Oregon Chapter of HFMA

PIPELINE

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In this issue

President's Message

Happy New Year, Oregon HFMA!

January brings new beginnings and resolutions for Oregon HFMA. To help guide us with this year's resolutions, our leadership team is using our 2010 membership satisfaction survey results, which are hot off the press, to improve our performance. Each year, we continue to see improvement, and this year is no exception! Results: **High satisfaction is at a record high 65 percent; national is 62 percent. High marks were for chapter education, networking opportunities, and chapter coverage of state and regional issues.** Don't you think it's time to celebrate?

You also told us we have opportunities for improvement. We couldn't agree more. That's why our team has already started to act on feedback received from members.

Beginning Jan. 1, the HFMA national certification requirements have changed. These changes include:

- Successful completion of **one** comprehensive certification exam designed for mid-level health care finance professionals.
- Minimum of 3–5 years of health care finance management experience
- Current and active HFMA membership

For more information, please contact our Certification committee or visit **http:/www.hfma.org/certification**.

The Oregon HFMA program committee is putting the final touches on our upcoming Oregon HFMA winter meeting. This year's meeting will be Feb. 16-18, at the Marriott in downtown Portland. Sessions at this meeting include:

- Single Business Office
- Provider Based Billing (Part 2) – from the land of the cheeseheads!
- Accountable Care Organizations
- Your Medicare cost report

Registration is now open, so sign-up today!

If your resolutions this year include being the best health care financial manager you can be, Oregon HFMA is here for you! Both networking and educational opportunities await you! As we continue to **Step Up** together, I also want to say **thank you, Oregon**! Your efforts are remarkable, for example, when you give your voice (I'm taking notes!) or attend an educational event and are present and engaged. Again, thank you for your ongoing support!

I hope this message inspires you to discover something new this year about HFMA, Team Oregon, or better yet, *you!*

Happy reading,
Terrie Handy
Oregon HFMA President 2010–11

Get to know us: Your Oregon HFMA officers are here to help members succeed

In 2004 I attended my first HFMA Leadership Training in San Francisco. At that time, I had the opportunity to hear National Chair Dave Canfield talk about why he chose "It's Personal" as his national theme. He said HFMA membership reaches far beyond tangible things, and one of the most important things is networking. I couldn't agree more! So please take a moment to learn more about your Oregon HFMA officers, who are here for you, our members. I hope the following short biographies give you a flavor, not just professionally but personally as well, of who we are! — *Terrie Handy*

Terrie Handy, President

Terrie is Director of Revenue Cycle for Legacy Health in Portland. She currently oversees patient business services for hospital, professional/clinic, laboratory and hospice billing. Terrie has over 20 years of experience in revenue cycle management. Prior to Legacy, Terrie attended Pacific Lutheran University before receiving her undergraduate degree from the University of Washington in 1987.

Terrie has been an active Oregon HFMA member for several years and enjoys all HFMA has to offer, including ongoing education, industry/performance benchmarking and networking opportunities. Terrie has been a board member, Patient Accounting Problem Solving committee chair and is currently our Chapter President.

Terrie and her husband, Dave, live in Longview, Wash., and have been married over 19 years. Outside of work, Terrie's teenagers, Matthew (15) and Ari (14), keep her running. Her hobbies include downhill skiing, boating, hiking, traveling and most importantly, hanging out with her family.

Megan Underwood, President–Elect for 2011–12

Megan is a financial analyst with Samaritan Health Services. Currently based in Corvallis, she has worked for SHS for over 15 years. Prior to working in health care, Megan worked as a corporate accountant for several years in the banking industry. She earned her bachelor's degree in accounting from Oregon State University.

Megan has been a member of HFMA since 1997, achieved CHFP status in 1999, and FHFMA status in 2005. She was editor of "Pipeline" for two years, and has served on the Communications Council, Certification Committee, and Board of Directors.

Megan and her husband Clay live in Lebanon and have three children. Next to her family, Megan's biggest loves are music and chocolate.

Dustin Taylor, Secretary, President–Elect for 2012–13

Dustin is Vice President of Network Management for United Healthcare Oregon. Dustin started with United at the beginning of 2010. Prior to that he worked as the director of revenue cycle and contracting for PeaceHealth, a regional health care system with a 300-bed hospital and more than 125 employed physicians. He was with PeaceHealth for over seven years.

Dustin earned his bachelor's degree in business administration from Oregon State University. Dustin and his wife, Sandi, have been married for 10 years and have one child, Grace, age 6. Dustin is an Oregon State fan, and enjoys golfing whenever he can find the time.

James Parr, Treasurer

James is Director of Finance and Strategy at Salem Health in Salem and has been with the organization since 2007. James has over 10 years of experience in health care finance. Prior to Salem Health he was at Seattle Children's Hospital as the Director of Research, Finance and Strategy. He also was an audit manager in the health care practice at KPMG and Arthur Andersen. James was born and raised in Great Britain, growing up on the south coast in the county of Hampshire, before moving to the U.S. in 2000. He is waiting for football (soccer) to catch on here but suspects that meaningful health care reform will be an easier sell.

Navigating the Storm:
Getting Control of Your Self-Pay Population

Even though patients and hospitals are struggling with debt, there is a win-win solution

The term "perfect storm" has been used many times during the current economic downturn. It is especially true when referring to the challenges patients face while trying to pay for health care.

Consider this: Employers are offering fewer benefits, which results in employees paying higher deductibles and more out-of-pocket medical expenses. Despite reduced insurance coverage, health care costs continue to increase. The **Milliman Medical Index** reports that health care costs for a typical family of four increased 7.2 percent in 2009, to an all-time high of $18,074.

With unemployment at a 27-year high, fewer people have health insurance, forcing them pay out-of-pocket for the majority, if not the entirety, of their health care expenses. Patients are doing their best to pay their obligations and avoid being sent to collections. However, there are fewer lenders in the market and the Credit Card Accountability Responsibility and Disclosure Act of 2009 has made it more difficult for most consumers to obtain credit.

Patients who are not able to meet the provider's minimum payments are being referred to collections, which in turn contributes to a deteriorating hospital-patient relationship.

The perfect storm shows no signs of letting up. As health care reform is implemented, insurance companies will be required to insure more people, resulting in even higher deductibles and additional strain on patients and the hospitals that will have difficulty collecting payment from the patients. A survey by **AMN Healthcare** revealed that approximately 70 percent of health care executives believe reform will hurt their facility's financial stability.

ClearBalance by CSI Financial Services, which provides patient-friendly loan programs, reports that the volume of loans being processed has risen dramatically over the past few years while the average loan amount has dropped from approximately $1,500 to $850 per patient. This statistic demonstrates that the rising cost of health care combined with challenging economic conditions makes it difficult for patients to pay a lump sum payment of nearly any size.

While the perfect storm continues, the sun is beginning to shine on self-pay patients and hospitals. Health care providers are enthusiastically embracing patient-financing programs that give patients the ability to pay out-of-pocket expenses over time, and which also can help reduce their bad debt and, importantly, reduce their A/R days.

The relationship between a health care provider and patient is crucial to the provider, the patient, and the community at large. Giving patients a financing option with greater flexibility to pay their self-pay balance will not only help preserve that relationship and improve the revenue cycle, but also increase census as patients continue to look for affordable health care.

For more information about ClearBalance, visit **www.ClearBalance.org** or contact Tyler Eppley at **teppley@clearbalance.org** or 858-200-9226.

Spending policy rules: Which one is right for you?

By Adam J. Smith, CFA, CAIA, and Samuel Adams

This article is an abstract of a piece on the benefits and drawbacks of various spending policy rules and rule hybrids. For the complete version, or for a complimentary pro forma analysis of how your portfolio would have performed under any of these spending rules, contact William M. Courson, president of Lancaster Pollard Investment Advisory Group, at 866-611-6555 or **wcourson@lancasterpollard.com**.

The traditional goals of an endowment are preservation (or growth), budgetary stability and intergenerational equity. Unfortunately, no spending policy can simultaneously maximize all three; each organization must implement a spending policy that best reflects these goals' relative importance. The two major tradeoffs of any spending policy are stability vs. utility maximization and spending vs. portfolio growth. Utility, in this article, is the real value of spending plus the current portfolio value, which accounts for the differences in a dollar amount's value over time.

Research of various spending rules has been somewhat sporadic, but a selection of conceptual rules can be applied to fulfill an endowment's specific spending objectives. Adopting one of these rules, or a hybrid thereof, can help endowments oversee their performance more efficiently and further the endowment's purpose according to steward-defined goals.

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Generally, spending rules are classified into two groups:

- **Stable** — Those that emphasize budgetary stability , and
- **Adaptive** — Those that emphasize total utility at the expense of volatility, with a secondary objective of balancing spending vs. portfolio growth.

Adaptive rule utilization is driven by the desire to spend more during years of plenty, while stable rules reallocate those higher returns to offset years with lower returns.

Stable rules

UPMIFA — The most commonly utilized spending rule is defined in the Uniform Prudent Management of Institutional Funds Act. It averages (at a minumum) the 12 most recent quarter-end portfolio values and spends a percentage of that average. This rule is simple to apply and provides a relatively stable spending amount. But any anomalous returns will continue to impact spending for at least three years.

Inflation-linked rule — Similar to UPMIFA, this rule begins with a spending amount, for example 5 percent of the existing portfolio value, that is adjusted annually by an inflationary index.

Adaptive rules

Yearly Spending Rule — A percentage of the portfolio value is spent at the end of the fiscal year. Essentially, this is the UPMIFA rule, but applied to a single point in time rather than an average. Its singular cross-section point of view and failure to account for other factors make this spending policy less than ideal.

Milevsky-Browne Rule — This and the Alpha/Beta rule have yet to be widely adopted due to their relatively volatile spending patterns. In simulations, however, they are incredibly effective at preserving corpus in real terms as well as maximizing utility. Milevsky-Browne's probabilistic approach follows a complex formula that intends to achieve a certain endowment value within a certain time frame. A simple example is an endowment that aims for a 99-, 95- or 90-percent probability of achieving returns of 6 percent per year over 30 years with a spending rate that ensures the target portfolio value is reached. Applying a higher probability makes this a conservative approach, but a lower probability can lead to higher returns with increased volatility.

Alpha/Beta Rule — This is a two-tiered approach. A small percentage of the real initial value of the fund (typically 2–3 percent, defined as Alpha α) is spent. A higher spending rate (typically 7–8 percent, defined as Beta β) is then applied to assets in excess of the real initial value. A portfolio with an initial value of $10 million might have a real value after five years of $13 million, while the portfolio's market value might be $16 million, leading to an excess of

Spending policy rules

continued from page 4

$3 million. The α spending rate would apply to the $13 million and the β spending rate would apply to the $3 million.

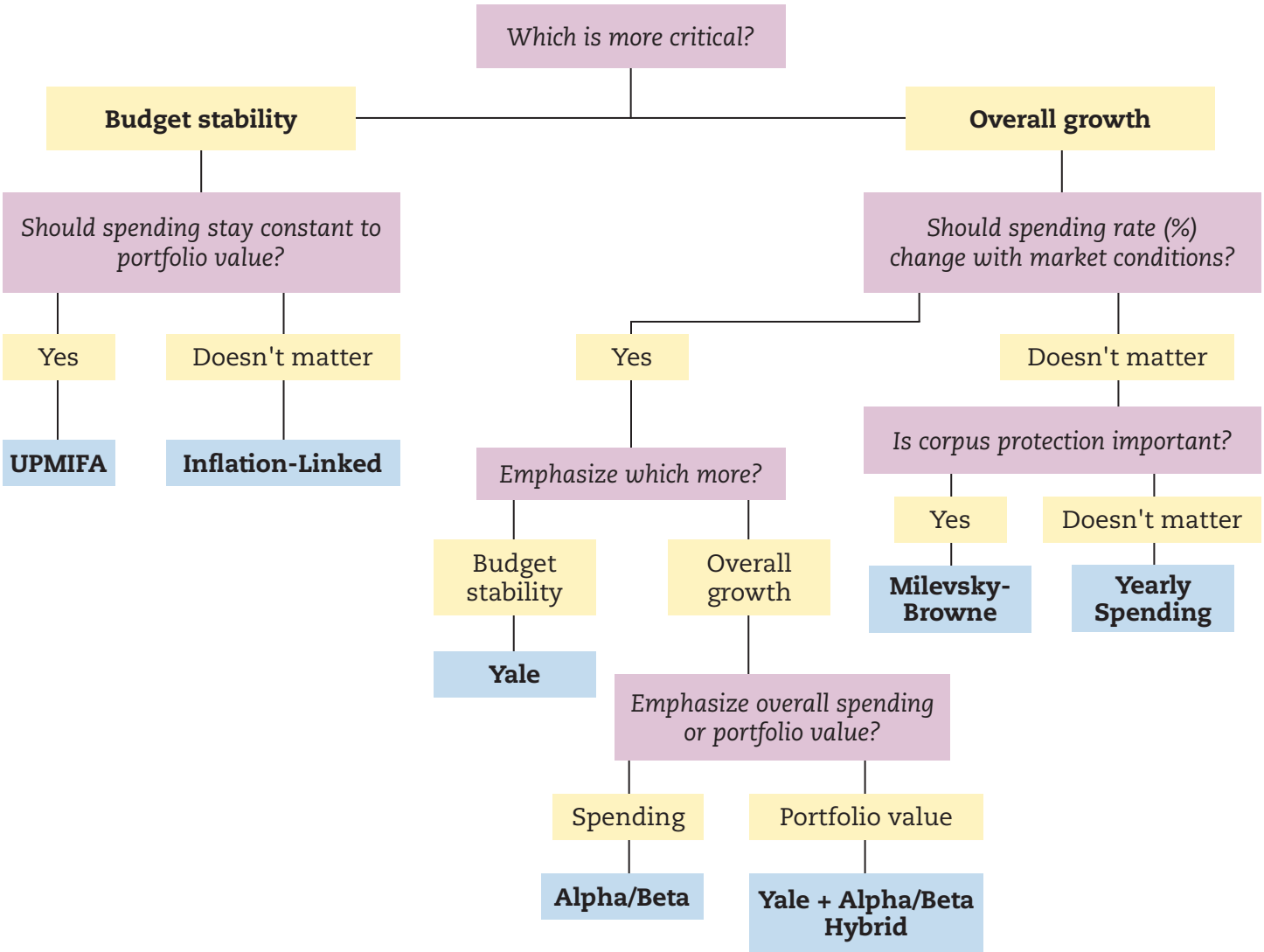
Hybrid rules

Yale Rule — Part of the annual spending amount is determined by the previous year's spending, adjusted for inflation, while the other part is a fixed target percentage of the portfolio's market value.

Yale and Alpha/Beta Hybrid — The previous year's spending component used in the Yale rule is combined with the standard Alpha/Beta rule, such that 70 percent of spending is dictated by last year's spending adjusted for inflation and 30 percent is dictated by Alpha/Beta. This combination protects corpus, but also allows for significant spending when markets are strong.

In conclusion

The need to develop and follow an effective spending policy is often overshadowed by the drive to re-examine investment strategies, especially in a down economy. A well-defined and tailored spending policy, however, allows for minimal annual oversight and the fulfillment of an endowment's specific goals. Applying rules can help balance the three objectives of endowment preservation, budgetary stability and intergenerational equity.



HIPAA Version 5010: Staying ahead of the curve

by John Blakey and Richard Lewis, Health Care Group

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was designed to simplify health care administration and improve efficiency and cost effectiveness. But the legislation didn't have a significant impact until 2003, when the Centers for Medicare & Medicaid Services mandated the use of electronic data interchange (EDI) and set standards for information privacy and security. More recently, HIPAA introduced a new national provider identifier (NPI) system, creating unique identifiers for physicians and health care organizations across the country.

Despite these sweeping changes, the work of simplification continues. For example, last year the Department of Health and Human Services published a final rule adopting the X12 Version 5010 for HIPAA transactions. The compliance date for Version 5010 is Jan. 1, 2012, which gives the industry an opportunity to test the new standards and ensure they're in good working order as they replace Versions 4010 and 4010A.

The main driver behind HIPAA 5010 is the need to accommodate the new International Statistical Classification of Diseases and Related Health Problems, Version 10 (ICD-10). Version 5010 significantly improves the handling of clinical data, enabling the reporting of diagnosis codes (ICD-10-CM) and procedure codes (ICD-10-PCS) and distinguishing among codes for principal diagnosis, admitting diagnosis, external cause of injury and reason for visit.

However, Version 4010 isn't compatible with the format of the new ICD-10 codes, meaning health care providers will have to upgrade to 5010 to report these codes in their HIPAA transactions. In practical terms, providers won't get paid unless they implement 5010 by the beginning of 2012, and they won't be reimbursed starting in October 2013 unless they submit ICD-10 coding.

An enhanced version of 5010 was required after the realization that certain parts of the HIPAA EDI lacked the right functionality to meet the needs of providers and payers. To rectify this, the industry has asked for hundreds of changes, such as better present-on-admission reporting on claims, improved use of NPI numbers, and an improved eligibility transaction that will provide more information during the treatment process.

Here are some of the changes in Version 5010, which will allow providers to better automate reimbursements:

- Authorization and referral transactions are significantly improved for enhanced implementation.
- Critical medical information has been added to allow health plans to make smarter authorization decisions.
- The implementation instructions are upgraded with logical guidelines.

Version 5010 also has data-reporting requirements that differ somewhat from the current transactions. These changes may require the collection of additional data or the reporting of data in a different format.

Many of the changes will boost efficiency and cut costs by reducing the need to contact health plans as well as appeals as a result of incomplete information. Version 5010 will also eliminate unnecessary customer support.

However, preparing for 5010 requires a good deal of advance work. First and foremost, you need a clear strategic approach to achieve compliance. Second, you must form a steering committee to help navigate the complex changes. Third, your technology infrastructure must be thoroughly assessed to make sure it can completely accommodate Version 5010, and your vendors in this area must be on board. Testing the new systems thoroughly is essential, as is in-house education to ensure that every part of the organization is on the same page. And finally, any investments made today must incorporate the next wave of changes to come after 5010 and ICD-10.

The time, energy and resources invested in HIPAA 5010 compliance are sure to reap dividends, because the entire industry is moving toward digital streamlining. The Council for Affordable Quality Healthcare, for example, is seeking to improve interoperability among volunteering providers and payers by making eligibility, benefits and claim-data transactions much more efficient and standardized.

To get the most out of their investment, health care organizations need to embrace HIPAA Version 5010 today, and act wisely and judiciously now to stay ahead of the curve.

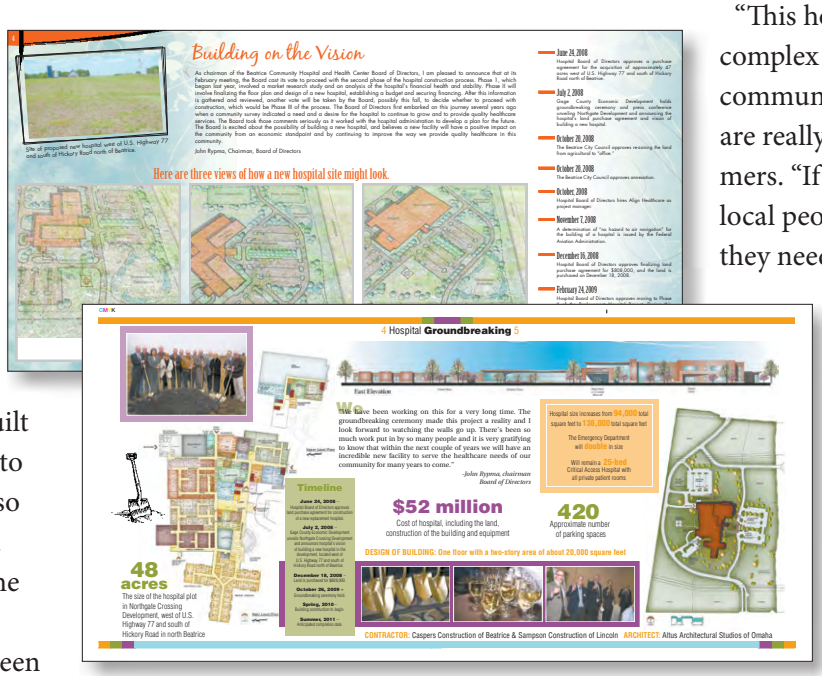
John Blakey serves a wide variety of health care clients, including physician groups, hospitals, and long-term care organizations. Richard Lewis is the director of sales for the Moss Adams Health Care Consulting Group.

The Bottom Line of Community Buy-in

By Quintin Harris

Several years of physician and community outreach have improved the transparency of Beatrice Community Hospital's (BCH) care delivery and finances, inviting more people to look in and directly contributing to an improved reputation and measureable savings.

Recent outreach efforts by the critical access hospital in Beatrice, a community of 13,000 in southeast Nebraska, have been part of a methodical and conscious effort to better prepare it for the future of health care delivery. These efforts culminated most recently in a replacement facility that was built with physician input, responds to community demands, and has so much buy-in that residents and staff have actually invested in the bonds issued to fund it.



Recent annual reports have detailed community involvement in the fund-raising and building of a new facility for Beatrice Community Hospital.

Building the reputation has been about a six-year process that started with listening, grew into talking, and became a two-way conversation that has so far resulted in a lower interest rate on the hospital's debt, an easier time recruiting, more satisfied patients, and a long-term strategy for strength.

Getting physicians and the board on board

Beatrice used to suffer from a lack of mutual understanding between its board and its physicians. It took Chief Executive Officer Thomas W. Sommers two years to recruit, at the community's request, the hospital's first female obstetrician.

So with a new facility in the long-term plan, Sommers started surveying doctors and the community to determine and integrate their needs and demands, and he relied on physician input in the new hospital's design.

Sommers also started bringing both physicians and board members to hospital governance institutes. He asked board members to listen to physicians' insights on how they function within BCH, and asked physicians to attend education sessions to better understand the implications and intricacies of operating as a nonprofit.

"This hospital is the most complex organization in the community, and revenues are really large," says Sommers. "If you're going to ask local people to manage it, they need to understand how. And the physicians need to be the ones who set the direction of where we go, but once they do that, they can't micromanage."

Five physicians attend board meetings; four have a vote. The feeling of empowerment and Beatrice's reputation for physician inclusion has spread. Beatrice recently hired its second female pediatrician, fulfilling the community's request for more female obstetricians and pediatricians. It took 60 days.

Conversing with the community

Coinciding with in-depth community surveys and identification of service priorities, Sommers lifted the curtain on Beatrice's plans, its finances and its pricing. An eight-page annual report details BCH's income statement, and the report is explained in depth on the hospital's radio show.

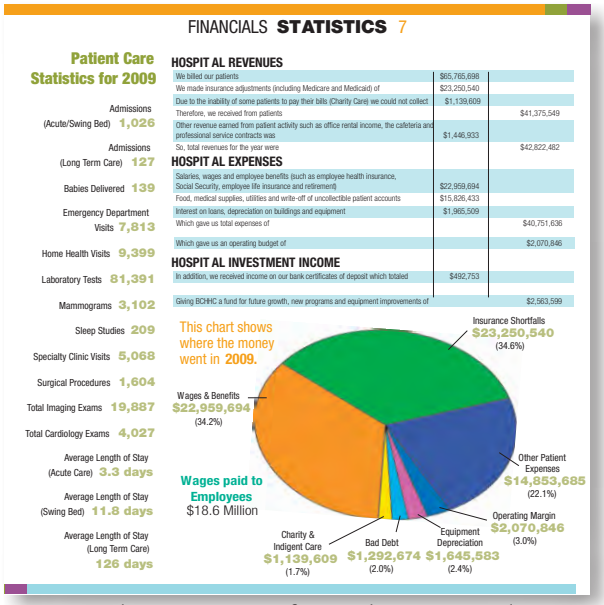
Community Buy-in

continued from page 7

"If we are ashamed of the bottom line, then we are making too much money," says Sommers. "We are a nonprofit organization. We're really owned by the community, and we have to provide our dividends in service to the community."

Conscious effort fosters the community dialogue that Beatrice Community Hospital started:

- "To Your Health," a bimonthly half-hour radio show featuring hospital staff and health care topics.
- Hospital representatives, including board members, regularly attend community events.
- An eight-page annual report publicly outlines the hospital's bottom line, pricing explanations and future plans.
- New-family welcome packets from the Chamber of Commerce include hospital information.
- Physicians and board members attend governance events to get a better idea of their respective responsibilities.
- Community meetings are held to explain future plans, pricing and other updates.



BHC annual reports present financial statistics in clear, unpretentious and accessible language.

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Sommers explains his recruitment efforts and his response to community demands for female obstetricians, as well as pediatricians and hospitalists. He uses radio, personal appearances and local media to explain BHC's needs for liquidity to issue debt, how that relates to pricing, and how Beatrice's pricing compares to national averages.

He shares pictures at community meetings, social clubs and other public events, explaining the new facility's design in terms of more modern hospitals familiar to the community — for example, a women's hospital outside Omaha known for its all-private rooms and comfortable atmosphere — thereby putting forth a vision stakeholders could relate to. He detailed the thinking behind building the new hospital on the north side of town, on the way to Lincoln, Neb., where it could absorb projected growth from the capital city.

And when the time came for the hospital to raise $45 million to build the replacement facility, it was the community that *literally* bought in: Nebraska banks and residents invested in the hospital by purchasing 38 percent of the bonds.

Community support strengthens

BHC went into its financing intending to involve the community. The hospital requested that local banks and individuals have the opportunity to purchase the bonds.

"We've constantly expressed that community members are the shareholders," says Sommers. "That's as close as we could get to having common or preferred stock."

Lancaster Pollard provided local bank and community access to the investment opportunity by offering a portion of the issuance as retail bond distribution rather than selling it all to institutional investors; 38 percent of the $45 million was sold via retail distribution. The entire amount was issued as bank-qualified bonds, which, along with the community's support as a key element of the hospital's credit profile, helped reduce the interest rate.

The community outreach continued with the Beatrice Area Chamber of Commerce, which helped connect local contractors with the hospital. A local cabinet company will be hiring new employees partly because of the hospital project. Electrical work went to another local business.

"When I came here six years ago, I didn't hear a lot about the hospital," says Lori Warner, president of the Chamber. "Now we have more people who are willing to come to our hospital. Residents say the quality is better. Tom and his staff have really been proactive. They're listening to the community."

New Members • New Members

Maryclair Jorgensen
Director of Payer Relations/Contracting
St. Charles Health System

Terri Maltby
Patient Registration Services Manager
Asante Health Systems

Greg Olson
Vice President of Business
Intermedix

Lisa Nearing
Reimbursement Analyst II
PeaceHealth

UPCOMING EVENTS

Winter Conference
February 16–18
Marriott Downtown
Portland, Ore.

Spring Conference
May 18–20
Salishan Spa and Golf Resort
Gleneden Beach, Ore.

Summer Conference
July 20–22
Mt. Bachelor Village
Bend, Ore.

Fall Conference
October 19–21 or 26–28
Hood River Resort
Hood River, Ore.

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.

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