Northwest Outlook

hfma washington / alaska chapter
healthcare financial management association

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2007

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Publication Objective

The NW Outlook is the official publication of the Washington/Alaska Chapter Healthcare Financial Management Association. Our objective is to provide members with information regarding Chapter and national activities, with current and useful news of both national and local significance to healthcare finance professionals and to serve as a forum for the exchange of ideas and information.

President's Message

by John Nutter, President

As we near the end of my first year as president, I would like to thank all of the board members and committee chairs that have worked very hard to help our chapter reach several goals throughout the past year. The additional quality programs we have added, including two annual meetings in Alaska now, has increased member participation. A big thanks to Cathy LeMay for making the Alaska meetings come together.

Our educational hours per member have remained strong and we have seen an increase in our member's interest to become more involved with chapter leadership. Never before have so many people participated in the leadership councils and committees. Must be that great free dinner the Maryann orders that keeps them coming back.

I would also like to thank our sponsors, your support has also exceeded expectations and has been critical in helping our chapter achieve our objectives. The quality programs we put on would never be possible without their generous support. Their financial support allows our chapter to keep meeting rates as low as possible, frequently less than half the direct cost per attendee once you add up the speaker fees, facility fees, and meals.

As we move into our next fiscal year, I would like to say thank you for not impeaching me during my first term, I hope my second year goes as well as the first. I can take very little credit for all the things that have gone well, the dedicated group of officers and committee chairs around me are responsible for our tremendous success making

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THANK YOU!!!

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sure we all get the most we can out of HFMA.

It has been a great experience and my pleasure to serve as your President for the past year. Thanks for all of your support! I hope to see all of you at the upcoming fall conference and please visit our chapter website www.waakhfma.org for chapter news including upcoming programs and events.

John Nutter
WA/AK Chapter President ■

National Provider Identifier (NPI) Dual Usage Period Extended for TRICARE Providers

by Rachel Southard | TriWest Healthcare Alliance

On April 2, 2007, the Centers for Medicare and Medicaid (CMS) published guidance to the healthcare industry regarding National Provider Identifier (NPI) contingency planning. CMS' NPI contingency plan guidance allows providers, vendors, clearinghouses and health plans ('covered entities') that demonstrate "good faith efforts" a maximum of 12 additional months (i.e., May 23, 2008) to achieve NPI compliance without financial penalty.

CMS encouraged 'covered entities' to assess the readiness of their communities and determine the need to implement contingency plans to maintain the flow of payments, while continuing to work toward compliance.

TRICARE Management Activity (TMA), having completed their assessment of TRICARE NPI readiness, issued direction to TriWest on April 25, 2007, to "extend the dual-usage period to May 23, 2008, or upon further notice from the contracting officer, should the industry demonstrate readiness before May 23, 2008."

TMA's direction allows TriWest to adjudicate HIPAA compliant standard electronic transactions (e.g., EDI claims) that use your current TRICARE provider identifier (e.g., UPIN, License number, Medicare identifier or TEPRV), only an NPI, or both after the initial compliance date of May 23, 2007, or until notified by the contracting officer.

How does TMA's NPI contingency plan impact you?
TriWest will not deny EDI claims without an NPI after May 23, 2007. However, you are required to get your NPI no later than May 23, 2007 and share it with TriWest as soon as possible to ensure you have demonstrated a good faith effort to become NPI compliant. In addition, you should be aware that TMA will be assessing industry readiness and may elect to implement NPI prior to May 23, 2008.

We encourage you to use your NPI today when submitting EDI claims. Network providers should contact their local network representative if they experience issues with their vendors or clearinghouses being ready. Non-network providers having issues should contact WPS EDI at 1-800-782-2680, Option 2.

Get, Share and Use Your NPI!
Refer to www.triwest.com/Provider Connection/ Your NPI Connection for information on how to get and share your NPI. If you have questions about how to test or use your NPI, please contact WPS EDI at 1-800-782-2680, Option 2. ■

Additional Compliance Guidelines Provided for Employee False Claim Education Under the Deficit Reduction Act of 2005

by James (Jim) J. Fredman III &
Sven G. Peterson | Foster Pepper PLLC

The Deficit Reduction Act of 2005 (the "DRA") was signed over a year ago and contains a section that mandates employee education about false claims (the "Employee Education Requirements"). The Employee Education Requirements are intended to combat waste, fraud, and abuse by ensuring that employees of health care organizations are informed of their rights and responsibilities under the federal false claims act ("FCA") and similar laws. The FCA prohibits the knowing submission of false claims to the federal government for payment and is a major tool in combating fraud, waste, and abuse in federal health care programs. Failure to implement the Employee Education Requirements could result in loss of eligibility for Medicaid payments and forfeiture of all Medicaid payments during the period of non-compliance. There is also the potential that the government could seek FCA liability on all claims made during the period of noncompliance. The Employee Education Requirements became effective on January 1, 2007 but many ambiguities about how to comply still exist.

Background:

The Employee Education Requirements amend the Medicaid requirements to require any entity that receives $5 million in payments from any state Medicaid program during the immediately preceding federal fiscal year ("Covered Entities") to establish written policies that provide "detailed information" regarding: 1) all applicable federal and state laws governing false claims and whistleblower protections; and 2) the Covered Entity's policies and procedures for detecting and preventing fraud, waste, and abuse.[1] The Policies must apply to all of the Covered Entity's employees, including management, and any contractors or agents.

If an employee handbook exists, then that handbook must include: 1) a "specific discussion" of the laws described in the written policies; 2) the rights of employees to be protected as whistleblowers; and 3) a "specific discussion" of the Entity's policies and procedures for detecting and preventing waste, fraud, and abuse. There is no obligation to create a handbook if one does not exist.

Existing Guidance:

The Employee Education Requirements lacks detailed descriptions on what Covered Entities must do to show compliance. To date, CMS has issued guidance regarding implementation of the Employee Education Requirements on three occasions to try to address many of the questions raised by Covered Entities attempting to implement the requirements . On December 13, 2006 CMS issued a letter to state Medicaid directors (the "Letter") which included a state plan preprint ("Preprint") with model language that could be used to amend a state's Medicaid plan to incorporate the Employee Education Requirements. On January 11, 2007 CMS held a teleconference for Medicaid providers ("Teleconference") to discuss CMS' interpretation of the Employee Education Requirements, and most recently on March 20, 2007 CMS issued further guidance in the form of a set of responses to frequently asked questions ("FAQ").

Meanwhile, most states have submitted amendments which essentially copy the language of CMS Preprint without offering any additional regulations or guidance. Despite the fact that most state plan amendments have not yet been approved and the fact that significant ambiguities remain CMS has taken the position that the Employee Education Requirements are currently binding on health care providers. Many of the clarifications provided by CMS guidance and many of the remaining ambiguities of the Employee Education Requirements are discussed below.

Who is a Covered Entity:

Any entity or individual who made or received $5 million or more in payments from a state Medicaid plan during the previous federal fiscal year beginning

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with fiscal year 2006 is a Covered Entity and must comply with the Employee Education Requirements. Initially, potential Covered Entities did not know which payments would count towards to $5 million threshold or whether the payments from multiple lines of services would be aggregated. CMS has clarified that it will aggregate Medicaid payments received by an organization from all lines of service, including hospital, physician, nursing home, etc., even if different tax identification or different provider numbers are used, to determine if the $5 million threshold has been reached. Only payments received directly from a state Medicaid agency are counted. Payments received from managed care organizations, such as Healthy Options in Washington state, are not. Although payments are not aggregated across state boundaries for purposes of the $5 million threshold, CMS takes the position that if an organization received $5 million in Medicaid payments from any state, then the organization must meet the educational requirements with respect to its employees and contractors in all states in which it operates, including those states in which it did not reach the $5 million threshold.

In light of the expansive definition of an organization that CMS has adopted, individuals, entities or organizations with questions about whether payments should be aggregated would be advised to err on the side of caution and aggregate their payments. Covered Entities should also bear in mind that if they operate in multiple states and reach the threshold in just one state, CMS is likely to require that they ensure that they are in compliance in all states.

Education Obligation:

Covered Entities must establish written policies (the "Policies") that provide "detailed information" regarding: 1) all applicable federal and state laws governing false claims and whistleblower protections; and 2) the entity's policies and procedures for detecting and preventing fraud, waste, and abuse. [2] The Policies must apply to all of the Covered Entity's employees, including management, and any contractors or agents. Unfortunately the Employee Education Requirements create a number of compliance questions with respect to the obligations of a Covered Entity including: 1) What is meant by "detailed information" or a "specific discussion" regarding the FCA and other laws? 2) Who must receive educational information? and 3) What education is required? Lack of clarity regarding the scope of contractors covered by the Employee Education Requirements adds ambiguity to all of these questions.

What "detailed information" or a "specific discussion" regarding the FCA and other laws must be included in the Policies? CMS has refused to offer guidance regarding "detailed information" or "specific discussion" that must be included in the Policies. In the FAQ, CMS stated that it will not provide model language, but that it will provide a summary of the FCA on its website. However, this is only one of several statutes that Covered Entities must educate their employees and contractors about, and CMS is not providing guidance regarding policies and procedures for detecting and reporting fraud.

To ensure compliance, the information provided to employees, contractors and agents should include a workable summary of all applicable laws. For example, this would include a description of the Federal False Claims Act (31 U.S.C. §§3729-3733), Federal Whistleblower Protections under the FCA, the Federal Program Fraud Civil Remedies Act of 1986 (38 U.S.C. §3801 et seq.). In Washington state, the Washington False Claims Act (RCW 74.09.230; RCW 48.80.020; RCW 51.32.240; RCW 74.09.210) and Washington State Whistleblower Protections (RCW 4.24.500 – 4.24.520) would be included. Washington Public Hospital Districts and other local government entities should also include a description of the Washington Local Government Whistleblower Protections in RCW 42.41.

This summary should provide useful examples of prohibited conduct and detailed information regarding whistleblower protections. Activities covered by the FCA include submitting claims for medically unnecessary services, using improper coding or billing practices, submitting a claim for services not provided or covered under a federal

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program, submitting claims from a provider excluded from a federal program, submitting a claim while engaging in acts that violate a statute or regulation, such as the Stark law, falsely certifying compliance with certain statutes or regulations, retaining a payment to which an entity knows it is not entitled or submitting claims for services which do not meet quality of care standards. Whistleblower rights and protections include the right to bring claims on behalf of the federal government and significant monetary incentives to whistleblowers in the form of a percentage of any recovery obtained on the government's behalf. Whistleblowers are also given significant protections against retaliation.

Who must receive a Covered Entity's Polices? Employees, contractors and agents must receive the Policies. CMS has provided additional guidance regarding who is an employee and who is a contractor, neither of which is defined in the Employee Education Requirements.

Employees. In the Letter, CMS defines "employee" to include "any officer or employee" of the Covered Entity. No further guidance is offered. To ensure compliance, Covered Entities should make sure that their Employee Education Requirements policies apply to employees, including administrators, managers and staff and officers including board members and directors of the Covered Entity.

Contractors. According to the Letter, contractors include all those who perform billing and coding functions, furnish Medicaid health care items or services, or are involved in monitoring health care provided by the Covered Entity. In the FAQ, CMS refused to provide guidance on who is "involved in monitoring health care." The FAQ did make clear that contractors providing "copy or shredding services, grounds maintenance, or hospital cafeteria or gift shop services" are excluded from the definition of "contractor" for purposes of the Employee Education Requirements. CMS appeared to conclude, however, that supply vendors with a contractual relations with the Covered Entity would qualify as a contract even if there is no written contract. This broad reading would also include medical staff members. Absent further guidance from CMS or the states in which they operate, Covered Entities would be advised to adopt an expansive definition of "involved in monitoring health care" and err on the side of including contractors within their Employee Education Requirements compliance policies unless they are unquestionably part of an excluded category.

What steps must Covered Entities take to educate their employees and contractors about the Policies? Covered Entities are required to provide the relevant information to their employees, contractors, and agents, and to make sure that the Policies are readily available to them.

Employees. Despite its name, the Employee Education Requirements does not technically require that Covered Entities engage in any specific educational training programs for their employees regarding false claims. A training requirement was included in the initial draft of the act, but was later removed. As a result, Employees need only be informed about and provided copies of the Policies. The policies or a summary of the policies and their requirements should also be incorporated into the Covered Entity's handbook, if one exists. While there is no formal training required at this point, we recommend that Covered Entities consider incorporating the Policies into their regular compliance training programs.

Contractors. CMS has not provided guidance regarding how entities should disseminate information to their contractors. In the Letter and Teleconference, CMS took the position that a Covered Entity's contractors would need to "adopt" the Entity's policies, though this language is not included in the Employee Education Requirements itself. CMS appeared to modify its position somewhat in the FAQ, stating instead that each Covered Entity must establish and disseminate policies for its contractors, and those contractors must abide by those policies in the work they perform for the Covered Entity. According to CMS, Covered Entities must determine for themselves how to ensure compliance. While it acknowledged that the issue would require further analysis and guidance, CMS reiterated that this requirement is currently

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enforceable.

In the absence of further guidance, it is good practice to establish Policies that are applicable to all employees of the entity and its contractors. We recommend that a Covered Entity's existing contractors be provided a copy of the Covered Entity's Policies and informed by letter that the contractor and the contractor's employees and agents must comply with the Policies when providing services to the Covered Entity. We also advise that similar language be incorporated into any new contract or amendment.

Enforcement and Penalties:

Neither the Employee Education Requirements nor the Preprint discuss enforcement of the requirements or penalties for failure to comply. In the FAQ, CMS stated that it will monitor state's compliance through its routine oversight of states. CMS is not prescribing the manner in which states must enforce Covered Entities compliance with the Employee Education Requirements, but it is requiring that states include the methodology for their compliance oversight in their proposed state plan amendments. States that fail to enforce compliance with the Employee Education Requirements risk loss of their federal financial participation. CMS also reserves the right to determine compliance of Covered Entities through its own independent audits.

Many states will likely enforce the new provisions as part of its ongoing monitoring process but there is no guarantee of this. At this point states could take advantage of existing avenues of enforcement, or they could create separate requirements for a Covered Entity to establish compliance with the Employee Education Requirements and penalties for failure to do so through implementing regulations. In fact, CMS will allow states to impose stringent compliance requirements and penalties as long as those requirements and penalties do not conflict with the Employee Education Requirements.

Conclusion:

The Employee Education Requirements place significant compliance burdens on Covered Entities and exposes them to rather extreme penalties. Although significant ambiguities remain, CMS takes the position that the Employee Education Requirements are currently binding on health care providers and CMS has indicated that there will be no grace period. Many states are unsure of how to proceed, and many do not intend to provide further guidance or draft any implementing regulations that could provide clarification.

Since the DRA went into effect as of January, health care providers cannot afford to wait for further guidance at the state or federal level. Entities should do their best to revise their policies and procedures to comply with the Employee Education Requirements and to minimize their exposure. Following the suggestions in this article should help minimize the risk of non-compliance but nothing can ensure compliance until further clarifying guidance is provided.

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[1] The DRA also includes a provision designed to encourage states to amend their false claims acts to make them more similar to the federal act. Although guidelines were issued in August of 2006, so far only a handful of states have amended their acts. None of the northwestern states has done so, and none of their false claims acts currently satisfy the federal guidelines.

[2] The DRA also includes a provision designed to encourage states to amend their false claims acts to make them more similar to the federal act. Although guidelines were issued in August of 2006, so far only a handful of states have amended their acts. None of the northwestern states has done so, and none of their false claims acts currently satisfy the federal guidelines.

THE MATERIALS IN THIS ARTICLE ARE FOR INFORMATION PURPOSES ONLY AND SHOULD NOT BE CONSTRUED AS LEGAL ADVICE ON ANY SPECIFIC FACTS OR CIRCUMSTANCES.

A Huggies® Class-Action: Consumers claim unfair pricing for non-Costco members, states' Attorneys General playing wait-and-see, Scruggs' name mentioned, Senate hearings inevitable.

by Corey Shank | Outreach Services

My daughter recently decided that eliminating body waste into a toilet was a more refined and princess-like process than peeing and pooping in diaper. My wife and I had a hand in that, we had an intervention with Ella: we locked us all up in the house for a weekend and by Sunday night, we had potty-trained our final kid, and hopefully bought our last diaper. My daughter's doing great, and I can give you the website for the technique if you'd like.

Until that fateful weekend, I had a real problem. Diapers are expensive, especially considering you have to use around five or six a day. So when we were buying 46 diapers for $15.99 at the grocery store, we were paying $62 a month, not including the price of those baby wipes. That's a couple of rounds of golf in Spokane.

Then, I was talking to some neighbors and they started talking about Costco, how things are so much cheaper there, like diapers. At Costco, you can get the same Huggies® brand diapers for $37.99 for a 176 count box. That is $39 a month, which is a whole lot less.

"It is completely unfair, it's an outrage!" I exclaimed. Why did my neighbors, card-holding members of Costco, only have to pay $39 a month, while I was paying $62 a month? I told my neighbors that I was going to call a lawyer and sue (who, I hadn't figured out, perhaps Huggies®), and I'd heard of a good attorney named Scruggs. After a minute or so, my neighbors settled me down and explained one law of economics: volume pricing. They said that by being members of Costco, they had access to discounts based on Costco's ability to purchase products and services in bulk. Although it seemed to make sense to me, I still wanted to sue someone.

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Okay, the story above is not true. In fact, my wife and I had been buying diapers at cut-rates at Costco for five years, since our first kid was in them. But, I did have a very similar conversation with a stranger on a recent business trip, except for he was the complainer and I was the friendly neighbor trying to explain economics. The subject of our conversation wasn't 'diapers'…it was healthcare. After briefly explaining what I did for a living, he went off on why these large insurance companies can get their members discounts from providers, while self-pay patients have to pay an egregious, full-price. He thought something sneaky was going on, and was mad at providers (funny though, he didn't seem upset at insurance companies). I got frustrated when the man didn't understand my point, which was that providers can give discounted prices to health plans because of plans' purchasing power, kind of like Costco. So I excused myself and pretended to make a call on my cell phone.

Well, this evening I was in a cul-de-sac in my neighborhood where kids and parents seem to migrate on nice days, and again I had the same conversation. This time it really was a neighbor of ours; this neighbor is in upper-management for the railroad. He, however, did understand my point after explanation…thank goodness, because I like this guy and I will have to be neighborly for some time. He ended by saying that he wished he could go and negotiate discounts with providers for the railroad. I don't know how the railroad works, but I told him that hospitals would most definitely be willing to talk. Of course I mentioned prompt-pay clauses and such.

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My real problem is that the story about diapers and Costco could never be true. People completely understand that it is fair to pay less per unit when buying in bulk (for anything other than healthcare). Really, has anyone ever complained that a single can of Coke costs 75-cents at a convenience store, but a six-pack costs $3.00, or

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50-cents a can? No. So, Costco is a CPMO (Consumer Products Maintenance Organization) and no one cares that its members get cheaper rates than the general public. But hey, don't get the public started on prices for healthcare.

Or perhaps, the real issue is that hospitals and providers have not done enough to provide consumer education to their patients. I think that the average public is more like my neighbor, and would appreciate education and would understand economics. I think the stranger I met in the airport would be the exception, the small sector of the population who does not care to understand any reality, but just likes to complain to anyone who will listen – don't get me started on why our politicians get so easily distracted by these people.

So, the next time you or your staff are on a call with an outraged patient, who for some reason other than indigence does not have insurance, and who is complaining about how much he is being charged for you saving his life; try the Costco analogy. Because in this day and time, the facts that hospitals are the foundation for any community's health and that hospitals are practically regulated to have margins of 3% or less are lost on patients who leave the hospital and receive a bill for the quadruple bypass that saved their life.

(Speaking of margins, if jewelry stores had only 3% margins there's a good chance I could get my wife a nice 10-year anniversary band, but alas, even at Costco they are really expensive.) ■

Using Creditors' Claims in Probate Actions as a Tool in Revenue Recovery

by Chris Gamache | Outreach Services

Hospitals may be able to obtain full or partial payment for outstanding medical bills from a deceased patient's estate. The procedure for making a creditor's claim against an estate is governed by state law and varies from state to state. This article outlines the basic procedures for making creditors' claims in probate actions in Washington or Alaska.

When a person dies, a probate action may be commenced after his or her death. Probate is the process by which assets are gathered, applied to pay debts, taxes and other expenses, and then distributed to beneficiaries. Probate actions are most commonly filed in the county in which the deceased person last resided or owned property.

Once a probate action is filed, the personal representative appointed to administer the estate will usually provide a Notice to Creditors. The Notice to Creditors requires that anyone with a claim against the estate present the claim within a specified amount of time or be forever barred from maintaining an action against the deceased person's assets. The Notice to Creditors must be published once a week for three consecutive weeks in the county in which the probate action is pending. In Washington, the personal representative may also elect to provide "actual notice" by serving the Notice to Creditors directly on known creditors.

In response to a Notice to Creditors, any interested creditor may assert a Creditor's Claim. The Creditor's Claim includes the name and address of the creditor, the nature and basis of the claim, the amount of the claim, and should be signed by the creditor. The Creditor's Claim must normally be filed within four months after the first publication of the Notice to Creditors, although this time frame may vary under certain circumstances. In Washington, the Creditor's Claim must be filed with the court and served on the personal representative. In Alaska, either filing with the court or service on the personal representative is sufficient

Once a Notice of Creditor's Claim has been filed, the personal representative has a duty to either allow or reject the claim. Valid, timely claims for medical expenses are usually allowed. If, however, the personal representative determines that a claim should be rejected, the personal representative must provide a formal notice of rejection to the claimant. The burden is then on the claimant to bring a lawsuit to enforce the claim. Laws in Washington and Alaska require that any such lawsuit be brought within a very

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short time after notice of rejection of a claim.

After all of the assets of the estate have been gathered and inventoried, and the time for filing claims has expired, the estate is distributed first to pay allowed claims, and then to beneficiaries. This process may take anywhere from a few months to over a year, depending upon the nature of the assets and liabilities at issue. While most hospital expenses are included with other ordinary debt owed by the estate, hospital expenses that relate to the deceased person's last illness may be paid prior to other types of debt. At any time in the probate process, the personal representative also has the ability to compromise claims owed by the estate.

Although an attorney is not needed to assert an uncontested Creditor's Claim, the rules pertaining to these claims contain various nuances, are detailed and require timely action. As such, hospitals may elect to delegate responsibility for filing Creditor's Claims to an employee or contractor familiar with the procedures governing probate proceedings.

Note: This article is published for informational purposes only. These materials should not be considered as, or a substitute for, legal advice. ■

My LTC Experience

by Peggi Ann Rufener, MBA, CCS-P, CCS | Incoming WA/AK HFMA Board Member

I was invited to attend HFMA's Leadership Training Conference (LTC) as a newly elected board member for the WA/AK Chapter (thank you for your votes).

The conference was to be held in San Diego in April (sounded like a great idea since it was snowy out). Then I began to think, a three day conference just for HFMA Leadership training?? Oh gosh, what have I gotten myself into?? How much of a time commitment is being on the Chapter Board? What will my 'assignment(s)' be? Oh I did I mention I will be changing jobs in April!

Sunday morning April 22nd started out overcast but warm ~ mid 50's (folks around me were complaining about the cold weather). I attended a session for Program Chairs and Co-Chairs ~ not my chapter "duty", but very interesting nonetheless. Program planning is a HUGE job, everything from securing locations, producing brochures, topics, speakers, evaluations, food etc. you get the picture it is a daunting task. No wonder we have a TEAM approach in our Chapter! Everyone's contribution and participation is our KEY to continued success.

Our keynote speaker, Allison Levin spoke to us about her expedition to Mt. Everest. The importance of team work, breaking down huge tasks into workable chunks and making a difference. The same strategies she employed in 'mapping' out the team's expedition are the same strategies we can and should (perhaps you already do) do in our everyday strategic planning. A strategic plan is not always the acquisition of a new practice or building, it may be as "simple" as planning for coverage of a department head that is headed out for a four week vacation!

The afternoon session I attended was on Getting Set for Success: Editorial Planning for your Chapter Newsletter. Again, not my Chapter job, however our editor was unable to attend. Being an editor is akin to being an orchestra conductor. Timing, timely, consistency, correctness, review, production, editing, solicitation of article topics, authors, sponsors, future meeting dates, current job listings just to name a few topics discussed. Wow, the "rules" about writing are darn near as complicated as GAAP. There is an 800 page reference book our speaker indicated was a "must have" along with a current Webster dictionary. Our Chapter is always looking for articles – all submissions are welcomed (we don't have the reference book so no worries there)!

After a long day of learning and reflecting on what my new "volunteer" experience with WA/AK HFMA was going to entail I was more than willing to head to the Social Hour! Day one down, two more to go!

HFMA was been a wonderful network for me and my career development. Now I will have to "step up" to the challenge and give back some of what I have learned and gained over the last dozen years. ■

Courage in Leadership- from Inspirational Theme to Tactical Action

by Mike DeLuca | GHC

HFMA National Chairman Joe Fifer's theme this year is Courage in Leadership. I had the privilege to hear him speak on this theme last year at the annual Leadership Training Conference and have been engaging chapter members in conversations since then about how we can bring this theme to life in our chapter. Those of us on the chapter board would like to involve everyone with an interest and a passion around this, so please read on.

This theme will begin to inform the content of our chapter workshops and conferences starting this May. Joe is joining us in Coeur d'Alene; he'll be giving the keynote address and leading a panel discussion on this topic with leaders from provider and payer organizations. After the May conference, we'll be taking a focused approach to how Courage in Leadership can be translated to many of our educational offerings.

I spoke with Joe a few months ago about how we might turn this theme into tactical action. We distilled the theme into three main points:

- **Do we understand what's at the core of the issues?** We, as a chapter, need to ensure that all our members share the same thorough understanding of what's at the core of the healthcare crisis. How financing works, what issues drive the disconnect between our current financing model and what would be a more rational model:
  - Incentives for higher cost procedures due to profit margin, not clinical need.
  - Government "underpayments" and the need to cross-subsidize.
  - Uninsured and the narrowness of the risk pool.
  - America's wellness issues - obesity, etc.
- **Can we communicate and translate these issues?** We as a chapter can provide skills development in effectively articulating and translating these complex points to diverse audiences so that each member can engage in these conversations in the workplace, boardroom and community.
- **Are we creating opportunities to have the conversations?** We as a chapter can take the initiative to invite key stakeholders (payers, providers, patients, employers, policy-makers, vendors) to have these courageous conversations rather than simply exhorting members to take this on themselves.

We discussed this at our chapter board retreat in early May, and here are some of our initial ideas on how this will further shape our educational offerings:

- I'll be partnering with our educational committee chairs to select specific focused topics that tie their subject areas with the three main points above.
- We'll be looking for opportunities to bring specific leadership training seminars to the chapter, similar to some of those that are offered at the National level.
- We'll continue to brainstorm ways that our HFMA chapter can fully embrace its role as a thought-leader on healthcare finance issues.

As I said above, those of us on the board would like your feedback, brainstorming and involvement in translating this philosophical theme into tactical actions that benefit all our chapter members, our industry, and our communities. Please contact me by phone or e-mail; I look forward to seeing you at an upcoming chapter event. ■

Financing with Section 242

Have You Thought of FHA Mortgage Insurance to Finance Your Hospital's Expansion or Relocation?

by Robert N. Kaplan | M&T Realty Capital Corporation

Given the number of older hospitals in the region, and the dramatic growth we are experiencing in certain areas, many hospitals need to examine the need for a replacement hospital or look at undergoing significant renovations on their existing facility. Given the pressure from an obsolete physical plant, and the day-to-day operations of the hospital, many CEO and CFO's do not know where to turn when considering how to finance a new facility. As such, they often turn to financial consultant and existing banking relationships to handle the process and identify which program best suits the hospitals unique requirements.

In doing this, many consultants often overlook one of the best programs available for hospitals of all sizes. These hospitals often have low or no credit rating, or might be a large hospital in need of significant credit enhancement, which exceeds the capacity of many Wall Street firms. So where do they turn, the Federal Housing Administration's (FHA) mortgage insurance program for hospital financing through the U.S. Department of Urban Development's (HUD) 242 program. The FHA mortgage insurance program provides an outstanding long-term, fixed low interest rate source of debt financing and has been used for a number of hospitals across the country. It can be used to either credit enhance tax-exempt bonds, or as a direct loan to the hospital facility.

When used by any size hospital it provides them with no less than a AA rating, without tying up additional reserve capital or having to cross collateralize the loan with other property or other hospital facilities within the organization. This allows the hospital to borrow at the lowest costs in the market. Other benefits of HUD's 242 program are that it is completely non-recourse, and it is stand alone financing. Hospitals across the county have taken advantage of the Section 242 program to reduce their cost of capital.

The basic overview of the program is as follows:

- The loan can be used for either new construction of a hospital facility or the refinancing/ renovation of an existing facility. If it is a refinancing or renovation at least twenty percent (20%) of the proceeds must be used for modernization or new construction purposes and can include equipment.

- The loan is fixed rate, interest only during construction, with a twenty-five (25) year term and amortization period. No balloon payments, and as mentioned above it is fully non-recourse both during the construction period and the permanent loan stage.

- The facility must be owned by an entity that is either a proprietary, private non-profit corporation or association, local government owned, or publicly held entity (acceptable to HUD), and provide community service for in-patient acute medical care.

- No more that 50% of the patient days can be attributed to Chronic Convalescence Care, Drug or Alcohol Care, Mental or Nervous disorders, Epileptic Care and Tuberculosis unless the facility is a Critical Access Hospital.

- The program also allows for secondary debt through the use of another HUD program, Section 241, which can provide additional debt for future expansion, or significant facility modernization at a future date. This program is also a 90% loan.

- Streamline processing for Critical Access Hospitals (CAH).

The Financial Underwriting standards of the loan are:

Lesser of:

- 90% of estimated hard and soft Costs,

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including equipment; plus 90% of book land Value, or appraised value
- Last three years operating margin must average equal or greater than 0.00
- Last three years debt coverage ratio (DCR) must be equal or greater than 1.25
- Stabilized debt coverage ratio of 1.40
- Requires monthly contributions to mortgage reserve fund

In addition to HUD, the loan the application process involves the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA). Don't worry these two agencies work well together and have pretty much eliminated the bureaucracy that you might expect when dealing with two federal agencies. HRSA provides key health care program expertise under contract to HUD to assist in the underwriting evaluation of acute care facilities and manages the design and construction review process. Your FHA mortgage lender will provide overall oversight, prepare the application and coordinate the review of the application.

When underwriting the loan, the mortgage banker reviews the hospital's current operation and future projections via the expansion or replacement facility; for CHA the scope of the report is reduced. Our review requires a feasibility assessment, provided by a firm experienced in such reports. We will work with you in identifying one of these firms, as they must be pre-approved by HUD/FHA's health care facilities office in advance of the assignment.

The feasibility study and underwriting of Hospitals and Acute Care Facilities, looks at the entire operation to include all forms of ancillary services, and both income and expenses. For existing or expanding hospitals, the viability assessment will look at the last three years of operation. The various unit types and associated services with levels of care should clearly identify the census/occupancy attributable to each. This is important in the income/expense analysis as many expense categories are based on a per-unit cost, so census/occupancy assumptions can generate a lower expense in some instances and be of benefit to the underwriting.

HUD's 242 program can be utilized in all states. If the state requires a CON (certificate of need), HUD will require that it be issued before closing on the new debt. Most campus settings are eligible, as long as a first lien collateral mortgage/deed of trust is available. Sites can be fee simple, ground leases and even "scattered" sites. Since this is a federal program, any new construction, or substantial rehabilitation, is subject to Federal Davis Bacon wage rates. In many areas of the county, given the competitive nature of such construction, these wage rates are not too significant, with little increase to a contractor's budgeted cost.

HUD recognizes the role the architect and contractor play in the development of a new facility, or in its renovation. As such, we recommend that they be brought in early with the mortgage banker and financial advisor. If costs are too high, obviously the project is not financially feasible. Further, an ineffective design can also create operational issues that affect the facilities bottom line. While it is not practical to layout existing facilities, or design urban hospitals in advance, due to their unique requirements, HUD has developed a prototype facility for small rural hospitals including most CAH's. This not only reduces costs, but will also insure a functional design enhancing the bottom line. It is a great way for these smaller facilities to save significant amounts of money.

What about future expansion and growth down the line? Not an issue with FHA, as we can provide a supplemental loan, Section 241, to fund capital expansion and equipment in later years.

In summary, we believe the Section 242 program is one of the most viable options for financing. The financing is time-proven and provides not only a smooth transition from construction to permanent financing, but the best long-term debt, and the lowest interest rate to create a facility that can best serve its community. ■

Alaska Healthcare Watch

This column is intended to share and inform the Chapter Members about Alaska healthcare financial news

Written by David Morgan, Reimbursement Director, Southcentral Foundation

Edited by, Cathy LeMay, Patient Accounts Director, Southcentral Foundation

Medicaid (First Health Services Corporation) - NPI contingency Plan:

Centers for Medicare & Medicaid Services (CMS) announced that it is implementing a contingency plan for covered entities who will not meet the May 23, 2007 deadline for compliance with the National Provider identifier (NPI) regulations under the Health Insurance Portability and accountability a\Act (HIPAA) of 1996.

CMS guidance clarifies that covered entities that have been making a good faith effort to comply with the NPI provisions may implement contingency plans that could include accepting legacy provider numbers on HIPAA transactions in order to maintain operations and cash flows.

1. Share your NPI with Alaska Medical Assistance. Submit NPI information updates to your provider enrollment records no later than June 1, 2007.
2. Use it –Dual use – submit both your Medicaid Provider ID number (MCI) and NPI number on electronic transactions. After May 23, 2007, continue to submit both your Medicaid Provider ID number (MCI) and NPI number on electronic transactions.
3. Full NPI compliance will be assessed on an individual provider basis. Alaska Medical Assistance will announce the sunset of the dual use period at a future date.

More information on NPI can be obtained on the First Health Services' website at https://alaska.fhsc.com.

The Alaska Department of Health and Social services has found that nearly every other payment to a Medicaid Provider has an error. The state's sample review revealed a 43% error rate. This could cost the state millions of federal matching funds next year.

The State's review was conducted in anticipation of the mandated program called the payment error rate measure (PERM). To reduce the error rate, the department has started and education and streamlining program.

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Alaska

March 15-16, 2007 at the
Westmark Fairbanks Hotel

The HFMA Fairbanks Alaska Workshop

The Fairbanks' Conference in Anchorage was a great success. Our first HFMA Conference Event in Fairbanks had 42 in attendances. The Alaskan HFMA Planning team would like to thank you all for making our educational conferences better than ever. Holding Chapter Conference helps us to stay connected with information vital to our industry, both on the national level and issues within the State of Alaska.

Conference Highlights –

Jim Heilsberg was the Conference Keynote Speaker this year. What a great presentation!

Mr. Fuller, Medicaid Director for the State of Alaska - provided an update on current agency developments, priorities, initiatives and plans for FY 07.

Leo Blas from the Department of Health and Social Services (Commissioner's Office) provided an overview of Surveillance Utilization review System (SURS) and Payment Error Rate Measurement (PERM) audits.

Von Mason presented modalities of telemedicine services with instructions on how to improve billing telemedicine claims.

Michael Bell, CPA detailed the Department of Health and Human Services Office of Inspector General Work plan that list issues that the OIG will be investigating for the Federal fiscal year, and reviewed healthcare related systems of cost accounting.

Nicole Hunt, CPC reviewed clinical code assignments and issues that effect code reporting with "Achieving Coding Excellence."

Day Egusquiza presented Effective Accounts Receivable (AR) Management involving the ongoing use of statistical analysis to present surprises, identify trends and component of pending receivables in management pieces. This was action packed session.

Several Conference attendance toured Fairbanks Memorial Hospital and Denali Center.

Cathy Lemay and the Alaskan Planning Team would like to thank all the speakers and presenters.

Conference Photo Gallery:

Click to view photos

Mark Your Calendar

June 24-28, 2007
National HFMA ANI Conference

Manchester Grand Hyatt
San Diego
California

SEE YOU THERE!

Would you like to check your progress toward a Founders Merit Award.

Individual scoring records for the Founders Merit Award program are maintained for chapter members by LCC Council III.

To receive a copy of your record, please contact

Tom Muller

Telephone: (360) 459-8994
Email: tjwashington@reachone.com

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The Chapter would like to thank the following companies for 2006 - 2007 sponsorships:

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hfma washington / alaska chapter
healthcare financial management association

Job Opportunities

TITLE	ORGANIZATION	LOCATION	CONTACT
Accountant, Staff	Michael R Bell & Company	Spokane, WA	bellcpa@bellcpa.org
CFO	The Poly Clinic	Seattle, WA	joe.shields@Polyclinic.com
Decision Support Analyst	Overlake Hospital Medical Center	Bellevue, WA	Jennifer.Garrepy@overlakehospital.org
Decision Support Analyst	Providence Everett Medical Ctr	Everett, WA	heidi.miller@providence.org
Decision Support Coordinator	St. Johns Medical Center, PeaceHealth	Longview, WA	dtroyer@peacehealth.org
Director of Home Health (RN)	Visiting Nurse Services of the Northwest	Mountlake Terrace, WA	jking@vnsnw.com
Director - Patient Registration	Alaska Native Medical Center	Anchorage, AK	yaknecht@anthc.org
Director Fiscal Services Decision Support	Central Washington Hospital	Wenatchee, WA	www.cwhs.com
Director, Revenue & Financial Reporting	Mercy Medical Center	Roseburg, OR	mikec@wexfordexecutivesearch.com
Director of Finance	Community Home Health & Hospice	Longview, WA	swalsh@corridorgroup.com
Financial Analyst	350 bed III Trauma Center	Suburb Seattle	bspontello@adurogroup.com
Financial Analyst	Providence Everett Medical Ctr	Everett, WA	heidi.miller@providence.org
Financial Analyst	Sacred Heart Medical Center	Spokane, WA	www.shmc.org
Financial Sys. Analyst - Hosp Info Systems	Yukon-Kuskokwim Health Corporation	Bethel, AK	David_Friday@ykhc.org
Internal Audit Manager	CAHN	Pendleton, OR or Nampa, ID	
Manager Patient Accounts	Southcentral Foundation	Anchorage, AK	tjohnson@scf.cc
Mgr Reimbursement	Providence Health Systems	Portland, OR	LisaMarie.May@Providence.org
Payroll Customer Svc Specialist	Providence Washington Regional Svcs	Renton, WA	pwrsrecruit@providence.org
Payroll Specialist	Providence Washington Regional Svcs	Renton, WA	pwrsrecruit@providence.org
Payroll Supervisor	Providence Washington Regional Svcs	Renton, WA	pwrsrecruit@providence.org
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Revenue Cycle Mngt Auditor/Analyst	Providence Washington Regional Svcs	Renton, WA	pwrsrecruit@providence.org
Senior Contract Analyst	Virginia Mason Medical Center	Seattle, WA	ibhbjs@vmmc.org
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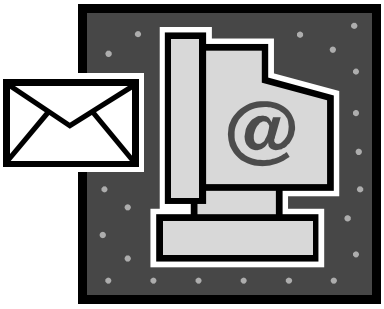
Senior Financial Analyst	Providence Everett Medical Ctr	Everett, WA	heidi.miller@providence.org
Service Area Director – Revenue Cycle Mgmnt	Providence	Walla Walla, WA	pwrsrecruit@providence.org
Senior Accountant	NW Emergency Physicians of TeamHealth	Federal Way, WA	ashley_swor@teamhealth.com
Senior Acturial Analyst	Providence Murray Business Center	Beaverton, OR	marie.chambers@providence.org
Senior Financial Strategic Analyst	Seattle Children's Hospital Research Institute	Seattle, WA	mikke.lindblom@seattlechildrens.org

For more information on these listings or to include a listing, please contact Kimie Delos Reyes at (360) 906-9258, ext 2711 or mailto:kdelosreyes@professionalcredit.com

See also National HFMA's website (www.hfma.org) for additional job listings.
[Last Update:April 26, 2007]

How Do I Change My HFMA Information?



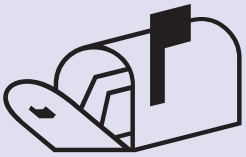
All of our chapter directory information including e-mail and addresses for the newsletter are received from the National HFMA database.

The easiest way to make changes is via the internet. Simply follow these steps to change any of your personal information.

1. **Log on to http://www.hfma.org**
2. **Go to the membership section**
3. **Log in using the username and password prompts**
4. **Follow instructions to access your Profile**
5. **Edit information.**

$100

You could win $100 by writing an article for N.W. Outlook! Share your knowledge & experiences with other HFMA Members. You can help make a difference!



Please send information & articles for upcoming newsletters to:

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Phone: 206-215-2333
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fandreasson@outreachservices.com

New Members

The Washington/Alaska Chapter is pleased to announce the following new members:

William Anderson
SEARHC

Kathy Beery
Group Health Cooperative

Rita Campbell
Group Health Cooperative

Anthony Carr
Group Health Cooperative

Linda Clark
Providence Health System

Karen Fredrickson
Searhc

Alexander Gross
Swedish Physician Division

Tracie Hagy
Univ. Of Washington

Chris Hargis
Providence Health

Nancy Huseman

Salvacion Ignacio
Group Health Cooperative

Kandi Johnson
Emdeon Business Services

Sonja Kreshel
Highline West Seattle Mental Health

Carolyn Leptich
Regence Blueshield

Joel Lewis
Olympic Medical Center

Jeff Loney
Med Data, Inc.

Rhonda McBride
Allied American Credit

Sheelaghlynn Mock
Group Health Cooperative

Denise Moreland
Healthcare Resource Group

Lisa Morris
Group Health Cooperative

Jermaine Ogden
Group Health Cooperative

Janice Parman
Allied American Credit

Dawn Pier
Group Health Cooperative

Regina Prince
KPMG, LLP

Carrissa Sanchez
Tribal Health Care,
United States Public Health Service

Joyce Saunders
Group Health Cooperative

Geoff Schwiermann

Wendy Simmons
Children's Hospital & Regional Medical Center

Zachary Smulski
Sea Mar Chc

John Tobin
Group Health Cooperative

Amy Tufano
Virginia Mason Medical Center

Jeremy Tyndall
Group Health Cooperative

Lars Tysver
Physicians Care Network

Mary Viveiros

Heather Williams
Group Health Cooperative

Donna Woodcock
Harborview Medical Center

Get Connected!

Upcoming Chapter Meetings

June 24-28, 2007

National HFMA ANI Conference

Manchester Grand Hyatt, San Diego, California

www.waakhfma.org

NW Outlook

March - May 2007

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