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

In This Issue

What the Election of Donald Trump Could Mean for the Health Care Industry

BY JIM WATSON, PARTNER, PBC ADVISORS, LLC

The first week of November 2016 will go down in history as one of the most momentous: The Chicago Cubs won their first World Series in 108 years, and America elected Donald Trump as its 45th President.

Since the election, I know we've all been overwhelmed with questions from clients, colleagues, friends and family about President Trump's plans for healthcare. What does he really mean when he says he's going to "repeal and replace Obamacare"? The goal of this article is to begin a dialogue on what our new President's plan is for healthcare, for the ACA/Obamacare, and importantly, what it means to all of us as healthcare providers, patients, consumers and businesses.

"Repeal and Replace"

In the days since the election, Mr. Trump has backed off his rhetoric about repealing Obamacare, or the Affordable Care Act (ACA). Perhaps because he realizes the magnitude and complexity of it and its many parts or perhaps as reported after his initial transition meeting with President Obama he's seeing more of its benefits. And increasingly, Republican and Democratic leaders (as well as the voting public) are demanding something tangible on the "replace" side of this discussion.

During his campaign, President Trump issued a "7 Point Plan for Healthcare." Here it is verbatim:

1. **Completely repeal Obamacare.** Our elected representatives must eliminate the individual mandate. No person should be required to buy insurance unless he or she wants to.

(continued on page 2)

2. **Modify existing law that inhibits the sale of health insurance across state lines.** As long as the plan purchased complies with state requirements, any vendor ought to be able to offer insurance in any state. By allowing full competition in this market, insurance costs will go down and consumer satisfaction will go up.

3. **Allow individuals to fully deduct health insurance premium payments from their tax returns under the current tax system.** Businesses are allowed to take these deductions so why wouldn't Congress allow individuals the same exemptions? As we allow the free market to provide insurance coverage opportunities to companies and individuals, we must also make sure that no one slips through the cracks simply because they cannot afford insurance. We must review basic options for Medicaid and work with states to ensure that those who want healthcare coverage can have it.

4. **Allow individuals to use Health Savings Accounts (HSAs).** Contributions into HSAs should be tax-free and should be allowed to accumulate. These accounts would become part of the estate of the individual and could be passed on to heirs without fear of any death penalty. These plans should be particularly attractive to young people who are healthy and can afford high-deductible insurance plans. These funds can be used by any member of a family without penalty. The flexibility and security provided by HSAs will be of great benefit to all who participate.

5. **Require price transparency from all healthcare providers, especially doctors and healthcare organizations like clinics and hospitals.** Individuals should be able to shop to find the best prices for procedures, exams or any other medical-related procedure.

6. **Block-grant Medicaid to the states.** Nearly every state already offers benefits beyond what is required in the current Medicaid structure. The state governments know their people best and can manage the administration of Medicaid far better without federal overhead. States will have the incentives to seek out and eliminate fraud, waste and abuse to preserve our precious resources.

7. **Remove barriers to entry into free markets for drug providers that offer safe, reliable and cheaper products.** Congress will need the courage to step away from the special interests and do what is right for America. Though the pharmaceutical industry is in the private sector, drug companies provide a public service. Allowing consumers access to imported, safe and dependable drugs from overseas will bring more options to consumers.

In the first few days since the election, Trump has stated that he is going to get right to work on healthcare in his first 100 days. And he has. Leading up to the Inauguration, he spoke to several media outlets, including lengthy interviews on his healthcare plan with the *Wall Street Journal* and *60 Minutes*. Several of those comments can be used as basis for his thinking about his actual plan:

- Trump has always supported certain provisions of the ACA, even though his campaign rhetoric was to destroy it. Specifically, he stated that he wants to retain the provision forbidding discrimination based on pre-existing conditions and the provision to allow young Americans to remain on their parents' health insurance until the age of 26.

- He clearly stated that there will be no gaps in coverage for people covered by ACA plans and that the time between repealing and replacing these plans would be "simultaneous."

- The *Washington Post* noted the change in Trump's messaging to be more in line with the Republican Party's positions, citing the omission from the Trump website of Trump's call to allow Americans to import prescription drugs from other countries where they are sold at lower prices.

- Some of his post-election comments could sound contradictory; on one hand he has stated that he likes the ACA mandate that requires every American to be insured, but on the other hand in his plan he states that "our elected representatives must eliminate the individual mandate. No person should be required to buy insurance unless he or she wants to."

- Trump may find it difficult to retain certain provisions he likes (i.e., forbidding pre-existing condition exclusions) while eliminating certain provisions he doesn't like (i.e., the penalty for not buying insurance and the subsidies to help pay for insurance). Republican politicians have tended to criticize both of the incentive provisions. The subsidies have been attacked as excessive government spending. The mandate has been criticized as an inappropriate use of government power.

One could piece together his statements and conclude that, in reality, President Trump may bring us closer to universal health care coverage in America, or certainly one step closer:

- The only way to get the insurance industry to stay in the Marketplace is to relieve them of the adverse selection (sick people) that have enrolled. He's touted "high risk pools" as a means to do that, but as far as he's described them (which is not a lot) it amounts to providing these people in these pools with a public option (i.e., Medicare for All).

- He's also indicated that while he wants to repeal the ACA's Medicaid expansion provision, his goal is to reform state Medicaid options so that "nobody falls through the cracks because they cannot afford coverage."

So with all this as backdrop, here are some things we might see President Trump get to work on when he takes office:

- Expect him to hit the cost of healthcare hard. Several options at his disposal there: He could change the "essential benefits" defined to be an ACA "qualified health plan." The benefits are rich, which drives up the cost of coverage. He has indicated that coverage should look more like major medical coverage than the comprehensive-pay-for-everything-plans we have today. That could

(continued on page 3)

What the Election of Donald Trump Could Mean for the Health Care Industry (continued from page 2)

mean that high deductibles and narrow networks become the norm.

- He will likely not be kind to Medicare or Medicaid funding increases, but it is likely he will continue support for the ACA-funded Center for Medicare and Medicaid Innovation (CMMI). The CMMI was established via the ACA and given $10 billion in funding through fiscal 2019. Although the ROI on ACOs, bundled payments and other "innovation" models borne out of CMMI can be debated, it is essential to the transformation of the Medicare program, and CMMI is supported by Republicans and Democrats alike.
- Work to move the Health Insurance Marketplace to the states (current 12 million enrollees and all future enrollees), while at the same time working with the states to move total responsibility for Medicaid programs to them. He proposes doing this via block grants and will likely address the elimination of "Medicaid expansion" funding to states in one fell swoop. He will need to be careful to not disrupt coverage for those 10 million newly covered eligibles.
- Work on legislation to allow purchasing of health insurance policies across state lines.
- Expand tax credits for health insurance premium payments.
- Expand utility of Health Savings Accounts (HSAs).
- Expand high risk pools for individuals.

In the end, there's one comment he's made that stands out and is hopefully reflective of where he will put his energy on healthcare: "Everybody's got to be covered. This is an un-Republican thing for me to say. But I'm going to take care of everybody. I don't care if it costs me votes or not. Everybody's going to be taken care of much better than they are taken care of now. It's gonna be great healthcare but for much less money." While these statements are not backed up yet by a specific plan, they are foundational statements that hopefully can be made a reality while we wait for the detailed plan from President Trump and his team. More to come.

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WikiLeaks, Hackers and Cybercriminals Keep Healthcare IT Stakeholders on Guard

BY PHIL SOLOMON, VP MARKETING STRATEGY

WikiLeaks; The Hacker's Hacker

You would have to be living entirely off the grid to be unfamiliar with WikiLeaks, the multi-national media organization founded by Julian Assange. WikiLeaks has elevated itself as the most well-known name in hacking, exposing classified, censored or otherwise restricted official materials involving war, spying and corruption. The organization is despised for uncovering secrets that were not meant for public consumption and applauded by millions who believe that the world's most persecuted documents should be available to everyone. Who would have thought that hacking could land someone on the cover of TIME Magazine as the coveted Person of the Year? Mr. Assange held that distinction in 2010.

WikiLeaks is not the only hacking organization keeping Information Technology (IT) stakeholders up at night. Recently in healthcare, hackers have locked down provider databases, essentially putting them out of business until they pay a ransom to regain access to their data. Hospitals and health systems have more to lose than organizations in other sectors when it comes to hacks. According to the Becker's Health IT and CIO Review, patient data now sells for more money than any other kind of information on the black market, and the healthcare industry experiences more ransomware breaches than in any other amounting to over 88 percent of all attacks.

The Ransomware Epidemic

One reason hospitals may be particularly vulnerable to ransomware is the multitude of systems and devices in use. There are many more entry and axis points for cybercriminals to exploit. Recent innovations in the hacker community make it difficult to guard against new strains of ransomware. Once patient data is infected, hospitals and clinics are locked-out of their system. Unlike other industries where access to data is not as time critical, not having access to patient data could mean the difference between life and death.

Ransomware breaches represent a big payoff for criminals, and it's quite clear why healthcare is the primary target. According to the 2016 IBM X-Force Cyber Security Intelligence Index, a stolen medical record is worth more than 10 times that of a stolen credit card.

In a prepared statement, Jocelyn Samuels, director of the U.S. Department of Health and Human Services Office for Civil Rights, said, "One of the biggest current threats to health information privacy is the serious compromise of the integrity and availability of data caused by malicious cyberattacks on electronic health information systems, such as through ransomware."

In a ransomware attack, how do cyber criminals attack the healthcare infrastructure? Typically, the standard method is malicious email attachments with the most common being Microsoft Word documents, Adobe files and JavaScript. Other schemes include links to booby-

trapped and compromised websites, malicious web advertisements, malware links in social media posts, and unpatched versions of Microsoft Office and Adobe Reader or Flash. Once an organization is infected, cybercriminals exchange a decryption key to regaining access and in return receive an untraceable Bitcoin payment.

Medical Data Hacking on the Rise

According to X-Force research, healthcare record theft is up 1,100 percent in 2016, with more than 140 million medical records compromised worldwide. Out of the 249 incidents submitted to the Office for Civil Rights (OCR) through October 26, 2016, 83 were caused by hacking or IT incident. While hacking incidences garner the most attention, there were 104 unauthorized access or disclosure breaches, 46 cases of theft, 12 incidents involving loss and four caused by improper disposal.

The top five unauthorized breaches in 2016 were Banner Health, Newkirk Products, 21st Century Oncology, Valley Anesthesiology and Pain Consultants, and Hollywood Presbyterian Medical Center. Banner, a large Arizona-based health system discovered an incident on July 7, 2016, that affected approximately 3.6 million patients, members and beneficiaries, providers, and food and beverage outlet customers. Newkirk Products, a New York-based service provider that issues healthcare ID cards for health insurance plans, announced in August 2016 that it experienced a data breach potentially compromising approximately 3.4 million plan members. 21st Century Oncology notified the OCR of a data breach in March 2016 that may have affected an estimated 2.2 million individuals, and Valley Anesthesiology and Pain Consultants announced in August 2016 that 882,590 patients might have had their information exposed when an unauthorized party inappropriately accessed one of its computer systems.

The highest profile medical data breach in 2016 happened to Hollywood Presbyterian Medical Center in California. In March, the hospital was locked-out of its Electronic Health Records system for over a week.

(continued on page 5)

 (continued from page 4)

During that time, providers reverted to operating via pen and paper until they made a decision to pay the hackers $17,000.

The advent of medical data hacking appears to have no end in sight. No one is immune to having his or her medical records compromised. It is troubling to think that even with best security protocols in place, one out of every three people had a healthcare record compromised in 2015.

Medical Devices Also Pose a Security Threat

Most people do not realize that medical devices are often mini-computers linked to a corporate network. Without having an embedded encryption capability, hackers are easily able to gain access to the core network or other networks throughout the organization, including the electronic health records.

Hackers have one of two motives for what they do, says Stephanie Domas, an ethical hacker and lead medical device security engineer at Battelle, a research and development firm. She hacks organizations and is paid for it. Some devices hold a sizable amount of hackable data, while others don't contain much data but are a gateway to the network for hackers. Medical devices can include fetal monitors and other monitoring machines, ventilators, anesthesia machines, bypass machines, electrocardiographs, lasers, gamma cameras, medical apps, diagnostic imaging systems, powered wheelchairs, implantable defibrillators and pacemakers, and much more.

Derek Jones, a senior security advisor at the consulting firm Impact Advisors, offers his advice how to protect medical device data. In an article published by Health Data Management, he said, "Many hospitals only use a perimeter firewall to provide protection for moving in and out of the core network, with no other firewalls protecting internal systems. Multiple firewalls across the organization—to the greatest extent possible, given available resources—represents a good start toward improving device security."

"Layered security is important because we can't trust the Internet," he explains. "All these devices that get plugged into the network, like security cameras, cash registers and biomedical devices are a risk to data security. Network access makes it easier to use the devices, but we often forget they are mini-computers and must be protected."

Too often, Jones adds, the built-in firewall that comes with Microsoft Windows is viewed as adequate, and as a result, more advanced software with better scanning and reporting features is not deployed. A more sophisticated firewall will remove the Windows firewall, which does not have the capacity that enables a network administrator to know that malware has infected a computer or a device.

New and old medical devices alike can be a security threat. Both require the addition of embedded security, which includes the encryption of data at all access points. The U.S. Food and Drug Administration has provided guidance for manufacturers to follow to reduce medical device hacking risks. However, there are no penalties for non-compliance.

The Human Element in Medical Data Security

The biggest threat to healthcare IT security is the human element. According to the 2016 HIMSS Cybersecurity Survey, the two primary healthcare IT security concerns from healthcare organizations (hospitals and physician practices) are phishing attacks (a concern for 77 percent of respondents) and viruses/malware (67 percent). Both events require human interaction for hackers to access patient data.

Training clinicians and staff one time is not enough to guard against attacks. Continuing education is the key. A study by Wombat Security Technologies and the Aberdeen Group suggests that upgrading employee mindfulness can lessen security risk by anywhere from 45 to 70 percent. There is no such thing as a 100 percent secure IT system if people use it. It certainly makes no sense to make significant investments securing a technology if system users are not trained properly.

Steps for Prevention and Protection

The number one rule in securing medical data is to never assume you are completely protected. There are no "one size fits all" protections against security breaches. When implementing an effective prevention and protection strategy, you should consider these 12 points:

1. Initially, train users about the risk.
2. Implement consistent high-frequency data backups.
3. Block all executable attachments that do not pass your security software assessment.
4. Keep systems patched (especially J-Boss web servers, which are common in healthcare).
5. Keep antivirus solutions updated.
6. Maintain strong passwords.
7. Ensure that active accounts connect to a current staff member.
8. Make sure departing staff members return laptops and other mobile technology.
9. Allow only the minimum necessary access to sensitive information.
10. Secure medical devices by encrypting data and securing access points.
11. Audit the system regularly.
12. Provide consistent ongoing security training for every staff member.

Summary

Leveraging robust user training, including an investment in preparedness, and implementing key security controls and protocols will go a long way in securing an organization's medical data. It doesn't end there. Health Enterprises must also ensure that they have an all-encompassing backup and recovery process that allows them to get back to business as usual quickly after a breach or attack.

CAREER Corner

BY VICKIE AUSTIN

Katie White, CHFP, MBA

*This issue of "Career Corner" focuses on **Katie White, CHFP, MBA,** director of accounting and finance for Land of Lincoln Health. Katie has been an active member of HFMA and was instrumental in developing the program that earned the First Illinois HFMA Chapter the Yerger Award for Outstanding Performance in Innovation from HFMA in 2014 and 2016*

Q: What was your first job?

A: My first job was for Mendel Plumbing & Heating, in St. Charles, Illinois. I rode my bike to work because I wasn't old enough to drive yet! I really cherished this first job during the more than eight years I worked there, through high school and college, because I had the opportunity to work in all areas of the business, from stocking inventory, marketing and customer service to accounts payable/receivable. The job gave me a great foundation of knowledge about the elements of a successful business.

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

A: My parents. They were individuals who always worked so hard; I never heard them complain, and they always supported me in whatever I did in life, whether that was sports, school or my career. They never pushed me into anything or told me how to do things, which allowed me to find and pursue my own direction and aspirations.

I've also had some great mentors. Dan Yunker, then senior VP of Metropolitan Chicago Healthcare Council (MCHC), fostered my passion to always do more and make things better. He was also the one who got me involved in HFMA. Adam Lynch, another past president of FIHFMA, also has been a great resource and friend, helping me navigate and truly thrive within my healthcare career.

Q: What had you choose healthcare as a career?

A: I wish I could say that I chose healthcare but, in fact, healthcare really chose me. I got into healthcare through a friend, and for that I couldn't be more grateful. It's an industry that fits me and my personality so well. Healthcare is challenging, ever-changing, rewarding and life-gratifying work, an industry that makes a huge difference in the world. Being a competitive person, I enjoy the challenge of creating effective and efficient strategy solutions in an evolutionary environment.

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

A: I would have to say it was while watching a short video in my healthcare management master's class, a Cleveland Clinic video on "The Human Connection to Patient Care." I think everyone should watch it whether they're in healthcare or not. The key message is about having empathy toward everyone. The day we watched this video in class I had what I thought was a pretty rough day of work and after watching that video, I felt so grateful. It reminded me that we never know what someone else is going through, and we need to approach every person and situation with that perspective in mind. The message also taught me to be more patient, understanding and down-to-earth in situations or confrontations, more so than I had been in the past.

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

A: 1) Set goals for yourself. You should always have something that you are working toward or working for. Make sure to assess and adjust along the way.

2) Always network within your profession/industry. You never know where your next career move will be, so the more people you have in your network, the more advocates and avenues you will have in finding that next opportunity.

3) The importance of having mentors, no matter where you are in your career. Never stop learning!

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

A: HFMA plays a very essential role in my career development. My participation has allowed me to network and find mentors and colleagues who also aspire for success, both from a career perspective and an industry perspective. This organization is a great resource for like-minded professionals to share with one another and learn from one another.

Q: What are you reading?

*A: **Hustle: The People at the Top of the Mountain Didn't Fall There** by Joshua Medcalf.*

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

A: Get involved, not only with professional groups like HFMA, but also within your company. Look for opportunities to learn about different areas of the organization and how they work. This will allow you to see how everything fits together so that you can effectively create change and grow within your organization. Don't be afraid of challenging how things have been done in the past when you see opportunity to improve them for the future.

Vickie Austin

Vickie Austin is a business and career coach and founder of CHOICES Worldwide. She's a frequent speaker at HFMA chapters around the country. You can connect with her at vaustin@choicesworldwide.com 312-213-1795. Follow her blog at http://vickieaustin.com and connect via Twitter @Vickie_Austin and via LinkedIn, www.linkedin.com/in/vickieaustin.

The Essential Elements of CJR

BY MARIA C. MIRANDA, FACHE, DIRECTOR OF REIMBURSEMENT SERVICES, BESLER CONSULTING

Introduction

While the Comprehensive Care for Joint Replacement (CJR) program is positioned as a "test," given the infrastructure being put in place by the Centers for Medicare and Medicaid Services (CMS) to run the program, CJR is likely just the start of a larger effort by CMS to implement additional mandatory bundled payment programs. Therefore, it's very important that hospital financial stakeholders become familiar with CJR even if their hospital isn't currently a participant.

Program Summary

The Comprehensive Care for Joint Replacement (CJR) bundled payment model is effective April 1, 2016, and is set to continue through five performance periods ending on December 31, 2020. CMS is implementing this model via its authority under section 1115A of the Social Security Act as modified by Section 3021 of the Affordable Care Act, which established the Center for Medicare and Medicaid Innovation (CMMI). CMMI was created to test new payment and service delivery models with the goals of reducing CMS program expenditures while maintaining or improving outcomes.

CJR will test a new bundled payment model for inpatient lower extremity (i.e., hip and knee) joint replacements.

Unlike voluntary programs such as BPCI, with few exceptions participation in CJR is mandatory for hospitals in 67 selected MSAs.

CJR Episodes

A CJR episode starts with admission of an eligible beneficiary for an LEJR procedure ultimately discharged under one of the following two MS-DRGs:

- MS-DRG 469: Major Joint Replacement or Reattachment of Lower Extremity with MCC
- MS-DRG 470: Major Joint Replacement or Reattachment of Lower Extremity without MCC

CMS refers to these two MS-DRGs as "anchor MS-DRGs."

The episode also includes all related Medicare Part A and Part B care for 90 days after discharge. This includes additional hospital stays, care received at SNFs and other post-acute providers, physician visits, physical therapy, etc., unless the provided service is on a CMS exclusion list.

The day of discharge counts as the first day of the 90-day post-discharge period.

CMS will exclude subsequent unrelated hospital stays from the episode based on MS-DRG. Similarly, CMS will identify unrelated outpatient care based on ICD-9 / ICD-10 code. CMS will update the lists for both exclusion types on an annual basis, at a minimum,

during the CJR program. The exclusions will apply to the calculation of both target prices and episode spending.

Target Prices

CMS uses three years of historical data to set target prices. The historical data will be updated every other year during the program. Both hospital-specific and regional data is used. Regional pricing is included in the calculations to provide gainsharing opportunities for hospitals that are already well-performing.

CMS will provide hospitals with a number of target prices for each performance year, segmented by MS-DRG, presence of hip fracture and submission of optional quality data. In addition, since CMS will normalize prices based on various IPPS and OPPS program changes (which go into effect on October 1 and January 1 of each calendar year, respectively), CMS will further distinguish target prices for episodes initiated between January 1 and September 30 vs. episodes initiated between October 1 and December 31.

CMS applies a discount factor to the target prices, which is Medicare's portion of the reduced expenditures from the CJR episodes.

Episode Spending

CMS calculates the spending for an episode by summing payments for qualified hospitalizations under MS-DRG 469 and 470 and all subsequent related Part A and Part B care for 90 days post-discharge.

(continued on page 8)

Quality Measures

CMS is implementing a composite quality score to determine eligibility for reconciliation payments and to potentially reduce the discount factor applied to episode spending when determining the amount of repayment or reconciliation payment.

The composite quality score is based on three weighted measures:

- Hospital-level risk-standardized complication rate following elective primary total hip arthroplasty (THA) and / or total knee arthroplasty (TKA)
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey
- THA/TKA voluntary patient-reported outcome and limited risk variable data submission

Reconciling Payments

After each CJR performance year, CMS will perform a retrospective reconciliation of CJR episode spending compared to the target prices by calculating the Net Payment Reconciliation Amount (NPRA). The NPRA is the sum of the amounts above and below the target price for each CJR episode in the performance period.

If the final NPRA is below zero, that amount is paid to the hospital as a "reconciliation payment" as long as the hospital meets a minimum composite quality score. If the NPRA is above zero, that amount is owed to CMS by the hospital as a "repayment amount."

Hospitals will not be responsible for any repayment amount due for the first performance year but may earn reconciliation payments for all performance years.

Data Sharing

CMS will provide detailed and summary claim and payment data related to CJR episodes to participant hospitals so that they may better understand their target price calculations and operational performance, and identify areas for improvement.

Financial Agreements with Other Providers

Since CMS considers care coordination critical for successful LEJR outcomes, they are allowing CJR hospitals to establish risk-sharing and gain-sharing relationships ("sharing arrangements" described in "collaborator agreements") with other providers ("CJR collaborators").

When risk-sharing payments are made to a hospital by a CJR collaborator, CMS refers to the payment as an "alignment payment." A hospital that shares a reconciliation payment with a CJR collaborator makes a "gainsharing payment."

Waivers

In order to make the implementation and operation of the CJR program more efficient and potentially more effective, CMS is introducing a number of program waivers related to home health visits, telehealth and the SNF 3-Day Rule.

Conclusion

Providers should be working now to proactively identify areas of risk under CJR and put a program in place that measures their ongoing performance.

A special report is available at besler.com/cjr that further explains how CJR works and expands on the responsibilities of participating providers.

Maria Miranda

Maria Miranda is the Director of Reimbursement Services. Maria has 25 years of progressive experience in healthcare administration and is a longstanding member of the Health Care Financial Management Association and a Fellow of the American College of Health Care Executives. Maria holds a Bachelor of Science degree in Health Care Administration from St. John's University and a Master of Public Administration in Health Services from Fairleigh Dickinson University.

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Value-Driving Certification

BY JOSEPH ABEL, CPCC, ACC, PHD

Impressive job skills are no longer enough to land a job with smart employers or to ensure a promotion. Employers want value-drivers.

Value-drivers are people with the capacity to continuously learn, develop new skills and adapt to the dynamic business needs of the continuously evolving health-care industry. This type of employee understands the business context and consequently sniffs out opportunity, provokes thought and helps shape innovation. Technical depth, breadth of perspective and the inquisitiveness to search out new business approaches are the foundations for this value-driving work style.

HFMA's Certified Healthcare Financial Professional (CHFP) is intended to build this highly prized value- driving work style. The CHFP:

- Is a learning program
- Presents the business context in which health operates
- Builds comprehensive, multidisciplinary perspective on the pressing mandate to improve value in health care through clinical cooperation

The CHFP is a value-driving certification in that certified healthcare finance professionals can take on a value-driving work-style characterized by:

- Business Awareness – The ability to recognize the business implications of information presented to them
- Business Understanding – Thinking with the big picture, the business context at play
- Creativity – The readiness to explore potential new business initiatives
- Engagement – Getting into action; bringing new ideas to life to create value and growth
- Smart employees – People who not only see the need to be value-driving employees, but also commit to building that value-driving work style

The Value-Driving Equation:

Value-Driving finance professional = (professional skills and experience) X CHFP

The program consists of two modules:

1. HFMA's Business of Health Care course
2. Operational Excellence: Pursuing Strategy

The program is entirely online, self-contained and self-paced. The CHFP designation is achieved by the successful completion of both modules. A downloadable learner's Concept Guide is available with the course and many HFMA chapters provide CHFP preparation assistance. The CHFP program is easy to access on HFMA's website,

simple to use and brings the business knowledge needed today into one place.

More details can be found here: www.hfma.org/CHFP.

Joseph Abel is HFMA's Director of Career Services.

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Healthcare IT Spending on the Rise: Survey finds top drivers of healthcare IT investment are improving patient experience and engagement

BY BRIAN KEE, FIRST AMERICAN HEALTHCARE FINANCE

In an era of digital natives, new technological solutions to healthcare challenges appear almost daily. Not surprisingly, two-thirds of hospitals report increased tech budgets for this fiscal year. Additionally, over a quarter of hospitals have seen more than a 5 percent increase. A recent survey by First American Healthcare Finance, in partnership with the American Hospital Association, identified this rise in budgeting for hospital and health system information technology.

Where Are Healthcare Organizations Investing?

With endless possibilities, where are providers investing IT? In 2016, First American met with over 700 unique healthcare organizations to learn about their top investment priorities. Out of 900+ projects, top IT investments fell into four buckets:

- Infrastructure to run operations and keep data safe with server, software and wireless infrastructure upgrades
- Communication to make verbal and digital flow of information more efficient, using tablets, iPhone, nurse call systems, EMR upgrades and telehealth
- Patient monitoring devices to boost preventative care using heart failure prevention devices (necklaces, wristbands and watches), nutrition tracking devices and apps, and food scanners.
- Revenue generating items such as da Vinci robots, hybrid operating rooms, cutting-edge ultrasound and imaging equipment, artificial intelligence in robots and 3D bio-printing.

In the past, technology in healthcare organizations meant a handful of computers, some digital monitoring equipment and a few pieces of imaging equipment. In today's healthcare environment, technology has never been more aligned with every aspect of the patient experience. Additionally, as physicians utilize these devices, it is more important organizations invest in them. Also, every organization has an EMR system and diagnostic results are shared via mobile devises, many times through cloud computing networks. With this shift in the use of technology, providers must also focus on appropriate security measures to ensure the data they are collecting is safe.

Randy McCleese, CIO at St. Claire Regional Medical Center and former member of the CHIME Board of Trustees, describes how technology is impacting every aspect of healthcare, not just the IT department. "Medical equipment is a huge issue for us. In healthcare, we tend to keep pieces of medical equipment for a number of years, sometimes even until it is 15-20 years old. When the equipment was manufactured, the security requirements for that piece of equipment were so different than security requirements today. We must pay attention to devices that are connected to the network and how much data they can share across that network into our EMR. That falls into security because we have to make sure that

they are secure and the data flowing from them is secure, so we don't have ransomware getting into those devices."

As healthcare organizations invest in new technology, they should consider the overall impact of the equipment to the organization, staff and patients. Examples of some questions to ask are:

- Will additional training for staff be needed?
- What data will be stored on the device?
- Does the equipment sync with current systems or will additional software be needed?
- Do patients have access to the data?
- If so, is it full access or partial?
- Are our current systems robust enough to keep data safe?

Alternatively, routine questions should be asked about old technology to make sure equipment does not become obsolete. Examples of questions to ask about old technology would be:

- What is the recommended useful life?
- Does the old technology sync with the new?
- Are there gaps in the technology that make data vulnerable to attacks?
- Would new technology create efficiencies that old technology cannot match?

As technology factors more and more into patient care and satisfaction, it is important to stay informed of changes by using peer organizations to find new best practices and to receive guidance from industry associations and key partners.

For more information, please contact Steve Omans at 630-290-9613 or steveomans@totalhospitals.com

Choose Your Partners Wisely

BY MEAGEN LANE, VICE PRESIDENT, SOUTH REGION CHOICE RECOVERY

Every successful organization forms alliances with other companies; it's the smart way to do business. But choosing the right partners is no easy task. You want them to be reputable, credible and reliable. The wrong ones can cause numerous headaches and may even contribute to significant financial losses.

There are many reasons to consider forming a partnership, but you must do your due diligence, exploring a company's work ethic, approach to business, performance record and reporting protocols. Online tools such as Google, the consumer review site Yelp, and social media channels like LinkedIn will help you quickly learn about any company, as will the Better Business Bureau rating. Read company profiles and see what endorsements a company has received, and visit websites and look at the press releases and news sections. In short, learn all you can about a potential partner before you make a commitment.

Here are some guidelines to help you determine whether the partnership is right for your business.

- The company has core offerings similar to or complementary with yours. You want to expand your product and service lines with a company that has a proven track record of profitability and cash flow.
- An experienced management team is in place that will be compatible with your leadership team and will work hard to make the partnership a success.
- The company fills gaps in either the skills that are core to running your business or has products and services to complement your product / service lines. A blend of technological expertise, financial acumen, operational skills and business development capabilities is ideal.
- The organization has a good relationship with its customers, so that you can smoothly integrate them with your customer base. You want a partner that treats its customers fairly and fosters a positive customer experience.
- The firm has a long-term growth strategy and potential for revenue growth, not a troubled company looking for a bail-out.

Your bottom line is most important, and a robust internal culture with happy employees can help it grow. Find a partner that has a strong focus on a nurturing, proactive work environment, and you'll find a healthy team that performs at a much higher level than any of its competitors. An organization that maintains a positive, inclusive, productive atmosphere is a much better option than one in which employees are so competitive they work against each other. Ask whether the company invests in the personal and professional development of its staff. A company that uses some of its budget to build a world-class team tells you that management feels employee growth is essential.

You might also want to consider the size of the company you are considering, whether it is a huge nationwide / global company or a small mom-and-pop shop. Big companies are likely filled with bureaucracy and politics that might hinder performance. A big corporate structure with levels of management can't compete with a strong private company where all the employees know and trust each other. On the other hand, mom-and-pop shops don't have enough structure or the experience to compete. The mid-sized organization that allows flexibility, autonomy and transparency, and has an organizational chart that keeps everyone connected, just may be the perfect choice.

Don't be afraid to ask questions of a potential partner, to delve into the heart of a company's business practices and learn what makes it tick. Only then will you be able to determine if that company is the right fit for you.

Meagen Lane

Meagen Lane, Vice President
South Region, Choice Recovery
352-359-3170
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What Is Value-Based Care What It Means for Providers?

BY JACQUELINE BELLIVEAU, EDITOR, REVCYCLEINTELLIGENCE

Value-based care has emerged as an alternative and potential replacement for fee-for-service reimbursement based on quality rather than quantity.

Value-based care is a form of reimbursement that ties payments for care delivery to the quality of care provided and rewards providers for both efficiency and effectiveness. This form of reimbursement has emerged as an alternative and potential replacement for fee-for-service reimbursement which pays providers retrospectively for services delivered based on bill charges or annual fee schedules.

In order to transform how healthcare providers are reimbursed for services rendered, the Centers for Medicare & Medicaid Services (CMS) has itself introduced an array of value-based care models, such as the Medicare Shared Savings Program and Pioneer Accountable Care Organization (ACO) Model. Private payers have in turn adopted similar models of accountable, value-based care.

While the traditional fee-for-service reimbursement model promoted quantity of services, federal officials have proposed several reimbursement programs that reward healthcare providers for the quality of care that they give to patients. Value-based care aims to advance the triple aim of providing better care for individuals, improving population health management strategies, and reducing healthcare costs.

In more basic terms, value-based care models center on patient outcomes and how well healthcare providers can improve quality of care based on specific measures, such as reducing hospital readmissions, using certified health IT, and improving preventative care.

The Department of Health & Human Services (HHS) has set a goal of converting 30 percent of fee-for-service Medicare payments to value-based payment models by the end of 2016. The agency expects 50 percent of traditional payments to make the transition by 2018.

As the healthcare industry transitions to this new way of delivering care, many healthcare providers are left wondering how value-based care is different than the traditional model, what programs are available, and how successful has it been?

The next sections will examine the basics of value-based care and help readers understand how the model works.

How is value-based care different from fee-for-service models?

In the traditional fee-for-service reimbursement model, healthcare providers were paid for the amount of services that they performed. This has incentivized many providers to order more tests and procedures as well as manage more patients in order to get paid more.

The costs were determined by what commercial payers would pay in the private market and a percentage of what Medicare would have paid for similar services. Rates for services were also unbundled, meaning each service was paid for separately.

> *"The goal is straightforward but ambitious: Replace the nation's reliance on fragmented, fee-for-service care with comprehensive, coordinated care using payment models that hold organizations accountable for cost control and quality gains."*

Under fee-for-service models, cost variations for procedures and tests increased and the healthcare industry was spending more to treat patients even though patient outcomes were not necessarily improving. The model also challenged provider workflows because physicians were seeing more patients and each claim had to be processed in a fragmented network.

To drive down healthcare costs and improve patient outcomes, the federal government designed value-based care programs. These reimbursement and care models hinge on advancing quality of care while increasing patient access and accounting for price at the point of care.

"The opportunity exists to transform how healthcare is delivered," explained a 2014 State Health Care Cost Containment Committee report. "The goal is straightforward but ambitious: Replace the nation's reliance on fragmented, fee-for-service care with comprehensive,

(continued on page 13)

coordinated care using payment models that hold organizations accountable for cost control and quality gains."

Value-based reimbursements are calculated by using numerous measures of quality and determining the overall health of populations. Unlike the traditional model, value-based care is driven by data because providers must report to payers on specific metrics and demonstrate improvement. Providers may have to track and report on hospital readmissions, adverse events, population health, patient engagement, and more.

Under the new models, providers are incentivized to use evidence-based medicine, engage patients, upgrade health IT, and use data analytics in order to get paid for their services. When patients receive more coordinated, appropriate, and effective care, providers are rewarded.

To participate in value-based care, CMS has developed several models for providers, such as the accountable care organization, bundled payments, and patient-centered medical homes.

What value-based care models are available?

Value-based care comes in a variety of types, generally differing as to the risks assumed by providers and sharing of savings or losses.

Accountable care organizations

An accountable care organization (ACO) is a network of physicians, hospitals, and other providers that give coordinated, high quality care to Medicare beneficiaries. CMS designed the program to help providers ensure that patients receive the most appropriate care at the right time. ACOs also aim to prevent unnecessary and redundant services while reducing medical errors.

Providers volunteer to participate in an ACO, such as the Medicare Shared Savings Program, Advance Payment ACO Model, or the Pioneer ACO Model. Under the payment model, the network of providers shares the savings if the ACO is able to deliver high-quality care and reduce healthcare costs.

On the other hand, providers in most ACOs must assume some financial risk for joining. While the potential of savings could be great depending on the agreement, there is also a potential for shared losses. Providers may have to repay Medicare for not providing value-based care to patients.

"We see development of and participation in ACOs as an important part of our future as we move from a fee-for-service based payment system to population-based models based on quality, safety and the patient experience," said Lee Huskins, President and Chief Administrative Office at John Muir Health's Physician Network, to RevCycleIntelligence.com.

Bundled payments

A Bundled payment, or episode-based payment, is a single payment for services provided for an entire episode of care. Providers are collectively reimbursed for the expected costs to treat a specific condition that may include several physicians, settings of care, and procedures.

For example, if a patient undergoes surgery, CMS would combine the set payment to the hospital, surgeon, and anesthesiologist, rather than paying each separately. The bundled payment is determined on historical prices.

> *Value-based care is still a new concept for most healthcare providers and many are still trying to implement the appropriate systems into their workflow.*

The bundled payment relies on a certain level of risk. If providers are able to decrease the cost of the services below the bundled payment price, then they can pocket the savings. However, if the costs are more, then providers bear a financial loss.

"Thus, bundled payment arrangements present many opportunities to re-tool the types and mix of post-acute care, and materially improve patient care and lower costs," explained the American Hospital Association in a statement to the House Health Subcommittee of the Committee on Energy and Commerce. "Such efforts may include more standardized hospital discharge practices and post-hospitalization protocols for medical, rehabilitation and other post-acute care services."

Patient-centered medical homes

The patient-centered medical home (PCMH) is a care delivery model that focuses on coordinating patient care through a primary care physician. The PCMH is designed to provide patients with a centralized care setting that manages the different needs of a patient.

The PCMH certification indicates that providers deliver patient-centered care, team-based methods, population health management, personal care management, care coordination, and consistent quality care. Patients in a PCMH can except to develop personal, one-on-one relationships with their care providers, who determine healthcare needs based on medical and environmental factors.

Through this value-based care model, a Colorado-based PCMH reported a 15 percent decrease in emergency department visits, an 18 percent reduction in inpatient admissions, and a return on investment of $4.50 for every dollar spent. Another Maryland-based PCMH stated that it saved $98 million and increase their quality scores by 10 percent in one year.

How popular are value-based care models?

In reality, value-based care is not an option for most healthcare providers. As HHS pushes to move more payments to alternative payment models, more providers are feeling the pressure from public and private payers to participate in alternative payment models.

CMS has also worked to expand participation in value-based care programs, such the proposed MACRA rule and the Value Modifier program. For example, the proposed MACRA rule would first apply to eligible clinicians, including ambulatory physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered

(continued on page 14)

nurse anesthetists. As the program matures, CMS intends to expand eligibility requirements to encompass more providers.

Eventually, CMS aims to tie all Medicare payments to value-based care models.

Several incentive programs have also helped providers quickly transition to more value-based care methods, such the EHR Incentive Program. According to the Office of the National Coordinator for Health Information Technology, more than 90 percent of hospitals have certified EHR technology.

What successes has value-based care achieved?

Last year, HHS announced that 20 percent of Medicare payments in 2015 were made through a value-based, alternative payment model.

In the same announcement, HHS reported that ACO programs had saved $417 million for Medicare and value-based payment models helped reduce hospital readmissions in Medicare beneficiaries by eight percent.

A CMS initiative that has quantified value-based care success is the Value Modifier program, which adjusts Medicare payments based on positive or negative quality assessments. In 2016, only 129 physician groups received an increase in Medicare payments of 15.92 percent or 31.84 percent.

The majority of physicians, which represents 8,208 total, will not see any change in payment adjustment due to a neutral performance or insufficient data.

Value-based care is still a new concept for most healthcare providers and many are still trying to implement the appropriate systems into their workflow.

"The transition from fee-for-service to pay-for-value has been referred to as one of the greatest financial challenges the U.S. healthcare system currently faces," stated a recent survey from Healthcare Information and Management Systems Society.

"Although this change is expected to happen over an extended period of time, CMS has announced aggressive goals for making the move with Medicare providers and hospitals. This requires healthcare providers to effectively navigate the challenges posed by a payment model that requires sharing and analyzing of data in ways that fee-for-service and its legacy revenue cycle management systems and business processes never contemplated."

As new programs, such as MACRA emerge, and healthcare organizations become more comfortable with new tools, such as EHR systems, value-based care has the potential to further decrease spending and improve quality of care.

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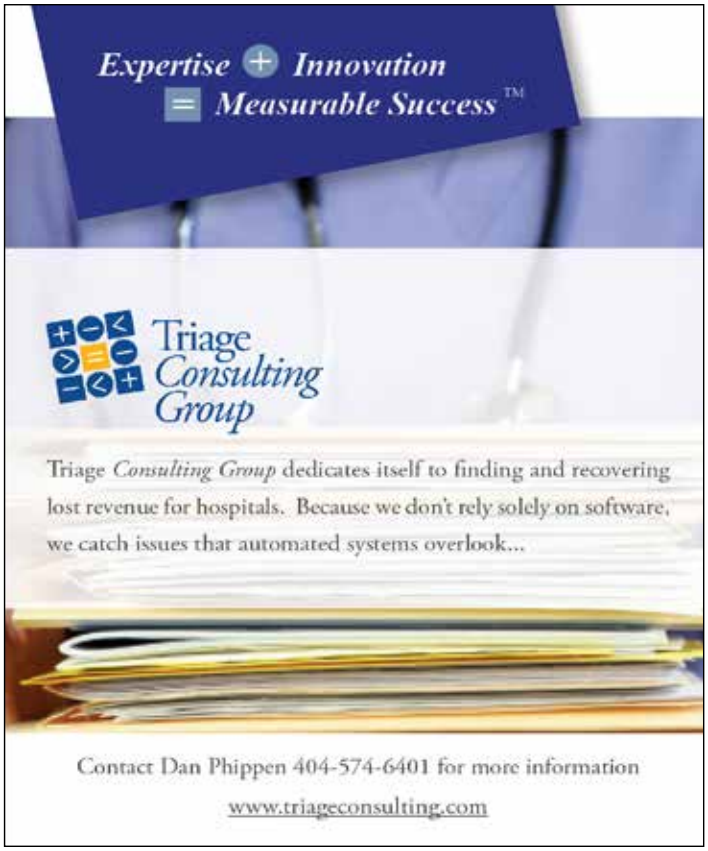
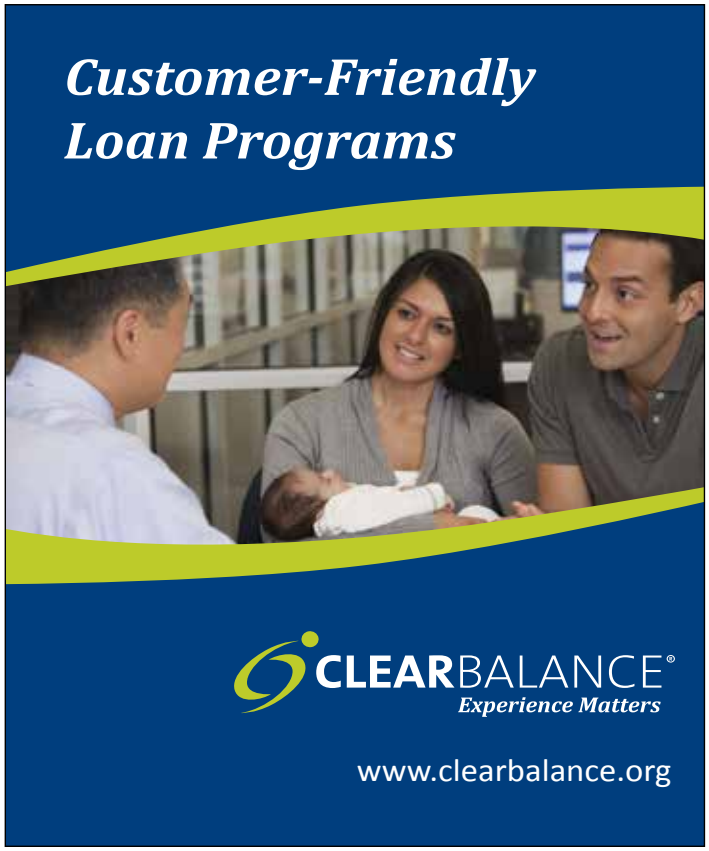
Visit our website at www.revcycleintelligence.com
Link to this article: http://revcycleintelligence.com/features/what-is-value-based-care-what-it-means-for-providers





CMS MACRA Final Rule Issued

BY HFMA STAFF

For more information on MACRA see HFMA's Executive Summary of the CMS MACRA Final Rule at http://www.hfma.org/physician.

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healthcare financial management association

MACRA timeline: MIPS and Advanced APM reporting requirements for payment year 2019

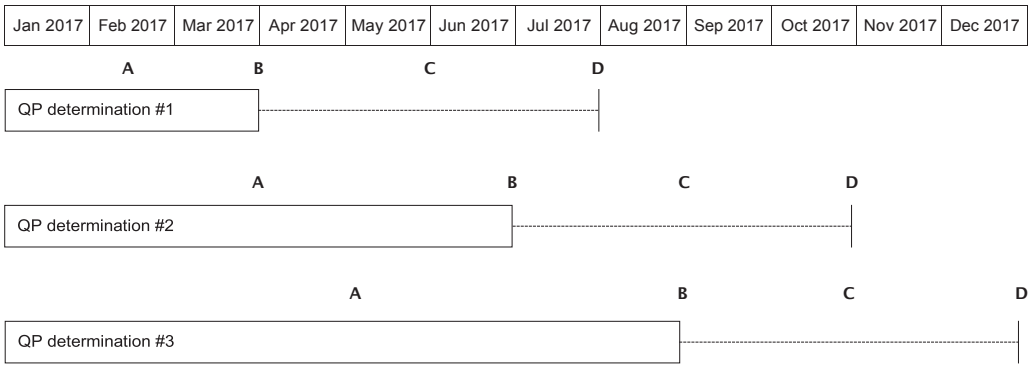
	2015	2016	2017											2018											2019											Notes
			J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	
MIPS																																						
Baseline Period (for "Improvement")	1																																					1. "Improvement" not scored for first year of MIPS (Performance Period 2017), thus first Baseline Period will be 2016 for 2018 Performance Period, 2020 Payment Year
Performance Period			2																																			2. For Part B claims, QCDR, Qualified Registry, and EHR reporting, a minimum of a continuous 90-day period is required to be reported; and the performance period may vary by performance category. Reporting must start by 10/2/2017. A 12-month period is required for reporting via CMS Web Interface, CAHPS, and administrative claims-based measures.
Date of Service range for claims																																						
Processing Date range for claims																																						
Payment adjustments announced														3																								3. Announced no later than December 1st prior to Payment Year
Payment Year																																						
Reporting Mechanisms																																						
REGISTRATION: Qualified Registry, EHR, QCDR, Attestation, Administrative Claims	No registration required																																					
REGISTRATION: CMS Web Interface					4																																	4. Groups of 25 or more ONLY; must register by 06/30 of applicable 12-month Performance Period
REGISTRATION: CAHPS data					5																																	5. Must register by 06/30 of applicable 12-month Performance Period
SUBMISSION: Qualified Registry														6																								6. Submission period begins January 1, 2018; ends March 31, 2018
SUBMISSION: EHR														6																								
SUBMISSION: QCDR														6																								
SUBMISSION: Attestation														6																								
SUBMISSION: Administrative Claims			7																																			7. Submission is automatic via claims processing. Claims must be processed no later than 60 days following the close of the performance period.
SUBMISSION: CMS Web Interface														8																								8. 8-week period after close of performance period, ending no later than 03/31; specific deadline to be published on CMS website
SUBMISSION: CAHPS data													9																									9. Survey must be reported on behalf of the organization by a CMS-approved survey vendor. Survey will be administered November 1, 2017 through February 28, 2018 and be sent to selected patients from the 2017 Performance Period.
APMs																																						
Advanced APM list published		10																																				10. No later than January 1, 2017
Eligible Clinician Performance Period			11																																			11. EC Performance Period is 01/01/2017–08/31/2017
Eligible Clinician Volume Assessment				12			12		12																													12. If EC qualifies in any of the three snapshot periods,
Notice of QP/PQP Determination								13																														13. EC groups will be notified of their QP/PQP status determination results as soon as determinations are made and validated by CMS. This will not occur before Summer 2017. Please note that the notification dates are approximations and not clearly defined in the final rule.
5% Payment Incentive Program payment base																																						
Date of Service range																																						
Processing Date range																																						
QP/PQP Incentive Payment																																			14			14. Not before Summer 2019, no later than December 31, 2019

* Proposed APM scoring standards require MIPS eligible clinicians to report certain data under MIPS regardless of whether they ultimately become Qualifying APM Participants (QPs) or Partial Qualifying APM Participants (Partial QPs) through their participation in Advanced APMs. Medicare believes it is necessary (for operational and administrative reasons) to treat these eligible clinicians as MIPS eligible clinicians unless and until the QP or Partial QP determination is made.

MACRA timeline: MIPS and Advanced APM reporting requirements for payment year 2019

(continued from page 13)

Appendix



A = claims data period used for QP determination

B = the snapshot date (Participation or Affiliated Practitioner List)

C = claims run-out period

D = estimated completion date of QP determination

At the end of each QP snapshot period (3/31, 6/30, 8/31) an assessment will occur and a determination will be made, pending CMS verification. Once an eligible clinician reaches QP status, the QP determination remains in force until the end of the performance year.

HFMA Event Promotions

FIHFMA Annual Managed Care Program

Thursday, February 9 at University Club Chicago

Join us for an day of learning, networking and fun at the Annual Managed Care Program. This year's program will be held Thursday February 9, 2017 at the University Club, Chicago, beginning at 7:30am with Continental Breakfast and ending with a Social Hour from 4:30-5:30pm.

The FIHFMA Managed Care Committee and Committee Chair Cathy Peterson have once again put together an exceptional slate of speakers and topics:

- Keynote: Kaveh Safavi, MD, JD,
  Managing Director of Global Health Business, Accenture
- How to Achieve Growth and innovation for a physician practice
  Mike Kasper, CEO, DuPage Medical Group
- Bundled Payments: 2017 and Beyond
  Chad Beste, Partner, PBC Advisors, LLC
- Personalized Medicine – Healthcare for What's Next
  Peter J. Hulick, MD, MMSc, FACMG, Medical Director, Center for Personalized Medicine & Division Head, Center for Medical Genetics, NorthShore University HealthSystem
- A New President, Congress and Health Policy Agenda: What to Expect
  Chris Dawe, Vice President, Payer Partnership Solutions, Evolent Health
- MACRA: What does it mean for your hospital and doctors
  Aaron Margulis, Principal, Vizient

To register, visit the FIHFMA website at www.firstillinoishfma.org/events.

Hope to see you there!

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Health, United States Spotlight

Health Care Expenditures & Payers

September 2016

ABOUT *HEALTH, UNITED STATES*

***Health, United States* is the annual report on health, produced by the National Center for Health Statistics and submitted by the Secretary of the Dept. of Health and Human Services to the President and Congress.**

The report uses data from government sources as well as private and global sources to present an overview of national health trends. This infographic features indicators from the report's **Health Care Expenditures & Payers** subject area.

For more information, visit the *Health, United States* website at: http://www.cdc.gov/nchs/hus.htm.

Four Subject Areas of *Health, United States*

- Health status & determinants
- Health care resources
- Utilization of health resources
- Health care expenditures & payers

MEDICAID COVERAGE

ABOUT THE DATA

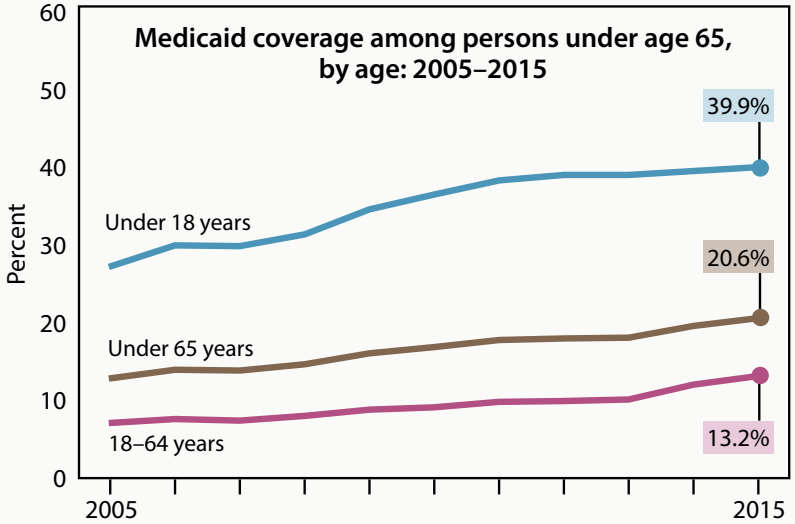
Source: NCHS/National Health Interview Survey (NHIS)

Respondents: Noninstitutionalized civilians.

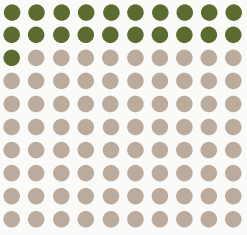
Methodology: Coverage for adults was respondent-reported. Coverage for children was reported by a parent or a knowledgeable adult.

Notes:

- **Medicaid** includes coverage by Medicaid, state-sponsored plans, or the Children's Health Insurance Program.
- Type of coverage represents coverage at the time of interview.

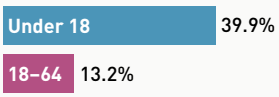


In 2015, approximately **21 OUT OF 100** people under age 65 had Medicaid coverage.

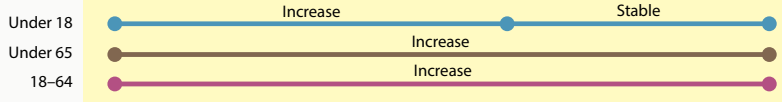


= 55.4 MILLION PEOPLE under 65 with Medicaid

Children under age 18 were **3 TIMES MORE LIKELY** than adults aged 18–64 to have Medicaid coverage in 2015.



How has Medicaid coverage among persons under 65 changed from 2005 to 2015?



CHANGE IN MEDICAID COVERAGE BETWEEN 2005 AND 2015

UNDER 18 YEARS	18–64 YEARS	UNDER 65 YEARS
		
27.2% (2005) ▲ 46.7% → 39.9% (2015)	7.2% (2005) ▲ 83.3% → 13.2% (2015)	12.9% (2005) ▲ 59.7% → 20.6% (2015)

Welcome New Members

Jim Berkhout

Nicole Mims
Consultant

Erin Cobb
McHenry Radiologists and Imaging
Business Manager

Randall Gienko
SRG
Consultant

Cheryl Timkang
Strategic Reimbursement Group LLC
Senior Consultant

Daniel Burke

Alice Bae
Heidrick & Struggles
Engagement Manager

Derrick Heldt-Alvarez
Weiss Memorial Hospital
Director Revenue Cycle Operations

Julie Workinger
Workday
Healthcare Account Manager

Michele Newkirk
American Hospital Association
Senior Financial Analyst

Doug Spaete
State Collection Service, Inc.
Control/Director of Finance

Hathuy Nguyen
Strategic Reimbursement Group
Senior Consultant

James Knepper
Law Offices of James A. Knepper
Sales/Services

Ambreen Farooq

Phillip Betts
Crowe Horwath
Staff

Phillip Long
Plante Moran
Principal, Cybersecurity

Neeraj Mehta
TransUnion
Director, Healthcare Data Analytics

Dominick Diomede
Technosoft Corporation
Manager, Healthcare

Ben Bancoro
Future Health Solutions Inc.

Brandon Solomon
HealthScape Advisors
Managing Director

David Huffman
Northwestern Memorial HealthCare
Manager, Decision Support

Christian Waterstraat
Strategic Reimbursement Srvcs, Inc.
Consultant

Mario Pistilli
Presence Health
Manager, Imaging Services

Michael Morrell
The Claro Group
Analyst

Mishelle Pedenko
Accenture
Chicago Healthcare Market Lead
(Accenture Healthcare Practice)

Alisa Wrenn
Presence Health
Sr. Accountant

Robert Marshall
University of Chicago Medicine
Director, Business Analytics and Market Intelligence

Kyle Coates

Stacy Stoll
Elavon Healthcare
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Katherine Gibbs
Experian Health
Product Manager, Claims

Jeffrey Bono
Northwest Community Healthcare
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Stephanie Glass
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Gannon Williams
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(continued from page 21)

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Deloitte and Touche

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University of St. Francis
Professor

Robert Baillie
Navigant Consulting
Associate Directors

Stephanie Stilling
iVantage Health Analytics
National Business Development Manager

Angelica Purpura
RSM US LLP
Associate Consultant

Tami Kaczmarski
RML Specialty Hospital

Mark Serain
Rush University Medical Center
Manager, Finance

Jerita Williams
University of Illinois Hospitals
Reimbursement Analyst I

Robb Cozad
Ventas (REIT)

Philip Grodin
Ventas (REIT)

Michael Stowe
University of St. Francis
Associate Professor

David Smith

Donald Ensing
McGuireWoods LLP
Partner

Corey Schaefer
Ventas
Financial Analyst

Corey Hebel
Ventas, Inc.

Lawrence Elisco
Wipfli, LLP
Healthcare Partner

New Member Profile

Derrick Heldt-Alvarez

MIT-PM (Master's of Information Technology-Project Management),
BSN, RN

Director, Revenue Cycle Operations for Conifer Health Solutions, a company that provides revenue cycle services for a number of hospitals, including Tenet Health

Questions:

How long have you worked there?

13 years, in various positions in the company. I started at Weiss in February 2004 in the intensive care unit as a nurse.

How did you transition from the clinical side to financial services?

Back in 2004, I met with the chief nursing officer one day and she asked me, "What do you know about computers?" I talked with her about my past experience and she had me meet the chief operating officer. The COO offered me a job, transitioning the hospital to a new billing system. So by the next day I was Order Communications Nurse Coordinator! I was pulled from working in the intensive care unit to building our new admissions/discharge/transfer computer system.

After that was completed, I was given the opportunity to implement other systems as well, such as Midas, Kronos, Materials Management System, Clinical Documentation and ED Tracking Board Systems. I was the quality assurance manager at Weiss then promoted to manager of nursing informatics at West Suburban Medical Center, our sister hospital we had just acquired. From there I went to the corporate office to maintain the IT side of the materials management system used at all Vanguard Health Systems hospitals.

Two years later Vanguard Health Systems was acquired by Tenet Healthcare. At the time I was working in Texas to assist with the opening of a new hospital, Resolute Health. I worked with materials management to ensure we could charge for all the items that were being ordered. While setting up their charge master, a new job was created, Director of Revenue Analysis. I formally accepted the role and moved to Texas for two years. This year, Conifer created a position at Weiss: Director, Revenue Cycle Operations. So I applied for a transfer and came back to the same hospital where I worked in 2004 (!!). My knowledge in implementing computer systems and understanding the logistics of billing led me to where I am today.

How long have you been in healthcare? 18 years

Favorite class in college? Anatomy and physiology

Passions? Baking, especially cheesecake [Editor's note: Must meet this guy.]

Millennial, GenXer or Baby Boomer? Borderline GenXer/Millennial

What's your favorite "brand" and why?

Starbucks. They have my favorite coffee, Pike Place Roast, and also Jade Citrus Mint Green Tea. And you can get it pretty much anywhere you go.

Anything else you'd like us to know about you?

I have a Donskoy cat (a hairless cat breed of Russian origin) named Bella and a Boxer named Bacchus.

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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.

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