

CT SCANNER

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by Janet F. Roemer, FHFMA

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This is a winning situation for the Chapter members and the sponsors. The sponsors enhance their brand equity and their positions as thought leaders in the healthcare

industry while gaining key networking opportunities. The Chapter can offer first-class education conferences, events and networking experiences for their members.

In this issue you will see the advertisements of several of our sponsors. You will also find a wonderful timely article written by Coleman Casey from our sponsor Shipman and Goodwin LLP. Please thank our sponsors by learning about their products.

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It's Not Too Early to Start Thinking About the 2012 CT HFMA Annual Meeting

Last year's Annual Meeting was a huge success!

Planning has begun for next year. Sponsorship opportunities will be available for this prestigious event.

Look for more information coming soon.

Inside this issue

President's Corner	2
New Members	3
Education	4
The Myths of Meaningful Use and How to Protect Your Incentive Payments	5
Tax-Exempt Project Financings through the State of Connecticut Health and Educational Facilities Authority ("CHEFA")	7
Grabbing the Reins of Your Self-Pay Population	9
Notes from the Co-Editor	9

President's Corner

by Joe Pajor, FHFMA, Chapter President

Life's Challenges

As Hurricane Irene approached in August, I knew the chances were great that our household would lose power. Sure enough, five days without power. During this time, I kept my cool, learned to listen to transistor radio broadcast Red Sox games, play scrabble and early to bed.

The power came back on early Thursday night. Instantly, I adjusted back to life with power. Reset the clocks, turned on the appliances, and get ready to watch a televised Red Sox game. At 9:00 p.m., my TV lost its AT&T U-verse signal. For the next 45 minutes, I dealt with AT&T U-verse customer service. I became extremely frustrated, angry on the phone, and lost my cool. All I wanted to do was watch my ball game!



The next day I just laughed at my reaction to the TV signal loss. For five days, loss of power never bothered me once, but within four hours, the loss of a TV signal pushed me over the emotional edge. I realized I had failed once again in my lifetime challenge of managing expectations.

With the hurricane approaching, I expected power loss — the expectation was set. Power loss came, my expectation met, so I never got upset over the five-day window.

When the power came on, I expected my normal nightly routine to return immediately. Expectation was set, game on, TV on, sit back and relax. Loss of signal, expectation not met, I go borderline ballistic.

I have learned through the years that nothing can be more valuable to keeping an even emotional keel than setting realistic expectations. From the simple, what time will one be home, to the complex, what will my retirement look like, we all consciously or subconsciously set expectations daily, yearly or lifetime. When they are met or surpassed, we are pleased and happy. We lead a contented life. When they are not, we react with negative emotions leading to disappointment, anger, and/or frustration. Life is a glass always half full.

So my greatest challenge continues to be setting realistic expectations for myself, day in and day out.

While we all have our own personal expectations, as an American society, we have developed our own set of expectations. I have written before in this column about the major contrasts of our healthcare system compared with most European systems. The real key is that the systems are driven by each country's citizens' expectations.

We can, even within our own country, view what we want out of our healthcare system differently. For those with healthcare coverage regardless if it's through a government or private insurer, the expectation is that there will be no major delay in scheduling an exam, treatment, or care. For those with access, imagine being told one will have to wait three months for a CAT Scan or to see a specialist. A cry would surely ring out that our healthcare system is broken and in need of repair.

Others without healthcare coverage would think a three-month wait for an exam would be a blessing. At least they would be seen. Others would say just the ability to have access to our system would be welcome.

Years back, my brother's restaurant's catering manager was experiencing severe arm and chest pains for over two days. Everyone advised him to go to a doctor if not an emergency room. His expectation was that without insurance coverage, he could not afford hospital care. If he only understood that he could have been treated and cared for at the local hospital, he might have lived another day.

So many of us (including me) fail to realize we can always control all of our expectations, change them if inappropriate, or improve them to gain better quality of life. After all, we alone created them.

After I got the signal back, the Red Sox lost the Thursday night game to the Yankees that I so desperately wanted to see.

I didn't expect that outcome but I should have. My bad.



CT SCANNER

Connecticut Chapter — Healthcare Financial Management Association

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CT HFMA New Members

We extend a sincere welcome to the following individuals who have chosen to join the Connecticut Chapter of HFMA. We hope our new members will contact one of the Chapter Officers or Directors with any questions they may have and also let us know if they have an interest in becoming involved or participating on one of our committees.

Scott Brabant

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Education

<p>Healthcare Information Technology <i>Learn about the various healthcare technologies being used by healthcare organizations as well as the risks associated with different technologies, and how to implement data security measures to protect yourself, your employees and your patients from the catastrophic events following an unintended release of protected health information.</i></p>	<p>September 15, 2011 (8:30-Noon)</p>
<p>Navigating Medicare Cost Report Changes <i>CHA and HFMA are co-sponsoring an education program on Medicare Cost Report Changes for Acute Care Hospital filing of Form 2552-10. Participants will be provided with an update on changes to the Form 2552-10, as well as insight into new worksheets, changes in software, transferring prior year data, utilizing the PS&R reconciliation tool, and much more. The program also provides time for an open discussion of current events (Taxes, DSH Audits, DSH & Supplemental Payments, ASO Developments, etc.). Speakers from the National Government Services Inc. (NGS), Medicare Administrative Contractor (MAC) for Connecticut and New York, and Health Financial Systems (HFS) will present this program).</i></p>	<p>September 29, 2011 (8:30-4:15)</p>
<p>CDM Management Webinar Series <i>Join us, as the Connecticut HFMA sponsors a five-part CDM Management Educational Series to take your Charge Master management skills to significantly higher levels. The program is web-based and presented live.</i></p> <ol style="list-style-type: none"> 1) Core Skills for Charge Master Management 2) Data & Resources for Charge Master Management 3) Charge Master Annual Updates for 2012 4) Charge Master Management: CDM Process Improvement 5) Charge Master Management: Assessment & Monitoring Techniques 	<p>October 2011 - February 2012</p> <p>October 12 (10:30-Noon) November 9 (10:30-Noon) December 14 (10:00-Noon) January 18 (10:30-Noon) February 8 (10:30-Noon)</p>
<p>Assessing Your Readiness for ICD-10 <i>We all know ICD-10 is coming. Yet, the majority of health care providers (including both physicians and hospitals) have not begun addressing the planning process, or taken concrete steps to prepare for this systemic change in coding. To put it as plainly as possible, those health care providers who fail to prepare for the ICD-10 transition properly will likely experience cash flow issues for months following the October 2013 implementation. To create a uniform awareness of the impact on the Connecticut Health Care Industry, the Connecticut Chapter of HFMA is conducting a one day program featuring hospital, physician and payer perspectives in preparing for the first major overhaul in the ICD-10 coding system since its inception over 30 years ago.</i></p>	<p>October 19, 2011 (8:30-4:00)</p>
<p>Healthcare Reform</p>	<p>November 2011</p>
<p>CT Legal Update</p>	<p>November 2011</p>
<p>Annual Medicare Update</p>	<p>December 2011</p>
<p>Hospital / Physician Relationships</p>	<p>March 2012</p>
<p>Revenue Cycle Program</p>	<p>March 2012</p>
<p>Accountable Care Organizations</p>	<p>April 2012</p>
<p>Medicare Boot Camp</p>	<p>April 2012</p>
<p>Corporate Compliance Program</p>	<p>April 2012</p>

The Myths of Meaningful Use and How to Protect Your Incentive Payments

by Phyllis A. Patrick

Have you received incentive payments for implementing electronic medical records, as part of the Federal Electronic Health Record (EHR) incentive program funded through the healthcare reform legislation? Are you about to complete the process and look forward to receiving payments in FY2012? Are you preparing to file for State meaningful use funding?

You may be thinking that buying and implementing an EHR system is all you have to do. After all, you and your colleagues have worked hard to qualify for these bonus payments and implementing electronic health records is a major goal of Congress.

We have heard a few “myths” and confusing statements regarding the meaningful use incentive program. Be forewarned and don’t fall subject to the meaningful use “myths” that are out there. Here are a few we have tried to de-mystify for you:

Myth #1: The money is free, no strings attached, and no additional reporting or attestation is required.

Fact: The incentive monies come with strings attached. If you attest that you have met the criteria and receive an incentive payment, you may be subject to an audit by CMS or by the State Medicaid agency. If an audit finds that a provider is not eligible for the bonus, the payment will be recouped. CMS is also conducting prepayment edits checks to detect inaccuracies in eligibility, reporting, and payment.

CMS has indicated that an audit finding may trigger further audits of the provider. You can lose not only the incentive check, but you can also end up in a larger investigation.

Myth #2: A risk analysis that addresses the technical requirements of the HIPAA Security Rule or the EHR application is sufficient to meet the Security criteria for attestation purposes.

Fact: The technical safeguards in the HIPAA Security Rule address IT controls, access controls, and audit controls. The technical safeguards represent less than 25 percent of the full requirements of the Rule. The administrative safeguards (representing more than 50 percent of the requirements), the physical safeguards, and documentation requirements of the Rule must also be met. Analyzing the risks associated with an EHR or other application(s) also does not meet the requirement.

Myth #3: The requirement of providing patient records (in electronic format) to the requesting patient within three business days of the request applies only to the records of the patient’s physician.

Fact: If the patient request is made to the practice, not to the individual physician, CMS expects the practice to deliver all records of the practice pertaining to the patient. This involves

more tracking and reporting of information. For example, if an ancillary or covering provider has interacted with the patient, these records must also be included in responding to the patient’s request.

Myth #4: Filing a false or incomplete attestation is not fraud, just an oversight or error, on the part of the provider.

Fact: As with all government programs, there is potential for fraud and abuse of meaningful use incentive monies. Filing a false attestation creates two separate potential False Claims Act (FCA) violations: (1) an initial violation for the false claim itself; and (2) a secondary violation for the false certification.

Due to recent legislation, stepped up anti-fraud efforts, and increased protections for whistle-blowers, it is expected that false attestations for meaningful use monies will draw the attention of work force members, contractors, and others who may decide to become relators and file actions with the government against the provider. The FCA remains the government’s best weapon in fighting healthcare fraud. Enactment of the federal Fraud Enforcement and Recovery Act (FERA) of 2009 has made it easier to file a claim.

CMS Definitions:

Fraud: The intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true, and makes, knowing the deception could result in some unauthorized benefit to himself or some other person(s).

Abuse: A range of the following improper behaviors or billing practices including, but not limited to; billing for a non-covered service; misusing codes on the claim (i.e., the service coded on the claim does not comply with national or local coding guidelines or is not billed as rendered); or inappropriately allocating costs on a cost report.

Myth #5: All systems that include patient health information must be certified in order to receive meaningful use incentive payments.

Fact: Information technology systems that act as data sources (e.g., your ADT system) and are not intended to perform required capabilities in accordance with adopted certification criteria do not need to be certified simply because they supply data to a Complete EHR or EHR Module. If the other IT systems

Continued on page 6

Myths

Continued from page 5

have not been developed to, and cannot perform required capabilities in accordance with adopted certification criteria, then certification of those other IT systems would not be available.

For the purposes of certification, an EHR technology developer must be able to demonstrate to an ONC-ATCB that its Complete EHR or EHR Module can perform the capabilities specified by all applicable certification criteria. Thus, in circumstances where the Complete EHR or EHR Module is designed to be implemented in multiple ways, including the ability to receive data from a different IT system, the EHR technology developer needs to demonstrate during testing that, regardless of the source from which the Complete EHR or EHR Module receives data, it is compliant with all applicable certification criteria for which testing and certification have been sought.

Protecting Your Incentive Payments and Preparing for Possible Audits

In order to protect your organization and your incentive payments, be prepared for EHR incentive audits. Here are some steps you can take, if you have received funds or, more importantly, BEFORE you complete the attestation process.

1. Create an internal process to handle a potential audit. Designate an individual to gather and maintain the documentation and keep records on training.
2. Conduct internal audits regarding the use of the certified EHR technology.

There are inherent documentation pitfalls in the use of some EHR technology, including cloning of notes and medical information (copying and pasting the same notes for several patients or for several visits for one patient) and over-documentation (the system may automatically copy information and include it with the documentation for each visit).

- Use sampling guidelines from the OIG's self-disclosure protocol during audits.
 - Audit functions and features, including capturing types of user accesses, by user, with specifics of the time, date, and location of access.
 - Audit data from the clinical system going to the patient billing system to verify the accuracy of clinical data supporting claims for payments.
3. Review and revise documentation and record completion policies, procedures, and practices to meet electronic record requirements. Don't automate the same old workflows;
 - reinvent and reconfigure workflows to meet electronic requirements and idiosyncrasies.

4. Sign and date all changes to medical records.
5. Be honest in completing the attestation for meaningful use incentive funding.
6. Save supporting documentation (electronic and paper) to support the attestation and the clinical quality measures reported.
7. Save documentation for at least six (6) years.
8. Monitor developments in standards and certification of EHR technology used by your organization. Ask your vendor if you are not sure.

Phyllis A. Patrick, M.B.A., FACHE, CHC is President of Phyllis A. Patrick & Associates, a collaboration of consultants specializing in providing security, privacy and compliance advisory services to the healthcare industry.

Ms. Patrick has worked in security, privacy, and compliance at major academic medical centers in the New York area, including The Mount Sinai Medical Center, Hospital for Special Surgery, and Montefiore Medical Center. Ms. Patrick is a frequent speaker at national and regional meetings, including the HIPAA Summit and the AMC Security and Privacy conferences.

She is available on the Web at www.phyllispatrick.com and can be reached at 914.696.3622 or phyllis@phyllispatrick.com.

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Tax-Exempt Project Financings through the State of Connecticut Health and Educational Facilities Authority (“CHEFA”)

by Coleman H. Casey, Shipman & Goodwin LLP

The cost and terms of borrowed funds are always critical to the tight fiscal management of any institution. Even the wealthiest institutions use borrowing as a part of investment strategy. However, for smaller institutions, borrowed funds are often the lifeline for upgrading facilities and thereby remaining competitive and up-to-date. Borrowing funds on a tax-exempt basis, therefore, can be an important tool, especially if the legal arbitrage coming from lower interest rates on borrowed funds can be created by investing funds not borrowed at a higher longterm return. The use of tax-exempt bonding in this sense has often been seen as a way of leveraging endowments over the longterm.

Under Connecticut statutes, qualifying “health care institutions” (which typically include all not-for-profit hospitals and other licensed healthcare institutions) may issue tax-exempt bonds through CHEFA to finance the acquisition and/or renovation of capital projects used in furtherance of their tax-exempt purposes. Such projects can range from the acquisition of land and the construction of facilities to the renovation of existing facilities and the purchase of equipment (such as computer and communications systems, medical equipment, and the like). These bonds are sold in the public markets, where there is often significant competition for them (because of the market’s understanding of the high quality of CHEFA bonds), which drives the interest rate on the bonds lower. Bonds can be issued in both fixed and variable rates (or a mixture), and are typically payable over thirty years. The smallest issuance size is usually \$5,000,000, as the cost of issuance of bonds runs higher than a typical bank loan.

In addition to the longer term bonds, CHEFA has equipment financing programs (either EasyLoan or EasyLease) which are very simplified and have lower costs of issuance, wherein a bank or other institution essentially provides all the loan proceeds. Such transactions normally are between two and five million dollars with terms not exceeding ten years.

Depending upon the credit strength of the borrower, bonds can be issued on the credit of the borrower alone, although more typically a bank letter of credit or other form of credit enhancement (such as bond insurance) is utilized.

Because tax-exempt bond financing is more complex than traditional bank financing, the involvement of outside counsel and accountants is an important first step in analyzing whether such arrangements are appropriate and viable. The following is a checklist of other important steps, but is not exhaustive:

1. For new projects, you should recognize that your project will be bond financeable only when it has all the governmental approvals in place necessary to proceed, including planning and zoning and Certificates of Need.

2. You will also need to have your board adopt a so-called Reimbursement Resolution before any hard construction or acquisition costs are expended.
3. You will want to be sure that bond proceeds will be used solely in furtherance of your tax-exempt purposes and will not involve any so-called “private activity” (non-tax-exempt) uses or users.
4. You will want to have engaged a construction manager or general contractor who is prepared to proceed on a guaranteed maximum price or stipulated sum basis, to assure CHEFA that your project can be completed with bond proceeds and other funds available.

Many borrowers have done multiple financings through CHEFA because of the benefits of issuing these bonds. If you have any questions about these matters, please feel free to contact Coleman Casey at 860.251.5112. Coleman has broad experience with CHEFA bond issuances, and would be happy to answer any questions that may arise.

Coleman H. Casey’s email is ccasey@goodwin.com.



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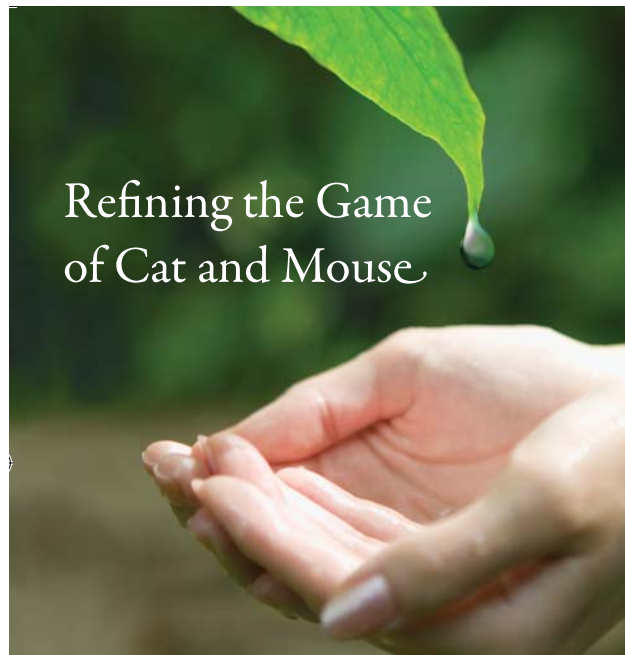
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Grabbing the Reins of Your Self-Pay Population

by Shawn Lane with CSI Financial Services

While Patients and Hospitals Struggle with Debt, There is a Win-Win Solution

The term "Perfect Storm" has been used many times during the current economic downturn. It is especially true when referring to the increasing challenges patients are facing while trying to afford healthcare.

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

With unemployment at a 27-year high, fewer patients have any form of health insurance, forcing more patients to use their rapidly dwindling savings to pay for the majority, if not all, of their healthcare expenses. Patients are doing their best to pay their obligations and avoid being sent to collections, however, there are fewer lenders in the market and the Credit CARD Act of 2009 has made it more difficult for most consumers to obtain credit.

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

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

While the Perfect Storm continues, the sun is beginning to shine on self-pay patients and hospitals. Healthcare providers are embracing with greater enthusiasm patient financing programs that give patients the ability to pay out-of-pocket expenses over time, which can help reduce their bad debt and reduce their A/R days, while also improving patient satisfaction.

According to Ken Ursin, corporate director of Patient Financial Services for Adventist Health System, providers *and* patients have benefitted from the implementation of a healthcare bank loan program.

"It has been a win for our financial counselors in that they have an excellent tool to resolve the patient's balance," Ursin said. "And, it's a win for our patients because they have a program that is more suitable for their budget."

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

Notes from the Co-Editor

Thirty years ago I became a certified member of HFMA Fellow (FHMA) and two years later I became a Certified Manager of Patient Accounting (CMPA). The Association has done away with the Certified Manager of Patient accounting and has made one designation a new designation of Certified Healthcare Financial Professional (CHFP) after which meeting further requirement you become a Fellow. The purpose of HFMA's certification programs, like all certification programs, is to assess and recognize individuals who possess the knowledge and skills identified as essential to professional practice within the scope of a profession. For HFMA, the knowledge and skills assessed are those of a seasoned, mid-level (and aspiring executive) healthcare finance manager.



HFMA's certification programs prepare you for increasingly responsible positions in the healthcare finance industry. Certification demonstrates your comprehensive understanding of healthcare financial management overall.

This year HFMA has created a new certification program for those in the Revenue Cycle (CRCR) Certified Revenue Cycle Representative. It is aimed at developing a deep understanding of revenue cycle operations. This program will help set standards of performance for revenue cycle staff. You and your Revenue Cycle team could have the credentials that prove you have achieved a high level of revenue cycle knowledge and expertise.

This program is available for organizations and individuals, both the course and exam are available in an online format through www.hfma.org/crcr. By purchasing the CRCR program, you receive unlimited access to the self-study course and examination for a period of one year.

Who will be the first CTHFMA "CRCR"?

For more information call Chris Burke at 800.252.4362, ext. 392.

John Roemer, HFMA

Editorial Policy

The statements and opinions appearing in articles are those of the authors and not necessarily those of the CT HFMA Chapter, or the editor. The editor reserves the right to edit material and accept or reject contributions, whether solicited or not. All correspondence is assumed to be a release for publication unless otherwise indicated.

Article Submission

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January Newsletter

Deadline for Submission: December 8, 2011

Diamond



Platinum



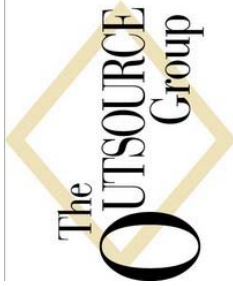
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