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healthcare financial management association

The Quill Exchange

SOUTH DAKOTA HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

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Advanced Asset Alliance (AAA) is a consortium of accounts receivable management companies that specialize in the accelerated recovery of aged accounts receivable. Their method is technology driven, performance based, and compliance focused.

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President's Message by Maureen Cadwell

The summer is almost over and school is getting ready to start here and around the state. This all means that SDAHO conference is coming and we will be getting together again to catch up on changes or lack of changes in the healthcare arena as well as the chance to network with colleagues. This year's conference is looking to provide us with this and much more and thanks to Bryce Pattison and Tom Loff, the Healthcare Finance Management Association track will meet our healthcare finance needs.

In July, SDHFMA hosted a Critical Access Hospital seminar on reimbursement issues. The topics ranged from Medicare reimbursement to Medicare choice products and issues that providers are facing. In addition, a table discussion was held where attendees could share issues, resolutions or information informally. Highlights of this discussion were: Sales Tax audits, Cost Report items, and Provider-Based clinics.

The SDHFMA conference in November is shaping up to be interesting and informative on tax issues in healthcare. From Sales Tax to Non-Profit status, we hope to bring experts and information to all medical facilities. Be on the look-out for the brochure and mark the dates of November 3rd and 4th on your calendar for being in Sioux Falls for this meeting.

I hope to see you all at the SDAHO conference in Rapid City and the upcoming SDHFMA conference in Sioux Falls and if there are any questions or if you have ideas for what SDHFMA can do for you, do not hesitate in contacting me at cadwellm@siouxvalley.org or (605) 234-7120.

Maureen Cadwell, CHFP

SDHFMA Chapter President

Upcoming SDHFMA Meetings

September 21-23, 2005—SDAHO, Rapid City, SD

November 3-4, 2005—Sioux Falls, SD

February 2, 2006—Chamberlain, SD

March 30-31, 2006—Spring Symposium, Sioux Falls, SD

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Meet New Member— Ryan VandeBerg

"I'd love to spend a month in Europe, just sightseeing." That's how Ryan VandeBerg would like to spend his dream vacation – right after he builds his dream home in Glenwood Springs, Colorado. But I think it's safe to say it may be a bit before he gets there.

Ryan came to South Dakota after growing up in Fond du Lac, Wisconsin. As a youngster, he had always liked math so thought that accounting would be a good fit. Now Ryan has worked for University Physicians since October 2002. He enjoys the variety and the opportunities that present themselves each day. Before joining the world of healthcare, Ryan worked at the CPA firm of Jones, Kramer & Haber in Sioux Falls.

Even though Ryan asserts that he doesn't make New Year's Resolutions, he did resolve to join HFMA in May 2004 to help him understand the ever-changing world of healthcare. So far, Ryan has found that the monthly magazine presents plenty of possibilities that get him excited about his job and what he can accomplish.

Ryan spends his time at home with his wife Noel and their daughter Hayley, who is 3 years old, and their son Houston, 3 months old. At times, you might find Ryan out walking with his family as well as the family dog during our great South Dakota weather. Ryan admits that with the little youngsters at home, his own hobbies and interests do take a backseat to their needs, but he does enjoy reading law novels and management books.

Welcome to the South Dakota chapter of HFMA, Ryan!

Check out the SDHMFA Website

www.sdhfma.org

HFMA Roundtable Discussion

July 21, 2005 in Chamberlain, South Dakota

By Joel Aas

I was in a roundtable discussion at the July 21st meeting in Chamberlain that probed a couple of interesting questions. The first question was brought about as a result of a slide from a presentation that day. The slide indicated that we need to show operating margins of 3% to 5% to maintain our ability to afford technological advances and a sound infrastructure over the long term. My question was, "How are we going to produce a 3% operating margin if 70% or 80% of our services are reimbursed on a cost basis?" Cost based implies a 0% operating margin.

It was pointed out that we're now getting 101% of cost, which should lead to a 1% margin. Actually we're getting 101% of "allowed" costs, which is likely closer to a negative operating margin for most of us. At our hospital about 68% of our patients are Medicare beneficiaries, 6% are on Medicaid, 6% carry BC/BS (which emulates cost based reimbursement), 12% carry non-managed care insurance policies, 2% have some type of managed care coverage, and 6% are uninsured. Charity care and bad debts typically stem from the uninsured, which leaves little room to cover all the costs that aren't allowed to be reimbursed under the Medicare program.

Even if we could get to a positive margin, it would be pretty slow going to build the funded depreciation accounts necessary to finance a major project like replacing our 55 year old inpatient rooms since we have no designated funds presently. Our ability to replace capital comes from cash generated from operations, and garnered through gifts and bequeaths. Also, since 60% of our assets are already depreciated, at break-even we're not receiving enough funds to cover the cost of replacing 60% of our assets. Stated another way, that amount of depreciation isn't reflected on the cost report, so we need to make up for it elsewhere. Thus, it is very difficult to generate enough cash to continue annual capital improvements, and designate funds for the much larger scale projects like hospital expansion that will definitely be required at some point in the future.

It was suggested that we're now paying the price for the inefficient use of funds while the hospital was under the prospective payment program. Perhaps, or is it possible that the prospective payment program didn't consider the economies of scale rural hospitals simply cannot generate. Whether or not we absolutely needed to use capital asset funds to finance daily operations in the past is just that…in the past. Today we need to figure out how to finance such expansion in the future.

I suggested one way would be to do what ever was necessary to finance the expansion project now. Under our current reimbursement system, if we embarked on a large expansion project, we would put depreciation and interest expense on the cost report. Since depreciation is straight line, it will be higher than the capital portion of the loan payments over the first half of the loan (e.g. the first 20 years). Thus, from a cost based perspective, we'll actually be receiving more cash than it will take to make the loan payments. The excess cash should be set-aside in accounts designated for future loan payments. The other assumption is that our reimbursement from the other payers will be high enough to cover their portion of interest and depreciation.

One of the largest risks is that the current system will change. Although the window of opportunity to become a critical access hospital will be closing December 31st, is does not appear that Congress is interested in creating undue hardship on existing critical access hospitals in the near future by changing the system dramatically. However, they are monitoring spending patterns, and it is conceivable that they could apply caps to expansion projects (possibly based on need) to curtail runaway spending. In our case, even under that scenario, I believe we could justify the need to replace inpatient rooms that are over 55 years old, since it is common for hospitals to start planning for replacement of inpatient rooms once they reach 30 years of service.

Discussing the cost based system led to another question…"Why should we be afraid to increase salaries enough to attract employees from urban areas to rural areas? After all we'll get most of it back through the cost based system." The response was that none of us are 100% cost based so the reimbursement from other payers needs to be high enough to cover those costs or we'll be losing ground on

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Round Table Discussion Continued

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the operating margin. Clearly there is a point where we'll start losing money by paying too much, but are our information systems sophisticated enough to let us know where that point is?

We can look at various productivity and profitability ratios, but we should be cautious with our comparisons. The Compensation Ratio for instance is salaries, benefits, and professional fees divided by total operating revenue. The ratio measures people costs compared to revenue produced. If our compensation ratio is 75% it would appear to be more salary than we could uphold over the long term.

However, what if we are operating at minimum staffing levels, but simply have very low census levels. Since the ratio is calculated on net revenue, in a hospital mostly cost based reimbursed operating near break even, it turns out to simply indicate they spend 75% of their money on people as opposed to supplies and other expenses. The high ratio does indicate inefficiency, but that might be the cost of providing rural health care in a particular area. Most people in the roundtable discussion were uncomfortable with this line of thinking, because the implication seemed to be that it was encouraging operational inefficiency.

I don't think that was the implication, but rather an observation of what such indicators really mean when comparing hospitals. The critical observation seems to get back to whether our operating margins are negative or positive, and if it's negative, how are we proposing we continue providing healthcare in our rural settings. One conclusion we seemed to be in agreement on was that Congress should mandate a study of highly efficient hospitals in various settings, and let us know how they're doing it so we can emulate their policies and procedures.

Speakers at the Summer Meeting Held July 21st in Chamberlain

Ruth Krystopolski, Sioux Valley Health Plans, presents "Contract and Payment Issues with Medicare Advantage Payers for Critical Access Hospitals"

Sue Ankeny, RSM McGladrey, Inc.., presents "Understanding the Opportunities in Reimbursement and Billing for Physician Services in Critical Access Hospitals"

Dues Relief and Educational Seminar Fees Relief

South Dakota HFMA's has a policy to assist facilities that are undergoing tough financial times, but at the same time be fair to HFMA members who are paying full rates to SDHFMA seminars and annual HFMA dues. Each year an amount to provide for dues relief and educational seminar fees relief is decided by the Officers at the Spring Planning Meeting preceding a review of prior year financial statements and the current year's budget To apply for this, a letter of application should be submitted to any SDHFMA member. Approval will be decided by a majority vote of the Officers.

Dues Relief Requirements

1. If applying for a full year of HFMA membership dues, the application must be turned into any SDHFMA Officer.
2. If the application is approved, the applicant must actively participate on at least one SDHMFA committee in the year dues relief is utilized.

Successful applicants applicants meeting the dues relief requirements will be reimbursed for an amount up to 100% of paid HFMA membership dues. Please note that this will be granted to only one individual in each facility (Hospital/Nursing Home).

Seminar Fees Reduction Program

HFMA Members meeting the Dues Relief requirements may attend one seminar annually at no charge. The second seminar attendance would be discounted 50%; all other seminars attended would be at a 25% discount. All seminars, excluding SDAHO would be eligible for this program.

Facilities (Hospital and Nursing Homes) that do not currently have an HFMA member, will receive reduced seminar fees according to the following: first seminar attended—50% discount, second seminar attended—25% discount, all other seminars will be at the regular non-member price. All seminars, excluding SDHAO, would be eligible for this program

NOTE: These discounts apply only to the seminar fee, the motel and travel costs would still be the responsibility of the facility or individual.

If you feel your facility may qualify, please submit application to any SDHFMA Officer. If you know of Hospitals or Nursing Homes that do not have an HFMA member, please let them know of this policy and encourage them to apply.

Plan to Attend the 79th Annual SDAHO Convention

September 21-23, 2005

Rushmore Plaza Civic Center and Holiday Inn Rushmore Plaza, Rapid City, SD

(Brochures have been mailed, if you did not receive brochure contact Rhonda Christensen at SDAHO)

Please Attend the SDHFMA Business Meeting, Thursday, Sept. 22, 3:00-4:00 p.m.

About HFMA

HFMA is the nation's leading personal membership organization for more than 33,000 financial management professionals employed by hospitals, integrated delivery systems, long-term and ambulatory care facilities, managed care organizations, medical group practices, public accounting and consulting firms, insurance companies, government agencies, and other healthcare organizations.

Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant, information management specialist, consultant, and other professionals who seek excellence in the financial management of integrated health systems and other healthcare organizations.

HFMA, through its chapters, regions, and National office, helps members meet challenges by providing professional development opportunities, networking and communicating information and technical data with the ultimate goal being to create a more supportive environment in which members do their business.

The Quill Exchange

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Members Network during Break at July 21 Meeting in Chamberlain