MS HFMA

November 2021

PUBLICATION FOR THE MISSISSIPPI HEALTHCARE FINANCE COMMUNITY

Mississippi Headlines

info@mshfma.org

hfma mississippi chapter
healthcare financial management association

OFFICIAL NEWSLETTER OF THE MISSISSIPPI CHAPTER OF HEALTHCARE FINANCIAL MANAGEMENT

President's Message

Andres Posada, President

As I sit here writing this message from the airport after attending HFMA's national conference in Minneapolis, Minnesota, I cannot express the happiness it brings me to finally be able to be back on-site at our conferences. This marks the second conference in November I have been able to attend since the pandemic, and it was wonderful getting to see so many familiar faces. I can honestly say that Region 9 and HFMA's Annual Conference were both a huge success even with the challenges of COVID. This brings me great hope that our meeting in December will also be a wonderful event.

Speaking of our December conference, for those of you who have not been able to register, our event is December 1st through the 3rd. We have great sessions in store for you coupled with great social activities!! This will be the Mississippi Chapter's first on-site meeting since the pandemic began. We have had to cancel some meetings and make some meetings virtual, but this is it! The time has come for all of our members and sponsors to be back under one roof!! As I mentioned earlier, it was great to see so many familiar faces at Region 9 and the Annual Conference, but this will not compare to when I get to see all my Mississippi friends back in Biloxi, MS. I really hope that many of you accept this invite and join us in December. It is time to show the association that Mississippi is back!!

Not to dim the light to our December event, but as we look ahead into 2022, please plan to attend the HFMA MidSouth Institute January 26th through 28th. In addition, mark your calendars for April 20th through 22nd when we'll be back in Biloxi, MS, for our Annual Conference. At this meeting, we'll be able to introduce our future officers and board members, which no doubt will do a great job representing the MS chapter in the future. We will also have an opportunity to thank the officers and board members who served during the pandemic and whose term is coming to an end.

With 2022 just a little over a month ahead of us, let's take some time this holiday season to be thankful for our family, friends, health, and everything else that makes our hearts beat with happiness. The past couple of years have been difficult for all of us, but positive attitudes and thankfulness for all the little and big things make everything worth it.

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

Warm regards,

Andres Posada

President

Mississippi Chapter of HFMA

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Upcoming educational opportunities

Save the Date!

MS HFMA Summer Institute December 1st thru 3rd, 2021

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12 CPE HRS

REGISTER

Midsouth HFMA Annual Conference

Jan 26th thru 28th, 2022
Gold Strike Casino, Robinsonville, MS

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SAVE THE DATE

MS HFMA Annual Conference
April 20th thru the 22nd, 2022

hfma healthcare financial management association

MISSISSIPPI HEADLINES

PUBLICATION FOR THE MISSISSIPPI HEALTHCARE FINANCE COMMUNITY

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All article submissions must be typed and submitted as a Microsoft Word document.

Please email your submission to:

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Mississippi HFMA…Your Educational Resource...

HFMA's Online Membership Directory

Have you visited HFMA's Online Membership Directory lately? Log in at **www.mshfma.org** or

http://www.hfma.org/login/index.cfm. When you select "HFMA Directory," not only can you search for members of your chapter, you can also search for all your HFMA colleagues by name, company, and location—regardless of chapter! Using an online directory instead of a printed directory ensures that you always have the most up-to-date contact information. While accessing HFMA's Online Membership Directory, you can view your current contact information and make edits to your profile. You can also see products you have ordered, events you have registered for, your CPE credits, your Founders points, and more! It's vital that HFMA has your correct information, so please take a moment to review your record now. By doing so, you'll ensure that HFMA continues to provide you with valuable information and insights that further your success.

HFMA Membership Benefits

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

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

To learn more about the benefits of your HFMA membership visit **http://www.hfma.org/Membership/**.

WELCOME TO OUR NEWEST MEMBERS!

Mason Graves, Revenue Manager	University of Mississippi Medical Center
Michael Wilson, Accountant	Medical Management Systems
Baxter Howell, Senior Associate II	BKD, LLP
Abbie Smith, Associate	HORNE, LLP
Kristi Wiggins, Denials Management Specialist	Trinity Health
Walter Tolero, Careerpath Analyst	Optimum Healthcare IT
Brian Enis, COO	Kanopy Healthcare Partners
LaToya Baker, Student	
Jessica Washington, Director of Business Office	Trace Regional Health
LaDarrion Grant, Assurance Associate	HORNE, LLP
Kelli Holway, Admissions Manager	Magee General Hospital
TK Kimmel, EVP	Equipro Investments
Nicholas Isbell, Manager Cash Application	North Mississippi Health Services
Kimbery Voyles, Student	

Denials Management - Organization for Success

Beth Jones, Director Revenue Cycle Solutions Project Manager
Trilogy Revenue Cycle Solutions

The struggle to manage denials is real. Most facilities do their best to keep up but are often overwhelmed about where to start.

Create a Team

Create a Denials Management Team with a defined leader, C-Suite executive support, leaders from each revenue cycle area, such as Billing, Patient Access, HIM/Coding, Case Management and I.T. Define objectives and team responsibilities, reporting, goals, monitoring, KPI review and round table discussions. Don't just talk about it. Take actions! Here are a few key functions to consider.

Check your system

Each Electronic Health Record (E.H.R.) patient accounting system has a file maintenance table for appropriately classifying both CARC (Claim Adjustment Reason Codes) and RARC (Remittance Advice Remark Codes). Review current settings with Washington Publishing /CMS codes (291 codes available) and see WPC (Washington Publishing Company) complete list. We often discover most manual work can and should be automated if the system is set up correctly. This is a crucial step to complete.

Talk to the back-end billing/collections staff assigned to work partial payments/denials. Are they manually writing off balances off that should be automated? Are denied charges included in the contractual adjustments or patient responsibility? Do staff move co-pay, deductibles, and coinsurance to patient responsibility?

Also review the Claim Adjustment Group Codes grouped with the CARC code on the EOB. These codes along with the CARC code are associated with an adjustment, meaning they must communicate why a claim or service line was paid differently than it was billed. Each CARC should have a Group Code assigned so as to identify how the payment/denial is further handled within your system. This review is payor specific. Below are the 5 EOB claim adjustment Group Codes:

CO- Contractual Obligation

CR- Corrections and Reversal

OA- Other Adjustment

PI- Payer Initiated reductions

PR- Patient Responsibility

Make the necessary system updates internally or place a service request ticket to table file owner. This process takes time and is cumbersome to complete. Make sure you assign this to someone who understands how the settings affect patient balances and are payor defined. Example: Blue Cross Blue Shield may be different than Medicare or Medicaid. This exercise takes the longest to complete but is the foundation for routing workflow.

Analyze

Once your table files are set appropriately, analyze data daily, weekly, and monthly:

- 835 EDI remit denials
- Accounts written off due to denials by transaction alias
- Sort out the top denials by reason for highest balances and # of denials

You will uncover issues that need to be addressed with Coding, Billing, Registration, Case Management and Managed Care staff as well as clinical documentation by providers/physicians and nurse practitioners.

Denials Management - Organization for Success Continued...

Education and Communication

There is a difference in a denied vs a rejected claim. Staff education is key. Investigation skills are a requirement for billing staff to perform a root cause analysis. Educate staff to review the EOB/ERA for insight into root cause and potential resolution. When all else fails call the payor.

It is important to educate staff on payer specific appeals and claim resubmissions processes. Develop cheat sheets for clinical and technical appeals teams by payor such as:

appeal templates, claim submission timely filing limits, appeal timely filing limits, and payor address/electronic submission instructions

Set Goals/Measure

Set goals based on industry standards and best practices. Measure denial KPIs and report them in monthly denial meetings. HFMA has map keys to calculate denial metrics several different ways and for trending indicators of denied claims. Review and measure what is best for your facility.

Develop an internal policy for denials management. Outline each area's responsibility, meet at least monthly to measure, monitor/audit, and repeat. If you need assistance building your denials management program or an assessment of your revenue cycle operations, you can contact Trilogy Revenue Cycle Solutions for assistance in getting your organization set up for success.

Beth Jones
Director, Revenue Cycle Solutions Project Manager
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972-831-0501

Annual Conference 2021 Thank you to Andres, Roze, Amy, and Suzette for attending and representing MSHFMA!

A Clear Path to Standardized, Medicare Cost Report Reimbursements and Cloud-based Technologies

By Dave Frank (CEO, F2 Healthcare) & Laura Gillenwater (Senior Manager, HORNE LLP)

Healthcare information technology has had a long run of standardization and continuous improvement. Companies like EPIC, Cerner, and Meditech coupled with niche bolt-ons have made their mark optimizing most parts of the revenue cycle through technology. Although there is still room to optimize many of these components further, the improvements in efficiency and effectiveness thus far are incontestable.

Outside but connected to the typical revenue cycle of a health system are Medicare reimbursements reported through Medicare cost reports annually. In the typical health system, and definitely when viewed through the lens of national systems and standards, these "back-end" revenue streams have been left woefully behind and technologically dormant. Too many reimbursement leaders still find themselves manually preparing reports, scrambling for documentation to satisfy auditors, managing reams of data with spreadsheets, and then still receiving too many notices of disallowed reimbursement adjustments.

Medicare cost report reimbursement is a largely missed technology opportunity in healthcare. Hospitals pile up massive value in Medicare bad debts, uncompensated care, disproportionate share, and many other niche components. A lack of integrated technology solutions allows an average of 10% or more of eligible reimbursement (equating to billions of dollars nationally) to disappear through a perpetually leaky bucket. Unfortunately, this problem for healthcare leaders remains inadequately addressed by a myriad mix of manual, disparate approaches getting lackluster, inconsistent results.

Technology can change this, and healthcare leaders would be shocked to realize how much money can be recovered as a result. Add to this the saved human resource costs of dealing with dated processes and methodologies along with the business case for standardizing and moving to cloud-based technologies, and we have a compelling case for change.

Why is this happening?

The challenges in these net revenue areas result from interrelated nuances in key drivers without meaningful technology to sequence and hold them together over the typical filing and collection cycle.

These 4 disconnected drivers are:

- **People** - healthcare finance and reimbursement professionals are not typically on the same organizational chart as revenue cycle teams. To make it worse, many times, one or both groups are outsourced to multiple vendors.
- **Time** - there is a long realization cycle for Medicare cost report reimbursements. The Medicare cost report itself is typically filed five months after fiscal year-end and corresponding audits can be 2-3+ years out.
- **Data Processes** - while today's revenue cycle systems have significant data warehouses and archiving, many times the data needed for reporting purposes is not being tracked and/or organized in required formats. In addition, long-term gathering of detailed audit support is typically taxing due to months or years of inattention.
- **Regulation** - ever-changing Medicare regulations, varying by Fiscal Intermediary, can make the entire net process frustratingly cumbersome and fruitless.

Case Study: A Growing Health System Gets a Game-Changing Solution

A recent example of a 26-hospital national health system's experience vividly frames this complex set of issues. Having acquired several hospitals within a six-month timeframe, the health system recognized that the data needed to submit and support Medicare bad debt reimbursement had become a spaghetti of loose ends due to different patient accounting systems, employee turnover, delayed collection agency reconciliations, disorganization of data, and pending deadlines. The CFO and her finance team were overwhelmed.

They sought help from HORNE LLP, a professional services firm built on a cornerstone of public accounting. With six decades of service to health systems, HORNE's team knew the complexities and understood that a rapid, manageable solution was paramount to achieve the right outcome.

"It was not humanly possible to solve these problems without a smart technological solution. It would have taken too long, been too expensive, and wouldn't have achieved the results we knew were possible," said Laura Gillenwater, a senior manager with HORNE in Conway, Arkansas.

Laura's team combined their professional expertise in cost reporting and hospital operations with F2 Healthcare's Medicare reimbursement analytics technology to organize and analyze all the data in weeks. The results have been astounding.

"*HORNE and F2 Healthcare went above and beyond a traditional Medicare Bad Debt 'project' to provide a high level, detailed summary of what was happening across a myriad of different platforms and processes within our health system,"the health system's CFO said. "They then helped us implement solutions to recoup value in the past and preserve value going forward."*

A Clear Path… continued...

READ THE ENTIRE ARTICLE ON MSHFMA'S BLOG:

Bert Pickard, Director

HORNE Healthcare
"*HORNE and F2 Healthcare went above and beyond a traditional Medicare Bad Debt 'project' to provide a high level, detailed summary of what was happening across a myriad of different platforms and processes within our health system,"the health system's CFO said. "They then helped us implement solutions to recoup value in the past and preserve value going forward."*

Since then, HORNE has continued to partner their services with F2's reimbursement analytics technologies across their client base. We share a common goal to create the same experience and value for health systems in our mutual footprint and open up new doors to envision a new, technology-based services solution in the future.

Click, Click, Send with Standardized, Cloud-based Technologies

Imagine a world where all the real-time Fiscal Intermediary approved information needed to submit for Medicare cost report reimbursement was being gathered and prepared in the background with little to no attention from the reimbursement and revenue cycle leaders. When the cost report comes due, reimbursement teams could click a few buttons and "voila!" it's "99% done" with exception reports that highlight certain risks and focus final management and professional reporting attention. If the Medicare Fiscal Intermediary auditor needs data to support the numbers, it is readily accessible. With that sort of solution, it would be possible to keep teams across the organization focused and reimbursement optimized. Much like the standardization of cost report software and associated methods, reimbursable components in the cost report need the same outputs that have regulatory buy-in.

Pivoting to a Technology-based Platform Nationally

The tools, workflows, and people gathering data for cost reporting varies widely between health systems. This wheel of components is being reinvented continually, resulting in providers foregoing lasting long-term improvement as a whole. In short, people-driven processes are dated and cannot solve these problems dynamically over the long-term. A mostly technology-led process could provide a national standardized platform for healthcare professionals, including support vendors serving them, mitigating many of these risks associated with longer-term inconsistency.

To unify thousands of provider resources, methodologies, consultants, and governmental agencies nationally, these four things must happen:

- **Collaboration.** We need to create a community of like-minded people in the reimbursement IT space including service providers, fiscal intermediaries, and technologists in delivering a solution.
- **Standardization.** We must create a national standard to support commonly accepted approaches to gathering and preparing reimbursement detail for Medicare cost reporting.
- **Integration.** We need to create a technology that integrates with what hospitals are already doing with easy ways to plug in a reimbursement solution to their current systems.
- **Perfection.** We need healthcare leaders to believe that technology can outperform even the smartest internal and external teams in producing a reliable, consistent outcome annually.

A vision is forming to gather all the participants together to eliminate common pains for all. Eliminate fiscal intermediary challenges through more transparent reporting and relationships, make data gathering easy, and reimbursement submission a breeze. Billions of dollars will flow back through health systems, who can continue to provide for their noble, critical mission in our lives.

Partnership - "A mandate you should be aware of"

Dick Williams, ARS Collections, MSHFMA Platinum Sponsor

"A partnership is an arrangement between two or more people to oversee business operations and share its profits and liabilities". Miriam Webster Dictonary

Does the word **"partnership**" have a more important meaning today than ever in the world of recovering your past due accounts? In today's highly regulated environment with HIPAA, HITECH, FDCPA, TCPA, and now REG F the answer is yes. It means that your collection **partner** needs to be on their toes while protecting you and your consumers while they also understand how to comply with many complex regulations. We all need to perform better in this age of litigation where a hyper technical error becomes very costly. So, our need to communicate within the "**partnership**" is essential.

We need to understand the capabilities of each other's systems, data points and internal processes, so as to provide the consumer with the legally required information to properly collect the account. That means understanding the terms ***"last statement date, charge off date, last payment date, transaction date."*** Your collection "**partner**" must disclose one of these dates in their first letter to the consumer. Once it is decided which of these four choices you will use, then you will disclose the ***original balance on the itemization date, any fees, charges, interest, credits, payments, refunds or adjustments*** since the itemization date. As you can see an exact understanding of the consumer's account and how it got to the balance placed in collections is critical. Timely file transfers with exact details will be necessary if we are to do our job for you and make the **partnership** work.

As **partners** we share an equal need to keep each other informed about any changes on the consumer's account such as payments, insurance recalls, late posting charges, and NSF payments and do so in real time. In addition, mail returns and or disputes must be shared promptly to avoid consumer complaints. It must become a priority for both **partners** and not just an inconvenience where daily is the rule and weekly or monthly is not good enough. Remember here the goal from the CFPB is to inform the consumer and reduce confusion for the consumer, that is why using an itemization date should be familiar to the consumer.

Since our **partnership** is designed to collect your accounts it is also designed to prevent consumer litigation if we fail to provide the EXACT information required by the CFPB. That means we keep both your business and ours out of court and from incurring expensive litigation. Courts have held creditors liable under vicarious liability in other collection actions, so our **partnership** is essential for both our organizations and their wellbeing.

The requirements of **Reg F** go in effect on **11/30/2021**, so work with your collection agency and build a **partnership** which is strong and that provides the necessary information to benefit both organizations. A **partnership** in actual daily practice and not just a word just in theory.

5 Key Areas Affecting A Looming Crisis: Patients' Lack of Access to Coverage is Leading to Billions of Dollars in Uncompensated Care

By Kemberton - October 2021`

With billions of dollars at stake due to uncompensated care, healthcare providers need to rethink patient eligibility and enrollment options in light of a growing uninsured and underinsured population.

The number of Americans without health insurance continues to rise. According to the latest available data, 10.9% of non-elderly individuals in the U.S. — or approximately 29 million people — were uninsured in 2019, representing an alarming increase for the third year in a row. This number is even higher today as the economic impact of the Covid-19 pandemic has led to millions of people losing their jobs and their employer-based healthcare coverage. Meanwhile, among those who do have coverage, around 43% remain inadequately insured, according to the Commonwealth Fund biennial health insurance survey, signaling a "looming crisis" in access to needed healthcare.
For hospitals and health systems nationwide, the growing uninsured and underinsured patient population will worsen losses with uncompensated care. Since 2000, uncompensated care — the overall measure of hospital care provided for which no payment was received from the patient or insurer — cost providers $702 billion in lost revenue, reaching $41.61 billion in 2019 alone. With record job losses and a growing uninsured and underinsured patient population, this number is even higher today. Uncompensated care not only depletes hospitals' revenue streams, but it also negatively impacts hospital operations and even quality of care, leading to a cycle in which treating patients becomes increasingly challenging and excessively costly.

What is uncompensated care?

If patients cannot easily access care and coverage for care, hospitals struggle to deliver services and subsequently cannot generate revenue, thus resulting in uncompensated care. Therefore, improving patients' access to healthcare coverage is key to recovering funds owed for the care provided. For uninsured and underinsured patients, the most important prerequisite of access is identifying and securing appropriate coverage, in order to afford the medical care they need.

Inadequate information collection during intake

At point-of-service, providers' ability to capture reimbursement is at its highest. Inadequate data — including incomplete information from the payer or patient, lack of communication around procedures the patient needs, and insufficient screening for financial assistance or other program eligibility — ultimately affect providers' likelihood of getting reimbursed for services delivered. Additionally, uninsured and underinsured patients may not raise concerns about payment until additional tests or hospitalization are required, further increasing the cost of care. Getting all parties on the same page from the get-go helps ensure a positive patient financial experience while minimizing revenue loss.

Relying on manual patient access workflows

Around half of denied claims occur at the front end of the revenue cycle. Some of the most common reasons for claim denial can be avoided simply by ensuring registration and eligibility verification are properly completed. Paper-based processes lack visibility into missing demographic information that can uncover alternative sources of coverage for the patient. And with thousands of patient accounts to process, patient eligibility verification can be a daunting challenge for hospitals and health systems that rely on manual patient access workflows. Traditional approaches — including mailing statements and calling patients to follow up on bills — is extremely time consuming and labor intensive. Studies estimate that providers collect only one-third of patient balances larger than $200, with the rest being sent to collections or written off as bad debt.

Inaccurate patient eligibility verification

One of the most common reasons why a claim gets rejected is inaccurate patient information, including misspelled names and typos in entering policy numbers, SSN and date of birth, or a misspelled name. Providers must also verify that the patient's insurance is active at the time of treatment. To minimize claim denials later on, patient access staff must ensure patients' eligibility for coverage at the time of appointment or perform a batch check prior to a patient's visit. Adequate training and expertise among patient access personnel is vital to ensure patient eligibility is verified in a timely and accurate manner. For example, there is a common misperception that all uninsured or underinsured low-income adults can receive health coverage through Medicaid, when, in fact, there are only a few eligible pathways available — and strict eligibility requirements makes Medicaid coverage difficult to keep. To maximize reimbursement and help patients identify the most appropriate coverage to best fit their unique needs, staff must keep up to date on a vast array of eligibility options for a complex range of available programs including:

Medicaid
Children's Health Insurance Program "CHIP"
Medicare Savings Programs (QMB, SLMB, QI)
Social Security Administration Benefits (SSI, SSDI)
Behavioral Health Benefit Programs
Coverage and Assistive Programs for NICU Babies
Veterans Benefits
Crime Victims Compensation
Indian Health Benefits
Hospital Presumptive Eligibility
Motor Vehicle Accident Insurance
General Liability Insurance
Workers' Compensation
Cobra Eligibility

With Billions At Stake… continued...

Misalignment between departments

Revenue loss can be minimized by streamlining processes between front and back-office teams. At most healthcare provider organizations, departments work in siloes and do not act in unison even if they have the right resources. For example, in the case of uninsured patients, lack of information from patient intake to the billing office may lead to billers pursuing the patient and/or the wrong payer, only for the claim to be denied, as proper eligibility was not determined upfront. This can be prevented with better coordination of available coverage options and a keen understanding of the entire eligibility and enrollment process.

Lack of patient enrollment assistance

A recent survey suggests that public understanding of available coverage options — and how to apply for them — is especially limited. Out of all respondents who received assistance in enrolling for coverage, 40% said it is unlikely they would have found coverage without help. The same survey also revealed that 12% of patients, or nearly five million people nationwide, tried to find help for enrollment but did not get it. Healthcare organizations need to provide comprehensive eligibility and enrollment assistance programs to best improve patients' access to coverage, which also leads to improved patient satisfaction and reduced bad debt, ensuring optimal reimbursement and enhanced denials prevention downstream.

How Kemberton can help

Our comprehensive Disability Eligibility and Enrollment Services provide a streamlined patient experience focused on helping your most vulnerable population receive the benefits they deserve as quickly as possible. With specialized patient advocates to help patients navigate through the complex applications of various health insurance programs, Kemberton ensures not only optimal revenue recovery for your health system, but also continuity of service for uninsured and underinsured patients. To find out how we can best assist you, contact:

Roze Seale, CRCR, Regional VP Sales C: 251-232-3742 rseale@kemberton.net

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The Value of Certification

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

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

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

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

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

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

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

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

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

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

For more information on HFMA Certification, visit http://www.hfma.org/certification/.

CMS finalizes changes to the price transparency penalty, inpatient-only list and more for 2022

By Nick Hut - HFMA.org excerpts

- **Medicare payments for outpatient services will increase by 2% for 2022 without factoring in scheduled across-the-board cuts to the program.**
- **Previously proposed changes to the penalty for noncompliance with price transparency regulations and to the inpatient-only list were finalized.**
- **Two new measures are being added to the Outpatient Quality Reporting program.**
  Hospitals are disappointed that the reduced payment rate for 340B drugs will be retained as a Supreme Court review looms.

"Price transparency

CMS finalized its proposal to change the penalty for noncompliance from $300 per day for all hospitals to a sliding scale based on bed count. Specifically, the penalty will increase by $10 per day for each additional bed beyond 30, up to a maximum of $5,500 per day for hospitals with at least 550 beds. The penalty for a full year of noncompliance would range from $109,500 to slightly more than $2 million.

The approach "affirms the administration's commitment to enforcement and public access to pricing information," CMS wrote.

The updated regulations specify that machine-readable files with price information must be accessible to automated searches and direct downloads.

"We are very concerned about the significant increase in penalties for noncompliance with the hospital price transparency rule, particularly in light of the many demands placed on hospitals over the past 18 months, including both responding to COVID-19 as well as preparing to implement additional, overlapping price transparency policies," Stacey Hughes, executive vice president of the American Hospital Association, said in a written statement."

READ THE ENTIRE ARTICLE HERE

THE LATEST NUMBERS

Ken Dulaney
info@mshfma.org

National Debt at last edition - $28,581,957,178.00

National Debt as of today—$28,953,016,500.00

Total Debt to GDP Ratio: 125.95%

Debt Per Taxpayer: $229,705.00 Debt Per Citizen $86,956.00

Mississippi Debt $13,800,000.00 Population: 2,954,230

National Unemployment Rate: 4.6%, down from 5.9% last edition

National LABOR PARTICIPATION RATE: 61.6%

Mississippi Unemployment Rate as of today: 4.7%

National Average Household Income - $67,521 / Mississippi - $45,081

Certification Pathways

Your future, you decide!

Certification programs with HFMA have become extremely user friendly on the website and guide you along your path to professional excellence. I'd like to share how you can validate your expertise and demonstrate your commitment to the profession with certificatio

Certified Healthcare Financial Professional (CHFP)

14 CPEs

Dive into the new financial realities of health care and come up with a better business skill set, new ideas on financial strategy, and insights into future trends.

LEARN MORE

Certified Revenue Cycle Representative (CRCR)

14 CPEs

Increase your knowledge, competencies, and productivity with best-practices recommendations to positively impact the revenue cycle and enhance patient experience.

LEARN MORE

Certified Specialist Accounting & Finance (CSAF)

14 CPEs

Strengthen your skills and mastery of financial reports and statements, risk-sharing arrangements, managed care contracts, and profitability ratios.

LEARN MORE

Certified Specialist Business Intelligence (CSBI)

10 CPEs

Learn methods for looking at data and using tools to ensure the right information is illuminated and used to enable powerful actions and decisions.

LEARN MORE

CREDENTIALS MATTER

David Williams

Carr, Riggs & Ingram

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

David Williams, Certification Chair

CPA, MPH, FHFMA

David.williams@cricpa.com

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

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

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

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

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

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

Thanks,

David Williams

For more information on HFMA Certification, visit http://www.hfma.org/certification/.

Www.HFMA.org/Certification

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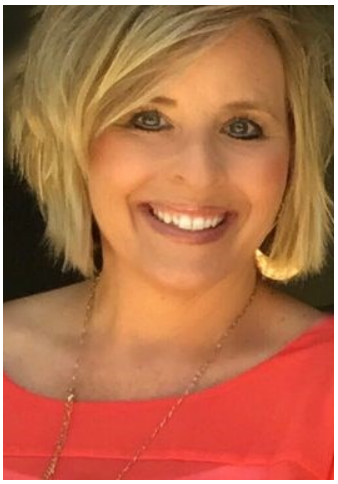

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ABOUT HFMA

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

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

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

Vision

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

Purpose Statement

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

Quality Statement

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

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

Values Statement

We believe that service to members is our highest priority.

We believe in excellence in all that we do.

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

We believe in the importance of individuals.

We believe in encouraging innovation and creativity.

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

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