**April 2017** 



News, Events & Updates of the First Illinois Chapter begin on page 19



III I III I I I I I I I I I I I I I I	
Telehealth/Telemedicine: Is the Future Here	1
Hospital C-Suite: Partner and Grow Renenue Quickly	4
Career Corner	6
Mitigating Risk: Five Key Areas of Focus	7
An Overview of the American Health Care Act (ACHA)	10
Getting Ready for 2017: Five Focus Areas for Medical Groups	11
Understanding HCC-HHS Risk Adjustment	14
Booming Demand: How Urgent Care Centers are Impacting Hospital Operations	17
Chapter News, Events and Updates	19
Welcome New Members	21

**New Member Profile** 

**Sponsors** 

22

23

# Telehealth/Telemedicine: Is the Future Here Now?

# BY ERIC BRODSKY, FACMPE, SENIOR CONSULTANT, PBC ADVISORS, LLC

There's been a lot of talk lately about Telehealth or Telemedicine services becoming more and more prevalent in healthcare today. But is it something that providers and hospitals need to engage in now? Or is it still too early to jump on the bandwagon?

What's the difference between Telehealth and Telemedicine? Some entities argue that one is a subset of the other or that they each refer to a specific type of care being provided. However, the American Telemedicine Association (ATA) uses both terms interchangeably in that they both use remote technology to deliver healthcare. In general, we're talking about the use of audio and/or video conferencing to consult about or provide direct care to a patient. I'll only use the term Telemedicine for the rest of this article.

There are many entities across the U.S. that have welcomed Telemedicine in their clinics including some that have a comprehensive system in place to offer this type of care to as many of their patients as possible. Cleveland Clinic, Mercy Health in

Missouri, and Children's Healthcare of Atlanta are some examples. Typically, a third-party is involved in delivering the technology that is needed. Some of the types of care that are currently being provided via Telemedicine include urgent care, general health assessments, and behavioral health. In the case of Cleveland Clinic, their Express Care Online service allows patients in Ohio to receive treatment by a doctor at any time via their computer with a camera or via an app downloaded to their smartphone. Consultative services between providers are another use for Telemedicine, particularly when visuals must be shared. According to the ATA, benefits include:

- Value for payers, patients and providers
- Increased patient access
- Enhanced reach of healthcare services
- · Reduced cost structure
- 24/7 coverage
- Higher customer satisfaction
- Reduced cost structure

(continued on page 2)



# Telehealth/Telemedicine: Is the Future Here Now? (continued from page 1)

The Wellness Council of America has indicated that more than 30 percent of physician and ER visits are entirely unnecessary. This would indicate that patient triage needs substantial improvement and that the use of Telemedicine could aid in reducing costly in-person visits. However, there is some concern that Telemedicine could drive up the cost of healthcare as many patients will still need to be seen in-person after their Telemedicine visit, creating two separate encounters when there would only have been one encounter via the traditional approach.

But who's paying for Telemedicine and is it covered by insurance? There are currently 33 states in the U.S. that have some law enacted or recent legislation passed that requires commercial payers to reimburse for Telemedicine services. The specifics as to what is covered depend on each state. However, Illinois is not one of the 33 states. Still, these entities in other states are oftentimes providing Telemedicine to their patients as a non-covered service and they make arrangements directly with the patient/insured to pay for this unique type of care. Some employers have chosen to offer Telemedicine services for their employees as they believe that they

can deliver high quality care without subjecting the employee to always having to be seen in-person.

From a government perspective, Illinois HFS/Medicaid does provide some coverage for Telemedicine (they distinguish it from Telehealth in that Telehealth is the communications system used while Telemedicine is the medical service component). For the purposes of this type of care in Illinois, it is not meant to replace face-to-face inperson care with a provider but rather to allow for a second provider at a distant site to be "called in" to assist in the case. Only the originating site is eligible for reimbursement and the distant site is to be reimbursed by the originating site directly.

CMS/Medicare is similar to HFS, albeit with some differentiation. Beneficiaries that are eligible for Telehealth services under Medicare have to have their care provided in an originating site in a county outside of an MSA (Metropolitan Statistical Area) and a HPSA (rural Health Professional Shortage Area). The distant site provider bills the appropriate CPT code with a modifier GT. The originating site provider bills HCPCS Q3014. Both entities receive reimbursement if the criteria are met. Eligible CPT codes are:

CY 2017 COVERED TELEHEALTH SERVICES						
Code	Short Descriptor	Code	Short Descriptor	Code	Short Descriptor	
90791	Psych diagnostic evaluation	96151	Assess hlth/behave subseq	99407	Behav chng smoking > 10 min	
90792	Psych diag eval w/med srvcs	96152	Intervene hlth/behave indiv	99495	Trans care mgmt 14 day disch	
90832	Psytx pt&/family 30 minutes	96153	Intervene hlth/behave group	99496	Trans care mgmt 7 day disch	
90833	Psytx pt&/fam w/e&m 30 min	96154	Interv hlth/behav fam w/pt	99497	Advncd care plan 30 min	
90834	Psytx pt&/family 45 minutes	97802	Medical nutrition indiv in	99498	Advncd are plan addl 30 min	
90836	Psytx pt&/fam w/e&m 45 min	97803	Med nutrition indiv subseq	G0108	Diab manage trn per indiv	
90837	Psytx pt&/family 60 minutes	97804	Medical nutrition group	G0109	Diab manage trn ind/group	
90838	Psytx pt&/fam w/e&m 60 min	99201	Office/outpatient visit new	G0270	Mnt subs tx for change dx	
90845	Psychoanalysis	99202	Office/outpatient visit new	G0396	Alcohol/subs interv 15-30mn	
90846	Family psytx w/o patient	99203	Office/outpatient visit new	G0397	Alcohol/subs interv >30 min	
90847	Family psytx w/patient	99204	Office/outpatient visit new	G0406	Inpt/tele follow up 15	
90951	Esrd serv 4 visits p mo <2yr	99205	Office/outpatient visit new	G0407	Inpt/tele follow up 25	
90952	Esrd serv 2-3 vsts p mo <2yr	99211	Office/outpatient visit est	G0408	Inpt/tele follow up 35	
90954	Esrd serv 4 vsts p mo 2-11	99212	Office/outpatient visit est	G0420	Ed svc ckd ind per session	
90955	Esrd srv 2-3 vsts p mo 2-11	99213	Office/outpatient visit est	G0421	Ed svc ckd grp per session	
90957	Esrd srv 4 vsts p mo 12-19	99214	Office/outpatient visit est	G0425	Inpt/ed teleconsult30	
90958	Esrd srv 2-3 vsts p mo 12-19	99215	Office/outpatient visit est	G0426	Inpt/ed teleconsult50	
90960	Esrd srv 4 visits p mo 20+	99231	Subsequent hospital care	G0427	Inpt/ed teleconsult70	
90961	Esrd srv 2-3 vsts p mo 20+	99232	Subsequent hospital care	G0438	Ppps, initial visit	
90963	Esrd home pt serv p mo <2yrs	99233	Subsequent hospital care	G0439	Ppps, subseq visit	
90964	Esrd home pt serv p mo 2-11	99307	Nursing fac care subseq	G0442	Annual alcohol screen 15 min	
90965	Esrd home pt serv p mo 12-19	99308	Nursing fac care subseq	G0443	Brief alcohol misuse counsel	
90966	Esrd home pt serv p mo 20+	99309	Nursing fac care subseq	G0444	Depression screen annual	
90967	Esrd home pt serv p day <2	99310	Nursing fac care subseq	G0445	High inten beh couns std 30m	
90968	Esrd home pt serv p day 2-11	99354	Prolonged service office	G0446	Intens behave ther cardio dx	
90969	Esrd home pt serv p day 12-19	99355	Prolonged service office	G0447	Behavior counsel obesity 15m	
90970	Esrd home pt serv p day 20+	99356	Prolonged service inpatient	G0459	Telehealth inpt pharm mgmt	
96116	Neurobehavioral status exam	99357	Prolonged service inpatient	G0508	Telehealt con initial ccare	
96150	Assess hlth/behave init	99406	Behav chng smoking 3-10 min	G0509	Telehealt con subseq ccare	

# Telehealth/Telemedicine: Is the Future Here Now? (continued from page 2)

As mentioned previously in this article, Illinois has not created any legislation requiring commercial payers to offer Telemedicine services. However, this does not mean that payers are standing by idly waiting. As of 2016, Blue Cross and Blue Shield of Illinois began offering Telemedicine via third-party MDLIVE. The service was limited to self-insured groups with 500+ employees but now may be available to all employer groups. A board certified doctor is available 24/7/365 by phone or 7 a.m. to 9 p.m. central time by video. BCBS also offers 24/7 access to an RN via their NurseLine service. The key here is whether or not the employer has added this Telemedicine service as part of its benefit plan. The employee will pay out-of-pocket for the service, likely at a reduced rate.

Aetna currently offers access to a board certified doctor via phone 24/7/365 in conjunction with a company called Teladoc. Aetna states that Teladoc is not available in all states and that the employer elects whether or not to offer the program to their employees. It is unclear if Illinois is one of the states in which this service is available. Teladoc charges the member a consult fee which appears to be a non-covered transaction. The service is, however, eligible for payment via the member's HSA account if they have one. Interestingly, Costco lists Teladoc as an available option on their employee benefit website. This would appear to indicate that at least some Illinois residents can partake in Teladoc services via Aetna.

All-in-all, Telemedicine is definitely a train arriving to your nearest station. The overall advances in technology dictate that this is a natural progression from the standard face-to-face setting that we've previously been accustomed to. However, in order for a service to be truly successful in healthcare, insurance coverage is a must. Without that coverage, we're all relying on patients to cough up another out-of-pocket payment which is in addition to their already extremely high deductibles. Moreover, the commercial payers are probably somewhat reluctant to pursue Telemedicine to a high degree as its usage could supersede the traditional care currently being provided by most physicians in Illinois—a scary thought indeed! For now (at least here in Illinois), general acceptance of Telemedicine appears to still be a future concern. I plan to revisit this topic a year from now. We'll see if any momentum has been gained by then.

Eric Brodsky, FACMPE, Senior Consultant PBC Advisors, LLC 903 Commerce Dr Ste 333 Oak Brook IL 60523-8723 Phone: (630) 928-5206 Fax: (630) 571-8810

E-Mail: eric\_brodsky@pbcgroup.com

www.pbcgroup.com

# eCare NEXT®

Payment Certainty for Every Patient® Increase collections and reduce bad debt



# Improve Revenue Cycle Management Decisions with Data-Driven Insight

**Experian Health** and **Passport** provide the healthcare industry with a single solution that orchestrates every facet of the revenue cycle.

eCare NEXT\*, our integrated platform, redefines efficiency with Touchless Processing™ an exception-based workflow, and unmatched data and analytics to ensure payment certainty from patients and payers.

Visit experian.com/health or passporthealth.com to find out how you can reduce the work in your workflow and put revenue back in your revenue cycle.





# Hospital C-Suite: Shift Focus, Partner and Grow Revenue Quickly

# BY MATTHEW BERNARD, ELEMENT HEALTHCARE PARTNERS

hen was the last time your hospital leadership shifted their focus from cutting and managing costs to growing revenue through new business opportunities? Anymore, cost may be the strongest driver that's transforming healthcare and that transformation is affecting everyone involved. Healthcare leaders, in particular, are under severe pressure to not only reduce the cost of care per patient, but also to quickly reduce the cost of delivering that care. According to a survey conducted last year by PwC, 73 percent of Healthcare CEOs stated that they were planning to implement a cost-reduction initiative<sup>1</sup>. A more recent survey<sup>2</sup>, which was completed by 183 C-suite executives, listed that finding innovative approaches to expense reduction is the second most pressing concern, compared to 26 other issues. In that same study, minimizing unwarranted clinical variation and controlling avoidable variation were the number four and five top issues, accordingly. These types of concerns and initiatives typically warrant various cost-management strategies and mindsets that have the tendency to inadvertently dilute core business capabilities. As such, a serious problem that many organizations continue to encounter in executing these initiatives is "doing more with less."

As many health system executives understand, working capital is essential to not only delivering quality care, but also to executing strategic initiatives<sup>3</sup>. In many cases, it's only when a hospital or health system has the necessary funding that successfully executing strategic initiatives can be accomplished. However, procuring the necessary funding while remaining autonomous can be challenging, and performance improvement activities to squeeze available cash out of back-office functions (i.e., IT, HR, Finance, Revenue Cycle, etc.) are arduous and time consuming. Furthermore, those hospital executives who manage hospitals with limited or negative net working capital don't have the luxury of excess time, and they need an immediate solution to quickly address their financial problems.

The next logical step is to look to new business revenue opportunities. But for hospitals and health systems that are already engaged in across-the-board cost management and cost cutting initiatives, drumming up new business through capital intensive marketing campaigns or expanding one's footprint through acquisition aren't viable as options. So, are new business revenue opportunities dead?

The short answer to that question is, no. New business revenue opportunities aren't dead, and revenues can be realized quickly (within 1-2 months) by implementing a laboratory outreach program. Because so much focus and strategic efforts have been directed towards the inpatient and ambulatory care settings in recent years, a key asset and opportunity for many hospitals and health systems has been overlooked in the laboratory setting. By leveraging their hospital laboratory infrastructure and by strategically partnering with an established network of multi-specialty physicians in the region, healthcare executives can:



- Accelerate top and bottom line growth
- Penetrate their market
- Enhance long-term financial and clinical value

The good news for hospital executives is that there's promise for many hospitals that are facing strong financial headwinds and are struggling with generating revenue to fund various initiatives. As a strategic response to market and competitive forces, hospitals can transform their hospital laboratory from a complex cost center into a flourishing profit center, thus enabling superior enterprise performance and strategic effectiveness.

To effectively accomplish such an initiative, hospital leaders must connect their strategy with a clear, fundamental approach for execution. Typical programs usually disrupt existing business operations and create strain on existing resources. Furthermore, in healthcare organizations where change is constant, employees can burn out at an accelerated rate, thus amplifying deteriorating morale, productivity and care quality. To avoid these common drawbacks, hospital executives must approach this type of initiative by focusing on their core strengths and capabilities. New, requisite capabilities for executing strategy can be seamlessly accessed through an innovative partnership and/or alliance.

According to the aforementioned survey of Healthcare CEOs by PwC, 59 percent of those surveyed are focused on new strategic alliances. By strategically partnering to gain access to new capabilities, hospital executives can continue to deliver quality care by focusing on and allocating their available resources towards their organizational strengths. Hospital executives should consider the following steps prior to initiating this type of new, unfamiliar initiative:

- Consider the direction for your organization and what business and operational components are needed to reach your strategic care delivery goals.
- Identify and prioritize resources to support your organization's strengths and core capabilities.

(continued on page 5)

# Hospital C-Suite: Shift Focus, Partner and Grow Revenue Quickly (continued from page 4)

- Determine what additional capabilities are required to effectively and efficiently reach those goals.
- Select the appropriate partner who can provide not only the desired capabilities but also can seamlessly integrate with your existing business model and operating components (e.g., people, process, technological infrastructure, information and governance).

The more unified their hospital's operations, the sooner healthcare executives can realize the benefits of growing their business. The key element is finding a partner that can add lasting value to an organization. A strategic partnership/alliance that focuses on short- and long-term value, in addition to financial gains, will buttress any care delivery strategy, regardless of the hospital's direction or organizational complexity.

If you are a hospital C-suite executive, how confident are you that your institution can continue to provide quality care by itself? If you have the opportunity to develop, manage and grow your hospital laboratory's outreach business, what qualities and capabilities do you look for in a partner?

#### Notes

- 1. PwC 19th Annual Global CEO Survey: Healthcare industry key findings
- 2. Rosin, Tamara. 5 biggest concerns for health system executives in 2017. Becker's Hospital Review. http://www.beckershospitalreview. com/hospital-management-administration/5-biggest-concerns-forhealth-system-executives-in-2017.html
- 3. Rauscher S, Wheeler JR. The importance of working capital management for hospital profitability: evidence from bond-issuing, not-for-profit U.S. hospitals. Health Care Management Review. October/December 2012 - Volume 37 - Issue 4 - p 339-346



# {Just right.}

Which audit, tax, and consulting firm is the right size for your organization?

Too small and you may not benefit from industry experts and the bench strength to meet your needs. Too large and you could feel that your needs don't come first.

For more than 90 years, Plante Moran has delivered knowledge, pragmatism, and high-touch client service. As a result, we are able to report unparalled client satisfaction and client loyalty scores.

If you want to experience the Plante Moran difference, contact us today.

A higher return on experience.

Ed Slack | 847.628.8796 | ed.slack@plantemoran.com

healthcare.plantemoran.com

# **CAREER Corner**

BY VICKIE AUSTIN





Janet Guptill

This issue of "Career Corner" focuses on Janet Guptill, FACHE. executive director of Scottsdale Institute and president-elect of the Greater Illinois Chapter of the Healthcare Information Management Systems Society (HIMSS). She is a graduate of the University of Arizona and holds a master's degree from Tulane University in health systems management.

# Q: What was your first job?

A: My first healthcare jobs were in college during the summers when I worked at the Arizona Health Plan, an HMO. One summer I was the switchboard operator and the next summer the radiology darkroom tech - both jobs that have completely disappeared due to changes in information technology!

# Q: Who were some of your early influences and role models?

A: I have been lucky enough to work with some remarkable thought leaders in my career. As I started my career in hospital management, I worked with two hospital CEOs, David Pitts and Rick Henault, who taught me a tremendous amount about leadership and management. When I switched to consulting, I was fortunate to work with several visionaries, including Jeff Goldsmith, a notable healthcare futurist, and Michael Sachs, an amazing entrepreneur who developed several healthcare technology-based businesses. Later, I worked for Dr. David Brailer who became the first national "healthcare technology czar" as director of the Office of the National Coordinator (ONC) for Health Information Technology, part of the U.S. Department of Health and Human Services. He was another brilliant thought leader. Many other people along the way were major life influences. I am lucky to have known so many smart, caring and thoughtful healthcare leaders over the years.

# Q: What had you choose healthcare as a career?

A: I was on my high school debate team and one year our topic was "Should there be a guaranteed minimum annual income for all Americans?" It struck me then how there are plans for housing, food and education—but not healthcare. Was healthcare a right or a privilege in this country? I thought that was a noble career to pursue, so I majored in health services management in college and then went on to get a master's degree in health systems management. This topic continues to be a critical one for us to address today.

# Q: What was one of your most "teachable" moments?

A: Frankly, I learn something new every day and often from some surprising sources. The pace of change is accelerating—I am never at a loss for "teachable" moments in my everyday work and life!

# Q: What key lessons about career management have you learned along the way?

A: When I was growing up, whenever we would complain that we didn't know how to do something my mother always had this quick comeback: "You'll never learn any younger!" And she was right—we are never too old to learn something new, and we can't let the fact that we don't know something stop us from trying something new and learning new skills.

# Q: What role has HFMA played in your career development?

A: HFMA has provided thoughtful, collaborative approaches to complex, difficult topics, such as "How do we move from a fee-forservice mindset to a value-based care model?" and "What is required for healthcare pricing to be more transparent to the end consumer?" The answers to these questions require thoughtful, deliberate and non-judgmental processes that draw upon expertise across the organization—financial, clinical, operational and technological—and this collaborative approach to addressing the systematic change we need to lead in healthcare is a hallmark of HFMA programming.

# Q: What are you reading?

A: I am currently in the middle of Thomas Friedman's book, Thank you for Being Late: An Optimist's Guide to Thriving in the Age of Accelerations. This is a fascinating book about the furiously fast pace of technological advancement, combined with equally dramatic changes in the globalization of today's economy and the impact of climate change. I highly recommend it!

# Q: What advice would you have for someone just starting out in the healthcare financial management profession?

A: In any healthcare business we must continually prove the "value proposition"—we must understand the levers of cost and the meaning of value for the services we provide. Understanding both sides of that equation are critical. My advice is to not shy away from understanding the data and connecting with the end product, the patient care delivery process. It is essential to put ourselves in situations where we continually learn more about both the cost and quality side of the healthcare value equation.



Vickie Austin

Vickie Austin is a business and career coach and founder of CHOICES Worldwide. She's a frequent speaker at HFMA chapters around the country. You can connect with her at vaustin@choicesworldwide.com, 312-213-1795. Follow her blog at http://vickieaustin.com\_and connect via Twitter @Vickie\_Austin and via LinkedIn, www.linkedin.com/in/vickieaustin.

# Mitigating Risk: Five Key Areas of Focus

# BY JEREMY WHALE

ealthcare liability insurers cannot tell physicians or midlevel providers how to better practice medicine or avoid surgical mistakes but can offer guidance that can help you mitigate risk. Here are five key areas to focus on that can help protect your practice.

# Use Technology with Caution

Healthcare looks very different than it did 25 years ago. Physicians are using tablets, smartphones, interactive apps and other electronic means to provide efficient healthcare to patients.

According to several sources, between 75 and 85 percent of physicians use a smartphone or tablet for professional purposes. Uses include email, research, EMR entry, X-ray review, telehealth and more. While electronic devices have many benefits, their use presents new risks.

Chief among these risk exposures is the increased possibility of a HIPAA violation. While a HIPAA violation is not the same as a malpractice claim, it can still negatively impact you and your practice, staff and patients.

HIPAA concerns arise in several areas of electronic device use. Losing a device may allow an individual access to protected health information (PHI) stored on the device. If the device is not properly encrypted or secured, an individual may access PHI through apps, email or hacking into a system using the device's connectivity.

Another risk arising from mobile electronic devices involves app usage. There are approximately 26,000 healthcare apps available, and 7,400 of those apps are marketed to physicians.<sup>2</sup> Somewhat surprisingly, the FDA has only approved 10 healthcare apps as of July 26, 2016.<sup>3</sup>

One physician wrote about a blood pressure app he was using that gave inaccurate readings. When he contacted the app's developer, he was told the app was in the "beta-testing stage" and intended for "entertainment purposes only." Despite this information, the developer was selling the app to end-users—without any disclaimers or mention of its test status.<sup>4</sup>

Healthcare providers need to be vigilant when deciding whether to use certain apps. Research the app's usage and do preliminary testing to ensure its accuracy. Use the app, then verify the results with traditional testing until the physician is satisfied the app's results are accurate. Another suggestion is to contact the app's developer and request testing/clinical trial results on its accuracy.

Use of smartphones, tablets, laptops, etc., in healthcare becomes more main stream every day. Be sure you are proactive in mitigating the accompanying risks. You may need to contact an IT security specialist to help ensure you are managing potential risks as effectively as possible.



# Track and Follow Up on Your Tests

Missed or delayed diagnosis is one of the most often litigated allegations in medical malpractice.<sup>5</sup> These claims often result from tracking and follow-up procedure failures.

Lab testing is one of three key areas (the others are referrals to specialists and missed/canceled appointments) where tracking and follow-up are vitally important. A retrospective study researched the frequency of patients not being informed of test results, concluding there was a 7.1 percent failure rate. Tracking and follow-up procedural safeguards can be implemented and have a large impact on potential liability claims.

A reliable test tracking and follow-up system ensures the following steps occur:

- 1. The test is performed.
- 2. The results are reported to the practice.
- The results are made available to the ordering physician for review and sign-off.
- 4. The results are communicated to the patient.
- 5. The results are properly filed in the patient's chart.
- 6. The results are acted upon when necessary.

Here are some suggestions for improving your process:

- Route all test results to the ordering physician for review. Procedures to
  ensure the ordering physician receives each and every test result can
  help lessen the risk of a result "falling through the cracks." Something
  as simple as a log book or email notification can help facilitate physician
  review.
- Ask the ordering physician to review and sign off on each ordered test result. Physicians order lab tests for specific reasons; physicians are encouraged to sign or initial each test result following review.

(continued on page 8)

# Mitigating Risk: Five Key Areas of Focus (continued from page 7)

Notify your patients. Several practices notify patients only when
there is an abnormal result. Some practices choose to send a
letter for normal results and call the patient for abnormal results.
Others call patients with all results. In today's technology-driven
world, an email may be appropriate for normal results, or an email
directing patients to a portal where results can be reviewed.
Patient notification of all test results is advised—however your
practice chooses to do so.

Ensuring all tests ordered by your physicians are handled in a consistent manner will help avoid tracking and follow-up errors.

#### Set and Review Policies and Procedures

A policy and procedure manual is an important tool for defining practice operations. In well-run practices, there is one set of rules every staff member understands and follows. The alternative is risky—procedures that vary from physician to physician or between staff members make it easy for errors or omissions to occur.

Develop a comprehensive manual of specific policies and procedures that explains how tasks are performed in your office and make it readily available to all staff. It's important for staff to review and initial that they have read and are aware of these policies and procedures.

The following is a list of suggested topics to address in your policies and procedures manual:

- 1. Clinical Protocols/Patient Care
- 2. Patient Relations and Confidentiality
- 3. Health Information Management (Medical Records)
- 4. Laboratory (Test Tracking and Follow-up)
- 5. Radiology
- 6. Appointment Scheduling
- 7. Patient Tracking and Follow-up
- 8. Infection Control
- 9. Human Resources
- 10. Practice Operations
- 11. Special Procedures
- 12. Safety

You may need to add or subtract certain topics to best address the specific areas of your practice.

### Maintain Accurate Medical Records

A medical record is crucial to the defensibility of a case; occasionally it can be the biggest hurdle. The primary purpose of a medical record is to provide a complete and accurate description of the patient's medical history. This includes medical conditions, diagnoses, the care and treatment you provide and results of such treatments. A well-documented medical record reflects all clinically relevant aspects of the patient's health and serves as an effective communication vehicle.

The medical record also has a critical secondary function: it is the most important piece of evidence in the successful defense of a medical professional liability claim. On average, a medical malpractice lawsuit takes five years to resolve. Most physicians cannot recall specific patient encounters from several years ago—so it is important to have accurate, thorough and timely documentation of all your patient encounters.

Good medical record documentation may help prevent a lawsuit. Your defense team may be able to disprove a patient's assertions if the physician has thoroughly and accurately documented the patient encounter.

Good medical record documentation includes, but is not limited to, the following elements:

- 1. Legible If your handwriting is not legible, consider dictating your notes.
- 2. Timely Most electronic medical record systems document the date and time of all entries. If you still use paper records, note the date and time of each entry, with an accompanying signature or initial. It is best to chart patient encounters either contemporaneously or shortly after the visit for more accurate and thorough documentation.

(continued on page 9)



# Mitigating Risk: Five Key Areas of Focus (continued from page 8)

- 3. Accurate Ensure your documentation accurately reflects what occurred during a patient encounter.
- 4. Chronological Documentation is more easily understood when it is sequential by date and logical in process. The SOAP (subjective, objective, assessment, plan) format, or something similar, is suggested when documenting patient encounters. A logical, clear thought process is compelling evidence to present to a jury.
- 5. Thorough The old adage "if it's not documented, it didn't happen" still applies today. It is challenging to show something happened if there is no documentation to support that assertion.
- 6. Specific and objective Make documentation as specific as possible (e.g., using actual measurements rather than descriptors such as "small" or "large" in size).

Additions, corrections or addendums may be pertinent in certain situations, but altering a medical record is strongly discouraged. It will destroy your credibility in the eyes of a jury and cast doubt on the legitimacy of the entire chart. Alterations include modifying accurate information for fraudulent or self-serving reasons.

To properly correct a written chart, strike a single line through incorrect information, leaving it readable. Then make the correction or addition as needed. Be sure to authenticate the change with a time and date, along with your initials or signature. In the event of litigation, be prepared to be questioned about any changes made to the patient's chart—especially if they occurred after the incident in question or suit was filed.

Follow the same authentication principles in electronic records; consider using a "strikethrough" function rather than deleting information. Making any corrections or additions to a medical record after a claim or lawsuit has been filed—or after receiving notice a claim or lawsuit may be filed—is strongly discouraged. These actions will likely be viewed as self-serving and could severely undermine your defense.

### Keep Your Team Trained and Informed

Office staff is a critical component of a medical practice. Patients often have more interaction with staff than physicians. Properly trained and educated staff can be strong protection against a professional liability claim. Consider the following risk tips for office staff issues:

- Prepare written job descriptions for all staff. Review each staff member's job description at his or her annual performance evaluation to determine whether the description accurately reflects the individual's responsibilities and capabilities.
- Ensure each staff member works within the boundaries of state laws regarding appropriate job functions.
- Provide clear instructions to your staff on the amount and type of advice they may relay to patients and limitations on such advice.
- Establish a formal orientation period for new employees. Include a review of administrative practices, emergency medical procedures, and clinical skills and responsibilities.
- Establish procedures to ensure professional staff are credentialed.

- Educate all employees on patient confidentiality and have them sign a confidentiality agreement annually.
- Document employee training, including clinical competency, credentialing, performance evaluations and annual reviews in employees' personnel files.
- Conduct regular staff meetings with designated agendas.
- Provide frequent feedback (both positive and negative) to staff.
- Ensure tasks are delegated to staff with the appropriate education, training and experience to perform the task.

While the risk of a medical malpractice claim can never be eliminated, the information provided herein will help you reduce your practice's risk of a claim. If you have a specific question regarding your practice, please contact an attorney.



Jeremy Whale

Jeremy Wale is a licensed attorney in Michigan where he works as a Risk Resource Advisor for ProAssurance. He has authored numerous articles about mitigating medical professional liability risk. Wale also conducts loss prevention seminars to educate physicians about new and emerging risks.

<sup>1&</sup>quot;Mobile Officially a Staple in the Doctor's Office," March 26, 2015, <a href="http://www.">http://www.</a> emarketer.com/Article/Mobile-Officially-Staple-Doctors-Office/1012271>, accessed on October 11, 2016.

<sup>&</sup>quot;Professional usage of smartphones by doctors in 2015," October 27, 2015, <a href="http://www.kantarmedia.com/us/thinking-and-resources/blog/professional-usage-">http://www.kantarmedia.com/us/thinking-and-resources/blog/professional-usage-</a> of-smartphones-by-doctors-in-2015>, accessed on January 30, 2017.

<sup>&</sup>lt;sup>2</sup>Sher, D, MD, "The big problem with mobile health apps," March 4, 2015, <a href="http://">http:// www.medscape.com/viewarticle/840335>, accessed on October 13, 2016.

<sup>3&</sup>quot;Mobile medicine resources: FDA approved apps," July 26, 2016, <a href="http://">http://</a> beckerguides.wustl.edu/c.php?g=299564&p=2000997>, accessed on October 13, 2016.

<sup>&</sup>lt;sup>4</sup>Sher, D, MD, op. cit.

<sup>&</sup>lt;sup>5</sup>"PIAA Closed Claims Comparative: A comprehensive analysis of medical professional liability data reported to the PIAA Data Sharing Project," 2015 Edition.

<sup>&</sup>lt;sup>6</sup>Casalino, L.P., et al., "Frequency of Failure to Inform Patients of Clinically Significant Outpatient Test Results." Archives of Internal Medicine 169 (2009): 1123-9.

<sup>&</sup>lt;sup>7</sup>Suszek A., "How long will it take to settle your medical malpractice case?" <a href="http://www.alllaw.com/articles/nolo/medical-malpractice/how-long-settle.html">http://www.alllaw.com/articles/nolo/medical-malpractice/how-long-settle.html</a>, accessed on October 31, 2016.

# An Overview of the American Health Care Act (AHCA)

BY FI HFMA STAFF WRITERS

ne of President Trump's core initiatives has been to "repeal and replace" the Affordable Care Act (ACA). After months of waiting, the American Health Care Act (AHCA) was introduced March 9, 2017. To make a long story short, it was so poorly received that even the Republicans decided not to take it to vote because they simply did not have the votes to pass it.

We will plan on providing a more comprehensive update at such future point in time as the President is able to produce a bill more likely to be made law. In the interim, below is a brief summary of the core provisions of the AHCA:

 Repeals individual and employer mandates retrospectively to 2016; imposes a Late

Payment Penalty of 30% of premium for those who had lapse in coverage for 63 days or greater during a 12 month look-back period prior to date of new coverage

- Repeals Tax Credits and replaces them with different Tax Credits
- Repeals Cost Sharing Subsidies
- Modifies Age Ratings limit of 3:1 to allow 5:1, unless states adopt something different
- Repeals Medicaid Expansion effective 12/31/19
- Converts federal Medicaid funding to Per Capita model ("Block Grants")

- Introduces support of Patient Stability Fund and State Stability Fund ("high risk pools")
- Provides incentives for expansion of HSAs
- Prohibits federal funding for Planned Parenthood
- Eliminates the Prevention and Public Health Fund
- Adds state option to require work as a condition of eligibility for nondisabled, non-elderly, non-pregnant Medicaid adults

Reaction to the AHCA proposal has been generally negative. Estimates from the non-partisan Congressional Budget Office (CBO) state that the legislation would lead to 24 million fewer insured Americans by 2026. The CBO Cost Estimates show little/no cost impact. As of press time, the following organizations have formally voiced opposition to the AHCA:

- The American Hospital Association (AHA)
- The American Medical Association (AMA)
- America's Health Insurance Plans (AHIA)
- American Association of Retired Persons (AARP)

After the AHCA bill failed to be taken for a vote, President Trump stated he was done negotiating on healthcare, that we are "stuck with Obamacare" and that he was moving onto his other initiatives that are going to make America great again. In more recent days, we've seen new discussions and proposals being floated. We will provide an update on this developing story in our next edition.



THE POWER OF BEING UNDERSTOOD AUDIT | TAX | CONSULTING





# Getting Ready for 2017: Five Focus Areas for Medical Groups

BY LUCY ZIELINSKI, VICE PRESIDENT, GE HEALTHCARE CAMDEN GROUP

# CHALLENGES LOOM IN THE AREAS OF PAYMENT, PATIENT ACCESS, CONSUMER ENGAGEMENT, POPULATION HEALTH MANAGEMENT. AND PROVIDER ALIGNMENT.

For medical groups, the last few years have been tumultuous with the shift to value-based care. In 2017, medical groups will continue to experience change on all fronts, including payment, care delivery, and interaction and communication with patients. Medical groups must contend with new payment models, fierce competition in their markets, increased regulatory requirements, clinical advances, digital and information technology changes, and population health management implementation.

In response to these shifts, medical groups should focus on five key areas to position themselves for the future. As Socrates said, "The secret of change is to focus all of your energy not on fighting the old but on building the new." And that is what medical groups need to do in 2017: build the new by transforming the old ways of practice management.

# New Payment Models: Focus on Quality and Cost

Depending on geography, "value-based contracts" range from fee-forservice arrangements with incentives for value to 100 percent riskbased agreements. While the degree varies by market, commercial insurance plans will tie more payment to value and risk in 2017. Medical groups will be faced with increased pressure from payers to assume additional risk for the delivery of high-quality care at lower costs.

To succeed under new payment models, medical groups will need to transform their practices and consider new capabilities and the resulting implications for care delivery and management. Potential outcomes include better-coordinated care at a lower cost, a positive social reputation and financial rewards.

Reporting under the Quality Payment Program (QPP) of the Medicare Access and CHIP Reauthorization Act begins in 2017 (MACRA). Medical groups need to determine their QPP payment track: Advanced Alternative Payment Models (APMs) or the Merit-based Incentive Payment System (MIPS). To be successful under either, groups are required not only to track measures and activities but to perform well in those areas—and even to outperform their peers.

Medical groups should have a plan in place in preparation for MACRA, including the selection and implementation of specific measures and activities. Groups should establish a plan for monitoring performance to ensure high performance compared with peers. MIPS groups should develop a strategy and timetable for transitioning to the APM track, which offers bonuses and removes some of the reporting requirements that practices face under MIPS.

In addition to the start of MACRA, Medicaid expansion continues throughout the country (the future of Medicaid expansion after the recent election remains to be seen), and Medicare Advantage plans continue to grow. Success in these areas likewise requires an

emphasis on providing high-quality, coordinated care while reducing the medical spend.

To be effective, the care delivered to patients, specifically those with a chronic illness, needs to be managed across the continuum. Medical groups need to work and align with other providers of care, such as hospitals, surgery centers and post-acute facilities. To support care delivery across the continuum, components such as technology, care protocols and care management, and a focus on primary care services are critical.

Focusing on primary care services may require changing staffing models to support efficient care and to demonstrate quality. Any staffing model needs to be evaluated to ensure an appropriate mix of clinicians as well as to determine whether staff and clinicians are working to the top of their license.

(continued on page 12)



## THAT'S THE VALUE OF COLLABORATION

For over a decade, our revenue cycle experts have been increasing net revenue 1%-6% and reducing cost-to-collect by 10%-20% for hundreds of hospitals, including those within one of America's largest healthcare systems. In fact, today we stand at over \$35 billion in annual cash collections. Learn how you can leverage our scale to achieve strategic advantages throughout your organization.

**Read Revenue Cycle** as a Strategic Advantage at parallon.com/RCS



Revenue Cycle Purchasing Supply Chain Consulting Services **Information Technology Workforce Solutions** 

© 2014 Parallon Business Solutions, LLC.

# Getting Ready for 2017: Five Focus Areas for Medical Groups (continued from page 11)

Ideally, physicians should focus on revenue-generating work, while support staff such as nurses, medical assistants, and administrative staff perform other activities in accordance with their scope of license and their abilities. These activities may include clinical work such as taking patients' vitals or history, appointment scheduling, patient education and callbacks, and triaging.

A practice may need to consider adding midlevel providers and other clinicians to help manage and deliver the care to the patient populations served by the medical group. Practices also should determine whether the behavioral health and socioeconomic needs of the patient population are being served.

### Patient Access: Focus on Innovative Care Models

The healthcare industry is experiencing significant shifts in the way care is accessed and delivered, and medical groups need to build strategies to expand patient access and engagement, increase and retain market share, and minimize their risk in value-driven payment models. In simpler terms, medical groups should focus on improving patient access by providing the right care at the right time in the right setting, with right defined by both patient preference and clinical criteria.

Recently, a variety of high-tech and high-service medical groups have entered the market. Many of these are for-profit venture-backed companies that are taking advantage of traditional physician practices' lack of patient access and service. To thrive, medical groups will require innovative care models that lead to better care delivery at a lower cost, patient retention and increased patient satisfaction.

Patients are demanding immediate access to care, convenient hours and multiple ways to communicate with their physicians. They want to be able to navigate the system to find the right care at the right time. Medical groups need to assess the patient experience from the patient's perspective: What is the patient experience like in the practice? How do patients navigate their care? How does the medical group support the process? How does technology, such as patient portals and online options, support patients to ensure they receive the right care at the right time?

Care delivery is changing. Consumers are seeking convenience and are increasing their use of technology; depending on the situation, care can be provided virtually. The use of telemedicine will not only increase in remote rural areas but will be used by patients who don't want to leave their home for care. Patients are accessing care and "seeing" their physicians on their cell phones. Many payers, including Medicare, are expanding coverage for telehealth and even behavioral health services that are delivered virtually. The use of mobile technology and applications for telehealth and self-monitoring is exploding, allowing, for example, patients with complex conditions and the elderly to be managed more effectively.

In light of these developments, medical groups should examine their virtual-care and telehealth offerings and strategies. What technology does is being promoted to the patient population?

### Consumerism: Focus on Customer Service

Consumer-driven health care is on the rise. Patients have options when selecting their coverage policies, with many choosing high deductibles and accepting responsibility for a larger portion of the cost of their care. In turn, patients are becoming more familiar with the process of actively choosing providers and services; medical groups need to be cognizant of that dynamic.

Additionally, new competitors such as retail clinics, virtual and telehealth providers, home healthcare providers and others are entering the marketplace and offering patients more convenience, more choice, better service and, in many cases, more affordable care. How should medical groups respond to these competitors? The consumer experience, as well as the consumer's preference, matters significantly.

Maintaining or, better yet, building patient loyalty becomes an important driver of patient retention. Consumers expect information—not only about their health condition and treatment options but also their coverage and the price of their visit, among other issues. When group practices attend to the consumer, the result is higher patient engagement, which correlates to better care and overall outcomes—not to mention an increase in patient satisfaction and a positive reputation for the medical group. Satisfied patients also are more likely to pay their bills, leading to a decrease in the cost to collect.

Understanding the distinct patient population by performing market studies, then segmenting consumers into groups (e.g., age and condition, demographic, mental health needs) will provide medical groups with insight into what matters to their patients—including consumer preferences and how they want to be engaged—thereby allowing the group to meet those needs.

For example, new mothers may be seeking a social outlet for information about infant care or breast-feeding, perhaps via education, a portal, or even a Facebook group. Older patients diagnosed with uncontrollable diabetes may need group support or behavioral therapy. Many surveys suggest that the most important issue in a patient's experience is the way in which staff and providers treat and communicate with the patient. Organizations such as Cleveland Clinic even have their employees undergo empathy training to better relate to patients.

In the age of consumer-driven health care, patients have high deductibles and responsibility for a larger portion of the cost of their care. In essence, "patients" may be one of a medical group's top payer categories. For this reason, price transparency is important as patients potentially shop around and seek low-cost providers. Additionally, collection from patients is more costly and has a lower collection rate compared with collection from insurance carriers.

Medical groups should ensure they have a solid financial policy in place that addresses patient collections along with methods to collect patient-due balances such as self-service options and keeping a credit card on file.

(continued on page 13)

# Population Health Management: Focus on Data and **Analytics**

Typically, medical groups do not have the requisite data for obtaining the information they need to manage patients across the continuum of care. Yet, they are held responsible for the cost and quality of the care of a patient population (factors that help determine payment).

For this reason, medical groups must strive to understand their patient populations, manage their care better, and know where they are going and what kind of services they are receiving. The risk environment makes it especially important for medical groups to have strong transition-of-care and care-coordination technologies along with protocols that maximize the efficiency of the care. These elements are necessary to ensure optimal care management, reduce cost while improving quality and maintain or increase referrals.

For medical groups, managing patient populations takes a concerted effort to partner with other providers to share and exchange information. Medical groups must optimize the use of their electronic health records (EHRs) to support care management across the continuum. In addition, MIPS measures address the advancing of care information and the interoperability of systems. For example, clinicians are required to exchange electronic summary-of-care documents during care transitions.

A data-source gap exists for many medical groups, with claims data and data from other providers not aggregated for analysis. However, medical groups can use the data they have from their EHR, practice management system and registry, and from payers, a physicianhospital organization or clinically integrated network (CIN), the Centers for Medicare & Medicaid Services (CMS) and other sources.

For example, CMS' Quality and Resource Use Report (QRUR) shows clinician or group performance on quality and cost measures, including the per capita costs (or medical spend) for specific conditions such as diabetes, COPD, CAD and heart failure. These costs are based on payments for all medical claims submitted by providers, including Medicare Part A and Part B, which includes providers that do not bill under the group's taxpayer identification number.

Practices that participate in Medicare Advantage plans should be reviewing their scores and ensuring that providers are accurately coding. Under many new payment models, diagnosis coding drives risk adjustment and ultimately payment. Practices should consider implementing reviews, provider education and system edits to support accurate coding.

Medical groups should review their QRUR report or other payer data and consider what the data reveals about ways in which patients may be better managed. In general, groups should understand how payers are linking quality and cost to payment and make efforts to review and understand accessible data.

# Improved Care: Focus on Network Alignment

Consolidation will continue across the healthcare industry, and hospitals and health systems will continue to acquire and employ physicians. However, physician employment is not the only strategy. Alignment with all providers across the continuum of care is the real key.

Insurance plans and providers, including medical groups, are collaborating to offer high-value, low-cost plans. To better manage care delivery and costs, narrow networks allow consumers to save money and get the care they need within a network of participating providers in an organized system of care. When medical groups work together across the network, the results include better care, shared data and access to technology and care management support, better contracts and network participation, and referral retention.

Hospitals, health systems and other organizations continue to form CINs to respond to changing healthcare dynamics and to promote value-based care. CINs are designed to control costs and ensure care quality by managing patients and focusing on the goals of the Triple Aim. Forming a CIN is a physician alignment strategy, with physicians providing leadership and focusing on clinical quality improvement and efficiency, as well as appropriate utilization management.

For medical groups, the value proposition of participation in a CIN is alignment with a system to preserve patient volumes and referrals and to provide an opportunity for better payer contracts. Additionally, CINs support physicians by providing an infrastructure, including technology, analytics and care management.

# A Year of Challenges, Opportunity

In 2017, medical groups will continue to experience change and feel pressure from consumers, payers, other providers and new competition in the marketplace. This year promises to be one of change, threats and opportunities for medical groups, which must take action to survive and outperform the competition.

The overarching task for medical groups in 2017 is clear: build the new by transforming the old ways of practice management to meet the demands of the consumer, compete in the market and provide better care at a lower cost.

Lucy Zielinski is vice president, GE Healthcare Camden Group. Publication Date: Monday, January 09, 2017

# Understanding HCC-HHS Risk Adjustment

BY PHIL SOLOMON, VP MARKETING STRATEGY, MIRAMED

#### Introduction

The Centers for Medicare and Medicaid Service's (CMS) Hierarchical Condition Category (HCC) risk adjustment model is used to calculate risk scores, which will adjust capitated payments made for aged and disabled beneficiaries enrolled in Medicare Advantage (MA) and other plans.

The CMS-HCC model design uses two risk segments with separate coefficients to reflect the cost patterns of beneficiaries. The community model represents those who live in the community less than 90 days, as opposed to more permanent residence in an institution. Beneficiaries residing in an institution for 90 days or more fall into the long-term care category which incurs an additional risk adjustment. By design, both models predict healthcare costs for beneficiaries.

The CMS-HCC risk adjustment model looks at prospective data to predetermine the cost for the next year. CMS pays a per-member/permonth fee to the payer based on the prospective year's risk scores. Providers must identify all chronic conditions and/or severe diagnoses their patients have in a given year to substantiate a "base year" health profile for each patient that predicts costs in the following year.

For Medicare accounts, expected differences in resource needs of patients or health plan enrollees are risk adjusted so the payments made to healthcare facilities, such as hospitals, skilled nursing and home health agencies, reflect the proper premiums it pays to health

The risk adjustment program is designed to ensure that premiums are adequate for patients or plan enrollees who require more resources than the average Medicare beneficiary does. The program is set up to protect beneficiary access as well as the financial condition of the provider or plan. At the same time, risk adjustment modeling lowers payments or premiums for beneficiaries who expect to use fewer resources to reduce incentives for providers or plans to favor these beneficiaries.

# **HCC Auditing Options**

The search for more efficient and effective care of chronic conditions is gaining increasing attention. Developing risk models can contribute to this effort by efficiently identifying enrollees within defined populations who are likely to generate high costs and who could benefit from integrated care.

CMS has the needed resources to continue refining the forecasting models of high-cost users of healthcare. Few providers have the resources and are proficient enough in risk adjustment modeling to mitigate all of the compliance risks that they face. This creates a problem for providers because there are significant dollars at risk for their enterprises. In order to reduce risks, providers either hire expert HCC auditors as an internal resource or look to outside firms who are experts at executing risk adjustment and HCC auditing. Many companies are capable of providing this service however; the best practice approach is to work with a company that can guide providers to keep up with CMS's requirements for compliance while monitoring healthcare outcomes.

### Understanding the Requirements of HCCs

In 2010, the Patient Protection and Affordable Care Act (ACA) included legislation that leveraged the model known as CMS-HCC. HCCs have been the basis for reimbursement for Medicare Advantage plans (Medicare Part C) since 2004. HCCs model prospective data to determine predicted costs for enrolled members during the next year of coverage. Such estimates come from demographic information, such as age and major medical conditions, documented from patient encounters in the previous 12-month period. Its current use is to adjust Medicare capitation payments to Medicare Advantage health plans based on the anticipated risk of enrollees calculated from relevant ICD-9-CM (DOS prior to September 30, 2015) or ICD-10-CM codes (DOS after October 1, 2015).

Because of the proven success of HCCs in predicting resource usage by Medicare Advantage enrollees, the model now determines, in part, reimbursement for Accountable Care

(continued on page 14)



# Understanding HCC-HHS Risk Adjustment (continued from page 14)

Organizations (ACOs) and the Hospital Value-Based Purchasing (HVBP) program. Few providers traditionally have assumed the risk for outpatient documentation and coding. Under ACOs and HVBPs, however, more providers are assuming risk when they record health status for their patients. That means good things for providers that accurately capture their patients' health status benefits. For those providers who fail to capture relevant conditions, they receive lower reimbursement payments.

Prospective risk models applied to retrospective data have a number of potential applications for health plan managers and other decisionmakers concerned with identifying high-cost cases. A straightforward application is to use a risk model as a primary or complementary needs assessment tool. Large organizations can produce their own model coefficients and predicted expense scores, whereas smaller providers can just score their own memberships with factors based on larger, more generalized populations. Plans can use these individual-level cost predictions for case management patients who are most likely to exceed a predetermined cost threshold, whether set in dollars or percentiles. The cost limit will be set according to budgetary constraints and organizational objectives.

There is value in the identification of more clearly established chronic disease cohorts, such as enrollees with asthma. The disease classification system underlying a risk model can help stratify enrollees with asthma by the level of expected cost and comorbidity to develop appropriate disease management. For example, an enrollee with asthma, congestive heart failure and/or emphysema will cost more and utilize additional resources compared to an asthma patient without complications. Risk models could be especially important in the disease context because, at least for some conditions, case management proves to be effective similarly, a risk model in use to identify high-cost members of demographic groups such as children (and their families) is invaluable. Targeted conditions would be those that are particularly expensive within those groups.

Depending on organizational interests and data availability, two-to three-year time gaps between risk-factor assessment and realized expense begs exploration. Shorter, six-month time gaps can also be examined, especially among subgroups with well-defined modifiable risk factors such as tobacco and alcohol use or sedentary lifestyle. This will be facilitated by more frequent, i.e., monthly, updates to diagnostic data that enhance the predictive performance of risk models by identifying patients closer to when the risk is realized. In addition, risk models can be used to create individual-level clinical profiles that might take the form of an overall expected cost (or alternatively, a normalized risk score) and a list of the various disease classes or categories into which the patient falls. These clinical profiles can guide case managers in choosing the appropriate treatment.

A critical part of the risk adjustment program is data validation. CMS provides guidance for Risk Adjustment Data Validation (RADV) on the CMS.gov website, and there is more information located in the March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting **Discussion Paper.** 



The following may help to determine a record's suitability for RADV and provide some key criteria that should be considered when building a medical record checklist.

# When submitting a record for RADV, consider the following:

- Is the record for the correct enrollee?
- Is the record from the correct calendar year for the payment year being audited (e.g., for audits of 2011 payments, validating records should be from calendar year 2010)?
- Is the date of service present for the face-to-face visit? Is the record legible? Is the record from a valid provider type (hospital inpatient, hospital outpatient/physician)?
- · Are there valid credentials and/or is there a valid physician specialty documented on the record?
- Does the record contain a signature from an acceptable type of physician specialist?
- If the outpatient/physician record does not contain a valid credential and/or signature, is there a completed CMS-generated attestation for this date of service?
- Is there a diagnosis on the record? Does the diagnosis support an HCC? Does the diagnosis support the requested HCC?
- If the condition warrants an inpatient hospitalization, the HCC may be supported by an inpatient record. Examples of such conditions may include septicemia, cerebral hemorrhage, cardiorespiratory failure and shock. For these conditions, an inpatient record, a stand-alone inpatient consultation record or a stand-alone discharge summary may be appropriate for submission.
- When possible, obtain a record from the specialist treating the condition, e.g., an oncologist for a cancer diagnosis. These records may be more likely to sufficiently document the condition.
- Pay particular attention to cancer diagnoses. A notation indicating "history of cancer," without an indication of current cancer

(continued on page 16)

# Understanding HCC-HHS Risk Adjustment (continued from page 15)

treatment, may not be sufficient documentation for validation. For example, if in an attempt to validate HCC 10 (Breast, Prostate, Colorectal and Other Cancers and Tumors) an MA contract submits a record that indicates a patient has a history of cancer that was last treated outside the data collection year, the HCC may be not be validated.

- When reviewing medical records, pay special attention to the problem list on the electronic medical record. Often, in certain systems, a diagnosis never drops off the list, even if the patient is no longer suffering from the condition. Conversely, the problem list may not document the HCC your MA contract submitted for
- Any problem list in submitted documentation should be included and not just referenced.
- Records provided to validate HCCs that encompass additional manifestations or complications related to the disease (e.g., HCC 15, Diabetes with Renal Manifestations or Diabetes with Peripheral Circulatory Manifestations) should include language from an acceptable physician specialist that establishes a causal link between the disease and the complication. An acceptable record that clearly defines the complication or manifestation and expressly relates it to the disease may validate the HCC. A record that does not identify and link this relationship may not validate the HCC.
- If a physician or outpatient record is missing a provider's signature and/or credentials, consider using the CMS-generated attestation that was provided with your data. CMS will only consider CMSgenerated attestations for RADV.
- Minimum requirements for inpatient records state that these must contain an admission and discharge date. In addition:
- Inpatient records must include the signed discharge summary.
- Stand-alone consultations must contain the consultation date.
- Stand-alone discharge summaries submitted as physician provider type must contain the discharge date.

### Getting Ready for 2017 and Beyond

The ultimate purpose of the CMS-HCC payment model is to promote fair payments to Medicare providers and Medicaid Managed Care Organizations by rewarding efficiency and encouraging the delivery of outstanding care for the chronically ill. The model has evolved over the past 20 years from detailed research with careful attention to clinical credibility, real-world incentives and feasibility tradeoffs.

Continuous feedback between government technical staff and policymakers at CMS has shaped the CMS-HCC model. CMS has an ongoing commitment to evaluate the effect on organizations and the beneficiaries they serve. Their continued assessment of the model will identify the practicality and effects of matching healthcare resources to patient's needs.

To that end, CMS has been working on areas for improvement by recently requesting comments and suggestions with the 2017 Payment Notice (81 Federal Register 12204).

After receiving feedback from the public and in response to the comments received, CMS is continuing its evaluation of potential data sources and determining if the risk adjustment methodology adequately captures the risk associated with:

- Partial year enrollment
- Prescription drug utilization as a predictor in the model
- · Under compensates for new or fast-growing plans
- Pooling of high-cost enrollees
- Proper evaluation of concurrent and prospective risk adjustment
- Models based on outdated data
- Improvements by including prescription drug utilization data as a

Continued priorities for CMS include making improvements in the risk assessment methodology to ensure that all of the provisions incorporated are accurately recalibrated for 2018 and 2019.

The information contained in this document provides general guidelines and information for the CMS Risk Adjustment Model and is in no way offering legal advice. CMS reserves the right to make changes as necessary.



# Thanks to our trusted partner, our late-stage receivables just boosted our bottom line.

Transform the conversation around your revenue cycle by partnering with Capio. As your trusted partner, we turn endcycle receivables into value while treating your patients with compassion along the way. It's a win-win

capiopartners.com/hero



# **Booming Demand:** How Urgent Care Centers are Impacting **Hospital Operations**

BY CONNER GIRDLEY, VICE PRESIDENT, LANCASTER POLLARD, ATLANTA & KEITH JONES, ASSOCIATE, LANCASTER POLLARD, COLUMBUS



he construction and use of urgent care centers in the health care industry has steadily increased over recent years. The growing popularity of urgent care centers presents an opportunity for hospitals to extend networks or expand partnerships in order to reach new clientele. Further, it offers an opportunity to enhance brand recognition in new and existing markets.

According to the Urgent Care Association of America (UCAOA), urgent care dates back to the late 1970s and was created with the intention of meeting a community's immediate health care needs. It was a slow but steady start for urgent care in the beginning, but the concept of seeing a physician without an appointment eventually began to gain popularity among patients. Over the past 20 years, the urgent care industry has continued to expand and earn the trust of those seeking a safe and affordable place to receive medical attention.

Today, urgent care centers are physician-staffed and typically offer extended hours (evenings and weekends), providing quality care without the costs and wait times associated with the average emergency room (ER) visit. Urgent care centers are best suited for situations that require more immediate attention; often times, this serves to be more practical than seeing a primary care provider, who can be challenged with offering consumers the hours or immediacy an illness or accident can demand.

### Why the Increase in Popularity?

There are various drivers behind the recent growth of urgent care. The UCAOA estimates that growth has been steady the last several years, as between 300 to 600 urgent care centers are added per year, resulting in the current population of around 7,400 centers. Challenges on the supply side, such as difficulty in finding a primary care provider

### Urgent Care Association of America's 2016 Benchmark Report

- In 2015, 96% of urgent care centers said the number of patients increased at 90% anticipated growth in 2016.
- 73% of urgent care centers acquired or built a new location in 2015.
- 92% of patients report a 30 minute or less wait time to see a provider. 90% reported a 60 minute or less wait time.
- The top five urgent care diagnoses in 2015 were: acute upper respiratory infection, acute sinusitis, acute pharyngitis, cough and acute bronchitis.
- On average, there were 7 exam/treatment rooms in urgent care centers in 2015.
- Urgent care centers reported that they handled an average of three patient care visits per hour in 2015.

Source: http://c.ymcd.com/sites/www.ucaoa.org/resource/resmgr/ benchmarking/2016BenchmarkReport.pdf

and the increase in costs associated with ER visits, are a factor in the increase. A larger demand by consumers for convenience, both in terms of proximity and hours, has also resulted in a need for more urgent care centers. More recently, lenders and investors have recognized the success of the urgent care model and have begun to look for opportunities to participate in the ongoing growth.

The business model is based on low-margin, high-volume care, as the average visit costs \$150 with a total visit time of under 60 minutes in 84% of cases, compared to an ER visit that averages \$1,354 and consumes four hours of wait time. Costs are much

(continued on page 18)

# Booming Demand: How Urgent Care Centers are Impacting Hospital Operations (continued from page 17)

lower in an urgent care setting, as detailed with some of the more commonly treated ailments shown in the chart below:

An easy conclusion to reach would be that an urgent care center would draw lower-acuity patients away from emergency rooms, resulting in less overcrowding of the ER and improved efficiency. However, a study presented in April, 2016 by Grant Martsolf, et al, found that retail clinics opened near emergency departments are not associated with a material reduction in low-acuity emergency department visits. This data supports the notion that urgent care centers prompt patients to seek care for conditions that might have been treated at home or at a primary care office. Thus, urgent care centers may not be an avenue for reducing ER overcrowding, but may provide an opportunity for accretive revenue through partnership or expansion. This widening of a hospital network may increase referrals and retention of patients who will seek care through urgent care centers and might find themselves referred to physicians or testing facilities within the network. If a hospital invests in quality care and branding, the uniformity of care provided in an urgent care setting will enhance a patient's overall experience and may engender confidence in the entire health care system, prompting patients to utilize other services of the hospital.

Condition	ER Cost	<b>Urgent Care Cost</b>
Sore Throat	\$525	\$94
Sinusitis	\$617	\$112
Urinary Tract Infection	\$665	\$112
Strep Throat	\$531	\$111

# How Hospitals are Getting Involved

For hospitals interested in expanding their network to include urgent care centers there are several options. Some hospitals have pursued partnerships with an existing provider of urgent care services. This allows the hospital to step into a relationship with an existing provider that has experience in managing the low-margin environment that demands a unique staffing approach. This partnership has benefits for both the urgent care provider and the hospital because the provider receives benefits from the local hospital's brand recognition and gains access to physicians employed by the hospital. In return, the hospital benefits from a reduction in initial investment requirements and receives another referral source. It is estimated that the majority of urgent care centers in the U.S. continue to be operated as freestanding facilities, while 20% are owned solely by hospitals and another 15% are structured as joint ventures. Hospitals that pursue the partnership model must be aware of the challenges that come with information sharing beyond their existing network.

Hospitals that opt to open urgent care centers have the ability to target neighborhoods and demographics that are either underserved or have a potentially advantageous payor mix. The hospital's brand recognition can provide immediate legitimacy to the start-up centers and these centers have the ability to share complete patient information, ensuring a seamless patient experience. Hospitals pursuing this path must ensure that staffing and the scope of care

provided do not tarnish the hospital's brand in the initial stages of the learning process. Traditional sources of financing for nonprofit hospitals, such as tax-exempt bonds, the U.S. Department of Housing and Urban Development (HUD)/Federal Housing Administration (FHA) Sec. 242 program, the U.S. Department of Agriculture (USDA) Business & Industry or Community Facilities program, or bank direct purchase financing, are typical options for financing these assets on a standalone basis, or as part of a larger strategic plan.

As demand for lower-cost alternatives to care that do not sacrifice quality continues to grow, opportunities for hospitals to expand into the urgent care center environment will continue to present themselves. Hospitals can act on these opportunities to grow market share and expand brand recognition, while simultaneously meeting patients' needs and providing quicker, lower-cost care than that offered in a typical ER setting.



Conner Girdley is a vice president with Lancaster Pollard in Atlanta. He can be reached at cgirdley@lancasterpollard.com.

Keith Jones is an associate with Lancaster Pollard in Columbus. He can be reached at kjones@lancasterpollard.com.

Conner Girdley

<sup>1</sup>http://c.ymcdn.com/sites/www.ucaoa.org/resource/resmgr/Media/UCAOA-Infographic-UCvsER FIN.pdf

<sup>2</sup>https://www.debt.org/medical/emergency-room-urgent-care-costs/

<sup>3</sup>http://www.annemergmed.com/article/S0196-0644(16)30998-2/abstract

4http://www.modernhealthcare.com/article/20170125/NEWS/170129940



# — YOUR PEERS, YOUR STAFF, YOUR MOVE — **MEMBER-GET-A-MEMBER PROGRAM**

You know-more than anyone — the value of belonging to HFMA.

Spread the word. Invite your peers, your staff, and your colleagues to join you-and join HFMA.

Win prizes for each new member you recruit.

HFMA.ORG/MGAM

# **HFMA Event Promotions**





**OCTOBER 24-25, 2017** 

# **HFMA Event Summary**

# Another Great FI HFMA Managed Care Program

# Thursday, February 9 at University Club Chicago

The FI HFMA Managed Care Program has become one of the chapters most popular and well-attended events in recent years. Chaired by Cathy Peterson and Denise Cameron, the FI Managed Care Committee once again put on a great program on 2/9/17.

The program was held at the historic Cathedral Hall in the University Club Chicago; a setting fit for a day's worth of thought provoking presentations, networking, and a chance to catch up with colleagues.

The program's theme was "Innovations" and began with keynote speaker Kaveh Safavi, M.D. JD, Managing Director of Global Health Business, Accenture. Dr. Safavi is a Chicago area native, who has gone onto international acclaim. His keynote address was titled "How Digital Technology Will Make Care More Productive and More Personalized". Many in the audience reflected that Dr. Safavi's presentations are always engaging, informative and cutting edge. It was great to have him "back home" with us.

Other presentations included:

- MACRANOMICS (Aaron Margulis, Principal, Vizient)
- A New President, Congress, and Health Policy Agenda: What to Expect Next (Chris Dawe, VP, Payer Partnership Solutions, Evolent Health)
- Bundled Payment Programs: 2017 and Beyond (Chad Beste, Partner, PBC Advisors)
- How to Achieve Growth and Innovation for a Physician Practice (Mike Kasper, CEO, DuPage Medical Group)

The day ended with a Social Hour and raffle. Thanks to the Committee and Event Sponsors for another great Managed Care program!



Cathy Peterson and Denise Cameron



Chad Beste, PBC Advisors



Kaveh Safavi, MD Accenture



Peter Hulick, MD NorthShore University Health System

# Welcome New Members

**Chris Setzler** 

UroPartners COO

**Thomas Giella** 

Korn Ferry Chairman, Healthcare Services

**Kevin Britt** 

Analyst

**Annie Hinkel** 

**PNC Bank** 

**Maya Daniel** 

**Michael Carnrite** 

nThrive Director

Susan Clarke

Advocate Healthcare Executive Director, Patient Access Services

Susan Yeazel

Point B Healthcare Principal

Kenneth Miller Jr.

NTT DATA, INC Healthcare Technologies Senior RCM Specialist

**Ryan Downs** 

Huron Healthcare Manager

**Matthew Booth** 

**PwC Partner** 

**Kathleen Heaton** 

speroMD

Director, Business Operations

Nathan Myhra

Navigant Consulting Services Managing Consultant

John Barakat

Cardiac Surgery Associates, S.C. CFO/COO

Julie Kralis

Advocate Sherman Hospital Director, Imaging Services

Shane Wakefield

Global Recovery Alliance Business Development

**Shekinah Bishop** 

Southwest Orthopaedic Specialists PLLC Administrative Manager

Julie Vallejo

Southwest Orthopaedic Specialists PLLC Director, RCM

Mary Adducci

Northwestern Medicine Senior Financial Analyst

**Collin Hickey** 

**Gretchen Torres** 

Ericka Adler

Roetzel & Andress Partner

**Norah Volpp** 

Northwestern Medicine Project Manager of Financial Affairs **Dustin Long T** 

Tsap

Jimmy Burnett

Navigant Consulting, Inc. Managing Director

Theresa Thapedi

**Chakarra Hull** 

Universal Health Services Assistant Controller

**Scott Hewitt** 

UnitedHealthcare VP Value Based Contracting Strategy

Zamira Ashe

KPMG

Manager

Ryan Ashe

KPMG Manager

Sara Novakovic

KPMG Associate (Emerging Leader)

# Is Workers' Comp Keeping You Puzzled?

EnableComp works with over 450 hospitals and health systems nationwide to identify every dollar they are entitled to for the services they provide to injured workers.

Let EnableComp be your missing piece for recovering the best possible revenue.



CompRecover- Zero Balance Accounts



CompResolve- Aged Accounts



CompDirect- Day 1 Placement



CompAdvocate-Negotiated Settlements



ContractVue- Analyze & Benchmark Agreements



www.EnableComp.com





# Welcome New Members

(continued from page 21)

# Robin Schroeder-Janonis

McKesson Sales Exec, Payer Market

#### Kristin MacCallum

Tenet Healthcare **Director of Reimbursement** 

#### Eric Brodsky

PBC Advisors, LLC Senior Consultant

#### **Matt Onesko**

**Associate Director** 

#### **Thomas Albrecht**

ARMCO Partners, LLC Director, Client Development

#### Ales Cejka

Meddata **VP Operations** 

#### **Krystle Carey**

Centegra Health System Revenue Cycle Specialist

#### Cassandra Elia

Centegra Health System Revenue Cycle

#### Varghese Mathew

**Ambulatory & Community** Health Network Administrator

#### **Robert Watson**

Patientco Enterprise Sales Executive

#### **Brady Stern**

Hammond Hanlon Camp LLC Vice President

# **Timothy Fergus**

Advocate Health Care Sr Financial Analyst

#### Tanisha Hogan

TransUnion **Product Owner** 

### Cynthia Coleman

Cook County Health & Hospitals System Dir.- Financial Control II

# **New Member Profile**

# **Shane Wakefield**

# Account Manager, Global Recovery Alliance, Baar, Switzerland

Manages a portfolio of more than \$200 million and serves as key point person for international business development.

#### Questions:

### What was your first job?

I have fond memories of picking fruit and helping out on local farms in the west of England. After leaving school I trained as a chef. I attended college during the day and worked evenings at a large hotel chain, as well as working at a traditional English pub on weekends. By working in different environments within the catering field, I was able to learn more traditional techniques, volume and home-style comfort cooking, allowing me to progress from home cooking to running a professional kitchen within two years.

### Who were some of your early influences and role models?

My Dad. Spending many years on the English police force, he taught me the benefits of right and wrong. We spent weekends in the shed at the bottom of the garden, building models, bird tables and aviaries. He also took me to my first football (soccer) match when I was 9 years old, resulting in a lifelong passion for the game.

#### What was one of your most "teachable" moments?

Learning manners and eye contact. Politeness and manners, even under stress, cost nothing but are of great value, and it's important always to make eye contact when talking to others. I learned from my experience of moving to a country where I encountered language and cultural barriers that if you don't make eye contact then your mouth is not directed at the person you are talking to. This can result in misunderstandings and mistakes for both parties.

### What key lessons about career management have you learned along the way?

I think the two most important words and lessons you can learn while managing and progressing in your career are: Plan & and Team.

Plan: You need to clarify your objectives. There is no harm in asking a thousand people the same question to get the right answer. Once you know your path, then make your plan and stick to it. Ask for help when needed but also be prepared to provide assistance when you are called upon.

Team: As the age-old saying states, "There is no 'I' in Tteam!" Help those around you and work together to solve problems. Experience is knowledge, so share that knowledge with your team.

#### What role has HFMA played in your career development?

I am a new member to HFMA. However, I have been attending HFMA conferences in the U.S. since 2011. I have met many inspirational people along the way who have taught me many things about U.S. healthcare. I also hope that I have taught them something. The more involved I become with HFMA, the more I learn.

#### What are you reading?

I have an 11-month-old daughter who loves to sit while I read The Hungry Caterpillar and The Tickle Monster to her. When I do get some free time I like to read sport autobiographies. I am currently reading Paolo Di Canio: The Autobiography. Di Canio played football (soccer) at the highest level and also managed the team that I have supported since I was 9 years old.

# What advice would you have for someone just starting out in the healthcare financial management

Ask questions, lots of questions. Listen to everyone and learn. Do your research, join groups and network. HFMA can help a lot with this. Remember, you are the future of healthcare. One day, you may have people coming to you for answers, and those answers are the foundation of a new generation of healthcare professionals.



# The First Illinois Chapter Sponsors

The First Illinois Chapter wishes to recognize and thank our sponsors for the 2016-2017 chapter year. Thank you for all your generous support of the chapter and its activities.

Silver Sponsors Elmhurst College

Crowe Horwath

MiraMed

Veralon

**TransUnion** 

**Bronze Sponsors** 

Triage Consulting Group

# **Titanium Sponsors**

Experian Health
Global Recovery
Horizon Financial
Management

Strategic Reimbursement

# **Platinum Sponsors**

RSM

PBC Advisors, Inc

Powers & Moon, LLC

Plante Moran

Harris & Harris

Parallon

Capio Partners

# **Gold Sponsors**

Litmos

Bolder Healthcare

Solutions

Nationwide NCC

Enablecomp

**HPS-Healthcare** 

Payment Specialists



#### **Publication Information**

#### Editor 2016-2017

 Shane Ramsey
 312-515-7854
 Shane@imagemovermd.com

 Jim Watson
 630-928-5233
 jim\_watson@pbcgroup.com

Official Chapter Photographer

Randy Gelb ..... 847-227-4770

Sponsorship

Chad Preston ......615-414-1025

cpreston@avectushealth.com

raelb@mbb.net

Design

DesignSpring Group, Kathy Bussert

kbussert@designspringinc.com

#### **HFMA Editorial Guidelines**

First Illinois Speaks is the newsletter of the First Illinois Chapter of HFMA.
First Illinois Speaks is published 4 times per year. Newsletter articles are written by professionals in the healthcare industry, typically chapter members, for professionals in the healthcare industry. We encourage members and other interested parties to submit materials for publication. The Editor reserves the right to edit material for content and length and also reserves the right to reject any contribution. Articles published elsewhere may on occasion be reprinted, with permission, in First Illinois Speaks. Requests for permission to reprint an article in another publication should be directed to the Editor. Please send all correspondence and material to the editor listed above.

The statements and opinions appearing in articles are those of the authors and not necessarily those of the First Illinois Chapter HFMA. The staff believes that the contents of First Illinois Speaks are interesting and thought-provoking but the staff has no authority to speak for the Officers or Board of Directors of the First Illinois Chapter HFMA. Readers are invited to comment on the opinions the authors express. Letters to the editor are invited, subject to condensation and editing. All rights reserved. First Illinois Speaks does not promote commercial services, products, or organizations in its editorial content. Materials submitted for consideration should not mention or promote specific commercial services, proprietary products or organizations.

#### Style

Articles for First Illinois Speaks should be written in a clear, concise style. Scholarly formats and styles should be avoided. Footnotes may be used when appropriate, but should be used sparingly. Preferred articles present strong examples, case studies, current facts and figures, and problem-solving or "how-to" approaches to issues in healthcare finance. The primary audience is First Illinois HFMA membership: chief financial officers, vice presidents of finance, controllers, patient financial services managers, business office managers, and other individuals responsible for all facets of the financial management of healthcare organizations in the Greater Chicago and Northern Illinois area.

A broad topical article may be 1000-1500 words in length. Shorter, "how-to" or single subject articles of 500-800 words are also welcome. Authors should suggest titles for their articles. Graphs, charts, and tables (PDF or JPG only) should be provided when appropriate. Footnotes should be placed at the end of the article. Authors should provide their full names, academic or professional titles, academic degrees, professional credentials, complete addresses, telephone and fax numbers, and e-mail addresses. Manuscripts should be submitted electronically, on computer disk or by e-mail as a Microsoft Word or ASCII document.

#### **Founders Points**

In recognition of your efforts, HFMA members who have articles published will receive 2 points toward earning the HFMA Founders Merit Award.

#### **Publication Scheduling**

#### **Publication Date**

July 2017 October 2017 January 2018 April 2018 Articles Received By

June 1, 2017 September 1, 2017 December 1, 2017 March 1, 2018