MS HFMA

February 2021

PUBLICATION FOR THE MISSISSIPPI HEALTHCARE FINANCE COMMUNITY

Mississippi Headlines

info@mshfma.org

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OFFICIAL NEWSLETTER OF THE MISSISSIPPI CHAPTER OF HEALTHCARE FINANCIAL MANAGEMENT

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President's Message

Andres Posada, President

I hope you and your loved ones have been staying healthy during this pandemic. As we saw COVID numbers rising, Region 9 and Midsouth meetings had to make the difficult decision to go virtual.

Our hope has been that everyone would be able to get back together at our Annual Meeting in April on the Coast; however, after much consideration, the Board has decided to hold this event virtually. It is certainly not what we wanted, but we felt it was the right decision at this time.

Our Annual Conference will be April 22nd and 23rd, so mark your calendars for some great speakers and topics. The good news is that we already have a virtual meeting under our belt, so we are ready to rock this one. Additional information on the meeting will be coming out soon, so keep an eye out for it.

As we approach a new HFMA year, we would like to get new faces involved in our committees. If we have learned anything from COVID, we have learned that we can all work together regardless of your location. If you have an interest in any of our committees, please reach out to me, an officer, or a board member, and we would be more than happy to get you started. In order for our chapter to keep growing and doing great things, we need involvement from the membership, so please consider serving. I can tell you from experience that it is one of the best decisions I've made.

As always, your officers and board members are here to serve and help provide value for your membership. Please reach out to any of us personally with questions, comments, or concerns.

Warm regards,

Andres Posada
President
Mississippi Chapter of HFMA
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MS HFMA Annual Institute

April 22nd & 23rd, 2021

VIRTUAL MEETING

Registration details coming soon

Region 9 HFMA Conference

October 31 thru November 2, 2021

Registration details coming soon.

MISSISSIPPI HEADLINES

PUBLICATION FOR THE MISSISSIPPI HEALTHCARE FINANCE COMMUNITY

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Please email your submission to:

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As you experience the value HFMA provides, don't forget to value the experience. HFMA offers opportunities to network with those who face similar challenges and successes. If you are looking to gain experience in a safe environment, or would like to share the experiences you've gained, opportunities to volunteer at the Mississippi Chapter or at a national level are plentiful.

The bottom line is that HFMA is comprised of more than 35,000 people just like you. What do we know about our members? We are value driven. We are forward thinking. We are innovative. And together, we are defining, realizing, and advancing the profession of the financial management of health care.

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Big News Regarding the Big Three: Stark Law Revision

By: Horne LLP

Let's hear it for clarity! Thanks to the Department of Health and Human Services' (HHS) revision of the Physician Referral Law (aka the Stark law) in November 2020, we now have more explicit guidance for the key definitions. And for physician compensation experts, it's about time…

Over the past twenty years, healthcare systems have been challenged to comply with the Stark law's requirements, sometimes resulting in financial disaster. In 2013, South Carolina's Toumey Health Care System was ordered to pay $237 million in fines for $39 million in fraudulent Medicare claims. The Toumey case is just one of many where the Court's interpretation of the Stark definitions differed significantly from CMS's intended meaning, leading to significant confusion and uncertainty among parties, and ultimately hampering the ability of parties to enter into Stark compliant arrangements.

At the epicenter of the confusion has been the law's three most important requirements: commercial reasonableness, fair market value, and the volume and value of physician referrals. Commonly referred to as the 'Big Three,' the definitions are the core elements of the Stark exceptions applicable to most arrangements between healthcare systems and referral source physicians. Ideally, Stark's Big Three definitions enable healthcare leaders to make compensation decisions with greater confidence that they will comply with an applicable Stark exception.

So, where did the Big Three initially fall short, and how does the new CMS regulation shed light? To better understand, first note that each requirement stands independently. For example, the commercial reasonableness standard does not depend on fair market value pay or vice versa.

Stark Law Revision: Commercial Reasonableness

Until the revision, healthcare organizations often linked a physician hire's profitability to its commercial reasonableness. However, in a recent episode of HORNE Healthcare's Buy-in podcast, Julie Kass, a Stark law expert and attorney with Baker Donelson in Maryland, stated that, as a result of the Stark revisions, a hospital can reasonably hire a doctor at a financial loss if there is a legitimate business reason to do so, using the example of a hospital bringing on multiple medical directors.

In the example, even though the combined arrangement may create a loss, the hospital may have a strong business case for why it makes sense and serves a legitimate business purpose. For example, the hiring of three medical directors may be necessary even though, for a given hospital, the arrangement is not profitable. Kass further explained that the business case for any hire requires documentation. The critical insight is that is possible for a compliant arrangement to be commercially reasonable without necessarily being profitable. This is certainly welcome guidance from CMS.

Stark Law Revision: Fair Market Value

Prior to the new regulations, interpreters of the Stark Law have often conflated the Big Three when evaluating fair market value of a doctor's salary. It is now clear that they are separate elements, and that is especially helpful when considering fair market value. CMS removed references to the Volume or Value of referrals from the fair market value definition but did make

some illuminating statements in the commentary about fair market value.

First, use of data between parties in a position to refer to one another generally should be avoided when determining fair market value.

Second, consideration of the referrals between the parties when determining fair market value, while not strictly prohibited by the new fair market value definition itself, may still be inappropriate, as it may be prohibited by the volume or value standard, or give rise to a violation of the Anti-kickback statute, or both.

Finally, consideration of benchmarks in physician salary survey data, while still regarded by CMS as a prudent practice, should not be the singular determinant of fair market value. CMS mentioned several times that survey benchmarks should neither be considered as a cap, nor a floor for fair market value, which is an absolutely crucial insight, given the nature of arguments that often have been made in Stark qui tam cases.

Ms. Kass used the example of a rural or urban hospital that doesn't have the patient population to generate the Work Relative Value Units (wRVUs) to justify a physician getting paid at the median. Still, it might make sense to pay them higher to incentivize qualified candidates and serve the public. Again, similarly to the commercial reasonableness requirement, the justification for a physician's compensation should be documented at the time of the transaction.

Stark Law Revision: Volume and Value of Referrals

While the need for justifications can allow for some subjectivity, the third of the Big Three requirements in the Stark Law regarding the volume and value of referrals is more straightforward. Thanks to the CMS revision, the regulations now contains a reference to the mathematical formula used to determine compensation, to evaluate whether an arrangement meets the volume or value standard or not. This requirement tests to see if a positive correlation exists between physician compensation and the volume or value of their referrals.

Similarly, if the physician is compensating the health system (or similar entity), as might be the case in a lease of medical office space, then the test looks for a negative correlation between the formula for the lease rate and the volume or value of referrals.

A Step Toward Clarity for the Big Three

CMS's clarification is welcome effort to provide relief to physicians, hospital leaders and their legal counsel. Still, is the revision perfect? By way of example, many commentators had hoped for but did not get a rebuttable presumption for fair market value. However, on the whole, while Stark is still a highly complex law, CMS's revision of the Big Three in the Stark law is a significant step forward. It provides greater context and meaning to the core definitions and better enables doctors and hospitals to work together with far less concern that important care initiatives may be unnecessarily impeded by the nuances of the Stark law.

HORNE LLP stands ready to guide your organization through today’s ever-changing healthcare valuation landscape. For information on how HORNE can help, contact us. (https://hornellp.com/about/contact-us/)

Solving the Unique Complex Claims Challenge to Optimize ROI

By: Greg Snow, Senior Vice President of Market Strategy, EnableComp
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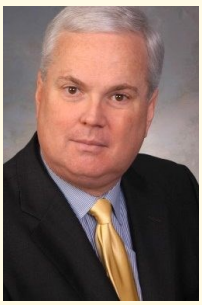

The percentage of hospitals outsourcing complex claims has doubled over the past several years. The number of complex claims outsourced to specialized, third-party companies has increased from 20.4% to 39.8% and continues to grow.

Nationwide, reduced operating margins require healthcare management to capture 100% of net expected reimbursement, according to the recent survey responses for 1,309 hospital chief financial officers and business office leaders.

Approximately 76% of healthcare administrators believe outsourcing complex claims improves productivity of in-house staff and frees up their time to focus solely on optimizing traditional claims. With respect to the growth within this area, there is an emphasis on complex claims outsourcing and this segment is expected to grow 18% annually.

Complex claims typically include Veterans Administration, Workers' Compensation and Motor Vehicle Accident accounts as they present a mixture of challenges for the revenue cycle management staff. These claims tend to be marginalized because they represent a relatively small amount of total hospital reimbursement in conjunction with a lower productivity rate. This results in complex claims being written-off when it is determined that limited revenue cycle resources are better spent managing traditional claims. When compared to traditional claims, complex claims were adjusted/denied at a much higher rate than traditional claims. (i.e., 3X greater)

Outsourcing complex claims to a specialized, first-tier partner rose 51% in recent years and continues to increase. Both payers and providers cannot find enough specialized talent for the successful resolution of complex claims, especially Veterans Administration. Revenue cycle processes must be extremely efficient in this new age of healthcare, requiring the utilization of more experienced personnel for making high-risk decisions in order to optimize hospital resources.

The overhead for recruiting, retaining, and utilizing specialized staff challenges the largest systems, let alone the small to medium-sized organizations. Outsourcing complex claims has become the standard operating procedure for complex claims needing specialized review. This allows in-house staff to focus solely on optimizing traditional claims while improving internal productivity in excess of 80% based on current productivity standards.

Complex claims present a mixture of challenges for the healthcare system revenue cycle staff, who usually have limited experience in dealing with non-traditional payers. These claims also tend to be marginalized because they account for a relatively small amount of total hospital reimbursement (i.e., 3% to 4%). This often results in complex claims being written-off or not fully pursued.

Key Findings:

- Hospitals state that 81% of them lack the specialized talent to resolve difficult complex claims, including 92% of hospitals with less than 150 beds.
- 69% of hospital CFOs state they must utilize high-cost back office associates to compensate for current systems, which lack the functionality to manage complex claims.
- 49% of hospital CFOs acknowledge that outsourcing is becoming a more viable alternative for various segments of their revenue cycle claims processing.

In conclusion, a recent survey reported that 96% of healthcare system leaders that were surveyed (1,100 CFOs and revenue cycle leaders) reported they are now in the process of evaluating, acquiring and/or deploying advanced, external complex claims solutions. Write-offs have increased dramatically in recent years and the payer's systems are rejecting and/or downgrading complex claims, which the typical healthcare business office is not staffed to handle. In the current situation, with hospital margins decreasing significantly, the need for greater net revenue and reduced time in accounts receivable is critical to the organizations' survival in 2021 and beyond.

During the coming months, we will be publishing a series of case studies to further highlight the results achieved for our customers. To find out how EnableComp can become an extension of your RCM team "down the hall" and help collect every dollar you're owed, visit www.enablecomp.com.

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2021 What's Ahead for the Mississippi Health Care Landscape?

David Williams, CPA, MPH, FHMA
Partner, Carr Riggs & Ingram, LLC

Wow! How do you even begin to describe the tumultuous 2020? A year that was filled with politics, a Public Health Emergency, a pandemic, a soft close of the economy, politics, over 330k+ lives lost attributed to a deadly virus, more politics, health care providers stretched to the limits, (yes) more politics and funds to assist with this never ending CO(corona)VI(virus)19(2019). As I'm writing this on the 28th of December I am anxiously awaiting 2021 and the hope it brings with the vaccine on the horizon and including more information coming out daily about treatment for those of us who have or will contract COVID 19.

What does the health care landscape look like for Mississippi in 2021? I'll take out my crystal ball and provide some insights and observations. Ultimately, we can look back in January of 2022 and see what actually came to fruition. Please no snarky emails next January and I promise I will return the favor and not say "I told you so". Deal?

Mississippi

* Our State's hospitals rendered over $600mil in uncompensated care in 2019, projections provided to the Mississippi Hospital Association (MHA) indicates waivers on Mississippi Medicaid could reduce that cost by 40 to 50 percent.

* SFY 2021 Mississippi Hospital Access Program (MHAP) the Hospitals are scheduled to receive $533mil in payments made up by two components – Fee Schedule Adjustment of $318mil and Quality Payments of $215mil.

* Mississippi Medicaid Disproportionate Share Hospital Payments (DSH): With the passage of the Consolidated Appropriations Act of 2021 (CAA), scheduled DSH cuts have been eliminated until FY 2024. Consequently, the SFY 2021 DSH payments to hospitals will be approximately $224mil thereby escaping what would have been an otherwise reduction of $81mil for SFY 2021 and additional proceeding years.

* Mississippi Hospital Assessments: The reduced FMAP that was part of the CARES Act relief legislation has reduced the tax burden on Mississippi hospitals. After adjusting for the DSH cut delay, hospital assessments for FY 2021 are still expected to be significantly lower than historical levels.

* The Mississippi State Plan is being opened this year and MHA in collaboration with other healthcare provider groups have provided several recommendations for the benefit of providers that include – covering additional low income wage earners, extended benefits for pregnant women and an expedited appeal process with Medicaid in order to provide more certainty with cash flow in future periods.

* A concern for our governmental Nursing Homes is the consideration by Mississippi Medicaid to move nursing homes into Managed Care Organizations, the unfortunate consequence of this action would be the elimination of the Nursing Home Upper Payment Limit (UPL) for these facilities.

* Finally, as competition for patients continues to heat up, Hospitals must keep an eye on legislation that would eliminate the current Certificate of Need (CON) for services. Hospitals have felt the impact of reduced payments through site neutral adjustments and if more facilities open there is a risk that safety net facilities may be left with uninsured or under-insured patients in many instances. Maybe, I'm wrong on the impact but it is worrisome to me.

Federal – COVID

* The current Public Health Emergency is scheduled to expire on January 20, 2021. This will probably be extended since the case rate is still high and funding dates have been extended until the end of 2021.

* Single Audit Guidance – Good news and bad news. For those facilities with year ends before December 31, 2020, the reporting requirements have been deferred until 2021. It should be noted that certain disclosure requirements will be needed for those facilities.

* Accelerated Payments - Providers that received accelerated payments will begin repayment of those funds unless legislation delays or changes the nature of the repayment.

* HHS reporting requirements – The first reporting due date for providers who received at least $10k in provider relief (PRF) payments is scheduled to be February 15, 2021. Considering changes made in the CAA concerning eligible damages, HHS has currently not changed the current reporting schedule.

Federal – Medicare

* Additional pricing transparency requirements start on January 1 as well as the additional coding and documentation requirements under the Outpatient Prospective Payment System (OPPS). Here I will prognosticate that some providers will see a slowdown in payments as well as a new area for coding audits by regulators. Time will tell if they come to pass.

* Continued Pressure on hospital outpatient services – This is by far my sleep disrupter! First, it was restrictions on provider-based (PB) criteria, followed by reductions on PB payments, then price transparency and now, elimination of inpatient only procedures. All of these have the same intended consequence, squeeze hospital outpatient volume and margins and infusing non-hospital providers into this space. Even more troublesome, it is not just Medicare making this push but also many commercial payers. On its surface, the policy argument for this approach sounds appealing considering technological advances and the power of consumerism but deeper considerations reveal a staggering policy void. One must consider that the reason most hospitals were compelled to expand their outpatient services was to subsidize their inpatient reimbursement shortfalls. In other words, the hospital had to generate additional revenue streams to cover its fixed cost of operation. Furthermore, it is a sure bet that despite these aforementioned initiatives there is one payer group that hospitals will inevitably retain known as self-pay. Somehow these new outpatient providers will find a way to unload these "unprofitable" patients on hospitals. All of these facts ultimately beg the question from a policy standpoint – how do hospitals cover this fixed overhead once policy makers have successfully wrestled this necessary revenue stream from traditional hospital providers and how does that position hospital readiness when the next pandemic strikes?

* Audits and Desk Reviews – Medicare Bad Debts – Geez, if a provider can't collect a debt doesn't that make it a bad debt for Medicare Allowable purposes? If only it was that simple – periods of collection, character of the debt, nomenclature of the debt as well as other nuances should receive special attention by providers to minimize the disallowance by auditors. Medicare Audit Contractors have signaled this will be an area of focus so don't say you weren't warned.

* And now for some good news, sequestration has been deferred until March 2021 giving a few extra months to avoid the 2 percent reduction.

Federal – Medicaid

* As mentioned above, the CAA deferred the reductions for DSH payments. While this is a reprieve for a couple of years, providers should continue to push for a permanent repeal of this section of the Affordable Care Act (ACA). With a federal matching rate greater than 75% our Mississippi providers are disproportionately (pardon the pun) affected by this legislation.

Well, that covers a brief summary of some activity that is anticipated to occur in 2021. But, as we know based upon our most recent year, the health care community must be prepared to adapt to the changing environment. I would like to commend each of our providers for stepping up and serving us as individuals with the most respect and professionalism as anywhere in the U.S. I'm definitely proud to say I know a lot you in the Mississippi health care delivery space.

David Williams
CPA, MPH, FHMA
Partner
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The Value of Certification

Many healthcare organizations in today's challenging economy recognize their workforce as their most valuable asset. As such, these organizations tend to hold workforce development as a primary business strategy.

Investment in developing the talents, knowledge and skill sets of staffs are critical to the organization's success. HFMA's *Healthcare Financial Pulse* research identified this dynamic and noted that successful organizations today commit to the "bread and butter" of financial management, i.e. technically strong and comprehensive financial management.

Likewise, many individual financial managers today recognize the importance of assuming personal responsibility for their careers' success. More than ever before, individuals understand the importance of acquiring and maintaining comprehensive skill sets to ensure their ability to provide the financial management demanded today. These individuals frequently seek out relevant professional development opportunities.

The larger business environment resulting from these forces is a heightened interest in workforce development initiatives including certifications and credentialing. Credentialing programs have exploded across the past couple of decades and include:

- professional associations offering certifications
- community colleges offering curriculum-based certificates
- corporate sponsored in-house credentials for employees
- technology companies providing proprietary credentials to customers

HFMA certification provides a fundamental business service to our industry, namely HFMA certification offers:

- Assessment of job-related competency
- The opportunity for an individual to demonstrate skills and knowledge
- Independent verification of the skills and knowledge
- Confirmation that an individual is current in the practice field

The value of HFMA certification can be seen in several reported "value-adds":

- Increased departmental cooperation
- Heightened self-confidence among participants
- Increased performance against selected metrics
- Verification of staff knowledge and skills
- Assistance in structuring career paths

HFMA is committed to being the indispensable resource that defines, realizes and advances healthcare financial management practice. As such, HFMA provides professional certifications to achieve this purpose in today's business environment. This makes HFMA Certification a smart workforce investment strategy.

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The CFO Checklist: Financial Strategy & Forecasting During COVID-19

The COVID-19 pandemic is causing major economic disruptions and has left many health systems struggling to find ways to drive cash supply and forecast budgets. The ability to pivot and prepare a financial operating plan that provides a path toward solid financial footing and support from banks, rating agencies, and stakeholders represents a new discipline that will help to ensure your ability to carry out your mission - to save lives and maintain healthy communities. Presenters will discuss new financial planning and forecasting strategies that consider 90+ factors to help you validate and pressure test your forecasting models six-month, 12-month, three-year outlook. Original Live Webinar Date: 7/24/20

Some Numbers That Affect Revenue

National Debt at last edition - $27,245,706,000,000.00

National Debt as of today—$27,887,090, 000,000.00

Mississippi Debt $7,470,450,000.00

National Unemployment Rate – 6.3%, down from 6.9% last edition

Mississippi Unemployment Rate as of today—6.3% down from 6.8 in November, 2020.

National Average Household Income - $63,179 / Mississippi - $43,567

National Poverty Rate – 10.5% / Mississippi Poverty Rate – 19.7%

Ken Dulaney
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Certification Pathways

Your future, you decide!

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14 CPEs

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CREDENTIALS MATTER

David Williams

Carr, Riggs & Ingram

The process for application, testing and certification can be found on the HFMA.org website at hfma.org.

David Williams, Certification Chair

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HFMA has credentials for those seeking certification or certified specialist programs.

Let's discuss the CHFP program which includes a the broad range of business and financial skills essential for succeeding in today's high-value healthcare environment:

- Business acumen
- Collaboration
- Financial strategy
- Understanding future trends

The CHFP is geared toward financial professionals, clinical and nonclinical leaders, and payers – all those whose jobs require a deep understanding of the new financial realities of health care. The CHFP program includes two modules (*both modules must be successfully completed to earn the CHFP*): The CHFP consists of two online modules:

- **The Business of Healthcare:** A big-picture overview of healthcare finance, risk and risk mitigation, new payment models, financial accounting and cost analysis, strategic financial issues, managing financial resources, and shifting payment models.
- **Operational Excellence:** The application of business acumen includes exercises that use a case study approach to understanding the business of health care.

In addition to the CHFP, HFMA offers specialist programs in accounting/finance, managed care, physicians practice management and business intelligence. For more information contact me.

Thanks,

David Williams

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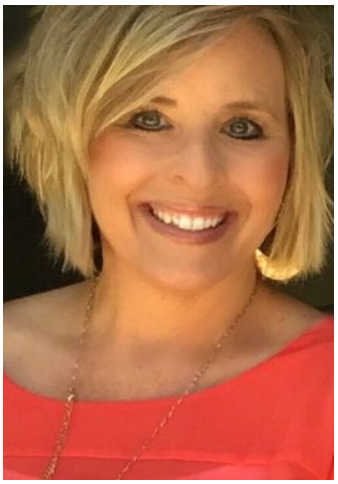

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ABOUT HFMA

HFMA is the nation's leading membership organization for healthcare financial management executives and leaders. More than 35,000 members—ranging from CFOs to controllers to accountants—consider HFMA a respected thought leader on top trends and issues facing the healthcare industry. HFMA members can be found in all areas of the healthcare system, including hospitals, managed care organizations, physician practices, accounting firms, and insurance companies.

The Mississippi Chapter of HFMA, along with other regional chapters and the national HFMA, helps healthcare finance professionals in Mississippi meet the challenges of the modern healthcare environment by:

- Providing education, analysis, and guidance.
- Building and supporting coalitions with other healthcare associations to ensure accurate representation of the healthcare finance profession.
- Educating a broad spectrum of key industry decision makers on the intricacies and realities of maintaining fiscally healthy healthcare organizations.
- Working with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices, and standards.

Vision

HFMA's vision is: "To be the indispensable resource for healthcare finance."

Purpose Statement

To define, realize, and advance the financial management of health care by helping members and others improve the business performance of organizations operating in or serving the healthcare field.

Quality Statement

Quality is the foundation of the Association and the keystone of its efforts to ensure member and customer satisfaction. HFMA's objective is to:

- Consistently provide services and products that meet the quality expectations of its members, customers, and employees.
- Actively pursue a program of continuous quality improvement that enables employees and volunteers to do their jobs right the first time.
- Quality is a major, strategic association goal. It lies at the heart of everything done for members and customers. HFMA strives continually to improve the quality of services and products offered, the processes and procedures used to produce them, and the manner in which they are delivered.

Values Statement

We believe that service to members is our highest priority.

We believe in excellence in all that we do.

We believe that teamwork is essential in meeting the objectives of HFMA.

We believe in the importance of individuals.

We believe in encouraging innovation and creativity.

We believe in conducting HFMA with financial responsibility and a prudent approach to business.

hfma
healthcare financial management association

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