

PUBLICATION FOR THE MISSISSIPPI HEALTHCARE FINANCE COMMUNITY

Mississippi Headlines

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hfma mississippi chapter
healthcare financial management association



OFFICIAL NEWSLETTER OF THE MISSISSIPPI CHAPTER OF HEALTHCARE FINANCIAL MANAGEMENT

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President's Message



Andres Posada, President

As we close out another HFMA year, I've been able to reflect over the past two years that I served as president, and I'm really excited for the future. These past two years were difficult for the chapter, but as a team, we took it head on. COVID brought a lot of challenges, but at the same time, it allowed us to learn new things. Our pain points were several: canceling meetings, not getting to socialize and see each other for over a year, having to re-evaluate our finances, and many more. These challenges, however, brought great opportunity. Our team learned to respond to crisis in a quick and effective manner. We made our meetings virtual, and all of them were very successful. We gave our sponsors new avenues to highlight their services which strengthened our partnership with them. We built a team with a strong bench, which should keep us going through 2025.

Fortunately, the tough times didn't last my whole two years of service! We finally were able to have meetings back on-site in December and once again in April. Not only were we able to meet in person, but we also took this opportunity to serve those that are less fortunate. In December we made toy donations to Toys-for-Tots, and in April our Annual Conference attendees stuffed 100 animals to donate to Batson Children's Hospital. We are all aware of how important it is to give back, and we plan on keeping this going with our future meetings.

With the many challenges over the past two years, I truly believe our team stepped up which has us in a better spot than ever before. I would not have been able to do this alone, and that is why I want to thank our board and committee members. Every one of you stepped up to make our chapter successful, and for that I am very grateful.

On another note, our leadership team for the upcoming year was able to attend HFMA's Leadership Training Conference in Phoenix this past April. The team has come back re-energized and ready for the new year. Under the leadership of Kimberly Williams, we plan to reach out to our members to figure out ways to serve you better. Please take some time and share with us how the chapter can help you. We also have several innovative things in the works, but I will let Kimberly share those with you in the future!

Finally, today I'm saying goodbye to you as President, but I'll still be around. I plan to serve the chapter in whatever capacity it needs me. If you would like to join me, please reach out. There are several ways you can volunteer to help the chapter.

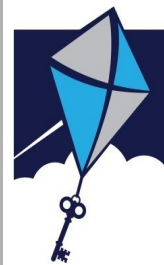
It has been a true honor and privilege to serve as President for the past two years. Thank you to everyone one of you that went on this roller coaster ride with me.

Warm regards,

Andres Posada
President
Mississippi Chapter of HFMA

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

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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/>.

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Medicare's proposed increase for inpatient payments in FY23 doesn't meet hospitals' expectations

By Nick Hut, HFMA.org

- **The hospital industry expressed disappointment with the proposed increase for inpatient payments in FY23.**
- **The concern over the payment increase was exacerbated by proposed reductions to supplemental**
- **CMS is seeking to stabilize the calculation of UC payments and annual changes to a hospital's wage index.**
- **Long-term care hospitals would see a small payment increase under the proposed rule.**

The updates in Medicare's FY23 proposed rule for hospital inpatient payments will leave hospitals and health systems in a tight spot financially, advocates said.

MS released the proposed rule April 18, putting forth a 3.2% payment increase for hospitals that meet quality-reporting requirements and fulfill the criteria to be designated as meaningful users of electronic health records. The payment boost stems from a projected market-basket increase of 3.1% and statutory adjustments that result in a net gain of 0.1%.

Advocates say the increase isn't sufficient in an era of surging wage and supply costs. What's more, the payment-rate change could be close to zero or even amount to a decrease for some hospitals.

While CMS estimates that the payment increase will total \$1.6 billion in aggregate, it also projects a decrease of \$800 million in Medicare disproportionate share hospital (DSH) and uncompensated care (UC) payments, and another \$800 million reduction in new-technology add-on payments.

In addition, a \$600 million decrease is anticipated for facilities categorized as Medicare-dependent hospitals and low-volume hospitals, barring legislation to extend those payments.

Add it all up, and it's not the type of update that hospital advocates were seeking.

"This is simply unacceptable for hospitals and health systems, and their caregivers, that have been on the front lines of the COVID-19 pandemic for over two years now," Stacey Hughes, executive vice president of the American Hospital Association, said in a written statement.

The Federation of American Hospitals (FAH) described the payment increase as "woefully inadequate. It does not reckon for the hyperinflation, staffing crisis and the continuing pandemic, which will impact resources necessary for patient care well into the future."

[READ THE ENTIRE ARTICLE FROM HFMA.ORG](#)



As the number of Veterans utilizing VA health benefits increases over the next five years—learn how a specialized revenue cycle partner can maximize reimbursement

By Kemberton | 2022

With the highly complex nature of Veterans Administration claims, working with a specialized revenue cycle partner for VA claims processing is a much more efficient and cost-effective option for providers.



Rising traffic of VA patients at non-VA health facilities

As the largest integrated healthcare system in the U.S., the Veterans Health Administration runs over 1,200 Healthcare Facilities, but these facilities alone cannot adequately meet the needs of over 9 million Veterans enrolled in the VA healthcare program. Over the past several years, more non-VA healthcare providers are treating a higher traffic of VA patients. However, the highly complex nature of VA claims makes getting reimbursed for care a unique challenge for providers.

Up to [60% of VA enrollees](#) seek concurrent primary care at non-VA healthcare facilities, especially in rural areas where the nearest VA facility may not be easily accessible. Studies by RAND have found that VA patients get more than [half of their care](#) through non-VA sources, especially for prescription drugs and inpatient visits associated with surgery.

Exactly how many VA patients come through your health system depends on the unique environment, location, and population mix of your organization, but the general consensus is that the number of Veterans who rely on VA health benefits is [expected to increase](#) over the next five years before levelling off. Data from the Census Bureau also projects the changing demographic distribution of Veterans in the near future: more Veterans concentrated in urban areas, more women, and younger patients overall. Recent legislative changes have also made it easier for Veterans to obtain care at non-VA facilities. The Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, intended to give Veterans access to healthcare when and where they need it, has led to higher VA traffic at non-VA facilities. Meanwhile, a landmark [Court of Appeals ruling](#) in 2019 paved the way for non-VA healthcare providers to be reimbursed for up to \$6.5 billion in emergency care services delivered between 2016 and 2025

VA claims: A tedious, time-consuming process

With all these factors, healthcare providers must be acutely aware of how to treat VA claims or risk higher proportions of aged A/R and millions of dollars in underpayments — if claims are even successfully resolved at all. While most healthcare providers' patient financial services and revenue cycle teams are equipped to collect reimbursement from traditional health payers more efficiently, VA claims can be an entirely different ball game altogether — overly complex, extremely time and resource consuming, and requires highly specialized expertise. Rather than develop the necessary training and expertise in-house, healthcare providers may find outsourcing VA claims to be a far more efficient and cost-effective option that enables them to reallocate time and resources toward more viable claims. Some of the reasons to consider working with a specialized revenue cycle partner for VA claims are:

1. Identify appropriate payers and ensure timely filing

The most important step of getting claims properly reimbursed is complying with the VA's stringent filing requirements. Depending on your healthcare organization's status in the VA's network and how the care was authorized, claims must be filed with the correct third-party administrator. As of March 31, 2021, the VA has transitioned from Patient Centered-Community Care (PC3) to Community Care Network (CCN) with an established transition period for care through PC3 within Regions 5 (Alaska) and 6 (Pacific Islands) through March 31, 2022.

For authorized care in Regions 1-3, providers that are enrolled in CCN need to go through Optum United Health Care, while Regions 4-5 providers should file claims with TriWest Healthcare Alliance for both CCN authorized care and transitory PC3 claims. If your organization has a Veterans Care Agreement (VCA) or are not part of one of VA's formal networks, claims should be filed directly with the VA.

Source: https://www.va.gov/COMMUNITYCARE/providers/Community_Care_Network.asp

The deadlines for filing claims are as follows:



Continued

Program	Filing Deadline
Authorized Care	180 days
Unauthorized Emergent Care (service-connected)	2 years
Unauthorized Emergent Care (non service-connected)	90 days

Minimize rejected and denied claims

Unlike other payers, VA regulations differentiate denied and rejected claims, although lack of visibility into the claim status can be a source of impediment for healthcare providers. “Denied” claims declare there is no basis for payment, while “rejected” claims cannot be decided until the additional or corrected information is provided. In either case, intervention is required and more often, appeals become the norm. Unaddressed denied and rejected claims shift the financial burden of care to the Veteran, which then presents a significant financial risk to providers as these medical bills mount and end up as bad debt.

Avoidable errors — even those as small as an additional space or punctuation in the patient’s ID number — can cause a claim to be rejected. According to the VA, these are the top reasons claims are rejected:

- Missing/Incomplete/Invalid Insured ID
- Outpatient Claim has a Missing “Admission Type” Code
- Missing Admission Type when Admission Date is Present
- Referring and Attending Physician NPI are Equal
- Claim Contains a Missing/Incomplete/Invalid Billing Provider Address

Adding to providers’ long list of challenges in processing VA claims, the VA does not provide a traditional route to appeal denied claims. This highlights the importance of filing claims on time and correctly the first time, every time — and the necessity of assigning specialized resources with the necessary experience and expertise to navigate all the piles of paperwork associated with VA claims.

Navigate the complex challenges of all VA programs

In the traditional revenue cycle, health insurance claims ideally can be recovered in no more than one or two touchpoints. VA reimbursement, on the other hand, requires extraordinary effort and multiple touchpoints. Successfully adjudicating VA claims depends on persistent and knowledgeable follow-up. Although the VA stipulates claims will be processed within 30 to 45 calendar days, providers can spend up to a year or more waiting on unpaid claims, leading to aged A/R and a much lower likelihood of collection.

In addition, many providers don’t have the time or resources to follow-up on each VA claim — a tedious, time-consuming task — in an efficient manner. For example, phone access hours are limited, and VA call center staff adhere strictly to the number of claims that can be discussed for each call. Instead of spending hours to follow-up on one VA claim, which leads to overwhelmed staff and higher costs to collect, working with a specialized VA claims partner enables your revenue cycle team to refocus their time and efforts on higher and more viable reimbursing payers.

Enhance the patient experience

Finally, one of the biggest advantages of outsourcing your VA claims is an improved experience for Veteran patients. Instead of an overwhelming maze of red tape, patients are guided with personalized advocacy and compassion by experienced VA specialists through every step of their healthcare journey — which greatly increases engagement, enhances the patient experience, and reduces anxiety due to the uncertainty of potential medical costs

How Kemberton can help

When you partner with Kemberton for your [Veterans Administration Claims](#), you gain access to VA collections specialists and experienced Veteran claims Advocates, comprising of a proficient and focused team, with the knowledge and experience to comply with all of the VA’s complex filing requirements. Working as an extension of your team, we help providers maximize reimbursement, reduce denials, and lower bad debt reserves on VA claims.

To find out how we can best assist you, contact:

Roze Seale, CRCR,
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Motor Vehicle Accident Claims	Eligibility and Enrollment Services
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Retention Strategies During the Great Resignation



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Popular News sources report that employees are leaving the workplace in mass and looking for new jobs and have labeled this workplace exodus as the great resignation. Retention and recruitment for healthcare revenue cycle employees is becoming increasingly challenging, and this is especially true for frontline gatekeepers working in Patient Access in various settings. Revenue Cycle leaders must continue to focus on retention and recruitment and be open to new and different strategies to achieve revenue cycle success.

According to an article on People Scout at <https://www.peoplescout.com/insights/engage-and-retain-healthcare-workers/>, a healthy healthcare organization has happy and well engaged employees. The article references a survey conducted by Leaders for Today that included 852 participants of clinical and non-clinical employees. The survey results showed that 43% of respondents were with their current organization for less than 2 years and 65.7% stated that they were with their hospital less than 5 years. More than one-third of the survey respondents had planned to leave within 2 years and 68.6% were planning to leave in 5 years. Additionally, there is the high financial cost of employee turnover.

The best way to retain employees and achieve sustainable business growth is by aligning the goals of employees with those of their directors and leaders and providing a world class employee experience. Since COVID 19, it is no longer business as usual in how we engage with employees to align their experience with the organization's purpose, brand and culture. One of the primary questions we must address is how to retain good people remaining committed to do their jobs during a time of uncertainty?



Retention Strategies During the Great Resignation

Outlined below are some strategies to consider in retaining your employees and providing that world class employee experience:

1. Evaluate compensation rates and incentive options to remain competitive in what is now a global market for recruiting and retaining top talent.
2. Establish clearly defined goals and performance standards with options for professional development and performance-based incentives.
3. Evaluate onboarding process to ensure new employees experience organization's values and culture during the onboarding process and are affirmed in their decisions to work for you.
4. Provide ongoing training for staff development and provide clear path for career progression.
5. Remain intentional in staying connected to all team members to have a personal touch in building relationships and morale. Consider options for leaders to connect with team members to let them know they are cared for, appreciated and valued perhaps with a handwritten card, virtual lunch to celebrate wins, water cooler chat within Microsoft Teams and/or spontaneous check-in to ask how team members are doing personally.
6. Keep teams connected with frequent team huddles.
7. Allow an alternate work schedule to enhance work life balance while continuing to meet the needs of the business and ensure adequate coverage.
8. Conduct monthly meetings to share vital information to keep everyone abreast of new issues or areas of concern.
9. Have door prizes that employees can win to show appreciation. Employees enjoy winning prizes, and they feel appreciated.



Retention Strategies During the Great Resignation

10. Provide lunch once a quarter to show appreciation for the employees with messages of appreciation for all they do.
11. Provide timely feedback on employees' progress and continued opportunities to learn and grow.
12. Provide timely recognition and praise for doing good work.
13. Ensure employees have frequent opportunities to provide feedback and suggestions through virtual suggestion box, formal employee engagement surveys and exit interviews and ensure leaders provide timely feedback to address opportunities identified.

Employees are any organization's most important assets. Organizations must be consistently assessing employees' needs and develop talent carefully to keep employees engaged and committed to their jobs.

References: Dyson, E. (2022, March) *Medical Staffing: How to Engage and Retain Healthcare Workers* PeopleScout
<https://www.peoplescout.com/insights/engage-and-retain-healthcare-workers/>



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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 leaders explain final plans to restrict Medicare coverage of new Alzheimer's drug

By Nick Hut - HFMA.org excerpts



- CMS mostly finalized previously proposed criteria for covering Aduhelm, which has been promoted as the first drug to treat the underlying pathology of Alzheimer's disease.
- The coverage criteria have been expanded to include additional types of clinical trials and settings.
- State Medicaid programs are statutorily obligated to cover the drug but can apply utilization-management processes.

Aduhelm didn't pass muster as a product that should be widely covered by Medicare, but the new Alzheimer's disease drug and future drugs in the same class still can prove themselves worthy of comprehensive coverage.

That was the primary takeaway from CMS's recent [coverage announcement](#) and comments by agency leaders, who emphasized that they sought to make the decision-making process transparent and evidence-based.

The final coverage determination in large part adheres to the proposed criteria that were announced in January, after which more than 10,000 comments were submitted by stakeholders. Tweaks to the proposed coverage determination are designed to modestly expand coverage of the drug while its efficacy is studied.

The decision prevents coverage of Aduhelm in most healthcare encounters in response to the widespread concerns about the drug's safety and effectiveness that arose leading up to the FDA approval's on an accelerated basis last June.

One expansion of the proposed criteria applies to Aduhelm (the brand name for the drug aducanumab) and any other monoclonal antibody treatments that receive accelerated approval by the FDA and are designed to reduce amyloid in the brain. Several such treatments are in development.

[READ THE ENTIRE ARTICLE HERE](#)

THE LATEST NUMBERS

National Debt 90 days ago - \$29,914,107,500,000.00

National Debt as of today—\$30,452,888,000,000.00

Total Debt to GDP Ratio: 128.97%

Debt Per Taxpayer: \$242,985.00 Debt Per Citizen \$91,466.00

Mississippi Debt \$15,249,237,564 vs 90 days ago \$15,135,000,000.00

National Unemployment Rate: 3.6%, down from 3.8% 90 days ago

National LABOR PARTICIPATION RATE: 62.40%

Mississippi Unemployment Rate as of today: 4.2%

National Average Household Income - \$67,521 / Mississippi - \$45,792

Gas per gallon May 2021—\$3.10 Gas per gallon May 2022—\$4.08

National Poverty Rate – 10.5% / Mississippi Poverty Rate – 19.7%



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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

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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](http://www.HFMA.org/Certification)

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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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