A (Fantastic) Year in Review

In writing this column, I was struck by just how much your association has accomplished this year – where the membership truly benefited from our success. We added new members Cognizant, GeBBs and PracticeInsight bringing our strength to 33 companies. This increases the number of healthcare providers who use our PM system vendor’s software to over 750,000.

There have been over two-dozen high-value and relevant topics presented to the membership through our two membership meetings and monthly webinars. These presentations and in-depth discussions gave members a chance to grow their business, learn what’s in the future of healthcare, and take-away best practices that give them a competitive edge over PM vendors who don’t belong to HATA. Here are just a few examples:

- A CAQH update on Prior Authorization, Value Based Payments, 2016 CAQH Index Report and Phase IV Certification;
- A presentation on how to “Prepare Your IT Systems to Embrace Future Shifts in Revenue Cycle Management”;
- A discussion around “Organized Medicine as a Strategy for Engagement with Physicians” with the Medical Association of Georgia (MAG);
- A panel discussion on “Attachments – Short and Long-Term Impact on PMS Roadmap”;
- Practical examples on marketing do’s and don’ts with, “Hashtags, Handshakes and Health IT: Relationship Marketing for your Business”;
- Getting Ready for the New Medicare Card;
- The Future for Vendors in the Alternate Payment Model World;
- Re-association for Your Clients – and How to Make it Happen;
- Using Artificial Intelligence in Healthcare EDI;

- An overview of the role that DirectTrust has played in growing networks for HIE’s;
- “Washington Update” with Capital Associates President, Bill Finerfrock;
- Aetna gave an in-depth look at how to utilize NaviNet to its fullest potential;
- Optum presented on “EDI, Link and Provider Self-Service”;
- AlphaII helped members untangle the complexities of the Quality Payment Program and how to effectively transition to value-based care;
- AMA helped members understand how they created the Proxy Model for CPT/HCPCS Licensing, and tools they could use to help support clients questions.

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HATA is also being sought out as a thought leader. I was honored to present at the Health IT Marketing and PR Conference (HITMC) on, “How to Create Synergistic Relationships with Associations” and was the Keynote Speaker at American Medical Billing Association (AMBA) Annual Conference.

Throughout 2017, HATA continued to make progress on its four initiatives:

1. **ERA/EFT CALL TO ACTION** – Partnered with NACHA to raise awareness on the ways banks and practice management systems can collaborate to increase ERA and EFT matching (see above)

2. **ELIGIBILITY** – Conducted Survey and Interviews with a number of practice managers to identify pain points with the eligibility transaction, and began to have monthly discussions with Aetna and UnitedHealthcare on those findings (see below).

3. **PRIOR AUTHORIZATION** – HATA researched the barriers to adoption for Prior Authorization to understand the current utilization and barriers to develop a meaningful workflow for efficient use. HATA was also invited to serve on the Prior Authorization Council, formed by WEDI while also participating in the WEDI Prior Authorization Workgroup.

4. **EMERGING PAYMENT MODELS** – With assistance from David Mauzey, Director of Value Based Care at Optum, HATA drafted a “Value Based Care Fact Sheet: Key questions to ask prior to moving into a Value Based Care Program.”

**NEW FOR 2018:** The HATA Board approved a new initiative to engage all PM vendors and create one voice to proactively formulate HATA recommendations for the NCVHS Predictability Roadmap. The objective of this new initiative is to increase adoption of EDI across clients and the industry at large, reduce unnecessary administrative costs of manual processes by increasing actionable messaging and compliant standard transactions, reduce the cost of maintaining non-compliant transactions, reduce the cost of EDI, banking transactions significantly less than EDI, and reduce the need to go to portals, gain ability to place information within the PMS workflow.

HATA also produced a big member benefit — the Vendor Directory to bring acknowledgement to our vendor member partners as they not only provide great value to the provider vendor community, but also to the Healthcare Administrative Technology Association as they are critical sponsors of technology that ensure the efficiency of the HIT space.

One of the core pillars of HATA’s mission is Advocacy. This year we were in a position to impose our collective knowledge in a meaningful fashion with regulatory officials that have direct impact on the administrative technology industry. To that end, HATA put together a “CMS and ONC Day” on November 2nd in Baltimore and Washington DC. We met with leadership from the Division of National Standards, CMS’ Chief Information Officer, Program Management and Division of National Standards, Business Applications Group, Provider Compliance Group, Center for Program Integrity, the CM/Provider Communications Group, the Director of ONC Office of Standards and Technology, Director of HIT Infrastructure and Innovation Division, Office of Standards & Technology, the ONC Health IT Certification Program and Sr. Policy Analyst of the ONC EHR Certification and Meaningful Use.

HATA members gave an overview of HATA’s initiatives, focusing on the urgency to reduce provider burden through PM Systems’ ability to increase administrative simplification. We discussed HATA’s Certification Program for PM Vendors, our recommendations regarding the NCVHS Predictability Roadmap and recommendations around Prior Authorization and Attachments.

HATA was consulted earlier this year in CMS’ New Medicare Card Initiative, and as a consequence of our recommendations, the adoption date was pushed out by 18 months. HATA also worked with athenahealth and presented our recommendations around the 277CA to X12.

HATA uses its influence to reach out to the Payer community as well. We conduct monthly calls with Aetna and United Healthcare to discuss the latest on HATA’s initiatives and discuss how HATA’s research can help with their administrative simplification efforts. HATA also conducts quarterly calls with AHIP and BCBSA. “Talk Ten Tuesday” producer Chuck Buck engaged HATA to serve on the Editorial Board of ICDMonitor (which reaches over 10,000 viewers monthly) and submit monthly articles.

HATA’s also been very active with HIMSS, participating in their Vendor Challenge, Prior Authorization Breakfast, and Revenue Cycle Task Force. HATA also serves as the Vendor Representative on the NUCC Committee.

As you can see, we had a FANTASTIC year. I’m proud of our Board and Members who take to heart the Mission and Vision of their association. I look forward to more great things to come in 2018!

Happy HATA New Year!

Tim McMullen, JD, CAE, Executive Director
How Do You Know When Your Customers Love You?

Four things: 1) They trust you, 2) they identify with your brand, 3) they want to give you their business, 4) they evangelize on your behalf. For practice management companies, we believe making customer love can be your greatest differentiator and key to getting your business where you want it to be.

To help companies make customer love, we developed a framework we call the Amare Way™. Amare is a Latin word for love. The essence of the Amare Way™ is connection. The connection starts with alignment among the goals and values of the company, employees, and customers. Companies that practice the Amare Way™ are happier, have more loyal customers, and make more money than their competitors.

The Amare Way™ is not an exclusive, proprietary, or secret method. It’s not a new idea per se. What is new is the integrative framework that connects a lot of familiar dots in a way that we hope makes the ideas and practices easy to understand, relate to, and successfully do.

The Amare Way™ framework consists of a business philosophy, culture, language and set of practices. It works for CPG retail companies as well as B2B technology companies - just with different tactics. Though the rewards are great, the Amare Way™ is not a short-term fix and not necessarily easy. It is relationship-based, and the antithesis of the transactional business model. Consider if it’s right for your company.

1. PHILOSOPHY: The Amare Way™ philosophy is comprised of six tenets: 1. We all want love. 2. We are all connected. 3. Business is personal. 4. Companies and people share fundamental goals and values. 5. Feelings come first. 6. Relationships rule.

Assess the fit with your company. But first, do you have a business philosophy? If you do, to what extent is it aligned with the Amare Way™ philosophy? If it’s not well-aligned, do you want it to be?

2. CULTURE: The Amare Way™ culture enables your people to be themselves - to bring their whole selves to work, as Zappos puts it. Executives in Amare Way™ companies that set the tenor of their culture know it’s not about them. They find happiness in authentically connecting with their purpose, their people, and their customers, through a culture of customer love.
The Amare Way™ culture invests in knowing and delighting customers. Happiness is an important KPI. The culture rewards efforts to make customer love. Plato famously remarked in the Republic that “What is honored in a country is cultivated there.” In the same spirit, we assert that what is honored in a company is cultivated there. Does your company honor making customer love as much as making products or making sales?

3. LANGUAGE: The Amare Way™ language expresses compassion, understanding, and empathy. It does not communicate the idea so pervasive in today’s times of company as the hunting predator and customer as prey to be captured, subdued, and consumed.

Consider the language you use internally. Does it include violent references, like crushing competition, or stealing market share, or hunting down target customers. Or does it convey that customers are valued and you want to engage with them for mutual benefit? Language is the main social interface between human thought and action. In business, your language matters.

4. PRACTICE: The practice of the Amare Way™ is how you make customer love, and has three main components - authenticity, confluence, and belonging. Authenticity is a way of being in business, confluence is a way of doing what you do, and belonging is a way of having the results you want. In the next issue, we will cover the practice of the Amare Way™ in detail.

We believe that making customer love can be your company’s highest calling.

As a framework, the Amare Way™ can advance your mission and measurably improve your performance. It is a way to be, to do, and to have in business that is rooted in love. Should you embrace it, may it bring you happiness and prosperity.
The world in which Practice Management Systems’ (PMS) clients operate is changing, and their ability to survive in this changing environment while maintaining their small and medium-size independent practices depends on PMS vendors’ ability to change the way you do business.

The transition from fee-for-service to pay-for-value payment models puts a greater premium on data than ever before. Providers are being asked to provide information on health care activities and patient outcomes at an unprecedented volume. Increasingly common financial risk-sharing arrangements necessitate a level of encounter data tracking, integration between clinical and administrative data, and financial accounting processes most provider offices find foreign and overwhelming. Regulatory and market response has been to look to electronic health record (EHR) vendors to provide the technical functionality needed to perform these tasks. Unfortunately, the demands being made on these systems far exceeds those they were initially created to perform, and the track record for those EHR vendors who have dared to accept the challenge has been less than stellar.

Operating in a value-based world requires a high degree of alignment between the financial activities of payers and providers. It requires providers not only be able to identify and effectively manage their high-risk patients, but to also be able to recognize what activities are driving their overall costs (care delivery and operating expenses), move quickly to improve inefficiencies, where appropriate, and develop appropriate pricing and payment arrangements. Providers need systems that will allow them to contribute or acquire and integrate data from all of the various participants in an episode of care, including EHRs, commercial payers, durable medical equipment companies, and pharmacies and patient satisfaction survey tools. They must be able to analyze this data to generate financial, clinical and quality reports that will drive physician behavior and critical business decisions.

This vision of the not-so-distant future is well articulated in the HIMSS Revenue Cycle Management task force’s Patient Financial Experience of the Future. The task force has developed an infographic and microsite to help explain what it believes the patient financial experience should be, from the moment the patient determines he/she needs care to the moment everyone involved in that care agrees it has been financial resolved. Many of the activities discussed in the task force vision could be supported by practice management systems (PMS).

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PMS vendors specialize in patient demographics, appointment scheduling, payer information, billing tasks and generating reports, activities that should be leveraged to realize the task force’s vision. The challenge is that the sophistication needed to deliver the task force’s vision and meet the requirements of value-based payment models necessitates that PMS vendors expand their approach to product development to consider how the vendors might partner with payers, financial institutions, hospitals, acute care facilities and others to ensure consistent and smooth process flow across the full continuum of care. Too often we hear stories of PMS vendors who have been approached by a commercial payer or financial institution to modify a solution to improve that payer or financial institution’s exchange of information with providers, only to be told that the vendor will only consider doing so if their customer, the provider, requires it. In this ever-changing environment, your provider customers need you to be their advocate. They need for their PMS vendors to understand what is being asked of them without the provider having to spell it out, to understand the complexity of relationships they are being asked to put in place, and to ease their administrative burden by delivering solutions that meet those needs. PMS vendors have an opportunity to emerge as the heroes of the emerging payment models era. Will you embrace the opportunity?

About HIMSS

HIMSS is a global, cause-based, not-for-profit organization focused on better health through information technology (IT). HIMSS North America, a business unit within HIMSS, positively transforms health and healthcare through the best use of information technology in the United States and Canada. As a cause-based non-profit, HIMSS North America provides thought leadership, community building, professional development, public policy, and events. HIMSS North America represents 64,000 individual members, 640 corporate members, and over 450 non-profit organizations. Thousands of volunteers work with HIMSS to improve the quality, cost-effectiveness, access, and value of healthcare through IT. To learn more about HIMSS and to find out how to join us and our members in advancing our cause, please visit our website at www.himss.org.

About the HIMSS Revenue Cycle Improvement Task Force

The HIMSS Revenue Cycle Improvement (RCI) task force encourages the advancement of healthcare revenue cycle management tools and processes to support a patient financial experience that is efficient, consumer-centric and adds to a favorable impression of the patient’s overall experience with the healthcare system. The task force has created a vision for the Patient Financial Experience of the Future that keeps administrative cost containment, interoperability, and consumer engagement front and center. Its membership includes representatives from all major stakeholder groups, including physicians, hospitals, retail health clinics, financial services, health plans, consultants, industry associations, and vendors.

For more information about how to get involved in HIMSS Revenue Cycle Improvement efforts, please contact Pam Jodock at pjodock@himss.org. To learn about HIMSS membership, please visit the HIMSS website at www.himss.org.
After coming off a successful Membership Meeting in Anaheim, HATA’s Director of External Affairs, Sherri Dumford exhibited for HATA at the 29th Annual PAHCOM Conference. Thank you to PAHCOM’s Executive Director, Karen Blanchette and the entire PAHCOM staff for your wonderful hospitality and all the effort that goes into putting together an amazing conference. HATA’s time at PAHCOM is extremely important as we continue our efforts to reduce barriers in areas of eligibility, prior authorization and non-fee for service. Members of PAHCOM operate on the front lines of healthcare and HATA is committed to reducing their burden by supporting the vendors that provide the administration solutions of the practice.

Then later in October, HATA’s Executive Director Tim McMullen was honored to be the Keynote Speaker at the 17th Annual AMBA Conference. Tim gave a timely and entertaining presentation, “Why in the *!@#% does it have to be so difficult!” to an audience of over 160 billing executives. His presentation highlighted the work HATA is doing with its members around Eligibility, Prior Authorization and Re-association and talked about the resources HATA created for non-fee for service payment models. The main thrust of his speech was about the unique relationship between the billing company and PMS Vendor, and showed where HATA can help cut down on the labor intensive workflow issues. Tim gave a shout out to the HATA Members who exhibited at the show: AdvancedMD, AzaleaHealth, Clinix, and HealthPac. By being at AMBA, it also gave HATA an opportunity to show potential members the value this organization could bring to their business. Look for “Welcome New Member…” emails soon!

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HATA wrapped up a successful Fall with a trip to CMS and ONC in Baltimore and Washington, DC respectively. Kudos to the members who attended: **Chris Bruns**, Product Manager, MedInformatix; **Eric Cunningham**, Product Manager, PaySpan; **Mary Dooley**, Operations Manager, Alphall, LLC; **Barbi Elmore**, Director, Project Management, PracticeAdmin; **Brad Gnagy**, Information Technology Director, HealthPac; and **David Heller**, Industry and Government Affairs Manager, Greenway Health. Over 35 attendees from CMS came for the meeting to learn more about the association and to discuss HATA’s initiatives: Eligibility, Prior Authorization, Non-Fee for Service Payments and ERA/EFT including their survey results, and focusing on the urgency to reduce provider burden through PM Systems’ ability to increase administrative simplification. We also discussed NCVHS recommendations around Prior Authorization and Attachments and HATA’s input, the new Medicare Card: collaboration, including concerns, and information CMS can provide. We explained our newest initiative around recommendations regarding the NCVHS Predictability Roadmap and highlighted HATA’s new Certification Program for Practice Management Vendors. “Thank you so much for coming to CMS and sharing information about all of your initiatives and what you’ve learned from your members. I received a lot of feedback from a number of individuals who were impressed and wanted to know more,” said Lorraine Doo, Senior Policy Advisor, National Standards Group adding, “I think you made the impression you hoped for on both the Medicare FFS side and the “national standards” side of the house. Very much appreciate all of the effort that went into preparing for the meeting, and for the wisdom you shared.”

*Look for another CMS road trip in the Spring!*
Take the easy road
Try electronic claims for faster payments

Paper claims
The slow way to go

Day 1
• Find a paper claim form
• Fill it out by hand
• Put your daily claims into an envelope
• Calculate — and buy — postage
• Drop it in the outgoing mail bin

Days 2 – 4
We get your claim by snail mail — we’ll sort it with the hundreds we get daily.

Days 5 – 8
Our mailroom opens your envelope, removes and scans all contents.

Days 9 – 10
Your claim is processed — hopefully everything’s readable.

Grand total: nine days longer than if you did it yourself.

Days 11 – 12
We’ll finalize your claim and generate a statement, like an Explanation of Benefits (EOB)*

Electronic claims
All gas, no brakes

Days 1 – 2
Just complete your claim online and send it to your vendor/clearinghouse — they’ll forward it to us.
• We’ll let you know automatically after we receive your claim.
• Next, we’ll process your claim.

Day 3
We’ll finalize your claim and generate a statement, like an Explanation of Benefits (EOB)*

3 days versus 12 days?
Talk about an easy choice — electronic claims.

Have a question?
Need a vendor?
We’re here to help!

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