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Official Newsletter of the North Dakota Chapter of the Healthcare Financial Management Association

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Presidents Message

by Mike Schumacher

I hope everyone is enjoying the summer. It seems like yesterday that I decided to run for the North Dakota Chapter Board. Six years later I find myself in a very important role as your President. I want to thank the Chapter members for this wonderful opportunity. I also want to thank Becky Hansen, our Past President, for her influence, encouragement, and friendship as she guided me through the chairs. Becky's leadership and dedication has enabled the Chapter to offer excellent education and networking opportunities to our members and their organizations. Recently the North Dakota Chapter, under Becky's leadership, was recognized at the national level with the following awards for fiscal year 2006-2007:

- o The Charles F. Mahler Gold Award for Education
- o The Helen M. Yerger Special Recognition Award for Education

Congratulations to Becky and our other chapter leaders who worked so hard throughout the year to achieve these awards. Also, a thank you goes out to our Chapter members for attending Chapter educational meetings, volunteering, and being a part of this great organization.

Planning for the Upcoming Chapter Year

On April 11th the Chapter Board met in Fargo for its annual planning session. Discussion on our goals and objectives for the upcoming fiscal year along with assigning committee members and discussion of the fiscal 2008 budget were covered. The Board also reviewed strategic plan initiatives, developed educational programming for the upcoming year, and discussed future collaboration opportunities with the North Dakota Hospital Association (NDHA) during the meeting. I am happy to announce that we will be offering an educational session on September 12, 2007 in Bismarck in connection with NDHA's fall conference.

We also discussed the many changes at National HFMA (National) and how these changes will be impacting our Chapter including National's transition to a "Balanced Scorecard" concept for measuring chapter performance. It should also be noted that on April 6th, at the directive of National, the North Dakota Chapter separately incorporated under the State of Illinois. The Chapter's bylaws were also amended to conform to recommendations from National.

"Make a Difference"

"Make a Difference" is HFMA's theme for fiscal year 2007-2008. In late April, Chapter Officers Jodi Atkinson, Steve Lindemann, Paula Wilkie, Lori Kudrna-Blees, and I attended National's Leadership Training Conference in San Diego. The conference was very informative and we came back with several ideas to improve our educational programming and member communications in the coming year. Stay tuned! It's been a busy and gratifying time to be a board

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member with the Chapter. The many opportunities to network with chapter members at the state, regional, and national level have been the most rewarding for me, and I highly recommend each one of you consider running for the Board or volunteer to participate on a Chapter committee. We all can "Make a Difference".

Thank you again for this opportunity to serve as your President. I am excited about the upcoming year and look forward to networking with you at future Chapter events. Take care and have a wonderful summer.

Mike

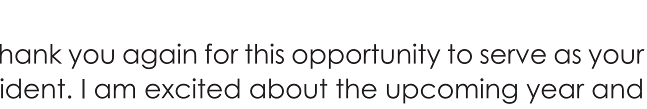
PREVENTING BAD DEBT BY ASSESSING PATIENTS' PAYMENT HISTORY

BY THE ACADEMY OF HEALTHCARE REVENUE

Patient access representatives are often the first face-to-face point of contact patients have with a hospital. However, sometimes the patients who arrive for treatment have received services from the hospital before—and have failed to pay their financial responsibilities. The question of how best to serve these patients has become more important for providers as margins grow tighter, and as hospitals' financial health must be balanced with providing high-quality healthcare for all patients who need it. In fact, according to The Academy's research, bad debt as a percentage of gross revenue has increased in recent years at surveyed hospitals nationwide, from 2.9 percent in 2005, to 3.2 percent in 2007.

Patients who have failed to pay their portion of healthcare costs in the past pose a conundrum for healthcare providers. To respond to this dilemma, at best-performing facilities patient access staff members are frequently the ones who identify these patients, assess the situation, and determine which course of action to take. Academy research shows that at least half of surveyed facilities use key patient data at point of service in order to guide staff members' actions. By providing these staff members with consistent policies and effective tools, leaders can help their patient access staff to consistently identify patients with a history of bad debt and take strategic steps to protect the organization from incurring it further.

Accurately identifying patients with a history of bad debt is the central issue. In order to do this effectively, patient access staff must have clear



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visibility into each patient's payment history. Consistently reviewing each patient's payment history and key financial criteria also helps registrars and patient financial counselors to more accurately and reliably identify patients who qualify for charity care or financial assistance. With this insight into each patient's account history and ability to pay for services, patient access staff members are placed in a better and more informed position to help all patients resolve their accounts. Additionally, identifying patients who are eligible for financial assistance consistently enables hospitals to better allocate their billing and collection resources, focusing collection efforts on the accounts of patients who are able to pay—and providing financial assistance to those who are not.

To check each and every patient account history would be an extremely time-consuming and labor-intensive task if manual methods were used. This type of data tracking and checking is most efficient when providers are able to develop a degree of automation that helps staff to efficiently assess accounts upfront.

For organizations to implement expanded front-end patient account data checks, several steps must be taken. First, it is important to identify the specific data in patients' payment history that will be tracked and used to guide front-line staff members' interactions at point of service. Once the pertinent patient financial information to be tracked has been identified, integrate the system where this information is stored, such as the master patient index, with scheduling and registration systems. For instance, organizations may configure their registration systems to flag patients who have previously accumulated bad debt and who have previously qualified for charity care (or other financial assistance programs), so that patient access staff members are alerted when these patients return to receive further treatments.

For example, one community hospital in Colorado makes use of its IT systems to alert patient access staff members about incoming patients with bad debt, as this hospital's staff members check to identify if patients who are arriving for non-emergent services are in the organization's Master Patient Index due to a previous visit. If a patient has accumulated bad debt in the past, the system flags the patient's name with a flashing red indicator. This lets patient access staff members know that they should refer these patients to financial counselors so that they can discuss their current and prior balances, while also attempting to finalize some type of payment arrangements when appropriate.

In addition to developing automated alerts issued to revenue cycle staff, leaders must also make a dedicated effort to train staff members in both pre-registration and registration on specific steps to take based on the alerts they receive, especially if these staff members are unfamiliar in conducting financial interactions with patients. For instance, staff members could be trained to always connect patients who have previously accumulated bad debt with financial counselors before scheduling these patients for non-emergent services.

Organizations aiming to decrease bad debt

continued on page 4

Bright Ideas ...

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and increase point of service collections should strongly consider implementing strategies that enable front-end staff members to view key elements of patients' payment history, helping staff to assist each patient effectively. By adopting this approach, providers can reduce bad debt by gaining visibility into patient accounts early in the revenue cycle, and then take appropriate action with patients who are identified as having past due balances.

You can reach The Academy of Healthcare Revenue at 888.700.5223 or contact@healthcarerevenue.org

OIG DECIDES NOT TO DEFINE EXCESSIVE CHARGES

The Department of Health and Human Services Office of Inspector General (OIG) announced it would not move forward with a final rule to define excessive charges. The OIG stated that it could not identify a "single, fixed numerical benchmark" that would apply across the industry. In addition, the OIG expressed concern that the rule might increase healthcare costs.

The OIG stated it would "continue to evaluate billing patterns of individuals and entities on a case-by-case basis." Individuals or entities found to charge "substantially in excess" of "usual charges" can be excluded from the Medicare program, but the OIG's long-standing position is that "when calculating their 'usual charges' for purposes of Section 1128(b)(6)(A) [pertaining to exclusion for excessive charges] individuals and entities do not need to consider free or substantially reduced charges to (i) uninsured patients or (ii) underinsured patients who are self-pay patients for the items or services furnished."

CATHOLIC HEALTH ASSOCIATION RELEASES PRINCIPLES FOR HEALTHCARE REFORM

The Catholic Health Association of the United States has released a draft document, Our Vision for U.S. Health Care, which includes principles against which reform proposals can be assessed.

Included are principles stating that the healthcare system should "provide a basic health benefit package to everyone" and "never limit access to health care coverage based on one's age, health status, employment status or financial means."

The principles are being made available for comments from Catholic health care leaders, caregivers, administrators, and other professionals, whose input will shape the final document to be released later this year.

REDESIGNED FORM 990 INCLUDES SECTION ON HOSPITAL COMMUNITY BENEFIT

The IRS released for comment and discussion a draft Form 990, including a new portion designed to quantify community benefit of tax-exempt hospitals. Form 990 is the annual return required to be filed by tax-exempt organizations to report information about their operations. The IRS hopes to have the form ready for use for the 2008 filing year (returns filed in 2009).

Of special interest to hospitals is a new form, Schedule H, that attempts to quantify the community benefit standard applicable to tax-exempt hospitals. The IRS used the Catholic Health Association's community benefit reporting model for Schedule H, which includes sections on:

- Billing and collection practices
- Management companies and joint ventures
- Community needs assessment
- Identification of all the facilities the organization operates for the provision of hospital or medical care
- The redesign of Form 990 is based on three guiding principles:
- Enhancing transparency to provide the IRS and the public with a realistic picture of the organization
- Promoting compliance by accurately reflecting the organization's operations so the IRS may efficiently assess the risk of noncompliance
- Minimizing the burden on filing organizations

In releasing this redesigned form, the IRS said it is soliciting comments, especially in connection with the goals of increased transparency of information and use as a compliance tool. The comment period lasts until Sept. 14, 2007.

AMERICA'S TOP CEOS OUTLINE KEY STEPS TO HEALTHCARE REFORM

Business Roundtable, an association of CEOs whose companies represent more than 10 million

employees and provide healthcare coverage for more than 35 million Americans, unveiled Health Care Costs in America: A Call to Action for Covering the Uninsured, which includes the organization's principles for healthcare reform.

Business Roundtable is also a founding member of Divided We Fail, a national effort with AARP and SEIU designed to engage healthcare consumers, elected officials, and the business community to find broad-based, bipartisan solutions to healthcare and long-term financial security issues.

Calling for a combination of private market reforms and changes in government programs, the Business Roundtable's principles assert, among other things, that all Americans must have access to affordable coverage, that they have a responsibility to obtain coverage (catastrophic coverage at a minimum), and that safety nets play an important role and low-income individuals may need subsidies.

"These principles are based on the premise that the employer-based healthcare system is valuable, and the CEOs of Business Roundtable are committed to maintaining and improving it," said Mike McCallister, CEO of Humana and chairman of the Business Roundtable's healthcare task force.

COLLECTION AGENCY PERFORMANCE: MONITORING TO IMPROVE

By The Academy of Healthcare Revenue

In an era of increasing self-pay balances (with every hospital surveyed reporting that their patients had noticeably larger residual self-pay balances), hospitals' relationship with and management of collection agencies is vital. This is especially true given the significant portion of self-pay accounts that these vendors 'touch', whether the accounts are outsourced at day one or outsourced as bad debt accounts after a period of 180 days, for example. Furthermore, the number of hospitals with contracts for outsourcing all billing and collection processes has grown significantly in recent years. As a whole, The Academy's research has found that more than three-quarters of surveyed providers outsource uncollected self-pay accounts to collection agencies within 120 days of service.

Maintaining frequent contact with collection agencies and monitoring the practices they utilize is important for two primary reasons. First, this helps hospitals to prevent scrutiny and possible litigation by ensuring agencies use appropriate tactics when pursuing payment from patients, thus enabling hospitals to maintain their good reputation in the community as well. As the president of the Catholic Healthcare Association once stated, scrutiny over hospitals' practices often results more from hospitals' "inattention than from a deliberate decision to hound poor people." Hospitals must pay attention to their collection agencies' practices and also identify patients who are unable to pay in order to prevent these types of problems from occurring. To proactively prevent any type of scrutiny, best-performing hospitals may bring all representatives from collection agencies onsite and train representatives by utilizing the same training that hospitals' own collection staff receive, focusing on key issues like collection guidelines and standards of practice.

Another reason why it is vital to monitor agencies' practices and performance is to identify strategies for increasing self-pay collections (agencies' recovery rates) and ultimately reducing bad debt. Regularly tracking several performance-driven metrics for the collection agencies used by your organization via agency report cards can help you to identify if changes should be made in order to increase collections, such as how and when accounts are distributed. Several items can be included on these report cards, including the following metrics:

- Total collections made by each agency
- Number of patient complaints received
- Number of times each agency pursued legal action against debtors (if this practice is allowed by the hospital)
- Total percentage of accounts resolved by each agency
- Total dollars collected vs. the total value of all accounts each agency receives
- Average time from when an agency receives an account until the time a collection is made

Tracking this type of data serves several purposes, such as providing leaders with objective information for comparison purposes. An increas-

ing number of providers are contracting with two or more collection agencies to foster competition in an effort to bolster collections; 56 percent of hospitals responding to an Academy survey reported that they then reward best-performing agencies with a higher percentage of patient accounts. However, this type of incentive program requires revenue cycle leaders to pay strict attention to agencies' practices to ensure that competing for accounts does not lead to practices that could be construed as over-aggressive.

Another benefit of using multiple collection agencies is that accounts which one agency is ineffective in pursuing over a specific time period (e.g., 4 – 6 months) can be transferred to competing agencies. This enables each of hospitals' agencies to utilize their specific strategies in an attempt to resolve accounts.

While closely tracking collection agency performance, utilizing incentives to drive up recovery rates, and transferring uncollected accounts between agencies are best practices, revenue cycle leaders must realize that regular communication is needed with all agencies to whom accounts are outsourced. Frequent phone conversations and face-to-face meetings allow both hospital and agency leaders to examine agencies' performance and confront any issues that arise, such as below-average cash collections or the unintended outsourcing of accounts that may qualify for charity care. These types of discussions also provide leaders with the opportunity to ensure that collection agencies remain aware of and compliant with hospitals' fair collection guidelines—a must in an era of increasing self-pay balances and scrutiny.

You can reach The Academy of Healthcare Revenue at 888.700.5223 or contact@healthcarerevenue.org

CMS REQUIRING NATIONAL DRUG CODE ON MEDICAID CLAIMS

The Deficit Reduction Act includes a request that providers begin reporting by Jan. 1, 2008, the National Drug Code for certain drugs and biologicals provided to patients in an outpatient setting for claims paid by Medicaid. The purpose of the NDC reporting is to enable Medicaid to obtain rebates from the pharmaceutical companies that manufacture those drugs.

Although the provider community generally agrees that Medicaid is entitled to the rebates, there is much concern regarding the reporting of the NDC on institutional claims. For one thing, obtaining the NDC and then applying it to an institutional claim is currently a labor-intensive and manual process. However, the primary concern is that the NDC is issued by the drug manufacturer and does not always correspond with how the drugs were dispensed in the hospital setting; it is not a one-for-one match.

Also, many pharmacy systems monitor their inventory through internal codes typically assigned through a chargemaster; these codes are not aligned with the NDC. One option, identified in the DRA, is to report the J codes in place of the NDCs. (J codes, which consist of five alpha-numeric characters, were developed by CMS and identify certain drugs and biologicals.) The final rule is expected to be issued in July.

New Members!!

Ryan J Moorse
Analyst
Blue Cross Blue Shield of ND
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Janice K. Porter
Contract/Denial Supervisor
Altru Health System
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Pamela Unrah-Bettenhausen
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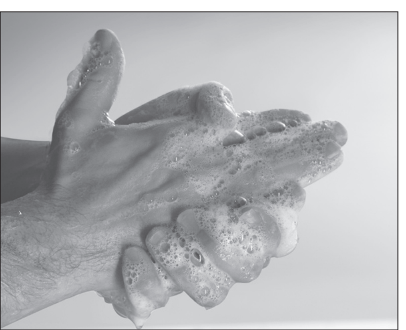

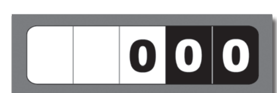

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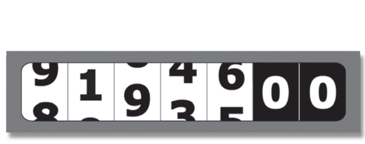

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- ✔ Concordia Institute
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For more information or if you have suggestions for conference topics, please call Jodi Atkinson at (701) 228-9312

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