65 Years of Excellence 1949-2014

STATE COLLECTION SERVICE INC

The State of Collection

A State Collection Service, Inc. Newsletter
Volume 20, Number 2 • Second Quarter 2014

PRIOR EVENTS

State Collection Service Webinar
501r and the Use of Presumptive Charity - *recording available*

State Collection Service Webinar
Be Prepared for the New Self-Pay Reality: The Impact of the Health Exchange Rollout - *recording available*

WI HFMA Webinar
Medical Debt Advisory Task Force Update - *recording available*

ACA International's March for Success
Using Speech Analytics to Improve Patient Satisfaction

WHERE WE'LL BE

HFMA ANI 2014
June 22 - 25, Las Vegas, NV

ACA International's 75th Annual Convention & Expo
July 23 - 25, Chicago, IL

IN THIS ISSUE

LOCATIONS

800.477.7474

Madison, WI
Milwaukee, WI
Beloit, WI
Chicago, IL

Some Things Never Change

—Tom Haag, Chairman and CEO

Nearly twenty years ago, when I was serving as President of ACA International, I was tasked with the responsibility of writing a monthly President's Message in the association's magazine known as The Collector. In one issue I was asked to write about customer service, which was perhaps the easiest article I ever wrote because it has been the cornerstone of State Collection Service since my father started the company in 1949.

Interestingly, when you ask people to talk about their experiences with customer service, they normally begin with an example of bad service; unfortunately, one never forgets a bad experience. With that in mind, our goal must be to create positive experiences that too will not be forgotten. Even on the occasion where a mistake is made, apologizing sincerely, working to fix the problem, and then verifying satisfaction with the customer are all musts.

A simple motto we stress to every employee stems from an old Army advertisement – "Be All You Can Be". All of our representatives working with clients or the general public need to keep that as the focus of every communication. My father set that standard and none of us wants anything less.

Ahead of the Curve
(in the midst of change)

—Terry Armstrong, President

Right now, we find ourselves in the midst of changes facing healthcare providers and how they do business; it is imperative that as partners with our clients we stay ahead of the curve. While there may be several areas of concern we could discuss, I want to concentrate on the subject of improving patient satisfaction.

USA Today recently ran an article that stated healthcare costs have risen 9.9% for the first quarter of 2014, the highest increase in a decade. This dramatic rise is attributed to previously uninsured individuals utilizing healthcare providers now that they are covered by the Affordable Healthcare Act. Of course, there is no estimate yet on how much of this increase will have to be paid by the consumer. This increase is not expected to diminish anytime soon, putting additional pressure on providers to deliver easy access, simplified bills, and excellent customer service when questions arise.

There are several initiatives that can assist with this process. I was recently interviewed by HFMA for an article within their Revenue Cycle Forum. The article addressed how providers may want to organize to improve the patient experience. The article's point is that healthcare providers should have highly trained and informed account executives handling segments of their patients. While it might have been somewhat unique, I actually used a similar approach when I managed a business office years ago and many of our clients are using a modified approach today. We will have the article on our website shortly, however, the key point is that an educated, happy patient will not only continue to use the provider's network and services, but also will pay faster.

One of the ways we have already discussed improving patient satisfaction is the "one family, one statement" concept, which we do for several clients. In fact, we recently added a new client because the CFO, who was having his own problems with getting different bills for his family from several sources, was impressed by this concept. If the CFO of a major healthcare provider finds the billing process complicated and confusing, imagine how the average patient must feel. As more providers consolidate and form networks, "one family, one statement" will become increasingly more important. Of course, you can count on State Collection Service to continue staying ahead of this curve.

Recently we began using eNotice. Simply one more way for us to communicate with consumers, eNotice is fast, efficient, and allows direct access to pay the bill. Many of our clients are capturing email addresses and getting approval for this form of communication. Not only does it improve dialog but it reduces the cost of mailing statements, reminders, etc.

Hopefully, this will progress and soon lead to sending the same data via texts; unfortunately, at this time, the use of texting and even calling cell phones is still very restrictive per the TCPA laws. While many of our clients are getting approval to use dialers to call patient cell phones, the restrictions were put in place in the early 90's, when it cost a fortune to make or receive a cell phone call. In fact, Tina Hanson, State Collection Service Executive Vice President, recently testified in front of an FCC committee with other industry executives, outlining how such cell phone dialing restrictions were hurting businesses and consumers. With landlines becoming more and more obsolete, businesses such as healthcare providers are finding themselves more limited in contacting patients to resolve questions or concerns. Tina has shared more about this hearing in an article included within this quarter's issue.

While government agencies and laws may be slow to embrace new technology and introduce changes as needed, we will continue to do everything we can to "stay ahead of the curve" with the best interest of the consumer in mind.

State Collection Service is proud to announce the opening of a new location in Milwaukee, WI.

The new location opened its doors January 2nd with a staff of 35 made up of customer service representatives for our growing Extended Business Office (EBO) operations.

The decision to expand in Milwaukee was based on the employment needs in the area and the ability to find customer-focused staff. With the help of Goodwill Industries, we were easily able to fill the positions we needed.

The office was built to accommodate a total of 75 additional staff members, with room to expand beyond as needed. The additional space has also allowed us to add an Insurance Follow-Up team, which is a newer service offering.

We look forward to growing the State Collection Service family in the Milwaukee area!

We are extremely proud to announce that State Collection Service, Inc. was selected as the large business Winner of the 2014 Wisconsin Family Business of the Year Award! At a ceremony held in Madison, we were among a group of 19 family business nominees. Equally exciting, State Collection Service is the first receivables firm in the state to ever win such an award!

The Wisconsin Family Business of the Year Award was created to highlight and celebrate theaccomplishments and contributions of family businesses that make an impact on the business community. Winners are chosen by an independent panel of judges from nominations solicited from local family businesses.

Criteria for selection include the family business' contribution to its community and industry, its positive links between family and business, and innovative practices used in its business.

In an emotional acceptance speech, company CEO Tom Haag said, "You've made a 70-year old bill collector cry with this award. State Collection Service may be the Haag family's business, but without the hard work and dedication of every member of our staff, seasoned and brand new, we would not have made it this far. This award is for every employee of State Collection Service."

Left: Erin Warner, Tim Haag (Client Services Manager), Terry Armstrong (President), Tom Haag (Chairman and CEO), Tina Hanson (Executive Vice President)

This is a very exciting achievement that we now share with very few companies.
Congratulations to every member of the State Collection team!




WHY DO I NEED TO WORRY ABOUT THE TCPA?

—Tina Hanson, Executive Vice President

What do the Federal Communication Commission and the TCPA (Telephone Consumer Protection Act) have to do with you as a healthcare provider? There has been significant increase in TCPA class action lawsuits against providers and debt collectors in the last year – nearly 500 cases were filed between January and April 2014, compared to approximately 380 in all of 2013.

These cases are surrounding obtaining express consent to call a patient on their cell phone using dialing equipment. Why? The majority of you are obtaining some form of written consent to call a patient at the contact information given at the time of service. This gives you and anyone that is an agent of yours the opportunity to use that contact information to contact the patient regarding their bill. Some recent case law, particularly the Federal District court in Mais v. Gulf Coast Collection Bureau, Inc., 944 F. Supp. 2d 1226, 1239 (S.D. Fla. 2013), states: "There is no indication that the FCC intended its ruling to apply to medical care transactions." That sounds like it is a good thing, right? It is not! Read on.

The Court in Mais ruled that a medical provider does not fall under the category of a creditor under the TCPA. Because a medical provider is not considered a creditor under the TCPA, consent to call a cell does not apply to any agent affiliated with the provider. The ruling states that consent to call the cell phone of the patient was only given to the hospital, not to the independent contractor defendant, which was a hospital-based radiology provider in this case. If the interpretation of the "prior express consent" defense remained binding authority, each individual healthcare provider – regardless of whether they were providing related or simultaneous services – would be required to obtain separate written consent forms from the patient to be contacted by an automated call system to avoid liability under the TCPA. Therefore, separate written consent would have to be obtained by each "creditor" provider, including the hospital, radiologist, emergency room, each treating physician, pathology, and every other entity or individual providing any form of medical service.

This makes no sense. It would mean that an emergency room facility – located within the same premises as the hospital – to which the patient provided their phone number voluntarily would have to obtain separate consent to contact that patient even though the hospital and emergency room had the right to share information regarding the patient's treatment and related matters under HIPAA.

What has been done to try and remedy this situation? On May 5, I attended a meeting with the FCC along with three other industry experts and TCPA Attorney, David Kaminski, to bring this specific concern to their attention in order to obtain clarification on the law. We met with Kurt Schroeder (Division Chief, Consumer Policy Division & Information Access & Privacy Office, FCC Consumer and Governmental Affairs Bureau), Aaron Garza (Legal Advisor, Office of the Bureau Chief, FCC Consumer and Governmental Affairs Bureau), and Kristi Lemoine (Attorney Advisor, Consumer Policy Division, FCC Consumer and Governmental Affairs Bureau).

Tina Hanson (far right) with other members of an ACA International panel outside of the FCC building in Washington, DC.

As a result of our meeting, we made the following requests to the FCC:

- To declare that if a consumer or patient voluntarily provides their cell phone number to a healthcare provider, this establishes prior express consent under the TCPA for all entities with whom the consumer's protected health information (PHI) is shared. This means the billing company, the first party outsourcer, the collection agency, or anyone with a business associate agreement or provides healthcare services in conjunction with that patient's care (radiology, lab, etc).
- To clarify that a healthcare provider to whom a medical debt is owed constitutes a "creditor" as that phrase is used in paragraph 9 of the FCC2008 ruling.
- Declare that when a patient is incapacitated, the providing of a cell phone number to any healthcare provider on behalf of the incapacitated party – by a spouse, parent, representative, agent, partner or employer of the patient – constitutes express consent under the TCPA.
- Last, we encouraged the FCC to clarify that when human intervention is required to initiate a call to a cell phone made through the use of the automated dialing equipment, such a call does not constitute a call made via an ATDS (automated telephone dialing system) as defined by the TCPA.

The Mais case is currently on appeal with no decision yet. We cannot, however, count on the lower courts to rule in favor of the industry. It is imperative that you too get involved at a state level by getting word to your senators and congressional representatives. You can review your own processes to ensure that you are, at a minimum, obtaining consent from the patient today; hopefully this is written consent and the FCC will make a decision soon. We too are working with our association to get a vehicle for contacting our legislators about this matter that will be shared with all our customers to use as well.

We will keep you posted – look for more details to come.

Be Prepared for the New Self-Pay Reality: The Impact of the Health Exchange Rollout

— David Franklin - Connance

There is a storm on the horizon and it is closer than many think. Between a 600% increase in high deductible health plans since 2005[1] and the significant patient responsibility that accompanies Exchange-based plans[2], providers are faced with challenges from the rise of the consumer as a payer.

Collection Fundamentals

Patient responsibility represents a significant portion of outstanding A/R for hospitals and health systems. As reported in January 2012 by Healthcare Business Insights, self-pay A/R as a percentage of total outstanding A/R had reached 16.9%.[2] In addition, the cost to collect from a patient is twice the cost to collect from a commercial payer. The reality is, replacing commercial revenue with patient-pay revenue has significant impact to the bottom line.

Impact of Commercial Payor Revenue Shifting to Patient-Pay

	All Commercial Payer Paid	Small Balance Self-Pay Mix	Large Balance Self-Pay Mix	Collection Assumptions
Net Revenue	$1,000,000	$1,000,000	$1,000,000	
% Paid By Commercial Payer	100%	0%	0%	90% yield / cost to collect 4%
Self-Pay Composition				
Number of $100 S-P bills		5000	2500	80% yield / cost to collect 5%
Number of $500 S-P bills		1000	1100	55% yield / cost to collect 8%
Number of $1,000 S-P bills			200	30% yield / cost to collect 11%
Cash Collected	$900,000	$675,000	$562,500	
Cost to Collect	$36,000	$42,000	$40,800	
Net Cash	$864,000	$633,000	$521,700	

Source: HFM Magazine, "Acknowledging the Importance of BAI Accounts," September 2011

As patient responsibility increases, the payer mix for providers will continue to change and put provider cash at risk. As shown in above, for every $1 million in net revenue that shifts from commercial payor to patient responsibility, providers could find themselves with a $200-300,000 reduction in net cash. While the specifics for any given provider will vary, there is material risk borne by providers as the payer mix shifts to patient-pay.

How to Prepare for the Challenge

Despite the gloomy outlook, all is not lost. Applying data science to patient pay can help providers prepare for and succeed in this new climate. It is important to recognize that not all accounts are created equal - roughly 30% of patient-pay follow-up activity has no cash value; roughly 30% of accounts drive over 80% of cash collections. Therein lies the opportunity - we should refocus the efforts that had no value and apply them to follow-up activity that will yield cash. If you knew an account would be worth a lot of cash by working it quickly, you would make it a priority. If you knew that a patient-pay account would pay in 10 days regardless of your effort, you would wait 15 days before checking the status. Predictive analytics can unlock patterns that would otherwise be missed, providing actionable insights to proactively improve the process and the outcome. This approach creates an analytically optimized revenue cycle, delivering net income impact.

Collection Performance Improvements

State Collection Service has put theory into practice. By integrating predictive analytics into their collections process, they have seen quarter-over-quarter increases to their average collection rate by 66% at one provider and 37% at another provider. These improvements have remained relatively consistent over time. Leveraging analytics to predict how a patient will pay, how much they will pay and how best to engage with them, coupled with the right workflows and their consistent use, has yielded dramatic gains in the amount of cash they collect for their clients.

Summary

Increases in patient responsibility from the Affordable Care Act and high deductible health plans will challenge many providers' business office strategies. Patient-pay is a critical component of the payer mix. With opportunities to refocus efforts from low or no value follow-up, predictive analytics can provide a competitive advantage for providers and agencies alike. There are a range of ways to get started and to tailor the solution for a given provider. By creating an analytically optimized revenue cycle, organizations can significantly increase their cash collections and lower the cost to collect.

About the Author: David Franklin is one of the founders and COO of Connance, Inc. David is a member of the HFMA's Medical Debt Task Force and is a frequent speaker on the topics of predictive analytics and revenue cycle process. Connance is a predictive analytics company helping hospitals and health systems transform their financial performance with an analytically optimized revenue cycle. Connance's secure, cloud-based platform includes purpose-built analytics and advanced vendor management which deliver net income improvement.

1. AHIP 2013 January Census 2. Healthcare Business Insights, Billing and Collections Benchmarks, January, 2012 3. David Wiener, Self-Pay is Here to Stay: And It's Scary, May 18, 2013

Using an Effective Follow-up Solution to Minimize Denials

— Steve Beard, Chief Business Development Officer

A great deal of the conversation related to the Affordable Care Act has focused on the increase in patient responsibility. While this is undoubtedly true, it is important to note that a sizeable portion of the formerly uninsured population will now carry some form of insurance. It is assumed that the majority of that population will select high deductible health plans. Quickly identifying the estimated deductible through effective front end processes and rolling the appropriate balance to patient responsibility will be important in the new world of health care exchanges.

Equally important is the implementation of an effective denials management program. As you know, re-billing and appeals take time and energy away from an already taxed business office. Using an effective denials management program can improve the effectiveness of your revenue cycle by minimizing denials.

Denials management is typically associated with "denials after the fact." A denial may be the result of a true denial, a lower-than-expected reimbursement or no insurance payment at all. To truly minimize denials, rather than simply reacting to them, the revenue cycle leader must truly understand why claims are denied. The best practice is to utilize the information found on the 835 to trend and track the denials at the time of payment posting. Denials should be tracked by category and subcategory to determine the nature of the denial – Clinical or Technical. Codes should then be tracked at the type or CARC code (Claim Adjustment Reason Code). The denial type should be sorted by payer, provider, and biller.

By understanding the reason for the denial you will be able to establish trends by payer, admitting source or biller. As trends are identified, you can work to determine the root cause of the denial. This information should then be shared throughout the organization to establish processes and training protocols to avoid the denials in the future. The key to this exercise is getting to the root cause.

So where do you start? First – sort your denials by occurrence and dollar amount. Next, look at your top payers and select the top ten denials for your top payers. Once the information has been gathered and analyzed, it is important to share the details throughout the revenue cycle. This sharing of trends with the front end or access groups will create a closed loop in which known causes are rectified prior to claim submission.

As you work the denials, remember how important it is to work them in a timely manner. Communication with the payer is important in the process. Third-party payers have specific instructions for appealing denials and their instructions should be appropriately followed. Those who specialize in the re-billing and appeals process should develop a relationship with provider representatives at high-volume payers. Reimbursements generated from successful appeals can be tracked to demonstrate the value of monitoring and working denials. Being aware of the type of denials by payer enables the provider to take the appropriate action and potentially avoid similar denials going forward.

Are you interested in a strong denial management solution? In addition to a group of employees familiar with the insurance process, State Collection Service recently invested in Artiva Healthcare, a platform designed to track denials, create the appropriate workflows for rebilling and appeals, and follow up with the appropriate payers at the appropriate intervals. Contact your Account Executive today for like more information!

CallMiner BIA certified RUTH PODEST

Recently Ruth Podest was given opportunity to attend the Business Intelligence Analyst certification at CallMiner. This program was targeted for full time users/administrators of CallMiner. Criteria for being accepted in the program was a minimum of 3-6 months hands experience using speech analytics.

The daily classes focused on further developing and interpreting KPI's, call metrics and developing searches for our business needs. The group also had several opportunities to meet with CallMiner's development team and programmers. Ruth and the others were encouraged to provide suggestions that will play an integral part in how CallMiner can further enhance their programs.

Congrats, Ruth, on this well-deserved certification!

Section 501r- The New Self-Pay Environment

Will Your Hospital Financial Assistance, Billing & Collection Policies Stand Up To Scrutiny?

— Mark Rukavina, Principal of Community Health Advisors, LLC

Background
With passage of the Affordable Care Act (ACA), new requirements were put on our nation's hospitals non-profit hospitals. The ACA directed the Internal Revenue Service to establish Section 501 r of the Internal Revenue Code. Hospitals must meet these new requirements in order to maintain federal charitable status.

What are the Section 501(r) Requirements?
Section 501 r establishes the following requirements:

- Financial Assistance Policy (FAP)
- Limitation on Charges for (FAP-eligible patients)
- Billing and Collection Policy
- Community Health Needs Assessment (CHNA)

This article will focus on the financial assistance policies and limitation on charges. In our next article, the focus will be on billing and collection policies.

Though final IRS regulations have not been issued, proposed regulations on financial assistance, limitations on charges, and billing/collection requirements were released in June of 2012. The IRS has stated that these proposed regulations may be relied on until final or temporary regulations are issued and published in the Federal Register.

Section 501 r Notice of Proposed Rulemaking
The Department of Treasury, Internal Revenue Service (IRS) has issued the following Notices of Proposed Rulemaking:

- Additional Requirements for Charitable Hospitals (REG-130266-11), on June 26, 2012, (requirements relating to financial assistance and emergency medical care policies, charges for certain care provided to individuals eligible for financial assistance, and billing and collections);
- Community Health Needs Assessments for Charitable Hospitals, (REG-106499-12), on April 5, 2013. (requirements relating to the community health needs assessment (CHNA) requirements, and related excise tax and reporting obligations).
- IRS Notice 2014-2: Reliance on Proposed Regulations for Tax-exempt Hospitals , confirms that tax-exempt hospitals can rely on proposed regulations under section 501(r) noted above, pending publication of final regulations or other guidance.

In the proposed CHNA rule issued in April 2013, the IRS stated that it intends to finalize the 2012 FAP regulations in conjunction with the finalizations of the proposed CHNA regulations. More than 200 comments were submitted on the FAP-related Notice of Proposed Rulemaking and a public hearing was held on this rule in late 2012. Approximately 100 comments were submitted on the CHNA Notice of Proposed Rulemaking which closed on July 5, 2013. While there is no clear timeframe for finalizing the Section 501 r regulations, there is little doubt that most American non-profit hospitals hope the final rule will be issued soon, in order to further clarify the requirements.

For additional insight into the issues related to Section 501 r and the community benefit expenses of hospitals, readers are encouraged to review the IRS Form 990 Schedule H. Schedule H is used by hospitals and health systems to report their community benefit expenses. It also includes questions on issues related to financial assistance, billing and collection.

What Are the New Requirements for Financial Assistance?
Hospitals must meet certain requirements in order to maintain their federal tax exemption. Outlined below are the major provisions related to the financial assistance policy and limitation on charges requirements. They are intended to improve transparency of the financial assistance policies intended to help financially needy patients.

More information on the Notice of Proposed Rulemaking, and related information, may be found on the IRS website at: *http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501%28c%29%283%29-Hospitals-Under-the-Affordable-Care-Act*

Financial Assistance Policy

Level of Assistance and Eligibility
Written financial assistance policies must be established, describing the type of assistance provided under the policy. Policies should explain whether the assistance is free care, discounted care, or assistance targeted to medically indigent patients or those likely to suffer medical hardship due to extraordinarily high medical expenses. Policies are expected to describe the eligibility requirements for applicants and whether income and assets will be considered in making a determination. Neither the statute nor the proposed rules dictate specific eligibility or assistance terms. The specific terms are left to hospitals.

Applying for Assistance
Applicants must be informed of how and where to apply for financial assistance. The documentation requirements are to be clearly explained and no applicant is to be denied assistance based on omission of documentation not specified in the policy. Applicants are to be notified in writing of the eligibility determination.

Publicizing Policy
The proposed regulations call on hospitals to publicize information on their financial assistance policies. The financial assistance policy, an application form and a plain language summary are to be available free of charge. This information is to be posted on the hospital (or health system) website and available in hard copy format upon request. It is also expected that information on the FAP will be conspicuously posted in public locations throughout the hospital.

This information is to be made available in language other than English if the primary language spoken by limited English proficient populations constitutes more than 10% of the population in the hospital service area.

Continued on page 8

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Community residents are to be informed of the policy is a manner that is "reasonably calculated" to reach community members in need of assistance.

Emergency Medical Care
It is required that policies be established to ensure that care is provided, without discrimination, for emergency medical conditions (within EMTALA rules) for individuals regardless of whether they are eligible for financial assistance. The proposed rule prohibits actions such as demanding payment prior to delivering emergency services or permitting debt collection activities in the emergency department that could interfere with the delivery of emergency medical care or discriminate against patients eligible for financial assistance.

Limitation on Charges
The amounts generally billed (or more accurately, the amounts expected to be paid by the patient) by patients eligible for financial assistance are not to exceed the "amounts generally billed" insured patients. The policy must describe the method for determining the amounts generally billed FAP-eligible patients for emergency and other medically necessary care. The proposed regulations prohibit charging FAP-eligible patients gross charges.

The proposed rule described two methods for determining amounts generally billed. The rule states that once a hospital selects a method, it must continue to use the same method.

Look Back Method – Amount is based on actual past claims paid by:
a.) Medicare fee-for-service and any deductible or copayments paid by the Medicare beneficiary, or
b.) Medicare fee-for-service together with all private health insurers, as well as costs paid by Medicare beneficiaries or insured patients through deductibles, copayments or co-insurance.

Prospective Method - estimate the amount that would be paid by Medicare and the Medicare beneficiary for the emergency or medically necessary care.

It should be noted that Schedule H includes other methods for determining amounts generally billed; they include Medicare rates, the lowest negotiated commercial rate, the average of the lowest three negotiated commercial rates, and other.

Safe Harbor Provision
The proposed rule includes a "safe harbor" provision for certain charges made in excess of amounts generally billed. Hospitals will meet the proposed rule requirements if an eligible patient has not completed an FAP application and the hospital continues to make reasonable efforts to determine whether a patient is eligible for assistance. If a patient is later found to be eligible for assistance, any payment made in excess of amounts generally billed must be refunded.

Presumptive Eligibility Safeguard
Presumptive eligibility screening provides hospitals with an important safeguard regarding collection actions. It clearly shows that hospitals are proactively taking steps to qualify patients for assistance. The proposed rule requires hospitals using presumptive eligibility to extend the most generous level of financial assistance to those who qualify using this method.

Some hospitals realize that applicants receiving benefits under certain means-tested programs will also qualify for the hospital FAP since they share similar eligibility standards. Others go beyond this and utilize predictive analytics help identify accounts of financially needy patients who have not submitted applications for assistance. The use of predictive screening prior to sending an account to bad debt is a leading industry practice. It provides hospitals with an important safeguard which helps hospital avoid taking extraordinary collection actions against patients who might have qualified for the FAP, if they had applied. Accounts granted presumptive eligibility are categorized as financial assistance, not bad debt, and can therefore be claimed as financial assistance on Schedule H.

Formal Approval of Governance Board
After the policies have been designed and committed to writing, they must be approved by the hospital governing board or another body authorized to approve the policies by the governing body. The policies will be considered implemented when they are consistently carried out by the hospital.

Complying with the Section 501 r Requirement
As noted above, hundreds of comments were submitted on the proposed Section 501 r rules. Certain sections in the proposed rules were controversial and generated significant reaction from the industry. How the IRS chooses to respond will not be known until they issue the final rule.

But, even absent the final rule, it is clear that hospitals should have formal, written financial assistance and billing/collection policies. Between the guidance issued by the IRS and the information required to be reported on Schedule H, it should be clear to hospitals that certain elements must now be in place.

For hospitals to be tax-exempt under federal law, they must comply with these new Section 501 r requirements. If your hospital has not reviewed and revised its policies, it should consider engaging in a comprehensive review of its financial assistance and billing/collection policies to ensure that they comply with Section 501 r requirements. It may also consider an external review to provide the hospital with feedback on its policies and practices. Such feedback could be critical to ensure that policies and practices are clear, defensible, and that they comply with the requirements of Section 501 r. Regardless of how your review is conducted, it is crucial that your hospital have policies in place that comply with these new requirements; remember, your federal tax-exemption depends on it.

***Mark Rukavina**, Principal of Community Health Advisors, LLC, holds an MBA from Babson College and a BS from the University of Massachusetts in Amherst. He has more than 25 years of experience working on healthcare issues. In his current capacity he provides assistance on issues related to financial assistance, billing and collection, and community benefit requirements for tax-exempt healthcare providers. Mark has testified before US Congressional committees, and has published research and policy briefs.*

Prior to establishing Community Health Advisors, Mark served as Executive Director of The Access Project a national, non-profit, research and advocacy organization and before that served as Program Director for a hospital/community partnership in Massachusetts under a national demonstration program sponsored by the American Hospital Association's Health Research and Educational Trust.

Mark recently served on the Healthcare Financial Management Association/ACA International Medical Debt Advisory Task Force and the Healthcare Financial Management Association's Price Transparency Task Force. ❧

April is ACA's Personal Finance Education Month

Speaking at Madison's East High School

In April, in line with ACA's Personal Finance Education Month, State's own Bill Lindala (Training, Madison) had the opportunity to speak to an economics class at Madison East High School.

A group of 15 juniors and seniors joined in the presentation. The students were very engaged and many asked detailed questions along the way. ACA provided "Personal Finance Education" reference packets to each student in attendance.

Bill spoke highly of his experience with the high school students and looks forward to more opportunities within our local community.

HIRING OUR HEROES
U.S. CHAMBER OF COMMERCE FOUNDATION

State Collection Service has recently joined the movement to hire our military heroes!

In conjuction with the U.S. Chamber of Commerce Foundation's Hiring our Heroes program State has pledged to hire at least five heroes and five spouses of military heroes in 2014.

Hiring Our Heroes, was launched in 2011 as a nationwide initiative to help veterans, transitioning service members, and military spouses find meaningful employment opportunities. Working with the U.S. Chamber of Commerce's vast network of state and local chambers and strategic partners from the public, private, and non-profit sectors, our goal is to create a movement across America in hundreds of communities where veterans and military families return every day.

By registering our company with Hiring our Heroes, State Collection Service is given access to their resume database and we have posted our job openings on their opportunies site.

To date, more than 23,000 veterans and military spouses have obtained jobs through Hiring Our Heroes. More than 1,500 businesses of all sizes have pledged to hire 411,000 heroes as part of the Hiring 500,000 Heroes campaign. Of those commitments, 255,000 hires have been confirmed with thousands more in the pipeline right now.

In March, Zach Metz, Madison Collector, joined Wisconsin Governor Walker and several hundred service men and women (Zach's wife served in Afghanistan) who have obtained jobs after completing the Department of Labor's job training program for military personnel and their families.

The USDOL has made job skills training available to service men and women and their spouses. Zach completed the training last August and was hired by State in September. Since the program's inception, 500 service men/women and/or their spouses in Wisconsin have gotten jobs with the help of USDOL. Zach said the program was a big help to him, as he had never written a resume before.

Zach's manager, Mike Paumen (site manager, Madison) was also invited to take part in the festivities with Zach's family.

Top, Zach and his wife pictured with Governer Scott Walker. Left, Governer Walker and Mike Paumen

Welcome John Murphy, *State's new CFO*

John has more than 25 years of healthcare experience in healthcare revenue cycle and IT systems.

He most recently has worked with Dell Services for 3 years, setting up a 3,000 seat CBO in the Middle East for a 13 hospital and several clinic healthcare system and installing all financial systems in a 500 bed hospital in the same region.

In previous positions, John has held executive roles in healthcare IT companies like, EPIC Systems, where he was the CFO for 5 years, and HMDS (a hospital HIS system sold to Citation) in Madison where he was the CFO for 10 years.

John started his career with KPMG as a healthcare consultant/auditor. He is a Certified Public Accountant (CPA) and graduated from the University of Wisconsin with a bachelor of Arts in Economics and MBA in accounting. John and his wife, Sandy, live in Middleton.

Please join us in welcoming John to the State family!

WOW AWARDS

During the past quarter State Collection Service gave away a record number of WOW Awards!

The WOW Award was created to recognize those employees who go above and beyond in their role, provides a great example for others, and make us all stop and say, "WOW!"

Take a look at just a few of the outstanding examples of feedback our employees have received this past quarter!

A patient called and couldn't stop raving about the State representative who helped him.

"I love my doctors and their care is what keeps me coming back but this was the first time that a billing representative made me want to come back."

A patient called to let us know that after sending a letter of dissapointment over a bill, our rep called and first thanked her for her payment and also let her know we value her opinion. After learing about payment plan options for the future, she let a supervisor know how much she appreciated the time that our staff member took to acknowledge her opinion and, in her words,

"He restored my faith in my medical facility."

A patient and his wife were both on the phone trying to get an issue resolved that they had been working on for several months. They were pleased with how quickly a representative called back and solved their problem. The couple later raved about our rep's,

"...problem solving skills, articulation, and positive attitude."

Welcome Patricia Nelson, *State's new Training Manager*

Patricia comes to us with nearly 20 years of collection industry experience. She has held roles of Training & Recruiting Manager, Director of Corporate Compliance, Risk & Quality Assurance Manager, Collection Supervisor, and started her industry career as a collector. Patricia has received her Credit and Collection Compliance Officer designation through ACA International by completing ACA coursework in agency management compliance topics.

Patricia's home office will be in Milwaukee, however she will travel to all locations to meet the training needs across the company. Patricia will work with Bill Lindala and the rest of the training team and lead the department's training efforts.

Please join us in welcoming Patricia to the State family!

TRAINING
AHEAD OF THE CURVE

— Patricia Nelson, CCCO, Training Manager

Moving into the second quarter of 2014, the Training Department at State Collection Service will focus on designing, developing and enhancing our professional development program into a deeper, richer and more robust plan for staff at all levels. Training will also continue to propel ahead of the healthcare curve with office wide trainings to include:

Affordable Care Act: All new hires are receiving a comprehensive training of the ACA that not only introduces them to the Act, but also draws a clear and concise relationship to how the Act impacts our business and our consumers. With a better understanding of the ACA, our reps are prepared to pass this knowledge along to consumers and answers questions confidently as needed.

Insurance Basics: Our Insurance Basics training takes our representatives into a deep dive of insurance terminology, compliance, processes, standards and forms, to equip them with a broad range of insurance awareness for a thorough consumer experience during each and every call. Our reps are prepared for any situation with any patient at any time!

Certified Revenue Cycle Representative (CRCR): State Collection Service continues to partner with HFMA to develop our representatives' revenue cycle knowledge and expertise by way of training and certification. This year we are adding a full bodied Coaching Course that will offer support and understanding of the 8 content areas that the online training course covers (compliance, patient access, claims processing, accounts resolution, cash, financial management, healthcare reform, and other revenue cycle departments).

Professional Collection Specialist: The Training Department is conducting ACA International training to certify our representatives after six months of employment. This certification prepares the representatives with compliant and effective collection techniques that positively impacts their ability to manage calls at all levels of collection.

Additionally, we are determined to remain adept, focused and aware of training opportunities, before they arise, and being absolutely prepared for them. Some of the additional training objectives we hope to accomplish in 2014 are supplemental training for Supervisors to increase and encourage employee interaction, satisfaction and development; developmental training for third party collectors to enhance talk off, rebuttals, urgency and system usage; facilitate ACA Trainer Specialist Designation/Certification for all training staff to enable them to teach ACA International's core collector courses at any of our offices; and exceed the annual training goal of 1.5 hours of training per employee per month.

The staff at State Collection Service can look forward to consistant and effective training coming their way throughout 2014 and beyond. With increasingly developed healthcare training initiatives and curriculum, State Collection Service can blossom in ways never imagined and soar to new heights, gliding far ahead of the competitive curve.

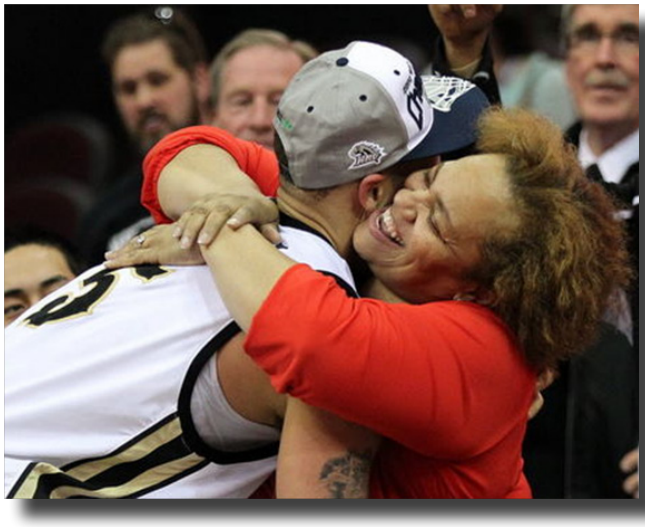
MARCH MADNESS
for State's own Pam Brown!

Pam Brown, (EBO supervisor, Beloit) had plenty to celebrate this past March when her son David was named the Mid-American Conference (MAC) tournament MVP!!

Western Michigan, 2014 MAC Champion!

David Brown, Tournament MVP!

Score, 98 - 77



March 15, 2014, the Western Michigan Broncos beat Toledo taking the MAC Championship and confirming a trip to the first round of the NCAA Men's Basketball tournament. During that match-up, David Brown had a career high 32-point game. David was named the tournament's Most Valuable Player (MVP).

On the path to MVP (MAC tournament) David suffered two potential career-ending injuries with a torn ACL during his junior year and a torn meniscus the following summer. Since his return, he has led the MAC in scoring, 24 points per game, achieving 1,000 college career points during the final game of the MAC tournament.

David Brown recently received his bachelor's degree in Sports Management with a minor in Communications at Western Michigan University in Kalamazoo, Michigan. In January, David began taking coursework towards his graduate degree in Sports Management.

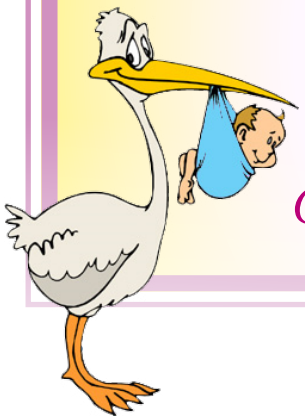
Because of David's two-year medical redshirt, he has petitioned to the NCAA for a sixth year of eligibility. This would allow him to potentially complete his graduate degree and another year of playing basketball which could boast his stock for playing at the professional level. The decision from the NCAA is pending.

Top, Pam Brown with son David. Left, David Brown with sister, Corinne Reed. Right, The Western Michigan team celebrating after the MAC tournament win.

Oh, Baby!

Congratulations to Mikey Johnson (EBO, Madison) on the birth of his daughter. Elena Lynn was born on February 19, weighing 6 lbs, and was 19 inches long.

Congratulations to Mikey and his family!



PARTNERSHIPS FOR A LIFETIME