

The logo for HFMA, consisting of the letters 'HFMA' in a large, bold, black, sans-serif font.

Healthcare Financial  
Management Association

The logo for Lone Star Express, with 'LONE STAR' in a bold, black, sans-serif font and 'EXPRESS' in a larger, bold, black, sans-serif font with a slight slant.

The Lone Star Chapter News Magazine

OCTOBER 2011, VOLUME 13, ISSUE 2

**Funding Issues of the Exchanges  
and Outreach**

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Passed...**  
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**Does the Revenue Cycle Impact  
the Total Patient Experience?**

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# UPCOMING EVENTS



## UPCOMING EVENTS FOR THE LONE STAR CHAPTER OF HFMA

**November 9-10 - Lone Star Meeting**

**Dallas, Texas**

- **Charity Social Mixer at the Dallas Comedy House**
- **Dinner meeting at Children's Medical Center in Dallas**
- **Join other members on stage to perform with improvisers while raising money for Children's Medical Center.**
  
- **November 13-15 - Region 9 Conference**  
**New Orleans, LA**
  
- **January 18-19 - Lone Star Winter Institute**  
**Dallas, Texas**

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The Publications Committee reserves the right to accept or refuse contributions whether solicited or not. All correspondence is assumed to be a release for publication unless otherwise indicated. All article submissions are requested to be typed and provided in electronic format, if possible. Send all correspondence to: **Diana Taylor, Sabine County Hospital, dtaylor@sabinecountyhospital.com.**

### IDENTIFICATION STATEMENT:

The Lone Star Chapter "Lone Star Express" is published quarterly by the Lone Star Chapter of Healthcare Financial Management Association.

### EDITORIAL POLICY:

Opinions expressed in articles or features are those of the author(s) and do not reflect the view of the Lone Star Chapter of the Healthcare Financial Management Association, or the Publications Committee. Questions regarding articles or features should be addressed to the author(s). The Healthcare Financial Management Association and Publications Committee assume no responsibility for the accuracy or content of any articles or features published in the newsmagazine. The Publications Committee reserves the right to accept or refuse contributions whether solicited or not. All correspondence is assumed to be a release for publication unless indicated. All article submissions are requested to be typed and provided in electronic format, if possible.

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# PRESIDENT'S CORNER

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The Holidays are fast approaching, marking the halfway point in our calendar year. The first quarter of the year was very successful with our May institute and we recently kicked off the second quarter with our August institute at the Rangers Ballpark in Arlington. I would like to thank the board and committee members for organizing a fantastic event. The sessions were well attended and the feedback was positive with regards to the location and educational content. We work very hard to meet the needs of our members and it is the participation of the membership at our meetings that makes us a successful chapter. On behalf of all those involved in preparing our meeting, I would like to say thank you for attending the meeting and providing us with the feedback necessary to meet your needs.

As we move through the rest of the year I would like to highlight our upcoming events. Our first satellite meeting of the year will be held October 6th in Lubbock Texas. I will be there and look forward to greeting our West Texas members. Then we have our dinner meeting November 10th at Children's Medical Center in Dallas. This event is an evening of education and fellowship for our membership in conjunction with the presentation of our annual contribution to a local charity. The next meeting on the agenda is the Region 9 Conference in New Orleans, Louisiana on November 13th – 15th. I look forward to seeing you at one of these fall educational events.

I would also like to encourage our membership to become more involved in the various committees to ensure we have a diverse representation of our geographically large chapter. Your attendance at the educational events is important, but we need your input and participation in committees to ensure that we are steering the chapter in the direction that will best serve the membership. Please take an opportunity to meet with one of our committee chairs at an educational event to discuss becoming an active committee member.

Active committee members are integral in the success of our chapter and accumulate Founder's points for their contributions as committee members. I would like to acknowledge our most recent Founder's award recipients. Chris Joiner and Mark Teresi, CPA, MBA recently received the Bronze award. William Galinsky, FHFMA, CPA received the Silver award and Phillip McCollough received the Gold award. Please take a moment at one of our future events to congratulate them for their service to the Lone Star Chapter.

*Yours truly,  
Christian O'Connor  
President*



**2011-2012  
President  
Christian O'Connor**

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**We work very hard to meet the needs of our members and it is the participation of the membership at our meetings that makes us a successful chapter.**

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Have you ever wondered how you are viewed by others in your financial managers' leadership role? I spent some time this morning talking to an R.N. who started her clinical career as a registrar, went to school and became an LVN and then progressed to her current status of R.N. where she is now serving as the Director of Nurses for a long-term care facility in East Texas. She commented on how through her experiences, she is now able to better emphasize with management regarding the "financial side of medicine" because she now sees things from both sides of the coin.

We realize that sometimes financial managers are viewed as the "bean counters" of the organizations to which we belong and while we certainly don't view ourselves with that mentality, due to the sheer nature of our positions, we find sometimes that others see us in that light. Taking a step back to see our role as others view us may give us greater insight into why they react the way they do towards us and our actions.

I had the opportunity to do some light reading the other day and read the book, *The Art of Racing in the Rain* by Garth Stein. This book was written from the perspective of Enzo, a lab terrier mix and his relationship with his human family. The relationships emphasis of the book was particularly interesting and it caused me to think about the relationships we develop in HFMA.

The relationships part is probably one of the best things we enjoy about our jobs and about HFMA. Meeting others with like interests and sharing ideas is one of the biggest perks of our membership in this organization. If you haven't had the opportunity to serve on a committee and really get to know others in the chapter, you are missing a chance to be strengthened in your professional career more than you could hope for. Take time today to see the activities planned for the upcoming months and plan to attend now or pick up the phone and call a committee chair and ask how you can be more involved—it will be worth your while!



**2011-2012  
Newsletter Editor  
Diana Taylor**

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**Taking a step back  
to see our role  
as others view  
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greater insight into  
why they react  
the way they do  
towards us and our  
actions.**

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# FUNDING ISSUES OF THE EXCHANGES AND OUTREACH

By Christopher Thunder and Ryan Brebner,  
R&B Solutions, Waukegan, IL

**A**t present, 26 states are involved in *Florida et al v. United States Department of Health and Human Services*, which challenges the Patient Protection and Affordable Care Act (PPACA) on the grounds that the act constitutes a federal mandate forcing individuals to purchase health insurance in violation of the Commerce Clause of Article I of the Constitution. On February 7, 2011, 21 Governors sent a letter to Health and Human Services (HHS) Secretary Kathleen Sebelius requesting complete flexibility and control over the structure and operation of the exchanges to determine what best benefits their citizens. Secretary Sebelius and the HHS responded claiming the PPACA already offers what the Governors were requesting. The legislation also makes it difficult for Governors to avoid their exchange-related responsibilities. If states fail to create an exchange accepted by HHS in time, the federal government will intervene to establish and operate an exchange of its own as outlined by the PPACA.

Even if the majority of states were not fighting the PPACA, they may have to refrain from making any significant progress on the exchanges until state officials address their looming budget deficits. According to the Center on Budget and Policy Priorities, “the upcoming fiscal year is shaping up as one of states’ most difficult budget years on record. Thus far, some 44 states and the District of Columbia are projecting budget shortfalls totaling \$112 billion for Fiscal Year 2012”. With budget constraints being a major hurdle to the creation and implementation of health insurance exchanges (HIE), Secretary Sebelius recently stated that the federal government plans to give grants to states and the District of Columbia to help establish them. On the other hand, some states have put the wheels in motion to remove the Federal money from their budgets.

However, states will have many options in creating the exchanges, or can choose not to create them at all. According to the National Academy of

Social Insurance, states will have five avenues in which to structure the exchanges: creating or using a government agency; a not-for-profit entity created by the state; a multi-state exchange; a sub-state exchange serving geographical areas; or allow the federal government to setup and run the exchange. While it might be difficult to imagine the insurance exchanges being built with legal and budget battles occurring nationwide, the multiple options indicate that ~ unless the bill is overturned ~ the insurance exchanges are likely to be formed.

The Medicaid piece may be the most complicated program to automate, and the insurance exchanges will need to coordinate with the Medicaid program to achieve the goals of the PPACA. In order to be as valuable to the citizens as possible and give them the most effective way to find the medical coverage they need, the health insurance exchanges should be overly inclusive giving people the highest possible number of administrator and program

options. If the HIE is not a “one-stop-shop” for citizens to search for insurance and public programs they are eligible to enroll in, then it will not have achieved its purpose. A single selection tool must also be capable of combining the insurance exchanges with Medicaid eligibility and enrollment screening. This tool could include state and local government programs, as well as charity care programs, for those eligible for insurance but may still need assistance on past medical bills. Perhaps the biggest question related to health insurance exchanges is whether the states will be able to handle the outreach necessary to get newly eligible people enrolled and meet the goals of the PPACA.

With Medicaid expanding to cover virtually all individuals under 65 with income levels up to 133% of the Federal Poverty Line (FPL), the Congressional Budget Office (CBO) estimates that by 2019 the PPACA will enroll 16 million additional currently uninsured people in the Medicaid program and 24 million more Americans will be enrolled in a health insurance option; 162 million will continue to receive insurance through the workplace. While this number appears to show that the PPACA will cover a large chunk of the estimated 40 million currently uninsured in the country, one needs to

take into consideration that only 83% of people presently eligible under minimum Medicaid program limits are actually enrolled. That means an astounding 17% of Medicaid eligible people before the PPACA’s expansion of the program did not enroll.

The current outreach that is necessary to maximize enrollment has clearly been insufficient. The Medicaid population is not static: someone who is not eligible today may be eligible

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## **The current outreach that is necessary to maximize enrollment has clearly been insufficient.**

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tomorrow. This makes constant outreach and education necessary to assist those eligible with the enrollment process. Considering the budget woes of states, it is hard to imagine an effective outreach program being developed to assist not only newly eligible people, but the current people who are eligible

that never enrolled. By 2014, states will have to implement an effective automated HIE that will incorporate both public assistance programs and various insurance options. However, uninsured patients will continue to enter hospitals as current outreach efforts fall short and future outreach efforts are at the mercy of state budgets. Those hospitals that become more proficient at Medicaid screening and have the ability to assist and educate patients in the enrollment processes of available programs will be in the best position to provide assistance to the uninsured and to ensure the services they provide will be reimbursed.

*Christopher Thunder is a policy analyst and writer for R&B Solutions, a Medicaid Advocacy company headquartered in Waukegan, Illinois.*

*Ryan Brebner is Manager of Business Development for R&B Solutions, and is responsible for leading the company’s sales and marketing. Ryan is an active member of HFMA, AAHAM, and NAHAM. For further information, Ryan Brebner can be reached at 847-887-8514.*

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Diversified Healthcare Services, Inc.  
christianpatrick1@msn.com  
972-238-1492

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Emdeon  
PMcCollough@emdeon.com  
512-731-1081

### Vice President

**William J. Galinsky, CPA**

Scott & White Memorial Hospital  
wgalinsky@swmail.sw.org  
254-724-1806

### Secretary

**Elizabeth A. Pulliam, CHFP, CPA**

ea.pulliam@yahoo.com  
806-433-7504

### Treasurer

Jonathan M Phillips  
GE Capital  
972-830-6647  
jonathan.phillips@ge.com

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**Kenneth A. Johnson, FHFMA, CPA**

Scott and White Memorial Hospital  
(817) 261-8466  
kajohnson@swmail.sw.org

## BOARD MEMBERS

**Ray Dzieszinski, FHFMA**

Children's Medical Center Dallas  
Ray.dzieszinski@childrens.com 214-456-2960

**Fred Savelsbergh**

Baylor Health Care System  
fredsa@baylorhealth.edu  
214-820-3724

**Mark Teresi**

Baylor Health Care System  
mark.teresi@baylorhealth.edu  
214-820-9443

**Bill Richburg, FHFMA**

MedAssets  
brichburg@medassets.com  
972-244-5879

**Pat A. Keel**

Good Shepherd Health System  
(903) 315-1820

**Lynn A. Gipson, CPA**

Texas Health Resources  
(682) 236-6430

**Chris Joiner**

Dell Revenue Cycle Solutions  
(817) 505-6501

**Malisa A Schrib**

(214) 840-1419

# LONE STAR COMMITTEES

The Lone Star Chapter would like to invite members to join one of our committees.  
Please contact the Committee Chairperson listed below for more information.

### Link Committee Chair

**William J. Galinsky, FHFMA, CPA**

Scott & White Healthcare  
(254) 724-1806  
wgalinsky@swmail.sw.org

### Newsmagazine

**Diana Taylor**

Sabine County Hospital  
dtaylor@sabinecountyhospital.com  
409-787-3300

### Founders

**Bill Richburg**

MedAssets  
brichburg@medassets.com  
972-244-5879

### Program Chair

**Malisa A Schrib**

(214) 840-1419

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**Jason Thomas**

Recondo Technology  
(214) 998-3763

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Baylor Health Care System  
(214) 820-7779

**John Armstrong**

Carepayment  
(972) 841-9041

### Certification Contact

**Billy K. Richburg, FHFMA**

MedAssets  
(972) 244-5879  
brichburg@medassets.com

### Webmaster

**Christian Patrick O'Connor**

Diversified Healthcare Services, Inc.  
(972) 238-1492  
coconnor@dhca.us



## Over Six Months have Passed Since the New Medicare Timely Filing Change.

### Has this Change Impacted your Organization?

By Kathy Ruggieri,  
Director, Revenue Cycle Services,  
Besler Consulting

On March 23, 2010, President Obama signed into law the *Patient Protection and Affordable Care Act of 2010* (P.L. 111-148) and its companion bill, the *Health Care and Education Reconciliation Act of 2010* (P.L. 111-152) (collectively the “PPACA”). Section 6404 of the PPACA reduced the time period for filing Medicare Fee-for-Service claims to one calendar year after the date of service, effective for services furnished on or after January 1, 2010. Prior to this change, providers and suppliers had anywhere from 15 months to as long as 27 months, depending on when the service was furnished, in which to file a claim with Medicare. This change was one of many provisions aimed at curbing fraud, waste and abuse in the Medicare program.

CMS did clarify through MLN Matters MM7080 the following:

- For institutional claims that include a span of service (i.e. a “From” and “Through” span on the claim), the “Through” date will be used to determine timeliness.
- For professional claims submitted by physicians and other suppliers using form CMS- 1500 or 837P that include span dates of service, the “From” date will be used to determine timeliness.
- On these professional claims, if a “From” date is not timely, but the “To” date is timely, the Medicare contractors will split the line item and deny untimely services as not timely filed.
- Claims having a date of service of February 29th must be filed by February 28th of the following year to be considered timely. If the date of service is February 29th of any given year, and is received on or after March 1st of the following year, the claim will be denied as having failed to meet the timely filing requirement.

CMS will allow the following few exceptions to the one-calendar-year time limit. These exceptions were outlined in MLN Matters MM7270:

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) and its companion bill, the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) (collectively the “PPACA”). Section 6404 of the PPACA reduced the time period for filing Medicare Fee-for-Service claims to one calendar year after the date of service, effective for services furnished on or after January 1, 2010. Prior to this change, providers and suppliers had anywhere from 15 months to as long as 27 months, depending on when the service was furnished, in which

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CMS will allow the following few exceptions to the one-calendar-year time limit. These

exceptions were outlined in MLN Matters MM7270:

### **Administrative Error**

This is where the failure to meet the filing deadline was caused by error or misrepresentation of an employee, the Medicare contractor or agent of the Department that was performing Medicare functions. In these cases Medicare will extend the timely filing limit through the last day of the sixth month following the month in which the beneficiary, provider or supplier received notice that an error or misrepresentation was corrected.

### **Retroactive Medicare Entitlement**

This is where a beneficiary receives notification of Medicare entitlement retroactive to or before the date the service was furnished. For example, at the time services were furnished the beneficiary was not entitled to Medicare. However, after the timely filing period expired, the beneficiary receives notification of Medicare entitlement effective retroactive to or before the date of the furnished service. In these cases Medicare will extend the timely filing limit through the last day of the sixth month following the month in which the beneficiary, provider or supplier received notification of Medicare entitlement retroactive to or before the date of the furnished service.

### **Retroactive Medicare Entitlement Involving State Medicaid Agencies**

This is where the State Medicaid Agency recoups payment from a provider or supplier six months or more after the service was furnished to a dually eligible beneficiary. For example at the time the service was furnished the beneficiary was only entitled to Medicaid and not Medicare. Subsequently the beneficiary receives notification of Medicare entitlement retroactive to or before the date of service. The state Medicaid agency recoups their payment from the provider or supplier and the provider or supplier cannot submit the claim to Medicare because the time limit has expired. Medicare will extend the timely filing limit through the last day of the sixth month following the month in which the state Medicaid Agency recovered its payment from a provider or supplier.

### **Retroactive Disenrollment from a Medicare Advantage (MA) Plan or Program of all-inclusive Care of the Elderly (PACE) Provider Organization**

This is where a beneficiary was enrolled in a Medicare Advantage plan or PACE provider organization, but later was dis-enrolled from the Medicare Advantage plan or PACE provider organization retroactive to or before the date the service was furnished and

the Medicare Advantage plan or PACE provider organization recoups its payment from a provider or supplier six months or more after the date the service was furnished. In these cases, Medicare will extend the timely filing limit through the last day of the sixth month following the month in which the Medicare Advantage or PACE organization recovered its payment from a provider or supplier.

Once a claim is submitted to Medicare there are opportunities to adjust claims outside of timely filing in certain situations. However, it is paramount that an initial claim be submitted timely.

### **THE BOTTOM LINE**

The recent change in timely filing is significant for providers who were accustomed to the flexibility of having 15 – 27 months to submit their claims. Although CMS has allowed some exceptions, there are very few exceptions for the everyday internal disconnects that challenge providers. Now that over six months have passed since the implementation of this change, it is important for providers to not only concurrently assess the impact of the change to their specific organizations, but to implement or fine tune controls if needed to ensure claims are billed timely. Here are a few suggestions:

- Routinely track untimely denials and share this information internally within all levels of your organization through task forces and internal meetings. Since there is a unique denial code designating a timely filing denial, automated reports can be run identifying these claims.
- Research each specific claim denial and provide education to the key areas where the delay occurred as process changes may be needed.
- Routinely track claims that are not billed to Medicare because they exceed timely filing and include these claims in your internal reporting.
- Enhance tracking mechanisms of Medicare aged claims approaching timely filing deadlines.
- Continue to educate all staff, including physicians. Timely coding and billing are essential components to the elimination of timely filing rejections.
- Do not wait for payment from the Medicare Advantage plan to submit the shadow bill for IME reimbursement. Medicare shadow bills should be billed concurrently at the time the Medicare Advantage plan is billed. In the event a claim should not have been billed to Medicare, an adjustment claim can be submitted.
- Conduct a retrospective review either quarterly or bi-annually to detect additional accounts that were not identified through established processes. This will ensure all IME and GME revenue that a teaching facility is entitled to is obtained.

Teaching providers who submit shadow bills to Medicare are also required to comply with this new timely filing change. Many teaching providers have been challenged with this new change and have experienced timely filing rejections. Here are a few suggestions for teaching providers entitled to additional IME and GME reimbursement:

In today's challenging fiscal environment, it is imperative that facilities ensure they are closely monitoring these types of changes as they occur to ensure revenues are not lost.

*BESLER Consulting provides a variety of IME and GME reimbursement services to help ensure revenues are not lost. For more information please contact Kathy Ruggieri at 732.392.8227 or kruggieri@besler.com.*

### **References**

CMS MLN Matters MM7270, Related CR Transmittal #R2140CP  
CMS MLN Matters MM7080, Related CR Transmittal #R734OTN

# Healthcare Financial Management Association Texas Lone Star Chapter

Sponsorship Term: *through May 31, 2012*

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| <i>Provide input to Programs Committee for potential speakers/topics</i>                                   | ●              |                |                |

**For more information, contact Alex Penn alex.penn@pnc.com**

\* coupon valid for pre-registered attendee only.

# WELCOME NEW MEMBERS

The Lone Star Chapter extends a warm welcome to the following members or to those individuals transferring from other chapters. As of the end of June, 2011, the Lone Star Chapter had 1,180 active members. We hope to see you at future meetings and invite you to become active! "Old" members who would like to welcome these new members personally can find contact information in the Members Only section of the web site [www.lonestarhfn.org](http://www.lonestarhfn.org).

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Cook Children's Health Care System

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Harris Methodist Ft Worth Hospital

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Dallas, TX

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Anthelio Healthcare Solutions

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ESI Healthcare Business Solutions

Richard D Yates, Jr.  
Sr Management Analyst  
Bearingpoint Consulting

# Does the Revenue Cycle Impact the Total Patient Experience? Are Hospitals Missing the Financial Opportunity?

According to Jennifer Robinson, Senior Editor for the Gallup Management Journal, “for over 20 years or so, healthcare organizations have realized providing exemplary medical care isn’t enough to engage hospital patients. That’s because, from the patient’s perspective, excellent medical attention is the least a healthcare organization can offer. Many hospitals recognize this and now focus on the patient experience.”

So what is the “Patient Experience”?

The Beryl Institute collaborated with healthcare professionals and practitioners at hospitals around the country to develop a definition.

**Patient Experience:** *The sum of all interactions, shaped by an organization’s culture, that influence patient perception across a continuum of care.*

This statement and effort is so powerful that 93% of healthcare leaders say patient experience is among their top 5 priorities. Additionally, HealthLeaders Media Patient Experience Leadership Survey indicated 45% of healthcare executives see this as a priority 5 years from now.

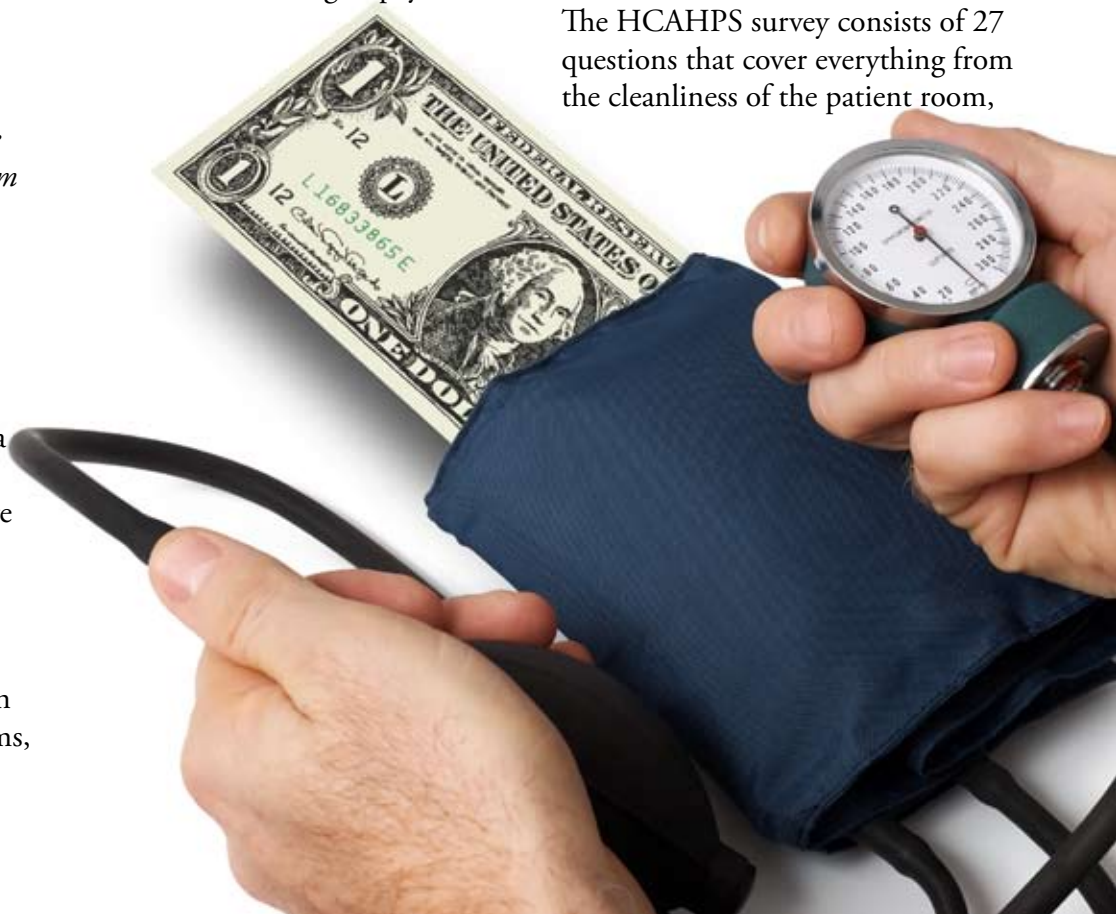
As consumers spend more and more of their disposable income on monthly health insurance premiums, higher co pays and out of pocket

By Steve Chrapla, Director Third Party Solution at Revenue Cycle Partners

expenses, they are demanding more from their chosen “provider.” In addition, the landscape around experience in healthcare is shifting dramatically in part due to the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS) and the pending value-based purchasing program that will link payments to clinical care. This will, in the future significantly impact the market basket index, that is used to annually adjust the Medicare Inpatient Payment Rates. The level of reimbursement hospitals receive from their largest payer will

be directly tied to the HCAHPS survey. Healthcare economists are advising hospitals with the advent of healthcare reform and future reimbursement levels, one of their financial objective hospitals will need to achieve is to generate positive returns under government reimbursement policies. This places increased significance on the outcomes of HCAHPS surveys and hospitals will need to take a more proactive step in managing their operations as they are reflected within the survey.

The HCAHPS survey consists of 27 questions that cover everything from the cleanliness of the patient room,



to nurse-patient communication, to pain management. However there are 2 questions, by their nature transcend the entire spectrum of the healthcare delivery system:

**- Rate the hospital on a scale from 0 to 10.**

**- Would you recommend the hospital?**

The responses to these questions can definitely be impacted by the administrative processes within the Revenue Cycle. Remember the revenue cycle representatives are usually the last contact with patients upon completion of their healthcare experience. While the time line for the HCAHPS survey requires the survey to be administered within 6 weeks of discharge, there is ability, for a deliberate focus on the patient interactions by the revenue cycle representatives, stressing the organization's culture and responsiveness to assist with the administrative challenges patients deal with, to influence the patient's perception of the hospital. This is not only good business sense from an accounts receivable management position but also allows for a world class customer service environment that is proactively managing the patient's account portfolio. In contrast to an approach that just puts out the fires and is limited to responding to questions and focused only on the immediate collection of a debt. Make no mistake collecting everything that is due is important but realize the collection of an out of pocket patient liability or even one entire patient account balance has far reaching effect on greater future reimbursements.

In fact hospital revenue cycle representatives are the final personal touch points that usually occur between patients and the hospital.

You need to ask these questions.

- Are these touch points/encounters being used to positively support the hospital's mission statement?
- Is there active participation with patients during these encounters to shape the hospital's reputation and brand?

The answer to these questions all center around how to guide the patient's journey through the healthcare reimbursement maze to find the most appropriate solution for the patient's situation. This journey can be accomplished through the use of specific tools that focus on enhanced communications and a comprehensive resolution of the patient's account. By using people-driven, technology supported services you can achieve a high level of patient satisfaction. Through this satisfaction you can enhance both patient and physician loyalty to the hospital.

The loyalty of these patients can unlock huge future potential revenue sources. The patient life time revenue value is the amount of revenue a patient can expect to generate for a hospital over their lifetime if they choose to utilize the same hospital for all the medical needs. With the impact of consumerism in healthcare this lifetime revenue value is becoming an important part of hospital's reputation management process and strategic marketing initiatives.

What are things you need to do to maximize the revenue cycle impact on the patient experience as well as protect your future patient lifetime revenue potential?

- Educate all employees of the patient experience initiatives

especially the revenue cycle representatives and their impact on the outcomes.

- Create an environment that fosters patient loyalty as a critical outcome.
- Design a patient centered revenue cycle process that is focused on customer service excellence while resolving all patient concerns.
- Integrate HCAHPS survey completion within the patient revenue cycle communication process.
- Utilize technology to support the customer service function with call centers personnel trained and motivated to achieve established goals.
- Insure all third-party service providers are fully supporting your mission and your initiatives to enhance the patient experience.
- Explore social media sites to communicate your message and encourage patients to be positive spokes persons for your organization.

Remember your reputation matters and what your patients are saying is crucial and these experiences are still be formed long after the patient leave the hospital. That is why revenue cycle operations are critical to effective Total Patient Experience initiatives.

*Revenue Cycle Partners, a division of Avadyne Health provides customer service solutions for hospitals nationally that improve profitability while enhancing the Total Patient Experience. Call Steve Chrapla at (847) 395-7655 to learn more about our Patient Experience and Reputation Management programs and how they can assist your organization.*

# LONE STAR CHAPTER MEMBER FOCUS

## Mike Reppart

*By Susan Dimick Green*



**T**his issue focuses on one of our West Texas members, Mike Reppart. Mike is well established in his position and has been at Hendrick Medical Center in Abilene as the Director of Business Services for the past 12 years. When asked what responsibilities his current position entails, Mike replied: “I oversee the Business Office, the Resource Eligibility and Charity program, manage the Charge Master, and prepare the annual revenue budget.”

Unlike most of us, Mike has been in healthcare most of his working days. “I started out in healthcare as a Medicare Auditor (2 years). I then went to work at what is now known as University Medical Center (“UMC”) in Lubbock. There I was the Reimbursement and Budgeting Coordinator for 5 years. Then I moved into Patient Financial Services and was a Director in that role for 5 years. Then, still at UMC, I was the Human Resources

Administrator and Safety Officer for 5 years. I left UMC to work with Blue Cross as a Provider Representative. After 4 years of that, I came to Hendrick to my current position.” Mike’s very first job, however, was NOT in healthcare but he literally started from the ground up by working in a dairy farm and was a greens keeper for a local golf course.

Well educated, Mike received his Associate of Arts degree from Ohio Valley University, then his Bachelor of Sciences degree in Accounting from Lubbock Christian University and finally, his Masters in Public Administration from Texas Tech University rounded out his credentials and have certainly prepared him for the challenges he faces in his current position. When he was asked what was the most satisfying thing about his current job, Mike chuckled and said “Making things work”. Certainly not an easy task in today’s uncertainty with healthcare financial management!

### Currently Reading

“I read mostly non-fiction. I am currently reading a book titled *Well Being*. It’s about maintaining a balanced life. I am also reading a book written by a friend, a professor at Abilene Christian University titled *Unclean*. It’s about how Christian communities treat people that live on the margins of society.”

### Favorite Food

“The kind you eat! Anything cooked with Mesquite.”

### Stress Buster

“Listen to music...all kinds (well sorta). I like music loud but I don’t like loud music. Does that make sense??”

### Family/Children

“Wife of 31 years, Kathy is a finance type person and works at a homeless services center. Two daughters, ages 21 and 26.”

### Pet Peeve

“People who don’t pay attention”

### Favorite Movie

“Wow! Only one?? The Princess Bride...Bull Durham. I could go on but...”

### Hobbies?

“Fantasy baseball and trying to keep my motorcycle running.”

### What would surprise people about you?

“I’m pretty athletic and flexible”

As with many of our HFMA members, Mike is faced with challenges. With a sense of humor about him he stated that the most challenging thing he has to deal with in his position as Director of Business Services is “that everything is so integrated in healthcare operations and that creates a lot of complexity. So many stakeholders with sometimes competing agendas make it a challenge to accomplish all that needs to be done. And that’s another thing...you never really get done, you just go home!”

For those who want to advance in a healthcare finance manager role, he offers three pieces of advice:

1. “Hang on, it’s a crazy ride!”
2. “Never stop learning.”
3. “Always read between the lines.”

Mike continues: “HFMA membership keeps me current on industry issues and best practices. It provides me the opportunity to feel equipped to handle my responsibilities. It also provides opportunities for networking and a place to share our ‘stories’.”

When asked what he does in his spare time “for fun”, Mike responded, “I officiate local High School football games, play Fantasy Baseball (a new undertaking), and I like to ride motorcycles (when I can keep mine running.)”

Mike, we salute you in your challenging role and we appreciate the time you spent in sharing your views and insights to the rest of us in the chapter!

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# HFMA MISSION STATEMENT

## HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION MISSION STATEMENT

### Vision

HFMA's vision is: "To be an indispensable resource for healthcare finance."

### Purpose Statement

To define, realize and advance the financial management of health care by helping members and others improve the business performance of organizations operating in or serving the healthcare field.

### Quality Statement

Quality is the foundation of the association and the keystone of its efforts to ensure member and customer satisfaction.

### HFMA's objective is to:

Consistently provide services and products that meet the quality expectations of its members, customers, and employees.

Actively pursue a program of continuous quality improvement that enables employees and volunteers to do their jobs right.

Quality is a major, strategic association goal. It lies at the heart of everything done for members and customers. HFMA strives continually to improve the quality of services and products offered, the processes and procedures used to produce them, and the manner in which they are delivered.

**The Lone Star Chapter - Chartered 1959 - More than 1,100 members throughout North Texas**

## LONE STAR CHAPTER MISSION STATEMENT

### **Vision Statement**

The Lone Star Chapter of HFMA will serve as the primary professional resource to support individual excellence in healthcare financial management for its members and other finance related healthcare professionals, thereby improving the business performance of organizations operating in or serving the healthcare industry.

### **Mission Statement**

We are a professional membership organization for individuals involved in the financial management of healthcare and managed care. The Lone Star Chapter, HFMA serves and represents members by:

- Providing professional development through education, information, certification, recognition, peer interaction and leadership training
- Supporting National HFMA efforts and the efforts of other organizations in influencing healthcare financial management and accounting policy decisions, principles and practices through advocacy and dissemination of information.

## LONE STAR CHAPTER STATEMENT OF VALUES

- **Service** to members is our highest priority.
- **Excellence** is the standard for all we do.
- **Teamwork** and **communication** are essential to our work.
- **Creativity** and **innovation** must be fostered.
- **Stewardship** of funds must be considered for all activities.
- **Respect for individuals** must be displayed at all activities.
- **Integrity** for all professionals must be maintained.
- The Highest standards for **professional and ethical conduct** must be supported.

# LONE STAR CHAPTER, HFMA ADVERTISING POLICY – NEW FOR 2011-2012

The *Lone Star Express* reaches more than 1,180 healthcare professionals. Effective June 2011, advertising will be limited only to sponsors of the chapter. If you have a product or service you would like members to know about, please consider becoming a sponsor. Our 2011-2012 sponsorship year has just begun with three levels to choose from. Sponsorships include exposure to Lone Star Chapter membership through May 31, 2012. For information on the Lone Star HFMA sponsorship program go to: [www.lonestarhfma.org](http://www.lonestarhfma.org). For additional information, contact Phillip McCollough at [PMcCollough@emdeon.com](mailto:PMcCollough@emdeon.com) or call 512-731-1081.

| Publication   |                                    | Lone Star Chapter Sponsorship Level |                                   |        |
|---|------------------------------------|-------------------------------------|-----------------------------------|--------|
|   |                                    | Gold                                | Silver                            | Bronze |
| <b>Lone Star Express magazine</b><br>(distributed to Lone Star Chapter membership only) | Magazine to include corporate logo | X                                   | X                                 |        |
|   | Ad space in each magazine          | Full page - 7.5" wide x 10.25 tall  | Half page - 7.5" wide x 5.0" tall |        |
|   | One feature article in magazine    | X                                   |                                   |        |

|   |                                   | Statewide Sponsorship Level |               |        |
|---|-----------------------------------|-----------------------------|---------------|--------|
|   |                                   | Gold                        | Silver        | Bronze |
| <b>Texas Voice state magazine</b><br>(distributed to all Texas HFMA membership) |                                   |                             |               |        |
|   | Sponsor listing in March magazine | X                           | X             | X      |
|   | Ad space in March magazine        | Quarter page                | Business card |        |

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