

Colorado Connection

The Official Newsletter of Colorado MGMA

President's Column By Mary Jo Heins, FACMPE

I did my New Years resolutions last July, so interestingly, my thoughts this New Year have turned to what I believe. What do I believe about CMGMA? That has been a work-in-progress over the past 3 years. When I began as an officer, I did not know that states do things in different ways: membership definitions, who can be an officer, vendor relations, education, local and chapter affiliates. The great collegial network of Colorado members, officers from other states, and former CMGMA presidents have solidified my ideas about CMGMA's organizational identity and goals. Here are some key beliefs for me as we enter this new year, 2009:

•Match educational programs to the needs/levels of our members

When I first joined CMGMA, the Spring and Fall conferences were a perfect match for the size of group I managed and my level of experience.

There are others in our membership who have educational needs not addressed by our traditional Spring and Fall conferences. Here's what we are doing to address a broader range of members:

Seasoned administrators of large practices—4 Corners Conference—Arizona, Utah, New Mexico, and Colorado are coming together for a conference that will be a "step up" from our bi-annual state conference. The speakers and accommodations will be first class. Administrators and CEOs will have a unique opportunity to network with their neighboring state peers.

Office managers of small and/or rural practices—Webcasts—We are developing webcasts on a variety of topics that will be helpful to all, but particularly for managers of smaller practices who do not have the time or budget to attend conferences.

•Grow the core of our organization—Medical Group Managers are, by definition, the heart of the Colorado Medical Group Management Association. Vendors providing products and services are an indispensable asset to each of us in our practices and hence indispensable to CMGMA. But the core of our association are those people providing the leadership within physician practices.

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Colorado MGMA**

We all know managers and administrators who are not among our CMGMA ranks. Perhaps an experienced administrator who has mastered this career decades ago. Or an inexperienced manager who doesn't know that CMGMA exists. We need to provide an association home for all Medical Group Managers by meeting their professional needs.

•Together, we are a force to be reckoned with—I was on an education conference call last week with Jan Krause, Lance Goudzwaard, and Sheri Page. About mid-way through, it struck me how many great ideas were coming together! I am also always thankful for Joyce Vollmer, Janet McIntyre, John Milewski and others who are networking with leaders in healthcare and at the capital to further the interests of CMGMA.

We have a talented and thoughtful membership! And we have resourceful, dedicated leaders! Many meetings, breakfasts, and phone calls have heightened the visibility and effectiveness of CMGMA.

•Inclusion means getting new people involved—"Make new friends, but keep the old. One is silver and the other gold." Anyone else remember this from Brownies? Associations with a volunteer, rotating leadership depend on the consistent support and collective memory of long time members. How do we acknowledge this and yet provide entry for new leaders?

I welcome your responses to these ideas as well as your continued involvement in our vibrant, vital association!



2009 Legislative Reception

Thursday, February 5

University Club
4:00-7:00 p.m.

2009 Conference Schedule

Spring Conference

May 7-8, 2009
Doubletree Hotel
Colorado Springs, CO

Visit www.cmgma.com
or call
303-756-8380
for more
information

The College Corner

By Julie Kjack, FACMPE

Greetings and Happy New Year! It is time for New Year's resolutions and one that will enhance your career is joining the American College of Medical Practice Executives. If you are already a member and a Nominee, your goal for 2009 could be to become a CMPE (Certified Medical Practice Executive). Lastly if you are already a CMPE you could write your paper or do the case studies and become a Fellow.

The following is a quote from Rebecca Dean, MA, FACMPE, Board Chair of ACMPE. Many of you will remember Rebecca as she attended our fall meeting several years ago.

"ACMPE took many significant—indeed, pivotal—steps forward in 2008. Chief among them was revising the Body of Knowledge for Medical Practice Management, the touchstone for our profession. Updated for the challenges of a technological world, more attuned to demands for quality, financial oversight and involvement in clinical systems, the Body of Knowledge continues as an essential resource for medical practice administrators."

"In 2009, we aim to increase the numbers of certified Members and Fellows. We will explore enhancement of the board certification resources. A busy year lies ahead and I ask for your total support. Where others see challenges, let's collectively see opportunities."

Fellow status is the highest level of distinction you can earn in the medical practice management profession. It signifies superior standards of performance and professional competency and encourages ongoing personal and professional development in the field. Fellowship also demonstrates your uncommon commitment to becoming the very best at what you do, as well as your willingness to pass your knowledge and insight along to others. In short, it sets you apart.

Colorado has been challenged by Oregon to see which state can have the most new Fellows in 2009. I challenge all Colorado CMPE's to make Fellow this year. Oregon had 5 Fellows in 2008 and I think we should have 5 or more in order to win the challenge. The MGMA Annual Conference will be in Denver from October 11-14th. It would be especially meaningful to attain Fellowship in our state. College Day is Tuesday and it will be a day to remember.

In order to become a Fellow this year you must have your outline turned in by May 1st and your final manuscript deadline by August 21st.

If you need more information call 877 ASK MGMA, extension 1869 or e-mail acmpe@mgma.com. I am always available for questions and support. You can reach me at 303-435-4444 or by e-mail at juliemkj@cs.com.

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Third Party Payer Report

By Jeffrey Milburn

2009 RBRVS Conversion Factor and Payer Contracts

The 2009 Medicare Conversion Factor (\$CF) has dropped from \$38.0870 to \$36.0666. This, and other changes, has a number of implications for medical practices. For instance, although the \$CF dropped 5.3%, the Budget Neutrality Adjuster (BNA) reduction factor has been eliminated. The BNA factor was implemented in 2007 as an offset to the increase in some E&M code RVU values and reduced the value of all work RVUs by 10-12% in 2007 and 2008.

I have seen one study that suggests the reduced 2009 \$CF and elimination of the BNA reduction factor results in a net +1.44% gain on average for all CPT code categories. You will need to analyze your own practice change because the BNA elimination impacts the code categories differently. The analysis I referred to indicated the changes range from +1.3% (surgery) to +3.1% (pathology). Radiology changed +2.9%, Medicine +2.0%, and E/M increased 3% on average.

This is also a good time to review how payer contracts utilize the \$CF to drive payments in this region. In my experience, many, if not most, contracts are tied to a % of the current Medicare \$CF and subject to annual adjustment. The contract will read "...125% of the current Medicare conversion factor..." and basically is subject to the manipulations of Medicare trying to balance their annual budget. In 2002 the \$CF dropped 5.4%, and unless you had a fixed \$CF, your reimbursement from Medicare and commercial payers dropped. Your 2009 reimbursement will also drop based on the change in \$CF, but this is offset by the elimination of the BNA reduction factor and the increase in work RVUs.

There are a number of medical groups who insist on a fixed \$CF in their payer contracts and therefore are not subject to the increases (minimal) or decreases (substantial) of the Medicare \$CF. The contract will read "...\$47.61 (125% of \$38.087) per RVU..." and the year version of the RVUs will be specified as a fixed year or the most current year. There are pros and cons regarding the selection of the year RVU version. Refer back to Todd Welter's article in the October 2008 CMGMA Colorado Connection for additional comments on the "integrity" of the RBRVS system.

My recommendation is to push your payer for a fixed \$CF. Some payers will say "take it or leave it" as they only contract with a variable \$CF. Ask if all their contracts are at a variable rate as I believe all the major commercial payers in CO will fix the \$CF if pressured and/or you have some leverage. Beware of payers who will try and selectively implement portions of the Medicare changes. For instance, they might insist on following the 2009 \$CF down but continue to use the 2007 or 2008 RVU schedule with the BNA reduction, or even try to stay on the 2006 RVU schedule to avoid the E/M code increases.

Employers, payers, and physician practices all have constantly escalating costs of doing business. There is no reason you should follow the Medicare \$CF or RVU changes down in any year. The Medicare budget balancing manipulations have nothing to do with the payer's or your budget.

The Third Party Payer Report continues on page 3 with Contractual Cahooting

Implementing Healthcare Systems Can Be Extremely Challenging.

At Solve IT, we have the expertise and experience to maximize your investment. We focus on helping medical practices improve their operations through the implementation of healthcare related technologies. Our team will work with your practice to understand your needs and act as your single source for technology solutions.

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Legislative Liaison Update

By Joyce Vollmer

The upcoming 2009 Legislative Session should prove to be an interesting one – following an election year. The House and Senate Committee rosters have recently been published. The Committees that typically hear and decide healthcare related bills are as follows:

2009 Senate Committees Business, Labor and Technology

7 members: Senators Jennifer Veiga, Chair; Rollie Heath, Vice-Chair; Joyce Foster, Ted Harvey, Shawn Mitchell, Mark Scheffel, Lois Tochtrop

Health and Human Services

8 members: Senators Betty Boyd, Chair; Lois Tochtrop, Vice-chair; Morgan Carroll, Shawn Mitchell, John Morse, Linda Newell, David Schultheis, Senate District 15 Vacancy Appointment

2009 House Committees Business Affairs and Labor

11 members: Representatives Joe Rice, Chair; Ed Casso, Vice-Chair; David Balmer, Laura Bradford, Sara Gagliardi, Larry Liston, Kevin Priola, Su Ryden, Christine Scanlan, John Soper, Amy Stephens

Health and Human Services

11 members: Representatives Jim Riesberg, Chair; Sara Gagliardi, Vice-Chair; Cindy Acree, Gwen Green, John Kefalas, Jim Kerr, Kevin Lundberg, Anne McGihon, Dianne Primavera, Ellen Roberts, Spencer Swalm

I strongly encourage you, as CMGMA members, to research the biographies of these Senators and Representatives to see their backgrounds, training and interests, specifically as it relates to healthcare issues and how they voted. Here is a link to the site where you can do this:

http://www.state.co.us/gov_dir/leg_dir/lcsstaff/StaffInfo/LegislatorBiography.htm

CMGMA Board Members are inviting and urging attendance of these 2009 Senate and House Committee members at our upcoming Legislative Reception scheduled for Thursday, February 5th at the University Club in Denver. We hope to count on **your** attendance at the Legislative Reception, where you will have an opportunity to talk with key members of the General Assembly who are responsible for making changes to healthcare regulations.

This is an excellent opportunity to make your concerns known and to help make a positive influence on Senators and Representatives as they begin the 2009 session. You may obtain a registration form at the CMGMA website. The fee for attendance is \$25 and it is a great value for the exposure and interaction you will experience with key legislators. See you there!

Third Party Report continued Contractual Cahooting

By Jeffrey Milburn

Many many years ago I spent hours watching the westerns on TV. Yes, some of them were broadcast in black and white and I'm sure most of you aren't even aware that TV wasn't always broadcast in color. Anyway, the westerns usually involved some bad guys who were "in cahoots" together to do something bad if not downright illegal. Back then the result was usually somebody got themselves shot (Dx 8679) and died of lead poisoning (Dx 9849) or was hung by the neck (Dx 9947) until dead.

The Federal Trade Commission (FTC) announced in December that they settled price-fixing charges against two physician groups, one of which was the Boulder Valley Independent Practice Association. They basically said the IPA group was illegally "cahooting" to fix prices and not play nicely in the sandbox to the detriment of the insurance companies and ultimately the consumer. You can read all about it at <http://www.ftc.gov/opa/2008/12/allcare.htm> and if you really want to punish yourselves follow the links to review the legal documents.

First of all, I'm not really sure it was the "bad guys" who were punished regardless of their cahooting. It might be argued that at least a few of the commercial payers are as or even more guilty of price fixing.

Second, regardless of who the good and bad guys are, you should be aware that the Sheriff (FTC) generally sides with the big ranch owners (payers) against the homesteaders (providers) and you need to be aware of what constitutes illegal cahooting among physicians. Reference the documents on the FTC website to get a flavor of the rules...especially the Complaint and the Analysis of Agreement Containing Consent Order to Aid Public Comment.

If needed, please contact Jeffrey Milburn at jmilburn@jmilburn.com for anything but legal advice.

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Salary Survey Update

By Eric Chappell

It's again that time of year to prepare for the 2009 Salary Survey. I am excited to be the new chair for the survey and I am currently recruiting and organizing this year's committee. The committee's meeting is held by conference call and independently tasked to encourage people outside of the Denver area to be actively involved. If you are interested in participating in this year's survey committee, please contact me by email at echappell@coloradosurgicalsevice.com.

The salary survey is in its 5th year. Every year, the survey provides office managers, administrators, and physicians a useful resource to set employee salaries and benefits within our practices. The survey provides data not only for us in the metro areas but also those in rural areas of Colorado. As always, the wonderful professionals at Krause, Kirkpatrick, and Bertrand will keep all information provided confidential!

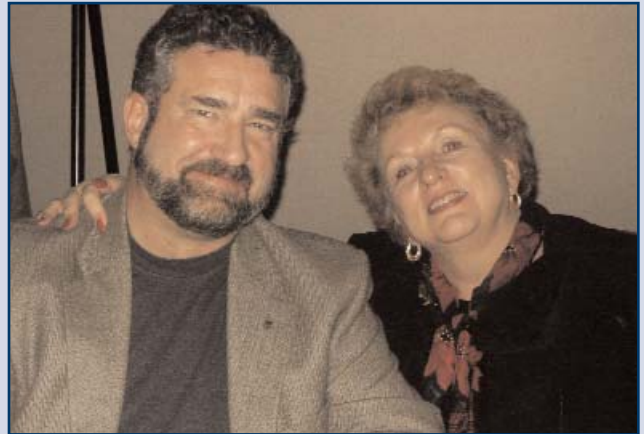
The 2009 Staff and Physician Salary Survey questionnaire will be distributed in February 2009. The timing coincides with your year-end practice financials and payroll record. This year, as a reward for your early participation, CMGMA will be giving away one \$100 Visa gift card in a weekly drawing. The earlier you turn in the survey, the more chances you have to win.

I would like to thank each of you in advance for your past participation and your ongoing participation with this survey. Without you, this survey would not be the valuable resource that it is to you and your colleagues throughout the state!

CMGMA Board of Directors Retreat and Past President Dinner



President Mary Jo Heins (left) and Past President Peggy Gustafson (right)



College Forum Rep and Past President Julie Kjack and her husband Mike



Member at Large Judi Spurgeon and Past President Dale Brinkman



Immediate Past President Janet McIntyre and her husband Ed



Legislative Liaison Joyce Vollmer and her husband Paul

Meeting Coding and Compliance Issues Head-on: Automated Solution Increases Accuracy and Reduces Payment Delays

By Craig Bridge

Few aspects of the revenue cycle are more complex, or cause greater distress, than coding and compliance.

Codes must be carefully chosen to match the work done. Modifiers, if applicable, must be assigned appropriately. And draconian medical necessity requirements must be strictly followed.

Rules instituted by Medicare and private payers that govern coding and medical necessity are the very foundation upon which physician practices generate revenue. Yet, because of regulatory complexity, even a small hitch may delay payment by weeks or even months. When this occurs, practices must dedicate time and resources to rework and resubmit claims. Further, a practice whose claims are repeatedly out of compliance, even unintentionally, will draw increased scrutiny from the Centers for Medicare and Medicaid Services (CMS).

This makes it imperative for physician practices to adopt tools to ensure compliance so they receive payment in full and in a timely manner. The lack of technological support to ensure claims are coded accurately and compliant with the latest payer regulations results in sluggish cash flow and the need to appeal rejected claims at the cost of practice resources.

On the other hand, practices whose revenue cycle is functioning at optimum levels rest assured that they are getting paid quickly and efficiently. The common denominator among these organizations is an innovative clearinghouse and receivables management solution that accommodates quirky coding rules and compliance requirements, whether public or private, national or specific, to an individual region.

Inherent to best-of-class solutions is a robust edit suite that flags coding errors and verifies that medical necessity issues have been addressed prior to submission. This is no easy task. As any savvy physician practice knows, coding and compliance rules are a fast-moving target. National Correct Coding Initiative (CCI) edits change quarterly, while private payer rules can be even more capricious. Significant human resources must be dedicated to staying on top of the constant change to maximize upfront payment and minimize back-end follow up.

Of course, practices today have a variety of options to verify claims, including basic edit functionality incorporated into the electronic medical record that assists physicians with coding at the point of care. This approach, however, is rarely embraced by physicians who may view it as a disruption to workflow. Likewise, many organizations make use of medical necessity edit modules bolted onto their practice management system. While effective as a back-office solution to help process clean claims, these often must be purchased separately, and then integrated and continually managed by internal IT staff.

A new generation of single-source, Web-based receivables management solutions like the one offered by Navicure has emerged to ensure that coding is accurate and compliant. These systems are anchored by edit engines that are continually updated and automatically scrub all claims against Medicare's Local Medical Review Policies (LMRP), National and Local Coverage Determinations (NCD/LCD), and a wide range of private payer edits. Online delivery means advanced functionality is hosted on the vendor's server, eliminating the need for health-care practices to buy, install and continually upgrade their own software, much less dedicate internal staffing resources to constantly research changing payer rules.

Additionally, these innovative solutions support cleaner electronic posting. When Medicare denies claims by service line, (paying lines 1 and 4, for instance, while denying 2 and 3) automated systems accurately match paid amounts to specific services. Those that need to be are reworked out kicked back for further review.

With a full-featured receivables management solution, practices can rest assured that their claims go out cleanly and in full compliance. And that produces payment and consistent revenue flow—a welcome event for any physician practice.

Craig Bridge is Chief Operation Officer for Navicure, a leading provider of Web-based account receivables management solutions that help physician practices profitability through improved claims reimbursement and staff productivity.

FTC Delays Red Flag Rules Enforcement

Reprinted from the October 29, 2008 MGMA Washington Connexion. Used with permission.

As a result of efforts by MGMA and other medical professional organizations, the Federal Trade Commission (FTC) has announced its decision to delay enforcement of the "Red Flag" rules until May 1, 2009. Under the original rules, creditors would have been required to implement an identity theft program by Nov. 1, 2008. The FTC is concerned that many, such as medical practices, do not realize that these rules might apply to them.

The FTC regulation defines a creditor as an entity that regularly extends, renews, continues credit or arranges for the extension of credit. The FTC would include a medical provider in this definition if the provider does not regularly demand payment in full for services or supplies at the time of service, which, according to the FTC, would be considered extending credit. The FTC attorney said there is no "bright line" rule for determining whether a practice meets this definition; rather it is determined on a case-by-case basis.

If a provider is considered a creditor, the FTC stated that the next determining question will be whether the provider maintains covered accounts of its patients. The FTC defines a covered account as a consumer account designed to permit multiple payments or transactions, or any other account for which there is a reasonably foreseeable risk of identity theft. For a medical practice, this includes patient billing records.

If a practice determines it qualifies as a creditor, the Red Flag Rules apply. The practice would be required to develop an identity theft program that contains "reasonable policies and procedures" to:

- Identify relevant patterns, practices, and specific forms of activity that are "red flags," signaling possible identify theft;
- Detect these patterns, or "red flags";
- Respond to those detected to prevent and mitigate identity theft; and
- Ensure the program is updated periodically to reflect changes in risks.

In administering such a program, a creditor would need to:

- Obtain approval of the program from its board or board committee;
- Involve the board or senior management designee(s);
- Train staff; and
- Exercise oversight of service provider arrangements.

The FTC stressed that an identity-theft prevention program could be flexible and based on the relative risk of identity theft in a practice's location and patient population. The requirements of this rule may also overlap with some of the requirements of the Health Insurance Portability and Accountability Act (HIPAA). For example, oversight of service providers could be through a modified HIPAA business associate agreement.

Because this regulation and the law it's based on were originally aimed at financial institutions, it has been unclear as to how it would be applied to health care providers. MGMA and 26 national medical associations recently submitted a letter to the FTC requesting clarification about whether or not this rule applies to medical providers. MGMA will continue working with the FTC and the provider community to determine the applicability of this regulation to medical practices. Additionally, we expect the FTC and other organizations to develop an identity-theft program template. We will notify you via the MGMA Washington Connexion when this information becomes available.

EMR Interface Reinforces Denver Practice's Bonds with Area Health Systems and Labs

By Craig Bakken, MHA, CMPE

As the number of medical groups deploying ambulatory electronic medical record (EMR) systems grows, it is increasingly important that practice managers give careful consideration to interfacing their EMRs with the patient record systems at the hospitals and outpatient laboratories to which they refer patients.

In our experience at Rocky Mountain Gastroenterology Associates (Denver), EMR interfaces are a significant physician satisfier, particularly in the area of enhancing physician decision-making. Our practice's EMR interfaces make patient records available to physicians within the practice EMR, within minutes of the data being posted to hospital and outpatient laboratory systems. This improved availability of patient data has led to enhanced patient care and satisfaction.

Although our overriding goals for establishing EMR interfaces were patient-centric, interfaces can also lead to substantial administrative efficiencies by reducing the costs associated with sorting, scanning, indexing and re-entering paper-based patient data into ambulatory EMRs. Moreover, since patient records are transmitted straight from hospital systems into practice EMRs, interfaces also eliminate privacy concerns created by fax, mail and courier delivery of paper documents.

Anecdotal evidence within our practice clearly indicates that EMR interfaces have helped our practice minimize the cost and exposure of performing duplicative tests and procedures. Because our physicians can now better track patient events in both inpatient settings and outpatient labs, we feel certain that we are preventing tests (radiology procedures in particular) from being performed unnecessarily.

The Path to Interfaces

Rocky Mountain Gastroenterology Associates (RMGA) is a 23-physician, five-midlevel practitioner practice. We have six primary offices and own and operate three ambulatory surgery centers. Our EMR is currently interfaced with four area hospitals (with three hospitals in one health system and one from another system), two national labs and four anatomic pathology labs.

We began the process of interfacing our EMR as soon as it was deployed in 2005. Traditionally, labs (especially national reference labs) have been far ahead of hospitals in terms of their interface capabilities. EMR interfaces to outpatient labs were readily available and easily integrated into our system. The good news is that hospitals are catching up, and we have established EMR interfaces with two of the three health systems where our physicians have privileges.

RMGA now has one of the most highly integrated EMRs in the Denver community. We receive and send patient clinical and administrative data, including lab results, surgical notes, radiology reports, transcribed reports and discharge summaries.

Distinguishing Interface Factors

It should be noted that not all EMR interfaces are created equally. Of the seven interfaces we have established, one lab-EMR interface and one hospital-EMR interface have risen above the others in terms of cost of deployment, integration with our EMR and range of functionality.

For one of our hospital-EMR interfaces in particular (which went live in March 2008), technology powered by software agents has proven highly effective as a mechanism for information exchange. Agents can be thought of as software "robots" installed within the hospital network; a software agent in the hospital network continuously collects, filters and distributes patient records to the designated ambulatory EMR based on the precise parameters established by the hospital and each practice. Another set of agents is downloaded from the Internet and installed on existing PCs in affiliated practices. These agents receive information that pertains only to that practice's patients and transfer the information into the ambulatory EMR. The patient results data is distributed over a highly secure and private Internet-based clinical messaging infrastructure referred to as a "grid".

We have found that this agent-grid platform distinguishes itself in three areas that, taken together, might ease the concerns of practices worried by the potential for cost, disruption and other complications that introducing an EMR interface could cause:

1. Upon initial setup, customization of the data and populating that data in the EMR was simple and fast. Each discrete data element is easy to identify.
2. The time needed to test and perform quality assurance measures was brief. The system was tested and verified simply and quickly by our staff.
3. The exchange platform is not affected by changes in hardware, including changes to servers. RMGA relocated all of our EMR servers shortly after deployment and experienced virtually no maintenance or restart issues associated with the system, unlike our other hospital interfaces.

A Real Connection

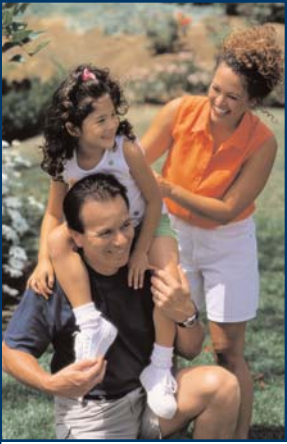
Even if a practice is convinced of the value of EMR interfaces, the fact of the matter is that most hospitals have to be convinced of the need to deploy them. In many cases, that task will fall to practice managers.

After the local hospital deployed the agent-based exchange solution described above, I made it a point to tell the hospital's CEO that the platform was serving as a very real binder between RMGA and his facility. It has continued to help us improve patient care and, therefore, demonstrated to RMGA that hospital's commitment to helping us fulfill our mission. As hospitals strive to be more responsive to the physicians in their communities, deploying efficient EMR interfaces is a tangible way to demonstrate a meaningful commitment to helping practices achieve their most important goal: delivering the best care possible in an efficient and cost-effective manner.

Craig Bakken (cbakken@rockymtngi.com) is Chief Executive Officer for Rocky Mountain Gastroenterology Associates and its affiliated company, Rocky Mountain Endoscopy Centers in Denver, Colo.



Colorado Public Health Insurance Programs



Colorado's economic landscape is changing, as it is around the country. As a result, more people are depending on public health insurance programs than ever before.

In response to the increased need, the Colorado Department of Health Care Policy and Financing is bolstering its provider recruitment efforts to provide greater access to Medicaid and SCHIP clients.

The Department administers the Medicaid and Child Health Plan Plus programs as well as a variety of other programs for Colorado's low-income children, families, the elderly and people with disabilities. The mission of the Department is to improve

access to cost-effective health care services to all Coloradoans.

The Department supports its providers by paying fairly (90 percent) of Medicare payments for evaluation and management visits for Medicaid visits. This is the third year of rate increases for providers. Colorado Medicaid pays claims faster than any other state in the nation.

The Department Web site, www.colorado.gov/hcpf, hosts provider billing manuals to assist with billing questions and offers information on all Department programs. Client eligibility and the status of claims payment can be confirmed easily on-line.

Becoming a Medicaid and CHP+ provider is easier than ever before. By incorporating feedback from providers, the enrollment process continues to improve.

The health of Colorado's vulnerable populations depends on the health of our providers. The Department is committed to partnering with providers to innovate delivery models, payment methodology, and administrative simplification to create a high performing, outcomes-focused system of care.

For more information about becoming a Medicaid or CHP+ provider, please visit our Web site at www.colorado.gov/hcpf or contact Cindi Terra at 303-866-5459 or cindi.terra@state.co.us.

President Elect Column

by Jan Krause

2009 is off to a great start with new talent in education planning! Sheri Page, MBA, Practice Manager, Integrated Ear Nose & Throat, Lone Tree and Lance Goudzwaard, MSHA, FACMPE, Chief Executive Officer, Arapahoe Gastroenterology, PC and related entities are CMGMA education co-chairs for the upcoming two-year term. We have been getting ourselves organized for the road ahead.

With these two high-energy, sharp people involved in selection and presentation of new speakers and programs you can expect an excellent spring conference in Colorado Springs and other upcoming opportunities. The spring conference will retain our new Thursday afternoon/Friday all-day format, and it is our pleasure to collaborate with our military counterparts again.

Planning also continues on the Four-Corners Conference for 2010. We have much to do for this major conference. Here is a link to the Sandia Resort and Casino if you would like to daydream a bit: <http://www.sandiacasino.com/>

Be sure to share any ideas for speakers, topics or networking with Lance, Sheri or me any time.

Membership Spotlight Hank G. Arellano

One of our new additions to the CMGMA membership committee is Hank Arellano.

Hank is the Practice Manager at the Vascular Institute of the Rockies where he has been for the past six years. Prior to working in management, Hank's background was in the clinical arena, specifically diagnostic ultrasound where he worked as a Registered Vascular Technologist as well as lecturing extensively. In a pinch, he still fills in, providing vascular ultrasound at the Institute.



His interests include history, cycling, golf, and working out. Hank joined CMGMA for the benefit of local networking at an affordable price.

I am sure many of you are affected by this recent announcement and have thoughts and concerns about the message it sends to physician practices everywhere. If you have comments you would like us know, please send them to me and we can share this feedback with BVIPA and other members. Whether you agree or disagree on the methods, it is helpful to understand how these issues affect each of us and to also communicate that back to our legislators so our voice is heard. I look forward to hearing from you.

Joyce Vollmer, CMGMA Legislative Liaison
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Statement of Boulder Valley Individual Practice Association in Response to the Announcement of a Proposed Enforcement Action by the Federal Trade Commission December 24, 2008

For over a decade, the Federal Trade Commission has brought multiple enforcement actions against physicians around the country, which accuse the physicians of bargaining jointly in an attempt to increase the reimbursement rates paid by health insurance companies. Most of these cases have been settled by consent decrees.

Today, in the latest of these cases, the FTC simultaneously announced its complaint against the Boulder Valley Individual Practice Association and a consent order that would bar the IPA physicians from contracting jointly with the insurance companies. The proposed order will still allow individual physicians or practice groups to contract directly with the health plans, and the order **is not going to have any significant impact on the ability of IPA physicians to treat patients in Boulder County.**

It is important to understand that Boulder Valley's acceptance of the consent order is not an admission that the charges made by the FTC are true. In fact, they are not, as will be demonstrated in detail below. Nonetheless, because it cannot afford to fight the federal government, the Boulder Valley IPA has decided to settle rather than litigate.

The Boulder Valley IPA is a group of over 350 primary care and specialty physicians located in Boulder, Colorado. It has contracts with 17 health plans that have significant membership in Boulder County. These health plans include billion-dollar insurance companies such as United Healthcare, Aetna, and CIGNA. By contracting with the health plans, the Boulder Valley IPA provides a readily accessible network of primary care and specialty physicians that are available to patients insured by the plans.

In past years, the Boulder Valley IPA has offered health plans three contracting options. The first option is that **at the request of the insurance company**, a health plan may negotiate a single agreement with the IPA that provides access to the entire IPA network of physicians through one contract. Large billion-dollar insurance companies such as Cigna, Aetna and many others have used this option, presumably because they have found it to be an efficient way to obtain access to an extensive panel of physicians in Boulder county at minimal contracting expense.

The second option is that the Boulder Valley IPA will act as a messenger on behalf of the insurance company by sending out contracts to the membership. United Healthcare is an example of this type of contracting model.

The third option is that the Boulder Valley IPA has facilitated the negotiation of contracts directly between the health plans and individual physician or small group practices. Anthem is an example of an insurance company that has contracted with members of the Boulder Valley IPA in this fashion.

The proposed complaint alleges that the members of the Boulder Valley IPA have refused to negotiate with the insurance companies individually or through their small group practices, but instead have forced the health insurance companies to negotiate with the group as a whole. It is difficult to understand how a group of doctors in Boulder County could "force" billion-dollar insurance companies to do anything. These charges – and others like them – are not only false, they are affirmatively disproved by unmitigated facts.

For example, the proposed complaint states "the only method that Boulder Valley IPA ever used was the single-signature contract." This simply is not true. In fact, Boulder Valley IPA members can and do contract individually with third-party payers. Anthem and First Health, and United Healthcare, are the only insurance companies that have expressed an interest in direct contracting with members of the Boulder Valley IPA. Each of these companies has successfully done so.

Over 90% of Boulder Valley IPA members – including all of its officers – contract individually with Anthem.

- A large primary care group, comprised of 25 primary care physicians (the largest group in the Boulder Valley IPA), has individual contracts with Anthem, United Healthcare, and First Health.

- A Longmont-based primary care group has individual contracts with Anthem and First Health.

- Hospital-based specialty groups have individual contracts with United Healthcare, First Health and Anthem.

- Most of the large single specialty groups have individual contracts with Anthem and First Health.

The allegation that the Boulder Valley IPA "never developed or used a messenger model in any negotiations with any payers" is equally false. The Boulder Valley IPA has contracted with United Healthcare with this particular contracting method since 2004.

The Federal Trade Commission's complaint ignores these facts. The Boulder Valley IPA provides health plans the opportunity to contract with a large number of physicians through a single agreement. If the health plans don't want that service, they are free to contract individually with the same doctors, either with the assistance of the Boulder Valley IPA or without.

In short, this case boils down to a simple dispute. The Boulder Valley IPA believes that that joint negotiations conducted **at the request of the insurance company or health plan** are legal, save money in the contracting process, allow greater access to a broad physician network, and can improve the quality of care. The FTC apparently believes that even when undertaken at the specific request of a payer, joint negotiations are illegal.

Regrettably, however, the cost of a fight with the FTC in this case is more than the IPA can afford, and would interfere with the ability of the members to meet their primary task – providing superior and cost-effective health care services to the residents of Boulder County. Fortunately, the present action by the FTC will not divert the IPA and its members from this task. The Boulder Valley IPA and its member physicians will comply and contract individually with the health plans. The accessibility of these physicians to patients in Boulder County will not diminish in any way.

For further information contact Cathy Higgins, Executive Director, Boulder Valley IPA, at 303-530-3405.