



Annual Institute
June 7-10, 2010
The Hilton Sandestin Beach and Golf Resort

The Annual "Beach" Meeting will be held in San Destin, Florida, June 7th through June 10th, 2010.

ROOMS

Rooms are going fast, please call today to ensure you're on site with us!! You can reach the hotel directly at 850-267-9500. The group code is HFM.

REGISTRATION

You can register via website and view the full agenda of speakers along with their topic description. Please register as soon as possible and join the fun activities we have planned.

Make sure if there are any events you plan on participating in to mark the event as you register or notify Sherri Harper via email: sherri.harper@na.first-source.com your intention if you have already registered.

GOLF

Cam Pearl is the coordinator for this event. To make your reservation mark this on the registration form in the designated area. Cam needs a minimum of 40 participants. Sign up early and don't miss out on the great opportunity to relax with some of your peers. Email: cpearl@agilisllc.com

KIDS NIGHT OUT

BACK BY POPULAR DEMAND – Kids Night out will be Monday from 5:30 to 9:30pm. This will be a fun time for children to get away from their parents while the adults are at the open-

ing reception. There will be t-shirts for each child, games, dinner and ice-cream including a lot of fun entertainment for all.

The event has been sponsored for the 3rd year so there is no additional cost, it's free! This will be 4 hours of fun-filled entertainment just for kids...children must be 4 – 12 years of age to participate. We need a minimum of 10 children in order for the function to take place. Contact Stephanie Martin via email: stephanie.martin@helenkeller.com if you plan your child/children participating.

If you have children under 4 you will need to make arrangements with the hotel facility for that service.

ADDITIONAL BEACH FESTIVITIES



Save the
Date
June 7-10, 2010
Hilton Sandestin Beach
and Golf Resort
Destin, FL

www.alabamahfma.org

 **hfma**™ alabama chapter
healthcare financial management association

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2009-2010 Leadership

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Vicki Parks, CPA, FHFMA
St. Vincent's Health System

Yolanda Rich, MBA, CHC
St. Vincent's Health System

President's Message

As I begin to write this, my last message as your 50th President, it is with mixed emotions; (some happy/ some sad). While I have been serving as President of the Alabama Chapter, I have had the opportunity to attend many functions at a National, Regional and Local level. I have made many new friends during this time and some of those I will always cherish. Leadership Training, ANI, Fall Presidents' Meeting, Dixie, and our own meetings are some that I had the pleasure of attending. Yes it has been a journey and one I will always remember!

We have celebrated this year to **THE MAX**. Everytime we have had an opportunity, it seems there was a cake of sorts. We have celebrated just to celebrate. Isn't that what families do? Just remember, we celebrated at our annual meeting in June and again at our Fall meeting in November. We even had a 50th CD made to remember the years and one was given to everyone that attended the Annual meeting (we do have some extras if you would like one). I, much like many presidents before me, came into office with many things to accomplish and soon realized I needed to concentrate on a few.

So, here are a few of the accomplishments that was targeted for this year.

- **Benevolence Project**

Coats for our Vets: During the Fall meeting we had the honor of presenting over 400 winter coats to the Veterans Administration for vets and their family members. What a suc-



Linda J. Maddox
President

cess!. Thank you Johnathan for a job well done!

Coffee for deployed soldiers: We joined with the Region 5 states, Florida, Georgia, South Carolina and Tennessee in an effort to send coffee to our soldiers in Iraq. Close to 300 bags of Boca Java coffee were sent to our troops for this combined project. I know they appreciate the special contribution and we appreciate each of you that took the time to give.

- **NEW FACES:**

We had the opportunity to bring in several new faces this year to the chapter as volunteers but : One that many of you have become very fond of: **FACEBOOK, Yes Facebook for our Alabama Chapter is now in place.** ARE you a part of that?

- **Chapter goes GREEN**

Have you missed the Bama Chatter showing up on your desk this year? As a way to go GREEN, and save the chapter money, it was decided to use only the WEB for the distribution of the Chatter. Special thanks to Libby Bailey for helping get this one in place.

- **Certification**

Vicki Parks, current Past President took on certification with a passion this year. Vicki's goal was to obtain at

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2009-2010 Leadership

DCMS Contact

Randy Comer
Athens-Limestone Hospital

Founders Contact

Donna Ezell, RN
Athens-Limestone Hospital

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Libby Bailey, CPA, FHFMA
Callahan Eye Foundation Hospital

Membership Chair

Lonnie Younger, CPA, FHFMA
Huntsville Hospital

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50th Anniversary Chair

Yolanda Rich, MBA, CHC
St. Vincent's Health System

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CFO Co-Chairs

Kim Shrewsbury, CPA, FHFMA
Decatur General Hospital

Craig Tolbert

PricewaterhouseCoopers, LLP

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Leigh Aufdemorte, RHIA
Callahan Eye Foundation Hospital

least a bronze and hopefully silver award for this program. WE are very close, and hopefully we will be able to announce good results at the end of the year. If you have not been certified, I encourage you to give it a thought.

● Added Education in new areas

We have heard you, and as an added effort this year, we took a one day seminar to Huntsville. You, the members supported this with over 100 attending and 12 sponsors in the vendor exhibition area who were there to help support the function as well. Tracy McCowan, with Huntsville Hospital was instrumental in putting this together and we all want to tell her once again; Thank You Tracy! WE WILL BE BACK BY POPULAR DEMAND. Next year plans are already in the making for taking a one day session to Montgomery and hopefully someone will step up and help us with one in the Mobile area.

● Road Shows

Back by popular demand, Tavie Bender PFS Forum Chair Person and her committee took education from the North to the South. Providers supported the efforts by coming out and speaking about new and upcoming changes. A great way to get additional education to your hospital employees! GREAT PROGRAMS TAVIE!

● Education Hours

We have increased our member hours this year to over 14 hours per member. We are in place for a Bronze award from National HFMA. All of this did not just happen. IT took all of the committee chairs and their members and other volunteers to make this happen.

I want to personally thank each and every one of you that contributed this year in some way - my mentors, you the members, all of our sponsors, all volunteers, those sitting for certifica-

tion, committees and those responsible for bringing the education of excellence to the chapter, and all of those that have supported our meetings. Thank you all for giving us the opportunity to network and for believing in HFMA ALABAMA! YES WE ARE ONE OF THE STRONGER ONES. YOU know what they say, "The strong survive".

To you the members: we have heard you loud and clear, and as leaders of the chapter, we hope to answer many of your questions and concerns. Please know that with all the extra volunteers, and the new ones to come, we can address every area that is needed. If you feel we have not, please let us know. If you are not involved, please consider the opportunity and let us know. There is plenty for us all to do.

Stephanie I wish you the best as you look ahead to your year as President. It is a great experience and one I know you too will treasure!

To my family, thank you for sharing me this year! I will soon have a few spare moments.

I can't begin to name all of the very special friends who have helped me along the way. I will be forever grateful! You know who you are and I am so fortunate to have you to serve with.

IT has been my PLEASURE to serve you the members! I have enjoyed every minute of the journey. Remember this year's motto? "**MAKE IT COUNT**". Make it count each day and in everything that you do! I know that motto has made a change in me.

May God bless each of you and your families daily!

- Linda Maddox
President 2009-2010
HFMA Alabama Chapter





Sandcastle Building Contest, come play in the sand and see who can build the grandest sandcastle or sand-animal! Sand buckets, shovels, fun and prizes will be awarded.

Water Balloon Toss, teams of two, how far can you throw while tossing between your legs and over your heads backwards. The last team with a balloon not popped wins prizes.

DINNER / ENTERTAINMENT

Get ready for a great evening social event with well known music from a blast of our past to the present, hosted line dancing and a chance to show your stuff....prizes will be awarded. Following dinner stretch your toes on the beach join us by the Bonfire and roast marshmallows and make S'mores.....as we gaze into the sky and enjoy a Firework Celebration.

EXHIBITS

Booth registration is now open to EVERYONE and we currently have a few spaces available. Contact Jeff Burkhardt via email: jburkhar@uab.edu for more information on exhibiting.

SPONSORSHIP OPPORTUNITIES

Sponsorship opportunities are open to anyone that would like to contribute. If you have marketing items that you would like to contribute to the conference, please contact Stephanie Martin via email: stephanie.martin@helenkeller.com. Deadline for receipt of items will be May 20.

I encourage each member to come join the fun & festivities at the beach. The Alabama Chapter is truly a remarkable group of healthcare professionals. Together we can "STEP UP" to the future challenges we face as healthcare reform becomes reality accepting changes as opportunities to excel and prosper. This conference has always been a special time to spend with family and friends.

I want to thank all of those that are participating this year. Especially to our speakers that provide a wealth of information to us. To our sponsors, vendors and exhibitors if it were not for your continued support it would be impossible for us to meet. To our members "old" and new without you our organization would not be the success that is today. Thank you for your continued support! I look forward to seeing each of you there!!!

- Stephanie Martin
President Elect

stephanie.martin@helenkeller.com



Annual Institute Keynote Speaker

Richard L. Clarke, DHA, FHFMA



Dr. Clarke is president and chief executive officer of the Healthcare Financial Management Association (HFMA), Westchester, IL, a professional membership association with more than 35,000 members in 68 chapters who share an interest in the financial management of the delivery of healthcare services. He has held this position since June 1986.

He holds a bachelor's degree in Industrial Distribution from Bradley University, Peoria, IL (1970), a master's degree in Business Administration (MBA) in management/finance from the University of Miami, Coral Gables, FL (1972), and a Doctor of Health Administration (DHA) degree from the Medical University of South Carolina, Charleston, SC (2005).

Dr. Clarke attained Fellowship in HFMA in 1983. He also was president of the Colorado Chapter of HFMA, served on the HFMA National Matrix, and was a member of HFMA's Principles and Practices Board. Dr. Clarke currently is the Immediate Past Chair of the Commission on Accreditation of Healthcare Management Education, having served in various capacities for that organization

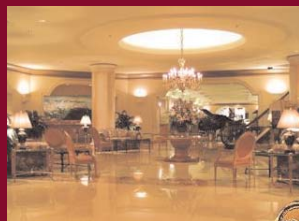
since 1997. He is also a former chair of AHA Financial Solutions, Inc. (a wholly owned subsidiary of the American Hospital Association). Additionally, he has served on the Federal Reserve Bank of Chicago's Advisory Council. Dr. Clarke currently holds an adjunct faculty position in the Department of Health Systems Management at Rush University in Chicago and also serves on the CHRISTUS Health Board of Directors.

Dr. Clarke writes a monthly column in HFMA's magazine, Healthcare Financial Management, and has written numerous articles on healthcare finance in HFM and other magazines and journals. He co-authored the books, Capitalizing Medical Groups: Positioning Physicians for the Future, published jointly by HFMA, MGMA, and McGraw-Hill in 1998, The Crisis in Health Care: Costs, Choices and Strategies, published by Jossey-Bass in 1990, and Beyond Managed Care: How Consumers and Technology are Changing the Future of Health Care published by Jossey-Bass Inc. in the summer of 2000.

Save The Date!

**2010 Fall Institute
November 11 and 12, 2010**

**The Wynfrey Hotel
Birmingham, AL**



HFMA's 2010 ANI The Healthcare Finance Conference

June 20-23, 2010



**Gaylord Opryland Resort
and Convention Center
Nashville, Tennessee**



Form 990 and Implications of Healthcare Bill: Time to Belly Up to the Table & Dig In

- *Doing Business with Board Members ; conflicts of interest ; independence*
- *Healthcare Bill's 'Special' section for Hospitals: Community Health Needs Assessment, Financial Assistance Policy, and more*
- *Sch H & K: Bond Compliance & Community Benefit/Charity Care*

In Scandinavia, a 'smorgasbord' is a buffet style meal, but in the South we call it 'a mess of somethin'. It's nothing new that hospitals are being hit with all kinds of new rules and regulations. However lately, with the revised Form 990, Healthcare Reform, etc. hospitals are being hit with a smorgasbord of new rules on a whole new level. The kicker is – we can't pick and choose as if we were at the buffet line. We must eat EVERYTHING. On this grand buffet board relationships and conflicts of interest are the lima beans, the collard greens are Schedule H's charity care and community benefit calculation, Community Needs Assessments/Financial Assistance Policies/Billing & Collection Practices are those strange fruit salads that have way too much mayo, and post issuance bond compliance is definitely the mystery fish swimming in a translucent liquid.

In this short article, we will attempt to address each of these issues and hopefully provide some insight and helpful ideas to get things started.

Business, vendor, and family relationships between both the organization and officers, executives, and key employees AND between officers, executives, and key employees themselves are now reportable to a much greater degree on the Form 990. The challenge is that the person in charge of completing the 990 (perhaps the controller and/or CFO) can't always know about these relationships. If you've had the pleasure of delving into the 990 form and instructions, the questions to identify reportable transactions can become very cumbersome. Varying rules apply to different situations with varying thresholds. For exam-

ple, if a board member's sister-in-law works in the cafeteria (making over \$10,000), that relationship as well as the sister-in-law's name and compensation has to be disclosed on the Form 990. The IRS REQUIRES that the organization put forth a 'reasonable effort' to collect this data (i.e. they have to be ASKED). Current and former officers, directors, trustees and key employees should be given a questionnaire on an annual basis. The questionnaire works well as an 'addendum' to the organization's conflict of interest policy and the completion of this form fits well within the board meeting setting. **TIP:** *Ask your 990 preparer for a sample 'relationship questionnaire' and have them attend the board meeting in which this questionnaire will be addressed.*

Charity care and community benefit calculations bring in a whole other dynamic to the Form 990 reporting. There is no doubt that this section of your hospital's Form (Schedule H) will be compared and contrasted with other hospitals by the IRS, your community, 'watchdog' groups, and other hospitals. The Health Care Bill stipulates that the Secretary of the Treasury will be required to review a hospital's community benefit activities at least every three years. Presumably this would include a review of the 990 and Schedule H. Tax exempt status could be questioned for those statistics falling outside of the norm. **TIP #1:** *Gather your team – 990 preparer, reimbursement person(s), community events coordinator(s), etc. and get them on board. They should be familiar with Schedule H way before it comes time to actually file the return. You can also lean heavily on specialists in this area to complete a 'mock Schedule H'. Tip #2: Keep in mind that the hospital's estimate of bad-debt expense (at cost) attributable to patients eligible under the charity care policy is an extremely important number. Watch this closely as things unfold in healthcare reform, because there will be an obvious connection between these numbers on the Schedule H and Medicare/Medicaid disproportionate share payments and funding.*

Largely due to the efforts of Senator Chuck Grassley, the Health Care Reform Bill (Patient Protection and Affordable Care Act) has enacted many new requirements directly addressed at tax exempt hospitals.

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Form 990 and Implications of Healthcare Bill: Time to Belly Up to the Table & Dig In, continued



Among these includes a “tightening up” of hospitals financial assistance policy, policy relating to emergency medical care, limitations on charges, and billing and collection practices. We’ve seen a flurry of activity in these areas over the past few years, so no new surprises here. Perhaps a little more news-worthy is a mandate for hospitals to complete a Community Health Needs Assessment. These Assessments must be completed once every three years, with the first one is ‘due’ by March 23, 2012. A \$50,000 penalty applies each year that a hospital doesn’t comply (presumably \$150,000 for one three-year cycle). Of course the bigger ‘penalty’ could be further IRS attention and unwanted publicity. Here’s a few of the more thought provoking requirements: (1) if the hospital operates more than one facility, an assessment would need to be completed for each facility (2) the hospital must also adopt an “implementation strategy” that meets the needs identified in the assessment, and (3) input is required from persons in the community including persons with expertise in public health. The third point raises the issue that the hospital is being charged with a task that is more of a local government obligation. **TIP:** *Plan on completing early. Talk to your audit partner to see if they can lead you in the right direction. Make sure you understand the planned components of the ‘public input’ portion prior to work being performed.*

Although tax exempt bonds were not a part of the Health Care Bill, they deserve an honorable mention. Most entities with tax exempt bonds will be required to file on the Form 990 a new Schedule K. This Schedule is similar to the Schedule H filing (for charity care and community benefit) in that Schedule K also requires advanced planning, many employee hours, and, very often, external assistance. Bond counsel and the trustee can also play an important role in completing this Schedule. We know that the IRS has initiated a very concerted effort to grow their personnel to allow for more audit activity. We have already seen more tax exempt bond audits in the last year, especially among healthcare providers. Schedule K will provide the IRS a very convenient way to determine who gets audited. Don’t be fooled by the brevity of Schedule K (only 4 parts, 2 pages). Schedule K is loaded with pitfalls. **TIP #1:** *Complete Schedule K now. Almost all of the data on the*

*Schedule K is not specific to the tax year, so no time will be wasted by preparing now. **Fiscal year entities will complete the entire Schedule for fiscal year ending in 2010. TIP #2:** Coordinate with the bond counsel, trustee, and tax preparer to address problem areas. Some common areas that may need improved documentation include: (1) data related to proceeds allocation, (2) tools [schedules or outside software] that track compliance with private use rules including the use of bond financed property, and (3) arbitrage rebate and yield restriction calculation/report.*

Your buffet of areas to address is likely much more expansive than the few discussed above. Some are more palatable than others. If these issues are the lima beans of your ‘to-do’ list, 2010 is the year to address these four key areas. The effort needed to achieve successful compliance will be great. The process will be made easier by organizing internal staff and enlisting the help of specialists. It’s time to belly up to the table & dig in!

- Amy Bibby, CPA
Senior Manager, Dixon Hughes PLLC
and
Curt Miller, CPA
Member, Dixon Hughes PLLC

About the Authors

Amy Bibby is a CPA with Dixon Hughes. Amy focuses 100% on healthcare tax issues and not for profit organizations. Amy can be reached by calling 828.254.2254 or by email, abibby@dixon-hughes.com.

Curt Miller is a healthcare audit member in the Birmingham, Alabama office. Curt is a CPA and has more than 25 years of healthcare accounting experience. Curt can be reached by calling 205.212.5300 or by email, wcmiller@dixon-hughes.com.



Top Ten Health Industry Issues in 2010

The healthcare industry was disrupted by external forces in 2009, placing organizations in a reactive mode. In 2010, there will be opportunities for organizations to move past the issues of the past year and stay ahead of the changes affecting the industry. The primary drivers of these opportunities will be an organization's ability to capitalize on new and existing relationships, impending health reform and regulatory change, and consumer demands. The following is an overview of the major points discussed in *The Top Ten Health Industry Issues in 2010: Squeezing the Juice Out of Healthcare* article published by PricewaterhouseCoopers' Health Research Institute.

Healthcare reform will continue to be a major issue in 2010. Already during the Obama administration, there have been several reform initiatives enacted, including an expansion of SCHIP to provide coverage to more children and increased investment in health IT and prevention programs under the federal stimulus plans. These measures are viewed as only the beginning of what could be a complete overhaul of the health care delivery system in the United States. As the debate continues regarding the extent of reform needed in the industry, providers, payers, and pharmaceutical companies must all prepare for and respond to regulatory changes as the legislative process plays out.

Consumers and businesses in all industries continue to feel the effects of the economic recession. While most industries experienced flattened growth as a result of the economic downturn, healthcare spending continued to increase during 2009. It is expected that the industry will see increased pricing pressures during 2010. As a result, cost reduction initiatives are being undertaken in a number of areas where providers, payers, and life science companies are looking to create additional savings. Among these, costs related to medical device and pharmaceutical agreements, purchased services, health insurance coverage for dependents, and the administration of insurance plans are already being targeted within the industry.

Reimbursement from government programs will con-

tinue to influence the industry in 2010. The government is shifting their reimbursement philosophies from volume-based to quality-based payments. There are a number of financial incentives available to healthcare providers who adopt and/or upgrade their current technology capabilities. As a part of the stimulus plan, the government is offering additional payments to providers who adopt electronic medical record systems. It is important that providers take advantage of these incentives while they are available as many of them will expire in the future.

The penalties for committing fraud have become much more severe. In addition to monetary fines, executives could face jail time as a result of their actions related to fraud and abuse. Losses from fraud continue to be in the billions and the Obama administration has made this an emphasis in its healthcare reform initiatives--this includes increasing its fraud and abuse budget by nearly 50% for 2010. Industry stakeholders must keep up with current prevention practice and ensure that controls are in place to stave off any opportunities for fraud to take place.

Telecommunications corporations have begun to take advantage of increased use of their products in the healthcare industry. Companies such as Verizon and AT&T have introduced products that offer services ranging from remote consultations to nationwide health information exchange zones. Telecommunication companies are well positioned to take control of a greater percentage of the healthcare business. The relationship between telecommunication companies and healthcare organizations was fostered by the need for communication channels that delivered specialized IT capabilities. This trend will likely increase because recent stimulus packages passed through Congress include monies designated for telecommunication-related upgrades.

Pharmaceutical companies have begun to focus on providing more comprehensive services to patients as growth in traditional revenue streams continues to

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Top Ten Health Industry Issues in 2010



slow. This shift in philosophy will have great influence on the healthcare industry as these companies begin to positively impact patient outcomes. The effects of this change are four fold. By supporting innovations in patient care, pharmaceutical companies will gain trust among consumers and be viewed as a positive force in healthcare. Pharmaceutical companies will forge relationships with providers and payers that will have a positive impact on health spending. The pharmaceutical industry, through its partnerships with other industry stakeholders, will have a positive impact on patient outcomes. And, the alignment of pharmaceutical companies with payers will aid in controlling costs while improving the utilization of treatment by patients.

Realignment of physicians with hospitals is occurring as instability in the market and rising costs continue to drive change. Providers are seeing decreased reimbursement related to physician-owned practices/services. Since 1994, physician employment by hospitals has almost doubled. Some healthcare systems are proposing a model of realignment with physicians called accountable care organizations (ACO). These ACOs are thought to improve cost controls and quality through more effective coordination of care between providers and payers. As the trend of physician employment continues to gain momentum among providers, systems will need to evaluate their relationships with physicians and consider all partnership opportunities.

Demand for better access to care and inefficiencies in the healthcare delivery system are forcing consumers to seek out less traditional, more convenient options for receiving treatment. As this shift in consumer demand continues, more alternatives are being created for providing care and providers are looking at alternative methods for delivering services to patients. Growth in home healthcare and disease management markets are expected to be around 25% in 2010 and in the years to come. We are seeing an increase in the number of retail health clinics in the market. The role of non-physician providers is set to expand as a result of this shift delivery methods.

Once again, the flu will put a strain on providers as people seek treatment for its symptoms. Experts

expect the flu to intensify this year. This includes another wave of the H1N1 strain. If this prediction comes true, it is expected that hospitals in many states will be left at or near capacity. While the CDC recommends all healthcare workers be immunized from the flu, it is estimated that only one in every three follows through. In response to this threat, organizations should educate their employees on prevention, care, and containment.

Community health initiatives are starting to be recognized and rewarded by government programs. The stimulus plan included millions of dollars directed at community health initiatives. Many of these initiatives are centered around educating the public on wellness and disease management. There are opportunities for providers to take advantage of these efforts. They can grow new health and wellness programs to attracting individuals to participate. Join the effort to promote and improve community health will also allow systems to enhance their corporate responsibility and community benefit efforts. Innovation and sustainability in the delivery system could be solidified through arrangements between systems and public programs.

As is apparent from the issues described in this write-up, there remains a great deal of uncertainty in the healthcare industry. An increased emphasis is being placed on controlling and reducing costs. Increased focus on quality measures will aid in driving the industry. The impact of non-traditional providers entering and expanding upon their services in the patient-delivery system is expected to be great. It is important that administrators stay ahead of the curve with regards to regulatory changes to ensure the long-term viability of their respective hospitals and health systems. The impending healthcare reform will have significant impact on the industry.

**- Lee H. Hammonds
Health Industries Advisory
PricewaterhouseCoopers, LLC**

Internal Delay Management - Hidden Cash Sources and Potential A/R Reduction

Successful Revenue Cycle management consists of bringing together numerous sub groups of cash maximizing, account resolving ideas and processes. This group of ideas comprises the model under which each hospital works. Clearly there are hundreds of processes that must be integrated in terms of timing and other dependencies. Much attention, as should be the case, is given to the key flashpoints within the Revenue Cycle – Preadmission, Point of Service, In-house, Unbilled, Billing, Follow-up, Collections, Reporting, etc. Unfortunately there remain numerous obstacles to resolution which have accumulated on hospital Aged Trial Balances.

As hospitals perfect or improve core areas, the focus shifts to more drill down details that can have a significant impact on each organization. When these second tier details are managed well, hospitals realize the marginal advantage in increased cash, reduction in the aged receivable and the ability to improve on a leaner work force. In the alternative, not addressing delay management, hospitals will incur some of the highest opportunity costs as high volume low dollar accounts and some high dollar accounts fall into the a growing “black hole” of non-worked or inefficiently worked accounts. ***In our analysis of several facilities of various sizes we noted between 8-12% of the aged receivable was tied up in some type of internal delay.*** This is over and above the DNFB delays which all hospitals should be closely monitoring.

As reimbursement rates, payer delays and other obstacles continue to impact Revenue Cycle performance, PFS professionals must maximize results especially in areas that can be controlled internally. Each hospital needs to determine whether or not they have a proper Internal Delay Management Program. This “second tier” area of Revenue Cycle Management whereby a hospital realizes marginal pick-ups and opportunity cost prevention is a proactive Internal Delay Management Program. These programs are especially effective as the delay elements are generally within a facilities internal control. Internal Delay Management is the process or portion of the model assigned to processing, monitoring and improving on internal delays. The following further outlines Internal Delay Management.

Elements of Internal Delay Management

- 1) Identification of delay items,
- 2) Control of the delay item statistics,
- 3) Ownership of each delay items,
- 4) Standards for turnaround of each delay item,
- 5) Procedure for each delay area,
- 6) Statistical Outcomes.

Delay Item Examples

- 1) DNFB – Although there is a component of DNFB which is dependent upon physician participation, in many cases this area is controllable as the delays are in coding or transcription. The hospitals should distinguish physician related delays versus other delays and employ the proper strategy for each type. The DNFB should also be reported and trended by type of delay. Since DNFB is generally well reported and addressed in most hospitals the focus of this review is more on the non-DNFB internal delay areas.
- 2) Medical Record Requests-Medical Record requests have diminished over the years but are still happening. Certain types of claims or certain payers will always require a Medical Record or portion of a Medical Record (ie Worker’s Compensation claims or certain Emergency Department claims). In these cases, if determined to be a valid request and a correct mailing address, the records should be sent with the original bill. Medical Record requests should first be qualified by staff. Question the need and narrow the request to the minimum amount of information necessary to process the request. This will eliminate some of the needless delays and provide a smaller burden on the Medical Records department or the person retrieving the request.
- 3) EOB Requests- Explanation of Benefit Requests are primarily needed for secondary or supplemental billings and follow-up.
- 4) Timely Filing Requests- Insurance companies want proof claims were filed timely. The hospital must identify acceptable documentation (usually from your billing/scrubber company).
- 5) Appeal Requests-The hospital should identify when an appeal is worth pursuing and which payers are amenable to appeals. Many insurance companies will pay for accounts with technical denials if you appeal and send certain minimal information.



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- 6) UB Request (and 1500's if applicable) - UB requests take the form of re-bills if the representative is told the account is not on file. In these cases they will need to verify the information. If we simply re-bill the account it may once again not make it to the payer. In most cases the UB requests are related to the secondary and supplemental billings.
- 7) Utilization Review Request- Utilization Review requests refer to situations whereby the payer does not agree with the consistency or level of the coding. These are often chargemaster issues with the hospital or the payer. A clinical employee generally needs to review these to determine if an error was made or if they can support refining the information to comply with the payer chargemaster.
- 8) Adjustments – If adjustments are centrally processed these will need to be tracked and processed timely.
- 9) Bill/Re-bill/Corrections – Similar to UB requests with appropriate changes or modifications.
- 10) Payment Researches – Relates to payments documented as paid by the payer but not posted to the account. This potentially impacts unapplied, credit balances, cash, account balances and/or patient account aging.

Control of the Delay Items

- 1) Identify when it is cost beneficial to pursue each of these items based upon resources available, potential return and regulatory requirements.
- 2) The hospital should use status codes or queues to group these accounts.
- 3) If there is not a good tracking system with the hospital's legacy system then a bolt on application should be considered.
- 4) The system should allow you to group the accounts, age the delay on an account level, age the accounts in a summary level and relieve the account from the status or queue once the item is received.
- 5) One challenge is to track multiple delay items e.g. a request for a UB and EOB on a secondary claim. Combining these "multiple request" accounts in reporting may overstate the impact.

Ownership of each Delay Area

- 1) The department and person responsible for fulfilling the request must be involved and understand the report tracking, the importance of the timely processing, the agreed upon standard, etc.
- 2) Someone from within PFS must ultimately be responsible for the integrity of the numbers, following through with the next steps as the requests are fulfilled, reporting and providing feedback to all, including upper management.
- 3) A process to foster feedback from the Delay Management program should be set up with a mission to include identifying systemic fixes and tactics to refine the request process.

Standards for Turnaround of each delay item

- 1) Standards should be set for the turnaround time of each type of request or delay area.
- 2) Standards must be agreed to by all involved.
- 3) Compliance to the standards must be graded weekly.

Impact of Internal Delay Management Programs

- 1) Improved cash flow as claims are processed more quickly,
- 2) Reduced losses due to timely filing denials,
- 3) A/R days reduction as claims are resolved more timely,
- 4) Opportunity gains as staff is more efficient in processing like claims and not having to re-ignite these delayed claims on a 1 off basis.
- 5) Marginal cash is key to success.

Summary

In summary it is essential to manage all aspects of your receivable. An Internal Delay Management Program and review will help hospitals understand the aged portion of their receivable. By taking action to ensure the controllable portions are clean hospitals will realize significant benefits and will be able to draw attention and improve the areas beyond their control.

- Tom Westerkamp, Principal, Westerkamp Group, LLC
tmwest@westerkampgroup.com, www.westerkampgroup.com

Tom Westerkamp is the founder and Chief Strategic Officer of Westerkamp Group, LLC (WG). Tom has delivered results oriented, third party early out programs and other revenue cycle solutions within the healthcare industry for over twenty eight years. Westerkamp has provided extended business office services, consulting and interim management to hundreds of hospitals and managed the collection or resolution of well over a billion dollars of hospital revenue.



MEMBERSHIP COMMITTEE

Who We Are:

Lonnie Younger, Huntsville Hospital, Chair
Chris Allen, Amsher
Annette Baker, Blue Cross/Blue Shield
Jonathan Bedell, MedAssist, Inc.
Megan Elliott, Warren, Averett, Kimbrough & Marino
Ryan Schultz, PricewaterhouseCoopers, LLP
Carol Slivka, Huntsville Hospital

NEW MEMBERS: JANUARY

Dee Long, Manager
MedAssist, Inc.
Sponsor: Linda Maddox

David Jones, Vice President, Business
Development
RealTime Medical Data
Sponsor: Eugenia McWilliams

Laura Gossett, Business Manager
INRI Medical Associates, PC

Sherree Clark, Executive Director
Jane Yoakum, Contract Manager
Huntsville Hospital

Katie Bynon, Medical Record Director
Helen Keller Hospital

Edward Hill, Student
Kathryn Parker, Student
Jamie McAdams, Student
Caroline Sarratt, Student
Brandon Wallace, Student
Nikaeta Georgwis, Student
Melissa Schuermann, Student
Carl Landry, III, Student
Corey Everett, Student
Samantha Wiginton, Student
Peter L. Basten, Student
Jordan Voigt, Student

Allison Clemmons, Student
Joshua Hewiett, Student
Claire O'Rear, Student
Kathryn Haley, Student
William M. Hill, Jr., Student
Graham Walton Howard, Student
Christopher Brown, Student
Kanwar Singh, Student
Samuel Lynd, Student
Richard Foy, Student
John Kyle Bremer, Student
Joshua Moore, Student
Kristin Harris-Heald, Student
T. Jones Bush, III, Student
Derrick Wheeler, Student
Sponsor: Jeff Burkhardt

NEW MEMBERS: FEBRUARY

Michael McCann, Division Director, Patient Access
The Children's Hospital of Alabama
Sponsor: Dana Blackman

Jim Kent, Area Manager
Medical Pay Solutions

Paris Owens, Patient Services Coordinator
MedAssist, Inc.

Keith Wooten

Rebecca Baggott, Student
Taleah Collum, Student
Josue Patien Epame, Student
Rudy Allen Lindsey, III, Student
Harold Neumeier, Student
Calvin Elam, Student
Caresse Campbell, Student
Olena Mazurenkno, Student
Atanur Yilmaz, Student
University of Alabama in Birmingham
Sponsor: Jeff Burkhardt

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NEW MEMBERS: MARCH

Brenda Bryant, Tradeshow Coordinator
The SSI Group

Ria Story, Regulatory Affairs Manager
East Alabama Medical Center

Brian Patterson, Government Billing Supervisor
Baptist Health System

Brad Stein, Director, Hospital Financial Operations
St. Vincent's Health System
Sponsor: Vicki Parks

Vickie Lux, Director, Business Office
Russell Medical Center

Anna Arnold, Business Development
Armstrong & Associates
Sponsor: Ashlye Hix

Kristine Marsh, Regional Vice President, Sales
Executive Health Resources

LaDonna McDaniel, Financial Manager
Prattville Baptist Hospital

Derek Daniel, Assurance Manager
Joseph, Decosimo & Company, PLLC

Jeff Wall, Regional VP, Spend Management
MedAssets

Wendy Koch, Director
MedAssist, Inc.
Sponsor: Linda Maddox

Suzi Achter, Director, Revenue Integrity
Huntsville Hospital

Erin Snow, Student
Julianne Vaughn, Student
Sponsor: Jeff Burkhardt

TRANSFERS

Mike McKnight, CFO
Stringfellow Memorial Hospital

Danny Hinson, Director Sales & Compliance
PMAB, LLC

Maron Joseph Boohaker

Daniel Brazen, Vice President
Healthcare Treasury Sales Consultant, US Bank

Make it Count is the national slogan for HFMA and we are COUNTING on our current members to help grow our Membership.

\$25 Cash Card
when you recruit a new member.

\$50 Cash Card
when you recruit a Sr. Financial Executive

Welcome to all our new members and transfers. I would encourage each of you to consider volunteering in the chapter.

Lonnie Younger, Membership Chair



Reminder

The CPAR test will be held on
Saturday, May 15, 2010 from
8:30am - 1:00pm

If you have any questions, please
contact Tavie Bender by phone
at: 205-599-3846 or via email:
tavie.bender@
trinitymedicalonline.com



A Message from the Region V 2009-10 Regional Executive



I had the pleasure of participating in the Fall President's Meeting (FPM) with representatives from Region V Chapters. The five Presidents of the Alabama, Florida, Georgia, South Carolina and Tennessee Chapters attended along with their President-Elects. We also had representation from the HFMA National Board. The time was well spent discussing items that were priority; not only for National, but also for all the chapters; and which all ultimately centered around 'you' the 'membership'. Their number one Goal is making sure they are continuing to provide the Value to you that is even more important today through communication and education opportunities, whether it be in workshops, seminars, teleconferences, publications or websites. Everyone was open with what was working or wasn't working in their chapters and were eager to share and benefit from each other's knowledge.

Since the FPM, I have also participated in calls with the Chapter's Leadership and have attended several of the Chapter Board meetings. In mid-February, I attended the Region V Dixie Institute in Charleston hosted by the South Carolina Chapter. It was an excellent site for a meeting and the speakers were great. The overall attendance exceeded their plans and the meeting was a huge success. In case you haven't attended one before, the Dixie is a nice way to get outside the Alabama Chapter for Education at less expense than the National Institute. They rotate

this meeting through the 5 regions and it will be hosted by Tennessee next year.

Although I already knew it, I am even more convinced of the Strengths of the Chapter in Region V and the dedication of your specific Chapter Leadership in Alabama. The time spent to keep your chapter not only running, but to make it even better with less, is



Mitzi Winters, FHFMA, CHAM

amazing. As we all know, our day jobs keep us pretty busy, so the midnight oil is burning with a lot of your Chapter Leaders. If you aren't participating in your chapter in some form, I would highly encourage you to get involved. Every chapter is reaching out to their membership through committees to engage members in their areas of interest. Sometimes, I think our problem is that we make it look too simple. You come to an event and it goes smoothly (hopefully) and you don't realize the number of hours and the number of people that worked behind the scenes making it happen. Trust me; you would be amazed in most cases - lots of behind the scenes work.

Being a member of the Alabama HFMA Chapter since 1989, I have had the pleasure of direct participation and it is a fulfilling feeling. Having the honor of being Region Executive for one of the BEST Regions has been a humbling and educational process. So think about what you'd like to do, or maybe an area that you feel needs concentration. With the HFMA year quickly coming to an end, contact a Board member and MAKE IT COUNT for you and for your Chapter.

**-Mitzi Winters, FHFMA, CHAM
Region V - Regional Executive**



Robert M. Coats Policy

Policy Number 8 - Effective Date June 1, 2009
 Revision Date November 13, 2009 - Revision 2

Purpose

An annual award shall be made for outstanding individual contribution for betterment and growth of the Alabama Chapter, HFMA. All members of the Alabama Chapter, HFMA shall be eligible except elected officers. The period of achievement to be considered shall be from May 1 to April 30. The award shall be presented at the annual meeting and shall consist of the following:

**WHO SAYS HARD WORK
 DOESN'T PAY????**

You could be the next Outstanding
Member of the Year.



Policy

The award shall be presented at the annual meeting and shall consist of the following:

1. The recipient will receive paid registration and lodging (limited to \$2,000) to one HFMA sponsored event
2. The cash award must be used within a two year period from the date of the award
3. The recipient will receive a plaque relative to achievement.

The winner will be determined as follows:

Points

1.	Attendance at Chapter's Annual Institute	250
2.	Attendance at Fall Meeting	200
3.	Attendance at Dixie Meeting	100
4.	Perfect attendance at Annual Institute, Fall and Dixie	100
5.	Attainment of FHFMA (in year of attainment)	300
	(each year thereafter)	100
6.	Chairman, Committee	300
7.	Member, Committee	150
8.	Participation in National HFMA role	100
9.	Sponsor new member	25

*Limit of 5

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Robert M. Coats Biography

The origins of naming the Alabama Chapter's Outstanding Member Award after Robert M. Coats began in 1951 when he joined Ernst & Ernst. His dedication to his profession, his firm and, later, his industry were already there. Bob was the only person not affiliated with a hospital at the first meeting of the Alabama Chapter-American Association of Hospital Accountants now known as HFMA.

Bob is credited with steering Ernst & Whinney into the healthcare field and being a pioneer in providing accounting and consulting expertise to the healthcare industry. He also made friends across the country and started or helped many careers in healthcare. He served HFMA in many roles. He was chairman of the Uniform Accounting and Cost Reporting in connection with Third Party Cost Reimbursement Formulas project in 1962. The results of this project produced a cost reporting system that was one of the forerunners of the current cost reports and cost studies. He was awarded the William G. Follmer Award in 1969 and the Robert H. Reeves Award in 1974 in recognition of his active role in HFMA. He also earned the Muncie Gold Award in 1986. Prior to his winning, only eight Alabama Chapter members had received the Muncie Gold Award.

On October 31, 1986 the Alabama Chapter voted to name the Outstanding Member Award in his honor. Although he never received this award from the Alabama Chapter, nearly every recipient was influenced by Mr. Coats. Many of the recipients worked for him at Ernst & Whinney. Although he easily could have put himself into the position to be the outstanding member, he preferred instead to encourage and support others. That was the kind of man he was

COATS AWARD WINNERS UPDATE (FOR UNUSED AWARDS BY PAST RECIPIENTS)

The Coats Awards Policy has recently been updated and approved by the Board of Directors.

The change made is the timeline in which the award must be used or it will be forfeited.

For any of you past winners who have not used the award, and it is over 2 years old, you will have until the end of June 2010 to use it.

It may be used at Annual or ANI. If for any reason it cannot be used at that time, we do apologize; but due to financial planning of the chapter, we felt the need to update the policy for more accurate budgeting.

Please send an email to Eric Jeffries, current Treasurer, at Eric.jeffries@bhsala.com and advise him of your intent to use the award before the expiration guidelines.

Thank you for your understanding.

The 2009-2010 Voting Board

Linda Maddox, President

Spring





Greatest Revenue Cycle Cash Resource

The Greatest Revenue Cycle Cash Resource? Your People.

To Healthcare Business Office Executives, From an Industry Veteran:

I've spent more than 25 years in healthcare, specifically working in or with business offices and patient access departments. When discussing front-line staff members and their impact on the overall revenue cycle, business office managers constantly tell me either: a) their front-line employees just don't understand how to do what needs to be done, or b) the hospital is limited in the type of people (education level, experience, etc.) they can hire due to geographic area, competition with larger facilities, salaries or other related issues. These excuses – blaming the people behind the desk – are cited over and over again when explaining an under-performing patient access department.

However, the one thing I have found to be always true is this: "There is no greater cash resource than people." Don't believe me? The following 10 steps can show you how to change lost dollars into cash, simply by maximizing the skills of your people. I've been there – on the front lines, in the management office, and now on the other side looking in from a different perspective – and I've seen these steps work wonders.

1) Recognize that you did not hire inadequate people. Many times, very talented people become buried in the chaos of daily tasks, or perhaps their skills become limited simply due to lack of training in what they have been hired to do. During the interview process, you saw something special in every individual on your staff that made you choose to employ him or her. For those employees who were there before you, they too were interviewed and chosen at some point. You did not hire limited, unskilled or inadequate people.

2) Start over: Pretend all your employees have just been hired. They are all skilled, capable individuals, waiting to be taught to do all you need them to. Consider and then accept the fact that there are no members of your group who can't contribute to a winning team – but there may be some who won't.

3) List the tasks that must be completely *accurately* and *timely*. Make sure your employees understand what tasks mean, and that they know exactly how to do them! Repeat, repeat, repeat.

- Patient must be registered accurately.
- Insurance must be verified accurately.
- Collections attempts must be made on all patient-due portions accurately.
- Precerts must be obtained accurately and timely.
- Billing must occur accurately and timely.
- Payment must be posted accurately and timely.

4) Set reasonable, step-by-step goals for the business office based on the tasks that must be done.

Share these goals with all employees. Explain how every individual plays a part in meeting the goals. Let them know what part they play. Post results for AR days, upfront cash, unbilled accounts and net revenue. When setting goals, don't begin with your "dream" of where you would like to be. Begin with "better than you are now," and raise the bar every time a goal is reached. If you are currently collecting \$50,000 per month, set the goal at \$55,000. When \$55,000 is reached, raise the bar to \$60,000. Implementing a team incentive program that includes the goals you have set will keep the employees focused on being the best and keep them striving to do even better. Start small and increase the bonus as their financial contribution increases.

5) Identify a leader. The newly appointed leader may be a supervisor, or she or he may be a great registrar, biller or collector. But there is always one individual who has either been with the facility long enough to learn a lot about the revenue cycle, or has a true desire to be the leader and spends his or her time learning, helping others and proposing ideas. This individual has communication skills, believes in the facility, and is well respected by coworkers. Make this individual your facilitator with your new staff (see Step 2). He or she will make things happen because this leader is not afraid of change, needs to feel needed (in a good way),

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and loves sharing knowledge.

6) Let the leader train. Challenge the new leader to train on a new topic at least once each month. The topic may be something as simple as “What Are Days in AR?” or “Determining Coinsurance” or “How to Process Charity.” Or, the subject matter could even be something new to the leader, something he or she has to learn and research before training. Allot at least one hour each month (yes, that’s only 12 hours per year) to training everybody. Consider: The registrar who understands that the facility doesn’t get paid if you don’t have a precertification will be much more likely to ensure precertification is obtained during the registration process.

In addition to monthly training, have the new leader train individuals daily. Train billers to register patients, train collectors to be cashiers, train registrars to collect cash. Train, train, train. *Knowledge is cash.* Knowing what to do and when to do it results in dollars collected, dollars properly billed and denials eliminated. Solicit feedback from the leader on who the key performers are. Remember, there are none who can’t, but there may be some who *won’t*. On that note ...

7) Get rid of those who won’t. By now, you are witnessing and identifying skills you did not know your team members had. On the flip side, you also may be noticing those who are negative, who do not want to participate in reaching goals, and who constantly drag down the rest of the staff. (Many times, these are the people you always thought had the best skills.) Ask them to join your “new” team, and let them know the consequences if they don’t. If they don’t change, let them go. They are slowing down your progress.

8) Provide feedback. Post results for those goals you made in Step 4 (another good assignment for the leader). Identify those who made you successful. Posting number of accurate registrations by registrar, cash by registrar, or unbilled by biller is not negative feedback. It’s reality. When employees see who does the best, they solicit input from the best to see what they can do better. Hiding results leads employees to believe everyone performs at the same level – and can be depressing, or at the very least discouraging, to those who are doing all the work. Posting results allows those who are not pulling their weight to see themselves compared to others. Build the competition among employees based on facts. This approach will take away the excuses and instill pride and competition.

Greatest Revenue Cycle Cash Resource



9) Don’t tolerate excuses. “We don’t know how to ask for money.” “We only have one person who can do that.” “We are too busy.” “We’ve always done it this way.” No more excuses! Stress that the team you have chosen will complete tasks accurately, timely and as a team. Let them know you only require that they be the very best at what they do.

10) Reap the rewards, and reward the team. Because your staff now knows how to do their tasks, and they are working together as a team to accomplish daily jobs and assignments accurately and timely, *cash will increase, days in AR will go down*, and bad debt will decrease. All of these results have a direct impact on the cash keeping your facility financially viable. Make it a point to let your team – and all of administration – know the improved revenue cycle is a direct result of your team’s effort and hard work. Continue to reward them, and continue to post those results. They are now proud of their work, and proud to be part of a winning team.

Irene Barron is chief operating officer and product management officer of nTelagent, Inc. (www.ntelagent.com), which has developed a point-of-service collection solution called the Retail Application for Healthcare. Barron has more than 25 years of experience in business office operations and revenue cycle management, with extensive knowledge of registration, insurance billing, collections and reimbursement, as well as overall monitoring and reporting of accounts receivable.





Minimize Your RAC Financial Risk

Seven Ways to Minimize Your RAC Financial Risk

The Recovery Audit Contractor (RAC) demonstration project found over \$1,000,000,000 of improper payments from just a handful of states. The permanent program will likely generate several times that amount. Even though your organization may not be receiving many complex review letters yet, you should be preparing to minimize your financial exposure as much as possible. Here are seven ways to accomplish just that:

1) Mail Yourself a Mock RAC Letter

Many providers are concerned about how the RAC letters will be handled in their facilities. Some popular questions are: Who will the RAC letter be routed to within our hospital? How long will it take for that letter to get to the right person after we receive it from the RAC? Will there be any consistency to how our internal team treats this process?

One quick and inexpensive way to address these questions is to mail yourself a letter as if it was from your RAC. Go ahead and make it look official, address it to the person who is responsible for RAC letters and document exactly what day you put it in the mail. Then, wait to see what happens. Even if you are already receiving letters from the RAC and they appear to be handled correctly, I would suggest that you mail a sample letter every month to ensure that your process is still running smoothly. (If it is not, wouldn't you want to learn that from a practice letter before you miss a deadline with your RAC because the right person did not receive their mail in time?)

2) Review All Four RAC Websites

All issues need to be formally approved and posted on the RAC websites before they can pursue those

with providers. Given that, review your regional RAC website on a weekly basis to see if there are any updates. However, do not stop there. Take a few minutes every couple weeks and review the other three RAC sites as

well. If a different region has had success with a series of DRG's, it only is a matter of time before your RAC will add that to their approved list as well. Be pro-active and see what is going on from a national basis and get your team prepared. You can learn more about the four national RAC's at: www.aha.org/rac.

3) Increase Your Billing & Coding Resources

While medical necessity was the category that produced the most improper payments during the demonstration project, the permanent program has only approved DRG related issues as of the first quarter of 2010. Many hospitals have built up their RAC team largely focused on clinical resources, but they do not seem to have added certified billers and coders to meet the increased demand that is soon to be coming. If your facility gets inundated with RAC letters, your existing team members will likely not be able to handle all of that additional work. I would encourage you to add another FTE if possible or partner with a company who could provide this as a service to you. Doing nothing will probably result in adding to your financial exposure from the RAC's.

4) Plan for an Audit Revolution

Given the overwhelming financial success of the RAC demonstration project, all other payers must be salivating over the opportunity to perform similar audits on you in the future. While this is painful to think about, your audit concerns need to focus on more than just the RAC's. Plan for Medicaid, Blue Cross, United, Aetna, etc. to quickly piggy-back off of the wild success that the RAC's have had.

Accordingly, your internal committee should probably not be called your "RAC Team" but rather your "Audit Response Team." Think more globally about how auditing will change in the near future. It would be helpful to have a plan in place to handle audits that come from any payer, not just RAC.

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5) Focus on Getting it Right from the Start

While responding to the RAC's is a necessary endeavor, your real goal should be much broader than that. In an ideal world, you would like the auditors to never find any reason to come calling. In order for that to happen, you must be focused on revenue integrity and data correctness right from the start. How do you do that?

Get more committed to your denials management process! Regardless of how good you think it is now, there is always room for improvement. You probably need to have parallel task forces to accomplish this. One would be for your newly named "Revenue Integrity Team" and the other would be your "Audit Response Team." The combination of both of those efforts will produce short and long term results which will pay dividends to your organization.

6) Be Prepared for the Long Haul or Partner with Someone Who Is

Even though a defined appeals process has been established for the RAC's, that timeframe has turned out to be much longer than anyone expected. For example, there are many providers from the demonstration project that are still waiting to have resolution on their appeals. Given that the permanent program will grow to 50 states, what will the appeal timeline look like for you? Common sense would suggest that many appeals in the future will take years to finalize. Given that, do you have the time, resources and patience to work through this process over the course of several years? If you are not sure, I would encourage you to partner with a company who can help you do just that. And, make sure they charge you a flat fee for the appeals; otherwise you may end up winning the RAC appeal but giving all of your proceeds to your vendor.

7) Build Your External Team and Plan for Implementation

Many providers THINK they have everything in place to manage all of the audits coming their way. However, so did most of the hospitals during the demonstration project. The unfortunate reality is that many of you need help. If you cannot pull

Minimize Your RAC Financial Risk



together funds to add FTE's, then partner up with external resources who can help. You should have a RAC attorney who you can call when you need their services. Additionally, do you have a company that can provide both DRG and medical necessity claims review and support in the event your existing team cannot manage the increased volume? Hopefully you will not need to utilize all of these services, but since you cannot really tell what your workload is going to be it is wise to set some partnerships up now.

If you agree that you may need some external help, please remember that most partners need some time to implement. You need to sign an agreement and then given the nature of the RAC reviews, you may also need to set up electronic access to your system. This can take two or three months. Don't wait for the RAC's to create a problem for you, proactively plan for success in this area.

Hopefully these ideas will help minimize your current and future financial risk related to the pending audits. While it can sometimes be difficult to plan for the unknown, there is simply too much at risk not to be prepared. Do yourself a favor and implement the steps above. It would be great to have all of them in place and not need them than the other way around!

**-Brian Shannon
Leadership and Sales Trainer**

If you are interested in learning more about Brian Shannon, please visit www.brianshannon.net, or he can be contacted at brian@brianshannon.net or (704)887-6707.



Avoiding a Medical Data Breach

More than 30 health care networks of all sizes recently have been victimized by identity thieves and data breaches, and more are expected in 2010. These events are extremely costly to the organization. In the short term, the reparations and notices to patients and the fines imposed by government entities are quite costly. However, the greater risk is the long-term negative impact on the hospital's credibility and reputation in the community.

Unfortunately, experts predict this trend to continue well into 2010 and beyond, and hospitals want to mitigate their risk as well as protect their patients' medical information and their network from this potential financial and public relations disaster.

Health care is well-suited for breaches

Most data breaches can be attributed to employee theft or mismanaged data practices, often initiated by disgruntled or departing staff. This is bad news for hospitals. Health care organizations experience a high churn rate of employees annually — 6.5 percent — almost double the general turnover average of 3.6 percent, according to the Ponemon Institute. With more employees entering and exiting the hospitals' payroll, the risk of breaches increases.

Additionally, health care is expensive, and identity thieves see it as a business opportunity. With more individuals out of work or underinsured, the market for health information is more lucrative, which draws even more attention from identity thieves.

The government responds with the HITECH Act

Proactive protection of health information is now mandated under the Health Information Technology for Economic and Clinical Health (HITECH) Act — which requires health care institutions to develop notification and prebreach programs — as well as state laws in California and Missouri. This 2009 legislation expands current federal privacy and security protections of health information.

According to the Energy and Commerce, Ways and Means, and Science and Technology committees, the HITECH Act strengthens the enforcement of federal privacy and security laws by increasing penalties and providing greater resources for enforcement and oversight. Among other mandates, the HITECH Act outlines how hospitals notify their patients and community of a breach through the following notice types:

- **Actual notice:** Affected individuals, guardians or next of kin must receive written notice at their last known mail or email address.
- **Substitute notice:** If contact information is not available, the health care network must provide substitute notice, usually in the form of a conspicuous posting on the network's Website or other location and/or a media notice, as soon as reasonably possible.
- **Media notice:** For breaches affecting 500 or more residents of a single state or jurisdiction, the hospital is required to provide notice to prominent media outlets in that area.
- **Secretary notice:** Hospitals must notify the U.S. Department of Health & Human Services in all instances of breach. The format and timing of the notice vary based on the number of affected individuals. Given these guidelines and penalties, a hospital's best choice is to proactively curb medical data breaches before they occur.

Best practices for hospitals

Deterring and detecting data breach threats don't happen by chance. Leading health care companies are taking advantage of new processes and proven solutions used in other industries, namely financial and credit card markets, to prevent breaches from occurring. The following are a few best practices that hospitals should consider implementing in 2010:

- **Appoint a responsible party.** Hospitals should make data breach avoidance part of an individual's or a team's job description. Naming an accountable resource will initiate process improvements, direct noncompliance inquiries to a centralized area, determine who would perform any investigations, and lead all legal and notification efforts in the event of a breach.
- **Expand compliance training.** A variety of individuals need access to patient health information to perform their job. They may be staff, contractors, third parties or temporary workers. Hospitals need a process to ensure that all these individuals participate in annual compliance training. No exceptions.

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• **Build a compliance culture.** The entire hospital community should value the privacy of patients' data as part of the organization's mission. This includes offering trusted avenues to report noncompliance activities. All individuals — staff, contractors and partners — should be diligent in their compliance and alert the responsible party to processes and/or individuals who may be operating outside of privacy policies.

• **Monitor information.** Automated monitoring of employee and patient information will alert hospitals of possible data breaches, often before they impact hundreds of individuals. Used by thousands of corporations across the United States, third-party products and services are available to monitor credit reporting agencies and proactively alert organizations of fraudulent events. Equipped with this unbiased information, hospitals can take appropriate action.

Medical data breaches are problematic for hospitals. Progressive health care professionals are looking at new means to protect themselves, and they are find-

ing their answers from colleagues in other industries. To provide maximized results, hospitals need to advance their culture, training and systems to encourage compliance in every activity and have planned responses to potential threats.

- Bruce Nelson, Vice President
SearchAmerica®, a part of Experian



*The family of
Dr. Johnston
acknowledges with deep appreciation
your kind expression of sympathy*

*To my HFMA friends,
Thanks so much for the beautiful flowers you
sent for my Dad's funeral. Your thoughtfulness meant a
great deal to me and my family.
It is such a blessing to serve with caring people like
each of you.*

*Thank again,
Shirley, Susan & Andrew*





Fraud Referrals from the RACs Likely

Fraud Referrals from the RACs Likely

In March, the Department of Health and Human Services' Office of Inspector General (OIG) released a report titled "Recovery Audit Contractors' Fraud Referrals" (<http://oig.hhs.gov/oei/reports/oei-03-09-00130.pdf>), examining how recovery audit contractors (RACs) referred cases of potential fraud to the Centers for Medicare & Medicaid Services (CMS) during the 3-year RAC demonstration project.

The RACs are charged in their statement of work to identify improper Medicare payments and are not responsible for identifying and reviewing claims with possible fraudulent activity, a charge left to their Zone Program Integrity Contractor (ZPIC) counterparts. The RACs are, however, responsible for referring to CMS any cases of potential fraudulent activity that they identify during the course of their own improper payment investigations. According to the report, the RACs only referred 2 cases of potential fraud to CMS during the 3-year demonstration project during March 2005 and March 2008. The OIG report proposes that the RACs may have a disincentive to refer potential fraud cases to CMS because they do not receive their contingency fees on cases that are determined to involve fraud. The report also suggests that CMS did not provide the RACs with any formal training during the demonstration project to identify and refer potential fraud cases to CMS.

In the report, the OIG makes these recommendations to CMS:

1. conduct follow up to determine the outcomes of the two referrals made during the demonstration project”
2. implement a system to track fraud referrals”

and

3. require RACs to receive mandatory training on the identification and referral of fraud”

In response to the report, CMS agreed and accepted the recommendations and reports now that it has provided training sessions on fraud to the RACs as part of the permanent Medicare RAC program. Responding to the OIG's recommendation for mandatory fraud training, CMS said it had already provided two training sessions to the permanent RACs and was in discussions with the OIG and the Justice Department on additional training.

So what does that mean for providers now?

In light of the OIG spotlight on this issue, it is likely that CMS and the OIG are going to continue to measure this shortcoming from the demonstration project and will refine the processes to make them more efficient through training and additional monitoring. Despite the fact that the RACs don't receive a contingency fee on making possible fraud referrals, it certainly would be a feather in the cap of a RAC auditor who identified a fraud case and passed it off to their ZPIC cohort. It is a slippery slope for a RAC auditor to not interrupt fraud investigation activity and also support the discovery of possible fraudulent activity. CMS did identify in its RAC Demonstration Evaluation Report-

(http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf) that during the demonstration project that the RAC contractors did not disrupt Medicare's anti-fraud efforts. "The RAC demonstration succeeded in developing the cooperation needed to ensure that RAC activities did not compromise ongoing law enforcement investigations. The relationships built during the RAC demonstration have improved the overall coordination of these activities and will provide a

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Fraud Referrals from the RACs Likely



framework for the nationwide expansion of the RAC permanent program.” The report also goes on to describe some of the delineation of roles between all the various contractors by using the RAC data warehouse that was developed to provide CMS with an automated means of administering and overseeing the claim activity during the demonstration project. “The RAC data warehouse serves as the repository for data about all claims with improper payments identified by the (Claim) RACs, and it is used by CMS to ensure that RACs do not review claims previously subjected to medical record review by another review entity (such as a QIO or Medicare claims processing contractor) or currently under a fraud investigation. This important tool minimizes the unnecessary burden to providers and prevents overlap with other Medicare program safeguard activities. The RAC data warehouse is also the principal data source for reporting improper payment findings to CMS and the public.”

An important transmittal to note as well to describe these various roles and activities is Transmittal 152, CR 6384 from June 12, 2009 (<http://www.cms.hhs.gov/Transmittals/Downloads/R152FM.pdf>). In it, the following issues are clarified:

- 1) Use of the RAC data warehouse for tracking appeals.
- 2) How to handle potential fraud referrals. “The RAC will refer any claims it determines to be potentially fraudulent to the appropriate CMS RAC Project Officer who will then forward this claim information to the CMS Division of Benefit Integrity Management Operations.”
- 3) Dissemination of information between the RAC and MAC

There will probably be a fair amount of scope creep as the details of this new protocol is worked out between the MACs, the RACs, the OIG, and CMS. Providers will unfortunately be in the middle of it as it's being worked out so this is another very good reason to have processes in place yourself that identify possible duplicate claims under review under these various auditing bodies

**-Carla Engle, MBA
Product Manager
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Open to Everyone!

Inaugural Region 5 Past-Presidents Reunion Cruise

June 2011

This will be a one of a kind way to connect with past, present and even future HFMA Region 5 family and have a wonderful vacation as well. You don't have to be a past President to come either! This is open to friends and family as well. You have plenty of time to prepare. Because we are expecting a large group, we will need to get cabins reserved as early as possible. I am working with a wonderful agent that is keeping up with Royal Caribbean's cruise schedule.

7-Night Greek Isles Cruise

- Split, Croatia
- Venice, Italy
- Corfu, Greece
- Piraeus (Athens), Greece
- Mykonos, Greece
- Katakolon, Greece
- Venice, Italy



3-Nights in Venice

(1 prior to cruise and 2 after cruise)

1 Night prior and 2 Nights after the cruise at a centrally located superior first class hotel in Venice - breakfast included.

Private transfer from the cruise ship to the hotel via private water taxi.

Hotel Taxes and service charges included.

1/2 day private tour of Venice with an English speaking local guide.

Gondola excursion.

Private transfer from the hotel to the airport by private water taxi.

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Exact dates cannot be given until Royal Caribbean sets the 2011 cruise schedule; we expect June of 2010 to be able to lock in on the week we can go. Below I have the rates if we were going June 2010 as an **estimate**:

Cruise Cost (per person)	<u>Interior</u>	<u>Outside</u>	<u>Balcony</u>
	\$ 839	\$1,049	\$1,749
Air Fare (approximate)	1,700	1,800	1,800
Sub-Total (per person)	\$2,539	\$2,849	\$3,549
Hotel/tour Package (per person)	765	765	765
Grand total	\$3,304	\$3,614	\$4,314

If you are interested, I need to get your contact information so you will get the updates and know when to get your deposit in so your space is secure. Email Rick Childs at Richard.Childs@Piedmont.org the following form:

To: Richard Childs Fax: 678/244-5135

Yes, Rick, I am interested in the June 2011 Cruise!

Name:

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If a past President what year?

How many in your party?

How many cabins?

A Note from the Editor

My my how time flies. This is the last Bama Chatter for this HFMA year. This year has been another challenging one for many of us. Many of us have had friends and families who have lost their jobs (some of them in our own market, or even in our own facilities), many of us have friends and families that have lost or close to losing their homes, and then there have been several of us who have lost loved ones. "Loss" is what I want to focus on for my last article.

Loss of a loved one can be so painful, and even a life changing event for many. This year has been a painful one for me, as I sat by and watched a good friend of mine who struggled as she lost her 26 year old daughter. Laura was a vibrant, beautiful girl, who was planning her dream wedding only to receive the news a few weeks before her wedding that she had ovarian cancer – a very rare, very aggressive type. She went ahead with her plans to marry the man of her dreams, and after 15 months lost her battle. I tell you all this, not to bring tears to your eyes, but to say to you. . .live everyday to its fullest. And WHAT does this have to do with HFMA and the Bama Chatter you ask – more than you think.

As we continue to face our challenges in this healthcare market – sometimes we feel as if we have lost or are losing everything. The days of knowing all patients would be taken care of without worrying about how they were going to pay are over, the days of being sure we would always have the time to visit and joke around with our co-workers are becoming less and less as we get busier and busier, the days of knowing that if you were a healthcare worker you would always have a job are now questionable, the days of knowing you could "for all practical purposes" forecasts financial plans/strategic plans 3 to 5 years out are becoming more difficult – some forecasts 12 months out may be outdated.

Life, as we've known it is lost, and is changing day by



Libby Bailey, CPA, FHFMA

day, or sometimes we even feel minute by minute. How do we keep up with what changed today, how do we keep up with a new idea to survive the latest costs cutting measures, how do we remain focused on our mission of taking care of the patient while worrying about the "red ink", and last but not least, how do we just survive and "want" to continue doing the jobs that we selected to do? In my last "lots of years in healthcare", without my connection to HFMA, I'm not sure I would have survived. The things I've learned in the educational sessions, the idea sharing I've picked up from the networking sessions over a glass of wine, the opportunities I've had to meet people in other states, or even speakers that weren't in the healthcare areas, but had information that encouraged me to try something different, and then last but certainly, not least, the friends I've made by becoming involved in my chapter have been overwhelmingly critical to my survival.

Our industry is not going to get any easier, and if you've not been "involved" in your chapter – PLEASE invest in yourself; step up to the plate, get involved, and I promise the returns will far outweigh the "sometimes frustrations" you experience by being on committees, serving on the board, helping with meetings, etc. Just like anything in life, the more you invest in it, the more you get out of it. HFMA has changed over the years by trying to provide educational opportunities to a larger market while at the same time trying to keep costs at a minimum, and sometimes even no costs. Your chapter officers are always willing to listen to your ideas and needs. . . don't be bashful, don't get lost, let us know what works best for you.

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This year, the Bama Chatter went totally electronic which has afforded us a greater opportunity to include more articles, and more information about your chapter and the people in it. I do sincerely appreciate those of you who have stepped forward and written articles, or have gotten me connected with folks that would submit articles. Remember, if you submitted an article this year, your name will be put into a drawing during the Annual Meeting for a cash prize.

As I close my last Editor's Note – I remind you, live each day to its fullest; and when you are having a bad day, or want to be down and out. . .pick up the phone, or shoot an email to a friend you have connected with in HFMA. You won't find a better group of folks – they are there for you on a professional level as well as a personal level. Again, be an active member – **MAKE IT COUNT.**

- Libby Bailey, CPA, FHFMA
Newsletter Editor
Callahan Eye Foundation Hospital



Member on the Move

Vicki H. Parks, CPA, FHFMA had been named as the Chief Accounting Officer for St. Vincent's Health System in Birmingham, Alabama. In her new role, Vicki will be responsible for financial reporting to the parent company Ascension Health, audits, tax reporting, budgeting, payroll, and accounts payable. Vicki has been with the health system since 1997 and was previously the Vice President of Finance for St. Vincent's Hospital.

Editorial Mission

The **Bama Chatter** supports the mission of the Alabama Chapter by serving as a key resource for individuals involved or interested in the financial management of health care.

Editorial Policy

Opinions expressed in articles or features are those of the author and do not necessarily reflect the view of the Alabama Chapter, the Healthcare Financial Management Association, or the Editor. The Editor reserves the right to edit material and accept or reject contributions whether solicited or not. All correspondence is assumed to be a release for publication unless otherwise indicated.

Publication Objective

The **Bama Chatter** is the official publication of the Alabama Chapter of HFMA and is written and edited principally to provide members with information regarding Chapter and national activities, current and useful news of both national and local significance, information about seminars and conferences and networking with colleagues, and to serve as a forum for the exchange of ideas and information.

Article Submission

The **Bama Chatter** encourages submission of material for publication. Articles should be typewritten and submitted electronically to the Editor. The Editor reserves the right to edit, accept or reject materials whether solicited or not. HFMA Founder Points are granted for any articles published in the Bama Chatter.

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The **Bama Chatter** is a quarterly, four-color publication. All four issues are e-letters and are emailed to our entire membership roster.

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Please refer questions to our editor:

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