Hello Wyoming HFMA members,

It was good to see some of you at the Fall Conference in Cody, Wyoming. We had a great conference with outstanding speakers. Our dinner at the Buffalo Bill museum was excellent. They opened up part of the museum for us and we were able to wander around that part after dinner. Thank you, Barry, for being the program chair for the event.

Now it is time for the Spring Conference. It will be held March 13-15, 2019 at the Holiday Inn in Casper, Wyoming. Hope to see you all there. You will be receiving a “Save the Date” soon and also a registration email. As I have mentioned before, we are using Cvent as our registration platform. It seemed to work well for our last conference.

While I was at the HFMA Western Symposium, Joe Fifer, president of HFMA, presented at the opening and introduced the New All-Inclusive Membership. Starting January 24th the association introduced an all new all-inclusive, fixed price membership. Membership will increase to $425 giving members unlimited access to power their potential with career-building content, certifications and connections to help members stay on the cutting edge of what’s new and what’s next. For one price, members can unlock the following: certifications, content and online education and still have everything from before. This should be beneficial to us as members.

The board will be meeting prior to the conference for strategic planning. Any of you are welcome to join us. If you have any ideas or concerns that you would like us to address during this planning meeting please send me an email stating what you would like us to address for the upcoming year.

At this time I would also like to thank our sponsors. Without them we wouldn’t be able to have our conferences. We encourage you to attend our spring conference and take some time and thank them.

Hope to see you in Casper March 13-15th.

Chad Turner

Chad Turner
We are approaching a golden age in medicine, powered by hard-won advances in science and technology that enable treatments and outcomes that once were the stuff of science fiction. And yet for most patients, their healthcare experience remains firmly, and frustratingly, stuck in the past.

With all of its associated paperwork, insurance authorizations and administration, even a commonplace doctor’s office visit can be confusing—and far more so if a hospital procedure is required. The result is a distrust of the overall healthcare system for many, and a considerable population that is woefully underserved. This, despite Americans paying more for their care than patients do virtually anywhere else in the world.

Neil Jordan, general manager of Microsoft Health, says that the healthcare system has historically focused on the experience and satisfaction of patients last, rather than making it a priority. “We’ve grown up in a world where the expectation of the health system is that it takes action on patients, versus patients making their own choices,” he says. “While that is changing, there’s much yet to be done.”

In conjunction with adopting value-based care practices, which incentivize outcomes and efficiency, healthcare providers and payers are reimagining their practices to put patients and their experiences first. “They want to understand their patients more deeply so they can provide better service, but they also want to understand the demographics that enable them to manage and develop their own services,” Jordan notes.

In fact, by adopting successful practices pioneered in sectors like financial services and the hospitality or retail industries, tomorrow’s healthcare journey will get a lot more streamlined, more understandable, and transparent.

Radical Transparency

For most Americans, the U.S. healthcare system is defined above all else by a fundamental lack of transparency. For instance, as a consumer, it’s fairly easy to research the particulars of something when considering a purchase, whether it’s electronics, a car, or a house. However, attempting to do the same for a healthcare procedure—especially one that is complex—is far more difficult if not impossible.

Keith Roberts, vice president of engagement for Change Healthcare, says this disconnect at the last mile is the main point of friction for the prevailing patient experience. “Imagine if you went to a restaurant and received an exquisite meal. Then after months of back and forth with paper artifacts, the final bill arrives. Over several pages, the meal components are laid out: the farmer, the rancher, the distributor, the dishwasher—it is all itemized, with pricing for each. That meal is no longer as delightful in your memory as it was,” he says. “That is a ridiculous notion, yet for patients today it’s the status quo of their care.”

Roberts says radical transparency, not only in pricing but also in the choice of care itself, is fundamental to a new approach to healthcare. “That is where the friction occurs in the U.S. healthcare system, because we have patients seeking hope, health and healing, and they are instead confronted with a transaction or a customer experience that’s confusing,” he says. “It erodes trust in the entire system—including the provider who is giving a world-class clinical experience.”

The solution lies in engaging the patient directly and openly with all of the available choices—including quality ratings and pricing, and working with them to make the best possible decisions for their outcome. It’s also about communicating before, during, and after care in a way that is timely, orchestrated, and personalized. While that may not sound like rocket science, compared with most of today’s experiences, it’s positively revolutionary.

Customer Service Industry

Roberts says that the healthcare community could take guidance from successes in the retail industry, itself emerging from an epic transformation to create more personalized shopping connections with consumers. By taking a holistic approach to the patient relationship, providers will foster a dynamic that is complementary rather than adversarial, as it often feels today.

“The world’s best healthcare providers are not only world-class in the clinical experience, they are making great strides at becoming world-class in the customer experience itself,” Roberts says. “For patients, the goal is: Help me trust you, simplify things for me, and personalize my interactions for me.” To do that, it’s necessary to simplify healthcare interactions and present patients with highly relevant information when and where they need it, whether that’s before, during, or after care.

Today it’s common for patients to be involved in a plethora of administrative activities, from upfront securing medical authorization for procedures to...
providing financial and insurance information. “It can be a research project to understand your benefits, determine your financial responsibility, and negotiate with providers and payers to land on an acceptable outcome,” notes Roberts.

Following even basic services, there are multiple levels of communication between provider and payer, manual clerical processes, coding, verification, billing and more, all requiring multiple people, hours of work and perhaps weeks to complete. It’s a cumbersome, mostly manual, friction-filled process, and the output is still largely confusing for patients, breeding distrust rather than confidence in the system. But introduce technology, and the process can be transformed.

**Data-Driven Improvements**

As financial services and retailers have learned, translating data into actionable information is the fuel for customer relationship management. Healthcare providers and payers are focused on rapidly doing the same. In the clinical realm, data interpreted using artificial intelligence (AI) and machine learning processes can allow for faster, cheaper and better patient outcomes when used with diagnostic imaging tools and an expert clinician. But Roberts and Jordan say data and AI are also key for creating a vastly better patient experience overall.

From identifying and reaching out to patients with chronic conditions to simplifying patient statements, payers and providers are already using information and technology to create stronger ties with the patients they serve. “By applying AI and analytics, organizations can reason across different types of data to help people make better decisions,” Jordan notes.

But more can and is being done, particularly when it comes to reducing friction in the healthcare system. “Imagine knowing the price of a procedure, your financial responsibility, and the quality rating of your doctor—without 10 phone calls to piece it together yourself or secure the medical authorization,” says Roberts.

“Further, imagine that afterward you receive one itemized, accurate bill that reflects all the services you received for that care. That’s how you simplify the patient experience while building confidence and loyalty.”

**A New Patient Experience**

It is inevitable that, as with retail consumers, patients will elevate their expectations of service as they experience what’s possible when powerful data techniques are put to work. While everyone involved in the healthcare journey—patients, providers and payers—will benefit from better outcomes at lower costs, it is the patient who stands to gain the most.

“The expectation of the patient, the consumer, is that the interaction they have with the healthcare system is going to be so much more digital than it is today. And not only will that help them navigate their way around a very complex and fragmented system, but also stay much more engaged pre-, during-, and post-care with their treatment and their payments,” says Jordan. “Patients, really for the first time, will have the ability to understand and chart their own course.”

Change Healthcare is inspiring a better healthcare system. Learn more at www.changehealthcare.com.

*Developed in collaboration with CNBC Brand Studio.*
Health Care Trends to Watch in 2019

This time of year always elicits lists, so here are a few of the large trends I’m keeping my eye on.

The rise of the lawsuit. I see a continued trend of using lawsuits to fight new laws or regulatory policies. Lawsuits may be the only viable way for states, providers, payers and consumers to fight legislative and executive branch policies. For example, the ACA lawsuits continue, including the ACA recently being struck down in Texas v United States. Another ruling came out in favor of hospitals related to the 340B payment cuts (AHA, et al. v Azar, et al.), and a ruling is expected in 2019 on agency rulemaking authority (Azar v Allina Health Services). These are just a few examples. There are any number of other federal and state-based lawsuits underway as well.

The rise of the states. With split control in Congress, major health care policy change will stem from the states. Those will be from 1332 or 1115 waivers (which we discussed earlier this year in our article, Medicaid Waivers Bring Opportunities to State Programs), other Medicaid policies, new payment or delivery (like direct primary care) models and more.

The normalization of risk (value-based payments). Bundled payments for hips and knees are already mandatory in certain locations nationally, and HHS indicates continued interest in mandating other bundles, like radiation oncology and cardiac care. Along with other models, HHS finalized a new Accountable Care Organization model (Pathways) that pushes risk faster. And Medicare Advantage plans – what I’ve called the “Godfather” of the value-based movement – are rapidly growing. Risk-based models or contracts will become even more commonplace.

The shrinking health care margin. From hospital cuts to post-acute care payment changes, HHS wants to equalize what it pays across settings and/or pay for value. Add on to this that the next chairman of the U.S. Senate Finance Committee is none other than health care oversight guru Chuck Grassley, watch for more attention in DC on health care providers and cost. There is also increasing competition from new entrants and current competitors alike while overall costs (of drugs, labor etc.) have not decreased.

The growing concern with drug costs. What exactly will happen is yet to be seen, but there is strong (and often bipartisan) interest in addressing the costs of pharmaceuticals. HHS has pushed international reference pricing and allowed Medicare Advantage plans to have more negotiating power for drugs. Typically an ally to PhRMA, last year a Republican-led Congress dealt them an almost $12 billion hit. Provider-led Civica Rx is on track this year to produce its first batch of drugs in short supply. Drug costs will continue to be on the table, and innovations or policies to ensure access at better prices will be an ongoing focus.

The shifting marketplace. Whether it’s Apple or Amazon’s health care moves, the Cigna-Express Scripts or ProMedica-ManorCare deal, tons of mergers, acquisitions and partnerships (big and small) will continue in 2019, resulting in ongoing disruption in the health care sector.

The rise of virtual health, tech. Consumer wearables, virtual visits, telehealth, remote monitoring and much more will allow for more virtual care delivery. Blockchain, Artificial Intelligence, APIs, direct to consumer applications/services and biotechnology advances will continue making progress.

What trends are on your list for 2019?

Jennifer Boese is the director of health care policy at CLA. Her article originally published on CLA’s Health Care Innovations & Insights (HI2) blog. Subscribe to the HI2 blog at: http://blogs.claconnect.com/healthcareinnovation/.

Credit Collections Bureau was established in 1987. CCB currently has over 100 employees and several office locations. CCB has national agency size that produces locally expected recoveries. CCB offers standard 3rd party collection services as well as 1st party recovery services. CCB’s Strategic Mission is to utilize Amicable Recovery Techniques (SMART Collections) to best recover the dollars owed to you!
The transition from fee-for-service to value-based reimbursement is one of the greatest financial challenges in health care. Reduced admissions coupled with high deductible plans and movement to alternative visit methods hold the potential for increasing bad debt and decreasing revenue from acute care volume. Therefore, you need to review and track your denials in order to eliminate lost revenue. With the transitioning to value-based payments, denials management will play a major role in helping organizations maximize reimbursement.

Denials Rapidly Growing

Hospitals will need to review, track and trend the impact of denials management on the revenue cycle. Recent estimates show that gross charges that are denied by payers have grown to an alarming 15 to 20 percent of all claims submitted, and of those claims, roughly 67 percent of all denials are appealable. The top denials include:

- Claim lacks information or has billing/submission errors.
- Non-covered charges, service is not covered under the benefit plan.
- Precertification/authorization notification is absent.

This leads to issues such as lack of payment transparency and inaccurate or unfair payment.

Identifying Missed Revenue

To begin, you will need to look at the timely capture of charges by answering the following questions: Did you charge for all of the services that were provided? Did you code for all conditions that were documented by the provider? Does your facility perform internal audits to determine missed opportunities and take the time to identify issues? If not, you create the opportunity of missed revenue. Since value-based programs reward health care providers with incentive payment for the quality of care they provide, it is important that you capture and report all services that are documented from the provider to allow for the highest reimbursement amount for services rendered.

Items to include during the review of charge capture include:

- Reviewing the charge capture process for each clinical depart-

ment. This will identify any potential gaps, such as outdated charge slips.
- Following the charge through any system interfaces to ensure the charges are flowing through to billing as expected.
- Following the charge from the patient accounting system to the final edited claims sent to the payer. This involves a review of the itemized statement, pre-edited bill, post-edited bill and the insurance remittance.

Denial Management to Prevention

When you begin to track and trend denials, it allows for education to be provided to both providers and staff. In addition, it allows the opportunity to improve processes and to share in the satisfaction of improving and eliminating delays in the accounts receivable. Transitioning from denial management to denial prevention starts with making sure your staff understand the difference between a soft and hard denial.

The two types of denials are defined as follows:

- Soft Denial: A temporary or interim denial that has the potential to be paid if the provider takes effective follow-up action.
- Hard Denial: A denial that results in lost or written-off revenue. With these denials, an appeal is required.

Another opportunity is presented in reviewing your clean claim rate. What percent of edits impact the claims that you are trying to send out to your payors? Do revenue cycle leaders review and monitor claim scrubber reports ...Continued on Page 7
Continued from Page 6...

to identify manual processes, which result in delays to the submission of claims?

When you analyze the data, it is important to look at the people, process and technology in order to determine the source of the denial. A missed opportunity equals increased denials, increase accounts receivable and decreased patient satisfaction.

Your health care organization should develop a zero-tolerance mindset for preventable and avoidable denials. Process improvement should focus on breakdowns in prevention. Start tracking your denials today. After all, each denial is a loss of revenue!

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2019 SPRING CONFERENCE
CASPER
WYOMING
Mar 13-15, 2019
@ Holiday Inn Casper
*Please note that the schedule is subject to change.

WEDNESDAY, MARCH 13TH
1:00 - 4:00 PM ................. Strategic Planning Session/Chapter Successes Plan
4:00 - 5:00 PM ................................................................. Board Meeting
5:30 - 7:00 PM ............ Tour of Wyoming Medical Center & Hosted Dinner

THURSDAY, MARCH 14TH
7:00 - 8:00 AM .......................................... Registration & Breakfast
8:00 - 8:15 AM ................................................ Welcome & Announcements
8:15 - 10:00 AM ................... Speaker: Kevin McDaniel, Wind River Strategies
“You’ve Been Upgraded”
10:00 - 10:30 AM ......................... Break & Refreshments with Vendors
10:30 - 12:00 PM ......... Speaker: Kim Stanger, Holland & Hart
“Cybersecurity & HIPAA”
12:00 - 1:15 PM .................................................. Lunch & Business Meeting
1:15 - 2:15 PM.......................... Speaker: Amy Hayes, The Office Assistant
“Changes in Coding & Documentation”
2:15 - 3:30 PM .................................. Speaker: Shar Sheaffer, DZA
“Reimbursement Landscape”
3:30 - 4:00 PM ...................... Break & Refreshments with Vendors
4:00 - 5:00 PM ............... Speaker: Amy Canady, Collection Center
“Personality Traits”
6:00 - 8:00 PM ....... Dinner at Yellowstone Garage – 355 W Yellowstone Highway,
Casper, WY

FRIDAY, MARCH 15TH
7:00 - 8:00 AM .......................................... Registration & Breakfast
8:00 - 8:15 AM ................................................ Welcome & Announcements
8:15 - 10:15 AM ................. Speaker: Greg West, HRG
“CAH Leadership: The Revenue Cycle Leader—Run it Like You Own It”
10:15 - 10:45 AM ......................... Break & Refreshments with Vendors
10:45 - 11:45 AM .......... Speaker: Josh Hannes, Wyoming Hospital Association
“Legislative Update”
11:45 - 12:00 PM .................. Closing Comments & Adjourn

Details to follow later — for questions or suggestions, contact:
Barry Burkart, Wyoming Hospital Association
307-632-9344  •  barry@wyohospitals.com

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Ask for “HFMA” rate – $90/Night

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