



hfma™

healthcare financial management association

Volume 21 Number 1
August / September 2008

gulf coast lines



August 22 Program

The Revenue Cycle & All Those RACs!!

8:00 am - 4:45 pm

Edwin Hornberger Conference Center - Houston

Learn from senior revenue cycle executives from some of Houston's largest healthcare systems - and get invaluable information on RAC - Recovery Audit Contractors.



8:30-9:30 am

**Keynote
Address: The Things That Keep CEO's Up at Night**

David S. Lopez, CEO, Harris County Hospital District

Conference Fees

\$95 HFMA Members / \$145 Guests
Add \$25 after Aug. 15

Up to 8 hours CPE Credit Available

For more information on the Agenda, Location, Registration & Sponsorship, visit the Chapter website at www.hfmatxgc.org

10:00-11:40 am

Revenue Cycle Executives Panel

- **Michael Bennett**, System Executive Operations/Finance, Memorial Hermann
- **Arden Biggar**, V.P. Financial Services, Methodist Hospital
- **Sue E. Green**, V.P. Revenue Cycle, St. Luke's Episcopal Health System
- **Jaima Pravel**, Tenet Health
- **Cindy Price**, CEO, HCA Shared Services - Houston

12:10-1:00 pm

Are You Ready to RAC 'n Roll?

Kathy Reep, V.P. Financial Services, Florida Hospital Association

1:30-4:45 pm

RAC Attack! - Lessons Learned, Getting Ready, and Targets for Internal Risk Assessment

Day Egusquiza, President AR Systems, Inc.

Conference Location

The Edwin Hornberger Conference Center
2151 West Holcombe at Pressler St.
Houston, Texas

Complimentary parking in garage 8 on Holcombe at Pressler

In this issue...

[President's Message...2](#)

[HFMA Calendar...2](#)

[Member Spotlight: Cindy Price...3](#)

[New Members...3](#)

[Changing the Status Quo: Moving Collections to the Front End of the Healthcare Revenue Cycle...4](#)

[Mitigating Risk with Price Transparency...4](#)

[10 Things to do When the RAC Comes Calling...5](#)

[Are You In the Dark About CMS-855 Reporting Requirements?...7](#)

[Members on the Move...8](#)

[When Will VA Pay?...9](#)

[Chapter Leaders...11](#)

[Chapter Sponsors...12](#)

**TAFHA/HFMA
2008 Joint
Symposium**

Ride the Wave of Change

**The Marriott
Waterway Hotel
The Woodlands, Texas**

September 21-23, 2008
www.tafha.org

HFMA Texas Gulf Coast Chapter
P.O. Box 631206
Houston, Texas
77263-1206
Tel: 713.776.1314
Fax: 713.776.1308
info@hfmatxgc.org

Message from the President

By Cindy Price, FHFAM, Chief Operating Officer
HCA - Shared Services



Cindy Price, FHFMA is Chief Operating Officer for HCA-Shared Services. She also serves as the 2008-2009 President for the HFMA Texas Gulf Coast Chapter.

42 Years! It is hard to believe our Chapter's Charter was signed 42 years ago.

As the 2008-09 President for the Texas Gulf Coast Chapter, I am pleased and honored to serve with such a committed and passionate group of professionals who continue to build on the many successes of our past Chapter leadership teams. During my recent service as Vice President and President Elect, I experienced first hand, the timely, cost-effective education programs provided to our membership and was touched by our community outreach programs serving and supporting those in need.

Our Past President, Nancy Brock, excelled as an effective mentor to the Chapter leadership team. She embraced the 2007-08 HFMA National Chairman's theme of "Make a Difference" allowing our Chapter to continue to build on prior success. This year's volunteer efforts achieved 100% of the goals that were established for the Local Chapters. A few of the highlights of success for the 2007-08 membership include:

- √ **55% Improvement - Education Hours Per Member**
- √ **9.54% Improvement - Membership Growth and Retention**
- √ **5% Improvement - Member Overall Satisfaction**

The 2008-09 HFMA National Chairman's theme is "Making Connections". What a great transitional theme! "Make a Difference by Making Connections. It's perfect; while each of us have our unique situation/affiliation issues; the one area where we all can benefit from is sharing our professionalism and knowledge. To help foster "Making Connections" our Chapter and volunteers will continue strive to provide timely, cost-effective programs that reach out and connect with our membership as well as the needy in our community. There will be new networking venues that enable us to continue Making Connections by sharing our experiences and building new and stronger friendships. I encourage you and your associates to become actively involved today. The Texas Gulf Coast Chapter's Committee website, <http://www.hfmatxgc.org/hfmaCommittees.php>, provides the purpose and contact information for each committee.

Again, I am excited and honored to serve as your 2008-09 President. Thank you for your support and allowing us to make a difference in your organizations and community.

Sincerely,

Cindy Price, FHMA



Clint Owen of DECO Recovery Management awards Christine Blackmon of Houston Hospice with a gift basket at the HFMA Texas Gulf Coast Chapter Annual Meeting & Conference on May 15, 2008.



Chapter Administrators Dean & Terry Newton handled registration for the event.

Save the Date Calendar of Events

August 22 Revenue Cycle Conference

8:00a-4:45p

The Revenue Cycle & All Those RAC's!!

Edwin Hornberger
Conference Center
www.hfmatxgc.org

September 21-23 HFMA/TAHFA Joint Symposium

Ride the Wave of Change
The Marriott Waterway
Hotel, The Woodlands
www.tahfa.org

October 17 Monthly Luncheon

11:30a-1p

Union Activity in Texas

December 3-5 HFMA Region 9 Conference

11:30a-1p

The Sheraton New
Orleans

500 Canal Street

www.hfma-region9.org

Luncheon meetings are generally held on the 3rd Friday of each month at 11:30 am. However, please confirm dates/times in advance.

Our regular meeting location is:

Methodist Hospital
6565 Fannin
Dunn Rio Grande
Conference Room

Topics and Speakers
subject to change.
Credit Cards accepted.

Cindy Price – New President for the Gulf Coast Chapter of HFMA



Tim Eng is VP of Corporate Compliance and Internal Audit for Valley Baptist Health System. He also serves as a Director on the Board for the HFMA Texas Gulf Coast Chapter and as the 2007-08 Newsletter Editor.

As we begin our new fiscal year, we see some familiar faces and names as well as some new faces and names serving on various committees and the board.

One name that should be familiar to you is **Cindy Price**, who begins her tenure as our chapter's new President. Cindy, has been active in Healthcare since 1983 and HFMA since 1990. She has served in a number of roles in the chapter including Program Chair, Vice President, President Elect and of course, the Board.

Although you may have seen, heard or read about Cindy in past HFMA functions, you might not know much about her professional and personal background, which if you did, might help you appreciate what a dynamic, kind and gracious individual she really is.

Cindy currently serves as the Chief Operating Officer for HCA – Shared Services. In this capacity, Cindy's primary duties encompass overseeing the accounts receivable function for well over \$5 billion dollars in accounts receivables in a multi state environment. Her operational areas of responsibility include Patient Access, Central Insurance Verification, Billing, Collections, Support Services and Vendor Negotiation and Contracting. Cindy is also certified as a Fellow of the Healthcare Financial Management Association, which is quite an accomplishment!

On the personal side, Cindy is married and has one grown son and two babies, (in the form of Schnauzers!) She received her BBA in Accounting from the University of Houston and is a Civic Association Board Member. Incredibly, this very busy professional is also a licensed private pilot and completed a marathon! (...which explains her exquisite form and good looks!)

Feel free to stop by and speak to her before or after the next monthly luncheon, as I'm sure she would be happy to hear any ideas, or concerns you might have.



Texas-sized waffles were served for breakfast at the HFMA Statewide Conference at the Driskill Hotel in Austin in April.

Has Your Contact Info Changed?

If you are relocating, changing jobs, changing e-mail addresses or phone numbers, don't forget to update your information on the National HFMA website at www.hfma.org, or e-mail your new contact info to memberservices@hfma.org

Also, please notify the Chapter office of your changes at 713.776.1314 or info@htmatxgc.org

New Chapter Members

Hanie Abdul Sathar
Methodist Health Care System

Micky Allen
UMC Health System

Kelly Barnes
Methodist Hospital

Kevin Boatman

Daniel Briscoe
Roche Diagnostics

Adela Castanon
Methodist Hospital

Jonathan Church
Memorial Hermann

Karen Clark
Christus Health

Paul Das
Meridian Revenue Solutions, LLC

Angela Doggett
Baylor College Of Medicine

Diana Felder
UT MD Anderson Cancer Center

Xufang Feng

Susie Fernandez
Texas Children's Health Plan

continued page 4

Changing the Status Quo: Moving Collections to the Front End of the Healthcare Revenue Cycle

by Charlotte Piontek

The U.S. healthcare payment system processes \$1.9 trillion a year, consuming 15% or more of each dollar spent on healthcare (compared with about 2% for the payment system in the retail industry). Expenditures on the processing of bills, claims and payments, bad debt, and other transactions total more than \$300 billion a year.¹

In today's fiscal environment, healthcare organizations must increase revenue and improve administrative and collections processes in order to remain successful and financially viable. In fact, the need for hospitals and other healthcare service providers to be proactive in increasing upfront collections has never been greater. This is because the patient-responsible portion of the bill has increased dramatically in recent years for a variety of reasons, resulting in a higher number of self-pay patient accounts.

For example, trends such as increases in co-pays, co-insurance and deductibles for traditional insurance plans, and the creation of consumer-driven health plans such as health reimbursement arrangements and health savings accounts — have shifted more financial responsibility to the individual patient. Many employers continue to shift a greater share of healthcare costs to employees. Just consider this telling statistic: Since

“Many healthcare service providers are aware of the growing need to move collections from the back end of the revenue cycle to the front end — but most want to do so by *keeping the status quo.*”

[See “Revenue Cycle” page 8](#)

Mitigating Risk with Price Transparency

By Karl Kimball

Price transparency is an important topic for all hospitals. The ease and low cost of international travel has created more than just vacation time abroad, it has created access to markets that now cater to consumers. The attraction of low cost health care on par with the best of U.S. health care combined with the luxury and services of a vacation resort is increasingly the choice for major clinical procedures. Soon, even common procedures will become routine for the consumer because they can be combined with a vacation or business trip. Just as royalty and foreign dignitaries opted for treatments in the U.S., common Americans will opt for treatment where the convenience, cost, and quality combination makes it their best choice. The bottom line is that there is now competition for traditional health care.

The driver for this competition is not the chance for Mom to have her hip replaced in exotic India or Indonesia. The driver is cost. The continuing rise in U.S. health care costs is the driver that created choice for the consumer. Competition is also coming from the bottom i.e. retail health care from Walmart and others who provide affordability. Walmart leverages their low overhead to cherry pick specific high profit, high volume procedures. Again, low cost health care providers target and commoditize

[See “Price Transparency” page 6](#)

New Chapter Members

continued from page 3

Stephanie Frisch
Christus St Joseph
Hospital

Deanna Fuehne
Rice University

Bryan Garver

Cyndi Guerra
Methodist Hospital

Terri Kasold
Park Plaza Hospital

Lynne Keller
Experian

Cheryl Kelley
Methodist Hospital

Jessica Kitchens
Memorial Hermann
Healthcare System

Karen Krey
BFL Associates, Ltd

John Linn, Jr.

Cynthia Lowe
Texas Children's Health
Plan

Dara Lynn
Lynn Consulting Services

Stacy Maloy
Surgical Associates Of
East Texas, LLP

Vanessa Matthews
Southwest Orthopedic
Group, LLP

Ilanit Meckley
PricewaterhouseCoopers

continued page 5

Ten Things to do When the RAC Comes Calling

By Bill Richburg, M.S., FHFMA



Bill Richburg, M.S., FHFMA is Director of Government Programs & Compliance for Accuro Healthcare Solutions. He also serves on the Board of Directors of the Lone Star Chapter of HFMA.

1. Enforce records completion. An irritated physician in your group or on your Medical Staff is a small price to pay compared to fines, interest, penalties and worse from CMS for billing undocumented services.
2. Have the staff ready and able to audit everything the RAC audits. They are supposed to document both under and over payments, but they only get paid for overpayments.
3. Appeal every decision the RAC makes, IF it is legitimately "appealable." The RAC gets paid for identified overpayments even if they subsequently are reversed in your favor. So they have little to lose, and much to gain, by reporting anything they THINK might be an overpayment.
4. Be prepared to repay overpayments within 30 days to avoid interest charges. If you are appealing, pay the alleged overpayments in 30 days anyway, because you'll owe LOTS of interest if you lose the appeal. If you win the appeal, CMS is required to pay you interest on the alleged overpayment amount.
5. Be certain you are using the Medicare Coverage Questionnaire on admission, to identify whether Medicare is secondary, as Medicare Secondary Payor is an integral component of the RAC audits.
6. Confirm you are up to date with Local Coverage Determinations (LCDs). If you use software for NCD/LCD screening on your outpatient claims, confirm your vendor keeps the LCD files current.
7. Provide Medical Records within 45 days after the RAC request. If you cannot, you must contact the RAC for an extension prior to the expiration of the 45 days. RACs MUST request medical records when there is a "high probability" (but not "certainty") of an overpayment.
8. Assure you have records of all claims previously audited by a Carrier, FI, MAC, DMERC, Program Safeguard Contractor, OIG or QIO. RACs are not supposed to review ANY claim that already has been reviewed by another federal entity.
9. Change policies and practices to prevent future recurrence of overpayments the RAC identifies. If you have a "denials management" group, add this to their role. If not, create one.
10. And the toughest of all: Self-disclose BEFORE the RAC comes to visit, if you know you are being overpaid or underpaid. If you have access to software that can help in this process, use it on 100% of your claims. If not, select a statistically significant sample and extrapolate those results to your entire book of Medicare business.

New Chapter Members

continued from page 4

Roger Miller

Apollo Health Streer

Donald Mitchell

Signature Hospital Corporation

Cassandra Murphy

Methodist Hospital

Jason Reinhardt

Msr Consulting

Lynne Sassi

Sullins & Johnston

Patrick Saucier

Christus Spohn Kleberg

Dan Smith

Tops Hospital

Milissa Spayde

Park Plaza Hospital And Medical Center

Willie Thomas

HCA Physician Services

Bob Wright

South Texas Health System

Brad Wright

Memorial Hermann Health Care System

David Young, CPA

Lattimore Black Morgan & Cain, PC

HFMA Job Bank

HFMA Texas Gulf Coast Chapter Job Bank

Contact Dianne Love, PhD at love@cl.uh.edu to post job opportunities and/or to be added to the HFMA e-mail distribution group for future job opportunities.

HFMA National Job Bank

http://www.hfma.org/careers/job_bank_new.cfm

Price Transparency

from page 4

procedures that provide a combination of convenience, cost, and quality attractive to the consumers. Eventually they will dig deep into the mainstream health care market cherry picking and commoditizing more and more procedures.

Health care historically never thought of itself as an industry. However, the pressures that traditional U.S. health care providers are feeling is industrial in nature i.e., competition, quality of service, and consumer (patient) value.

The competition will not go away. Hospitals are challenged to be competitive but find it extremely difficult to both comprehend and to also take actionable steps to thwart the competition. Perhaps the first step for health care is to provide price transparency. Consumers must know what the price is for health services. Consumers do not accept a continuous chain of discovery and follow-on charges. Consumers

"Hospitals are challenged to be competitive but find it extremely difficult to both comprehend and to also take actionable steps to thwart the competition."

demand fixed prices. However, price transparency carries risks for hospitals. These risks are especially high because Hospitals don't know their true costs for services and therefore are reluctant to give a fixed price. The simple task of providing prices for services is difficult for a hospital because the traditional way hospitals determined costs is based upon estimation algorithms of RCCs and RVUs. Both methodologies fail and are so inaccurate it puts the hospital at high risk. Further, quality initiatives to improve services are all but

impossible with RCCs and RVUs. From an industrial perspective, hospitals are challenged to provide competitive prices and quality commensurate with that price.

Scientifically, hospitals have not followed the science of quality (Edwards Deming model) and Activity Based Costing used to determine true costs. Hospitals must adopt these methodologies that will allow them to understand costs, which leads to profitability, and finally price transparency. Deming put forward a definition of quality as "meets requirements". This defined quality as set of metrics rather than a subjective evaluation. The early Volkswagen Beetle represented a low end car that was highly reliable from a low maintenance air cooled engine. It was manufactured with very few flaws and met the criteria that set the standard for "economy car". The consumer got exactly what they expected for a low price and low maintenance reliable car. Activity Based Costing is primarily a methodology of measuring the consumption of resources for a specific activity. This methodology is the heart of modern day supply chain and manufacturing that every successful company in every industry uses to insure that costs are known. Without known costs all other metrics are meaningless, i.e. profit, price, and quality.

Thus the path to price transparency is a path to industrialization for hospitals. Hospitals must transition because their competitors are taking their market away. For Hospitals to be successful they must provide price transparency and insure that the profit and quality they provide is competitive to stave off competition. Price transparency is the goal for hospitals to be competitive, however the price hospitals must pay is the cost to transition to scientifically sound methodology such as the Deming model and Activity Based Costing.

Karl Kimball is Vice President of North America for Cortell Health. Karl is a member of the Lone Star HFMA Chapter and can be reached at karl.kimball@cortellhealth.com.



Don't Forget E-Learning

Need CPE credits?
No time to travel?

Try E-Learning

Over 1,000 manageable lessons and you're in control

Accounting & Finance, Admissions, Billing, Joint Commission, Managed Care, Medical Terminology, Patient Financial Services, Physician Practice.

To find out more, go to www.hfma.org and select "Education & Events" from the left-hand toolbar. Then select "E-Learning Courses".

Are You In the Dark About CMS-855 Reporting Requirements?

By Lance S. Loria, CPA, FACHE, FAAMA



*Lance S. Loria, CPA,
FACHE, FAAMA is
President of LORIA
ASSOCIATES, LLC, and
also serves as a
Director of the Texas
Gulf Coast Chapter.*

Regulations mandating timely reporting of certain changes in provider management, control, location and other events have been in effect since June 2006. The specific rules can be found in Chapter 10 of the Medicare Program Integrity Manual. Some changes must be reported within 30 days while all others have 90 days. The kinds of changes affecting all providers and suppliers that are required to be reported include:

- Provider or supplier physical address;
- Use of billing companies;
- Changes in board of director or trustee composition
- Key management turnover;
- Adding a physician to a group practice;
- Adding a new home health agency branch;
- Adding an excluded unit (psych/rehab);
- Adding or deleting provider-based-provider location; and
- Adding or deleting procedures, practice locations, and supervising interpreting physicians or technicians at an Independent Diagnostic Testing Facility (IDTF).

It is very likely that every provider has experienced one or more reportable events during the past two years. Do you know if this reporting obligation has been fulfilled? Under the current regulations, penalties for failure to timely report changes include deactivation or revocation of billing privileges. Deactivation is a temporary suspension of billing until the required CMS-855s have been submitted and approved. Revocation carries with it the loss of provider agreement (termination).

The detail data required for CMS-855 reports may not be readily available in provider records. One common example involves Board changes that require not only: name, position and term; but also the birth date and social security number. Establishing appropriate policy, procedures and processes to capture needed information and identify reportable events on a timely basis are crucial to compliance with the regulations.

The following provider Preparedness Assessment may be completed as the first step in assessing the current state of readiness and compliance.

1. Have any CMS-855s been filed prior to June 2006?
2. Have any CMS-855s been filed subsequent to June 2006?
3. Has a "Delegated Official" as defined by the rules, been appointed?
4. Has responsibility for identifying and reporting changes been assigned?
5. Has there been communication or education of the requirements to stakeholders?
6. Has a policy regarding CMS-855 compliance been established in writing?
7. Have tools and checklists been developed to support monitoring and reporting?
8. Has a permanent filing system been established for all CMS-855s?
9. Have procedures been documented which support complete and timely reporting?
10. Has the organization performed a "look-back" review to the effective date to ensure all reportable events have been identified and reported?

The above action plan is not all-inclusive and a Preparedness Assessment should be customized to each provider's unique circumstances. Establishing written policies and procedures and submitting timely CMS-855s should provide satisfactory evidence of compliance effectiveness and minimize the risk of penalties arising from a compliance lapse.

Revenue Cycle

from page 4

2000, the average out-of-pocket costs for deductibles, co-payments for medications, and co-insurance for physician and hospital visits rose 115%.²

In addition, the more than 49 million uninsured and 16 million underinsured Americans are considered to be self-pay patients, and these populations continue to rise.

Many healthcare service providers are aware of the growing need to move collections from the back end of the revenue cycle to the front end — but most want to do so by “keeping the status quo.” The tendency to rely on collection agencies and early-out solutions in lieu of modifying the front end appropriately has become the norm. In fact, most healthcare service providers are sending indigent and government program eligibles to collection agencies, and they are not even aware that they are doing so.

The challenge for today's healthcare institutions is to become customer-focused and performance-based. These goals mean changing how they operate, beginning with pre-service and point-of-service patient interactions. It means changing the status quo.

While those revenue cycle management technologies and services that encompass the entire continuum of care — from the front end to the back end — are widely recognized as being most effective, providers have historically focused on post-service billing, denial management and collection activities. (That is, the back end of the process.) In fact, such large financial investments have been made to automate the back end of the revenue cycle that many healthcare service providers have been reluctant to abandon or significantly modify them. **Healthcare decision-makers and hospital CFOs across the country are on the lookout for technological enhancements that will save their organizations both time and money. For healthcare providers, changing collections to the front end is such an enhancement.**

Simply put, the sooner providers ask for what they are owed, the more likely they are to collect it.

In order to be successful in collecting payments upfront, providers must have appropriate policies and business rules in place for all patient types; they must be able to assist all healthcare consumers irrespective of their financial profile, insurance status or healthcare condition. For example, providers must be able to consistently and efficiently handle the accounts of those patients who fall under the following categories:

- No insurance — but charity eligible
- No insurance — but not charity eligible
- A government program with co-pays (Medicare/Medicaid)
- A government program without co-pays (workers' compensation)
- A self-insured or commercial insurance plan with and without co-pays

[See “Revenue Cycle” next page](#)

Members on the Move

By Carolyn A. Gay, Administrator, Hollaway & Gumbert



Peyton Carrie Page was born May 6, 2008 at 12:39 pm weighed 5.10 pounds and was 18.75 inches, according to **Greg Page**, new Dad and Director of Patient Access and Centralized Scheduling for The Methodist Hospital. Dad also reported that Mom (Tanner) and baby girl are doing great. Dad further advised that they are on cloud 9 and baby girl Peyton is precious. The photo confirms it's true! Congrats, Greg!

Certification News

**Next Exam Date
Friday,
September 12
at 9:00 a.m.**

Offices of Deloitte & Touche, LLP
Three Allen Center
333 Clay, Suite 2300

Please contact Victoria Nikitin at 713.566.4342 or e-mail at Victoria.Nikitin@hchd.tmc.edu if you are interested in additional exam information.

When Will VA Pay? Is Your Access Staff Asking the Right Questions?

By Carolyn A. Gay, Administrator, Hollaway & Gumbert



Carolyn Gay is administrator for the law firm of Hollaway & Gumbert. She also serves as a Director on the Board for the HFMA Texas Gulf Coast Chapter and as the Program Committee Co-Chair in 2007-2008.

If Veterans Administration is not paying your claims for services rendered in non-VA facilities, it is possible that you need to review your front end procedures to determine if your access staff is asking the right questions of Veterans presenting for services.

Veterans Administration established five (5) criteria for consideration of non-VA claims, under the Veterans Millennium Health Care and Benefits Act, H.R. 2116. According to Veterans Administration, payments may be issued if all five (5) of the following criteria are met:

- Veteran is financially liable to the provider for emergency treatment.
- Veteran is enrolled in the VA health care system and received treatment within a 24-month period preceding emergency care.
- Veteran has no other coverage under a health plan contract that would pay, in whole or part.
- VA facilities were not feasibly available and an attempt to use them beforehand would have been hazardous to life or health.
- Emergency services were provided in a hospital emergency department, a free standing urgent care clinic, or a similar facility held out as providing urgent or emergency care to the public, up to the point of medical stability.

Veterans Administration reports that the absence of any one of the above criteria precludes payment by the US Department of Veteran Affairs.

For more information about Veterans Administration claims and appeals procedures, go to <http://www.va.gov/>.

Revenue Cycle

from page 8

One strategy that will help organizations reduce the inefficiencies of denials — not to mention delayed or reduced payments and re-bills — is to determine the eligibility, benefits, and co-payments and deductibles for all patients from the outset. Today it is more important than ever to determine whether patients' insurance or patients themselves are responsible for fees, and what portion they are responsible for paying.

A dedicated upfront collections program allows front-line employees to increase early cash collection through targeted yet discreet methods, as well as to establish various patient payment options to make revenue collection more efficient.

In addition, a successful system will screen patients for eligibility programs and consistently apply discounting and charity policies where appropriate. Although the details vary from state to state, under most current hospital payment systems, there is some reasonable payment to providers for uncompensated care, treatment and service performed for the medically indigent. Demographic patient analysis can allow this type of care to be identified on the front end.

Meeting these goals requires tools specifically designed for the unique needs of healthcare organizations — tools that can capture, organize and verify patient information. For this approach to work in healthcare, three components must be in place, according to a McKinsey Quarterly report³:

- Providers must be able to tell patients how much they will owe while they are still at the hospital or doctor's office. (The real-time adjudication of claims, while

See "Revenue Cycle" next page

Revenue Cycle

from page 9

technically feasible today, could take years to gain acceptance in the providers' offices. Meanwhile, providers could give good-faith estimates by using pricing tools.)

- Providers must have systems to accept cash, credit or debit payments. For hospitals and providers undertaking larger transactions, financing options should be available.
- Providers must become firmer at the time of treatment about requiring patients to arrange for payment, even if they have insurance coverage.

In order to spend their healthcare dollars wisely, consumers need to know their financial responsibility in advance. Many patients find the billing process that takes place in the healthcare arena to be the number-one area of dissatisfaction with healthcare services. With an effective self-pay management system in place, providers can ensure patients receive visibility into their healthcare costs, their specific financial responsibility, and their payment options. This ability to effectively communicate an estimate of the patient's responsibility can result in dramatically improved patient relations.

Why the Status Quo Doesn't Work

Most patient accounting systems do not offer a payment solution that supports upfront collection efforts. In fact, front-line cashiers and registrars typically have no access to the availability of discount options, charity guidelines and price transparency for the patient portion of the bill, even if they do know an insured patient's co-pays and deductibles. Without the integration of all of this information, easily and quickly accessible, it is difficult to have a helpful conversation about the financial aspects of care.

It is imperative that healthcare organizations have a strategy for dealing with the ever-growing self-pay population in all situations — from inpatient admissions to the ED to

doctor's office visits to outpatient procedures. And this strategy must include tools and policies for consistently and appropriately offering discounts.

In many cases, self-pay patients are not offered discounted care, and hospitals effectively shift costs on to the uninsured. (CMS has reassured hospitals that deductions for self-pay patients are permitted.) Over the past several years, federal and state lawmakers and consumer advocates have taken action to ensure that low-income uninsured and underinsured Americans are charged fair (e.g., discounted) prices for their care and are protected from aggressive debt collection practices. Many healthcare providers are struggling to determine and implement proper, consistent processes for applying these discounts and sharing these prices at point of service.

With an effective upfront system in place, service providers can offer discounts at the point of service, taking into account a patient's current capacity to pay, total account balance and type of service. This enables fairness and consistency in the discounting process, as truly needy patients are identified, compared with those patients who simply choose to go without health insurance, even if they have the financial ability to obtain it.

Finally, out-of-pocket healthcare costs will only continue to rise, and patients will have increasing difficulty paying their debt. As a proactive, successful, caring facility,

"It is imperative that healthcare organizations have a strategy for dealing with the ever-growing self-pay population in all situations — from inpatient admissions to the ED to doctor's office visits to outpatient procedures."

See "Revenue Cycle" next page

Revenue Cycle

from page 10

there are steps providers can take to help patients with their healthcare bills. Here are just a few ideas to consider:

- Move financial counseling to upfront collections so patients will know what to expect and your organization will know what it is going to be paid.
- Provide patient access areas with additional tools that enable them to increase efficiencies automate work processes and improve customer service.
- In addition to providing your patients with excellent healthcare services, offer superior patient financing options.
- Develop clear charity guidelines and make sure hospital staff are adequately trained and adhering to those guidelines.
- Develop an upfront collection policy and adhere to the guidelines.
- Consider partnering with a lender instead of offering internal payment plans.
- Develop a relationship with a patient loan company that can quickly approve and fund patient loans.

In the case of self-paying patients, the best practice is to determine financial responsibility from the outset. Organizations that are unwilling or ill-equipped to implement this practice pay dearly. And, as patients are required to take on more and more costs for their healthcare, the importance of this practice will grow.

For more information, please contact Charlotte Piontek at 972.393.0867 or charlotte.piontek@ntelagent.com.

(Endnotes)

¹ The McKinsey Quarterly, Overhauling the US health care payment system, June 2007 (Web exclusive)

² National Coalition on Health Care, <http://www.nchc.org/facts/cost.shtml>
. Accessed June 4, 2008

³ The McKinsey Quarterly, Overhauling the US health care payment system, June 2007 (Web exclusive)



Newsletter Deadlines (All Years)

<u>Editions</u>	<u>Submissions Deadline</u>
July/Aug/Sept	June 1
Oct/Nov/Dec	September 1
Jan/Feb/Mar	December 1
Apr/May/June	March 1

Submit articles (MS Word) or advertising (.jpg or .tif files) to the newsletter editor, **Tim Eng at tim.g.eng@gmail.com**.

Gulf Coast Lines is published bi-monthly by the Texas Gulf Coast Chapter of the Healthcare Financial Management Association as a communication medium to Chapter members. Opinions expressed in articles are those of the authors and do not necessarily reflect the views of the Texas Gulf Coast Chapter or its members.

Members are encouraged to submit articles and report news of interest to the membership. Contact the editor to obtain deadlines for submitting articles. The editor reserves the right to edit any submission for clarity and length, and to accept or reject any submission. Please send all submissions to:

P. O. Box 631206 • Houston, Texas 77263-1206
Tim Eng, Managing Editor • tim.g.eng@gmail.com
Becky Turner, Layout/Production • rturner@npscmgmt.com



Texas Gulf Coast Chapter

President **Cindy Price**

President-Elect

Melissa Fisher

Vice President **Laura Comer**

Treasurer **Kim Reyna**

Secretary **Julie Rabat-Torki**

Past President **Nancy Brock**

Board of Directors

Lisa Dixon

Mark Evard • Carolyn Gay

Daniel Goggin • Steve Hand

Mark Kline • Lance Loria

Connie Lockhart

Mary Ann Missman

Victoria Nikitin

Lisa Schillachi

Debbie Teesdale

Kent Walters

Tom Watson • Kirk Pogue

Committee Chairs

Academic Affairs

Khairunnisa Jafry

Audit

Tom Watson

Awards

Mary Ann Missman

By-Laws

Scott McBride

Certification

Victoria Nikitin

Community Service

Lisa Dixon • Lisa Schillachi

Davis Mgmt. System

Kent Walters

Founders Points

Kim Reyna • Phyllis Speer

Job Referral

Dianne Love

Managed Care

Mark Kline

Charlene Parker

Membership

Debbie Teesdale

Natasha Mehta

Alice Sands

Newsletter

Tim Eng • Carolyn Gay

Lance Loria

Nominating

Eric V. Depew

Physician Practice

Kent Walters

Programs

Mark Evard • Lisa Dixon

Connie Lockhart

Public Relations

Eric V. Depew

Sponsorship

Arden Jean Biggar

Strategic Planning

Melissa Fisher

Chapter Administration
Non-Profit Services Corp.

Dean & Terry Newton

Tel: 713.776.1314

Fax: 713.776.1308

info@hfmatxgc.org

2007/2008
Platinum Sponsors

Deloitte.

HOLLAWAY & GUMBERT

www.healthlawtexas.com

2007/2008
Gold Sponsors

Baker Hostetler
Counsel to Market Leaders

BKD
LLP
CPAs & Advisors

ERNST & YOUNG
FROM THOUGHT TO FINISH™

**Financial Corporation of
America**

GE Healthcare

JW | JACKSON WALKER L.L.P.
ATTORNEYS AND COUNSELORS SINCE 1887

the
MASH[®]
program

**MEMORIAL
HERMANN**

Vinson & Elkins
Vinson & Elkins L.L.P.

X A M



hfma

P.O. Box 631206
Houston, TX 77263-1206
Tel: 713.776.1314
Fax: 713.776.1308
info@hfmatxgc.org

2007/2008
Silver Sponsors

Accenture

**Accuro Healthcare
Solutions**

Amegy Bank

**Cardon Healthcare
Network**

**CHRISTUS Health
Gulf Coast Region**

Craneware

Creditcare Systems, LLC

DST Technologies

**HCA Patient Account
Services**

MC AnalyTXs, Inc.

MCARE Solutions, Inc.

MEDCLR

**The Methodist
Healthcare System**

**Passport Health
Communications, Inc.**

**Perot Systems
Healthcare**

**St. Luke's Episcopal
Healthcare System**

TransUnion LLC

XactiMed