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Taking Security on the Road: Steps You Can Take to Secure Your Mobile Devices

Christopher Ryan, Esq.
Giarmarco, Mullins & Horton, P.C., Troy, MI

The creation of the Medicare/Medicaid Electronic Health Record (EHR) Incentive Program (commonly known as the "Meaningful Use Program") gave providers and hospitals a strong incentive to integrate EHRs into their practices. As part of their EHR system, many providers are using mobile devices such as laptops, tablets and smartphones. If used properly, these devices allow access to patients' EHRs from anywhere that a Wi-Fi connection (or cell phone signal) is available. This often results in quicker responses to questions from patients, families and other providers. While the use of mobile technology has benefits, providers choosing to utilize this technology must pay special attention to making sure they do so in a manner that conforms to their group or facility's security policy and protects the privacy of the information.

This article will outline some of the various mobile security tools and internal policies providers can implement to aid in protecting their patient's EHRs and avoid an expensive HIPAA security breach.

Draft a Mobile Use Policy

Providers should develop and implement a mobile use policy, or include specific provisions in their security policy regarding mobile use. To develop a mobile use policy, the organization must first decide whether it will allow its employees to access EHRs via a mobile device. Assuming this will be permitted in some fashion, the group must consider whether physicians and other

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A quarterly publication providing topics of interest to the healthcare industry.

➤ INSIDE THIS ISSUE:

Patients Are Rapidly Becoming Accustomed to Virtual Care

This year, millions of consumers used their smartphones to order a prescription, have their first video consultation and likely stopped into new retail-style clinics to gain quick access to care. Due to the consumerism in healthcare trend we are experiencing, patients have become more involved with their own care by being more selective in choosing their provider and shopping to find the best price for treatments. While many Americans have faced increasing out-of-pocket obligations, payers and providers have offered new tools to help patients navigate our complex healthcare system. It has been an interesting year; that's for sure.

Speaking of the changes in healthcare, I recently reviewed the results of PwC's 2015 Consumer Survey, and the outcomes they predicted for 2016 have, largely, come true. Three of the top consumer and clinical trends were:

- 67 percent say they were "very satisfied" with their experience at a retail clinic.
- 21 percent have used a mobile device to order a refill of a prescription.
- 60 percent willing to have a video visit with a physician through a mobile device.

Also, the clinicians' survey results indicated that:

- 58 percent would rather provide a portion of care virtually.
- 38 percent use email to stay connected with their chronic disease patients.
- 81 percent say mobile access to medical information helps coordinate patient care.

The survey results indicated that both consumers and clinicians are taking full advantage of new methods to receive and deliver care.

MiraMed is committed to staying abreast of our rapidly changing industry. To that end, we attempt to deliver compelling and interesting content that reflects those changes. In this edition of *The Focus*, we have a great group of contributors. One of our newest authors, Christopher Ryan, Esq. of Giarmarco, Mullins & Horton law firm, offers his insight about the growing security threat in healthcare in his article *Taking Security on the Road: Steps You Can Take to Secure Your Mobile Devices.*

Phil Solomon, vice president for MiraMed Global Services, a frequent author in *The Focus*, provides his insight about today's consumer behavior in his article *Healthcare Consumerism and Personal Debt Accumulation*. Returning authors David Johnson, the CEO and Founder of 4sight Health, and Lyman Sornberger, president and CEO of LGS Healthcare and the chief strategy officer at Capio Partners, share their knowledge understanding of the challenges and opportunities in healthcare. Their articles, *Overcoming Medical Errors of Omission: The Cure Requires Organizational Empathy* and *Patient Advocacy and Collecting: A Perfect Combination*, focuses on the newest clinical challenges providers face and the rising cost of managing patient payment liability.

Denise Nash, MD, vice president of Compliance and Education, and Angela Hickman, vice president, RA-HCC Strategy and Business Development, both of MiraMed Global Services, wrote a nice piece about the growing trend in risk-based contracts, *Understanding HCC-HHS Risk Adjustment*. In his article, *Clinical Variation: The Hidden Gem in Bundles,* previous author Sheldon Hamburger, principal/consultant at the Aristone Group, demonstrates his deep domain knowledge of the industry's clinical applications and pricing strategies. Finally, Louis Carter, the CEO and founder of the Best Practice Institute shares his observations about how to treat consumers in his article *Four Ways to Be More Consumer-Centric.*

I believe 2017 will be just as dynamic as 2016. I am looking forward to observing the changes that all of us will experience in healthcare in the coming months. At MiraMed we are committed to staying ahead of the curve by utilizing the newest technologies and operational strategies for delivering our revenue cycle services. We believe the best way to serve our clients is to understand how our industry is changing and thinking ahead to where new trends are formulating. The great Wayne Gretzky, a Hockey Hall of Fame player, once said "I skate to where the puck is going to be, not where it has been." At MiraMed, we try to do the same.

I hope you find this edition of *The Focus* to be relevant and informative. Our commitment to our readers is to deliver the latest and most germane content written by some of the top thought leaders in our industry. Enjoy!

Best wishes to all,

Tony Mira
President and CEO

Consumerism and Personal Debt Accumulation

Phil C. Solomon
Vice President, MiraMed Global Services, Inc., Jackson, MI

Consumerism and Personal Debt Accumulation

Merriam-Webster defines consumerism as *the promotion of the consumer's interests* and *the theory that an increasing consumption of goods is economically desirable*. The United States has become a society of increasing consumerism, where individuals are making greater levels of purchases for a variety of consumer goods.

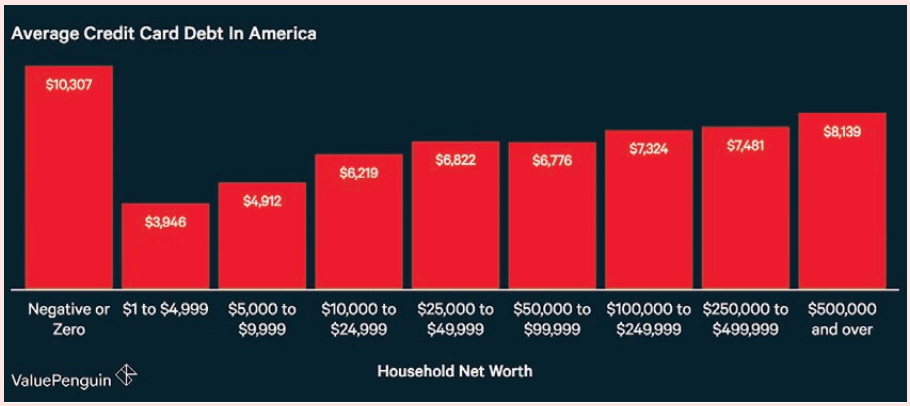
Retailers and service providers are enjoying expanded consumer spending, but that growth has come at a cost for all Americans. The U.S. population carries a substantial amount of debt. The typical American owns 3.5 credit cards and their household average balance-carry of credit card debt is $16,048.

In Figure 1, ValuePenguin estimated that households with a negative or zero net worth have over $10,000 in credit card debt and families with a net worth over $500,000 average $8,139. In 2010, the average outstanding revolving debt in the U.S. was $841 billion. As of March 2016, that number had risen to $952 billion and the total of outstanding debt was $3.4 trillion.

These economic factors have contributed to the growing challenge families are facing paying for their healthcare.

Healthcare reform is not the only major change the health industry is experiencing. The concept of healthcare consumerism is unfolding right in front of our eyes.

FIGURE 1 Average Credit Card Debt In America



The Rise in Healthcare Consumerism

Today, the term healthcare consumerism has become a popular way to describe the shift of payments and the delivery of services as the industry moves from a fee-for-service economic model to value-based care. Government programs and commercial insurance have largely been responsible for administering consumer payments and care authorization. Their programs have stymied the industry's effort to become more consumer-friendly. Nevertheless, that has not dissuaded consumer advocates from promulgating the concept of consumerism. Samuel Butler's saying from 1754, "win the day," best describes the results that supporters of healthcare consumerism have achieved. In reality, healthcare consumerism has "won the day."

There are two main considerations for consumerism in healthcare. They are:

1. The moral imperative for consumerism
   a. Save lives with increased quality of care and better population health
2. The economic imperative for consumerism
   a. Save money by lowering operating costs and service prices
   b. Create more jobs

The Patient Protection and Affordable Care Act has accelerated the current state of consumerism because it left many consumers with large deductibles

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providers will be permitted to use their personal mobile devices, or whether only "provider owned" devices will be permitted to access secure information. Those driving organizational policies should also contemplate whether all mobile devices are permitted to access EHRs or whether access will be restricted to certain types of technology. For example, a hospital or provider group may decide that laptop computers are permitted to access EHRs, but tablets and mobile phones are not. Providers may also want to implement some of the various specific suggestions contained in this article. After an effective policy is drafted, the organization should train its employees on the provisions of the policy and how they can achieve compliance with the same.

Follow Your Organization's Policy

Reading and complying with the group's or facility's policy is the number one step care providers should take when implementing mobile technology and choosing which mobile security techniques to utilize. A group's or facility's policy may contain specific requirements that are not discussed or that differ from the items outlined in this article. Questions concerning a group's or facility's policy, or how to best secure a mobile device, should be directed to the group's or facility's Security Officer. Depending on the type of mobile device a provider intends to use, the manner in which the EHR is accessed, and the software the group or facility uses to store the EHRs, some of the items outlined below may not be applicable to all providers. The Security Officer will assist the provider in making sure they are using mobile technology in a manner that is compliant not only with the HIPAA Security Rule, but also with the laws applicable in their specific jurisdiction.

Physical Security

Keeping mobile devices physically secure is the most obvious type of mobile security. Because mobile devices are, by definition, "mobile," they are easily stolen or misplaced. While nobody can completely prevent their mobile devices from being stolen, everyone can take steps to decrease the likelihood of a theft. Instead of leaving a laptop on the back seat of a car, providers should consider locking it in the trunk or not leaving it in a car at all. Do not leave a tablet sitting on the table at the coffee shop; instead, bring it with you when you get a refill of your coffee. If a provider uses their cell phone to access patient information, they should not let their child borrow it on the weekend. Finally, if it is utilized in public areas, providers should consider protecting the screen of their mobile device from being viewed by unauthorized individuals by using a privacy filter.

Passwords

Simply having a password to gain access to mobile devices is not enough. Providers need to make sure that they choose unique passwords that are not easy to guess. Studies have suggested that the most common passwords include "123456," "password" and "iloveyou." Common categories of passwords include using your telephone number, spouse's name or pet's name. These common passwords should be avoided because they are relatively easy to guess. Instead, providers should use a password that is easy for them to remember, but hard for unauthorized users to guess. Generally, passwords should be at least six characters in length, and should include upper and lower case letters, one or more numbers, and one or more characters such as "!", "#" or "@."

Providers should also remember that by using the same password for multiple accounts, they gain access to all accounts.

Therefore, unique passwords should be used for each piece of software that allows access to EHRs. Also, changing passwords frequently, and never storing passwords in unsecure locations, are also advisable. For example, placing a sticky note on a laptop that says, "Password: ComMun!que2013ABC" renders an otherwise strong password virtually meaningless.

Auto-Logoff or Timeout

Most, if not all, mobile devices have built-in features that automatically log the user off (or lock the device) after a set amount of inactivity. Providers should turn this feature on, and they should require a password to be entered in order to "wake" the device.

Saving Information Locally

Information may be stored on the mobile device itself, or it may be accessed remotely. The benefits of storing information remotely (i.e., not storing information on the device itself) is that the information is more likely to be up-to-date and require additional authentication to access the information beyond simply having access to the device. Some organizations may choose to allow providers to store information locally on the device so that it can be accessed at any time without a connection to the internet. Having locally stored information means that if the provider's mobile device is lost or stolen, an unauthorized user may be able to obtain patient information with greater ease. (See "Remote Wipe" below). If information is stored locally, providers should be sure to frequently back the information up to a secure server. Doing so means that if your device is misplaced or stolen, the information will not be lost.

Remote Wipe

Many mobile devices contain a feature that allows the owner to erase the memory or hard drive of the mobile device remotely in the event it is misplaced or stolen. Check with your device's manufacturer to learn more about whether your device contains this feature, and if it does, make sure it is set up and ready to be activated. If it does not, talk to your Security Officer and consider investing in software that allows this capability.

Firewall/Virus Scan

A firewall is a tool that monitors incoming and outgoing activity and blocks certain transmissions according to the user's specifications. For example, a firewall may be programed to prevent file sharing. Virus scanning software is designed to identify potentially harmful files and quarantine or delete them, as necessary. Both of these tools should be utilized by providers and kept up-to-date.

Where to Go for More Information

Utilizing mobile devices in a medical setting improves patient care by allowing physicians and employees to quickly access patient information from anywhere. In the event a mobile device is stolen or misplaced, or if a provider feels their mobile device's security may have been compromised, they should immediately contact their organization's Security Officer. Providers can also visit www.healthit.gov for more information about implementing health information technology, or contact a qualified attorney.

Christopher Ryan, Esq. is an associate at Giarmarco, Mullins & Horton, P.C. in Troy, MI. Mr. Ryan practices healthcare law, working with healthcare providers in the areas of corporate formation and dissolution, contract negotiation and health compliance. Mr. Ryan also practices litigation with a special emphasis on defending healthcare providers faced with claims of medical malpractice. He can be reached at (248) 457-7154 or at cryan@gmhlaw.com.

Consumerism and Personal Debt Accumulation

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that put pressure on them to find the most cost-effective care for the out-of-pocket dollars they are spending.

Consumers now have more control over their care and now are better able to evaluate the pricing and quality of the various providers they may consider engaging. The industry is moving toward full consumer transparency, but it is not there yet.

Previously, patients seeking information about a doctor or hospital were only able to uncover the most basic data, leaving them to make treatment decisions based on the limited amount of data they could understand—their insurance coverage and the availability of the care they needed. Now, many of those patients can access detailed information about important aspects of their care, such as a physician's experience with a particular procedure or a hospital's outcome track-record and readmission rates.

Increasingly, consumers have access to information, which is helping them decide who will deliver their care and what they will pay for it. Patients are slowly slipping into the healthcare driver's seat. They are now less likely to follow the provider's old paradigm of "doctor says and the patient does" as they transition into a new culture of consumer choice. With checkbooks in hand, consumers are now demanding more pricing transparency and better data so they can make informed healthcare decisions.

Do Patients Know What They Want From Healthcare Companies?

Consumers tend to have strong opinions about what matters most to them when making healthcare decisions or receiving healthcare services. McKinsey & Company (McKinsey), a research consultancy firm, conducted a study on healthcare consumerism from 2007 to 2015 where they surveyed over 11,000 people about how they perceive their healthcare needs and desires, how they select providers and how they make other healthcare decisions. Their results suggest that many assumptions about healthcare consumerism are inaccurate.

The evidence is surprising, as it suggests a disconnect between what consumers believe matters most and what influences their opinions. It appears that some factors play a greater role than most consumers realize. For example, a 2014 McKinsey Consumer Health Insights survey indicated that more than 90 percent of participants said they were somewhat satisfied with the care they received, and most of them rated the outcome achieved as the most important influence on their satisfaction. However, they found that empathy and support provided by health professionals (especially nurses) had a stronger impact than did outcomes. Also, the information participants received during and after treatment had a remarkable influence on patient satisfaction.

What consumers say is important does not always correlate with actual satisfaction levels. In general, the results suggest that people:

Overstate tangible factors such as:

- New/updated facility building
- A quiet environment and room appearance
- Cleanliness of room
- Simplicity of administration
- Availability and access to parking

Understate factors that are more emotional:

- Keeping them informed about treatment before and after
- Doctor and nurse empathy
- Outcome of procedure or care

Taking these results into consideration and other factors, expanding consumerism in healthcare "is easier said than done." Shopping for healthcare is not like shopping for clothes, cars or appliances. Unlike

retail purchases, where information on products and services is readily available, healthcare consumers do not have access to accurate pricing before they receive care. The complexity of healthcare pricing is the culprit for growing consumer confusion and frustration. Understanding the basic terminology of healthcare is a challenge for most consumers. There are many technical terms that consumers must understand to evaluate and purchase healthcare services. Here are some examples:

- In-network/out-of-network
- Reasonable and customary charges
- Billed charges
- Contracted pricing
- Global pricing
- Co-pay and deductible
- Procedural pricing
- Nonessential health benefits cost

With all of the overlapping reimbursement methodologies involved in current pricing practices and the way patients are charged for their healthcare services, it is no wonder they are exasperated and confused.

What You See Isn't Always What You Get

So, how will patients make an informed choice to select a provider? In traditional retail markets, pricing and feature richness determine how consumers choose products and services. In healthcare, high-priced medical procedures may not be the best value or produce the best outcomes. Since consumers often cannot get the comparative cost and quality data they need to make smart purchasing decisions, they have to "fly blind" by choosing a provider by referral or selecting them from a list of approved providers.

Consumers want to know what it will cost to see a physician or have a procedure. Regrettably, providers find it almost impossible to give patients true estimates for the cost of care. They can offer ballpark estimates created from inexact information, but not much more.

FIGURE 2 Knee Arthroscopy: Baton Rouge, Louisiana (2010)

Medical Provider	Lake Surgery Center	Baton Rouge General Medical Center	Our Lady of the Lake Regional Medical Center
Total Price	**$4,500**	**$7,500**	**$14,000**
Discount rate	20%	20%	20%
Actual discount	$900	$1,500	$2,800
Discounted balance	$3,600	$6,000	$11,200
Applied to deductible	$500	$500	$500
Member co-insurance (20%)	$620	$1,100	$1,500
Member responsibility	$1,120	$1,600	$2,000
Employer Cost	**$2,480**	**$4,400**	**$9,200**

Source: *Patient Care*

Comparing healthcare pricing is not a simple task. It is analogous to comparing apples to oranges. It is not as simple as formulating pricing from a list of gross charges or average reimbursements from Medicare or commercial insurance payers. They do not indicate what the patient will have to pay. The guesswork patients go through is frustrating, but they are not alone. Providers also need accurate pricing data to help them effectively compete in the marketplace.

Healthcare costs and quality can differ widely from one provider to another in the same network and even in the same city. In some areas, in-network prices can vary by 300-500 percent in the same town for the same service (e.g., endoscopy, CT scan, lab test, surgery). Many people do not realize there is such a massive variation in the prices providers charge. For instance, most consumers would be excited to save $100 or $200 on the purchase of a product or service like a magnetic resonance imaging (MRI) exam by just by choosing a different provider. What they do not realize is that an MRI might cost $600 at one provider and $5,000 at another just a few miles away. In the end, even with a discount, the total cost of the procedure could still be much higher and the patient would never know it. Surgeries can have thousands of dollars difference in pricing from provider to provider and their equipment capabilities can vary widely, which can have a dramatic effect on outcomes. With the availability of accurate data, consumers can save thousands of dollars by shopping for healthcare services. Figure 2 illustrates the differences in pricing for a knee arthroscopy at three Baton Rouge, Louisiana hospitals.

Selecting the Right Provider is Not Easy

As the changeover to a consumer-based model gains steam and more pricing data becomes available, patients will attempt to improve their healthcare decisions by selecting the right provider at the right price. To stay competitive, providers must begin to provide real pricing, not just estimates.

A well-informed patient will shop multiple healthcare providers for the best price. When the perception of quality is equal, the consumer will most often choose the provider who offers the lowest price. The recent trend toward enhancing the accuracy of provider quality comparisons is positive as it helps patients make decisions other than by

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price alone. There are no other service industries where the stakes are higher than in healthcare. Selecting the wrong healthcare provider can mean the difference between life and death.

Healthcare technologies that provide cost estimates for patient financial responsibility are rapidly becoming available. Once a healthcare provider knows the type and scope of services a patient requires, these new software platforms can combine previous average charges, expected payer reimbursement, and transactional data from commercial or governmental payers to provide relatively accurate pricing estimates. Previously, owning this type of technology was nice to have. Today it is a strategic imperative.

In a consumer-based market, if providers cannot provide estimates for the cost to the patient, they are at a competitive disadvantage. It is a good bet that healthcare providers operating with open transparency will win over patients and become market leaders.

Healthcare Pricing: The Good, the Bad and the Ugly

If you read any newspaper in the U.S., you will eventually find a story about the irrationality of healthcare charges. Unfortunately, these stories erroneously report that aggregated gross charges make up the price for services when the amount a patient pays is much lower. While this reporting is not accurate, it does shed light on healthcare pricing in general, which has helped build momentum toward full price transparency.

Today, charges for healthcare services are the byproduct of decades of payer contract negotiations and changes in reimbursement approaches. Over time, the disorderly modification of reimbursement methods has distorted charges, making them much harder for the average consumer to understand.

Since providers have such wide disparities between their costs to charge ratios compared to their competitors it perpetuates the perception that healthcare pricing is irrational, and consumers doubt its validity.

Why don't providers just reduce their charges? Because it's no easy task. There are currently payment mechanisms in use such as Medicare fee schedules that reimburse based on charges, therefore negating the ability to simplify provider-charging practices. For accurate reimbursement, a provider's charges must be equal to or greater than the fee schedule amount. Also, to mitigate any financial loss, the provider must have the ability to model the effect of changing charges on reimbursement. That requires owning a sophisticated contract modeling system to evaluate the effect of changing charges on reimbursement. The fact that many health systems have different contracts for commercial payers and different charge masters for each hospital only serves to complicate the effort. Ultimately, any sweeping change in pricing hinges on having an agreement from commercial and government payers about how they will view and evaluate charges.

Summary

Consumerism in healthcare is here to stay, and this trend will have a material impact on the way healthcare is perceived and delivered for the foreseeable future. Providers must develop a flexible approach so they can respond to the new consumer-centric economic landscape. They need to meet the demands of consumerism by designing products and delivering services that address patient needs and expectations. Patient education must advance to address the differences in patient health conditions and motivations. The days of the typical "one size fits all" educational approach are long gone.

Driving behavioral changes requires a deep understanding of individual patient needs and how to influence their choices. Pursuing qualitative analysis such as focus groups and evaluating quantitative data found in surveys offers some valuable insights; however, consumer participants do not represent a uniform population with similar views, beliefs and attitudes.

Improving patient satisfaction is a critical component for optimizing financial outcomes. With a solid consumer-based strategy, providers can make a significant impact on the health of an entire community while creating a resilient and more financially sound healthcare organization.

Phil C. Solomon serves as the Vice President of Global Services for MiraMed, a global healthcare revenue cycle outsourcing company, and is the publisher of Revenue Cycle News, a healthcare business information blog. Phil has over 25 years' experience consulting on a broad range of healthcare initiatives for clinical and revenue cycle performance improvement. He has worked with the industry's largest health systems, developing executable strategies for revenue enhancement, expense reduction and clinical transformation. He can be reached at phil.solomon@miramedgs.com, at (404) 849-8065 and on Twitter @philcsolomon.

Understanding HCC-HHS Risk Adjustment

Denise M. Nash, MD, CCS, CIM
Vice President of Compliance and Education, MiraMed Global Services Inc., Jackson, MI
Angela Hickman, MS, CPC, CPCO, CEDC, CPMA, AHIMA ICD-10-CM/PCS Trainer and Ambassador
Vice President RA-HCC Strategy and Business, MiraMed Global Services Inc., Jackson, MI

Introduction

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

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

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

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

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

HCC Auditing Options

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

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

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Understanding HCC-HHS Risk Adjustment

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providers to keep up with CMS's requirements for compliance while monitoring healthcare outcomes.

Understanding the Requirements of HCCs

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

Because of the proven success of HCCs in predicting resource usage by Medicare Advantage enrollees, the model now determines, in part, reimbursement for Accountable Care Organizations (ACOs) and the Hospital Value-Based Purchasing (HVBP) program. Few providers traditionally have assumed the risk for outpatient documentation and coding. Under ACOs and HVBPs, more providers are assuming risk when they record health status for their patients. That means good things for providers that accurately capture their patients' health status benefits. Providers who fail to capture relevant conditions receive lower reimbursement payments.

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

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

Depending on organizational interests and data availability, two- to three-year time gaps between risk-factor assessment and realized expense begs exploration. Shorter, six-month time gaps can also be examined, especially among subgroups with well-defined modifiable risk factors such as tobacco and alcohol use or sedentary lifestyle. This will be facilitated by more frequent, i.e., monthly, updates to diagnostic data that enhance the predictive performance of risk models by identifying patients closer to when the risk is realized. In

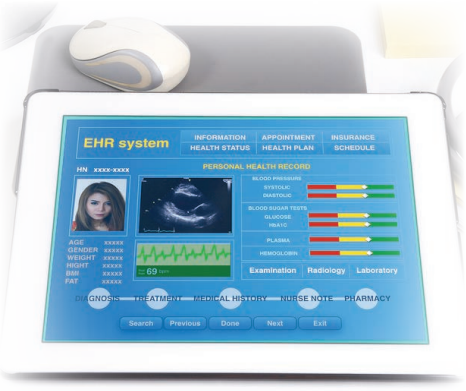
addition, risk models can be used to create individual-level clinical profiles that might take the form of an overall expected cost (or, alternatively, a normalized risk score) and a list of the various disease classes or categories into which the patient falls. These clinical profiles can guide case managers in choosing the appropriate treatment.

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

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

When Submitting a Record For RADV, Consider the Following:

- Is the record for the correct enrollee?
- Is the record from the correct calendar year for the payment year being audited? (For example, for audits of 2011 payments, validating records should be from calendar year 2010)



- Is the date of service present for the face-to-face visit? Is the record legible? Is the record from a valid provider type (hospital inpatient, hospital outpatient/physician)?
- Are credentials valid and/or is a valid physician specialty documented on the record?
- Does the record contain a signature from an acceptable type of physician specialist?
- If the outpatient/physician record does not contain a valid credential and/or signature, is there a completed CMS-generated attestation for this date of service?
- Is there a diagnosis on the record? Does the diagnosis support an HCC? Does the diagnosis support the requested HCC?
- If the condition warrants an inpatient hospitalization, the HCC may be supported by an inpatient record. Examples of such conditions may include septicemia, cerebral hemorrhage, cardiorespiratory failure and shock. For these conditions, an inpatient record, a stand-alone inpatient consultation record or a stand-alone discharge summary may be appropriate for submission.
- When possible, obtain a record from the specialist treating the condition, e.g., an oncologist for a cancer diagnosis. These records may be more likely to sufficiently document the condition.
- Pay particular attention to cancer diagnoses. A notation indicating "history of cancer," without an indication of current cancer treatment, may not be sufficient documentation for validation. For example, if, in an attempt to validate HCC 10 (breast, prostate, colorectal and other cancers and tumors), a MA contract submits a record that indicates a patient has a history of cancer that was last treated outside the data collection year, the HCC may be not be validated.
- When reviewing medical records, pay special attention to the problem list on the electronic medical record. In certain systems, a diagnosis never drops off the list, even if the patient is no longer suffering from the condition. Conversely, the problem list may not document the HCC your MA contract submitted for payment.
- Any problem list in submitted documentation should be included and not just referenced.
- Records provided to validate HCCs that encompass additional manifestations or complications related to the disease (e.g., HCC 15, Diabetes with Renal Manifestations or Diabetes with Peripheral Circulatory Manifestations) should include language from an acceptable physician specialist that establishes a causal link between the disease and the complication. An acceptable record that clearly defines the complication or manifestation and expressly relates it to the disease may validate the HCC. A record that does not identify and link this relationship may not validate the HCC.
- If a physician or outpatient record is missing a provider's signature and/or credentials, consider using the CMS-generated attestation that was provided with your data. CMS will only consider CMS-generated attestations for RADV.

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Understanding HCC-HHS Risk Adjustment

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- Minimum requirements for inpatient records state that these must contain an admission and discharge date. In addition:
  - Inpatient records must include the signed discharge summary.
  - Stand-alone consultations must contain the consultation date.
  - Stand-alone discharge summaries submitted as physician provider type must contain the discharge date.

Getting Ready for 2017 and Beyond

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

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

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

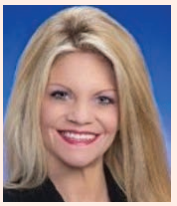
After receiving feedback from the public and in response to the comments received, CMS is continuing its evaluation of potential data sources and determining if the risk adjustment methodology adequately captures the risk associated with:

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

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

The information contained in this document provides general guidelines and information for the CMS Risk Adjustment Model and is in no way offering legal advice.

Denise M. Nash, MD, CCS, CIM, serves as Vice President of Compliance and Education for MiraMed Global Services, and as such, she is responsible for all compliance, education and training. She has more than 20 years of experience in the healthcare industry. Nash has worked for CMS in hospital auditing and has expertise in negotiation and implementation of risk contracting for managed care plans. She has also worked with individuals as well as physician groups on utilization and PQRS management to improve financial performance for the risk-based contracts and value-based purchasing programs. Nash also has experience with episode of care data and patient management in the ACO environment. She has worked with both hospitals and physician practices on the legal and financial aspects of adding new services. Dr. Nash is a consultant on coding/compliance audits at physician practices and hospitals, and has worked for insurance plans conducting second-level appeals. Her experience includes consulting for the Office of the Inspector General of New Hampshire in its Fraud and Abuse Division. She can be reached at denise.nash@miramedgs.com.



Angela Hickman, MS, CPC, CPCO, CEDC, CPMA, AHIMA ICD-10-CM/PCS Trainer and Ambassador, Vice President RA-HCC Strategy & Business, has 23 years of experience in healthcare. Her experience includes: clinical research, clinical workflow management and strategic implementation of EHRs and IS/IT, program management, project management, direct corporate compliance programs, policies and procedures creation, clinical documentation improvement program development, and the legal and ethical use of EHRs that supports continuity of care for patients. She has developed EHR best practices for organizations that are consistent with strict privacy and security standards, determined meaningful metrics for tracking and predicting quality and outcomes organization-wide, crossing all domains of healthcare. Angela has provided education for over 5,900 providers and developed 44 specialty and subspecialty trainings on ICD-10-CM/PCS for various organizations. She can be reached at angelahickman@miramedgs.com.

Patient Advocacy and Collecting: A Perfect Combination

Lyman Sornberger
President and CEO, LGS Health Care and
Chief Strategy Officer, Capio Partners, Cleveland, OH

Industry experts estimate that self-pay payments make up more than 30 percent of a provider's annual revenue. That puts providers at risk of losing one-third of their cash flow unless they have a strategy to maximize collections of self-pay dollars directly from patients. In addition, while it would seem self-pay is going away, it is not. Here is why:

- Under the Patient Protection and Affordable Care Act (PPACA), a maximum of 60 percent of a patient's healthcare is covered
- National out-of-pocket healthcare expenses will rise to more than $400 billion by the end of 2016[1]
- Nearly 30 percent of Americans are enrolled in employer-based high-deductible insurance plans
- Self-pay is the third most common form of compensation to providers behind Medicare and Medicaid
- Underinsured patients are becoming less collectable

Mandated coverage by the PPACA has increased basic insurance plans, leaving the patient to cover up to 40 percent of the cost of their care. Thus, self-pay takes on new meaning as more Americans become insured under new healthcare laws. Moving forward, "insured" does not necessarily translate to "covered." While some providers have resolved to outsource the entire collections process, other providers prefer to handle most collections internally. To do this successfully requires best practices and policies that, when properly executed, result in higher returns and greater overall efficiency in the collections process.

Educate, Educate and Educate

To optimize revenue cycle performance, providers should implement a strategy that makes patients more likely to pay their bill and explore all options to collect bad debt. Doing this successfully involves:

- Creating a clear and present self-pay policy.
- Providing payment options and incentives for early payment.
- Creating a culture for patient advocacy.
- Adequate internal talent and resources.
- A trusted partner to help with uncollected balances.

Providers who operate high performing revenue cycles use strategies to maximize both early and late-stage self-pay collections while still maintaining good standing with patients and the community. Offering payment plans and utilizing loan programs, estimator tools, propensity to pay scoring technologies, early-out programs and selling debt are all best practice financial strategies.

Creating an Understandable Self-Pay Policy

At the core of every great relationship, you will find good communication. It's all about setting boundaries and clearly establishing where expectations lie on both sides. This is true between patients and providers as well. Best practice patient communication begins with easy-to-understand policy notices. The following is an example:

> *Your good health is our number one concern. Quality care is the result of communication and understanding between you and your care provider. Our policy ensures that you clearly understand your responsibilities. Our policy includes payment options that can help you reduce your bill by up to 30 percent.*
>
> *We require all of our patients to pay for their care when they receive it. This allows us to provide you with affordable quality care. If we present a charge to you that you don't understand or don't agree with, please let us know. We want you to be comfortable that you are getting the care you deserve based on the fees for that care.*

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[1] Reference: Dig deep: Impacts and implications of rising out-of-pocket health care costs, Deloitte https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lchs-dig-deep-hidden-costs-112414.pdf

Patient Advocacy and Collecting: A Perfect Combination

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Establishing expectations before providing a service helps patients understand and appreciate their obligation and instills a sense of duty to pay for the services they receive. And, should the account go unpaid long enough for it to become bad debt, this initial clarification about the patient's financial responsibilities serves as a reference point and reminder of the initial agreement between them and a provider's practice.

Collection Compliance for Non-Profit Organizations

Requirements for 501(c)(3) Hospitals Under the Affordable Care Act, enacted March 23, 2010, added new stipulations that hospital organizations must satisfy in order to be deemed a non-profit organization. Section 501(r) requires providers to disclose their entire revenue cycle management policy to patients.

This means the patient must understand how you intend to handle their account should they be unwilling or unable to pay. The requirements extend beyond that. The law requires that providers disclose their intent to turn over an account to a collection agency or sell the debt if their account will be reported to a credit bureau, if it is subject to a lien and if they could be charged interest on all unpaid balances.

Creating a Culture for Patient Advocacy

The key to creating the right culture is creating an environment where your employees (or those of your partner) truly want to help your patients understand and resolve their bills. This fundamental premise has moved many organizations' cultures from a "collector" mentality

to a "financial counselor" mentality. A best practice operational procedure is to divide duties and roles among collectors into two distinct buckets. The goal of this process is to help patients reach a clear level of understanding regarding their bill and, ultimately, move them from bucket two to bucket one.

Bucket one – Patients who understand what they owe and need to talk through payment terms, settlement strategies, etc. These need to work with a staff member who is skilled in determining each patients specific set of circumstances and can advise them on the best payment option to fit their needs.

Bucket two – Patients who simply do not understand what they owe and/or why they owe it. These patients need to work with an "education-minded" staff member. These team members should be prepared and willing to evaluate every detail of the account and explain in detail how and why the patient has responsibility for the amounts owed.

When following up with patients who still owe on their bill, it is crucial that staff avoid threatening behavior that can put the patient on the defensive. To avoid this, make sure your policies include followup that is predicated on the idea of helping the patient versus collecting from them.

With these guidelines in place, patients will feel that the provider is on their side and willing to work with them to come to a mutually beneficial resolution regarding any outstanding or unpaid bills.

The Do's and Don'ts of Patient Advocacy

To ensure a high level of patient satisfaction during the collection process, be sure to consider these as you develop your policies and procedures for collecting unpaid accounts.

Do's

- Empower and train your team members to strive for 100 percent resolution on every call.
- Encourage team members to listen to each patient thoroughly and with compassion.
- Reward the right behavior and outcomes with your team (whether through bonus structures, department lunches/rewards or simply through broadcasting recognition freely and regularly).
- Use call recordings as learning experiences, not just grading tools.

Don'ts

- Overemphasize measurements that are not satisfaction oriented (e.g., call time limits, number of calls, etc.)
- Outsource patient contact to collection companies who are not that skilled in positive patient contact.

Talent and Technology Resources

Successfully asking patients for money and receiving it requires a special talent that involves a unique blend of people skills and systems management.

Rather than relying solely on the billing and customer service departments to handle all collection matters, have dedicated collection specialists who are in charge of both the face-to-face and telephone communication with patients. Having a qualified person handling the following types of tasks can mean the difference between successful collection outcomes and poor collection results.

- Writing patient communication scripts used in the collections process
- Dealing directly with patient billing conflicts
- Understanding the entire billing process and patient payment information
- Collecting co-pays and balances at the time of service
- Collecting payment for services prior to rendering services

Having the right technology in place can also mitigate some of the pitfalls of collecting self-pay accounts. For example, software solutions can now ensure proper compliance and optimal patient contact. These systems operate by uploading recordings of every call and then parse through call data to look for key words or terms. For example, to ensure that all staff are following proper protocols, software can search recordings for forbidden words or phrases on every call. The system then tracks calls based on meeting quality criteria. This information can be used to reward staff who are doing their jobs correctly, as well as to retrain those who are not.

Choosing the Right Collection Partner

Once all internal efforts to collect are exhausted, most providers look to professional collection agencies to collect aged receivables. Many providers fear damaging the provider/patient relationship, therefore allowing patient accounts to stagnate by not placing them with a third-party collection agency.

Providers can follow several approaches to collect aged receivables. They can:

- Write off the debt and not collect it.
- Transfer the debt to a professional collection agency for collection.
- Sell the debt to a trusted third party and let them collect it.

Regardless of the collection strategy a provider chooses to follow, here are seven questions providers should ask when interviewing an outside collection vendor:

1. How much can be collected while keeping a healthy patient relationship?
2. Are the collection partner's systems compatible?
3. Do they share the same organizational values?
4. Will the net financial return be greater if I attempt to collect my accounts receivables internally, sell the debt or place it with a collection agency?
5. Does the partner have a reputation for maintaining patient satisfaction throughout the collection process?
6. How have other providers benefited from collaborating with this vendor?
7. Does the partner offer a low-risk trial period?

Summary

Ideally, the patient-provider relationship would be healthy enough to avoid the need for late-stage collection measures such as placing receivables with a third-party collector or selling uncollectable accounts. Unfortunately, the majority of responsibility paying for healthcare services no longer resides only on the shoulders of commercial insurance companies. Patients are now responsible for a larger percentage of medical costs. This change has precipitated a need for more progressive or creative approaches to collecting patient balances.

To minimize the amount of uncollected debt, providers can employ the following practices:

- Creating a clear self-pay policy;
- Providing payment options and incentives for early payment;
- Creating a culture of patient advocacy; and
- Employing internal talent and hiring qualified external resources.

Lyman Sornberger is President and CEO of LGS Health Care and Chief Strategy Officer for Capio Partners. Prior to his roles at LGS Healthcare and Capio Partners, Sornberger was the Executive Director of Revenue Cycle Management for Cleveland Clinic Health Systems (CCHS) from 2006 – 2012. In this role, he oversaw revenue cycle management for all 11 Cleveland Clinic Health Systems Ohio and Florida Hospitals and 1,800 Foundation Physicians. His responsibilities included all CCHS Patient Access Services, Health Information Management and Billing. Prior to his affiliation with CCHS Sornberger was with the University of Pittsburgh Medical Center for 22 years as a leader in revenue cycle management. Sornberger is a graduate from the University of Pittsburgh with a bachelor's degree in science and a master's degree in business. He can be reached at 216-337-4472 or lyman.sornberger@aol.com.

Overcoming Medical Errors of Omission: The Cure Requires Organizational Empathy

David W. Johnson
CEO and Founder, 4sight Health, Chicago, IL

Organizations fail or decline more frequently because of what they did not do than because of what they did.

~ Russell L. Ackoff,
Professor of Management Science,
Wharton School, University of Pennsylvania

Organizational *errors of omission* occur when companies fail to undertake constructive actions that promote customer welfare. In medicine, omission errors harm and sometimes kill people. Payers deny life-saving treatments. Providers discourage vital second opinions. Patients languish in ignorance or powerlessness.

Cultural and economic factors exacerbate structural errors of omission within medicine. Physician education emphasizes individual responsibility for patient outcomes. Doctors, particularly specialists, believe they are their patients' best hope for a cure. They resist treatment standardization, independent second opinions and patient transfers.

Still-predominate fee-for-service payment rewards activity over outcomes and neglects patient experience when reimbursing providers for treatments. Estimates of healthcare "waste" approximate $1 trillion[1] or six percent of the U.S. economy.

One trillion is a huge, incomprehensible number. A trillion seconds is almost 32,000 years—long before the first human civilizations. Wasting $1 trillion in healthcare spending is hard to do. It requires lots of good people doing bad things as well as many bad people doing very bad things (e.g., Medicare fraud).

Even worse than healthcare's profligacy is its lack of empathy. In many, perhaps most, clinical settings, patient experience and treatment outcomes are secondary considerations. Revenue optimization is job #1. American healthcare is not only expensive, it is difficult to navigate, often unfeeling and sometimes cruel.

The solutions for addressing healthcare's stunted empathy lie within the ancient Hippocratic Oath: sharing knowledge; following scientific evidence; exhibiting compassion; putting patients' needs first; acknowledging limitations and emphasizing prevention. Healthcare must go back to its future.

Structural Medical Errors of Omission

In his book *Who Gets What—and Why*, Nobel economist Alvin Roth describes how kidney exchanges have dramatically increased kidney transplant surgeries.[2] Sophisticated software matches kidney donors and recipients. An "altruistic" donor initiates the transplant chain. The recipient's partner then donates a kidney to another diseased patient. The chain continues until a recipient's partner is unwilling or unable to donate a kidney. This happens rarely.

According to Roth, hospitals limit the effectiveness of kidney exchange chains. Surgical centers create registries

[1] http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_82.pdf
[2] Alvin L. Roth, Who Gets What – and Why, Chapter 3 *Lifesaving Exchanges*, Houghton Mifflin Harcourt, 2016

of potential kidney donors. Some kidney donors are easier to match. Centers "hoard" their easier-to-match donors, so they can perform and receive payment for related kidney transplant surgeries. The tragic result is fewer kidney transplants.

Kidney exchanges are just one of multiple examples where organizational prerogatives trump patient needs. It's time for American healthcare to re-examine its priorities. Paraphrasing former Vice President Hubert Humphrey:

Healthcare's true moral test is how it treats those in the dawn of life, the children; those in the twilight of life, the elderly; and those in the shadows of life, the needy.

How does U.S. healthcare do in these three categories?

- **Dawn of Life:** Medical science has proven that pregnant women carrying to term (39 weeks) results in healthier babies and mothers. It also reduces complications and neo-natal ICU admissions. Induced labor is very popular in most hospitals.
- **Twilight of Life:** 70 percent of people surveyed indicate a preference for dying at home. Nevertheless, 70 percent die in hospitals or long-term care facilities. Hospital and ICU admissions in the last six months of life are increasing.[3] Forty-four percent of Americans see 10 or more physicians in the last six months of life.[4] The end-of-life care treadmill is accelerating.
- **Shadows of Life:** U.S. healthcare dramatically under-invests in behavioral health, chronic disease management and preventive care. This under-investment falls disproportionately on economically-disadvantaged individuals and contributes to the double-digit life-expectancy disparity between America's rich and poor.[5]

The Empathy Gap

While informative, aggregate statistics are antiseptic, individual stories offer more compelling evidence of healthcare's empathy gap. Here are three from my universe of friends and acquaintances:

- A friend's father with pancreatic cancer was about to undergo Whipple surgery. A confident surgeon pressed to move forward even though he'd only performed six Whipple procedures and none of his patients had survived the operation. My friend transferred his father to M.D. Anderson where he underwent successful surgery.
- Another friend developed early-stage prostate cancer. His local surgeon recommended robotic surgery with likely loss of sexual function. Instead, he consulted a San Francisco specialist who performed less-invasive brachytherapy that cured him with no side effects.
- Under pressure from his oncologist son, a former health system CFO received a second opinion from Johns Hopkins on his bladder cancer. Turns out, the bladder cancer was actually a urethral carcinoma–different diagnosis and treatment.

The list goes on. Almost all Americans have similar stories. They illustrate clinical errors of omission. Clinical errors of omission are hard to detect. Poor subsequent outcomes are not even counted as medical errors.

Service errors of omission also occur regularly in healthcare. Excessive noise during diagnosis, treatments and recov-

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[3] http://www.pbs.org/wgbh/pages/frontline/facing-death/facts-and-figures/
[4] http://www.dartmouthatlas.org/data/table.aspx?ind=17
[5] https://www.brookings.edu/wp-content/uploads/2016/02/BosworthBurtlessZhang_retirementinequalitylongevity_012815.pdf
[6] Atul Gawande, Better, Chapter 3 *Casualties of War,* Picador, 2007

Overcoming Medical Errors of Omission: The Cure Requires Organizational Empathy

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ery triggers stress and retards healing. Unclear directions, opaque pricing and excessive waiting can be confusing, frustrating and even demoralizing to patients.

Military Triage

In *Better*, author and surgeon Atul Gawande describes how the military

reduced battlefield deaths during the Second Gulf War.[6] Despite medical advances, battlefield deaths had remained constant at roughly 25 percent of injured soldiers for 50 years. Focusing on outcomes and performance science reduced battlefield deaths to 10 percent during the Second Gulf War.

The military established sequential care levels with defined treatment protocols. Level 1 consisted of mobile "forward surgical teams" with 20 caregivers that followed soldiers into battle. They stabilized wounded soldiers within minutes of injury. More seriously wounded soldiers transfer immediately to nearby modular "combat support hospitals." After two – three days of treatment at these CSH facilities, soldiers with more advanced injuries transfer to level IV hospitals in Europe or the U.S.

Data was instrumental to performance improvement. Despite a chaotic environment and punishing hours, frontline caregivers kept injury, treatment and outcome logs with 75-plus data fields for each casualty. Over time, patterns emerged that improved diagnosis, care protocols and recovery times.

Overcoming physician reluctance to transfer their patients was a major challenge. Gawande describes the "trust no one" mentality that permeates medical training. Gradually, military physicians accepted the new system. The average time from battlefield injury to advanced treatment in U.S. facilities dropped to four days from 45 days during the Vietnam War.

Focusing on patients and outcomes without bias clarifies the caregiving process. Meaningful data and evidence-based protocols reduce treatment variation and improve care delivery. This isn't magic. It is performance science.

Actual and Virtual Reality

Last month, I shared a long Uber ride with Jowoon Kim, a Korean software engineer. Her company OnComfort develops virtual-reality programs that help people manage stress. We were on our way to the Medicine X conference at Stanford University where Jowoon was competing to win a prize for innovative patient-centric cancer care products.

Before long, I was wearing Samsung Oculus goggles and experiencing a soothing meditation routine called "Aqua." I was under water and modulating my breathing to a dolphin's tailfin movement. I relaxed and sank into my seat.

OnComfort uses meditation programs to calm patients during chemotherapy sessions. Early evidence suggests these programs stimulate EDSO (endorphin, dopamine, serotonin and oxytocin) chemical release and promote healing. What a great idea.

When we arrived in Palo Alto, I left my smart phone in the Uber. Still relaxed 15 minutes later, I called my Uber driver Romeo. He had left my phone with Felix at the hotel's front desk—an incredible, uniquely San Francisco experience.

The Medicine X conference emphasizes healthcare design and patient experience. Resident artist Yoko Sen asked attendees to identify the last sound they'd like to hear before dying.

Patients participated in all sessions and gave several TED-style presentations. The conference runs on empathy. It promotes inclusiveness and open-platform technology to advance medical discovery and healing.

Contrast this serenity and perspective with the jarring, chaotic jumble that most patients experience in hospitals. Consider the power of truly delivering patient-centered care.

Back to the Future

Modern medicine has lost its humility, its awe for natural healing and its reverence for humanity. High-tech interventions expand the frontiers of medical discovery while more people than ever suffer from chronic, debilitating conditions. Fragmented delivery and payment models cost too much, cause undue harm and foster unnecessary stress. Patients have become a means to higher revenues.

Hippocrates recommended that physicians serve "to help or, at least, to do no harm" to patients. Structural errors of omission don't help patients and often cause harm. They inhibit effective transitions. They frustrate caregivers. They confuse, discourage and even demoralize patients.

Health companies must reinvent themselves to truly serve patients. All sick individuals deserve compassionate treatment, care navigators and independent second opinions. Care delivery should attend to the mind and the spirit as well as the body. Military medicine absorbed these truths and revolutionized its treatment capabilities.

"Patients First" is an ancient truth. Medicine cannot move forward until it recaptures that truth.

David W. Johnson is the CEO and Founder of 4sight Health, a healthcare boutique specializing in thought capital, strategic advisory services and venture investing/capital raising. 4sight Health operates at the intersection of healthcare economics, strategy and capital formation. The company's four-stage analytic (Assess. Align. Adapt. Advance.) reflects the bottom-up, evolutionary character of market-driven reform. Mr. Johnson can be reached at 312-560-0870 or david.johnson@4sighthealth.com.

Clinical Variation: The Hidden Gem in Bundles

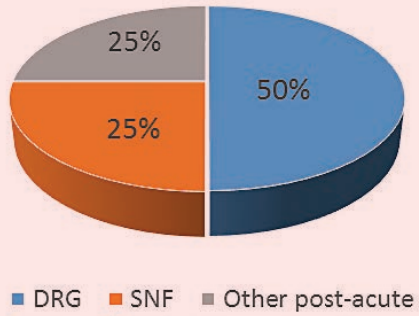
Sheldon Hamburger
Principal/Consultant, The Aristone Group, Raleigh-Durham, NC

The Centers for Medicare and Medicaid Services' (CMS) ongoing push into mandatory bundles is finally making the healthcare industry stand up and take notice. Because of the government's focus on reducing post-acute spend in these programs, hospitals follow suit and believe that their opportunity resides in the post-discharge venue. As we'll see, there is a much larger financial opportunity available for those willing to seek it out.

A hospital performing some "reasonable number" (let's say about 1,000) hip and knee replacements per year could be seeing a post-acute world that looks something like Figure 1 below. These percentages are approximate and more along the lines of "order of magnitude."

Note: After seeing many analyses of CMS data for both Bundled Payments for Care Improvement (BPCI) and Comprehensive Care for Joint Replacement (CJR), the below percentages seem

FIGURE 1 **Typical Orthopaedic Bundle Distribution**



Diagnosis-Related Group (DRG)
Skilled Nursing Facility (SNF)

to hold true with only minor variations on a facility-by-facility basis. For example, Diagnosis-Related Group (DRG) might be 46 percent, Skilled Nursing Facility (SNF) might be 28 percent, and so on.

Let's consider some approximate numbers using these percentages:

Annual # cases	1,000	Assumption
DRG $/case	$15,000	Assumption
Total bundle target price	$30,000	= 2 x DRG
SNF $ component/ case	$7,500	= 25 percent of total bundle
Total annual SNF	$7,500,000	1,000 cases x $7,500

CMS' Goal

CMS' nirvana in these bundle programs would be elimination of SNF bringing *their* total SNF spend to $0. More realistically, cutting SNF in half is probably the target. This would result in a $3.75 million annual savings to CMS in our example above. The hospital's share of this savings could be up to 20 percent in the newest mandatory models. This would generate about $750,000 per year for the hospital.

The strategy to effect SNF reduction revolves around sharing some of this savings with the physicians. Known as "gainsharing," such arrangements are generally not allowed in the healthcare world, but bundle programs have waivers to permit this. These gainsharing arrangements create economic incentives for surgeons to promote reduction in SNF utilization.

What's in it for the Hospital? More Than Most People Realize!

In every instance I've seen, hospitals follow the CMS lead and pursue post-acute savings as their lead source of

revenue in bundled payment programs. While not "chump change," the potential post-acute revenue to hospitals under these programs ($750,000 in our example above) is actually dwarfed by a unique opportunity CMS has provided.

In addition to sharing savings in the area of post-acute care, CMS also allows hospitals to generate savings under something it refers to as "internal cost savings" (ICS). These are savings the hospital achieves for care improvement under the bundle program by performance optimization within their own four walls as opposed to post-acute care.

Often, hospitals look at the ICS opportunity to mean, in orthopedic cases, for example, reductions in implant spending by standardizing vendors. This type of improvement may generate some savings, but the amounts are relatively small. Moreover, hospitals find it very difficult to get surgeons to standardize on these devices.

What's So Special About ICS?

The great thing about ICS is that there are no limits on how much a hospital can save *and* the hospital gets to keep 100 percent of that savings. Of course, you don't need to be part of any "program" to work on internal operational improvements. But as we'll see, CMS provides a special incentive to drive theoretical savings to reality.

A Note About Clinical Variation

For many years, hospitals have been struggling with the challenges of clinical variation, and rightfully so. Wide variations on a risk-adjusted, per case variation for any medical or surgical condition indicate inefficiencies that can only be addressed through direct physician engagement with credible data, as Don Berwick, MD, the quality expert, noted.[1]

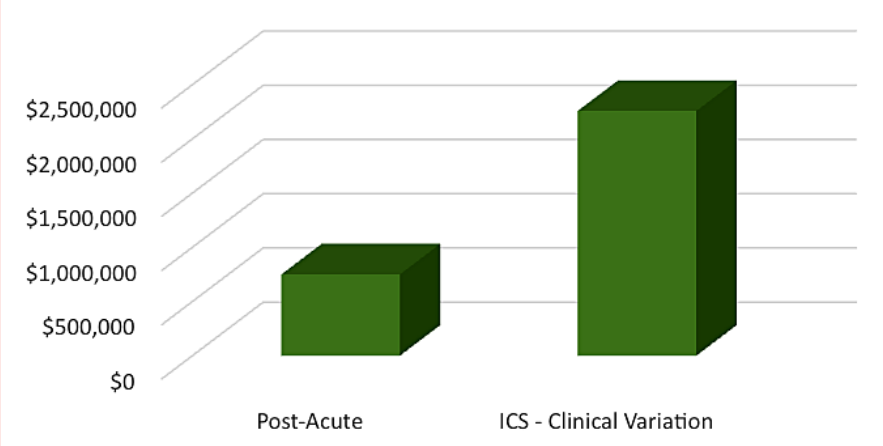
I often hear hospitals explain that they have ongoing initiatives in this area including the establishment of standardized order sets and the use of fancy data analytics tools. But when I drill down, reality is that these initiatives are hardly effective, if at all.

Studies show that, adjusted for patient acuity, a given surgeon's cases can vary up to about $30,000 per case.[2] For a hospital with 1,000 annual cases, this equates to a staggering $30,000,000 per year! Of course, it's not realistic to expect the elimination of all clinical variation. But even a reduction of just eight percent would yield $2.5 million to the hospital—three times the post-acute opportunity that is commonly the target of bundle programs (See Figure 2).

While this challenge of reduction in clinical variation is well known, hospitals have been unable to make inroads in improving the situation because the necessary changes fundamentally revolve around *changing surgeons' practice patterns*, which has always proven to be difficult, but not impossible, using reliable data. This makes sense. Changing human behavior is always difficult, but doctors will make rational decisions based on their own data, if it's objective, transparent and credible.

But, CMS bundle programs allow "gainsharing" with surgeons who cooperate in such behavior change. This gainsharing has always been the missing ingredient in a truly effective strategy to address clinical variation.

FIGURE 2 **Potential Bundle Savings. Which Would You Pursue?**



The Hidden Gem Emerges

This is the hidden gem in CMS bundle programs. Just look at the numbers. The hospital example cited above is chasing about $750,000 per year in post-acute savings. To achieve this, they will invest in care coordination software technology and additional staffing for care navigators and/or case managers. Those "investments" are ongoing; that is, they are new, annual expenses substantially reducing the $750,000 opportunity.

But the same hospital could choose to pursue $2.5 million per year in clinical variation savings. To achieve this, they will make initial investments in technology and training to effect the needed surgeon behavior change. Once that change has been implemented, the ongoing costs should be nothing more

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[1] Berwick, D. (1989). Continuous improvement as an ideal in healthcare. New England Journal of Medicine, 320, 53-56

[2] Source: Various hospital studies by Verras, the American Hospital Association's endorsed solution for clinical variation, repeatedly show variations of $20-$30K per case.

Clinical Variation: The Hidden Gem in Bundles

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than minimal technology. Even if these implementation and operational costs are double those of the post-acute opportunity, the net savings to the hospital simply dwarf anything in post-acute (See Figure 3).

Now look at the accumulated savings (these are hard dollars, not "efficiency improvement"), to the hospital over three years (See Figure 4).

And remember—there is no limit to the amount of savings the hospital can generate. And it keeps 100 percent of that savings.

What Are You Waiting For?

Given this unique opportunity that is only afforded in bundled programs, it is difficult to understand why hospitals simply don't ignore the post-acute area and instead focus on clinical variation as the key part of ICS.

Additional benefits come from these efforts. For example, new workflows and processes that result in the improvements in orthopedics will create a natural halo effect that crosses over to other services lines. This is additional free money—100 percent to the bottom line.

Obviously, there is much work and effort required to achieve the results here. But given the economic opportunity, this should be the primary focus of every bundle program under CMS.

FIGURE 3 Three Year Implementation/Operational Costs

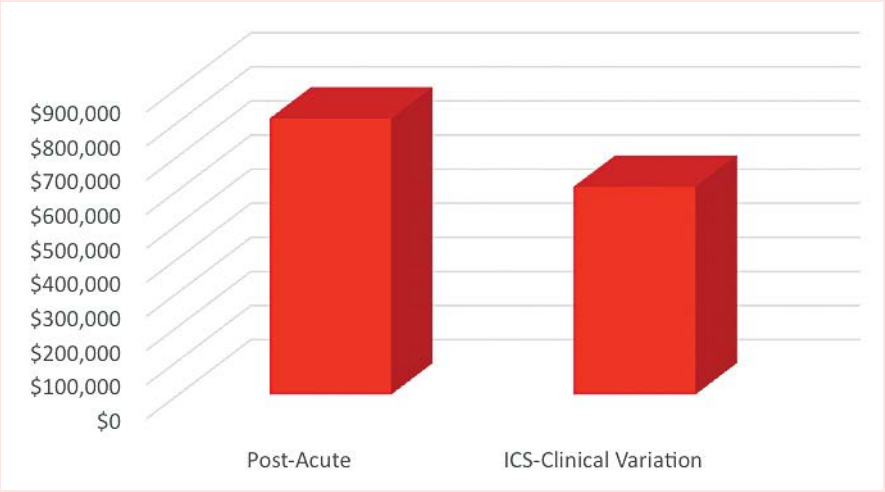
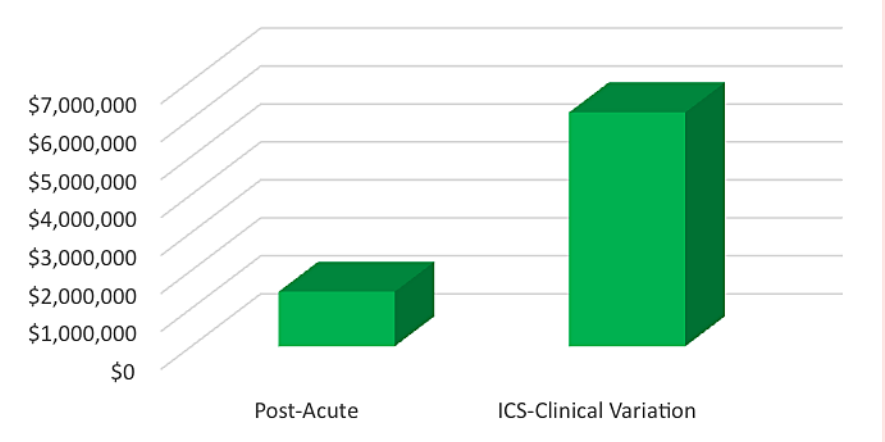
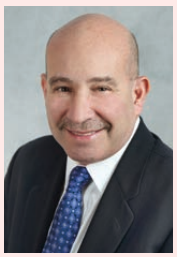


FIGURE 4 Net Return to Hospital Over Three Years



Sheldon Hamburger is an alternative payment model advisor for hospitals and healthcare firms nationally. With a focus on program implementation, he brings extensive knowledge and experience gained from more than 25 years of healthcare financial consulting, technology design and development, and sales and marketing strategy for Fortune 1000 clients. He is a frequently sought-after speaker and writer on regulatory and technology trends affecting hospital operations, provider reimbursement issues, BPCI/CJR, programs and regulations, medical expense strategies and payer-provider dynamics. Residing in Raleigh, NC, he is an active member of HIMSS, HFMA and ACHE. He earned his bachelor's degree in Computer Engineering from the University of Michigan. He can be reached at shamburger@thearistonegroup.com or (248) 613-7166.



Four Ways to Be More Consumer-Centric

Louis Carter
CEO and Founder, Best Practice Institute, West Palm Beach, FL

Being consumer-centric is one of the most significant aspects of any company or organization. One could even argue that it is the *most* important aspect of an organization's existence.

We see examples of consumer-centric operations in business sectors, such as healthcare, hospitality, finance and consumer products, but, by and large, these same operations, which are supposed to be more consumer-centric, are the ones that are not.

Giving the consumer the highest degree of importance has obvious benefits. If you would like to make your organization more consumer-centric, here are a few steps that you can take:

1. Interact Directly with Consumers

The best example of direct interaction is Amazon, a company that asks the consumer directly for their opinion, in order to build the 'Earth's most consumer-centric company.'

To implement that slogan, the CEO and the board of directors interact closely with the consumer base through various surveys and social media platforms designed to build better relationships. Close social interaction turns the consumer into a vital part of the company itself, ensuring that consumers never feel like they are just a transaction. When a consumer is regarded as a part of the company, their value multiplies for employees and new customer prospects.

2. Align Employees by Setting Goals

Consumer-centricity happens when everyone is on the same page. Each employee puts themselves in the shoes of their customers—or in healthcare, their patients—to better understand how to approach each given task.

Arrange multi-department brainstorming sessions, with representatives from each department within the organization, or, in the case of smaller companies, the entire staff together.

Airbus brings all the departments within its structure together to generate ideas. Enhancement of customer experience, the focal point of these meetings, has proven very fruitful. Other examples of organizations that adopt this whole-system methodology include Allstate and NASA.

3. Understand Consumer Demands Precisely

Gear the entire organization's efforts toward fulfilling the demands of the consumers they are serving. This direct involvement in serving the consumer changes the attitude of each employee and management, making everyone more consumer-centric.

Closely monitor the behavior of consumers and their opinions regarding the organization. Forums, social media platforms and blog sites are the best places to look for such feedback online. For physical indications, compare your direct sales numbers with those of your competitors.

The best example of this is Apple, whose customer research policy is built into their live customer service procedures. When a consumer is politely asked about their preferences, their specifications are noted, and the collected data contributes to a better product.

4. Channel Consumer Feedback into Improvement

Understand and act upon what consumers communicate about an organization, product or service as soon as possible. The consumer is likely to adopt another organization's substitute services if no change is seen. There are a multitude of options, so act expeditiously. Making immediate changes also has the added advantage of giving the impression that the organization cares about its consumers or customers.

Using consumer analytics is one way to act quickly and make effective, data-driven decisions, and nobody uses it better than Netflix. Netflix offered a $1 million prize to anyone who could design an algorithm that would capture consumer behavior in the most accurate manner. To this day, Netflix continues the practice of utilizing award-winning algorithms, and it is taking the on-demand streaming industry by storm.

Some of the best examples of consumer-centricity come from industries and organizations that are completely different from your own. When you hunt for ways to improve your consumer approach, think about how you would like to be treated as a consumer and design a program from that perspective. In our company, our computer programming takes advantage of a technique called user-side testing. I tell them to become the consumer after they are done. Did they experience it in a way that made them smile? If not, I ask them to go back and try again, because chances are when they turn over the working code to me, if they aren't smiling, I won't be smiling either.

Louis Carter is CEO and founder of Best Practice Institute, Chairman of the BPI Senior Executive Board, and author of over 12 books on best practices and organizational leadership. He works with organizations such as the Pentagon, United Nations and USAWC, among others, creating sustainable and purposeful partnerships that help promote positive working environments for people around the world and the Fortune 500 organizations on BPI's Senior Executive Board, such as Bristol Myers Squibb, Tyco, Pfizer, KeyBank, MasterCard, Hilton Worldwide, Aramco and Baxalta, among others. He has won the Leadership Excellence award, and was awarded the Top HR Product of the Year Award by the HR Tech Conference for his creation of www.skillrater.com. He is a frequent contributor and has been mentioned in Fast Company, Investor's Business Daily, Business Watch Magazine, Pando Daily and CIO Magazine. He has held numerous advisor, facilitation and acceleration roles focusing on public relations, research and technology consulting. Mr. Carter can be reached at lou@bestpracticeinstitute.org.

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PROFESSIONAL EVENTS

Date	Event	Location	Contact Info
January 9-12, 2017	American College of Healthcare Executives Bonita Springs Cluster	Hyatt Regency Coconut Point Bonita Springs, FL	https://www.ache.org/seminars/cluster.cfm?MEET=BONITA2017
January 15-18, 2017	Healthcare Financial Management Association 19th Annual Western Region Symposium	Planet Hollywood Las Vegas, NV	http://hfmaregion11symposium.org/
January 23-26, 2017	American College of Healthcare Executives Breckenridge Cluster	DoubleTree Breckenridge Breckenridge, CO	https://www.ache.org/seminars/cluster.cfm?MEET=BRECK2017
Jan. 30-Feb. 2, 2017	American College of Healthcare Executives Scottsdale Cluster	The Scottsdale Resort at McCormick Ranch Scottsdale, AZ	https://www.ache.org/seminars/cluster.cfm?MEET=SCOTTS2017
February 8-10, 2017	Healthcare Financial Management Association National Payment Innovation Summit 2017	The Westin Galleria Dallas, TX	https://www.hfma.org/npis/
February 19-21, 2017	Medical Group Management Association 2017 Financial Management and Payer Contracting Conference	Caesars Palace Las Vegas, NV	http://www.mgma.com/fmpc/why-attend
March 20-22, 2017	Ohio Health Information Management Association 37th Annual Meeting and Tradeshow	Hilton Columbus at Easton Columbus, OH	http://ohima.org/information/information145.html
March 21-24, 2017	Healthcare Financial Management Association 2017 Dixie Institute	The Westin Savannah Harbor Savannah, GA	http://www.hfmadixie.org/
March 27-30, 2017	American College of Healthcare Executives 2017 Congress on Healthcare Leadership	Hilton Chicago Chicago, IL	https://www.ache.org/congress/
April 5-8, 2017	National Cancer Registrars Association 43rd Annual Educational Conference	Gaylord National Resort and Convention Center Washington, D.C.	http://www.ncra-usa.org/i4a/pages/index.cfm?pageid=3866

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