Kentucky Chapter

Medicare Recovery Audit Contractor Program Resumes 2009 Launch

by Charles R. Keckler, Wyatt, Tarrant & Combs, L.L.P.

It’s time. The RAC army massing at the border can be held at bay no longer. Soon, throngs of people who have never set foot in your facility before and know very little about your operations will be rifling through your claims looking for mistakes...mistakes...overpayments. Legal action filed by two unsuccessful bidders in November 2008 put a temporary hold on the Centers for Medicare and Medicaid Services (“CMS”) implementation of a permanent (and nationwide) Recovery Audit Contractor (“RAC”) program to recoup alleged Medicare overpayments from providers. On February 4, 2009, however, the protest was resolved and the “stay” was lifted. It is full steam ahead for the permanent RAC program. Are you ready?

The permanent RAC program is the latest step in the federal government’s comprehensive effort to identify improper Medicare payments and fight fraud and abuse in the Medicare program. In 2005, CMS began a three-year demonstration project in California, Florida and New York, which are states with historically high Medicare expenditures. The demonstration project expanded in 2007 to include Arizona, Massachusetts and South Carolina. CMS tasked the independent recovery audit contractors with detecting and correcting improper Medicare overpayments and, although much less frequently, reimbursing or crediting underpayments. The demonstration project resulted in $1.03 billion in Medicare payments being corrected with overpayments collected from providers constituting 96% ($992.7 million) of the total and underpayments repaid to providers making up the remaining 4% ($37.8 million). Not surprisingly, the vast majority of the overpayments (85%) were collected from inpatient hospitals, with inpatient rehabilitation hospitals following at a distant second with 6%, and skilled nursing facilities accounting for 2% of the total.

The Tax Relief and Health Care Act of 2006 requires CMS to have a permanent and national RAC program in place by January 1, 2010. CMS is now back on schedule to meet this deadline and has released an aggressive expansion plan. The expansion schedule staggers implementation among all fifty states and between four contractors (each of which are compensated on a contingency fee basis of between 9% and 12.5% of the identified improper payment). The RAC assigned to Kentucky, Indiana, Illinois and Ohio is CGI Technologies and Solutions, Inc. of Fairfax, Virginia (the RAC with the highest contingency fee of 12.5%). It is expected that CGI will hold “town-hall” type informational meetings for providers in the months preceding the start of its recovery audit activities in August 2009. Providers who bill...
President’s Message by Bill Jones

Here starts a new chapter year. I want to thank Dale Skaggs and those that served with him for making 2008-2009 a successful year. I am fortunate to have many of those which served with Dale to be working side by side with me for the 2009-2010 year. In addition there are several new volunteers that will be working with us.

The Kentucky chapter continues because of dedicated individuals who believe in the cause. I encourage any of you to step forward and offer a volunteering hand. Any of our chapter leadership is more than glad to help you get involved.

Each spring a number of the chapter leadership attend what is called the Leadership Training Conference, or for those of you that love acronyms it’s called LTC. The coming year’s theme is “Making It Count” and the incoming Chair Person of the HFMA National Board of Directors is Catherine A. Jacobson. She is very excited about involvement from everyone of all ages.

This year’s conference had much to say about the generation span we have in HFMA nationally, as well as within our chapters. It is important to know the different needs of each generation and how to be successful at addressing those needs. How better to do that than to have cross sections of the generations serve at all levels of the chapter. So everyone, of all ages, get involved. You have much to offer.

I joined HFMA in 1989, WOW twenty years and I’m still learning, and I’m still having fun. The basic two reasons I became a member. You can receive current continuing education that is applicable, and at a reasonable price, even in today’s economy. As well, you can develop a network of contacts where there is a mutual respect and you can share ideas and solutions about issues pertinent to our industry. While doing all this there is time to have fun at our meeting. There is face to face opportunity to network and have fun while getting educated.

We are always on the lookout for timely, pertinent education topics; this is your opportunity to recommend topics and/or speakers. The chapter continues to have a strong sponsorship program allowing us to attract prominent speakers. Please E-mail Chris Woosley at cwoosley@bkd.com with your education ideas.

Equally important is networking with old friends, while taking opportunities to make new friends. The Kentucky chapter offers receptions, entertainment events and even breaks between education sessions to interact with each other. Please take the opportunity of “Making It Count”; you never know who could be the next person you have the privilege to inspire. The entertainment committee is working to plan networking events around our education sessions. Please share your thoughts for networking events with Meg Parry, Entertainment Chair at megedwards@credit-bureau.com.

In conclusion, I encourage you to take a chance, get involved, be a volunteer, share your talents, and attend the quality education events. “The service of one can impact many; are you that next one to serve?”

If I can assist you please feel free to contact me.
Bill Jones, FHFMA

The articles in Financial Scene often contain summaries of complex legal or accounting issues and may not cover all the “fine points” related to specific situations. Accordingly, they are not intended to be legal or accounting advice, which should always be obtained in direct consultation with a legal or accounting professional.
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Medicare should take care now to prepare for these recovery audits.

RACs will be targeting their reviews in areas they believe are most likely to reveal claims errors that could have resulted in an improper payment (both over- and underpayments) and will analyze Medicare claims data using proprietary data mining techniques. Historically, they have found fertile “improper payment” ground in duplicate services and claims, claims that are incorrectly coded, claims that fail to meet applicable medical necessity guidelines, charts that lacked adequate documentation, and claims that violate Medicare’s Secondary Payer rules. The RACs are required to comply with the same Medicare policies to which fiscal intermediaries and carriers are subject, including National Coverage Determinations, Local Coverage Determinations and CMS manuals. If your facility were to have a situation where both overpayments and underpayments are identified, RACs will set off identified underpayments against overpayments.

RACs perform two types of review: automated and complex. An “automated” review involves only a review of the claims data (not the medical record) and is only conducted where a claim is clearly erroneous (as in the receipt of two claims for the same procedure for the same beneficiary on the same day). On the other hand, if there is a high probability (but not certainty) that a claim contains an error, then a “complex” review will occur. A “complex” review entails the RAC requesting medical records from the provider. CMS has established limits for record requests based on the provider’s type and size to help inject some “record production equity” into the process. Additionally, RACs will be able to look back three years from the date the claim was paid, but will not be able to review claims paid prior to October 1, 2007.

A RAC audit finding of an overpayment and the resulting claim denial is subject to a five level appeals process: (1) a redetermination from the fiscal intermediary or carrier; (2) a request for reconsideration conducted by a qualified independent contractor; (3) a hearing by an Administrative Law Judge; (4) a Medicare Appeals Council Review; and (5) a judicial review in federal district court. The January 2009 evaluation of the demonstration project revealed that 22.5% of RAC determinations were appealed during the demonstration project, with approximately one-third of those appealed being overturned.

Overpayments will be collected through recoupment, which automatically occurs on the 41st day after receipt of the demand letter, unless the provider files a request for redetermination within 30 days of receiving the demand letter. Such automatic recoupment could be devastating if the overpayment demand is substantial. If the redetermination (Level 1) affirms the overpayment, then the intermediary or carrier can begin withholding funds beginning 61 days after the notice unless the provider again timely appeals the finding of an overpayment at the reconsideration level (Level 2). Caution should be taken, however, when filing a quick appeal at the reconsideration level due to the rules governing early presentation of evidence and issues. A failure to carefully file a reconsideration request will preclude later consideration of issues or evidence left out of the appeal.

The use of recovery audits to recoup alleged overpayments serves to put increasing pressure on providers already stretched thin, both in terms of potential repayment amounts and reallocation of limited resources needed to prepare for and respond to an audit. Providers can prepare for RAC audits by dedicating resources to:

- Understand RAC audits, including areas of inquiry and the rules.
- Create a special RAC committee composed of qualified and experienced stakeholders. These could include persons from legal, medical services, finance, coding, billing and medical records.
- Undertake a review of targeted areas and assess the organization’s exposure.
- If appropriate, take pre-emptive corrective actions.
- Prepare for the RAC intake process, including designation of a point person.
- Regularly monitor the RAC’s website for postings on new issues and review areas.
- Attend the RAC “town-hall” meeting(s).
- Educate your board of directors about the coming audit(s).
- Create a SWAT team for assessing and expediting the appeal process in light of possible recoupment.

From the “Test RAC” of the 2005 demonstration project to the pending “RAC Attack” of 2009, it appears that Medicare recovery audit contractors are here to stay. It is never to early (or late) to start preparing your team.

Charles R. Keckler is a member of the Health Care Practice Service Team at Wyatt, Tarrant & Combs. He can be reached at (502) 589-5235. This information is a summary of complex legal issues and may not cover all the “fine points” related to a specific situation or court jurisdiction. Accordingly, it is not intended to be legal advice, which should always be obtained in direct consultation with an attorney.

HFMA National’s On-line Membership Directory

Have you visited HFMA National’s On-line Membership Directory lately? Here’s the link: http://www.hfma.org/dual_login.cfm. When you select “HFMA Directory” not only can you search for members of our chapter, you can also search for all of your HFMA colleagues by name, company, and location — regardless of chapter! You may also view your current contact information and make edits to your profile, as well as view any products you have ordered, events you have registered for, your CPE credits, your Founders points, and more!

It is vital that HFMA has your correct information, so please take a moment to view your record now. By doing so, you will ensure that HFMA continues to provide you with valuable information and insights that further your success.
Many patients need financial assistance to cover their medical costs, and this population is growing quickly. This fact is well agreed upon within the healthcare community, especially as under-insured and uninsured patient populations increase daily.

The challenge is to correctly identify these patients accurately and quickly enroll them in the programs designed to assist them. Every day a hospital's financial and admissions staff must assess:

• Does this patient qualify for financial assistance?

• Which program(s) do they qualify for?

• Which program(s) does the hospital prefer to enroll the patient in (e.g., which programs will provide the best payback on their services)?

• How quickly can the hospital complete their screening and enrollment process?

Good questions. What the industry needs are answers. The answer for many is automation.

There are many advantages and lessons to be learned by the hundreds of hospitals who are using technology to streamline the screening and enrollment process for numerous financial assistance programs. In recent years, hospitals have used automated screening and enrollment processes to identify more than five million patients who qualified for various financial assistance programs. Without automation, individuals may not have been identified as candidates or enrolled in a program. They would have received medical bills that they couldn't afford, and the hospitals would have seen many of these accounts sent to collections and never recovered.

Financial Accounts are Triaged Too

Physicians routinely balance their time between numerous patients, serving those in the most critical need of care first. Financial counselors are no different. Their growing caseload requires them to select patient accounts that need the most attention, either they have the most dire financial circumstances or have a diagnosis that will result in costly medical treatment. These staff members need to keep the hospital's best interests in mind and maximize their recovery while serving out the hospital’s mission.

But, what about the remaining patient files that do not reach the top of the list, or perhaps don’t even make it the financial counselor’s desk? It is not the fault of the financial counselors, they are serving as many as they can. Instead, it is a symptom of an outdated process in need of a cure.

Hospitals and patients alike have much to gain by pursuing financial assistance with these accounts. It would greatly reduce their bad debt, as patients in financial need will be unable to pay their bills even if they wish to, and the hospital could gain much good will by setting a patient’s mind at ease regarding financial matters and enable them to focus more attention on their health.

Living Their Mission

In 2009, the United States’ healthcare system will need to treat even more patients who cannot pay for their services, in full or part. Rising unemployment, high deductible health plans, and increasing medical fees contribute to this unfortunate trend.

This is challenging news for hospitals as they seek to serve out their mission of providing healthcare to all in need within their communities. However, a hospital's doors cannot remain open if it is not reimbursed for its services. Today's headlines speak of hospitals needing to reduce their services or cut their workforces as the economic crisis deepens.

Hospital administrators know that they must be frugal with their finances as well as initiate new processes to secure timely payments from the patient or another party. Automation of the financial assistance screening and enrollment process is part of a hospital’s mission to care for its neighborhood.

Manual Processes Are Not Up to the Challenge

Many healthcare networks have chosen to tweak existing registration and collection processes, adding staff or rewriting enrollment forms. The results are minimal...
Financial Assistance within Reach for Patients and Hospitals with Automated Screening  

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and ultimately frustrate the patient and financial counselors, who are in need of help. To improve the entire financial assistance screening and enrollment process, hospitals must directly face the following challenges:

- Facilitate how they identify patients as potential program candidates
- Verify a patient’s financial situation
- Simplify the complex program eligibility rules and requirements
- Minimize the time needed to complete the screening and enrollment processes

Today’s manual processes used to screen and/or enroll patients for financial assistance programs is usually plagued with paperwork, long patient interviews, and performed indiscriminately. As with any manual process, consistency is unattainable and human errors will occur.

Adding to this complexity, not all financial assistance programs are created equal. Some will payout more than others to the hospital, making them more attractive. Or, the hospital may need to direct patients to their hospital charity care programs to fulfill quotas. These program attributes must play an important role in the process.

So, the hospital needs to not only triage the patient accounts but match them with the best alternative. This is no easy task to be performed manually. Patients may qualify for many financial assistance programs, and the hospital’s bottom line may depend on which program they choose.

Automated Financial Screening Works

Not surprisingly, hospitals are rethinking how they screen patients for third-party financial assistance or their charity program as well as automating the process. As healthcare networks overhaul their registration processes to automatically alert registrars and financial counselors of accounts likely to qualify for financial assistance, they are seeing measurable results.

Novant Health has more than tripled its number of charity cases and experienced a 50% decline in bad debt after automating its screening processes. In addition it reduced charity enrollment process time by 90 percent.

For with proper automation, healthcare networks can gain:

- Improved efficiencies in screening and enrolling patients
- Significant reduction in financial counselor interview times
- Financial reimbursement that otherwise may have not occurred
- Qualify a higher percentage of patients into appropriate programs

Technology can capture the complex eligibility rules of financial assistance programs to provide simplified screening for many programs, including:

- Medicaid
- Hospital Charity Care
- State/County/Parish Indigent Coverage
- QMB/SLMB
- SSI/SSDI Disability
- Children’s Health Initiative Programs (CHIP)
- State Children’s Health Insurance Programs (SCHIP)
- Chronically Ill & Disabled Children (CIDC)
- Veteran’s Administration
- Cervical and Breast Cancer Programs
- International Payment on Foreign Nationals
- Vocational Rehabilitation
- COBRA
- Third Party Liability
- Federal Crime Victims Compensation/Victims of Violent Crime
- Miscellaneous Private Policies
- Indian Health Services
- Long Term Care/Nursing Home Placement
- Internal Charity
- Add Baby Account
- And many more.

By automating the screening process, hospitals can quickly identify individuals who qualify for charity care or other programs 87 percent of the time, with patients incorrectly qualified less than 1 percent of the time. This level of accuracy is unmatched by today’s manual processes.

Today’s registrars can be equipped to perform the following tasks with the proper technology:

- Identify program candidates at point of registration (or pre-registration).
- Accounts can be flagged in the HIS screens to identify those patients who are likely candidates for various types of financial assistance while they are registering. This information would enable the registrar to immediately validate a patient’s demographic information and alert a financial counselor.

Verify a patient’s income, household size and assets. By accessing trusted third party data sources, hospitals can validate the financial background of the patient to more accurately predict whether or not they will qualify for a financial assis-

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tance program. This information is also readily available to the financial counselors to use in the enrollment process (often it can be automatically populated into the forms by the same technology).

Easy to use screening wizards determines program eligibility. Online screens can prompt financial counselors to enter any additional patient information to maximize their time during patient interviews. This data is used to ascertain a patient’s eligibility for particular financial assistance program immediately. By relying on technology to manage the complex rules of each program, the financial counselor can reduce their time with each patient and deliver improved options for them.

Pre-populated program applications. Patients no longer need to complete long qualification forms in the hopes of securing financial assistance. Instead, the automated system can pre-populate most enrollment forms using patient information in HIS and the financial information received by a third party. Within minutes, the form is completed and needs only the patient’s signature. The entire process can be performed at the initial meeting, eliminating the need for follow-up meetings as well as reassuring the patient that their financial needs will be met.

As today’s economy continues to challenge our healthcare system’s delivery and financial systems, hospitals are finding that automating this step in the process is reaping rewards. Often using the same number of financial staff, hospitals can secure more financial assistance to improve their bottom line.

“Technology enabled us to automate how we identify self-pay patients and screen for eligibility for our charity program,” said Linda Krish, Director of Revenue Cycle at Mercy. “Today, we have improved the quality of our data for self-pay patients which resulted in increased collections and improved accuracy of our charity care applications. Today’s easy-to-use solutions allowed us to take a paper intensive process and change it to a streamlined one. Our financial counselors love the solution and the time that it saves them.”

Answers are available. Just ask the hospitals that have automated and thereby helped more than five million patients receive financial assistance available to them.

Some people say accountants are all about the numbers.

Here are some numbers that are important to us...

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Up to Speed with UPMIFA

By Douglas J. Lukcsso

The flexibility to prudently manage an investment portfolio and its spending policy is crucial when the markets are down, and nonprofits in states that have adopted the Uniform Prudent Management of Institutional Funds Act into law may find it easier to weather the current volatility.

UPMIFA updates policies set in place in 1972 by the Uniform Management of Institutional Funds Act (UMIFA), which 47 states adopted into law. The new version introduces investment principles that incorporate modern portfolio theory. It gives organizations the direction to better manage endowment assets, updates spending rules to address market volatility and fluctuations in asset balances, and allows organizations with restrictions on assets or charitable purposes to modify or release them according to the doctrines of “cy pres” and “equitable deviation.” UPMIFA was approved and recommended for enactment in 2006 by the National Conference of Commissioners on Uniform State Laws. So far, it has been adopted into law by 26 states and the District of Columbia, and others have UPMIFA legislation pending. The major changes involve investment management, endowment spending, and the release or modification of restrictions.

Investment Management

1972’s UMIFA formalized the process by which endowment funds were to be managed, allowing organizations to invest in any kind of asset, to pool accounts, to retain property, and to hire professional investment management. But some of these guidelines were vague or open to interpretation. UPMIFA clarifies the standards of conduct in managing institutional funds and strengthens the rules governing management and investment decisions. In essence, it directs those responsible for asset management to use a holistic approach in making decisions and consider the fund’s risk versus return objectives. Further, it emphasizes diversification and asset allocation, which follow the ideas perpetuated by modern portfolio theory.

Nonprofits are now obligated to consider the following factors from the act, if relevant:

• General economic conditions
• Effects of inflation or deflation
• Tax consequences
• How each investment fits within the total portfolio
• Portfolio’s expected total return
• Other resources available to the institution
• Institutional needs and the relationship between distributions and capital preservation

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- An asset’s special relationship or value, if any, to the charitable purposes of the institution.

Most nonprofit boards today would see these considerations as standard good practice; UPMIFA codifies them. These imposed duties apply to directors, trustees, investment managers, officers and agents who invest institutional funds. Volunteers will be subject to the same standards, but may be less culpable under state and federal laws.

Endowment Spending

Nonprofits’ endowment spending policies are much more adaptable than they were before 1972, when spending was generally limited to interest from bonds and income from dividends. UMIFA let organizations appropriate realized or unrealized capital gains, as well, but it did not allow for spending that would subject the fund to fall below the original amount of the donor’s gift, or its historic dollar value.

UPMIFA allows for appropriation of the endowment as much as the institution “deems prudent for the uses, benefits, purpose and duration for which the fund was established,” subject to the evaluation of several specific factors including general economic conditions and the fund’s purpose.

To provide more direction, UPMIFA lets the states consider using language that creates a “rebuttable presumption of imprudence” for organizations that spend more than 7 percent of the value of the assets annually, where the value is calculated as the average asset balance over the previous 12 quarters. The rule does not imply that spending under 7 percent is automatically acceptable; any spending must be prudent under the factors listed in UPMIFA, and spending above 7 percent may be deemed prudent if the organization can provide a strong argument.

Release or Modification of Restrictions

Under UMIFA, assets that were restricted either had to remain restricted, or the restriction had to be lifted (released) completely; restrictions could not be modified. UPMIFA makes it possible to modify or release restricted assets. UPMIFA clarifies how those modified or restricted assets can be used by expressly including the trust law doctrines of “cy pres” and “equitable deviation.” These doctrines say, essentially, that if a donation cannot be used the way it was originally intended, then it must be used in a way that is close to the original intent. The donor can consent to the release or modification of a restriction or, if the donor is not available and the restriction has become impractical, the organization may petition a court to modify or lift the restriction pursuant to cy pres and equitable deviation.

Older, smaller funds can be released or modified by notifying the Attorney General of the intent to do so, without making a request to the court. As long as the account is less than $25,000 (or, in some states, $50,000 or $100,000) and more than 20 years old, the modification or release automatically takes effect in 60 days barring objection by the Attorney General, again, as long as it is in line with the donor’s intent.

Conclusion

UPMIFA should prompt nonprofits to evaluate their spending policies and asset allocations to ensure they are maximizing their mission’s resources. Donor impact also should be considered: Many donors are familiar with Sarbanes-Oxley and the increased demand for for-profit accountability, and they may seek similar accountability in their charities. UPMIFA can help nonprofits articulate to donors how their contributions will impact the organization’s long-term mission.

Has UPMIFA Been Adopted in Your State?

Organizations can check their state’s UPMIFA status and compare the new Act’s language with older regulations at www.upmifa.org.

These examples are hypothetical. Lancaster Pollard strongly recommends that you discuss UPMIFA and your investment portfolio with your attorney and your investment advisor to devise an appropriate spending policy and manage your assets prudently.

Situation 1:

A hospital receives an endowment of $1 million in 1952 that the donor restricts to polio research. The donor has since died. UPMIFA is not clear about whether cy pres is available to the hospital, and in many states, little case law on the subject exists. The endowment remains on the books, but the hospital has been unable to utilize the resources.

UPMIFA Makes a Difference: UPMIFA allows organizations to seek court approval to modify donor restrictions without fully removing them if, and only if, the restrictions are in the line of the donor’s original intent. The hospital can ask the court to change the restrictions to use the fund for juvenile arthritis research and assure future donos of the longevity of their gifts.

Situation 2:

A donor bequeaths 10,000 shares of his company’s stock to a skilled nursing facility. Under UMIFA, the guidelines for how to incorporate that donation into the investment portfolio were somewhat open to interpretation.

UPMIFA Makes a Difference: UPMIFA requires that the stock donation be evaluated in terms of how it fits into the portfolio, with due consideration given to tax consequences, the expected total return of the portfolio, the relationship be-
between distributions and the preservation of capital, and other factors.

Diversification of the single stock also should be considered as part of the duty to manage the portfolio, but if the nursing facility determines that the fund’s purposes are better served by holding the stock, it can do so. UPMIFA puts more accountability on the boards of nonprofit organizations.

**Situation 3:**
A school has a $50 million scholarship endowment dedicated for low-income students. The endowment has lost all of its earnings and more in a bear market, causing the value to drop to $49 million. UMIFA did not allow nonprofits to tap the original gift amount, rendering the fund useless to incoming students who are more in need of scholarships than ever.

UPMIFA Makes a Difference: UPMIFA lets nonprofits responsibly tap that original gift amount, pursuant to careful evaluation of various factors. These include impact on long-term fund viability and any state-defined presumptions of imprudence.

The ability to modify the school’s endowment spending policy to accommodate for the down market means that students who otherwise would have had to forego college because of the economy can still rely on the school for financial aid.

Douglas J. Lukcso is president of Lancaster Pollard Investment Advisory Group, which helps nonprofit organizations identify their true risk tolerance and appropriately manage their portfolios. He can be reached at (614) 224-8800 or dlukcso@lancasterpollard.com. Reprinted with permission from The Capital Issue at www.lancasterpollard.com.

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**Recognizing and Acting on Little Changes can Help Hospitals Move Forward**  
*By Matthew J. Lindsay, Vice President, Lancaster Pollard*

It can be argued that a combination of “little things” dragged the economy from a lofty high where nearly every individual and every business could borrow money. Now, “big things” in the forms of stimulus bills and bank restructures are attempting to stabilize the credit markets. Hospitals, however, are stuck in a meantime that hasn’t been generous to their “big thing” projects. Lack of liquidity in the current market has forced many to postpone projects or shrink their scopes, limiting the constant progress required of modern hospitals.

Fortunately, large-scale projects aren’t always the only answer for hospitals. Facilities across the country are showing that modest changes also have the potential to help hospitals stabilize their own internal economies and continue moving forward, and small changes to financing options should create opportunities for future big-ticket borrowing.

**Little Moves with Big Potential**

In Fremont, Ohio, 132-bed Memorial Hospital competes with several newer facilities. In seeking to constantly enhance its strong image in the community, the hospital identified opportunities to improve its “first impressions” with patients and visitors. Following some renaissance work involving photographs of competing hospitals, it is brightening and modernizing its lobby with new furniture, carpeting, lighting, a water feature and a fireplace.

“For even though ours wasn’t bad, you could tell ours was dated,” Chief Financial Officer Rick Ruppel said. The lobby was last renovated in 2001. “One issue in ours particularly was lighting. It was very dark.”

The lobby renovation is expected to cost about $200,000, and 75 percent already has been raised from within the hospital and the community. “Those kinds of first impressions, if they’re not positive, then that can influence a patient or visitor’s perception,” Ruppel said.

Golden Valley Memorial Hospital in Missouri is moving forward with patient satisfaction efforts a bit farther inside the building. With eventual goals of remodeling to have 100 percent private rooms, the interim plan includes more modest aesthetic changes with new ceiling tiles and paint for patient rooms. And following the Disney philosophy that every client is a guest, Golden Valley has empowered its staff to resolve patient satisfaction issues when they happen. Managers, for example, can offer a meal voucher to help assuage an upset family member, rather than escalating the issue through administration and delaying a resolution.

Staff satisfaction also is a good area to find opportunities for small changes that make a big difference. Sidney Health Center’s new work site wellness program offers a low-cost way to provide smoking cessation, healthy living and other programs to staff members.

Sometimes the best answer is still a more comprehensive project. New and proposed changes to existing financing options may help with access to capital. Hospitals still have access to lower-interest federal hospital mortgage insurance through the FHA Section 242 program. The Section 242 program has been used for replacement facilities, new construction and renovations. It cannot currently be used for straight refinances because 20 percent of the funds must be used for new projects. Taking on additional leverage or a complex project in this economy, however, is not tenable for many hospitals. The elimination of this requirement has been suggested, which could open up the 242 program as a viable refinancing option for hospitals now facing expiring debt, onerous bank covenants or other issues.

Local resources also have been boosted lately. The Federal Home Loan Bank can now provide its AAA credit rating to local banks for use with tax-exempt hospital bonds. This allows hospitals to issue bonds through local banks at lower rates usually available only from large banks, which tend to be lending only to the highest credits right now.

Bank-qualified bonds also are looking at a boost, as the federal stimulus bill includes provisions to increase the amount of bank-qualified bonds from $10 million to $30 million per year per borrower. This increase could allow a hospital to accom-
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accomplish a larger project via an affordable financing vehicle that may have greater market appeal, so long as the community’s banks have an appetite for the bonds.

Little things weakened the economy, and though some saw it coming, few recognized how the combination of these elements would play out. But little things also have the potential to come together to help hospitals. The keys are to be aware of what changes are forthcoming both within and without the facility, and to identify and act on small, low-cost items so their benefits can combine and compound to carry the hospital forward.

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HFMA, Leadership Training Conference – Ft. Lauderdale, FL
April 19–21, 2009 By Vanessa Pennoyer, Chapter Assistant, vpennoyer@blueandco.com

As the newly appointed chapter assistant, I had the pleasure of attending this year’s leadership training conference along with incoming officers Bill Jones (President), Theresa Scholl (Vice President/Communication), Chris Woosley (Vice President/Education), Elaine Younce (Vice President/Membership), Bob Barbier (Senior Financial Executive) and Scott Reed (Treasurer).

Honestly, I was overwhelmed! There were so many good ideas and information to digest. The opportunity to collaborate with other chapters helped me realize just how well organized the Kentucky chapter is!

I especially enjoyed and found useful keynote speaker, Cam Marston, “Four Generations in the Workplace.” While the title is self-explanatory, the presentation identified the four generations and offered insight into ways of communicating with the Kentucky members. We really aren’t that different, we just have different perspectives on life. The Matures (born prior to 1946) respect authority, are hard working and follow rules. The Baby Boomer (born ’46 to ’64) are workaholics, question authority and work efficiently. The Generation X (born ’65 to ’79) are independent, desire structure and direction and are typically skeptical. The Millennial (born ’80) are “What’s next” generation, multi-tasking, tolerant and very goal oriented. (I’m happy to share this further if you’d like to learn more).

Social networking was another important topic (Facebook, LinkedIn, Twitter, etc). As a communication tool, these venues are becoming part of our business culture. Therefore, the Kentucky chapter is establishing a presence on Facebook. We hope that you will join our group. The link is available on our website www.hfmakey.org.

Finally, this year’s theme is “Making it Count.” The chapter will be focusing on delivering services and programs that help its members connect, share, learn and grow professionally during this year. We hope you will become an active participant.
Meet the 2009 – 2010 Kentucky HFMA Chapter Leadership

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