ever, it is necessary to also be able to quantify the services, and to build systematic ways to do just that.”

The coverage facilitated through medical assistance outreach programs often covers the patient’s family; whereas charity assistance is hospital assistance, patient advocacy is truly a community assistance program. The community benefit of such a program can be reported by showing how many patients and families were covered. The benefit can be quantified by showing the true charges covered by the outreach program.

MEASURING THE IMPACT OF PATIENT ADVOCACY, CY05		
Empire Health Services, Spokane, Wash.		
Outcomes	Patients Helped	Charges Covered
COBRA facilitation	5	\$96,012
Crime victims' funds	18	\$182,401
Discovered insurance	60	\$1,143,259
Indian Health Services	29	\$718,457
Motor vehicle policies	732	\$2,717,613
Public assistance	536	\$14,911,871
Third-party liability	23	\$167,391
Veterans' Assistance	12	\$372,067
Workers' compensation	10	\$138,242
Total	1,425	\$20,447,312

This exhibit comprises data from Empire Health Services in Spokane, Wash., which operates two community hospitals. The exhibit reflects the number of patients served. A patient is not counted more than once, even if the patient has multiple accounts; however, the charges of the multiple accounts are included in the total.

Be sure to detail the benefit provided to the entire network of community providers, which would be defined as a broad fulfillment of community benefit. Facilitating medical assistance coverage provides much-needed payment to smaller-size providers who do not have the resources or basis for developing this account management service, mitigating losses incurred for treating indigent and patients with hardship. In one northwest community, physician practices have been afforded the opportunity to request eligibility information for patients seen in the hospital from the eligibility vendor for the four main hospitals. Tracking this information can show, in numbers, how community providers benefit from the hospital service.

Understand that for every successful outcome for medical assistance that the hospital facilitates, the hospital itself will be better able to provide financial assistance for those patients who are not eligible for other benefits and have no option for assistance other than charity care.

Reporting the Effort

To be able to tell the story of how the community benefits from an outreach service, the hospital must have a means to report its efforts in both narrative and quantifiable ways. A community benefit report, similar to an annual report, can be prepared that

describes how the hospital expends its resources to care for the community's social wellness, with numbers to illustrate the impact.

A few basic classification elements can be attached to accounts to allow for quantifying the effect created by an outreach program, the first being "screenings." Tracking how many accounts the program works with is important in order to determine a baseline of indigent care provided as well as to correctly attribute expenses for providing the program. For example, if a hospital only tracks how many accounts become approved, it will have difficulty demonstrating the total amount of indigent care delivered as well as its total expenditures in providing the service to patients.

Another key element to track is status or disposition. There are basically three potential outcomes in patient advocacy: approved, not eligible, and incomplete. "Approved" indicates success in facilitating coverage. "Incomplete" refers to one of two basic outcomes: The patient was uncooperative, or efforts to locate the patient were unsuccessful. "Not eligible" applies to accounts that were worked completely, and the disposition (denial) was justified due to excess income, resources, or some other programmatic disqualifier. When implemented well, efforts to collect from truly disqualified patients are more palatable and objective, and exclusion from charity assistance is more defensible.

A third key report indicator is the type of eligibility facilitated. By reporting the diverse set of outcomes, a hospital will be able to demonstrate the complete measures taken in providing care for the uninsured and underinsured.

Depending on the implementation mechanics, tracking these elements is a matter of classification within the patient accounting system as well as via the vendor's system to which this program is outsourced. All systems should have some way to stamp accounts with these basic reporting parameters, either by financial action codes, payer codes, or canned notes.

First and foremost, the hospital's patient accounting system should have a unique identifier that marks which patients' accounts are passed through this outreach service. This indicator should remain attached to the account permanently. Many hospitals use insurance codes (i.e., "Medicaid Pending"). The issue here is that when the account is approved, the insurance code should be changed to "Medicaid" for billing purposes; if the patient is not eligible, the insurance should be changed to "self-pay," making it hard to uniquely categorize the accounts for later reports. One simple solution employed by many hospitals in eastern Washington was to create a custom field in the "customer defined screen." The field was created with only three options.

If the field was never populated, the account was not referred for the outreach service. A "Y" indicates the account is active in the process, and an "N" indicates the account has reached disposition.

Once this process was put in place, the hospitals then developed fields for financial action codes and used their vendor's account taxonomy to categorize accounts that have either the "Y" or "N" designation. Accounts were classified not only by disposition, but also by the type of benefits facilitated (i.e., Medical Assistance, COBRA, VA, crime victims' funds). In fact, the partnership these Washington hospitals have with their service provider allows the hospitals to break down the types of eligibility facilitated by the program (i.e., pregnancy related, children's medical, disability related, and Temporary Assistance for Needy Families) using a unique class system.

Using these standard populated fields to run queries makes running reports that quantify the extent of community benefit provided both easy and accurate.

Sharing the Outcomes

Just as medical assistance advocacy and outreach is perhaps the farthest-reaching community benefit that hospitals provide, quantifying this benefit—and reporting the impact of this service on the community—is one of the most important opportunities that a hospital has in demonstrating how it is fulfilling its mission. Sharing the extent to which medical assistance advocacy and outreach benefits the entire community will foster goodwill toward the hospital—and help protect the tax-exempt status of not-for-profit organizations.

About the author

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HFMA's IDAHO CHAPTER RECEIVES NATIONAL AWARDS

CHICAGO—The Healthcare Financial Management Association's (HFMA's) Henry Hottum Award for Educational Performance Improvement and the John M Stagl Silver Award of Excellence for Education, were presented to the Idaho Chapter in June 2007 during the 54th Annual Chapter Presidents Dinner and Meeting at HFMA's Annual National Institute in San Diego, California.



The Henry Hottum Award for Educational Performance Improvement recognizes chapters that achieve a significant increase in educational performance from one year to the next. The award is based on exceptional growth in registrant hours over the last year. These awards honor HFMA's voluntary leaders and their chapters.

In addition to the Henry Hottum Award for Educational Performance Improvement, the Idaho Chapter also received the John M. Stagl Silver Award of Excellence for Education, which recognizes chapters that achieve outstanding performance in educational programming.

HFMA President and CEO, Richard L. Clarke, says, “The Idaho Chapter provides a great example for HFMA's 2007-08 Chairman's theme —Make a Difference. So many of their members are actively involved...contributing, sharing, and making a difference. Everyone applauds their family spirit, which shines through their many accomplishments. ”

The Idaho Chapter would like to thank President Calvin Carey and Vice-President/Program Chair Luke Zarecor for an outstanding and educational year.

Help Wanted

Business Office Director

Live, work, play and make the beautiful area of McCall, Id your home!

We are seeking an experienced and enthusiastic individual to join our team to manage and schedule Business Office staff and monitor functions to ensure achievement of revenue cycle performance.

Reporting to the VP of Finance and Support Services, the Business Office Director is responsible for maintaining appropriate internal safeguards over patient A/R and collection of cash; ensuring compliance with relevant regulations, standards and directives from regulatory agencies and third-party payers; establishing Business Office policy to maintain constancy of purpose focusing on continuous improvement and delivery of the highest degree of quality service possible; managing patient registration, switchboard and patient billing.

Known for personalized and timely patient care, McCall Memorial Hospital's mission is to be a community-sponsored service providing quality primary health care and promoting wellness.

Requirements: Ideal candidates will have previous hospital/healthcare and business office management experience with a minimum BS/BA degree. Successful candidates must value relationships and demonstrate business acumen. Strong interpersonal, financial, computer and communication skills are required. Must have leadership competencies, including goal achievement, people development, personal mastery, team orientation, innovation, commitment to service, organization, resourcefulness and reward/recognition. Personal values must be aligned with organizational values of Integrity, Trust, Relationship, and Vitality.

Visit us online at www.mccallhosp.org. Resumes may be sent to ledwards@mccallhosp.org. EOE. Open until filled.

ORHS's Efforts to Improve Patient Access

Work Quality and Accuracy

Chuck Kramer

Since implementing web-based Registration Quality Improvement (RQi) in June of 2005, Orlando Regional Healthcare System (ORHS) has measured 99% billing accuracy for all registrations. ORHS records 50,000 registrations per month and one day AR of \$2.6 million annualized.

“With RQi we are able to look at the account in two ways: Discharged (D) and Billed (B). With our manual process that was showing us 10% of accounts registered, we were usually in the 83-85% range,” said ORHS Director of Patient Business Craig Pergrem.

“As a corporation, we stand at 99% and have not been lower than that since May 2005. Several of our facilities maintain a score of 100% at “B” status, as well as, many of our representatives maintain 100% in both “D” and “B” accounts.”

Upon implementation, management was able to learn about the system in a live environment for one month. Following that, RQi was rolled out to staff with a 30-day grace period to learn the system without having it impact their coaching plan score.

“RQi is a continuous education tool that each staff member receives daily.” Pergrem said. “They are able to look at their errors on a daily basis and not only see what they did wrong, but get a chance to correct it themselves and know why the error was made.”

“The reporting capabilities in RQi allow us to pull reports on individuals for that period and break it down by error and the total account dollars that could be or were impacted with those errors.”

ORHS has been working to improve patient access professionalism, accuracy and accountability for years. By implementing RQi, ORHS has implemented the newest most cutting edge and cost effective way to review and account for 100% registration and information accuracy while achieving a level of employee training and accountability never accomplished before.

For more information on Registration Quality Improvement, contact Chuck Kramer at 407.872.7969, chuck@kramergroup.com or visit www.kramergroup.com.

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2007 – 2008

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