Hello Kentucky HFMA members! I hope everyone has been able to enjoy some time off this summer to spend with their family and loved ones. My wife and I recently visited Disney World for the first time in over fifteen years. I was amazed by the amount of attractions available and the thousands of visitors flooding the parks every day. One item that stood out to us during our trip was the impeccable customer service by the Disney employees. It makes you wonder how much more effective other scenarios would be if everyone provided the same customer service techniques. I have certainly brought back some ideas to implement in my business life.

We recently held our Annual Summer Institute on July 19th in Louisville. I would like to thank everyone who attended the event and all of the volunteers who helped make it happen. We covered excellent topics and had excellent speakers lined up by our VP of Education, Amy Karp and her committee. Jason Smith, MD from the University of Louisville Hospital spoke about the current opioid epidemic effecting the region. Jason shared excellent information and insight into the crisis we are facing. We have posted his presentation on the KY Chapter website along with many other presentations from the institute. I encourage you all to take a few minutes to read through the presentations.

I would also like to thank all of our chapter sponsors for their continued support. We would not be able to provide the valuable education to our members without their support. Elaine Fraim and Brad Wilkie are the chapter sponsorship co-chairs and they have done an excellent job coordinating with our sponsors this year. If anyone is interested in corporate sponsorships or individual meeting sponsorship items, please contact Elaine (elain.fraim@st-claire.org) or Brad (bwillkie@claimaid.com).

Our chapter is collaborating with a few organizations to provide additional education options to our members this Fall. The Kentucky Health Law Institute will be held on September 13-14, 2018 at the Marriott Griffin Gate Resort in Lexington. More information about this event can be found at http://hfmaky.org/downloads/healthlaw2018_web.pdf. We are also collaborating with the KY Chapters of MGMA this year. They are hosting their Fall Conference on September 27-28, 2018 at the Marriott East in Louisville. More information can be found at http://www.kmgma.com/event-2989373.

Our next KY HFMA meetings will be the 2nd Annual Women’s Event on October 24, 2018 at the Gheen’s Lodge at the Parklands of Floyds Fork. Registration should be open in the near future for this event. Our 2-day Annual Conference (formerly Spring Institute) will be held on February 27-28, 2019 at the Omni Louisville. We are excited about both of these events and hope to see you all there!

Nick Ficklin, CPA, FHFMA
FY 2018 - 2019 KYHFMA President
Upcoming HFMA Events

2018 Women’s Event
October 24, 2018
Gheens Lodge at the Parklands of Floyds Park
Louisville, Kentucky

Spring Institute
February 27 - 28, 2019
Omni Hotel Louisville
Louisville, Kentucky
Top 5 Eligibility Best Practices

Brad Skelton, HFMI Regional Manager

The revenue cycle begins with patient-facing tasks that have a huge impact on back-end claims management and reimbursement. One of the most critical front-end responsibilities is determining eligibility. It lays the groundwork for billing and collecting claims in the most efficient and effective manner possible by helping to prevent claim denials on the back-end.

Here are the top five eligibility best practices for improving revenue cycle management:

1. **Always ask to see insurance card and run eligibility checks at the registration desk.**
   
   Too often registration staff either fails to ask for insurance, or simply assumes prior coverage is still active. This misstep leads to an unnecessary, costly increase in self-pay accounts, or an increase in denials and additional collection costs. Each result leads to an increased workload for staff post-service.

2. **Train staff to properly read eligibility responses.**
   
   Many times patient representatives add a policy to a patient account, and that policy doesn’t carry the benefits needed for a procedure. Training staff on how to correctly read eligibility responses is crucial. In addition, an eligibility platform that displays information in a format that is easy for staff to view supports this effort. Failing to read/understand eligibility responses properly has a negative and sometimes costly impact on point-of-service collections (co-pay, co-insurance and deductibles). A well-trained staff can more confidently ask for payment at the time of service, without jeopardizing the patient relationship.

3. **Utilize an eligibility provider that also provides insurance discovery.**
   
   Utilizing an insurance discovery platform will locate any insurance coverages missed at registration, as well as any retro-approved coverages. Use insurance discovery to save money by not having to pay an early-out vendor or collection agency because you found eligible insurance coverage instead of them. What’s more, insurance discovery can actually earn money by capturing accounts before they reach filing time limits and frees up financial counselors so they can focus on accounts in need of their assistance.

4. **Train staff to review patient financial responsibility when viewing eligibility response.**
   
   Collecting co-pays, deductibles, and co-insurance prior to discharge impacts all areas of the revenue cycle. Staff’s abilities to read responses correctly and collect patient responsibilities are equally important. Patient responsibility that is not collected prior to discharge leads to an increase in patient statements generated, increased workload for early-out staff, and in many cases an increase in fees paid to early-out business office vendors.

5. **Partner with an eligibility provider that has a flat monthly fee model.**
   
   Too many providers pay eligibility vendors on a fee-per-transaction basis, or have entered into an agreement that limits the number of monthly transactions and imposes costly overage fees. This model is extremely challenging: 1) It is difficult to budget for when your organization is querying multiple payers to find insurance; and 2) Its high cost limits staff’s utilization of the system, leading to un-verified insurance coverages and costly back-end payment recoveries. Partnering with a vendor that offers a flat monthly rate ensures that staff can verify eligibility without limits at a pre-determined cost that is easy to budget for.

In order to accelerate the revenue cycle, you must receive prompt payment. But, this means great care must be taken to ensure you have processes in place to ensure eligibility up front to avoid the delay and expense of having to collect at the back end.
Evolution of Health Care: Bridging the Clinical, Administrative and Financial

Frazer Buntin, President, Value Based Services, and Kate Rollins, Vice President, Clinical Programs and Performance, Evolent Health

The new skills required to operate a value-based care business successfully are vast, and the financial return becomes viable only if a provider can go at-risk for enough lives to scale their investment. This reality is a major inhibitor to providers who want to move up the risk continuum and for those who tried and failed. Unfortunately, many value-based care (VBC) initiatives fall at the lower end of a spectrum of accountability, amounting to little more than glorified pay-for-performance tasks that check the box for bonus dollars. This doesn’t drive accountability into the care delivery system in the same way that taking on both upside and downside risk does. To effect lasting change, providers are moving up this continuum of risk-taking through mechanisms that allow them to capture more of their generated savings, but also hold them financially accountable for losses—such as Next Generation ACO or Medicare Advantage for Medicare populations.

Providers making the move toward risk are balancing the in-sourcing of new skill sets with outsourcing to third parties. Those who are seriously committed to VBC as their path forward are looking for partners that can help them rethink and redevelop their clinical model for effective population health, get technology in place to enable clinicians and administrators to operate effectively, and, for the most sophisticated, run the back-office administrative components that are culprit cost drivers, but which providers must own if they want to capture the maximum financial gain from the value they’re creating.

The way the industry is evolving, and where providers are innovating in the space, is bridging the clinical, administrative and financial:

Clinical:

• CARE TEAM PERFORMANCE:
  Using a care team to support high-risk patients is not a new concept, but has traditionally been challenging to directly measure impact/ROI. Having a concrete process and key performance indicators for care managers helps providers identify exactly what tasks correlate to improved health outcomes and lower costs. It also helps identify high and low performers so teams can replicate the best practices of the highest performers and deploy skills training for those who need coaching. Getting smarter on how to orient expensive clinical resources and directing that attention where the care team can make the biggest impact is a different construct than yesterday’s disease management programs.

• COMMUNITY HEALTH WORKERS:
  In one program, a provider deployed Community Health Workers as part of an extended care team for Medicaid populations. In a preliminary analysis of the impact on the care team’s workload and productivity, early data suggest that care managers can nearly double their case loads after successful introduction of Community Health Worker support. This could have major implications for how the industry thinks about creating capacity for both doctors and nurses, what roles are needed in the healthcare workforce at large, and the benefits of a community-centric approach to operationalize and deliver care. It also has implications for avoiding physician burnout. The more productive the care team is that supports that primary care practitioner (PCP), the more that PCP can trust that patients are followed and continually engaged outside of the point-of-care office visit. This helps them succeed at population health without taking essential time away from other practice areas, and sets them up for a better relationship with the patient when they’re face-to-face.

CLINICAL PROGRAM INNOVATION:

The same provider is also engaged in a partnership with in which some of their partners are piloting new clinical programs for targeted populations. One in particular is a pilot to prevent chronic kidney disease from escalating to end-stage renal disease. What’s interesting about this partnership is that the provider is helping their partners take the best academic models and determine how to operationalize them on the front lines. The provider is working to iterate, test and titrate at the population- and disease-specific level to drive better patient experience and health outcomes. The goal is to refine the approach and then scale it to the provider’s numerous national partners nationwide.

Administrative:

• THIRD-PARTY ADMINISTRATOR (TPA CAPABILITY):
  To capture the value that providers can create through clinical impact and savings, they need to be able to administrate claims, run effective utilization management and pharmacy benefits management, and in some cases support member services with call centers and staff. These aren’t traditional areas of expertise for a provider, but helping them take on these administrative services is beneficial.

• POWER OF CLAIMS PLUS CLINICAL:
  One provider successfully integrated its claims administration platform into Identify its core population health data analytics technology, last year. This means that their partner now has claims processing and data operating on the same scalable platform as their clinical and financial workflow tools. Claims traditionally have months of lagtime before they can be used to help identify patients who may need care management support. With the stratified clinical platform, knowledge about which patients may be high risk for an acute event can be quickly spread across the care continuum, and lead to accelerated conversations with the patient and her PCP. This helps achieve the ultimate goal of intervening before a medical event occurs.
Financial:

- **FINANCIAL METRICS ARE DIFFERENT FOR VBC:**
  When providers effectively learn the new clinical and administrative skills they need to be successful in risk, it drives financial performance, as well. Providers benefit from having reporting and analytics on the same infrastructure as their clinical and administrative tools. In the value-based care world, they need to be able to track, report and manage based on contract terms that work differently than fee-for-service.

- **FINANCIAL PERFORMANCE READINESS:**
  Providers participating in Next Generation ACO are faced with a complex financial situation. They need to monitor performance on clinical outcomes for a specific group of Medicare beneficiaries throughout the year to know if they’re on track to achieve savings or not. Knowing the financial trend of the value business early on creates opportunity to change approaches mid-year for a better chance at achieving savings targets. However, to do this effectively, providers need to get started before their performance year begins with CMS. They can deploy tools several months prior to the performance year to start analyzing and assessing the probable risk of their Medicare panel, get people in early for preventive care, and jump start the clinical program design process so that the entire care team can make a difference on day one of the performance year.

**KEY TAKEAWAY:**

Any given provider could pull all of these levers and still not see an ideal return if they’re only doing it for a few thousand patients. Once infrastructure and process is in place and there’s a roadmap for success via a smaller population test case, providers are then ready to place more risk lives under management. How they accomplish this depends uniquely on the dynamics of their local markets, which drives the wide variety of business strategies across the country. For instance, some take their PSHP to new geographies to get more membership; some create alliances with other provider groups to get more patients attributed to a successful ACO; some have immediate scale if they’re granted the opportunity to manage hundreds of thousands of Medicaid beneficiaries. Regardless of which strategy providers choose to navigate the shift to value-based care, it’s clear that they’re on the right track to serving a common goal of improving health.

*Frazer Buntin is the President, Value Based Services, and Kate Rollins is the Vice President, Clinical Programs and Performance, at Evolent Health. They can be reached at FBuntin@evolenthealth.com and KRollins@evolenthealth.com.*
Current chapter role and responsibilities:
VP of Education, work with committee members to plan the education events for the Kentucky Chapter

Employer/job title:
Bottom Line Systems/Regional Director

Family consists of:
Husband - Brian, Son - Brady (4), and Step-Daughters Mikayla (18), Payton (16), Morgan (14)

When you were young what did you want to be when you grew up:
A kindergarten teacher, which now having a 4 year old I have learned was NOT my calling after all!

Favorite college team:
UofL

What music is on your phone:
A little bit of everything…country, old school hip-hop, and current hits

Favorite song:
No favorite song, I like too many

Favorite movie:
Pride and Prejudice

TV shows:
This is Us

Hobbies:
Attending UofL sporting events, reading, hanging out with my family

Most prized possession:
My family, hands down

Something that most people don’t know about you:
Living on a farm for several years, I know more about tobacco farming than you would think!

Pet peeve:
Definitely dishonestly

How do you relax:
On the rare occasion I do relax, I love to read!

Guilty pleasure:
Anything dark chocolate that I don’t have to share with my child

Dream job:
I don’t think I have a dream job, but I do enjoy what I do know and the company that I work for.
Giving you that extra oomph.

Your team pushes hard, but a little boost never hurts when challenges get steep. If accounting and advisory expertise is what’s missing, our health care pros can help propel you toward your goals with cutting-edge market analytics, operational improvements and strategic guidance.

Everyone needs a trusted advisor. Who’s yours?

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CMS Proposed Changes for Calendar Year 2019
5 Things You Need to Know

Author: Adam Shewmaker, Director of Healthcare Consulting Services, Dean Horton Allen Ford

On July 12, the Centers for Medicare and Medicaid Services (CMS) issued proposed policy, payment, and quality provision changes for services furnished under the Medicare Physician Fee Schedule on or after January 1, 2019. According to CMS, the proposed rule is part of a “broader Administration-wide strategy to create a healthcare system that results in better accessibility, quality, affordability, empowerment, and innovation.”

As with past proposed policy changes governing healthcare reimbursement and related matters, the 1,000 plus page document is scheduled to be published in the Federal Register on July 27, 2018, but is already garnering much attention relative to the proposed rule changes.

As stated by CMS, the major proposed rule address changes to the Medicare physician fee schedule and other Medicare Part B payment policies to ensure that payment systems are updated to reflect changes in medical practice and the relative value of services, as well as changes in statute. There are dozens of payment, policy, and quality provision changes outlined in the proposed rule, and the following are five with perhaps the most widespread impact.

Changes to Evaluation and Management (E/M) code documentation

Described by CMS as a way to streamline E/M payments and reduce administrative and clinician burden, the proposed rule would allow practitioners to choose how best to document the services rendered as part of the E/M encounter. CMS proposes the following relative to E/M documentation:

- to allow practitioners to choose to document E/M visits using medical decision-making or time instead of applying the current 1995 or 1997 E/M documentation guidelines, or alternatively practitioners could continue using the current framework;
- to expand current options by allowing practitioners to use time as the governing factor in selecting visit level and documenting the E/M visit, regardless of whether counseling or care coordination dominate the visit;
- to expand current options regarding the documentation of history and exam, to allow practitioners to focus their documentation on what has changed since the last visit or on pertinent items that have not changed, rather than re-documenting information, provided they review and update the previous information; and
- to allow practitioners to simply review and verify certain information in the medical record that is entered by ancillary staff or the beneficiary, rather than re-entering it.

E/M single blended payment rate

CMS is proposing a single payment rate for new and established patients for office/outpatient E/M levels 2 through 5. A series of add-on codes and modifiers to account for resources involved in furnishing primary care and non-procedural specialty generally recognized services may be utilized to supplement the primary code. To account for the assumed documentation efficiencies suggested in the proposed documentation changes, a series of multiple procedure payment adjustments are proposed that could further increase or decrease the visit reimbursement. Specialties such as podiatry, for example, may have new coding guidelines to adjust for value to such services. There undoubtedly will be winners and losers under this scenario as some specialties will experience a new flat reimbursement amount that is less than historical, while other practitioners may receive an increase due to their historical lower E/M coding levels.

Reimbursement for Communication Technology-Based Services

CMS is proposing to pay separately for two newly defined physician services furnished using communication technology:

- Brief Communication Technology-based service, e.g. virtual check-in (HCPCS code GVC11)
- Remote Evaluation of recorded video and/or images submitted by the patient (HCPCS code GRAS1)

To help modernize Medicare reimbursement, these two new codes are proposed as a means of creating more efficiency for practitioners and convenience for beneficiaries. The purpose of these two codes are to create a virtual check-in for the patient and to review a photo or video to determine if a face to face visit is needed. Additionally, new codes are proposed for chronic care remote physiologic monitoring and internet consultation.

CMS also proposes recognizing these communication technology-based services for RHCs and FQHCs, whereby those organizations would be able to bill a newly created virtual communications G-code for payment.

Medicare Telehealth Update

CMS proposes to add HCPCS codes G0513 and G0514 for telehealth services related to beneficiaries with end-stage renal disease (ESRD) receiving home dialysis and beneficiaries with acute stroke. Renal dialysis facilities, homes of ESRD beneficiaries, and mobile stroke units are also proposed as originating sites, while not applying the originating site geographic requirements for hospital-based or critical access hospital-based renal dialysis centers, renal dialysis facilities, and beneficiary homes, for purposes of furnishing the home dialysis monthly ESRD-related clinical assessments.

Discontinuation of Functional Status Reporting Requirements for Outpatient Therapy

CMS is proposing to discontinue the functional status reporting requirements for services furnished on or after January 1, 2019 relative to outpatient therapy. Originally, these documentation requirements were implemented as a system to collect data to better describe a patient’s functional limitation and severity at periodic intervals. Due to data that has already been collected, feedback received by CMS regarding the burdensome nature of this documentation, and changes to the statutory therapy caps, CMS is proposing to discontinue this reporting.

To learn how this could significantly affect your practice or for more information, contact Adam Shewmaker, FHFMA, Director of Consulting Services at Dean Horton. Ashewmaker@deandorton.com
CONGRATULATIONS!

Happy Anniversary!

50 Years
Paul Jacobs

45 Years
John Yeager

35 Years
Stephen Estes

30 Years
Gene Hornback
Lisa Reynolds
Curtis Zoeller

20 Years
Anne Sawyer
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10 Years
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EDITORIAL MISSION
The Financial Diagnosis supports the mission of the Kentucky Chapter by serving as a key source for individuals involving in or interested in the financial management of healthcare.

PUBLICATION OBJECTIVE
The Financial Diagnosis is the official publication of the Kentucky Chapter HFMA and is written and edited principally to provide members with information regarding Chapter and national activities, current and useful news of both national and local significance, information about seminars and conferences and networking with colleagues, and to serve as a forum for the exchange of ideas and information.

ARTICLE SUBMISSION
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