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I am proud to serve as President of the HFMA Metropolitan NY Chapter and I feel privileged to be part of the distinguished list of healthcare leaders that have held this role before me. The Past President, the Board, Committee leaders and many others have worked hard to advance the chapter putting in the extra effort to ensure that the best educational and networking events are available for our members.

This year I would like to maintain many of the traditions that our chapter is known for however I would also like to bring forth innovation and new initiatives to align with National’s strategic plan to collaborate with payers and physicians, empower women and to engage early careerists this coming year. We will build on efforts to further develop a “Roadshow” program to bring education and relevant content to our hospitals and communities. The chapter will host a Women in Leadership Conference in early 2018 and we plan to collaborate with the health plan community to offer networking and speaking opportunities. As you may know we have embarked in a Mentee and Mentor program to give opportunity for mentees who strive to advance in leadership roles to learn valuable knowledge from a mentor’s experience and expertise while also providing them with the value of HFMA.

This year’s theme is “Where Passion Meets Purpose”. Carol Friesen, HFMA National Chair shares her personal story of a tragic accident and her family’s experience with the healthcare system. How she found passion in her work knowing that improving healthcare financial operations, allows for quality clinical care and has direct impact on the patient experience.

This theme is something that we all need to embrace. Our contribution is to lead healthcare finance. As leaders, we are met each day with the challenges to transform what we know into what our patients and families need. This year’s theme encourages healthcare finance professionals to find their passion. When passion meets purpose you become fulfilled in your role of helping others, life has meaning and you strive to do your best and be your best.

Our chapter is one of the largest in the country, we have the most dedicated volunteers and I encourage all of our members and new mentees to become more involved. The Officers, The Board of Directors & Committee Chairs are committed to leading this chapter through another successful year of providing quality education and networking opportunities.

We are very fortunate to have generous corporate sponsors that believe in our mission and enable us to carry out our events and programs throughout the year. Thank you for your continued support!

Maryann J. Regan
President
Greetings and a warm welcome to our first issue as co-editors of HFMA Metro NY’s quarterly magazine, Newscast. Hopefully, as you read this first edition you will have enjoyed some of the beautiful summer weather and perhaps a vacation or weekend away.

Of course Newscast is not a new venture, Marty Abschutz has handed off his editorship to us after many years at the helm and it is our hope and goal to maintain the same high standards of reporting on HFMA news. Marty’s volunteer spirit in Metro NY HFMA extends well beyond Newscast; he will continue to serve as a member of the Newscast and Corporate Compliance/Internal Audit Committees as well as on the Board of Directors. We thank Marty for being so generous with his time during this transition. It is our hope that Newscast will remain engaging and informative and, above all, useful.

Our first edition brings you the news, photos, features, and articles on a wide-range of Healthcare Finance Management topics that you’ve enjoyed in the past. What’s new is that we are developing sections that highlight our Metro NY leaders, past and present, and the chapter’s exciting, new mentor program. We are honored to share the work of so many dedicated members and volunteers. This issue highlights two of our chapter leaders, Diane McCarthy and Jim Petty.

As you read through the summer edition, you may also notice that we have changed the format a bit and hope that you enjoy the mix of photos and new features. We look forward to collaborating with all of our chapter members on the topics that are important to you. Please stay in touch – we are eager for your input and welcome all relevant submissions!

Enjoy the rest of the summer and we will see you again in the fall!

Alicia & Christina
### OFFICERS 2017-2018
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### Metro NY HFMA Newscast Schedule

**Electronic Publication Date**: 10/27/17

**Article Deadline for Receipt by Editor**: 9/29/17
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2017 IMPORTANT DATES

September 15, 2017  THE MID YEAR ACCOUNTING AND REIMBURSEMENT UPDATE SEMINAR  Uniondale Marriott

September 23, 2017  PAST PRESIDENTS’ DINNER DANCE  North Hempstead Country Club

September 26, 2017  MEDICARE FUNDAMENTALS: ELIGIBILITY THROUGH PAYMENT SEMINAR  NYU Winthrop Hospital Research and Academic Center

October 2, 2017  2017 HFMA METRO NY ANNUAL GOLF CLASSIC  North Hempstead Country Club

October 18-20, 2017  REGION 2 FALL CONFERENCE  Turning Stone Resort

FREE WEBINARS

August 31, 2017  CYBER SECURITY - CYBERCRIME  Local Webinar
MetroNY Spotlight on
DIANE MCCARTHY
CPA, FHFMA, Director of Finance, Episcopal Health Services, Inc.

The chance encounter that impacted my life and led me to a career in Healthcare was........
Having my conversation with a friend overheard by Chuck Zucaro leading to a position with
Blue Cross and getting my start in healthcare finance. This not only started my career but led
to me meeting my husband. We just celebrated our 30th wedding anniversary!!

Three words that best describe HFMA:
EDUCATIONAL
STIMULATING
CAREER-BUILDING

Serving on the Executive Board of the MetroNY Chapter is like being more than a part of a
team...it’s my HFMA family. I consider the Executive Board and many of the chairs and co-
chairs as friends. I am proud to be a part of this team and each individual I have come into
contact with have helped me to do a better job, be a better leader and a better person.

Hopes for the Industry: My hope is that everyone who has the power to make a change will
work collaboratively, with the goal being affordable health care for all.
At the Chapter’s 58th Annual Institute, our chapter came together to “give back” to those less fortunate in the communities that we serve. An area was designated to accept donations of canned food for Long Island Cares, Inc. - the Harry Chapin Food Bank. Long Island Cares supports over 575 Food Pantries, Soup Kitchens, and Shelters; Child Nutrition Programs and Veteran’s Service Programs in both Nassau and Suffolk Counties.

A special thank you to all who contributed!!!

---

May 10, 2017

Long Island Cares, Inc., - The Harry Chapin Food Bank

Gratefully Recognizes

METRO NY HFMA 58TH ANNUAL INSTITUTE

For The Receipt of

106 POUNDS OF DONATIONS

Thank you for joining us in our mission to ensure that more Long Island children and families do not go hungry. In addition to distributing more than 7 million pounds of food and supplies to our 580 member agencies, Long Island Cares, seeks to heighten public awareness about food insecurity and provides skills training to foster self-sufficiency among the population that benefits from our services. On behalf of all of the children and families served by Long Island Cares, William Gonyou, Community Event and Food Drive Manager, and I are truly grateful for your continued support.

Sincerely,

Paule T. Pachter, A.C.S.W., L.M.S.W.
Chief Executive Officer

---

Long Island Cares, Inc. - The Harry Chapin Food Bank
The Metropolitan New York Chapter of HFMA
Proudly Welcomes the Following New Members!

By Robin Ziegler, Membership Committee Chair

MetroNY HFMA is pleased to welcome the following new members to our Chapter. We ask our current membership to roll out the red carpet to these new members and help them see for themselves the benefits of HFMA membership. Encourage them to attend seminars and other Chapter events. We ask these new members to consider joining a Committee to not only help the Chapter accomplish its work, but to expand their networks of top notch personal and professional relationships. See the list of MetroNY HFMA Committee Chairs, along with their contact information, listed in this eNewsletter.

MARCH 2017

Smita Baliga
WithumSmith + Brown, PC

Pamela Roberts
Interfaith Medical Center

Mercedes Strier
SUNY Downstate

Andrew Rohil
Jzanus, Ltd

Maggie Alston

Kim Copeland
ALM Media, LLC

Paloma Hernandez M.S.
SUNY Downstate Urban Health Plan, Inc.

Jessie McIntyre
South Nassau Communities Hospital

Zachary Grauman
Veralon

Anthony Thompson
Empire BC/BS

Matthew Kamien
South Nassau Communities Hospital

Mary Ellen Connington RN,
MA, FNYAM
Advocate Community Providers

Dominick Setari
Montefiore Medical Center

Christina Iadanza
John T. Mather Memorial Hospital

Theresa Minieri
South Nassau Communities Hospital

APRIL 2017

Amanda Levine
Catholic Health Services of LI

Bryan Steed

Eileen Morales
NYU – Winthrop University Hospital

Matthew Robinson
NYU – Winthrop University Hospital

Jessica Sherrow
Catholic Health Services of LI

Jamy Pinto
NYU – Winthrop University Hospital

Kristen Coletto
Change Healthcare

May 2017

Jennifer Graves
Change Healthcare

Kevin Gregory
Aquiline Capital Partners

Benedict Baerst
Aquilina Capital Partners

Lila Han
Aon Hewitt

Mark Tomaino
Welsh, Carson, Anderson & Stow

W. Gregg Slager
EY, LLP

James Holihan
Montefiore Medical Center

Carmen Nieves
Optum 360

MAY 2017

David Asch
Val Health

Philip Chen

James Dowson
Vee Technologies, Inc.

Christian Furey

Coleen Hansen
NYU – Winthrop University Hospital

Kenneth Hom
Health – ROI

Mona Kelkar

Piyumika Kularatne
PWC

Julianne Pantaleone
Horizon BCBS – NJ – HNJH

Megan Quinn
Compliant Data Systems, Inc.

Vincent Satriano
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Marya Savola
JP Morgan

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Seshie Senyefia
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Vivek Venkataram
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WHEN PATIENTS PASS –
THE COMPLIANCE ISSUE EVERY PROVIDER NEEDS TO KNOW

By: Angela Horn, Esq., Vice President and Corporate Counsel at DCM Services, LLC and Forte, LLC

DCM Services is an organization dedicated to helping providers manage unique and specialty areas of revenue cycle such as probate. Probate is a creature of state law; managed by more than 3,450 courts across the United States to promote an efficient system for collecting and liquidating the assets of a decedent and making distribution to creditors and heirs. Nearly a decade ago, DCM Services conducted an informal survey of more than 100 health systems and other providers in an effort to understand current practices in the management of accounts for deceased patients. At that time, almost 85% of survey respondents indicated that they did not search for probated estates or file claims. Survey respondents also acknowledged that they knew there was opportunity to enhance compliance and gain substantial revenue by creating an effective estate strategy, but noted that they lacked the expertise and resources to search and file. Fast forward to today and we almost never hear this reply. Why?

Estate Revenue Cycle Challenges

The answer is simple. The convergence of important socioeconomic and demographic trends means that no successful provider can afford to ignore the opportunity. The baby boomer generation has aged into retirement, and the Centers for Disease Control (CDC) tells us that this group of people account for more than 75% of persons who pass away each year. By 2050, the number of people on Medicare who are 80 years and older will nearly triple; the number of people in their 90s and 100s will quadruple. We also know that, with regard to healthcare services, this group vastly outspends the number of people on Medicare who are 80 years and older will nearly triple; and the number of people in their 90s and 100s will quadruple. Finally, we know that self-pay percentages are rising for many providers by double digits year over year.

The end result is that revenue which at one time may have been thought of as a rounding error, or icing on the cake, has now become sizeable enough that it is imperative for providers to capture it as a matter of maintaining fiscal health. However, while many providers have recognized the value of estate revenue, they often miss the crucial compliance risks associated with failing to develop best practices in this area.

The CMS Requirement Many Providers Miss

Chief among the risks in the unique area of estate revenue cycle is failing to comply with 42 CFR 413.89 (e). This statute codifies the Centers for Medicare and Medicaid Services’ (CMS) requirements regarding bad debts, charity, and courtesy allowances, and it requires an estate search to be conducted and documented for every decedent whose bill goes on the cost report. CMS’ Provider Reimbursement Manual Part I §308 states that in order for a bad debt to qualify for the cost report it must meet four basic criteria:

1. The debt must be related to covered services and derived from deductible and coinsurance amounts.
2. The provider must be able to establish that reasonable collection efforts were made.
3. The debt was actually uncollectible when claimed as worthless.
4. Sound business judgment established that there was no likelihood of recovery at any time in the future.

Defining the Risk

§310 further defines the reasonable collection efforts as requiring a “genuine rather than a token collection effort and requiring documentation of those efforts.” Auditors and other compliance professionals have interpreted the CMS requirement that reasonable collection efforts were made in the context of a patient who has passed away to mean that:

• An estate search has to have been conducted with the courts
• Those search efforts have been documented. It is noted that reliance on a family member’s statement is not sufficient.

Examples of sufficient documentation used to determine that a deceased patient has no estate may include a screen print of system used for inquiry or a signed attestation from the Registrar Office of Wills. CMS has given guidance indicating that providers must retain evidence showing the date on which a search was conducted in a screen print or in the electronic system of record.

Despite the fact that the language of the statute has been essentially the same and in place for decades, it may be that many providers are unaware of the requirement until they are audited to the specific estate-related mandate. If this is the case, and the provider is unprepared, it can stand to lose hundreds of thousands or millions in reimbursement dollars.

1 K. Knight, A. Horn and D. Tran, HFMA Summary of Survey Responses, Research Conducted From HFMA Members, Oct. 2009.
5 “Medical Cost Trend: Behind the Numbers 2015”, Health Research Institute (June 2014).
7 Ibid §10
10 §42 CFR 413.89 enacted in 1982, Rev. 1996.
IMPORTANT STEPS IN PREPARING YOUR ORGANIZATION

Proactive Identification Is Key

In order to be prepared as a provider and not find yourself surprised by an audit, procedures must be put in place to insure that all of the bills for patients who have passed receive estate searches. Since the Provider Reimbursement Manual requires that the provider’s effort to find an estate and file a claim be a bona fide and similar to any effort that would occur for non-eligible debts, the process should be the same for all accounts. This includes patients who pass both inside and outside of a facility. Often, a provider is unaware that a patient has passed if the death occurs outside the facility. There are many cases where it can take an extended period of time to learn of the death when a provider relies on family or other reactive notification of a patient’s passing. The probate code of each state assigns a finite time in which to file claims, and in the majority of jurisdictions the time for providers to present their claims is as little as 60 or 90 days from the opening of the estate and appointment of a Personal Representative. This means that even providers who do search for estates often find them too late and fall out of compliance with the requirement to make genuine efforts to collect. It makes sense that, in order to comply, a provider should put in place one of the available decedent identification tools to proactively identify all patients who pass in a timely fashion.

Comprehensive, Continuous Searches Overcome Compliance Hurdles

Claim filing windows are brief as noted above. However, while the requirement is clear that an estate search must be conducted and it must be directly with the court or with a search engine which interfaces with the courts. Estates can take months and even years to open and 15 to 20% of the time, those probated estates are in a court which is somewhere other than the venue which corresponds to the patients last address. If an estate is not located at the last address in provider records, it could be in any of the 3,450+ probate courts in the US. Since the effort to collect on a debt by finding an estate must be genuine and not token, it follows that repeated and comprehensive searches are required. A provider could not search, for example, weeks after the patient passes and conclude that there is no likelihood of recovery in the future. A manual search conducted in a single location is also likely to miss a significant percentage of estates because those estates will open in a location other than the address of record.

Efforts will be for Naught without Documentation

We have all heard of the philosophical question posed initially by George Berkeley in his work, “A Treatise Concerning the Principles of Human Knowledge,” which can be paraphrased as asking whether a tree that falls in a forest with no one to hear it actually falls. To be certain, it is true that a provider who fulfills its duty by conducting even comprehensive and continuous searches falls short of compliance if those searches are not documented so that an auditor can see evidence of those searches. The CMS Provider Manual further requires documentation of reasonable collection efforts. Whether a provider is using an automated tool or manually conducting estate searches, there must be a process in place to secure real time documentation should an audit occur. This documentation should include one of the items described above, such as screen prints or reports from a search engine, notes from conversation with probate courts in the providers system of record made concurrent with those conversations, and/or correspondence both to and from the probate courts which corroborates a request and a reply.

The Components of a Successful Strategy

While understanding the requirements of a compliant estate strategy is key, what matters most is what you do with that information. Turning again to the survey of more than 100 health systems regarding estates, remember that the number one self-described hurdle to putting in place a successful strategy was not financial constraints or even information technology resources. The major hurdle was a lack of expertise or confidence in their own internal knowledge base. In order to surmount this challenge, a provider first needs to conduct proactive searches to timely identify both decedents and estates.

References

22 PRM 15-1 §308, §310.
24 E.g. DoD FinderTM ; LexisNexis®, Social Security Administration DeathMaster
27 Provider Reimbursement Manual Ibid.
28 See Probate Finder® and Probate Finder OnDemand®
30 PRM 15-1 §310
31 Cited supra notes 6 and 7.
Secondly, it is important to have a good mechanism to produce documentation which details the evidence of searches and search results. Providers will also want to have a process in place to produce the required claim packages in the event that an estate is located, and a process to manage those claims to collect on the sums owed. This can be a bit tricky as there are more than 3,450 probate courts in the U.S. and estates can be located in any of them. In 15-20% of cases, probate is opened in a location other than the address of record. This phenomenon may be for any number of reasons, but most often occurs when patients are traveling for care or have multiple residences. Each court has unique requirements for its claim packages including forms, affidavit requirements, filing fees, number of copies, and even the color of paper and ink.

The process will also need to manage claim filing deadlines which, as noted previously, can be as short as 60 days from the opening of an estate. Any process for finding estates should be able to search proactively for decedents and estates to insure timely filing. This means that nationwide, proactive searches are a requirement. Once a claim is filed, putting in place a process for claims recovery is also important. We have learned that while the filing of a timely and valid claim entitles a provider to the assets available for its class of claims and provider claims can take priority, an optimal post-claim collection strategy can produce more revenue and even expedite payment.

Finally, depending on the resources available internally and your overall revenue cycle strategy, you may choose to acquire the tools and the knowledge to build a self-managed process, or you may choose to partner with an expert to build your estate strategy.

**The Rewards of Compliance**

In conclusion, while compliance with 42 CFR §413.89 and the rules described in PRM 15-1, sections 308 and 310 will mean real dollars and cents for every organization who can prove it is entitled to reimbursement when they have searched, documented that search and not found an estate, there is a very sizeable opportunity for nearly all providers when they do find an estate. When an estate is timely located, the provider has a chance to present a claim and receive payment to the full extent of its claim and estate assets. In fact, many state probate codes recognize a health care provider’s services at or near the time of passing take priority and are paid over all other general creditors’ claims. As providers continue to strive to meet today’s regulatory and economic challenges, it is worth taking a moment to recognize that every now and then, like with estates and the CMS requirement, the two challenges coalesce and the benefits of best practice are twofold!

---


**Author Bio**

Angela Horn, Esq. is Vice President and Corporate Counsel at DCM Services, LLC and Forte, LLC. Ms. Horn specializes in the area of probate and probate litigation. She has more than a decade and a half of experience in these practice areas, and is a nationally recognized expert in the area of probate and creditors rights. Ms. Horn frequently speaks to regional and national organizations on the topic of probate and estate recoveries, and has written articles and been interviewed for national publications including HFM, Credit and Collections Risk, Fierce Health Finance, Healthcare Finance News and Long Term Living magazines. Ms. Horn also participated as an expert panelist in the Federal Trade Commission’s Workshop on Debt Collection and Technology. She is a Phi Beta Kappa graduate of the University of Minnesota and a Cum Laude graduate of Lewis and Clark Law School. She is a member of the American Bar Association’s Estates and Trusts Division and is admitted to practice law in New York, Minnesota and the U.S. District Court for the District of Minnesota.
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The HFMA Metro New York Mentor program is designed to allow the mentor and mentee to share experiences and observations in the industry. The program encourages involvement and participation in the educational mission of the chapter.

Program Criteria:

- The Mentor Program Subcommittee will review all applications for consideration in the Mentor/Mentee program. The application will be submitted to the Mentor Program Subcommittee and the selection process will be made based on a blind review by the committee.
- The Program will assign the Mentees to a Mentor in the Healthcare industry.
- The Program will offer up to ten (10) free memberships to the HFMA Metro chapter.
- The Program will provide vouchers for two (2) free seminars over the course of the education year.
- The Program will arrange a minimum of three (3) small group meetings/conversations with industry leaders.
- The Mentor Program Subcommittee encourages periodic meetings between the mentor and the mentee at chapter educational programs and social events.
- The Mentor Program subcommittee will be monitoring the program and will be available for any questions which may arise.

Criteria for becoming a Mentee
- Submit the Mentee application
- Sign up for a subcommittee
- Be available for face-to-face quarterly meetings
- Maintain phone/contact with Mentor
- Commit to the program for a minimum of one year

Criteria for becoming a Mentor
- Submit the Mentor application
- Be available for face-to-face quarterly meetings
- Maintain phone/contact with Mentee
- Commit to the program for a minimum of one year

Questions regarding the program can be directed to HFMA Mentor program@millermilone.com
By: Mike Ashley, Vice President, Lancaster Pollard and Henry Tracy, Associate, Lancaster Pollard

Since the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was signed into law, uncertainty has loomed over Medicare providers. The Act is slated for implementation on January 1, 2019, and will use clinician performance data from 2017 in determining payment for future reimbursement. The law passed with strong bipartisan support as it effectively eliminated the sustainable growth rate formula, which posed reimbursement risks in the event of economic downturn. Policymakers are optimistic the changes will support advancement in electronic health records and an increased focus on quality of care, while simultaneously implementing cost savings.

The Programs

Under MACRA, two new payment tracks will influence Medicare payments: Merit Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

MIPS is the default payment system for Medicare B clinicians, including: physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists. Clinicians billing more than $30,000 a year and providing care for more than 100 Medicare patients a year are categorized under the program. In a cost savings effort, MIPS will evaluate the following categories:

- Quality measures
- Cost measures
- Improvement activities
- Advancing care information

The program seeks to implement a payment system on value as opposed to quantity. This transition won’t be without its challenges, however, as many providers note quality measures do not always take acuity into account. Caring for high risk patients can affect quality measures and subsequently reimbursement. Further, CMS outlines 271 quality measures where clinicians are required to select those that best fit the individual practice. The quality metric is expected to be the most influential category in determining MIPS scores, accounting for 60% of the final score in the transition year.

As for APMs, clinician groups that participate in that program are eligible to earn a 5% annual payment increase and will be exempt from the MIPS program. Initially, APM participation is expected to be low, but over time, CMS expects to see more providers improve electronic records and participate in the alternative program. APM eligibility requires the following qualifications:

- Structure and use of quality measures comparable to the characteristics defined under MIPS
- Full demonstrated use of electronic health record (EHR) technology
- Demonstrates a “more than nominal financial risk”

Figure 1: MIPS Process Timeline

Source: https://qpp.cms.gov/
For the transition year, CMS created a “pick your pace” option, allowing providers to either: submit partial data after January 1, 2017 and report for a 90-day period after that date; or fully participate starting January 1, 2017. Providers who do not participate in one of the outlined programs are subject to a negative 4% reimbursement adjustment.

Eligibility Exemptions

Due to low volume (defined as 100 Medicare patients), rural and critical access hospitals are exempt from the new regulation. Skilled nursing facilities (SNFs) will continue operating under the Prospective Payment System (PPS). Indirectly, these providers will experience broader CMS changes gearing toward more transparent patient data and a renewed focus on quality of care.

Adjustment Period Timeline

Under the MIPS program, providers must submit their provider data by March 31, 2018 to receive an adjustment in January 2019 (Figure 1). In the interim period, feedback is available and the data will likely undergo an iterative review process.

Are Providers Ready?

In a recent Health IT Industry Outlook Survey of health care professionals conducted by Stoltenberg Consulting, 64% of respondents indicated they are either “unprepared” or “very unprepared” for managing and executing MACRA initiatives. Clearly, there is much work to be done, and respondents reported they believe preparing for MACRA should be a group effort. Sixty-eight percent of respondents believe preparing to comply with MACRA should be the responsibility of clinical, financial and IT departments. As for specific MACRA challenges, the top two cited concerns were “revising data management/reporting mechanisms to meet new reporting requirements” at 31% and “motivating the entire organization to collectively work together to achieve goals” at 29%.

In addition to reporting the survey results, Stoltenberg Consulting offered four tips for health care organizations who might be struggling in preparing for MACRA.

1. Hire the right IT staff. Effective health care IT requires a specialized skill set and organizations that invest in highly-qualified professionals will be a step ahead of those that don’t.

2. Invest in staff training. In addition to hiring qualified IT candidates, organizations should invest in their current staff to ensure they are knowledgeable not only from a technical perspective, but financial and clinical as well.

3. Team effort. For MACRA to be successful, staff will have to work together and combine their expertise to ensure data is captured, maintained, and analyzed in an efficient and effective manner.

4. Have a plan. Stoltenberg recommends adapting a multiyear MACRA roadmap created by a specialized team at the organization. This will allow organizations to more efficiently improve their program from year to year.

The Future of MACRA

MACRA is expected to be a cost-saving measure that will continue to generate bipartisan support. Knowing this, it seems unlikely the change in administrations following the presidential election will result in the repeal or delay of the program. It should be noted, however, that any modification to the program will have budgetary consequences and how those will be dealt with in regard to the administration’s overall budget remains unclear.

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The best people in life are those that volunteer. I have made many great connections with wonderful people as a result of HFMA, both locally and nationally.

Hopes for the Industry: I have heard that the “sky is falling” for nearly 40 years, yet somehow, some way, we are always able to adjust and adapt. We should always think positively because people will always need healthcare. I hope that the population at large learns to take responsibility for its own wellness, and that future healthcare systems create meaningful incentives to accomplish this.
The Importance of Credentialing

The process of credentialing refers to both obtaining approval for a provider to practice at a hospital (i.e. privileging) and to be reimbursed for services by a particular payer. Both processes require satisfying many criteria, including proof of identity, education, training, licensing and board certification, as well as verifying malpractice insurance and reviewing any claims or investigations of fraud, abuse or misconduct. A robust, comprehensive credentialing program is key for every healthcare provider organization.

Credentialing helps to ensure providers are qualified to provide high quality care, a key piece of patient safety. A lapse in credentialing status can be a violation of payer contracts, potentially jeopardizing revenue from payers and other federally funded programs. A lapse also exposes hospitals to possible negligence and malpractice claims, which can be costly to an organization’s reputation and finances. Further, failing to institute proper quality controls can reduce revenue in a value based reimbursement environment, a source of revenue that is likely to continue to grow.

Deciding Your Credentialing Approach: Balancing Investment and Control

Deciding whether to outsource credentialing or manage the process in house depends on your organization’s ability to invest time and resources as well as the organization’s desire to have control over the process.

Organizations willing to invest heavily in resources and technology in exchange for the most control should consider pursuing a delegated in house credentialing model. This option typically makes the most sense for large organizations. Investing in this model requires hiring and training credentialing staff to remain current on accreditation standards and payer contracts, maintaining the proper staff to provider ratio, as well as supporting an internal audit team. Technology is needed for internal Key Performance Indicator (KPI) monitoring, automated tracking of payer contracts, and provider documentation due dates. System integration is also critical to provide an accurate, real-time list of providers across all platforms.

Pursuing the non-delegated path requires less investment, but requires dependence on payer timelines to credential physicians. A dedicated department or individual, depending on the size of your organization, is needed to maintain this process for the provider, and should still be supported by an internal tracking system of payer contracts and due dates.

Outsourcing requires minimal investment in technology, hiring and training, but depends on the vendor to credential physicians. Technology and training are managed externally in exchange for a vendor fee. Clear processes and vendor management responsibility will need to be established and maintained, but require the least time and energy once the vendor has been selected and implemented, assuming the vendor follows processes as expected.

Managing the Credentialing Life Cycle

Staying on top of the credentialing life cycle is critical to maintaining compliance, accelerating physician onboarding, and preventing lapses in credentialed status.

To accelerate incoming physicians’ ability to gain credentials, coordinate with physician recruitment to make start dates contingent on submission of credentialing documents. Beginning with prospective candidates, providers should be aware of the credentialing process and what they will need to accomplish before seeing patients, including any required documents and expected timelines. As soon as they have accepted their offer, new physicians should begin the credentialing process. Coordinate with payers early by sending out prepared contracts when final offers are given to prospective physicians.

Preventing a lapse in credentialing status starts with an internal work-queue of anticipated or known due dates for credentialing activities. To emphasize the importance of current credentialing, appoint physician champions to promote credentials maintenance and encourage timely submission of documents. Develop a relationship with payer contacts to keep communication channels open, stay on top of deadlines, and have a forum to escalate potential issues. Coordinate with internal mail delivery systems to ensure timely distribution of hardcopy notifications from payers.

Organizational Controls to Monitor the Credentialing Process

Once the credentialing approach has been decided and processes have been established throughout the credentialing life cycle, controls should be put in place to monitor, maintain, and correct issues as they arise.

Particularly for organizations with delegated credentialing from payers, remaining audit-ready is critical to protecting revenue, and begins with internal strategies to establish, educate, and enforce organizational credentialing priorities. A policy and procedure committee should maintain organizational policies based on regulations, accreditation standards, and payer contracts and
communicate them to staff in a timely fashion. This is critical to organizational awareness and alignment on credentialing requirements. An internal audit group of independent auditors with knowledge and expertise of audit processes, all relevant policies and procedures, and audit templates can provide objective feedback to keep the organization ready for the real deal. A process for escalating and monitoring providers who are at risk should be installed, with provisions to terminate providers who do not maintain appropriate status. Formal training during onboarding and periodic refreshers for existing employees should use lessons learned from past audits as training points to avoid repeating mistakes.

Understanding the health of an organization’s credentialing process requires establishing credentialing KPIs and monitoring them against benchmark values. Average credentialing time should be monitored to reduce onboarding time for new physicians, reduce risk of a lapse in credentialed status, and maximize physician productive time. Organizations should strive to stay below the industry target of 60 days average credentialing time, and take immediate corrective action if this KPI exceeds 90 days.

Tracking denials and adjustments related to credentialing is a useful indicator for measuring effectiveness of the credentialing process. This can be done by generating a report on the total number of claims denied and number of accounts written off due to incomplete credentialing. Finally, a lapse in credentialed status for physicians in your organization indicates a breakdown in the re-credentialing process, which should be reexamined to determine where the breakdown occurred and how to resolve it going forward.

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Lauren is a Manager in PwC’s Health Industries Advisory practice, based in New York, NY. She has over nine years of experience improving efficiencies of providers. Lauren is experienced in both the clinical and financial aspects of healthcare and has assisted organizations in aligning value and quality. As a Certified Provider Credentialing Specialist (CPCS) through NAMSS, Lauren has helped organizations achieve revenue growth by improving credentialing practices.

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Emily Anne is a Manager with PwC in the Boston Healthcare Industries market. She has significant experience in physician and clinician credentialing, hospital revenue cycle, medical staff offices, price transparency, and patient access. She possesses 9+ years of healthcare experience and is HFMA CHFP certified. Emily Anne earned a BA from Swarthmore College and an MBA from Goizueta Business School at Emory University.

Spencer Budd
Associate, Denver, Colorado

Spencer Budd is an experienced Associate in PwC’s Health Industries Advisory practice based in Denver, CO. He has significant experience leveraging industry best practices to drive financial performance improvement with both payers and providers.
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YOU’RE NOT DISCHARGED?

By: Elizabeth Murphy, Esq.

Many times, hospitals' length of stay issues are not due to medical reasons, but to financial reasons due to inadequate insurance coverage. Your typical patient who wants to be discharged home from the hospital with care rather than to a skilled nursing facility may remain in that bed for much longer until the appropriate financial pieces and care are established at home. Most insurance companies don’t cover the hours necessary to care for a patient at home and patients must apply for Medicaid to supplement their home care.

The Lengthy Process:

The process from filing a Medicaid Application to having home care in place could take 4-6 months, assuming all of the requisite documentation needed is obtained and the patient is below the resource and income levels required for eligibility and no transfers need to be made. The agency has 45-90 days to process the application. Upon approval, the patient’s spend-down is determined and if applicable, the patient can enroll in a Pooled Income Trust to shelter excess income. Proof of enrollment is forwarded to the agency to adjust the budget since Medicaid would appear inactive if the patient has a spend-down. This could take 30-60 days, delaying services because some Managed Long Term Care Plans (MLTCP) won’t begin services unless they receive payment for the spend-down.

Once approved, patients have to qualify for community based home care (CBHC) and enroll in an MLTCP for home care services to commence. A Conflict Free Assessment is requested from the State to determine an applicant’s qualification for CBHC. Maximus has 5-7 business days to make an assessment which is good for 60 days. After Maximus approves, the applicant contacts MLTCPs to assess and approve appropriate hours of care. The date the patient enrolls in the MLTC determines when coverage commences.

New Shorter Procedure:

Although this process remains the same for many applicants, effective July 2016, for those who can show they have an Immediate Need for personal care or Consumer Directed Personal Assistance (“CDPAP”), the NYS Department of Health has implemented a faster procedure via Administrative Directive 16 ADM-02. The agency is required to review an application within 4 days of receipt. Once complete, the agency must determine Medicaid eligibility within 7 days. Within 12 days of approval, the agency must assess the client at her home, determine her eligibility for services, and authorize services in an amount they determine.

If a patient already has Medicaid, the directive provides that she submit an attestation form certifying an “immediate need” along with a physician’s order for home care to the local agency. Each county may have a different form for the physician’s order. If a patient does not have active Medicaid, a completed application and Supplement A must also be submitted.

To qualify for “immediate need” you must show: (1) you have no informal caregivers available, able, and willing to provide or continue to provide care; (2) you are not receiving needed help from a home care services agency; (3) you have no adaptive or specialized equipment or supplies in use to meet your needs; and (4) you have no third party insurance or Medicare benefits available to pay for needed help.

The patient will eventually need to enroll in an MLTC if she is a dual eligible and requires more than 120 days of care. Hopefully, this streamlined process will assist hospitals with their length of stay obstacles.

Elizabeth Murphy, Esq. is a Senior Associate at Miller & Milone, PC who works with Institutional and Private clients in obtaining community and chronic care Medicaid, attends Fair Hearings, and handles Estates matters. Ms. Murphy received her JD from Touro Law School and is licensed to practice in New York. In 2014 she was selected to Super Lawyers Rising Stars, New York Metro area. She is a member of the New York State Bar Association Elder Law section and the Nassau County Bar Association Elder Law, Social Services & Health Advocacy Committee.
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