First Illinois Speaks
hfma healthcare financial management association
HFMA's First Illinois Chapter Newsletter
April 2018

Where Passion Meets Purpose

News, Events & Updates of the First Illinois Chapter begin on page 18

In This Issue

Seven Steps to Maximize Electronic Health Record Adoption

BY LINDA BAILEY-WOODS, PRINCIPAL, PLANTE MORAN

Electronic health records offer advantages healthcare organizations need if they want to stay viable. But few providers realize the full potential of their EHR technology. These transformational steps can help ensure you maximize EHR adoption at your organization.

The past decade has seen a proliferation of electronic health record (EHR) technology. Healthcare organizations have made significant health information technology (HIT) investments of capital and operational expense, resources and time. They've done this for many reasons, including to satisfy regulatory requirements, demonstrate meaningful use, comply with HIPAA and share information through a health information exchange (HIE).

In addition, providers have invested and implemented HIT to realize the great promise: increased efficiency, staff reduction, improved physician satisfaction, better health outcomes and continuity of care and decreased care costs.

The drive to realize these benefits is necessary for health systems that want to position their organizations to remain viable and succeed in today's fast-evolving healthcare environment. And yet, most organizations haven't seen the full breadth and depth of promised improvements with their EHR technology.

What's getting in the way?

There are many obstacles on the road to maximizing EHR adoption. Changes in payment methodologies, service delivery models, consumer engagement and regulatory requirements all demand that providers change their approach for EHR to deliver a real return on investment. You can't trust the software vendor to drive EHR benefits realization. The implementation process must be orchestrated in tune with your strategic business plan and customized to facilitate your operations.

In addition to technical and funding issues, other broader organizational issues such as legal and policy,

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Seven Steps to Maximize Electronic Health Record Adoption (continued from page 1)

clinical, business and technical operations, universal workflows, maintenance and support and, most importantly, governance, all play a role in maximizing EHR adoption. In fact, these fundamental elements can galvanize nearly all EHR efforts, regardless of the particular product, to help realize latent potential.

Transformational steps to realize EHR benefits

Providers will have to work through the proper execution of the following seven transformational steps to maximizing EHR adoption and drive long-term success.

1. Provide adequate and effective EHR governance with active participation from all user constituents.
2. Develop an EHR funding model that incorporates the total cost of ownership and allowances for unanticipated costs associated with conversion revenue cycle issues, additional vendor fees for new modules or other technology requirements, and resource requirements.
3. Update EHR policies and procedures to support EHR workflows, functional and regulatory processes and the sharing of protected health information (PHI) and to meet PHI and HIE regulatory guidelines.
4. Define, assess and test the technical infrastructure requirements with the EHR vendor.
5. Assess, consolidate, refine and standardize clinical, business and technical operations into universal workflows, and thoroughly vet these operations across the organization to stimulate end-user engagement.
6. Assess EHR security, HIPAA and HITRUST requirements. For any deficiencies identified, develop and execute a corrective action plan to address them.
7. Create a maintenance and support model in concert with your EHR implementation and ensure the model is fully developed and in place at EHR activation.

These seven transformational steps aren't quick-hits; they'll take planning and time. But the return will be worthwhile, helping your organization maximize electronic health record adoption and make it a useful and effective clinical and business technology that supports the organization's strategic initiatives.

To learn more, visit plantemoran.com.

Message from FIHFMA President

HFMA Colleagues,

It's hard to believe we're already so far into calendar year 2018. The year has been flying by. I recently attended the Managed Care Conference at the University Club. The education event had over 150 registered attendees! We heard from excellent speakers and a great provider/payor executive panel. Big thanks to Cathy Peterson and Brian Washa, co-chairs, and the entire Managed Care Committee for all their hard work in preparing and organizing a very successful education program.

I'm pleased to announce that the new satisfaction survey results were recently provided to chapter leaders, and our chapter earned a score of 83 percent! This reflects scores of 4 or 5 stars. Thanks to all members who provided feedback and comments. I would like to especially thank the Executive Committee, Board or Directors and our very active volunteer leaders who made it possible for our chapter to earn this great score. This score exceeded our stretch goal as a chapter. The survey results will be reviewed in detail during the chapter's strategic planning for next fiscal year as we try to earn a higher score next year.

The accounting and reimbursement education event took place on March 22 at Prentice Women's Hospital. Larry Goldberg provided a national legislative update and IHA presented on a State Medicaid update. Other hot topics included the new ASC 606 revenue recognition requirements, important tax and Medicare reimbursement updates and a 340B update. Attendees were able to earn at least 7.5 CPE credits.

It's been a few years, but we're looking forward to a new revenue cycle 101 education program on April 19 at 161 N. Clark Street. Attendees can earn CPE credit. Please see the Events page on the First Illinois HFMA website to learn more and register.

It's been an honor to serve as your First Illinois HFMA Chapter president. If you have any suggestions or would like to get more involved with our chapter, please reach out to me at brian.katz@rsmus.com.

Respectfully,

Brian Katz
2017 – 2018 First Illinois,
HFMA Chapter President

CAREER Corner

BY VICKIE AUSTIN

Rich Schefke

*This issue of "Career Corner" focuses on **Rich Schefke, CPA, FHFMA,** director of Financial Planning and Analysis for Rush Copley Medical Center. Rich has worked for companies including Arthur Andersen & Co. and Northern Trust and Deloitte, and he was an assistant professor of accounting and finance at American Intercontinental University. He is also on the board of the First Illinois HFMA Chapter and is once again program lead for the 2018 FIHFMA Fall Summit.*

Q: What was your first job?

A: I was an usher for the Louisville Redbirds baseball team. The minimum age was 16, but I was persistent with calls and they hired me at 15. I learned a lot about interacting with many personalities.

Q: Who were some of your early influences and role models?

A: One of my role models was my dad who handled some adversity in his career and always managed to come back stronger. He also taught me to take care of things, so you have less financial stresses, and I have followed that by continuing to drive my first car, a 1995 Saturn. I had a high school accounting teacher, Jim Jorgensen, who cultivated my interest in accounting, and a college professor, Curt Norton, who helped me develop a passion for accounting. When I had my first professional job at Arthur Andersen I was surrounded by many who taught me the value of hard work.

Q: What had you choose healthcare as a career?

A: As a non-clinical person, I feel a strong connection to the community I serve. I help pay, plan and finance the future growth of programs that help many lives, including my own special needs children.

Q: What was one of your most "teachable" moments?

A: Sometimes events that will affect your career are out of your control. I experienced this early on with Arthur Andersen when some major clients left, and I ended up having to leave before being promoted to manager. I took a position outside of public accounting and a few years later ended up being hired by Deloitte as a manager, completing my comeback.

Q: What key lessons about career management have you learned along the way?

A: First, listen to your gut if you are being led in a different direction than you ultimately wanted to go. Also, take responsibility for your own career. I have taken three different risks in my career while following my gut, and I'm very happy with the results. Whenever setbacks happen, do not dwell on them. Instead, plan your comeback.

Q: What role has HFMA played in your career development?

A: I entered the industry at a management level without any healthcare experience, and HFMA was invaluable in bringing me up to speed, from the basics to the current issues. On my own vacation time, I studied and passed the Certified Healthcare Financial Professional exam.

Q: What are you reading?

A: "Barking up the Wrong Tree" by Eric Barker. I am always looking to improve as a leader, so this is right up my alley.

Q: What advice would you have for someone just starting out in the healthcare financial management profession?

A: First, be active in HFMA! The contacts and knowledge available are incredible. Next, focus on developing relationships with clinical people in your organization. The most valuable people in healthcare finance will be those who have a great two-way communication with clinical management, especially as the industry keeps moving from fee-for-service to fee-for-quality-of-performance.

Vickie Austin

*Vickie Austin is a business and career coach and founder of CHOICES Worldwide and author of **Circles of Gold: Honoring Your Network for Business and Career Success.** She has spoken at ANI and she's a frequent speaker at HFMA chapters around the country. Vickie is also a new contributor to HFMA's "HERe" e-newsletter. You can connect with her at vaustin@choicesworldwide.com*

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Three Foundational Shifts in Healthcare

BY PATRICK PILCH, STEVEN SHILL AND DAVID FRIEND

The Trump administration has signaled three major foundational shifts in its approach to healthcare. While there are many factors at play in the current environment, these shifts are the guiding principles behind major industry developments—from regulation, to deals and innovation.

1. Mandates to choice: Movement from an insurer marketplace governed by mandates to a system centered on choice
2. Regulation to competition: Movement from a marketplace characterized by regulation to a marketplace guided by competition when it comes to coverage and pricing
3. Subsidies to actuarial soundness: Movement from payments provided via subsidies to greater actuarial soundness

The impacts to various stakeholders in the healthcare ecosystem, however, are nuanced. In the wake of news like Amazon, Berkshire Hathaway and JP Morgan's announcement that they're creating an independent healthcare company, what do these foundational shifts mean for the healthcare's stakeholders?

(See page 7, Changes & Audiences Chart)

BDO Insights: Finding Your Footing

With any change in structure, stakeholders must adapt their strategy. We recommend the following steps to understand how these shifts impact your organization and end consumer.

- **Decode** the onslaught of political rhetoric, legislation, industry consolidation and regulatory change in healthcare.
- **Interpret** the impact for you, your customers and your stakeholders.
- **Evaluate** your current business model and activities.
- **Determine** the changes you need to make to stay on key.

Start with the matrix above as a diagnostic tool for steps one and two. Then, consider whether your current business model is contingent upon any of the old models. While these changes are in various stages of maturity, the industry is undoubtedly barreling away from mandates, extensive regulation and subsidies. It's important to settle on an honest assessment of where your business currently lies.

Each stakeholder will have different levels of exposure to each change. For example, payers will likely be most impacted by the policy shift from mandates to choice, but they must be careful not to miss the subtleties of the other two components. For a digital health player, the impacts may be entirely different. Public healthcare entities have the added complexities of examining shareholder outcomes and assessing the movement of their stock price.

Bringing in the outside perspective of a third-party advisor can be helpful to assess the full scope of your needs and risks. Then, healthcare entities must communicate their evolved approach to various stakeholders, including the boards and leaders who will help shape strategy moving forward, the employees who will need to align with and carry out the new vision, investors whose outcomes will be impacted and end consumers who may see change in their hospital room or bottom line.

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Changes & Audiences Chart

	Providers	Insurers/Payers	Patients	Investors	Drug Makers
Mandates to choice	"For providers, changes in the way individuals on Medicaid or exchanges are covered will have the biggest impact on margins. Those individuals make up a relatively small portion of the population. A change in the proportion of insured patients could disrupt revenue streams if bad debt means out-of-pocket costs go unpaid. "	With pared-down options and association plans more available to healthier populations, insurers' customer bases may trend toward costlier individuals. Insurers who have already set 2018 premiums could take a hit.	Cheaper, slimmed-down coverage or association health plans that would be available in the marketplace are likely to attract younger, healthier patients and reduce costs for those populations while increasing costs for older, sicker patients.	If new market entrants respond to demand for leaner, cheaper insurance plans, this could mean new opportunities for investors. If there is more choice in terms of how providers adapt to value-based reimbursement models, like bundled payments, investors may shift their focus from facilities that were more likely to receive reimbursement under certain mandates toward other avenues.	"In the face of threats from tech, traditional pharmacy benefit managers (PBMs) and drug distributors need to defend themselves. The proposed merger between Aetna and CVS is just that a defensive move in the battle for the bottom line. The potential merger is a watershed moment that may accelerate the push to value-based drug pricing."
Regulation to competition	The trend toward payment based on effectiveness of care versus care delivere could compound this disruption to revenue streams, potentially meaning less predictable margins for major insurance players.	Moves that merge prescription and medical benefits, like CVS' bid for Aetna, create opportunities for payers to determine the real correlation between drug prices and clinical outcomes. Rather than paying an arbitrary price per pill, a shift from regulation to competition would enable payment for drugs based on the clinical results or outcomes.	Pressure from tech giants encroaching on traditional healthcare players' territory are likely to drive more mergers of prescription and medical benefit providers. Moves like these will accelerate the shift to outcomes-based drug pricing. They could also give patients greater transparency into how their drugs are priced and what other options might be less costly and more effective.	"With a lessening of regulations that essentially serve as barriers to entry in various markets, new, disruptive entrants could be primed as investment targets. Ample opportunity exists in biotech, the wearables market, applications of artificial intelligence and more. Couple that with the trend toward shorter, streamlined FDA approval processes. If an approval process for a particular drug or medical device is cut by five or 10 years, the amount of time a company can collect on the patent becomes longer. If a disruptor can get to market faster and patent their product quickly, returns will grow for both the company and its investors."	"Artificial Intelligence and machine learning are enabling the tech giants like Google, Apple and Amazon to potentially manage prices more effectively than traditional pharmacy benefit managers and drug distributors. This gives them another avenue to enter the market, which could impact drug prices in the future. More pressure on drug pricing due to increased transparency and competition will encourage drug makers to find other ways to pursue R&D. A shift from regulation to competition would enable them to devote more funds to R&D and see quicker results without being slowed down by regulatory red tape. "
Subsidies to actuarial soundness	With a rollback of coverage mandates, insurance plans could trend toward including less comprehensive coverage of certain services. This could lead patients to choose certain procedures less often if they are not included in most plans. Revenue streams would evolve as a result.	Greater freedom in the structure of short-term plans, which were not allowed under the ACA, means premiums can align with scope of coverage, potentially allowing for more predictable margins after the dust settles from potential short-term losses.	ACA markets could trend older and sicker, increasing costs for these populations. The elimination of subsidies for those patients could mean more out-of-pocket costs. Subsidies under the ACA have meant that patients aren't paying the true cost of their care; the shift toward actuarial soundness may result in some patients dropping out of the marketplace entirely and opting not to purchase coverage.	Drug prices based on actuarial soundness may mean pharma companies with an expensive, but highly effective, product may become more attractive to investors. R&D of these types of drugs, which may have smaller customer bases, could accelerate.	Rather than drugs that must be administered over time, one-time or limited-time drugs with high costs and high efficacy could be prescribed more often. This would have implications for the agreements between PBMs and drug makers. If younger, healthier patients are opting for slimmed-down coverage, prescription of non-emergent drugs could decrease among these populations.

Telemedicine and Fair Market Value – What You Need to Know

BY CHRIS W. DAVID, CPA/ABV, ASA

Telemedicine (also known as telehealth) is a rapidly-evolving trend in the healthcare delivery space today. As the availability of medical providers declines and patient demand increases, many healthcare systems are searching for alternative solutions to traditional care models. Multiple studies have found that telemedicine can:

1. Provide access to care in underserved communities
2. Improve quality of care
3. Provide needed health education
4. Lower costs

The American Telemedicine Association (ATA) defines telemedicine as "the use of medical information exchanged from one site to another via electronic communication to improve a patient's clinical health status." Simply stated, telemedicine allows patients to connect remotely with physicians via phone or video conference to address healthcare concerns. This treatment method has been used for several years to conduct specialty consultations in rural areas with patients who have limited access to doctors.

Telemedicine health services are typically divided into three categories:

1. Store and forward
2. Video conferencing
3. Remote patient monitoring

Store and Forward

Store and forward technologies allow sensitive medical information, such as digital images, documents and pre-recorded videos to be transmitted securely via email. This information can include X-rays, MRIs, photos, patient data and even video-exam clips. Store and forward communications primarily take place among medical professionals to aid in diagnoses and medical consultations when live video or face-to-face contact is not necessary. Because telemedicine consultations do not require the specialist, primary care provider or the patient to be available simultaneously, the treatment process is streamlined for the patient and the provider.

Video Conferencing

Video conferencing uses two-way interactive audio-video technology to connect users when a live, face-to-face interaction is necessary. Video devices can include video conferencing units, peripheral cameras, video scopes or web cameras. Display devices include computer monitors, LED TVs, LCD projectors and even tablet devices. Video conferencing is the most common form of telemedicine practiced today. It is a cost- effective tool for a variety of applications, including emergency room and intensive care unit support.

Remote Patient Monitoring

Remote patient monitoring (RPM) uses digital technologies to collect various forms of health-related data. Patients electronically transmit medical information securely to healthcare providers in a different location for assessment and recommendations. Monitoring programs collect a wide range of health data from the point of care, such as vital signs, weight, blood pressure, blood sugar, blood oxygen levels, heart rate and electrocardiograms. Data is then relayed to monitoring centers in primary care settings, hospitals, intensive care units, skilled nursing facilities and centralized off-site case management programs. Healthcare professionals monitor these patients remotely to provide care as part of their treatment plan.

Demand for Telemedicine

Thirty percent of Medicare payments are now tied to alternative payment models (APMs). The Department of Health and Human Services (HHS) plans to raise the percentage by 50 percent by the end of 2018. Many healthcare providers are looking for ways to increase quality of care and patient access while keeping costs down. The Medicare Shared Savings Program (MSSP) is an alternative payment model that recognizes telemedicine services as a clinical practice improvement activity, which is one of four components required for incentive payments. Physicians who provide patients with free equipment for remote monitoring are now eligible for fraud and abuse waivers under recent changes to the MSSP program.

With today's technology, a physician or midlevel provider can perform primary care consultations, psychiatric evaluations, emergency care and other medical services remotely. At the same time, these new technologies create a cost-effective alternative to full-time physician employment. Telemedicine is especially attractive to rural health systems due to specialized physician access that is typically unavailable in these areas. Specialties, such as mental health, radiology and dermatology, are a few types of practices that are well-suited for telemedicine.

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Telemedicine Reimbursement

Medicare

Medicare first began to reimburse telemedicine services after the Balanced Budget Act of 1997 was passed. As of January 2017, Medicare reimbursement only includes video conferencing services under very specifi¬c circumstances. Store and forward, or asynchronous services, is not permitted for reimbursement (except for federal telemedicine demonstration programs in Alaska or Hawaii as stated by the Center for Medicaid and Medicare Services). Medicare claims for telemedicine services are billed using Current Procedural Terminology (CPT®) codes, along with the appropriate telemedicine modifier code "GT."

Medicare reimburses live video conferencing telehealth services according to a model that includes an "originating site" and "distant site practitioner." The patient in need of care is located at the original site, and the healthcare provider is located at the distant site.

In order to be reimbursed for video conferencing telemedicine, the patient must be located outside of a Metropolitan Statistical Area (MSA) or a rural Health Professional Shortage Area (HPSA). Additionally, Medicare limits the originating sites eligible to receive services through telemedicine to the following facilities:

- Provider offices
- Hospitals
- Critical access hospitals (CAHs)
- Rural health clinics
- Federally qualified health centers
- Hospital-based or CAH-based renal dialysis centers (including satellites)
- Skilled nursing facilities
- Community mental health centers

These sites are also eligible to receive a facility fee from Medicare to compensate for the use of their facility. A patient's home doesn't qualify as an originating site, in most cases.

The following list of distant-site providers qualify to deliver services via telemedicine through Medicare:

- Physicians
- Nurse Practitioners
- Physician Assistants
- Nurse midwives
- Clinical Nurse specialists
- Clinical Psychologists and clinical social workers
- Registered Dietitians or nutrition professionals

However, there is no limitation to the site where the healthcare provider chooses to practice telemedicine.

For telemedicine services provided in approved settings, healthcare professionals are reimbursed at 100 percent of the current non-facility fee schedule for the eligible service. Additionally, the originating site is eligible to receive a facility fee. The facility fee is billed under Healthcare Common Procedure Coding System (HCPCS) code Q3014 as a separately billable Part B payment.

Medicaid

Coverage of telemedicine services under Medicaid is determined on a state-by-state basis. The off¬icial policy indicates that states may reimburse for telemedicine under Medicaid as long as the service satisfies federal requirements of "e¬fficiency, economy and quality of care." This policy enables states to have unique standards for what services they deem appropriate for reimbursement, which causes gaps in the system due to a massive lack of uniformity. This results in differing reimbursement policies for each state. Recently, the Center for Medicaid and Medicare Services granted states flexibility to define their own telemedicine policy.

Similar to Medicare, video conferencing is the most common telemedicine modality that is reimbursed. As of January 2017, 48 states and DC were reimbursing for some form of live video telemedicine. However, there are often several restrictions on the type of provider, facility, service, or geographic location that can be reimbursed.

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Telemedicine and Fair Market Value – What You Need to Know (continued from page 9)

Reimbursement for the other two categories of telemedicine is less common. Store and forward is only reimbursed in nine states while remote patient monitoring is reimbursed in 16 states. There are often restrictions related to certain specialties and specific circumstances.

In addition to reimbursement to the healthcare provider, many state Medicaid programs provide a facility payment and, in some cases, a transmission payment to cover the cost of connecting the patient to the distant site provider.

Private Payers

Private payers, such as Blue Cross Blue Shield, Aetna and Cigna, are not required under federal law to provide coverage for any type of telemedicine service. For private payers that do reimburse for telemedicine services, there is no unique set of standards pertaining to insurance companies throughout the country. As of January 2017, 34 jurisdictions including DC have enacted (or will enact at a later date) laws that govern private payer telemedicine reimbursement. Some states mandate some sort of reimbursement, while others mandate reimbursement at the same level as in-person care under certain conditions. The existence of a state private payer law does not guarantee that all types of telehealth will be covered.

These laws often have restrictions, caveats and limited applicability. These qualifying clauses may set up certain conditions where an insurer has the flexibility to restrict telemedicine reimbursement within their contract. For example, many states limit their coverage requirement to live video real-time interactions. Others include limitations on the location, facility type, condition treated and eligible providers. Many private payer laws also often contain the caveat that telemedicine services must be covered but make it subject to the terms and conditions of the contract between the enrollee and payer. This may set up certain conditions and situations providers and consumers should be aware of.

In the absence of a state law requiring telemedicine coverage, providers must carefully read the policies of each insurance company in order to determine whether or not they can be reimbursed for services delivered through telemedicine. Even when there is not a private payer law, some insurance companies still may pay for service.

Basic Model

As telemedicine continues to evolve, more health systems will begin forming remote care arrangements. A basic arrangement involves an originating site (usually a rural hospital) with patients in need of care and a distant site (usually a larger health system) employing or contracting with specialists who deliver care. This is a basic hub-and-spoke model which is illustrated below.

Under the hub-and-spoke model, the originating site refers their patients to the distant site for the specialized care they need. This model can be structured in two different ways.

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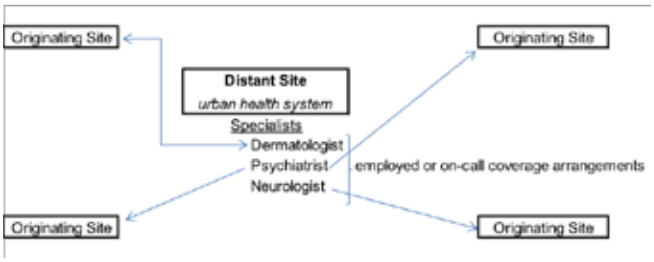
Telemedicine and Fair Market Value – What You Need to Know (continued from page 10)

1. The distant site would employ the physician on a full-time or part-time basis and the distant site hospital would bill and collect.

2. The distant site would enter into independent contractor arrangements with specialists to be on-call and provide certain telemedicine services when needed. The on-call physicians would provide the needed consult or service via the approved technology and subsequently bill and collect the professional fee. The distant site would collect a facility fee and possibly an additional data transmission fee to cover the telecommunication costs.

Fair Market Value (FMV) Concerns

Under Scenario 1, the distant site facility simply employs the physician on a fulltime or part-time basis at a fair market value (FMV) compensation.



Under Scenario 2, the dynamics get a little tricky. At first, the on-call arrangement appears to be very similar to a typical call arrangement for an emergency department. However, utilizing per diems reported in benchmark surveys to determine a telemedicine on-call rate is not exactly appropriate. It is important to remember that published call coverage data generally represents emergency department call coverage and will likely need to be adjusted when used for a telemedicine stipend calculation. Emergency department call coverage benchmarks typically consider the burden of responding in person to the emergency department to perform a consultation, surgery or other procedure. In a telemedicine arrangement, the on-call physician can likely deliver the consult or examination at his home, office or over the telephone, which is much less burdensome than having to come into the emergency department. In this case, the per diem rates published in the compensation surveys should be discounted to account for the diminished burden.

In addition to the coverage stipend for availability, the on-call physician may be compensated a flat rate per consultation, exam or an hourly rate. It's important to consider this component when analyzing the entire payment arrangement. For example, if a physician is going to be paid an hourly rate for his clinical time in addition to the per diem stipend, then the stipend may be a little lower. Or, if the physician is able to bill and collect for his professional services in a facility with a very favorable payer mix, then the daily stipend might be lower. However, if the physician does assume the risk of billing and collecting and the facility has a poor payer mix, then this factor would cause the daily stipend to be higher. Finally, the distant site would typically lease all the required hardware and terminals to the originating site at an FMV equipment lease rate.

Conclusion

Although the services offered under telemedicine arrangements may be similar to traditional on-call arrangements, determining the FMV of compensation for telemedicine requires a firm grasp of the legal and regulatory landscape surrounding these services. Providers are encouraged to consult with legal counsel when structuring a telemedicine arrangement. It is paramount to first have a proposed model or arrangement in place with a draft contract before seeking a third-party FMV appraisal. The appraiser needs to understand which parties will incur which costs and responsibilities in order to render a thorough and defensible FMV opinion.

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[1] http://thesource.americantelemed.org/resources/telemedicine-glossary "Telehealth Services." Center for Medicaid and Medicare Services. Medicare Learning Network. December 2015. < https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf>

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www.medicaid.gov/Medicaid/benefits/telemed/index.html

Measuring and Managing Patient Profitability

BY GARY COKINS, CPIM, ANALYTICS-BASED PERFORMANCE MANAGEMENT LLC

"The greatest wealth is health" (Virgil, Ancient Roman poet). There is nothing more important than taking care of ourselves and each other. However, focusing a health system on the appropriate goals in a complex political and social environment requires investment in the right combination of time, money, intellect and creativity.

Government agencies are bringing pressure on healthcare providers, vendors and insurance companies. For decades, our health system has been revenue driven, often with somewhat irrational pricing. Healthcare leaders must now pay closer attention to the middle line–costs–not just the top line (revenues) when working to improve the bottom line (profits).

The only financial value a healthcare facility will ever create for its stakeholders is the value it derives from its patients—its current patients and new ones to be served in the future. Healthcare organizations should view patients similarly to how commercial companies view existing and prospective customers. To remain competitive, healthcare facilities must determine how to keep patients and their families coming back to satisfy medical needs throughout their lifespan and to serve them more efficiently. To do this, they must maintain a high level of quality and patient satisfaction while growing revenue and controlling costs.

Healthcare organizations today still have a gap between the financial and clinical staff's agenda. That gap can be closed by building a bridge between patient outcomes, pricing, costs and profits. Profits (for-profit systems) and sustainability/growth (for-profit and nonprofit systems) are what the healthcare owners are seeking. In marketing terms this is referred to as value.

Value = Quality / Price

Everybody wants value in return for whatever they exchange. Customers and patients conclude they receive value if the benefits received from a product or service meets or exceeds what they paid for it (including time, investment, quality and cost). But shareholders and stakeholders believe if their investment return is less than the economic return they could have received from equally or less risky investments (e.g., a U.S. Treasury bill), then they are disappointed. Value to employees is another issue altogether usually tied to compensation, stability and job satisfaction.

What are the tradeoffs in providing value to these three groups? Is there an invisible hand controlling checks and balances to maintain an economic equilibrium so that each group receives its fair share? Adding to the conflict, "fair share" is a subjective concept (ask any politician). Are some groups more entitled to receiving value than others?

As the model of healthcare shifts focus from fee-for-service-centric to fee-for-performance-centric, some insensitive truths about high-volume unprofitable patient services must be analyzed. That doesn't necessarily mean those services should (or can) be discontinued. Are these services a "necessary evil" for the entire healthcare system or do they satisfy a basic need for the community? The labor and delivery of some services can lose money. However, the widely held belief is that mothers will come back for additional services in the future and, perhaps, even the whole family will stay in the system for years to come. This may be nice in theory; however, can it be proven with information generated from the healthcare facility's management accounting system?

Unfortunately, many hospital management accounting systems aren't able to report services, treatments, procedures and patient profitability information. Without reliable and accurate accounting information, they are limited to support analysis for how to rationalize which types of patients to retain, grow or win back and which types of new patients to attract that will be in harmony with the hospital's specialties, competencies and expense structure. Commercial companies refer to this as "customer rationalization." Hospitals need similar thinking – "patient rationalization."

Social media messaging about a health system and its competitors on websites like Facebook, Yelp and Glassdoor are becoming part of the decision process when a patient is "shopping" for medical care. Patients are increasingly becoming price-sensitive savvy buyers for their own healthcare needs. The general public may not know what HCAPP stands for or the technical definition of Readmission Rate, but they absolutely know about it when grandma gets an infection during her stay at a hospital or if a friend was readmitted twice back into the ER after being discharged from an inpatient stay.

Perception is Reality. Reality is Reality. Healthcare facilities must strategically shift their actions toward differentiating their services, patient cost containment and revenue cycle management while also improving patient outcomes. With traditional accounting's emphasis on only the costs of treatments, managers can't see the total income statement picture. Managers deserve to view all of the profit margin layers that exist. They should view reporting information from all patient-related expenses including non-standard patient services and payment behavior. Ultimately a profit and loss statement should be measured and reported for *each* patient stay and, better yet, across a patient's history within the health system.

Positive versus Negative Margin Patients

So, what are the troublesome patient services, treatments and procedures, and how much do they drag down the whole system's profit margins? What are the high-profit patient treatments and services, and are they enough to offset the low-or-no profit margin yet necessary patient services? *What's the difference between these?* More importantly, once these questions are answered, what corrective actions should healthcare leaders and employees take to increase the overall profit of their health system and to get those action items prioritized? It is expected that expenses for certain types of patients will exceed their revenues. That is a policy and community issue. But at least the hospital should know the magnitude of this deficit spending and for which types of patients.

(continued on page 13)

Clinical staffs already intuitively suspect that there are highly profitable and highly unprofitable patients. After all, they are living the day-to-day and know which type of patients tend to take more of their time and even why. Patient types can be categorized in several ways including: treatment, service, financial class, age group, gender, Primary Service Area (PSA), US Postal zip codes, comorbidity, diagnosis, procedure and even socio-economic factors. In today's highly-rich healthcare data environment, the list of patient categories is immense. Therefore, there are many ways to consider, understand and ultimately manage patient profitability. Health systems not only need to increase market share and grow volumes but to understand what's profitable and what's not profitable to identify the right mix of patient types and service volumes. What is needed is a mind shift to grow profitable volume.

In commercial companies, some types of customers purchase only a mix of mainly low-profit margin products. The same goes with treatments needed by patients. In addition, some extra services may be medically necessary. For example, a diabetic patient is going to require a higher level of care than a non-diabetic patient (all else being equal) due to dietary requirements and other medical considerations. In commercial companies, high-demanding and consequently costly types of customers may always be changing the schedule, returning goods or requesting special services. Unlike other industries, it is not viable for healthcare facilities to deselect or "fire" a patient the way a commercial company can when the customer shows no promise of ever being profitable. Costs will be incurred regardless of the existence or type of insurance coverage. Here's where population healthcare management can lead to significant long-term cost reduction. Real change must begin with a series of questions such as:

- Why are so many non-emergent patients showing up in the ER?
- Why are so many patients no-show or late to prescheduled surgeries?
- Why are Tuesday surgeries consistently off schedule?
- What is the health or socioeconomic issue our community suffers from most?

And the most important question…

- What changes can be made to work toward the betterment of our community and all our stakeholders?

Higher profit patients typically are one or a combination of 1) payers reimbursing at a higher level or 2) non-critical patients requiring a predictable level of care. What can be done about those patients that have a lower level of insurance or, worse, have no insurance or are the high-maintenance type requiring a higher level of care? After the level of profitability for all patients are measured, they can all be migrated toward higher profits using "profit margin management" techniques discussed further in this article. Making a very unprofitable patient less unprofitable by $1,000 is equivalent to making an already profitable patient more profitable by the same $1,000.

If a financial class type of patient is paying a lower rate for the same treatments and services as other providers in the area, then renegotiate the rate! But first, collect the necessary patient-level cost data to report and display the actual costs incurred for that type of patient. If an age group, gender or zip code tends to be less profitable, then research the details. Why is that happening? Is it a cost issue, a collection issue or both? Are there social factors such as English as a Second Language (ESL), lack of transportation to and from the facility or illiteracy that are preventing or adversely affecting the delivery of quality care? Could the cost of additional social services be justified by better long-run profitability and patient outcomes? Solving problems begins with identifying high-cost cases, asking a lot of questions and finding common denominators. Discovery and interrogation is a cornerstone to the increasing popularity with analytics and Big Data. The road to valid solutions is paved in data.

Activity-Based Costing (ABC) is a Multilevel Cost Reassignment Network

Activity-based costing (ABC) is the accepted method that will economically and accurately trace the consumption of a health system's resource expenses (e.g., salaries, supplies) to treatments, procedures and patients and also to the types and kinds of channels and delivery segments that place varying degrees of workload demand on the facility. It should no longer be acceptable to not have a rational system of assigning so-called nontraceable expenses that are consumed as cost to their sources of origin-spending. ABC is that system. Yet many healthcare facilities still use do not use ABC. The excuses for this are many and include:

- We are profitable, so why does it matter?
- We already know our "true" costs from our general ledger financial reporting system.
- We have done it this way forever. And we don't do ABC here. We already know everything. It is in our heads.
- We are a small hospital. We'll worry about better costing methods when we get larger.
- All this hype is just made up stuff from highly paid consultants.
- No one looks at the reports we create, so there is no point generating better reports.
- We cannot afford better software to fix our problems.
- We are way too busy doing other things.

ABC uses multiple stages to trace and segment all the resource expenses as calculated costs through a network of cost assignments into the *final cost objects*: diagnoses, procedures, treatments, services, distribution channels, patients, etc. It facilitates more accurate reporting because it honors costing's *causality principle* (i.e., the relationship between cause and effect) for expense consumption relationships. It answers not only WHAT your staff is doing, but also more importantly **HOW MUCH** and **HOW COME**. Consider the adage "In the land of the blind, the one-eyed man is king."

(continued on page 14)

ABC software is arterial in design, so it flows costs flexibly and proportionately to how and why the resource expenses are consumed. Eventually via this expense assignment and tracing network, ABC reassigns 100 percent of the resource expenses into the final accumulated costs of treatments, procedures, services, materials, channels, patients and business sustaining work. Visibility of costs is provided everywhere throughout the cost assignment network including for how costs are "driven" by the activity cost drivers that comply with the cause-and-effect relationships. This visibility aids in identifying where to focus improvement efforts.

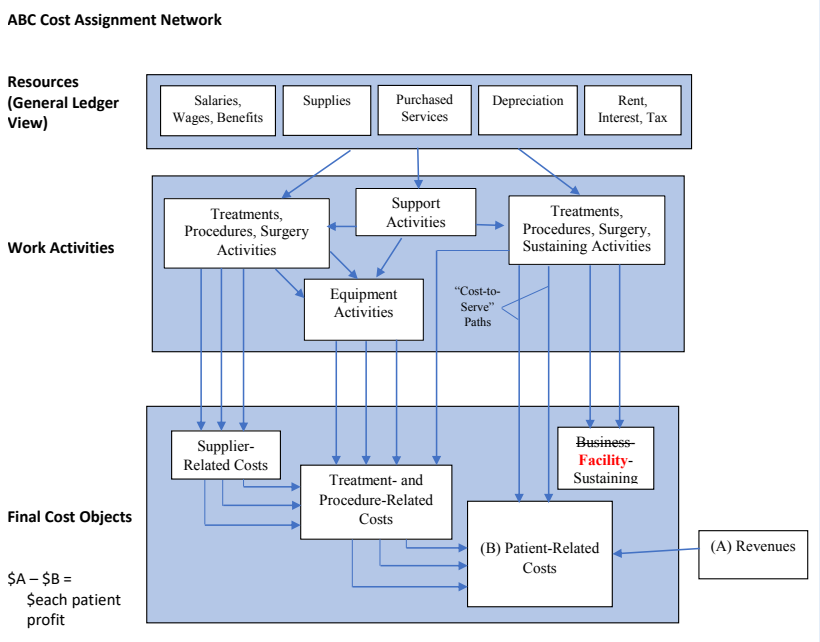
Examine the ABC cost assignment network in Exhibit 1 that consists of three modules connected by cost assignment paths. ABC provides a snapshot view of a time period's costs (e.g., a month). Imagine the cost assignment paths as wide pipes and thin straws where the diameter of each path reflects the amount of cost flowing. The power of an ABC model is that the cost assignment paths and their destinations trace costs from beginning to end—from resource expenses to each type of treatment and service (and optionally to each specific patient). Patients are the origin that results in the consumption of all of a facility's originating expenses and subsequent costs.

ABC Cost Assignment Network

To understand why patients are the origin for costs, mentally reverse all the path arrowheads in Exhibit 1 from bottom to top. This polar-opposite switch reveals that all expenses originate with a demand-pull from patients—and the calculated costs simply measure the consumption effect in the reverse direction. The same could be said for customers in any industry.

Resources (at the top of the cost assignment network in Exhibit 1) provide the available capacity to perform work. Think of resource expenses as coming from the facility's checkbook in the form of procurement purchases and employee payroll. Cash is exiting the treasury. Examples of resources are clinical and non-clinical staff, medical supplies and fixed assets. (Amortized cash outlays, such as for depreciation from a prior period, can also be modeled.) It is during this step that "resource cost drivers" are identified and measured as the mechanism to convert resource expenses into work activity costs. One basis for tracing or assigning resource expenses is the time (e.g., number of minutes) that people or equipment spend on

Exhibit 1 – ABC Cost Assignment Network



performing work activities. All cost assignments in the cost assignment network must normalize to 100 percent whether one uses time, quantities of the driver or percent estimates from knowledgeable employees.

Work is performed by both clinical and non-clinical staff (the most expensive assets in healthcare by far!), and resources are converted into the patient outcome and overall patient experience. Activity cost drivers are the mechanism to accomplish each assignment from the work activity cost to a final cost object. This can help to prove or disprove the alignment between the mission of the staff and what they are spending most of their time on. An example in a warehouse is the number of stocked items picked. In a bank, it's the number of automobile loans processed. In a hospital, it may be the number and type of lab tests administered. A bonus from ABC is it calculates unit-level cost consumption rates, which are useful for comparative benchmarking studies as well as for projecting future expenses and costs such as with rolling financial forecasts, what-if scenario analysis and outsourcing decisions.

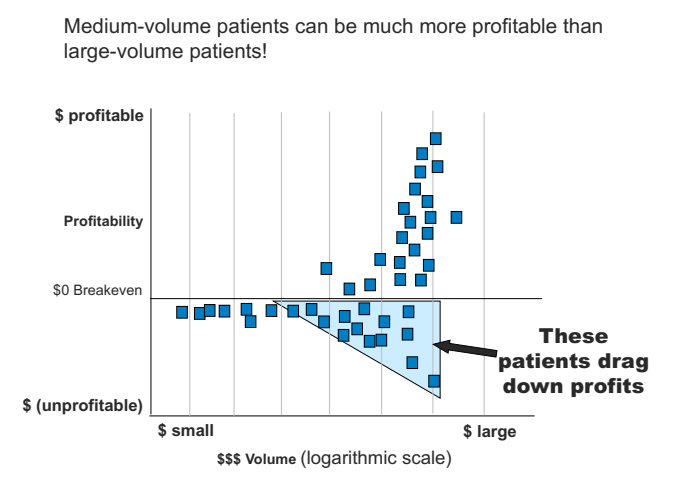
Final cost objects (at the bottom of the cost assignment network) represent the broad variety of outputs (e.g., treatments and services) where costs eventually accumulate. Patients are the *final-final cost objects.* They create the need, or at least the perceived need, for resource expenses to be supplied. It's important for financial and clinical leaders for a health system to have an open discussion on which patient-care costs are clinically necessary and which are more of a "nice to have" or perceived need. Are there clinical studies showing the newest, shiny implant will result in better outcomes? Healthcare providers are as susceptible to marketing trickery as any other type of buyer. Healthcare leaders must have this self-awareness and make decisions based primarily on data-driven unbiased research.

The key to a good ABC system is the design and architecture of its cost assignment network. The "nodes" in the network are the sources and destinations through which all the expenses are reassigned via calculated costs. The network with its nodes delivers the utility and value of the data for decision making.

(continued on page 15)

Exhibit 2 displays the type of results from ABC. It reveals the myth that the highest volume patients in terms of services are proportionately profitable. They are not. For example, some high volume patients are located below the breakeven profit line. They are likely requiring unprofitable treatments and procedures.

Exhibit 2 – Patient Revenue Volume versus Profits



Migrating Service Line to Higher Profitability

The crucial challenge is not to use ABC just to calculate valid patient profitability information from transactional data but to really *use* the information—and use it wisely. And often. Knowing that some patient types will cost more than others (and there's only so much one can do to reduce those costs before quality begins to suffer), it is paramount to know and capitalize on those treatments and services that are profitable and from which there is potential to increase market share.

The left-to-right sequence of the activity cost drivers creates profit margin layers like layers in an onion's skin. As a result, there can now be a valid P&L statement for each patient as well as logical segments or groupings of patients. Exhibit 3 is an example of an individual patient profitability statement.

Exhibit 3 – ABC Patient Profit and Loss Statement

PATIENT: John Doe (# 12704563)

Revenues	**$$$**	**Margin $** (Net Revenue - ΣCosts)	**Margin** % of Net Revenue	
Service-related				
Supplier-related costs	$ xxx	$ xxx	88%	Service- and distribution-related costs
Direct material and supplies	xxx	xxx	50%	
Treatments, procedures	xxx	xxx	30%	
Patient-Related				
Patient-type services	xxx	xxx	22%	Patient-related costs
Unique to patient	xxx	xxx	10%	
Facility-sustaining	xxx	xxx	8%	
Operating profit		**xxx**	**8%**	

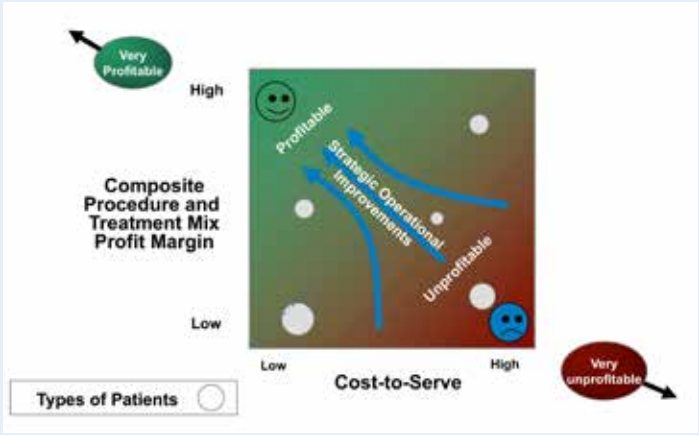
With an ABC P&L, managers can examine the individual services and materials purchased from suppliers in greater detail. They can also analyze the mix of high- and low-treatment-profit-margin treatments "consumed" by the patients, based on their own unit costs and prices as a composite average. Managers can also drill into details about the treatment and service-mix profit margins for more visibility. In addition, within each type of treatment and service, the manager performing as a business analyst can further examine the content and cost of the work activities and materials for each treatment and service. This patient P&L information quantifies what many employees already may have suspected. All patients are not the same with their profit levels excluding volume as described in Exhibit 2.

In any health system's P&L there are two major "layers" of profit margin:

1. By the mix of treatment, procedures and services offered
2. By the "costs to serve" patients apart from the unique mix of services, treatments and procedures (this is that "bottom half of the picture" referred to earlier)

Exhibit 4 combines these two layers as a two-axis grid: (1) the "composite treatment and service profit margin" of what each patient "consumed" (reflecting net prices to the patient) and (2) their *costs to serve*. Individual patients (or a grouped cluster of patients with similar traits) are located at intersections where the circle diameters reflect each patient's revenues to the hospital. Exhibit 2 debunks the myth that all volumes are good volumes. The objective is to generate more profits or operate at a more efficient level for all patients regardless of their intersection location. This is represented by driving patients to the upper-left corner of the grid. Examples of actions that will do this are represented in the Strategy/Tactic table in the next section.

Exhibit 4 – Migrating Patients to Higher Profitability



When analytics software is applied, hospitals can use profit increasing techniques used in commercial companies where their finance and marketing staff determine "next-best-offer recommendations" based on a market basket analysis of their offerings to customers. The analysis uses "association rules," which identifies items that frequently follow other items in transaction-based data. For example, if patients with a specific DRG typically have services A and B with supplies Y and Z, some physicians may order only service A for a

(continued on page 16)

sect of patients and a less expensive supply of X instead of Y. With that insight, financial leadership can talk to clinical leadership to understand the variability in care. The point isn't to suggest to physicians the best clinical path but to discuss when the extra cost is justified. Generating these needed conversations and creating higher levels of incentives *and* accountability is the reason for the emergence of value-based initiatives such as Accountable Care Organizations (ACO), Gainsharing and bundled payment programs such as Bundled Payment for Care Improvement (BPCI) and Comprehensive Care for Joint Replacement (CJR).

Note that migrating patients to the grid's upper-left corner is equivalent to moving individual data points upward in Exhibit 2. Knowing where patients are located on the matrix requires ABC information. An important reason for knowing where each patient is located on the profit matrix is to protect the most profitable patients from competitors.

Options to Raise the Profit Cliff Curve

What does a healthcare facility do with the patient profit information? In other words, what actions can it take to increase profits from its patients?

Although in Exhibit 5 below this is only a partial list of examples, a facility can increase profitability by doing the following [see Exhibit 5]:

Expand the Function

Much has been written about the increasing role of CFOs as strategic advisors and their shift from a bean counter to a bean grower. Now is the time for the CFO's accounting and finance function to expand beyond financial accounting, reporting and governance responsibilities. There should always be a balance between managing the level of patient care to earn patient loyalty and the spending impact that doing that will have on long-term sustainability for both the patient and the health system.

A longer-term goal for all health systems stakeholders (i.e., patients, community, employees, vendors, suppliers and partners) is to provide quality care for a patient population while "keeping the doors open." Think of each patient as if they are an investment in a stock portfolio. Think that the purpose of actions taken is to increase the financial and non-financial "return on patient (ROP)."

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Gary Cokins (Cornell University BS IE/OR, 1971; Northwestern University Kellogg MBA 1974) is an internationally recognized expert, speaker, and author in enterprise and corporate performance management (EPM/CPM) systems. He is the founder of Analytics-Based Performance Management LLC www.garycokins.com. He began his career in industry with a Fortune 100 facility in CFO and operations roles, then 15 years in consulting with Deloitte, KPMG, and EDS (now part of HP). From 1997 until 2013 Gary was a principal consultant with SAS, an analytics software vendor. His most recent books are "Performance Management: Integrating Strategy Execution, Methodologies, Risk, and Analytics" and "Predictive Analytics."

Exhibit 5

Strategy	Tactic
Lower patient's "cost to serve"	Exchange RN with Tech where possible
Establish a surcharge for or reprice expensive "cost-to-serve" patient activities	Charge extra for missed appointments or excessive tardiness
Upsell for premium elective services	Offer gourmet meals or cosmetic surgery options
Reduce services minimally valued by patients; engage with clinicians about what is truly clinically necessary	Do patients truly care or notice when wheelchairs are brand-new?
Consider introducing new services and standard service lines that have been profitable elsewhere	Is there an opportunity to gain market share for that specialized surgery that is doing well at the hospital down the street?
Renegotiate with payers and suppliers once patient-level costs are fully understood	Use detailed service line costing data to keep your vendors and payers honest. Are you being offered fair pricing when compared to your competitor's pricing arrangements?
Abandon unprofitable products, services or patients, or focus on cost containment for these	Which types of services should you offer? Which types of patients would you rather send to a nearby facility?
Improve healthcare organization processes resulting in higher productivity (do more for less)	Floorplan rearrangement to better accommodate workflow.
Better reimbursement management	Require upfront payments as much as possible; offer discounts for "prompt payments"
Increase specialization in activities that improve patient outcomes AND increase profits	Staff and patient education on prevention of readmissions, hospital infections, handwashing, equipment sterilization, etc.

Consumers, Healthcare Organizations Unaligned on Value-Based Drug Pricing: BDO/NEJM Catalyst Survey

BY PATRICK PILCH, STEVEN SHILL AND DAVID FRIEND

When it comes to aligning care outcomes with pricing, consumers and healthcare providers are, well… unaligned, a new survey from BDO and the *NEJM Catalyst reveals.*

Most patients (74 percent) are interested in outcomes-based drug pricing, yet the majority of healthcare organizations (59 percent) are not yet working with drug manufacturers to track care outcomes—and have no plans to do so. Only 8 percent of patients, meanwhile, said they were not interested at all in outcomes-based drug pricing, while 11 percent of healthcare organizations said they are currently working with drug manufacturers to track care outcomes.

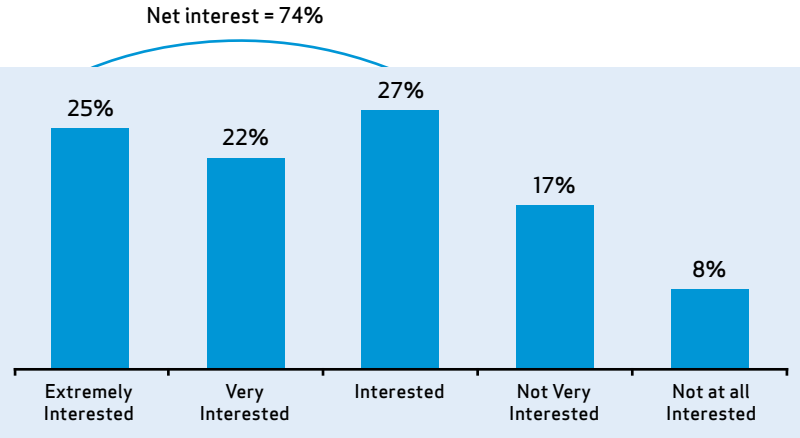
- **BDO's quick take:** The findings underline that while public pressure to curb drug prices continues to mount, the tactics of doing so realistically have not yet been realized. We believe this is because of continued high valuations paired with pharmaceutical companies that are under more pressure to maximize the profitability of a limited number of lucrative products. This provides little incentive for pharma to come to the table on outcomes-based pricing.

The December survey polled the NEJM Catalyst Insights Council, a qualified group of healthcare executives, clinical leaders and clinicians at organizations directly involved in care delivery. Respondents also said they expect innovative mergers like the CVS-Aetna deal—along with new market entrants—to continue to disrupt healthcare.

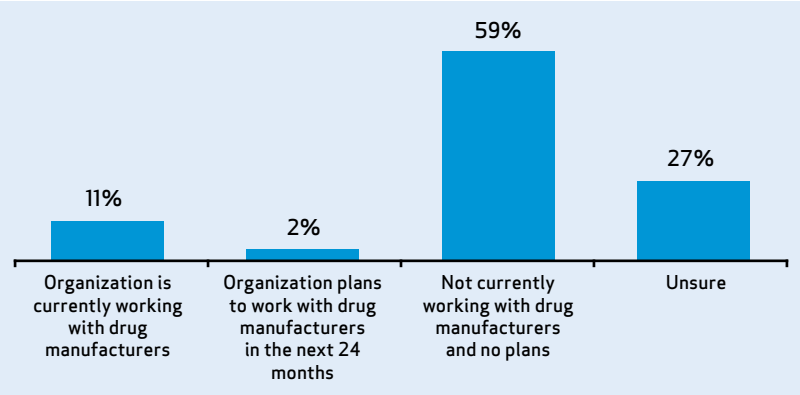
Eighty-one percent expect such mergers to continue disrupting the industry over the next three years. When asked which companies are expected to have the most significant impact on the industry during that time, CVS-Aetna came first, followed by Amazon, Optum-DaVita, Google and Apple.

- **BDO's quick take:** CVS-Aetna was a watershed moment in healthcare—one that will certainly unleash an avalanche. We see such deals giving consumers greater visibility into their care options and costs, offering them more convenient, effective and streamlined services. But the potential for Amazon and other tech giants to disrupt is even greater. Amazon could purchase a health insurer (or any healthcare company) tomorrow—turning the traditional care delivery and pricing model upside down and forcing other healthcare organizations to reimagine their business models to remain competitive.

Patient Interest in Value-Based Drug Pricing



Status of Working with Drug Companies to Track Outcomes



Impact of New Entrants in Healthcare Industry

	Net Impact	Significant Impact	Moderate Impact	No Impact
CVS-Aetna	97%	50%	47%	3%
Amazon	87%	42%	45%	13%
Optum-DaVita	84%	33%	51%	16%
Google	84%	27%	57%	16%
Apple	72%	22%	50%	27%

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Mark your calendars to attend our 2018 Fall Summit, October 23-24, at the Drury Lane Conference Center, Oakbrook Terrace, IL. While you are at it, dust off your party shoes as this October, the First Illinois Chapter celebrates its 70th year as a chapter of the Healthcare Financial Management Association (HFMA).

Cathy Jacobsen, FHFMA, CPA, president and CEO of Froedert Health and 2009-10 HFMA National Chair, is our keynote presenter on Tuesday, October 23. Patrick Carroll, MD, Division Vice President and Chief Medical Officer at Walgreen's will present on Wednesday, October 24. Leading-edge concurrent and general sessions are in the planning stages. Watch for more details at firstillionishfma.org.

Can we count on seeing you there?
Registration opens this summer. To join the 70th anniversary planning committee, send an email to fallsummit@firstillinoishfma.org.

The two-day program covers:

Critical provider care financial issues including:

- Illinois State Legislative Update
- Latest Updates on Illinois Medicaid
- Accounting and Financial Reporting Hot Topics
- Federal Financial Legislation and Regulation Update
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(continued on page 9)

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Articles for *First Illinois Speaks* should be written in a clear, concise style. Scholarly formats and styles should be avoided. Footnotes may be used when appropriate, but should be used sparingly. Preferred articles present strong examples, case studies, current facts and figures, and problem-solving or "how-to" approaches to issues in healthcare finance. The primary audience is First Illinois HFMA membership: chief financial officers, vice presidents of finance, controllers, patient financial services managers, business office managers, and other individuals responsible for all facets of the financial management of healthcare organizations in the Greater Chicago and Northern Illinois area.

A broad topical article may be 1000-1500 words in length. Shorter, "how-to" or single subject articles of 500-800 words are also welcome. Authors should suggest titles for their articles. Graphs, charts, and tables **(PDF or JPG only)** should be provided when appropriate. Footnotes should be placed at the end of the article. Authors should provide their full names, academic or professional titles, academic degrees, professional credentials, complete addresses, telephone and fax numbers, and e-mail addresses. Manuscripts should be submitted electronically, on computer disk or by e-mail as a Microsoft Word or ASCII document.

Founders Points

In recognition of your efforts, HFMA members who have articles published will receive 2 points toward earning the HFMA Founders Merit Award.

Publication Scheduling

Publication Date	Articles Received By
July 2018	June 1, 2018
October 2018	September 1, 2018
January 2019	December 1, 2018
April 2019	March 1, 2019