

THE BOTTOMLINE

MONTANA CHAPTER HFMA

President's Message

Volume 4, Issue 4

Autumn 2009

Inside this issue:

President's Message	1
Save the Dates	2
The Cost of Education	2
Inpatient vs. Observation	2
Denial Management	3
Reform Debate	4
TRICARE Update	5
Chapter Sponsors	7
New Members	8
Region 10 Executive	9
Region 10 Executive-Elect	10
Hospital Signs of Life	11
Warning Signs	12

Newsletter committee:

Tammy Trovatten, Chair
Don Miller
Bob Olsen
Donja Erdman
Tina Montgomery
Shar Sheaffer
Deb Green
Maria Conn

Submit your articles to:
TammyTrovatten@benefis.org

By Steve Scharmann
MT Chapter of HFMA

The other day I was looking through a stack of old pictures from my college days. As I was thumbing through the dingy, sometimes blurry pictures taken before digital photos were the norm, I realized that in some I looked pretty good when I was several pounds lighter and prior to four kids, and in some pictures I looked pretty bad (late nights studying of course). I got to thinking that snapshots such as these captured the peaks and valleys of my life at that time. I thought to myself, do I remember that era of my life as a peak, a valley, or somewhere in between? I thought about that as it relates to my career now. When I look back on these current "tough times", will it be a peak, valley or somewhere in between? I would submit to you, my colleagues in the Montana HFMA Chapter, it's what I make of it.

As I looked over the headlines in last few issues of the HFM magazine, I saw articles with wording such as protect your cash flow, no more lost clinic charges, how long can hospitals survive with negative margins, a business case for quality, rating agencies maintain negative outlook, and the list goes on and on. We would all like to think that Montana healthcare organizations have had our seasonal "financial flu vaccine" to make us immune from such challenges. As far as I know, that vaccine is behind the H1N1 vaccine in the research and development department. With the economic culture, impending reform legislation and a myriad of other issues, it's time for healthcare financial leaders in Montana to either batten down the hatches and ride out the storm (if we survive) or stay proactive in all facets of our responsibilities. From what I know of most of you, you'd choose the latter and look back on the mental pictures of this time and think of it

as challenging, yet rewarding.

How can HFMA help during these times? As your state chapter, we are continuously looking for opportunities to bring high-quality education to our members at an affordable price. The Current Issues & Task Force Committee will be bringing several audio conference opportunities to you in the near future. These conferences will give you a forum to address hot topics. By the time this newsletter is published, we will have had another successful Fall Conference in Billings that will help address the needs of financial and PFS managers.

From the national level, HFMA continues to bring relevant topics to us as members. On November 3rd, HFMA is offering a free webcast from a Washington healthcare analyst who will provide an overview and outlook of the healthcare reform legislation that is working its way through Congress. In November alone, HFMA National is offering 7 webcasts on various topics. I encourage you to take advantage of any of these educational opportunities. They are the primary reason we are members of HFMA. These educational opportunities are what will make these trying times peaks, instead of valleys.

Finally, as we embark into the holiday season of 2009, some of you may be hearing from Kim Lucke of our Nominating Committee. Montana HFMA is run by volunteers, and I hope you'd think about the opportunity to serve on the board. I have had many great experiences serving on the board. New insight is always welcome in our board meetings. Elections will be held in the next two months, with the new terms beginning in June. I hope to see your name on the ballot.

Thank you again for your continued support of Montana HFMA.

The Cost of Education

By *Tammy Trovatten*
MT HFMA Newsletter Chair

As we wrapped up the MT HFMA Fall conference last week in Billings, I started to reflect on the things that make those education opportunities possible. As Steve Scharmann notes in his President's message, the Montana Chapter of HFMA offers high-quality education at an affordable price. I get e-mails every day with chances to sign up for webinars and education series, but the usual cost of each of these sessions is \$200 or more. I am sure that many of you receive the same e-mails. So why does the Montana chapter have the ability to offer great education opportunities at affordable prices such as a whole conference for \$125 per member or \$175 per non-member?

First off, the Montana HFMA Committees and committee volunteers make it possible to have affordable education. The Task Force and Current Issues Committee provides conference calls, audio conferences, and webinar opportunities for the Montana facilities either at no or low cost due. This allows Montana HFMA members to stay on top of local and national issues. While the Program Committee provides the Spring and Fall Conferences each year at the low cost mentioned earlier. Each of these committee chairs and volunteer members work hard throughout the year to come up with relevant and affordable educational choices. Without their dedication and donation of time, the cost for our educational choices would inevitably increase while overall quality would decrease.

Most importantly, the sponsors that attend the Spring and Fall conferences of the Montana

HFMA Chapter are a huge supporting factor for our educational opportunities. Not all vendors that attend our conferences are created equally since some of them have gone above and beyond to become one of our sponsors. Not only do they provide excellent give-away prizes during the conference, they sponsor events during the conference, which keeps the chapter's portion of the cost down. For the Chapter's last fiscal year (June 2008 through May 2009), the sponsorship revenue was \$26,900.00.

This revenue helps fill in the gap between the education expenses and income while allowing the Program Committee to bring in great local and national speakers. Can you imagine the cost of the conferences and other education choices if we did not have the sponsors supporting us?

I thank my lucky stars for the chances I have for excellent and affordable education as a Montana HFMA member, I am honored to be a volunteer on the Montana HFMA Board and Program Committee. Before I served in these capacities, I had no clue as to the reasons behind the affordable education opportunities we have as Montana HFMA members. So please take a moment to thank a committee member when you talk to one or stop by one of the sponsor's booth during the next conference. If you aren't sure who our sponsors are, then look for the list included in this newsletter. We are lucky to have high-quality education at an affordable price.

I find that a "Thank you" or a few minutes of my time during the conference spent with a sponsor is a small investment for the return.

Inpatient vs. Observation: The Difference

Shar Sheaffer, Owner
Dingus, Zarecor & Associates PLLC



Stephen Rose, Chair, Health Law Department
Garvey Schubert Barer



Medicare Recovery Audit Contractors (RAC Audits) have focused their efforts on inpatient versus observation billings. The RAC Audits have dunned hospitals millions of dollars for confusing these two concepts. The purpose of this article is to provide some guidance on how to distinguish inpatient versus observation services.

The determination between inpatient and observation services must come from the physician. They are the ones responsible for deciding what type level of care a patient requires. However, the hospital should have guidelines to ensure physicians understand differences between inpatient services, observation services, recovery, and other monitoring.

So when should a patient be put into observation care services? Observation care services are an outpatient service. Inpatient care services are provided to a patient whom the doctor deems medically necessary to admit to an inpatient or ICU bed.

(Continued on page 4)

Save The Dates!

October

The MT HFMA Newsletter Chair will be sending out an e-mail survey on purchasing study guides for the Certification Exams. Please make sure you take the time to vote.

November

HFMA will be sending out a membership survey for the Montana Chapter in November. Please make sure you take the time to fill it out.

2010 Montana Chapter Spring Conference

April 14-16, 2010
 Red Lion Colonel Inn, Helena, MT

2010 ANI -The Healthcare Finance Conference

June 20-23, 2010
 Gaylord Opryland Resort and Convention Center,
 Nashville, TN

KICK OFF TO BETTER DENIAL MANAGEMENT:

Four steps you can take this fall to improve your denial management program

*By Alex Penn
PNC Healthcare*

Before you continue reading this article, answer this question. How much is 5% of your gross revenue? Do you know the number? On average, hospitals lose anywhere from 3% to 10% of gross revenue per year due to billing inconsistencies, underpayments and denied claims, so 5% of gross revenue is a reasonable estimate of the cost of your facility's denials. According to a study by America's Health Insurance Plans, 14% of claims submitted to payers are denied and one out of every seven claims has to be resubmitted, appealed, or written off. There is an abundance of evidence that suggests that a better approach to handling denials and underpayments could add substantially to a hospital's bottom line. This article will discuss four process improvement steps your hospital could adopt immediately to improve the efficiency of your denial management process.

DEFINE DENIALS

How do you define a denial? It seems like a simple question, but unfortunately many hospitals do not have a standard definition of a denial. The key to fixing denials is understanding the magnitude of the problem. You cannot understand the magnitude of the problem without having a clear definition of what a denial is. Since nonpayment from a payer can stem from numerous factors, the definition of a denial is not as clear as you might think. Some healthcare providers have a very narrow definition of denials, such as counting only clinical denials. Others define denials more broadly as not receiving revenue for any service for which you expected to receive revenue. Without clearly defining what a denial means for your organization, it will be very difficult for you to truly assess the current scope of your denial issues. But, more importantly, it could inhibit your ability to craft a successful game plan to improve your denial management process in the future.

ESTABLISH METRICS AND A PLAN

If you do not know where you are going, you will never get there. This is a famous saying that is very applicable to improving your denial management process. Once you have your standard definition for a denial, then you need to conduct a current assessment of your denial process.

You need to ask questions such as:

What is your denial rate?

How many clinical and technical denials do you handle monthly?

Who are your top five payers in terms of denials?

What are your five to ten most frequent adjustment codes?

There are plenty of measurements you can use to understand your current situation. After you evaluate your current state, leverage those same measurements to create your short term and long-term goals. A critical step in ensuring you reach those goals is to

implement a process to monitor your progress. A quarterly review of your progress and goals should provide enough information to judge the success of your plan.

DEDICATE RESOURCES

As hospitals shift more focus to improving their denial process, a growing trend is to create a stand-alone denial management team. Too many hospitals treat denial management as a "part-time" responsibility where their patient accounting staff tries to juggle denial management along with all of the other numerous responsibilities on their plate. However, more hospitals are realizing that in order to effectively manage their denials and capture all of the revenue that is due to them, they must commit dedicated resources to the process. Denial management teams are typically tasked with the responsibility of capturing, monitoring, and conducting trend analysis on denials. In addition, they are responsible for conducting regular meetings with different stakeholders such as Admissions, Case Management, Nursing, and the Business Office to ensure that there is alignment on the issues and that the appropriate steps are taken to rectify the denials.

OFFER INCENTIVES

A fourth tip is to consider providing your denial management team, and potentially the stakeholder departments that are ultimately responsible for implementing procedures to reduce denials, financial incentives for reaching specific goals. Providing incentives is an effective way to motivate the team and demonstrate the hospital's commitment to reducing denials. Holding employees accountable and rewarding them for reducing the overall denial rate or reducing the denial rate for your critical payers is a productive way to keep them engaged and ultimately to provide a major financial benefit to your hospital as well.

Agreeing to a standard definition of a denial, defining a set of long term goals, developing a dedicated denial management team, and giving employees incentives for reaching their goals are four steps you can take immediately to improve your denial process. Hospitals frequently look for new denial management tools to jumpstart their denial management process. While denial management tools are vital for helping hospitals aggregate and analyze denial data, they are no substitute for having a well thought out long-term plan and a solid internal denial management process.

Alex Penn is Assistant Vice President with PNC Healthcare, covering national healthcare clients in the Texas, Illinois, Nebraska, Oklahoma, Arkansas, South Dakota, North Dakota, Montana, and Wyoming markets. His previous experience at PNC includes managing PNC's healthcare clearinghouse operation in Tulsa, Oklahoma, and project management assignments in PNC's finance department. Penn's previous corporate experience includes seven years at Deloitte Consulting where he was a manager in Deloitte's system implementation practice. For additional information, or to comment on this article, email alex.penn@pnc.com.

The Reform Debate Grinds On

By Bob Olsen

Today brings a cold and snowy October day. Ah, Montana. Last week we were 40 degrees above seasonal norm, and now we're 20 degrees below common temperatures. I mention this only because the discussion about health reform seems to be a lot like talking about the weather in Montana. It's not usually like we think it should be, someone is always unhappy with it, and the most common theme: if you don't like it, wait a few hours and it'll change.

The Senate Finance and Claims Committee completed its work on a draft bill. The Congressional Budget Office has just released its estimate of the budget impact for the measure and the Committee will likely vote on the measure in a few days. The latest step in the legislative process will no doubt kindle another round of analysis and talking heads expressing their support, concerns or outright opposition to the measure.

This process will continue into the months of November and December. I doubt anyone really knows what happens, if and when, Congress completes its work. Or not.

In the back of my mind is the question, "What is really going to change due to the health reforms being considered in Washington?" If you think about it, private commercial insurance will continue to be the primary vehicle for most Americans to get - and keep - health coverage. Medicare and Medicaid will play a larger role in providing care to the elderly, the poor and disabled and others who can't afford private commercial insurance. The VA and Indian Health Services will continue largely untouched.

Depending on the final measure, Americans may, or may not, have to get coverage. That coverage may, or may not, include mandatory benefits. The government will plow a lot of money into private insurance companies to subsidize health plans. The government will plow a lot of money into Medicaid to cover the working poor. The government doesn't have a lot of money rattling around these days, so there are proposals to impose some taxes and fees, and to cut other spending to pay for the subsidies. So what's new?

Reining in health spending seems to be the key for Americans to both afford universal access to care, and to preserve some competitive position for American business. To reduce costs it seems the plan is to rely on the old stand-bys: reduce waste, fraud and abuse, trim medical payments or otherwise alter the payment incentives to bend the cost growth curve. Policymakers are banking on electronic medical records and health information to bring substantial cost savings. Tort reform is even beginning to show up on the agenda, although few expect tort reform produces big savings.

Consumers are also expected to use their purchasing power - and hopefully healthier lifestyles - to demand higher quality service and lower prices. Transparency will continue to be the buzzword, as most of the measures impose greater reporting requirements on hospitals and other providers.

So on it goes. We appear to be doing some good things to get more Americans covered by insurance. That might reduce the cost shift imposed by uncompensated care. There's no harm in modernizing our administrative processes while delivering care to a better informed patient. But today it feels like I'm watching the weather, and it just seem like there's big changes on the horizon. But if you'll tolerate one more weather analogy - it sure is windy around here!

Inpatient vs. Observation

(Continued)

If the physician believes the patient's condition will stabilize and they can be discharged within 24 hours, they should admit to observation status. This status can be used to determine if the patient should be admitted or sent home. Typically, the physician orders tests to assist in their decision.

Depending on the test results or a patient's waning condition, the physician may decide to admit the patient to inpatient status. For a PPS hospital, the observation is rolled up into the inpatient stay. For a critical access hospital (CAH) the charge is billed as outpatient and an inpatient stay is billed.

Observation services are based on the physician's opinion that the patient's condition will improve in less than 24 hours. The location of the service is not a factor. However, the location of the service must be considered on the Medicare cost report and, therefore, must be tracked.

Technically, observation services cannot exceed 48 hours. If continued care is required, patients should be admitted.

There are several areas of noncovered observation services. First is recovery. Observing a patient after surgery is recovery and not observation. If the surgery requires more than 24 hours of monitoring, the patient should be admitted as an inpatient. The hospital may bill the surgery charge, recovery, and a room charge (and related ancillaries). Same day surgeries can bill surgery, recovery, and the related ancillaries, but not observation.

Observing a patient after diagnostic testing is a noncovered observation service. The test or surgery may be complex and require an inpatient stay, but billing observation is not allowed.

A patient is admitted as an inpatient when the admitting physician believes the intensity of service or specialized care required for the patient is expected to require more than 24 hours of care.

However, the length of time a patient actually spends in the hospital is not the qualifier. It must be medically necessary for that patient to spend time in the inpatient bed.

Documentation appears to be key for supporting observation claims. The admitting doctor must document their decision to admit or observe a patient. Furthermore, the medical record should list the criteria and reasoning for the physician's choice.

(Continued on page 6)

Do you find yourself curious as to what is going on with TRICARE? TriWest Online Care Program Now Available

TriWest Healthcare Alliance is offering the TriWest Online Care program, a videoconference Tele-Behavioral Health Care program for eligible TRICARE beneficiaries in the West Region. This Department of Defense (DoD) initiative supplements TRICARE's existing face-to-face behavioral healthcare benefits and improves access to behavioral health providers.

Make the Connection

Military families may find themselves living through unusually stressful and difficult situations. Individuals may need an experienced professional to talk to, behavioral health counseling, medical treatment, or some additional support resources to help them through a challenging time.

TriWest's Online Care Program expands access to behavioral health services for eligible TRICARE beneficiaries in the West Region.

TriWest's continuum of online behavioral health services includes:

- Tele-Behavioral Health Care
- TriWest Behavioral Health Portal
- TriWest Behavioral Health Contact Center (BHCC)
- TRICARE Assistance Program (TRIAP)

Providers may participate in providing Tele-Behavioral Health Care to eligible TRICARE beneficiaries either as an Originating Site or Distant Provider. An Originating Site is the site where an eligible TRICARE beneficiary is located when Tele-Behavioral Health Care is being furnished via a videoconferencing system. Please note that an Originating Site does not have to be a behavioral health facility. A Distant Provider is the TRICARE network behavioral health provider rendering Tele-Behavioral Health Care via a videoconferencing system.

To sign up as an Originating Site or a Distant Provider for this exciting new program, please contact your local network representative. If you do not have their contact information, refer to www.triwest.com/provider, Resource Library, Phone Numbers. Additional information about TriWest Online Care can be found on the secure provider portal at www.triwest.com in the Behavioral Health Online Care section as well as on the Behavioral Health Portal at www.triwest.com/bh.

TriWest Online Care Program Summary

Tele-Behavioral Health Care

1-888-TRIWEST (874-9378)

- Clinical services such as consultation, counseling, psychotherapy and medication management
- Provided by TRICARE network behavioral health providers
- Accessed from Originating Sites, conveniently located throughout the West Region, via videoconferencing

TriWest Behavioral Health Web Portal

www.triwest.com/bh

- Access to evidence-based education 24/7/365 by beneficiaries and providers, reference information, streaming video and links to hundreds of community-based resources

- Topics include deployment concerns, stress, PTSD, parenting, relationships, depression, substance abuse, suicide grief, and more.
- TriWest Behavioral Health Contact Center (BHCC)
1-888-TRIWEST (874-9378), secure Web-based e-mail or live chat for eligible TRICARE beneficiaries at www.triwest.com/bh

- Beneficiaries are assessed and triaged
- Provides assistance with scheduling the first Tele-Behavioral Health Care appointment
- Crisis Line Services are provided 24/7/365 by licensed professionals, accredited by the American Association of Suicidology TRICARE Assistance Program (TRIAP)
1-888-TRIWEST (874-9378)

www.triwest.com/bh

- Confidential
- Non-medical counseling available 24/7/365 via Web-based video conferencing
- Discussion, problem solving and assistance with personal life issues
- Provided by Assistance Counselors (licensed Master's or Ph.D.-level counselors)

Clearing up the Confusion on Copying Military ID Cards

On August 10, 2009, U.S. Army North published a Force Protection Advisory (0050-09-FPA) entitled Photocopying of Military Identification Cards. It stated "Recent incidents regarding the photocopying of military identification cards and common access cards (CAC) by commercial establishments to verify military affiliation or provide government rates for service have been reported. Commanders and Supervisors are reminded that the photocopying of US Government Identification is a violation of Title 18, US Code Part I, Chapter 33, Section 701, January 3, 2007, and punishable by both fine and imprisonment. Many military members, family member and DoD employees are unaware of this law. Please pass to the lowest level and include in training for force protection, information security and OPSEC." The advisory was since rescinded by the Army on August 13, 2009, but it has caused confusion among Military personnel and providers alike in the West Region about copying military ID cards. Per Department of Defense (DoD) instruction and reinforced in the TRICARE Provider Handbook is both allowable and advisable for providers to copy a beneficiary's ID card to facilitate eligibility verification and for the purpose of rendering needed services. The DoD recommends that providers copy both sides of the ID card and retain copies for future reference. A valid uniformed Services ID card serves as proof of eligibility for TRICARE coverage. Title 18, Section 701 of the U.S. Code and the Department of Defense Instruction 1000.13, paragraph 6.17 authorizes the photocopying of the front and back of the ID card to establish the eligibility of the patient to receive care.

If you need any further information, please refer to the TRICARE Policy Manual at www.tricare.mil/.

Inpatient vs. Observation

(Continued)

So when can I bill for observation services and an inpatient stay?

Can a patient's status change from inpatient to outpatient? The answer to both is "yes" provided certain specific facts occur, but it will rarely happen. However, if it does occur, it must happen before the patient is discharged.

To change from inpatient to observation: Here the utilization review committee reviews the case determines the inpatient level of care does not meet the hospital's admission criteria. If the admitting physician concurs, the patient is still a patient of the hospital, and Medicare has not been billed an inpatient stay, the status can change.

To change from observation to inpatient: Here the patient's condition is deteriorating or the test results indicate an inpatient stay is necessary.

Therefore, the hospital can change from observation to inpatient status, but can only change from inpatient to observation in rare circumstances.

Inpatient versus observation is a question of who bears what portion of the charges. For an inpatient stay, the beneficiary pays a deductible. For outpatient services, they pay a co-insurance. In a PPS hospital, outpatient services performed within a specified window are rolled up into the hospital stay. For a CAH, the outpatient services are billed as outpatient regardless of a later admission. Therefore, the question of inpatient versus observation is whether Medicare is responsible for charges after the deductible or after co-insurance. For beneficiaries who have met their

deductible the out-of-pocket amount can be significantly different.

We now have a definition of inpatient and observation, the reason Medicare and the beneficiary would care, so what do we do now?

We recommend reviewing the hospital's admission criteria. There should be separate written clinical criteria for admitting to inpatient and observation status. This criteria should be followed by physicians. Although it is the physician's decision whether to admit the patient to inpatient or observation care, the hospital should work with their physicians to ensure that both the hospital and physicians agree on the criteria to be applied to make this determination.

The hospital should periodically audit the medical records of those patients placed into observation status to ensure the time, date, and clinical reason for admission to observation status is properly documented in the medical record. The hospital should also review medical records of those patients with short or one day stays to make sure that these admissions are properly documented. If issues exist with documentation or adhering to the written clinical criteria, the hospital should follow up with the admitting physician to determine why there is a problem and how to resolve it.

For PPS hospitals it is a significant RAC audit issue. For CAHs it may be a RAC issue, but we believe it will also be closely monitored to ensure the CAH is not using an observation bed unit to exceed the 25-bed limit.

Either way, it is crucial that hospitals and physicians understand the differences between inpatient hospital services and observation services.

If you have any questions or require additional information, please call Shar Sheaffer at 509.242.0874 or Stephen Rose at 206.816.1375.



CHECK OUT OUR WEBSITE

For more information about the Montana Chapter of HFMA please visit:

www.mthfma.org

Is your information up-to-date?

Visit www.hfma.org and login and check personal profile



Chapter Sponsors

Diamond Sponsors

*Healthcare Outsourcing
Network, LLC*

Siemens

Platinum Sponsors

Towne Mailer, Inc

Larson Allen LLP

Agency of Credit Control

Rocky Mountain Health Network

The MASH Program

Gold Sponsors

Blue Cross Blue Shield of Montana

Eide Bailly, LLP

Montana Facility Finance Authority

Outreach Services

Silver Sponsors

Array Services Group, Inc.

CBB-CBM-CBO-CBU Collections, Inc.

Centron Services Inc.

Collection Bureau Services, Inc.

Credit Associates

Dingus, Zarecor & Associates PLLC

Health E Web

J&H Office Equipment, Inc.

Med Assets, Inc. (MHA)

Medical Reimbursements of America, LLC

Moss Adams

New West Health Systems

Perot Systems

The Resource Center

United Healthcare

Bronze Sponsors

ACS

Allegiance

Caremedic Systems, Inc.

Collection Professionals, Inc.

Emdeon Business Services

HCFS

Healthcare Management Systems, Inc.

Humana

Pine Creek Healthcare Capital, Inc.

Recovery Resources

Tech Time





New Members

Helen Jones	Resolution Consulting LLC	Colorado
Steph Denham	Phillips County Hospital	Malta
Connie Prewitt	Billings Clinic	Billings
Tricia Wagner	Community Hospital Anaconda	Anaconda
James Young	Providence Health Services	Missoula
Rene Richmond	St. Vincent Healthcare	Billings

We welcome you to the Montana Chapter of HFMA!

A Message From the Region 10 Regional Executive: Hal Prink, FHFMA



Hal Prink, FHFMA

Region 10 Executive

halprink@comcast.net

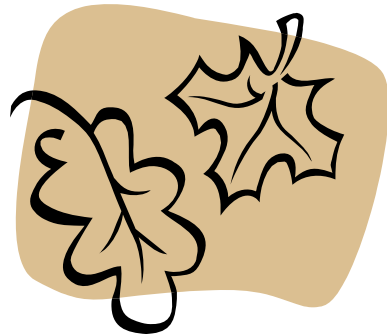
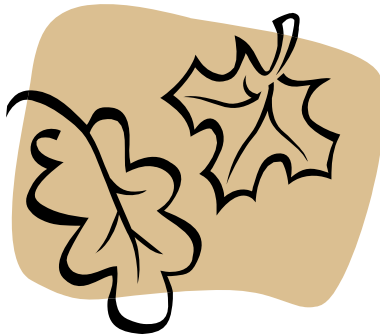
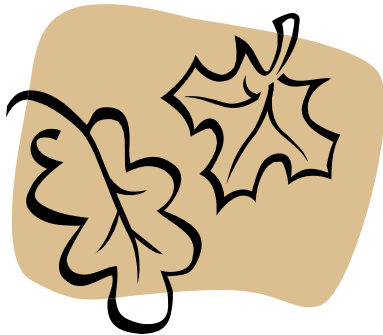
It is my pleasure to serve as the Region 10 Executive for our region which consists of the following chapters: Arizona, Colorado, Idaho, Montana, New Mexico, Utah and Wyoming.

The Role of the Regional Executive is as follows:

- ◆ Serve as the primary volunteer and policy link between chapters and the Association
- ◆ Assist chapter leaders in serving members
- ◆ Promote and lead change efforts to drive HFMA strategies
- ◆ Foster dialogue and communication at all levels of HFMA
- ◆ Represent the needs and interests of chapter leaders to the HFMA Board and staff
- ◆ Work to create a seamless system of service for HFMA members
- ◆ Encourage chapter to collaborate and help other chapters
- ◆ Attend chapter meeting to network with chapter leaders and volunteers and show support for their activities
- ◆ Talk with Chapter Presidents/Presidents-Elect at least once per quarter to assess performance
- ◆ Highlight best practices and share concerns

We recently had our Fall Presidents Meeting and will provide highlights of it and my visits to our chapters in your next newsletter.

I look forward to working with all chapters in fulfilling his role for our Region. In the meantime, if there is any way I can assist you in your communications with HFMA National, please let me know





Region 10 Regional Executive-Elect

By Tammy Trovatten

MT HFMA Newsletter Chair

Hal Prink, the Region 10 Regional Executive, was recently in Montana attending the Montana HFMA Conference in Billings. It was a great opportunity to meet him and very informative to hear news from the Region 10 area of Arizona, Idaho, Montana, New Mexico, Utah, and Wyoming. As of June 1, 2010, our very own JJ Carmody will start her term as the Region 10 Executive-Elect. JJ Carmody, from Billings Clinic, was elected as the new Regional Executive-Elect by the Chapter 10 Presidents (Arizona, Idaho, Montana, New Mexico, Utah, Wyoming) at the Fall President's meeting in Big Island, HI. JJ's Regional Executive-Elect term will begin June 1, 2010, followed by a year as the Regional Executive. Please join us in congratulating JJ on her new role and thank her for all of her hard work and dedication to HFMA!

THANKS JJ and CONGRATULATIONS



Congratulations!

A decorative graphic with the word "Congratulations!" in a cursive font. The text is surrounded by yellow stars and colorful streamers (pink and red) on a light yellow background.

Hospital Performance Showing Signs of Life

By Bob Olsen

Thirty-three Montana hospitals reported mixed financial results for the first 6 months of 2009 compared to the same period a year ago according to MHA Databank. Discharges fell by 3.65% during the period, while outpatient surgeries dropped by 1.73% and emergency department visits declined by nearly 3%.

Hospitals managed to post a collective loss of 0.86% on patient care, but critical access hospital patient service margin fell to -6.10% compared to a 4.03% loss in 2008. Collectively hospitals posted a 2.85% loss on patient services during the first 6 months of 2008. Total margins were much improved over 2008, as hospitals, buoyed by other operating income and nonoperating gains, posted an overall margin of 5.14%. Critical access hospitals showed a 2.74% gain during the period, while hospitals paid by fee schedules posted a 5.75% margin.

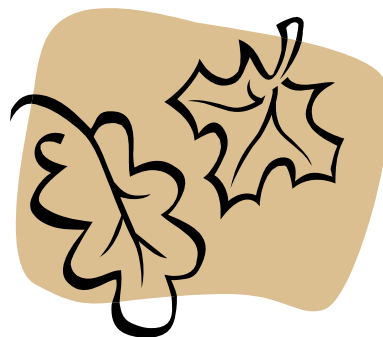
Hospital expenses also grew in 2009, increasing by about 7% over 2008. Bad debt expense surged by more than 32% over 2008 figures to \$64.4 million, a trend reflective of the flagging economy, while charity care remained steady at about \$50.4 million for the 6-month period, or 2.93% of charges. Paid hours grew just 0.6%,

Hospital charges grew by about 11.6% over 2008 to \$1.7 billion, but discounts for government payers and private commercial insurance surged to \$668 million, or 16.6%. Hospital accounts receivable dropped 3.26% to just under \$553 million, or 57 days. Amounts owed by Medicare and Medicaid dropped by 21% and 14%, respectively, while the amounts due from self pay and commercial payers grew by 5.8% and 5.3% respectively.



hfma montana chapter
healthcare financial management association

The Montana Chapter of the Healthcare Financial Management Association is a professional membership organization for individuals in financial management of healthcare institutions and related patient organizations.



Warning Signs of a Distressed Hospital

By Bob Vento

Reprinted with permission from Lancaster Pollard's 'The Capital Issue' at www.lancasterpollard.com

The typical hospital's business model and revenue stream are so markedly different from other businesses, its level of financial distress can be difficult to diagnose. The following early warning signs will help hospital leaders more clearly identify and proactively react to financial distress. While no single metric can accurately identify early-stage distress in all hospitals, the following financial indicators can offer helpful insight into the outlook of a hospital that might be in trouble.

Days Cash on Hand: Trend Analysis

The number of days of cash a hospital has on hand is a classic solvency metric. Astute analysts will track long-term trends, as well as

review individual instances. Analyzing multiple-year and/or monthly trend lines can add clarity to assessing hospital performance. Further investigation can help determine if large movements resulted from a favorable change, such as an increase in net patient revenue; a neutral change, such as an influx in cash from a real estate divestiture; or an unfavorable change, such as an investment loss.

Benchmark: Simply stated, decreasing cash from year-to-year or month-to-month is a sign of financial distress. In addition, an interim snapshot that reveals the number of Days Cash on Hand at a point materially lower than historical patterns or bond covenant requirements may well be cause for immediate review, concern and follow-up.

Current Ratio: Trend Analysis

Just like Days Cash on Hand, reviewing a hospital's current assets compared to its

current liabilities can be more instructive as a trend than as a single snapshot, especially for early detection of financial distress.

Developing a Current Ratio trend line for multiple years supplemented by a cycling of the most recent 12 months will likely provide compelling predictive value.

Benchmark: In general, a trending decline that has reached 1.5 is an early sign of financial distress. Any single instance that is 1.0 or less warrants timely investigation.

Accounts Receivable (AR) Days: Trend Analysis

An increase in AR Days is often indicative of a hospital with poorly negotiated managed care contracts, unfavorable market changes, or ineffective collection practices. The challenge of reducing AR Days is both critically important and exceptionally challenging in the healthcare industry due to highly complex and unorganized payment

(Continued on page 13)

the MASH program

strength flexibility balance

Put your self-pay eligibility services on the winners' stand. Call Diana Taylor at 903/926-0473, or Marya Marvin at 406/546-1097, or vault over to www.mashinc.com. MASH is a proud Platinum Sponsor of Montana HFMA.

IN MEDICINE, BIGGER DOESN'T NECESSARILY MEAN BETTER.

There are times when smaller is better. New West Health Services proves that every day. We're the perfect size to offer our customers smart, affordable plans with personal service that bigger insurance companies can't match. We also provide useful, money-saving online tools like MyNewWest to help you access claims records, estimate costs and compare every aspect of your plan. Join the thousands of Montanans who have become believers in New West. We're not the biggest, just the best.

NEW WEST HEALTH SERVICES

www.newwesthealth.com

Warning Signs of a Distressed Hospital (continued)

systems. Reviewing a 12-to-18-month trend of AR Days can indicate a hospital's ability to meet these challenges. Poor revenue cycle management will quickly exacerbate hospital financial distress.

Benchmark: Any trend of increasing AR Days is a sign of trouble; however, an average of 55 days paired with a trending increase is especially concerning. This is even more concerning when coupled with growing bad debt, a relevant consideration as increasing numbers of American workers find themselves unemployed and uninsured. The quality of the AR aging file is another relevant factor when evaluating the revenue cycle management process. That is, if

AR aging categories by payer are worsening over time, the probability that liquidity will suffer is high – an obvious indicator of distress.

Capital Expenditures vs. Annual Depreciation

Capital improvements are critical for hospitals to recruit physicians, attract patients and deliver quality care. A hospital that does not upgrade its facility and equipment to offset the depreciation of its capital assets, especially in revenue-generating areas of the hospital, is headed for trouble over the longer term. The effect of delayed expenditures is compounding, and the cost to “catch up” on postponed improvements can be far greater than an initial investment. A hospital's capital expenditures and annual depreciation should be calculated for each of the past 10 years to determine if it is keeping pace.

Benchmark: If depreciation has outpaced capital improvements in more than three of the past 10 years – or if this is the case for the most recent two years – the hospital is likely experiencing distress. In addition, if the facility's next scheduled capital project relies on funds exposed to market performance (investment income, grants from foundations or charitable donations), more serious financial issues may exist. This is especially true for hospitals nationwide that are facing challenges in accessing debt financing due to today's tight credit markets.

Internally Prepared Financial Statements

Clear financial statements are critical for sound decision making. A hospital that prepares a confusing, inadequate, or poorly organized set of financial statements may be unable to analyze data, look beyond the numbers, or make informed decisions. Reviewing several hospital monthly financial statements can show data being used to make routine and strategic decisions. A fundamental benefit of financial statements is predictive value.

Benchmark: General purpose financial statements that do not contain some narrative, lack compelling financial information (e.g., key statistics and cash flow data), and generally lack substance may be indicative of a hospital that is making decisions based on incomplete or erroneous information. Left unchecked, this can lead to unfavorable financial outcomes and ultimately financial distress.

The challenges are great for our nation's hospitals and health systems. Many need immediate intervention to prevent crisis situations. Early detection and swift intervention can help ensure that: (a) communities maintain access to the healthcare services they need, and (b) risk is mitigated for financial stakeholders in the hospital.

Bob Vento is a senior vice president for QHR Intensive Resources.

For additional information on QHR's consulting solutions, contact vice president Susan Hassell at (866) 371-4669.





MONTANA CHAPTER
HFMA

2009-2010 Chapter Officers

Steve Scharmann

President

Bozeman Deaconess Hospital

Donja Erdman

President Elect

Marcus Daly Memorial Hospital

Don Miller

Secretary/Treasurer

Community Medical Center

Tina Montgomery

Past President

Sidney Health Center

JJ Carmody

Past-Past President

Deaconess Billings Clinic

2009-2010 Chapter Directors

Maria Conn

Monida Healthcare Network

Robin Hill

Community Medical Center

Kim Lucke

Northern Montana Hospital

Linda Nygaard

Northeast Montana Health Services

Bob Olsen

MHA

Greg Peterson

St. John's Lutheran Ministries

Scott Thorn

Bozeman Deaconess Hospital

Tammy Trovatten

Benefis Heal System

Joe Vachal

Community Medical Center

Editorial policy: Opinions expressed in articles or features are those of the author and do not necessarily reflect the views of the Montana Chapter of Healthcare Financial Management Association or the Editor. The Editor strongly encourages the submission of material for publication. The Editor reserves the right to edit material and accept or reject contributions whether solicited or not.



hfma montana chapter
healthcare financial management association