Oregon Chapter of HFMA

PIPELINE

Volume 14, Issue 1 • Winter 2010

In this issue

President's Message

Health care reform leads the news for fall

First off, Happy New Year to all of you!! Hope you were able to spend valuable time with family and friends. My family, unfortunately, did not make the trip to Pasadena, but we look forward to the opportunity next year. Go Beavs!

One of the objectives of our strategic plan was to evaluate the current leadership structure of the Oregon Chapter for maximum potential of involvement. We identified two strategies to assist the board in making this decision:

1. Compare and contrast our leadership structure with that of other chapters in Region XI.

At the fall president's meeting, I led a discussion describing our current structure with the other chapter presidents and president-elects. We also had the benefit of our regional and national leadership representatives. Many of the other larger chapters, such as Southern Cal and Northern Cal, have structures very similar to Oregon, which includes years of service within the committee structure that progresses to board members and finally the officer track. Smaller chapters like San Diego and Nevada have a very short term for president.

The concluding theme was that all of the chapters were evaluating the terms in leadership and how to make their chapters as viable looking forward.

2. Consider eliminating the requirement that treasurer be part of the rotation to president.

We had a special board meeting in December to evaluate the pros and cons of this issue. Some of the pros included:

- Stability in the position for more than a one-year term
- Attracts accountancy experts to a position that does not require the succession to president
- Reduces the terms in the leadership structure by one year

After the discussion, we approved that the treasurer position would *not* be part of the succession to president. The position remains an officer and still has a two-year term. Our bylaws do not need to be amended to accommodate this change, but the board wanted to be sure that membership was fully informed about this decision.

In closing, let me say we are looking forward to our winter meeting, to be held Feb. 17–19 at OHSU in Portland. Key themes will be the hospital-provider tax and the implications of provider-based billing models. We will be offering sessions on Wednesday afternoon particularly focused on reimbursement-related issues. I hope to see you all there!

Until we meet again,
Diana Gernhart
Oregon Chapter President

Avoiding a Medical Data Breach

By Bruce Nelson, vice president, SearchAmerica

More than 30 health care systems of all sizes recently have been victimized by identity thieves and data breaches, and incidents such as these are expected to continue. 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 will continue into 2010 and well beyond, and health care organizations will 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 especially vulnerable to 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. According to the Ponemon Institute, health care organizations experience a high annual employee turnover rate — 6.5 percent, almost double the general turnover average of 3.6 percent. With more employees entering and exiting a health system's 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.

Governmental action

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 pre-breach programs, as well as state laws in California and Missouri. This 2009 legislation expands current federal privacy and security protections of health information.

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 law 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

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Avoiding a Medical Data Breach

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required to provide notice to prominent media outlets in that area.

- **Secretary notice:** Hospitals must notify the U.S. Department of Health and 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 won't happen by chance. To prevent breaches from occuring, leading health care companies are taking advantage of new processes and proven solutions used in other industries, namely financial and credit-card markets.

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. Many different workers need access to patient health information to perform their jobs. 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. There should be no exceptions.

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 non-compliance 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 finding 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.

PIPELINE is the official newsletter of the Oregon Chapter of the Healthcare Financial Management Association. Our objectives are to provide members with information about chapter and national HFMA activities and to provide a forum for reporting state and national issues relating to the healthcare industry. Opinions expressed in articles are those of the authors and do not necessarily reflect the view of the Oregon HFMA Chapter or its members. 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 of information for publication unless otherwise indicated. © 2010 Editor: Chris Brazil

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Recovering International Patient Account Reimbursement

By Marc Krimen, International Revenue Recovery Group, and Shawn Mimnaugh, director, Third Party Liability Outreach Services

Everyone in the health care industry has experienced the frustration of revenue loss by international exposure. All too frequently, hospitals encounter obstacles to reimbursement after caring for an insured international patient and, even for the experienced financial worker, those obstacles prove difficult to overcome.

Dealing with international reimbursement presents unique issues related to global marketing, sales and claims not seen with domestic health insurance. International reimbursement also requires sensitivity to international laws, cultures and customs. One should not be surprised or discouraged when a patient from the Philippines purchased travel insurance in Japan, and the Norwegian claims office seems perpetually closed for a national holiday. However, the basic methodology for approaching international reimbursement claims is analogous to that used when pursuing reimbursement from domestic insurers: identify sources of coverage, establish liability, and be prepared to provide support for the medical charges incurred.

International accounts can be broken into two basic categories: (1) the more common involving international travel or health insurance and (2) the less common where reimbursement is dependent upon establishment of third party liability. In the travel or health insurance scenario, the most difficult obstacle facing the provider is often the actual receipt of the medical payment. International insurers covet their option to reimburse the patient – not the providers. The complications arising from this scenario are only aggravated when the debtor/patient resides on foreign soil.

The latter scenario, with reimbursement arising out of third party liability, is even more complicated. The most traditional means of pursuing third party liability — litigation — is costly, time consuming and in many cases, ineffective, when the defendant lives abroad. International service of process is complicated and can take many months. Even if service is accomplished, the defendant may refuse to participate in the litigation. Although the provider can obtain a default judgment, there is no leverage to compel payment unless the foreign defendant has assets within the United States.

A disciplined approach to potential international claims can help avoid the many difficulties that may arise, whether dealing with foreign health or travel insurance or third party sources of reimbursement. As part of the admissions process, the provider should gather clear copies of the patient's visa, passport, government and /or country issued identification, and insurance information, including any insurance contracts or documents the patient may have in their possession. Once you have confirmed that you will be dealing with an international claim, obtaining a general information release from that parallels a specific medical release lends access and credibility when looking contacting potential payers. Having the patient execute an assignment of benefits will help remove any ambiguity as to whom reimbursement should be issued.

Obtaining a local contact can simplify communication with the patient while at the same time facilitate — at no expense to the provider — translating an insurance contract which may be written in a foreign language. We recently encountered a situation which involved a patient with an extended visa. Our advocate identified a family friend during the screening process who assisted in translation of the insuring agreement. That translation revealed that visa extension periods were expressly excluded from coverage. It wasn't the news we wanted to hear, but it eliminated wasted time pursing a payer that had no obligation to provide coverage.

Successful recovery of international claims requires both persistence and a willingness to think outside the box. The financial services worker must be willing to become familiar with world clocks, arrange for translators, e-mail in foreign languages and work odd hours to call foreign locations. However, patience, discipline and creative use of available resources will give rise to positive results. In one recent case, we sought assistance from a State Attorney General to obtain reimbursement from a travel insurer in China. In another matter, our persistence resulted in an insurer from Malaysia issuing payment directly to our provider in Washington for a patient from Thailand.

Presentation of claims should be in an orderly, organized fashion, and compliance insurer guidelines and requests for information is of the essence. Recovery from international sources is often quite arduous, but if attended to properly, will result in substantial increases to your revenue.

You are cordially invited to attend

Oregon HFMA Winter Meeting 2010

February 17–19, 2010

Oregon Health & Science University
Doernbecher Children's Hospital
Vey Conference Center, 11th floor
3181 S.W. Sam Jackson Park Road
Portland, Oregon 97239

Accommodations

Avalon Hotel and Spa
455 S.W. Hamilton Court
Portland, OR, 97239
503-802-5800
www.avalonhotelandspa.com

HFMA membership data is current as of Jan. 7. If you have not renewed, unfortunately you cannot receive the member discount.

Wednesday, February 17

9 a.m.–noon

Core Exam Certification Training

This optional session helps prepare chapter members interested in HFMA's certification (CHFP and Fellowship) for the four-hour core exam. To register, contact Sara Nofziger, 503-657-8663 x100 or sara@absportland.com. Sara will send you the chapter's copy of the study guide and the answer key to the end-of-course test. You may wish to purchase your own copy of the study guide directly from HFMA. To get the most out of this training, please pre-read the material before Feb. 12. The class is open to all Oregon HFMA members interested in the personal and professional growth and recognition associated with HFMA certification.

1–2:30 p.m.

Reimbursement Session: Medicare Appeal Issues and Litigation Update

by Sandy Pitler, shareholder, Bennett, Bigelow & Leedom, and Carol Sue Janes, senior attorney, Bennett, Bigelow & Leedom

The most significant PRRB appeals and Medicare litigations are always closely watched by the hospital community because of the direct impact they have on Medicare reimbursements to hospitals across the country. This session will focus on some of the ongoing appeals and court cases with national implications and provide in-depth discussion, including their background, the issues and contentions by the parties. The presenters will offer their perspective on the likely outcome of these cases and when we can expect to hear the final decisions. At the end of this session, you'll get the latest news on some of the most important ongoing appeals as well as legal battles currently raging in the court system.

1–5 p.m.

Certification Exam

Optional. This is your opportunity to take any one of the certification exams in a proctored setting. Exam applications are available on www.oregonhfma.org under "Educational Materials." Please complete this form (leaving proctor name and payment information blank) and fax it to Sara Nofziger (503-723-3180) no later than Jan. 27. Also let Sara know if you can bring a laptop computer. The Chapter pays the certification exam fees (maximum of two tries per exam) for its members. Please note: Due to limited space, attendance will be first-come, first-served basis, so please contact Sara as soon as possible.

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Wednesday, February 17, *continued*

2:40–4:10 p.m.

Reimbursement Session: New Medicare Hospital Cost Reporting Form-2552-10/Medicaid Elig Verif Process

by Cheryl Storey, partner, Moss Adams LLP, and Mike Biscup, partner, DSH Recovery Services

This session will feature a panel of two experts discussing two distinct topics, with significant implications on current and/or future Medicare cost reporting. Cheryl Storey will provide an overview of the new Medicare hospital cost reporting form, 2552-10, which will be required for all cost reporting periods beginning on or after Feb. 1, 2010. You'll learn about all the key changes, such as obsolete lines and worksheets, new and revised worksheets, charge compression and the impact on the Medicare cost report preparation process. Mike Biscup will discuss the Medicaid eligibility verification process, which relies on the MMIS system to document Medicaid days used to calculate Medicare disproportionate share payments. He'll highlight any ongoing issues with the MMIS and offer suggestions on policies that should be put in place to ensure that Medicare DSH payments to eligible hospitals are neither interrupted nor reduced.

Council Meetings

11 a.m.–Noon

Chapter Leader (Officers, Directors, Chairs, Co-chairs) Working Session

Terrie Handy, President Elect, thandy@lhs.org

Noon–2:30 p.m.

Luncheon Board Meeting

Diana Gernhart, President, gernhart@ohsu.edu

2:30–3:30 p.m.

Finance Problem Solving

Paul Holden, Chair, paul.holdent@mossadams.com

2:30–3:30 p.m.

Patient Accounts Problem Solving

Jaime Nichols, Chair, jaime.nichols@salemhospital.org

3:30–4:30 p.m.

Communications Council

Gina Sandler, Chair, ginas@triageconsulting.com

3:30–4:30 p.m.

Finance Program Council

James Parr, Chair, james.parr@salemhospital.org

3:30–4:30 p.m.

Member Activities Committee

Erin Baker, Chair, bakere@ohsu.edu

3:30–4:30 p.m.

Membership Council

Norma Pearce, Chair npearce@caremedic.com

3:30–4:30 p.m.

Patient Accts Program Council

April Kooiman, Chair, april.kooiman@trilogihealth.com

3:30–4:30 p.m.

Sponsorship Committee

Scott Harvey, Chair, harveysc@ohsu.edu

4:30–5 p.m.

Committee and Council Wrap-up

All

4:30–5 p.m.

Reimbursement Problem Solving

Gordon Edwards, Chair, gedwards@lhs.org

5–6:30 p.m.

Social Hour

Social Hour at the Avalon Hotel

Sponsored by Aldrich Kilbride & Tatone, CPAs & Business Consulting

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Thursday, February 18

7:30–8:30 a.m.

Registration and Breakfast

8:30–10 a.m.

Joint Reimbursement and Finance Session: Medicare Reimbursement and Regulatory Update

by David Snow, Shareholder, Hall, Render, Kilian, Heath & Lyman

This session will focus on recent Medicare billing, payment and reimbursement developments and trends that hospitals and health systems should be dealing with in 2010. The presentation will overview key legislative and regulatory changes as well as reimbursement strategies and related compliance considerations associated with industry trend.

8:30–10 a.m.

Patient Accounting Session: State of Affairs with DMAP and MMIS

by Alice LaBansky, section manager, Division of Medical Assistance Programs (DMAP)

This session is a panel of Division of Medical Assistance Programs' (DMAP) staff including the Section Manager Alice LaBansky. The panel will give a current status of the system conversion that took place in December, 2008, will outline outstanding initiatives, and address the timelines of when those initiatives will be completed. Question and Answer period to follow.

10–10:30 a.m.

Break

10:30 a.m.–12 p.m.

Finance Session: The New 990

by Martin Moll, principal, AKT

Form 990 is no longer an income statement, it has become an in depth statement of activities. For the first time, nonprofit hospitals are required to describe their corporate governance and executive compensation procedures. What was once a tax return is now an annual statement to the public regarding the activities and public benefit that the hospital provides. In many ways the tax return is now equivalent to a publicly-traded corporation's annual report to shareholders.

10:30 a.m.–noon

Joint Patient Accting & Reimbursement Session: Physician Supervision-Implications of Latest Policy

by Valarie Rinkle, director of revenue cycle, Asante Health

In the 2010 hospital outpatient PPS final rule published in Nov. 2009, CMS issued major policy clarification related to physician supervision of outpatient therapeutic services provided in the hospital and provider based departments of the hospital (both on-campus and off-campus). With FIs/MACs having begun enforcement of these new requirements in Jan. 2010, hospitals and critical access hospitals must be prepared. The main objective of this session is to discuss all the key components of the policy clarification and also address steps that hospitals must take to ensure that their physician supervision arrangements conform with the latest requirements. The presentation will also cover a brief history of physician supervision, including the differences between supervision of diagnostic and therapeutic services as well as incident to rule.

Noon–1 p.m.

Lunch

Sponsored by PNC Healthcare Group

1–2:30 p.m.

Joint Reimbursement and Finance Session: Oregon Provider Tax/DMAP Reimbursement Update

by Kevin Earls, vice president of finance and policy development, OAHHS

Since its introduction in 2004, the Oregon provider tax is credited with providing continued health care coverage to a segment of the population that would have otherwise joined the ranks of the uninsured in the state. This session will provide a comprehensive discussion of the provider tax, from it's beginning to the present state. You'll learn about the structure, how it works, who's currently paying the tax and the benefits to all the stakeholders. In addition to the provider tax, key legislative update and the impact on DMAP reimbursement for the 2010/11 biennium will be discussed.

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Thursday, February 18, *continued*

1–2:30 p.m.

Patient Accounting Session — Creating a Patient-Friendly Revenue Cycle: Lessons Learned from High Performers

by Claudia Birkenshaw Garabelli, MSA

What drives value in the revenue cycle? HFMA's patient-friendly billing project is identifying revenue cycle characteristics with the most impact on value to consumers and hospitals. The project studied high-performing revenue cycle hospitals and then surveyed America's hospitals to determine to what extent the practices of high-performers are in place throughout the industry. After comparing and contrasting practices, the project is further identifying what drives value at high performing hospitals.

The report was released at HFMA's fall 2009 revenue cycle conference in Chicago in November. Join us as we share some of the early insights and findings. Key areas that will be explored during this session include:

- An overview of the patient-friendly billing objectives;
- The high performing revenue cycle selection process; and
- Some of the characteristics of high-performing organizations.

3–4:30 p.m.

Finance Session: Your Strategy for Continuous Supply Savings

by Pat Noonan, vice president, Customer Development, MedAssets

When times are tough and cost reductions are the order of the day, C-suite leaders often look for solutions that will bring immediate results. These one-time efforts are particularly common in the supply chain, where savings can result from a relatively simple initiative such as switching from one item to another of lower cost. It's important to make changes that will allow the organization to reap benefits that are sustainable not just from one month to the next, but over multiple years. It soon becomes clear that significant change requires having processes in place for continuous improvement. This begins with establishing a baseline for supply chain spend relevant to how care is provided, defining an opportunity for improvement, measuring to ensure that any realized results equal planned results, and monitoring performance to ensure the organization is sustaining (or improving upon) the results. This session will focus on keys to continuous improvement and tips on tracking and benchmarking supply spend as well as insight on linking the supply chain to the revenue cycle.

3–5 p.m.

Joint Patient Accounting and Reimbursement Session: Challenges of Converting to Provider-Based Clinics

by Diana Gernhart, FHFMA, hospital CFO, OHSU; Stephanie Winchester, manager of Healthcare Operations Support, OHSU; and Gordon Edwards, VP/controller, Legacy Health

At the Feb. 2009 Oregon HFMA Winter Conference, we heard about the reimbursement opportunity of provider-based physician practices. This year, two organizations will discuss their journey in evaluating and/or converting existing physician practices to provider based status. This session will cover the obstacles, both the expected and unexpected. The hidden issues you might not think about (the size of exam room), the concerns of clinical operations (practice name, governance), the impact on patients and ultimately the benefits versus costs decision each organization dealt with.

5–6:30 p.m.

Social Hour

Social Hour at the Avalon Hotel

Sponsored by Asset Systems Inc.

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Friday, February 19

7:30–8:30 a.m.
Registration and Breakfast

8:30–10 a.m.
Joint Session: Performance Management

by Cy Wakeman, keynote speaker

In this keynote program, Cy will show how fast-paced organizations can thrive in challenging times as they break through "learned helplessness" and rally their teams to respond to challenges while maintaining 100 percent accountability.

> *From her website, cywakeman.com:* "Cy Wakeman is a dynamic, well-respected national keynote speaker, workshop facilitator and trainer who helps individuals and organizations recreate their mindsets so they can achieve results beyond their wildest dreams. Her unique programs help to develop and build successful leaders and teams. Her approach is unconventional, candid, and entertaining. [Using] her hard-hitting philosophy, Reality-Based Leadership,™ Cy has helped many groups and organizations break through their reasons, stories and excuses to develop innovative solutions to long-standing issues."

8:30–10:30 a.m.
CFO Roundtable

CFO Roundtable will be held in the Doernbecher Conference Room 09301 (9th floor).

Contact Aaron Crane if you have questions about this session at aaron.crane@salemhospital.org.

10–10:30 a.m.
Break

10:30 a.m.–noon
Finance Session: Physician Engagement

To be determined

10:30 a.m.–noon
Patient Accounting Session —
Customer Service in Health Care: Beyond Clinical Care

by Jeff Morgan, CHFP, Client Services, Revenue Cycle Partners

This session will present customer service communication skills to achieve world-class customer service for business office and patient access personnel. Patient expectations for customer service in health care are increasing. With consumerism in health care on the rise, price transparency on the horizon and health savings accounts in place, one of the only few competitive advantages hospitals will have to increase market share and value is their customer service and work quality from the business office. If you want to know whether or not there is a better way to providing world-class customer service and training business office personnel while improving net patient revenue, then this session is for you!

Spring Meeting, May 12–14
Salishan Lodge
Gleneden Beach, Oregon

Summer Meeting, July 21–23
Kah-Nee-Ta High Desert Resort and Casino
Warm Springs, Oregon

Fall Meeting, October 20–22
Portland, Location TBD

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