

CONNECTION

EXECUTIVE NOTE

By Michael Lipomi, President & CEO

Managed Growth...Not Easy But Worth The Effort!



A little over a year ago, I came to SMP with a tremendous amount of energy and enthusiasm. I saw a great company that had been providing exceptional service for over 20 years, operating in a market that was exploding

with growth and opportunities. At the same time, I saw all of the talented employees of SMP just looking for opportunities to showcase their depth and breadth of knowledge. Yes, we did have some of our leaders move on to start their own business. I promised our staff and each of our clients that I would not only replace the talent we lost but would in each case improve on the education, experience and professionalism when replacing them. I believe I have accomplished that. I have achieved that in hiring Reed Martin, COO; Rebecca Overton, Director of Revenue Cycle; and, Daren Smith, Director of Clinical Services. Knowing that we were going to expand, I also brought in a new Business Office Manager, Rose Fedt; Director of Marketing, Keri Talcott; and Director of Administrative Services and Human Resources, Amy Hanisch. We have also added several new coders and billers to more than accommodate our needs. In fact, we now have a higher staff to client ratio than any time in the history of Surgical Management Professionals. I am proud of what we have done, the growth we have experienced and the professional way we responded to the needs of our clients throughout this growth.

Over the past several months, SMP has continued to offer superior services to our clients and acquired an ownership interest and management agreement at Ashtabula Surgery Center in Ohio. In addition, we signed a full service management agreement with the Gateway Surgery Center in Clinton, Iowa. We

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FEATURE | By Rebecca Overton, Director of Revenue Cycle Management

Revenue Strategies for Successful, Sustainable Cash Flow

Developing successful revenue strategies in your facility is the key to unlocking your profit potential. Taking a proactive approach to developing and maintaining your revenue cycle processes always proves to be the most effective measure you can take to ensure appropriate, consistent and timely collections. Here are a few tips to help evaluate your current systems:

Front Office Operations

Front end verification of patient out-of-network benefits and collection of all estimated patient liability prior to the date of service can make or break your collection goals! Develop staff training and necessary tools to enable your staff to make "best practice" decisions. Development of deductible/coinsurance calculators, pre-registration collection scripts and financial counseling policies are just some of the tools that will empower your staff to be successful. Evaluate the need for healthcare credit at your facility (i.e., CareCredit) as an option for patients with high up-front cost.

Exhibit Confidence in Negotiating Per Case Settlement Agreements

When billing as an out-of-network provider with no contracted reimbursement or with certain worker's compensation carriers, many payers will hire outside companies to negotiate a discount on claims. Displaying confidence in negotiation of third-party settlement requests can get you the negotiated discount your facility deserves. Go into all negotiations knowing that your facility is the best – offering excellent staff, the newest equipment, wonderful patient outcomes and you deserve to be paid accordingly. Also know that third party companies such as Viant, Global Claims, etc. are in business to get you to reduce your bill. Their inability to reach an agreement with your facility is NOT good for their business. They only make money when they get providers to agree the reductions.

Aggressively Appeal Unreasonably Low Usual & Customary Allowables & Contracted Rates

Tracking payment trends and evaluating allowables for out-of-network claims is a must to ensure cases maintain profitability in the ever changing world of out-of-network billing. Understanding how each payer determines U&C as well as development of effective appeal letters are keys to success and ensuring you are maximizing revenue potential with the payer. The appeal must be precise, well organized and offer a valid argument for requesting additional money. Setting a realistic threshold for staff determination of need for appeal is important. (For example, "all out-of-network claims that allow less than 60% of charge should be appealed") This takes the guess work out of the scenario for your A/R team.

In addition, it is essential that your entire revenue team understand contracted reimbursement methodology for contracted payers. Creating contract summaries for staff reference or loading contracts into your Patient Accounting System is time well vested. The largest revenue losses typically come from inappropriate adjustments being made to accounts simply because the staff doesn't understand the contract terms and/or reimbursement methods, and without this basic understanding, it is very difficult to form a persuasive appeal to get more difficult claims paid.

Continuous Service Line Reimbursement & Supply Cost Analyses

Performing periodic analysis of procedure cost as compared to reimbursement on regular intervals can prove to be very valuable in many areas of revenue cycle optimization. Compiling this information aids in projecting profit margins and losses on proposed service lines or added procedures. It also provides the

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knowledge necessary to obtain reimbursement rates that make the added service profitable for your center. Sometimes this data is just the offense needed to ensure reasonable contract rates or carve-outs from the payer.

Understanding payer reimbursement and costs for specific procedures and supplies then applying that to billing processes is essential in maximizing reimbursement. Many facilities misunderstand billing requirements and bill all payers the same regardless of contract provisions. This can lead to revenue pitfalls and substantial revenue loss.

For instance, if you have established a standard mark-up of 200% of implant cost for implants dispensed in a case, your reimbursement could be negatively impacted by percent-of-charge based contract rates.

Below is an example of how supply and implant mark-up errors can lead to large revenue losses:

Implant Cost: \$220.00

Implant Charge with Mark-Up: \$440.00

Payer A Reimbursement – Cost plus 10%: \$484.00

Payer B Reimbursement – Cost plus 20%: \$528.00

Payer C Reimbursement – 50% of Charge: \$220.00

As you can see, Payer C reimbursement is equal to cost with no allowance for profit. Performing an analysis and building scenarios around various payer reimbursements will allow you to make sound decisions for billing according to payer guidelines but maximizing reimbursement at the same time. Because every contract is different, every contract and associated billing practice should be reviewed to ensure revenue capture is optimal yet within the constraints of your contract.

The revenue cycle process can be burdensome to smaller and even midsized facilities. There are many resources available from Surgical Management Professionals (SMP) than can help improve the revenue cycle process, verify accuracy and insure you are getting the maximum reimbursement allowed. SMP provides a full range of revenue cycle management and billing office services including coding audits, revenue cycle process audits, overall business office function review, managed care contracting and full service revenue cycle management. For more information, please visit: www.smpsd.com or call us at (605) 444-8297.

have also partnered with a group of doctors in Grand Junction, Colorado in a group called the Red Rock Docs, LLC. We are currently negotiating with a hospital/physician owned ASC trying to buy out the hospital interest. If we succeed, SMP will be both an owner and manager of the facility. If we do not complete this transaction we have already identified a site and have done some due diligence on a new ASC which will be owned by the doctors and SMP. Right here in Sioux Falls we have partnered with the Sioux Falls Surgical Physicians in a group called the Sioux Falls - Kearney Development, LLC. We are working on a hospital project that did not get completed in time to beat the current prohibition on physician ownership. The doctors have over \$13 million invested in the project and we are working on revitalizing the project, raising the needed equity and debt and completing the hospital building. This will be one of, if not the first, “real estate hospital” model in the United States. We are also working with a group of doctors in Northern Minnesota who have an interest of partnering with a hospital. SMP is providing the strategic planning and negotiations for the project. There is a possibility that SMP will be allowed some ownership and management in the new entity.

We have signed letters of intent to purchase percentage ownership in two different surgery centers in California and we are currently doing the required due diligence on these projects. We have also added several new consulting agreements services including billing and coding reviews, managed care contracting, and pre-survey preparation. Last year we introduced a new physician billing service and we have added several new physicians to this service as well as new anesthesia billing. All things considered, it has been a great year for SMP and we have only started. We will continue to look for quality opportunities to purchase, manage and or consult with physicians and surgical facilities. We are on a continual search for quality employees and will expand management when the time is appropriate. While we are aimed strategically at growth, we remain focused on service and performance. Our current clients are our priority and will always remain our priority. Adding new clients will only make us better, deeper, stronger, and more effective in our management and consultative services. Despite the growth that SMP has experienced, it is our main objective to be a resource of knowledge that is at all times accessible to our clients. It is important to us to maintain the small company feel, regardless of how large or small SMP might be.

Working with the Board of Directors, Executive Team and staff at SMP has been the highlight of my 30 plus year career in health care. What we have is unique and appropriately positioned to take a leadership position in the future of healthcare and we have our clients to thank for it.

More About Surgical Management Professionals

SMP, or Surgical Management Professionals, is a management, development and equity partnership company that operates in the ambulatory surgical center and surgical hospital workspace. SMP is a company with 25 years of proven expertise in managing and providing consulting services for multi-specialty ambulatory surgery centers and surgical hospitals. At SMP, we leverage the expertise of our physicians and experienced executives. In most instances, our clients are physician-owned or physician governed. Our unique business model not only helps to set us apart from the competition, it also reflects our dedication to helping you achieve success. We've been in your shoes, and because of this, we know what it takes to help you manage a productive and profitable future. Our business model is flexible in terms of both services provided and ownership. Depending on the situation, we may partner with physicians or hospital systems in a minority ownership position, or in many consultation projects, we provide services with no ownership required. Our services include but are not limited to:

Start-Up Consulting – Feasibility studies, on-site leadership, organizational development and governance, facility planning and

design, financing, equipment acquisition, third party contracting, IT systems and EMR, policy and procedure development, regulatory, licensure, accreditation preparation, staffing and employee orientation, corporate compliance program, quality improvement program, marketing and form development

Revenue Cycle Management – billing, coding, coding audits, AR follow-up, managed care contracting and negotiation, chargemaster review and physician clinic billing and coding services

Ongoing Operational/Clinical Services – quality improvement/best practices, human resources, supply management, privileging and credentialing, information systems and support, compliance, infection control, patient, physician and employee satisfaction, benchmarking activities, annual mandatory education for staff, culture/team building strategies, risk management, marketing and leadership development resources

Accounting – budgeting, financial statements, fiscal benchmarking activities, payroll and accounts payable

For more information on SMP, please go to our website: www.smpsd.com.

SMP Launches Medical & Pharmacy Cost Reduction Program

In an effort to provide additional value to Surgical Management Professionals (SMP) clients, a materials management program was initiated to examine the second highest expense after wages and salaries; medical and pharmacy supplies.

The project had the following goals:

- Provide an opportunity to SMP clients to join an affiliate group that pools purchase volumes to get access to higher tiers within Group Purchasing Organizations with no additional cost to the facility.
- Provide an opportunity to join an affiliate group that does not require major changes to the facilities current supplies or supply chain.
- Provide an opportunity to join an affiliate group that monitors and manages the supply contracts for correct pricing and expiration.
- Provide supply contracts that demonstrate a supply cost savings.
- Provide costing information comparing contracted materials management vs. self administered materials management program.
- Provide personal guidance and instruction for proper use of the software inventory module.
- Provide supply benchmarks for facilities to monitor their materials management functions.

The process started by investigating group purchasing organizations and affiliate groups to determine the best possible fit with these goals. We landed on an affiliate group that pools their volumes to leverage higher purchasing tiers within the Med Assets group purchasing organization. Considering their model met the goals of the project, we contacted them for a market basket analysis. The purpose of a market basket analysis is to provide a snapshot of the sites current supplies and pharmaceuticals to compare their current invoice price with the affiliate groups proposed pricing. We made the assumption that a savings within the market basket will translate to a savings overall. The market basket does not include any custom packs because it is too complex to make a fair comparison. We can reasonably assume that the components of the packs will follow the individual pricing.

We piloted the market basket comparison at High Pointe Surgery Center, an SMP partner center in Lake Elmo, Minnesota. The market basket demonstrated savings on the majority of products. The market basket also demonstrated very few physician preference items that would have to change (sterile gloves, gauze, suture, etc.). At High Pointe Surgery Center, the results of the market basket represent a potential savings of 18percent on medical supplies. The pharmacy market basket demonstrated a similar savings of nearly 14percent at High



Pointe Surgery Center. Assuming that this savings could be carried through to the rest of the products, the center could recognize considerable annual savings of \$100,000 or more. Traci Albers, Executive Director of High Pointe Surgery Center commented, “We have appreciated SMP’s leadership in the project analysis and support implementation. The savings we will realize as a result of this GPO affiliation will be significant to our overall financial outlook.”

SMP has performed market basket comparisons at other SMP partnered facilities with similar results. As part of the material management program, training was provided for the materials managers to give them the skills to manage the supply chain at their facilities. If you are interested in tackling your second highest expense, please contact SMP.

Accountable Care Organizations – Interpretation of the CMS Finalized Rules

On October 20, 2011, CMS finalized new rules under the Affordable Care Act to help health care providers better coordinate care for Medicare patients through Accountable Care Organizations (ACO’s). The Medicare Shared Savings Program will reward ACO’s that lower their growth in health care costs while meeting performance standards on quality and patient satisfaction. To participate in the Shared Savings Program, providers must form an ACO that meets program eligibility requirements including: procedures and processes to promote evidence based medicine, beneficiary engagement and coordination of care; serve at least 5,000 Medicare patients; and, agree to participate in the program for at least three years. Under the final rule, Medicare will continue to pay individual providers under the Medicare Fee-For-Service payment system. CMS will develop benchmarks for each ACO, against which ACO performance will be measured to see if it qualifies for shared savings, or under certain models be responsible for losses. The benchmarks will take into account

beneficiary characteristics and many other factors and will be updated each year. Under the Affordable Care Act, beneficiaries maintain the freedom to choose any provider and ACO’s will be required to publicly report their performance.

CMS has implemented two shared savings models. A one sided model with shared savings, but not losses; and, a two sided model with both shared savings and shared losses. The one sided shared savings model is available only during the first three-year ACO agreement. ACO’s adopting the two-sided model will be eligible for a shared savings rate up to 60%, while ACO’s with the one sided model will be eligible for a shared rate up to 50%. The two sided model also shares losses if the cost is at least 2% higher than the benchmark. Additionally, savings and losses will be capped and include dollar amount limits.

Quality of care will include 33 measures in four key domains: patient experience, care coordination/patient safety, preventative health, and at-risk populations. Reporting will be through a combination of web interfaces and

patient surveys. CMS will administer and pay for the patient surveys in the first two years of the program. For the first performance year, CMS is defining the performance standard as complete and accurate reporting for all quality measures. Thereafter, minimum standards of the national 30th percentile must be attained while performance above the 90th percentile will earn maximum points. ACO’s will need to achieve the minimum 30th percentile level on at least 70 percent of the measures in each domain to avoid a corrective action plan.

An Advance Payment ACO has also been established with upfront fixed, variable, and monthly payments to assist smaller physician owned and rural providers with less access to capital. Advance payments will be recouped at a later date through earned shared savings and only ACO’s entering the program in 2012 will be eligible.

In the final rule, the Secretary determined that certain critical access hospitals, federally qualified health centers, and rural health clinics are also

Ashtabula Surgery Center



Ashtabula Surgery Center became a partner with Surgical Management Professionals (SMP) on September 1, 2011, when SMP purchased interest in the center. Ashtabula Surgery Center located in Ashtabula, Ohio is a multi-specialty outpatient surgery center offering services in orthopaedics, ophthalmology, pain management, podiatry and chiropractic. The center is a 5,200 square foot facility with two operating rooms, one procedure room, 14 credentialed physicians, five credentialed CRNAs, and 15 employees. Ashtabula Surgery Center currently has a three year accreditation through Accreditation Association for Ambulatory Health Care, Inc. (AAAHC).

The Ashtabula Surgery Center is committed to providing high quality, individualized, compassionate outpatient surgical care. This patient focused approach is intended to promote a positive surgical care experience that leads to a high degree of patient satisfaction. The ASC team utilizes quality improvement to guide and maximize a safe, convenient and cost-effective environment. The center services the citizens of Northeastern Ohio and Northwestern Pennsylvania.

eligible to participate independently under the Shared Savings Program.

Based on the above, here are some thoughts on how an ASC or Surgical hospital might proceed:

- Transparency and quality reporting are here to stay, even if you don't join an ACO. Therefore, gather statistics on all 33 quality measures and develop committees to improve these measures. Even if you don't join an ACO, these statistics will likely impact your future payments.
- Evaluate ACO's developing in your area. Investigate the investment requirement, governance, capital, coordination of care, and IT capabilities. Gather your quality and cost statistics and see if these ACO's are interested in having your facility join their ACO.
- If you decide to join an ACO, consider starting with the one sided model. There is much to be learned on how CMS will benchmark and re-benchmark annually, and how limits and caps and other model inputs will be calculated, and the additional potential shared savings (50% for the one sided model versus 60% for the 2 sided model does not seem enough to justify the risk of shared losses in the 2 sided model).
- If you qualify for advance payments, strongly consider this option.

Proceed cautiously as there is still much to be learned about ACO's and their risks and benefits.

To join SMP's e-mail list to receive updates and other industry information, please send your contact information to info@smpsd.com or call Keri at (605) 444-8297.