Charting the Course in Changing Times
We must adjust to **changing times** and still hold to **unchanging principles.**”  James Earl “Jimmy” Carter, Jr.

Healthcare is going through massive changes in our day-to-day processes and workflow. How we approach those changes will be what determines our success.

There are many more changes for our industry in the future. From CMS changes in payment methodology\(^1\) that affect our facilities today to the United Nation reviewing mental health indicators that will hold governments accountable for progress in mental health over the next 15 years.\(^2\)

Facilities and providers are paid for not only the service they provide but also the underlying quality perceived by the patient. Each person in the workflow chain is responsible for the quality perceived by the patient.

During my practice administration days, the principle was simple. Treat our patients the way you want your elderly parents or your children treated in a healthcare setting. By practicing those principles, our patients’ perception of quality will increase but more importantly, we will leave the office every day knowing we are successful.

Imaging how many changes Jimmy Carter has seen in his lifetime. We witnessed how he approached those changes. Perhaps lessons will be learned, when developing a habit to apply the principles that matter the most to each of us in our workplace. Put to the test we have the resolve to ensure every patient that walks through our door leaves with the perception of better than expected clinical outcomes and the improved quality reflected in the principles that are demonstrated by our actions.

Trebb Putnam, CPC
Georgia Scroll Editor

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\(^2\) *It’s Time for a Change: Sing for Global Mental Health Indicators & Share Hope for the World*, Kathryn Goetzke
Presidents Message

Anyone who has worked in healthcare for any length of time has made the comment, “the only constant in healthcare is change”, and as we are all painfully aware, our industry, is going through monumental changes that we have little or no control over. So, as I began to write this Presidents message and thought about what to write about changing times, I searched for famous quotes that said something profound about change being inevitable or you can’t stop change so embrace it. During my search, I found quotes by famous scholars, philosophers, elected officials and so on; but the quote that resonated with me more than any other, was by author Tess Callahan. She said, “All your life you're yellow. Then one day you brush up against something blue, the barest touch, and voila, the rest of your life you're green.” What that means to me is that even the smallest interactions can change who we are, what we do or how we react to something.

We all get a “touch of blue” from various places, families, friends, places of worship, jobs and of course from HFMA. HFMA is a wonderful tool to add a little color to your professional and personal life; which can result in positive changes in and for you. A mere “brush” with someone at a HFMA event can turn into a lifelong friend and ally; someone that is a phone call away if you have a personal need, such as a health crisis or are searching for a new job. The added color can be in your professional life by cultivating relationships that have a positive impact on the growth of your business or by having a resource that you can discuss industry best practices and bounce ideas off of. Every interaction we have at HFMA adds color to our lives. It’s up to you on how you choose to let it change you.

We are not always in control of the changes our industry is going through, but we are in control of how we let the “touch of blue” in our life help us manage the change. By utilizing the relationships, education and the networking that you gain through HFMA, the constant change in our industry may be a little easier to manage.

I hope to see you at the Fall Institute in Savannah, November 4-6, 2015, to help the Georgia Chapter continue to celebrate our 60th anniversary. Who knows, maybe while you are there, you will get the “touch of blue” in your life to turn to it from yellow to green!

GOD Bless!
Kimberly Farmer, FHFMA
Calling all Early Careerist and their Mentors- Amazing Internship Scholarship Opportunity

As part of the National HFMA Initiative to engage Early Careerist in HFMA chapters, the Georgia HFMA Board has created an amazing internship/scholarship opportunity for a non-member Early Careerist. The details are below, but we need your help to identify and nominate these potential interns. Please forward this email to anyone in your organization whom you think would be interested in this wonderful opportunity!

Who is an HFMA Early Careerist? Standout in the Healthcare Finance Industry under 40 years old who is currently not a member of HFMA.

What is the Early Careerist Internship Scholarship Opportunity? A lucky Early Careerist will be selected to have an internship with the Georgia HFMA Board for the remainder of the 2015-2016 year.

What is included? Membership with National HFMA, registration and 3 night hotel expenses paid for the November (4th-6th) and April (27th-29th) Georgia HFMA meeting

What is the commitment? The Early Careerist will be expected to attend the Board Meeting on Tuesday night before the Fall and Spring Georgia HFMA meeting. The Early Careerist will also be expected to complete any assignments given to them by the Board. Additionally, the Early Careerist will commit to continue their activity in Georgia HFMA, by maintaining membership for the 2016-2016 year, and chairing a committee.

How do I apply? See attached Form. Forms are due September 25th to bjoness@HollowayCredit.com

How do I nominate someone? Give them the attached form and provide them their first letter of recommendation

Who do I contact for questions?

Bethany Jones  bjoness@HollowayCredit.com or

Elizabeth Richards  erichards@cahga.com
Andy Guth, GMGMA 2015-2016 President

2015 has been another year of change in healthcare. ICD-10 is now an active part of our daily activities as practice managers. Meaningful Use is driving many administrators to analyze the cost and benefits of participation in a complicated and time-consuming program. Insurance companies are merging and removing competition from the marketplace. Hospitals are acquiring practices at breakneck speed adding new duties and responsibilities to the administrator.

For this year’s fall meeting, GMGMA will partner with the Georgia Chapter of the Healthcare Financial Management Association (HFMA). This is a great opportunity to gain and share industry knowledge between our groups. Please welcome our members to our joint event and learn about their contributions to our profession. The sessions scheduled throughout the day are beneficial to all of us!

GMGMA is committed to providing the practice administrator the resources and tools needed to navigate the shifting tide in healthcare today. The GMGMA Fall Forum will address these and many other current issues in our environment. I encourage each and every administrator in Georgia to attend the day long event to learn and network with peers and experts in our chosen field.

Kimberly Farmer, GA HFMA 2015-2016 President

It is my honor and pleasure to be a part of this first joint venture between GMGMA and GA HFMA. It is fitting that this new endeavor happens during GA HFMA’s 60th anniversary year and GMGMA’s 50th anniversary year. This is the year for all of us to blaze new trails in healthcare finance - a year for us to join forces to educate and motivate our memberships. This is the year that we can learn from and encourage each other as we face new challenges like ICD-10, 501r, and the impact of the ACA. For GA HFMA, our theme this year is “Honor the Past, Celebrate the Present, Challenge the Future.” We are pleased to join with GMGMA this year to provide the very best in education and networking opportunities for our memberships. Together we will face the challenges before us as we strive to provide a superior experience for all patients in our communities.
Well here we are at the time of year I love most, fall. Pumpkin spice everything is back. The leaves start to turn beautiful hues. There is a little bit of a nip in the air. And, of course, there is SEC football. This means that the favorite schools of our region will beat the “tarnation” out of each other and help the weaker conferences get their teams on the playoffs. Just recently I saw my beloved Vols “give” Oklahoma a win in double overtime after having a death grip on them. This win would have definitely help Coach Butch Jones quite a bit. Then this past week I saw Alabama and Auburn fall to SEC West rivals LSU and Ole Miss respectively on the same weekend. What’s up with that? These two teams are not supposed to lose on the same weekend. Florida dodged a bullet to beat Kentucky and South Carolina, “bless their pea-picking hearts” has two losses. Georgia looks strong.

You chapter presidents and president-elect’s gathered in Chicago, rather than our beloved Caribbean, for the Fall Presidents meeting. We accomplished a lot but it is just not the same. I remember when I was president and the memories and bonds we made during the week of the cruise. But we engaged in lively and beneficial discussions on topics such as the way we will engage Young Careerists and Chapters 2.0. chapter and what each is doing to ensure a successful chapter year. We had a National Board member staff captive and gave them lots to board at the National level. At the they were somewhat frayed, much a good ole Southern butt whooping South Carolina, Florida or our social activities to make up for genuinely affectionate for our

Speaking of social activities, kudos Renee Jordan for the wonderful had dinner at Rosebud Prime on continued some of the ice-breaker The ice-breaker got off to a little bit a way to move the ball around without spilling sodas, water and food all over the place. At dinner the question “What is your most embarrassing moment?” was answered by all. Monday evening Renee had us planned for the Chopping Block where we separated into two groups, Presidents Group and President Elects Group, and cooked our own meal. Each participant was honored with a gift bag as a souvenir to take home for being a good sport. Again our National Board member and two National staffersjoined us for the festivities. If you miss seeing either your chapter’s president or president-elect you can assume they succumbed to their own cooking.

We all headed back to our respective chapters on Tuesday with plans in hand to make your proud. Thanks to all the presidents and president elects who so generously gave of their time so that you would have a better chapter. Their commitment to serving you as the members is beyond reproach. Thank them at your next chapter meeting. Special thanks to Martin Arrick, Jinna Davis and Jan Palfenier for putting up with our group and to Renee Jordan for her exceptional social events. She took a load off my shoulders in an area that is not my strength.

Best wishes to each chapter and I will be in touch in the next newsletter to give you a progress report. GBO, RTR, WDE, Chomp Chomp, Go Dawgs and Go Cocks. Please Coach Jones and dear Lord Jesus forgive me for some of the last line.
RelayHealth Financial Processes $25 Billion Worth of ICD-10 Claims

Over 13 million Claims from up to 2,430 Hospitals and 630,000 Providers Successfully Processed Since Oct. 1st

October 19, 2015 09:00 AM Eastern Daylight Time

ALPHARETTA, Ga.--(EON: Enhanced Online News)--As of today, RelayHealth Financial has successfully processed over $25 billion in claims using ICD-10 codes. This dollar volume represents more than 13 million institutional and physician claims processed using RelayHealth Financial’s revenue cycle management solutions, including RelayClearance Plus, RelayAssurance Plus, ConnectCenter, and EDI Services.

“From having our entire portfolio ready a full two years before the deadline to our comprehensive testing program and, most recently, the introduction of ICD-10 Central’s real-time analytics dashboard, RelayHealth Financial has led the industry with investments to help ensure a smooth transition for providers”

“From having our entire portfolio ready a full two years before the deadline to our comprehensive testing program and, most recently, the introduction of ICD-10 Central’s real-time analytics dashboard, RelayHealth Financial has led the industry with investments to help ensure a smooth transition for providers,” said Joshua Berman, ICD-10 Lead for RelayHealth Financial. “Claims are flowing successfully, and now the industry must be ready to tackle the next set of challenges: timely and correct reimbursement. As always, RelayHealth is ready to help its customers build on their ICD-10 successes.”

Providers can monitor critical industry KPIs affected by ICD-10 on RelayHealth Financial’s real-time analytics dashboard at ICD10Central.com. Among these metrics, Berman notes that Days to Final Bill is important to keep an eye on, as it indicates whether providers are generating claims using ICD-10 as efficiently as they did using ICD-9. This number could drop, but should rebound once providers gain proficiency in using ICD-10. If the number dips and does not rebound, urgent attention is required, Berman said.

Visit ICD10Central.com to monitor real-time Days to Final Bill results across the industry, as well as metrics including Days to Payment, Denial Rate, and Reimbursement Rate. For more information on RelayHealth Financial’s revenue cycle management solutions, visit http://www.relayhealthfinancial.com, learn from our experts at the RelayHealth blog, or follow us on Twitter at @RelayHealth.

For information on McKesson Health Solutions, please visit our website, hear from our experts at MHSdialogue, and follow us on Twitter at @McKesson_MHS.
How have the changes in Health Care impacted your organization?

Since I report to the CFO of the University Health Care System in Augusta Georgia, I thought it would be interesting to get his perspective on the current changes in Health Care and the impact they have had, and will have, on our system.

Dave Belkoski has worked in Health Care finance for over 30 years. He is a long time member of HFMA and is instrumental in guiding revenue cycle and financial Manager's and Director's from throughout our system to HFMA. He has often referred potential up and coming leaders in the field of Health Care finance to HFMA for growth and development opportunities. He views HFMA as a professional organization that brings value through benchmarking and keeping up with current events and topics in the field, as well as providing outstanding networking opportunities.

When asked the question about how the changes in Health Care have impacted our organization, he quickly replied that alternative payments such as Bundled Payments, ACO's and Capitation were going to have the biggest, most widespread impact on Health Care from a financial and revenue cycle standpoint. Alternative payment methods are heralding in a new age of Clinical and Financial teams working together to improve the coordination of patient care, the quality of patient care and the patient's throughput throughout the Health Care System continuum. Providing better and more cost effective care is the goal of these alternative payment processes. The result will be a transformation within Health Care that cements the focus of our entire industry on the patient.

Financial teams are working hand in hand with Clinical teams to identify system processes and their associated costs. Business intelligence and data mining now plays a major role in pointing clinical teams in the right direction to evaluate costs within each patient's continuum of care.

Revenue Cycle teams are diligently working to address issues related to the new ‘payer’ in the market, the patient. In the past, the self pay portion of the health care bill was a relatively small portion of the overall payment for insured patients. Today, that ratio has shifted significantly to the patient. The challenge is to find convenient and affordable methods of payment for the patient's and their families. Online bill pay, bank loan programs and hospital kiosks are just a few methods of updating the patient's billing and payment experience within Health Care. Bill consolidation with the hospital and physician practices or the Single Billing Office (SBO) concept is also being rolled out across the country in an effort to address the impact of alternative payments on the Health Care System.

Georgia Chapter Membership If you would like more information on the Georgia Chapter, or if you have any questions about HFMA membership, please send an email by filling out the form listed at the link above.

Join / Renew Process
If you already know you want to join the Georgia Chapter, or to renew your HFMA membership, please call National HFMA at (800) 252-HFMA. All Georgia Chapter membership issues, including renewals and billing, are handled through National HFMA.

Your HFMA membership will give you the opportunity to grow in your career as a healthcare financial professional. Information on joining National HFMA
Changing Times in the Revenue Cycle

Next year will mark my 27th year in the healthcare industry. Through the years I have always seen the industry from a vendor perspective as I have helped hospitals to maximize recovery from patient and third party accounts. I have spent a lot of time visiting with hospitals over the years to try and gain as much perspective as I can about the work they do and the challenges they face. I have had the opportunity to see people advance through their careers and some even retire or move on to other things. I will share with you what have been my observations about how it has changed from a “vendor” perspective and include some perspectives of revenue cycle leaders who have been around a long time.

I have always enjoyed the opportunity to get together with clients and prospective clients at their offices to see the environments they work in first hand and visit with their staff. I remember the days when I could call someone the day before I was going to be in the area and ask them to lunch. These days it seems that even with a couple weeks’ notice, it’s hard to get someone to commit to a date and time. And in some cases, even when they do commit, something pulls them away at the last minute requiring me to reschedule.

I have found hospital employees I’ve met in the revenue cycle to be some of the hardest working people I know. Our industry doesn’t allow us to be complacent anymore. More and more revenue cycle departments are implementing productivity standards to ensure everyone on their team is doing their part. Despite constant change in regulations, reimbursement rates, and technology, they continue to work toward achieving financial goals but it seems as though they continue to face the reality of having to do more with less.

I have also noticed a change in how the revenue cycle has been perceived over the years. The Business Office, or Revenue Cycle department, as it is now often referred to, is held in higher regard than it used to be. It used to be the “back office” and not considered a revenue generating entity of the hospital. Can you imagine? Not anymore. Turning all those patient visits into actual net collections has a greater emphasis now than ever before. A larger share of the bill is coming from patient responsibility as high deductible plans are becoming more common. Hospitals are feeling the urgency to streamline and re-engineer processes in hopes of cutting down on expense and backend administrative rework. Rick Childs, VP of Revenue Cycle at Floyd Medical Center, says “We have migrated from individual departments of Registration, Medical Records and the Business Office into an Integrated Service line called Revenue Cycle consisting of Patient Access, Health Information Management, Revenue Integrity, Managed Care, Denials Management and Patient Financial Services. There has been more recognition of the importance of the Revenue Cycle and the key role it plays in the success of a hospital or integrated system. It is now part of the decision making process. Twenty years ago there were very few VP of Revenue Cycle positions, unless it was a very large and progressive system. Today it is more the norm due to its importance.”

As a result of this consolidation of departments, there are less decision makers in many cases. Whereas before, there was a Director of this or a Manager of that, now it often falls under the head of the Revenue Cycle department. Cathy Dougherty, VP of Revenue Management at Gwinnett Hospital System, says, “The revenue cycle is more involved the strategic planning process at a lot of hospitals. Payers continue to deny claims or delay payment and the consumer is more demanding and interested in our processes.” She makes a good point. For all the changes there have been, some things seem to stay the same. Providers still face the never ending challenge of getting claims billed correctly and paid timely without having to spend countless hours on the phone with insurance companies resolving claim disputes.
Another change that comes to mind for me is the technological advances that have been made in the last 10 to 15 years. There has been a lot of technological growth in the industry, especially around electronic health records, but the challenge continues to be optimizing the technology and getting it to do all it is intended to do. Automation and Technology have really come a long way, partly due to the complexity involved in the business aspect of healthcare. Rick Childs remembers when manually keying claims data into terminals was “high tech” once upon a time. No longer, as we have fully integrated systems and pass our claims directly to the payer or a clearinghouse. Rick says, “the manual posting of remittances has been a huge step in automation and accuracy. Electronic insurance verification and online authorization have also been greatly improved. The technology allowing the automated scoring of accounts for presumptive charity or presumptive Medicaid eligibility along with predictive dialer technology has enabled providers to streamline and improve productivity.”

We have seen some technology companies with widespread utilization among providers while others have been a little slower to catch on or haven’t lived up to what they said they could do. For as long as I have been in this business, I have heard people say that it is a “relationship business”. The truth is, if someone likes you, your product or service still has to stand on its own. It is my opinion that providers expect more out of their business partners now than ever before. In many cases, fees have come down as the technology has improved, but what you get in exchange for those fees has become more important and has a greater impact than it ever has.

Gail Scarboro-Hritz, Managing Partner at Hritz Management Services, acknowledges some of the broader changes just in the past few years across the industry, and the impact they will continue to have on changing the healthcare landscape. “The Affordable Care Act(ACA) being passed into law continues to have an impact on providers at many levels, as does the consolidation of insurance companies creating market dominance which in turn threatens competition and therefore pricing and managed care negotiations.” Gail goes on to say, “the move to ICD-10, along with Population Health and ACOs representing the vision of providers and hospitals seeking to become healthcare enterprises to cope with all of today’s pressures is pushing them to develop platforms and the infrastructure to manage massive amounts of data, deliver efficient patient care, and streamline business and administrative functions. We are all busy trying to develop and deliver the value propositions for our organizations to resonate with multiple audiences; patients, physicians, employers, government agencies, insurance companies and the communities we serve. It is a very big undertaking.”

So in conclusion, I have always tried to be a student of the industry and the recognize the importance of learning about all phases of the healthcare continuum to better appreciate how each piece affects the other. It has also allowed me to keep up with the changes. Someone once told me early on in my career that whatever you learn in healthcare, put it in pencil because it is sure to change. Change is a constant in healthcare. Our initial instinct is to avoid change but the reality is, if we embrace it, it can help us stay at the leading edge of what’s still to come. Enjoy the ride!
A SEA CHANGE IN REIMBURSEMENT PARITY FOR BEHAVIORAL HEALTH

By William Bithoney, MD, FAAP, and Rachel Laureno, The BDO Center for Healthcare Excellence & Innovation

The behavioral health market has been undergoing a transformative shift making it ripe for growth and consolidation. With the sheer volume of patients now insured for behavioral health needs outpacing the availability of services to treat them, investors foresee compelling opportunities to enter the marketplace. Recent developments continue to set the stage for opportunity.

Underlying these occasions for investment and expansion is a subsector of healthcare that has often faced low reimbursement rates and lack of payment for behavioral health interventions. In 2008, Congress took a proactive step to address these issues and passed the Mental Health Parity and Addiction Equity Act (MHPAEA). It mandated that behavioral health issues and medical issues be treated under the same terms and conditions when covered by health insurers, and later revisions to the act required most insurance plans cover mental health and substance abuse services. Also in 2008, Congress passed the Medicare Improvements for Patients and Providers Act (MIPPA), which increased access to mental health in federal programs. In 2013, Congress issued clarifying legislation imposing penalties and sanctions on insurers that did not comply with these requirements. This spate of legislation was a welcome change for patients, mental health professionals and healthcare providers.

Less discussed, however, is the salutary effect this legislation will have on investments in behavioral health. The MHPAEA has resulted in a sea change breakthrough in reimbursement. This improved reimbursement has already resulted in an increase in investment activity in the behavioral health arena, especially in the many states where true behavioral health parity has been achieved.

Unfortunately, the reality of “parity” has been a mixed state-by-state patchwork of coverage (or lack thereof), which has resulted in an ongoing tussle between payers, treatment providers and regulators. Now New York State offers an intriguing model in which regulators are enforcing mental health parity laws as part of a settlement with Excellus BlueCross after alleging that Excellus had violated the using inappropriate behavioral health standards contract.

Mental Health Parity and Addiction Equity Act (MHPAEA) Mandates that behavioral and medical issues be handled under the same terms

According to the attorney general’s office, Excellus denied coverage to some clients for inpatient care. Such a protocol contradicts state law and is not applied by Excellus to medical care. Schneiderman alleged that some denials appeared arbitrary, and Excellus did not appropriately cover residential treatment for behavioral health conditions in its standard contract.

According to the attorney general’s office, Excellus had violated the MHPAEA. In March of 2015, New York State Attorney General Eric Schneiderman announced a BlueShield, headquartered in Rochester, N.Y., investigation, Excellus required that members reimburse approximately $9 million.

As a result, the nonprofit health insurer now must notify its 3,300 clients who were denied inpatient behavioral health services of their right to appeal, cover the cost of the attorney general’s $500,000 investigation and may be required to reimburse approximately $9 million.

This is an important moment in shaping the industry’s trajectory, as Excellus is one of five major companies to recently reach such a settlement regarding violations of the MHPAEA. Previously, Schneiderman’s office settled with ValueOptions, MVP Health Care, EmblemHealth and Cigna for parity violations.

With the aggressive enforcement of the federal MHPAEA mandate, the tide is continuing to shift toward greater coverage for patients with substance abuse and mental health issues in New York—which may now serve as a model for other states as they address issues of behavioral health and medical illness “parity.” This will provide an additional boost in behavioral health revenues, particularly for inpatient and substance abuse treatment centers. It will also set the stage for increased investment in behavioral health by healthcare investors, who will continue to see room for growth as reimbursed revenues increase.

Over the next five years, we envision more and more consolidations, mergers and acquisitions in this field as investors recognize the unique confluence of investment opportunities inherent in a market dominated by small niche behavioral health programs. As these programs join together, they will be able to create value for patients, communities and investors. The efficiencies created should result in improved care delivered by highly profitable, clinically excellent programs.

Dr. William “Bill” Bithoney, FAAP, is a Managing Director and Chief Physician Executive for The BDO Center for Healthcare Excellence & Innovation, where he co-leads clinical strategy. He can be reached at bbithoney@bdo.com.

Rachel Laureno is a Director in The BDO Center for Healthcare Excellence & Innovation. She can be reached at rlauren@bdo.com.
I’m not just the CEO of a Patient Revenue Cycle Company, I’m also a Patient

Patient Financial Engagement from a Personal Perspective

By Brian Kueppers, CEO, Apex Revenue Technologies

When my daughter was born 21 years ago, our out-of-pocket cost was $50. Today, a family might spend $5,000 or more. Hundreds of billions of dollars of responsibility has shifted to patients—and providers are struggling to collect. We’ve entered an era in healthcare where a focus on “Patient Financial Engagement” is critical. Patients must take much more responsibility for their healthcare costs, and providers need to offer more financial education to help them.

This is clear to me first and foremost as a patient. I’ve gone to the doctor a lot. From broken bones as a boy playing hockey to various injuries and ailments as an adult, I’ve experienced healthcare systems multiple times a year. As an entrepreneur, I always think about how things are done and if they could be done better or faster.

In my experience, there’s a disconnected financial conversation across patient touch points that must be addressed. Continuity will help patients resolve their balances, and strengthen the relationship between providers and their patients.

I recently went through a series of physical therapy appointments. When I made the first appointment, the scheduler reminded me to bring my insurance card. Ideally, the financial conversation would have gone deeper, including estimation of out-of-pocket costs to help me prepare for what was to come.

That conversation should continue at the front treatment, I was asked for my insurance staff is dealing with sick, stressed patients. it easier to have informed financial presents a prime opportunity to collect a expectations, determine appropriate patients up for online delivery.

No matter how many millions patient company, I still get surprised when I open I’ve received a $700 statement that I balances should never be a surprise, and should be tailored to the patient based on example, patients who are likely to pay in full could be could be offered a payment plan right away.

When it comes to payments, providers should establish multiple ways for patients to pay, including at least one online option that doesn’t require a login and password. Convenience helps avoid payment delays. Providers should cater to mobile needs, because young people don’t know where their checkbooks are, but they can pay by phone instantly.

A patient’s financial experience can make or make or break a relationship 30 days or more after a positive medical experience. Building continuity across patient touch points helps educate patients, avoid surprises, and better fit payment solutions to the needs of each patient. Done right, healthcare organizations will realize significantly better results to the bottom line. And the patient will have a feeling of “this is my doctor, this is the right place for me” throughout the entire financial process.

Brian W. Kueppers is Founder and CEO of Apex Revenue Technologies, based in St. Paul, MN. Apex is a patient revenue cycle solutions company that helps healthcare organizations Fit the Payment to the Patient™ to improve financial results and the patient experience. Contact him at bkueppers@apexrevtech.com or visit www.apexrevtech.com.
On July 9, 2015, the Centers for Medicare & Medicaid Services (CMS) proposed a new payment model that would bundle Part A and Part B services for hip and knee replacement surgery for hospitals in 75 geographic regions. Under the proposed Comprehensive Care for Joint Replacement (CCJR) model, designated hospitals will be financially accountable for the quality and cost of care across the continuum for 90 days following surgery. CMS is holding the hospital accountable for decreasing CMS’s current cost by 2% in the 90 day period. In addition, the hospitals will be responsible for repaying CMS some portion of costs that increase in the same time period.

This announcement seems to have taken many in the healthcare industry by surprise, and many are discounting CMS’s ability to implement the model. Healthcare executives should not be surprised since the payment structures have been moving in this direction for over twenty years. Earlier this year, CMS announced that it will tie 30% of all fee for service payments to value based models, like bundled payment, by 2016 and 80% by 2018.

CMS had success with testing bundled (global) payment. In 2010, the Affordable Care Act included language that required continued implementation of these models. This was followed by a 2012 report from the Congressional Budget Office which reviewed outcomes from 10 major CMS demonstration projects spanning more than 20 years. The determination was that bundled payments were the only efforts to show both an improvement in quality while decreasing costs.

The first bundled payment project, the Medicare Coronary Artery Bypass project is a great example of how bundling services had positive impacts for all parties. According to the formal report released by CMS, patients received the highest quality of care and CMS experienced significant savings. The most impressive outcome was that physician fees were preserved or improved, and hospital profits increased. Although, a project with four initial hospitals participating, the project saved Medicare 10% or $40 million between 1990-1994.

Why was this project so successful? For hospitals, many contribute the success to the gainsharing relationships established between the hospital and surgeons. At one hospital, Saint Joseph Hospital of Atlanta (SJHA), variable costs were the focus and savings achieved were to be split 75-25 between the hospital and physicians. For DRG 106 CABG with Cardiac Cath, profits increased 30% while variable costs reduced 25%. For DRG 107 CABG only, profits increased 74.5% and variable costs reduced 41%. Surgeons saw dramatic improvements in compensation as well. From 1991 to 1996, cardiac surgeons outside of the demonstration saw their average fees drop from $3,281 per case to $3,102 per case. Surgeons at SJHA saw their fees increase to $4,752 for the same time period.

CMS continued its efforts on bundled payment related concepts with many test project including the ACE Demonstration Project which included both hip and knee replacements and cardiac procedures. In 2011, CMS began a large effort in voluntary bundled payment called the Bundled Payment Care Improvement (BPCI). Hospital participation has not been as widespread in this project so it is not a surprise that CMS announced the CCJR Model on July 9th. The CCJR Model will target hip and knee replacement surgery (MS-DRG 469 & 470) and include 90 days post discharge. The implementation date is January 1, 2016 and will last 5 years. CMS has established a target 2% savings from baseline episode payments. CMS has proposed to implement the CCJR model in 75 geographic areas defined by MSA. Except for those providers participating in Model 1 or Phase II of Models 2 or 4 of the BPCI initiative, hospitals paid under IPPS and physically located in MSAs selected are required to participate.

The proposed model would hold hospitals financially accountable for the quality and cost of the episode of care. Hips and knees are among the most common surgical procedure for Medicare beneficiaries with over 400,000 procedures. The average Medicare expenditures for these procedures range from $16,500 to $33,000 across geographic areas. The rate of infections or implant failures can be more than three times higher at some facilities.
Each year, the model will set Medicare episode prices. Target prices would reflect a hospital’s historical payments minus 2%. Hospitals that save more than the 2% are eligible for a reconciliation payment while those with increasing costs will have a repayment penalty. Participating hospitals must meet or exceed performance thresholds on three quality measures that are currently reported in the Hospital Inpatient Quality Reporting Program to qualify for a reconciliation payment.

CMS believes the selected measures will help promote collaboration among hospitals, physicians and post-acute care providers. CMS expects hospitals will identify key providers and establish close partnerships with them. The potential financial impact to hospitals is significant. Hospitals that elect to “do nothing” can see an erosion of their MS-DRG payment of 4% if episode payments remain unchanged.

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<td>Per Case Variance</td>
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<td>($538)</td>
<td>$268.40</td>
</tr>
<tr>
<td>Annual Volume</td>
<td>410</td>
<td>410</td>
<td>410</td>
</tr>
<tr>
<td>Hospital Repayment/Reconciliation</td>
<td>($474,780)</td>
<td>($220,580)</td>
<td>$110,044</td>
</tr>
<tr>
<td>Hospital DRG Payment</td>
<td>$12,500</td>
<td>$12,500</td>
<td>$12,500</td>
</tr>
<tr>
<td>Repayment/Reconciliation as % of DRG Payment</td>
<td>-9.3%</td>
<td>-4.3%</td>
<td>2.1%</td>
</tr>
</tbody>
</table>

CMS is not the only group working on bundled payments. Medicaid, Private Payors, and Employers are all driving to bundled payments. During a recent HFMA webinar, over half of participating hospitals indicated that they are only beginning to understand bundled payments. It is important for all hospitals, not just those in the 75 geographic regions, to develop a proactive approach to bundled payments. The reality is that bundled payments are here to stay. How will your organization adapt?

Joane Goodroe, RN, BSN, MBA, Independent Consultant, is credited with helping to change the landscape of the health care industry by developing innovative solutions that allow hospitals and physicians to align economic goals to reduce costs and improve quality. She works as an independent consultant assisting hospitals and physicians with new models of care and integration.
Healthcare Liability Insurance: Is Your Hospital Addressing Current and Emerging Challenges?

Paul Sulaski, ProAssurance Vice President, Hospitals & Facilities

Healthcare is dynamic by its very nature, but rarely has U.S. healthcare experienced change on the scale of the past two years—with:

- over 10 million* people who have enrolled and paid for health insurance coverage through the Affordable Care Act (as of March 2015);
- an unprecedented number of hospital and medical group consolidations;
- urgent care centers, retail clinics, and other outpatient facilities proliferating;
- rapid adoption of electronic health records and an increasing number of healthcare data breaches; and
- a growing shortage of physicians.

How will these trends affect healthcare liability and what can hospitals do to prepare? You can help your organization meet the challenges of an evolving healthcare environment by clarifying what’s most important. You also must understand coverage options and the balance of risk and control. This two-pronged approach of knowing what’s most important and understanding risk/control options will help you ensure the right fit for your hospital’s needs.

What is Most Important to Your Organization?

To be effective, your healthcare liability insurance program must align with your hospital’s objectives, systems, and risk tolerance. This means your important control is respected—control over how the program is structured, how claims are handled, and strategies for containing costs.

You can help ensure program alignment with hospital objectives by considering:

- **Cost**—How can you utilize economies of scale, loss control strategies, and alternative options to reduce your hospital’s healthcare liability insurance premium? Can your insurance provider bundle coverages to lower costs and deliver a single-source solution (such as umbrella, D&O, E&O, cyber liability, etc.)?
- **Risk tolerance**—What level of risk is your organization willing to assume? Can your insurance provider structure a risk sharing program that addresses both budgetary constraints and your organization’s comfort level?
- **Control**—How can you help ensure your hospital retains important control over claims handling and key program parameters?
- **Mergers, acquisitions, growth**—What options are available to help make it easier to address coverage issues associated with consolidating new physicians and healthcare providers into your organization?
- **Loss control**—Does your hospital’s current approach address emerging healthcare liability risks? Would your risk management team benefit from added assistance and resources?

Many large healthcare organizations work with an insurance broker when deciding how to handle liability insurance. They then review how established insurance companies can offer expertise and resources to meet their needs, along with:

- **Financial strength and ratings**—Does the company have a history of proven financial stability?
- **Experience insuring hospitals and large healthcare entities**—Does the insurer have extensive experience, with a track record of successfully serving this complex market?
- **Ability to provide alternative and customized insurance programs**—Traditional healthcare professional liability coverage may not meet the needs of many of today’s complex healthcare organizations. Large organizations may wish to retain risk and, potentially, share in good outcomes. Can the insurer provide alternatives tailored to your organization’s unique needs?
- **Level of transparency**—Does the insurer provide straight facts, respect your expertise and knowledge, and work to help you fully understand how your insurance program could be structured and what services are included?
- **Ease of doing business**—Is the insurer vigilant in anticipating and helping you solve problems? Do they make it as easy as possible for you to secure coverage and services to fit your organization’s criteria?
• **Claims defense**—Does the insurer commit to providing the level of claims handling you want for the level of risk you are willing to assume?

**Alternative Options**

Hospitals and large healthcare organizations increasingly seek more sophisticated and customized alternatives for managing and financing losses associated with risk. Options within alternative risk include numerous methods of retaining, transferring, or financing risk. Advantages of these options include a high level of control and the opportunity for cost savings.

Another alternative for organizations large enough to support necessary start-up costs (generally those with premiums of $1 million-plus) is a self-insurance program. These programs allow the hospital to directly assume the risk of claims. Various types of self-insurance are allowed under federal law, including:

- **Risk Retention Groups** (RRGs) are corporations or limited liability associations that are organized for, and whose primary activity consists of, assuming and spreading some or all of the liability exposure of its members. An RRG must be owned by its members or by an organization that is owned by members of the group. Members contribute capital, and membership is limited to individuals engaged in similar activities. RRGs are not subject to state regulatory requirements, and their members are not protected by their state’s guaranty fund should the group become insolvent.

- **Risk Purchasing Groups** (RPGs) are formed by a group of individuals or entities with similar or related liability risks to purchase liability insurance coverage on a group basis. This is not an insurance company. The RPG does not underwrite its risks, but instead purchases coverage for its members, usually from an established insurance company licensed in at least one state.

- **Captive Insurance Company**—captive insurers are alternative risk vehicles that allow organizations to form an insurance company subsidiary to finance retained losses in a formal structure. Common types of captives include single parent, association, group, agency, and rent-a-captives. Healthcare organizations can use a “cell” of an existing captive facility for much easier captive-option access. Captives are not licensed by individual states and many are formed “offshore” at locations where regulation is not as stringent. This entity does not qualify for protection under state guaranty funds and retains responsibility for all dollar losses accruing from claims.

Unique solutions that address the needs of growing and merging healthcare organizations also are in demand. Innovative insurers are providing flexible protection, consultation, and service options to create the optimal program for a hospital’s situation and preferences. For example:

- hospitals can purchase unique joint hospital/physician professional liability coverage; and
- hospitals can allow acquired physician practices to maintain their own insurance and seamlessly merge risk into the hospital’s insurance program through risk transfer or retention layers.

**Traditional Options**

Healthcare organizations that do not meet premium levels necessary for self-insurance or that find such arrangements outside their comfort zone may benefit from traditional options. Insurance companies that are experienced with hospitals and healthcare entities can work with you to craft a policy with the coverage you desire. For example, you may save money through deductibles, retrospective rating, or staff participation in specific risk reduction activities or training. You also can take advantage of the insurance company’s risk resources and expertise to augment your patient safety efforts.

**Expertise is Key**

Whether you take an alternative or traditional approach to mitigating risk, it’s vitally important you are clear about your healthcare organization’s needs and are comfortable with the company you choose. Working with insurance experts who have proven experience and success in healthcare liability insurance and risk options—along with selecting a stable and expert carrier—will net the best result.


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