hfma northeastern pennsylvania healthcare financial management association

NEWSFLASH

A Newsletter from the Northeast Pennsylvania Chapter of HFMA

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IN THIS ISSUE

A Letter from the President...1, 2

NEPA Chapter Officers...3

Our HFMA NEPA Electronic Window...3

Summary of April 13, 2007 Educational Session...4, 5, 6

New Member Corner...7

HFMA NEPA Sponsors...8

Key Benefits of Our NEPA HFMA Chapter...8

Not for Profit Healthcare Sector will have Favorable Performance in 2007, says Standard & Poor's...9

Addressing Patients' Financial Responsibility in Pre-Access...10, 11

Examining and Addressing CDHPS...12, 13

A Letter From The President…

Dear Member,

This past year I am very grateful for the unique opportunity to spend more quality time with my precious son and to serve as President of our Northeastern Chapter of HFMA.

One of my personal goals this year for the Chapter included exercising all my leadership knowledge and skills to implement two major strategic initiatives to improve Member Satisfaction in the areas of Communications and Education. I am very grateful for the Board of Directors' support during the Spring 2006 planning meetings to move forward with these initiatives.

We have strived this year to provide increased communication and earlier notification of our events through the development of our own NEPA HFMA website www.nepahfma.org . As I look back at the seven months that have passed since the website's inception, I can truly see the value to our Member and supporting Colleagues based on website usage statistics. Significant activity (nearly 2,000 home page visits and over 10,000 hits) is being noted and users are accessing Education Programs, On-line registration, Newsletters, Officers contacts, and our Classifieds page. We intend to continue timely website updates, and add enhancements such as on-line surveys and future links to our Sponsor websites as we move into the planning phase for 2007-2008.

In the area of Education (our second initiative), we developed a two-tier education improvement model focusing on advance planning of educational events with a team approach to improve educational content. This past year we selected topics more futuristic and cutting-edge that reached out to other professionals along the healthcare continuum (e.g. long-term care, operations, physician practice) based on the 2006 Member survey suggestions. We also offered full and half day options to provide flexibility to attendees. We planned upfront and successfully held five NEPA education sessions and one co-sponsored session.

I believe some of the positives that came out of this process included:

- An established formal education team planning process for the Chapter
- First breakout session in the history of the Chapter during November 2006 (The Future of Healthcare – Long-Term Care and Acute Breakouts)
- Development of networks for future co-sponsored sessions (e.g. NEPA LTCA)
- Increase in Registrant Hours per Member by 72% over prior year

Attendance at meetings continues to be a challenge based on organizational cost constraints, individual time constraints due to consolidated or expanded job responsibilities, and education programs offered by other professional, national organizations or consultant firms. This past winter, the Officers and Leadership communicated these issues to all NEPA Senior Financial Executives. The Letter emphasized the unique benefits of NEPA HFMA and the criticalness of the Senior Financial Executives' role for our Chapter to continue to thrive with autonomy. We plan on keeping this message in the forefront and requesting CFO support by promoting staff attendance at all future meetings.

On a personal note, I feel very privileged and honored to fulfill a six-year commitment that began for me during May 2001. I would like to thank Erin Fitzgerald (past Chapter President) who solicited my interest and involvement in the NEPA Chapter six years ago as an incoming Board member. I never realized at the time how much I would learn and grow personally and professionally from my surrounding Officers, Board contacts, and Colleagues within the Chapter. ***I would encourage anyone to participate in a Committee of your choice. We can always make some extra time to do something that is fun, rewarding, and that will produce a benefit (network!) that will continue to give you a ROI in your professional future.***

I would like to thank my Team of Officers for their support, dedication and camaraderie during this year. This exciting and rewarding experience will remain with me throughout my professional and personal life. Finally, I would like to extend my sincerest support and best wishes to the incoming 2007-2008 Leadership Team as we continue the momentum and look toward future opportunities for our Chapter.

Sincerely,
Josephine A. Bradley, CPA, MHA
President NEPA HFMA Chapter

NEPA CHAPTER OFFICERS

2006-2007

President
Ms. Josephine Bradley, CPA, MHA

President–Elect
Mr. Loren L. Stone, CHE, MHA

Program Chair
Ms. Dianne Roberts, FHFMA

Treasurer
Mr. William Schultz, MBA

Secretary
Mr. Frederick Jackson

Our HFMA NEPA Electronic Window

Please visit our new Chapter website at www.nepahfma.org which went live on September 18th!

Our newest update is the establishment of our own NEPA Job Bank (during January 2007.) We offer on-line position posting to all Members and Colleagues a cost of $100 per individual posting for 30 days.

If you are interested in posting a classified ad you can go directly to our website nepahfma.org and click on the job bank browser. Within that section click on the contact_us@nepahfma.org mailer and send us your classified information (e.g. Word document)

We have also established links to the following Regional Chapters Classifieds to develop a future Regional Job Bank:

Philadelphia	Western Pennsylvania
Appalachian	New Jersey

We will be also facilitating a short Member Satisfaction Survey via the website in the near future. Please take the time to quickly submit the information as this will assist with future education and communications planning for our Chapter. An e-mail with the website link will be sent directly to you.

Other features of our website include on-line program registration, information regarding our sponsors and sponsorship program, certification information, current newsletters, our current leadership and committees/contacts, strategic initiatives, and even links to the national website.

Summary of April 13, 2007 Education Session

Our spring education session was held at the Hilton Garden. Attendance was approximately 50% of the norm; however, for those participating feedback was very positive regarding topic selections, speaker knowledge and effectiveness, and content value to bring back to their organizations. The April Education Team covered four separate topics with three out of state consultant speakers and one speaker from the Geisinger Health System.

Our morning opened with Zachary Hafner, Assistant VP from Kaufmann Hall (Chicago, IL) discussing Financial & Capital Planning for Hospitals & Health Systems – A Best Practice Approach. He laid out the thought process related to strategic and financial planning, how they are tightly integrated, and reviewed key concepts such as the "Corridor of Control" and "Survival of Performance Line". He discussed how credit rating agencies have shifted their focus to providers' strategic initiatives and business plans to the future detailing how they will survive with limited cash flow in a changing healthcare environment. He expanded further stating credit ratings (e.g., Moody's or S&P's) are more than a function of provider's liquidity, debt, and capital ratios. These agencies are focusing on the providers' market position and specifically:

1. *Track Record of Management Team*
2. *How Competitive is the Provider*
3. *Has the Provider achieved set Targets*
4. *Payer Mix Relationships*

In addition, details were presented regarding the nine key liquidity/debt ratios, Bond rating agency targets, sources and uses statements and projections proformas. A wrap up discussion followed with a provider case study example with specific strategic targets and how to best achieve them and optimize trade offs within an appropriate credit/risk context.

Our second presenter was Ben Hyman from Vision Share, Inc. presenting Medicare Contracting Reform Update: Upcoming Changes in Medicare and how it will Affect Medicare Providers. He discussed MAC Reform:

- *Resulting from Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA)*
- *Largest Medicare Change in 40 Years*
- ***Replaces current claim payment contractors with new "Medicare Administrative Contractors" (MACs)***
- *Reduces entities allowed to administer Medicare*
- *Reviewed every 5 years*
- *New transitions are likely in the future*

Ben further discussed the goals of MMA to implement contractor reform, offer open competition for all Medicare Contracts and Regions, eliminate duplication within the Medicare System, and simplify processing of Medicare claims and FISS access. He provided a comparison of the Medicare landscape in terms of intermediaries and carriers for Part A, Part B, Regional Home Health and DME as it currently exists and then after the planned completion of the MMA MAC transition. For example there are currently

25 Medicare Part A Fiscal intermediaries and 18 Part B Medicare carriers, however, the 25 Part A and 18 Part B Regions are to be consolidated to 15 "MAC Jurisdictions". We learned that Pennsylvania is part of Jurisdiction 12 (along with NJ, DE, MD, and DC). Awards for MACs currently involved in the bidding process will be announced during July 2007.

Dennis Kennedy, from Noblis Healthcare Division of West Springfield, MA, presented the results of a National Study centering on "Strengthening Physician – Hospital Relationships. Many details were discussed but the resulting road map for a successful relationship included:

- *Communicate in an Honest and Open Manner*
- *Substantive Physician Involvement in Decision Making*
- *Align Economically with Physicians/Multiple Strategies*
- *Improve Efficiency/accessibility of Care (infrastructure improvements)*
- *Support for Physician Practices/Growth*
- *Develop Physician Leaders*
- *Positive Organizational Culture*
- *Provide High Quality/Safe Patient Care*
- *Information Systems*
- *Be Visible and Accessible (CEO/Sr. Mgmt)*

Our last and most graceful speaker of the day was Brenda Snow, VP Strategic Program Development who discussed Patient Friendly Billing: Improving Processes in an Era of Consumerism. She provided an overview and historical perspective of the National Patient Friendly Billing Project (PFB) along with a wrap up discussion with identification of action steps for your organization.

This was a great tie in for those attending our February 23rd Consumerism Session and CFO Panel discussion. Key themes that came out of our past session and this related session included:

- Cultural Change – How we view and treat the patient
- Enhancing the Customer experience
- Meaningful Price Transparency (patient's obligation – tailored specific – ideally provided pre-service - combined with quality indicators)
- Revenue Cycle Impact – Upfront Processes
- Communication and Education – both Consumer and Employees
- Staff Support Issues

The National PFB Study was kicked off during 2001 and research started with eight focus group from four separate locations. Additional research was performed during 2003 and the following reports have been generated and are available on the HFMA National Website:

- November 2001: Patient Focus Group Findings & Task Force Solutions
- June 2002 : Approaches by Medical Group Practices
- June 2003: Emphasis on Technology

- February 2005: Uninsured/Underinsured
- June 2006: Consumerism in Healthcare

Brenda discussed the details of the consumer and focus group comments and how they fed into fourteen point recommendations summary below:

1. Establish customer service standards
2. Inform patients in advance about financial expectations
3. Measure success
4. Adhere to PFB guidelines
5. Coordinate information gathering process
6. Simplify contractual relationships
7. Consolidate Billing
8. Standardize written communications
9. Use understandable terminology
10. Rethink “this is not a bill”
11. Bill patient after insurance has paid
12. Provide concise financial communication
13. Make billing & cdm’s understandable
14. Provide on-line capabilities

Since Brenda did focus on the consumerism aspect of the PFB study (2006 report), she presented a very in-depth discussion covering the key revenue cycle themes relating to price transparency (what it is, why the push, examples of initiatives in action), patient payment expectations and terms, simplified charge and payment structures, patient access and scheduling and staff support issues.

Brenda concluded her presentation by providing suggestions of action steps to consider within our own organizations:

- Review guiding principles
- Help patients understand and use health services
- Improve price transparency
- Simplify charge and payment structures
- Make access & Scheduling respectful & convenient
- Upgrade your staff’s consumer service skills
- Improve communications with patients & community
- Collaborate with employers and payers
- Work toward automated & real time exchange of key demographic & insurance information
- Engage with government & other on standard for quality
- Advocate for regulatory revisions to facilitate a better patient experience

If you enjoyed a specific topic and would like follow up presentations or to suggest a future topic(s) for upcoming sessions, please let us know by e-mailing us through the ***“contact us”*** section of our website.

New Member Corner

We would like to welcome recent new members to our NEPA Chapter. We hope our new members will utilize the information on our website www.nepahfma.org , contact any of the Officers with any questions, and let us know if you have an interest in participating on Committees or becoming involved in an area they desire**. A great way to meet existing members and begin developing a solid network is by participating in our Annual Golf Tournament scheduled for June 18th- save the date!**

John M. Torcivia
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James E. Jones
Manager
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Jeanne M. Wisnewski
Director Provider Relations
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Breann Malia
Contract Manager
Moses Taylor Hospital, Scranton, PA

Christy L. Pehanich
Manager, Professional Insurance
Geisinger Health System, Danville, PA

Donna K. Miller
Hamburg, PA

Ronald Rapp
Controller
Charles Cole Memorial Hospital, Coudersport, PA

Our Annual Golf Tournament is slated for June 18, 2007. Our Golf Committee dedicates much time to make this annual high interest event a success. A separate notice will be sent to each member. Make it a priority to sign up for this fun event!

HFMA NEPA SPONSORS

The Northeastern PA Chapter of HFMA wishes to recognize and express their sincere appreciation to the following sponsors who have supported the Chapter activities for the 2006-2007 year.

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Key Benefits of Our NEPA HFMA Chapter

- High quality cutting-edge educational programs at an affordable price
- State Board of Accountancy sponsored credits
- Local education sessions reduce travel costs and precious travel time
- Progressive Chapter Leadership addressing healthcare colleagues education needs and requests
- New Website www.nepahfma.org featuring NEPA programs, hot topic newsletter articles, HFMA National links
- On-line recruitment postings at extremely reasonable rates
- Networking opportunities at every meeting and specific social events
- Membership comprised of the unique NEPA Healthcare Market

Not-for-Profit Healthcare Sector Will Have Favorable Performance in 2007, Says Standard & Poor's

Despite continued negative pressures on the not-for-profit healthcare sector, Standard & Poor's predicts a continuation of 2006's solid performance for 2007 and into 2008 for the organizations that it rates. The report, U.S. Not-for-Profit Health Care Rating Trends Should Remain Stable Despite Growing Pressures, says that although President Bush is calling for deep cuts to in federal healthcare spending, Medicare and Medicaid reimbursement will likely remain stable until 2009, and healthcare reform initiated by various states is still in the planning stages and thus won't significantly affect providers yet. Also expected for 2007 are strong "income and cash flow measures, growth in liquidity, and overall improvement in balance sheet measures across most rating categories." Rapid capital spending will continue over the next two years, although Standard & Poor's expresses worry that "increased debt levels, coupled with interest costs and depreciation expense that arise when projects are completed, could place further stress on organizations in the coming years when the revenue environment is expected to be less favorable."

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Addressing Patients' Financial Responsibilities in Pre-Access

By The Academy of Healthcare Revenue

Requesting full or partial payment of patients' financial responsibilities at point of service has become a practice vital to healthcare providers' financial health. Specifically, insured patients' out-of-pocket costs—which are significantly more difficult to collect after patients' discharge—continue to rise. The second most-prominent strategy that most businesses employ to contain their health insurance costs is increasing cost sharing with employees, in the form of larger premiums and benefit amounts. Research has found that approximately two-thirds of surveyed businesses increased their insured employees' co-pay or co-insurance responsibilities in 2006, while more than half of the businesses have increased individuals' deductibles as well.

Academy research consistently shows that between 60 – 70 percent of surveyed providers do actively collect patient balances at point of service. However, some patients may be unprepared to pay when out-of-pocket costs are requested at POS, which may potentially cause surprise, reduce collections, and negatively impact patient satisfaction. In response to this concern, many best-performing hospitals are proactively addressing patients' financial responsibilities prior to patients' appointments. Following are several tips that these providers have found important.

- **Optimize Pre-Registration Rates and Activities.** During pre-access, revenue cycle staff members can certainly advise patients that payment will be requested on the date of their appointments. However, in order to provide patients with their actual deductible or co-pay amounts, staff members will need to verify patients' insurance coverage—often requiring an initial conversation with patients, followed by calling patients' payers or verifying benefits through an online mechanism. Academy research shows that best performers currently pre-register 95 percent or more of scheduled patients—ensuring their benefits are verified and requests of deductibles and co-pays can take place at point of service.

  Some hospitals have begun to obtain patients' insurance information during scheduling by asking referring physicians or patients to provide their insurer's name and group number, as well as fax insurance cards to the hospital. Then insurance can be verified *before* patients are called by pre-registration staff—and at that time, pre-registration staff can inform patients of their actual benefit amounts, such as remaining deductibles.

- **Begin Financial Counseling Prior to Patients' Appointments.** During pre-registration phone calls, pre-registration staff members can also explain the payment options available to patients (e.g., credit cards and payment plans), while also informing patients that financial assistance is available for those who qualify. Pre-access also serves as an excellent opportunity for financial counselors to proactively call patients, set up meetings on patients' appointment dates, and encourage patients to bring specific documentation (e.g., tax returns)

that will help in determining their eligibility for aid.

Based on patient volume and the size of hospitals' financial counseling departments, patient access leaders can identify criteria for determining which patients will be contacted about financial assistance before service. The Academy's research found one facility that pre-registers most patients 14 – 21 days in advance of their scheduled appointments, enabling financial counselors to identify which patients are registered as self-pay patients and begin the counseling process before the date of service. If a patient is registered for a visit as a self-pay patient, the hospital sends a welcome packet to them, which includes information in four languages about the resources available for individuals who are unable to afford the care they're about to get. The packet also encourages the patients to bring certain documentation to their appointment, and to arrive early to see one of the hospital's financial counselors.

Alternatively, Academy research has found that financial counselors at another facility are responsible for collecting in pre-access. In this case, the hospital's counselors receive a daily census of patients with high-dollar accounts over $200 whom they should contact to make financial arrangements before each patient's date of service.

- **Utilize Multiple Means of Outreach.** The informational packet sent to self-pay patients by the hospital cited earlier illustrates a very important point: informing patients of hospitals' point of service collections and financial assistance policies does not solely need to be the responsibility of pre-registration staff. In fact, creating multiple outreach materials are vital in that they enable hospitals to convey their policies to patients who are not scheduled or pre-registered before service. For example, hospital brochures in local physician offices can explain why payments are requested at point of service, and how patients can apply for charity care. Communications such as advertisements or articles in local news media can also help to drive these points across, while firmly emphasizing hospitals' commitment to serving all patients and helping them to afford the cost of medical care.

With patients' personal financial responsibilities on the rise, many hospitals have recognized the need to collect at point of service. Furthermore, best-performing hospitals are adopting several strategies to ensure patients are aware that payments may be requested before care is provided, and that financial counselors are available to help those who may not be able to afford paying for services.

Examining and Addressing CDHPs

By The Academy of Healthcare Revenue

If your organization is experiencing an increase in insured patients' residual self-pay balances, you are not alone. Many facilities across the country are now faced with the task of collecting more dollars from patients, at least until patients' deductibles are met—deductibles which are consistently growing each year due to individuals' enrollment in consumer-driven health plans.

CDHPs, typically high-deductible insurance policies with tax-advantaged savings accounts such as health savings accounts (HSAs), continue to gain more share in the health insurance market each year. One primary reason for the influx of these types of plans is employers' desire to lower their health insurance costs, which have increased by an average of nearly 12 percent in the last five years. In particular, CDHPs have become attractive to employers and employees because of the plans' lower premium growth, often five percent less than traditional PPO and HMO plans.

According to research, in 2006 the average deductible for an HSA-qualified consumer-driven health plan was more than $2,000 for single coverage—an amount significantly larger than the smaller dollar amounts that hospitals have become accustomed to seeing, and that patients have become accustomed to paying out-of-pocket. Additionally, many of these plans do not have the smaller co-pay amounts (e.g., $50) that patients have historically been charged for visits to hospital emergency departments, or for tests such as MRIs. Patients are likely to be *fully* financially responsible for the costs of non-preventive care until deductibles are met—known as 'first-dollar' coverage—and may also have co-insurance responsibilities (e.g., patients pay 20 percent of costs above and beyond the deductible until their out-of-pocket maximum limits are reached).

Ultimately, providers may need to allocate more resources toward collecting self-pay receivables, especially for patients enrolled in CDHPs who are relatively healthy and do not seek enough care to reach their annual deductibles. Industry leaders have noted that patients with CDHPs are not the same as traditional insured patients—in actuality, they are self-pay patients up to a very high deductible.

In order to effectively identify and prepare for CDHPs' impact on your organization, it may be necessary to proactively assess the insurance market in your area to determine if—and in many cases, when—payers and employers will partner together to enroll more individuals in consumer-driven plans. Payers and employers are not likely to seek out your organization and inform you of their CDHP plans, and patients' insurance cards may not explicitly mention their enrollment in CDHPs either. Instead, as a revenue cycle leader you may need to stay informed by examining advertisements, other media, and news items in your communities that can alert you to CDHP offerings.

Payers and employers may also need to be contacted to determine the extent of which individuals are enrolling in CDHPs. By contacting employers and carefully tracking and trending the high-deductible accounts in your organization's patient accounting system, you will become better able to statistically project how many potential patients have consumer-driven, high-deductible plans. In turn, this will enable you to identify if CDHPs are gaining a share of the market in your area, and if dedicated strategies are

needed to ensure accounts featuring these types of plans do not cause a significant strain on your organization's financial health.

In particular, best-performing facilities have responded to the rise of CDHPs (and patients' residual self-pay balances) with two main areas of focus. The first is re-examining and in some cases adjusting the discounts contracted payers receive, especially if a significant portion of the payer's enrollees are enrolled in high-deductible plans. Historically, third-party payers have received discounts because they reimburse hospitals in a timely manner—often within 15 – 30 days of service. However, if more and more of payers' patients are enrolled in plans that increase patients' out-of-pocket amounts and 'first-dollar' responsibility, essentially hospitals are then providing payers with discounts to collect from patients what was previously payers' financial responsibility.

Second, the rise of CDHPs emphasizes the importance of collecting at point of service—ideally, patients' entire estimated balances up to their deductible limits—in order to reduce the risk of increased bad debt. Academy research shows that approximately one-third of providers have not implemented POS collections at their facilities; if you are concerned about the impact of high-deductible, consumer-driven plans, now may be the time to consider (or re-consider) this practice.

While the number of employers offering CDHPs is on the rise, as is the number of enrollees, the impact of these plans are not likely to be fully known until many more patients enroll. Meanwhile, it is important for leaders to strategically respond to the implications that are known in order to protect their organizations' future financial health.