First Illinois Speaks
HFMA's First Illinois Chapter Newsletter
July 2014

LEADING the CHANGE

hfma 2014 - 2015

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Changing Landscape in Health Insurance:

A Blurring of Commercial and Governmental Payors and Managed Care Networks

BY CATHY JOHNSON, SENIOR HEALTHCARE CONSULTANT, PBC ADVISORS, LLC

2014 remains an interesting and challenging year for healthcare providers. Amid pressure on revenue, reimbursement and costs we find a rapidly changing landscape with respect to health insurance, both in terms of "commercial insurance" (i.e., PPO/HMO plans offered by companies like Blue Cross and Humana, which are sponsored by employers for their employees) and "governmental insurance" (traditional Medicare, Medicaid government-sponsored plans). The objectives of this article are:

1. To help you understand how these changes could have significant impact on your Payor Mix, Market Share, and even Referral Patterns.
2. To help you understand the potential challenges and potential impacts on your practice driven by these market changes.
3. To outline for you the appropriate tactics and preparations in your Practice Management, Payor Contracting, and Strategic Planning initiatives.

Defining and understanding the changes in health insurance:

Historically, physician practices (and hospitals) patient volumes, or "Payor Mix," was comprised of four segments: Commercial, Medicare, Medicaid and Self-Pay. Most physicians accept Medicare, and it typically represents 25-40% of a practice's volume/revenue. Most private physicians also accept Commercial Plans, and they typically represent 25-50% of a practice's volume/revenue. The number of independent physicians accepting traditional Medicaid continues to decrease, due to the state of Illinois' low/slow payments; Medicaid typically represents 5-10% of a private practice's volume/revenue. Self-Pay patients are typically only allowed in an independent

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practice at the physicians' discretion (representing 5% of patients).

A physician practice's Payor Mix has been and continues to evolve. This began with President Bush's 2003 Medicare Modernization Act (introducing Medicare Advantage plans), followed by President Obama's 2009 Affordable Care Act (ACA) (introducing Health Insurance Exchanges, or Marketplaces), and the combination of state of Illinois Medicaid reforms and ACA Medicaid Expansion provisions in 2014—such that all four patient segments will increasingly come through the Commercial Payor networks and products.

This evolution will give commercial insurers significantly higher volume of patients, as well as significant influence in how patients are directed and services paid for in managed care networks. These patients previously could go wherever they wanted to, and we as providers knew the fee schedule we would be paid. The administrative processes for handling Medicare and Medicaid patients is relatively easy compared to the administrative requirements of managed care plans. That is all changing, and you need to think through how to manage these changes.

Health Insurance Exchange (HIX) goes live 1/1/14: The first wave of significant change began on 1/1/14 with the introduction of Health Insurance Exchange (or Marketplace) products (referred to here as HIX Plans). We all know the "metallic" levels of coverage (Bronze, Silver, Gold, Platinum); what we are all starting to see is that these products have significant deductible amounts, so that people are paying very low premiums with no coverage until deductibles of $6,000-$12,000 are met.

We are also experiencing difficulty verifying patient eligibility and obtaining cost-sharing or network information. Many of us know all too well that our patient bad debt has been increasing due to the dramatic increase in patient out-of-pocket expenses, and unfortunately that trend will sky-rocket, further exacerbated by the fact that the patients with these high deductibles tend to be the poorer patients that can least afford these high out-of-pocket expenses.

Additionally, several HIX products are "narrow networks" that limit the number of "in-network" physicians and hospitals. While one could argue that it's ok for us to take a pass on the new HIX patient population, and some of the health insurance products and narrow networks that serve these patients, over time, as more patients migrate from Commercial Plans to HIX Plans, that could accelerate volume loss and limit practice growth.

One final, significant challenge represented by HIX Plans is management of the "Grace Period" provision on these plans. Under the ACA legislation, the Grace Period provides that an insurer may not terminate coverage for a patient who does not pay their premium for a 90-day period. The impact of that provision is that (a) you may provide services to a patient you think has coverage that does not, (b) you may need to suspend billing of such patients during the Grace Period until eligibility is confirmed by the 90th day, and (c) you need to manage A/R aggressively for these patients.

Although initial 1/1/14 enrollment estimates were low, HIX enrollment since the beginning of the year has increased rapidly. Additionally, employers continue to look at moving their employee coverage to the HIX, either Public Exchanges or Private Exchanges.

Medicare and Medicaid managed care growth and changes in 2014: The next significant change coming relates to governmental plans, and there are three (3) significant initiatives underway:

- Changes in Medicare Advantage plans and contracted provider networks
- CMS Medicare-Medicaid Alignment Initiative (MMAI) related to "Dual Eligible" patients
- State of Illinois Medicaid Expansion and Reform

Changes in Medicare Advantage plans and contracted provider networks: Medicare Advantage (MA) enrollments were slow in the first few years of its existence, but today enrollment is approaching 25% of Medicare volume for many practices. As ACA drives reductions to MA Plan reimbursements, the MA plans are reacting by (a) reducing reimbursements and incentives, (b) terminating low-volume and low-value providers, (c) increasing patient cost-sharing, and (d) increasing "pay for performance" or "value-based purchasing" provisions in their provider contracts.

CMS Medicare-Medicaid Alignment Initiative (MMAI) related to "Dual Eligible" patients: For decades, patients that were eligible for both Medicare and Medicaid were covered under separate federal and state health plans. Subsequently, providers who treated this patient population dealt with two different billing and reimbursement processes (one with CMS for Medicare coverage components, one with the state for Medicaid coverage components).

Under the CMS MMAI initiative, these coverage provisions are combined under one program, and are being migrated to contracted MMAI plans (these patients are and will continue to be Medicare Primary under MMAI). The result is you must be contracted with these MMAI plans in order to continue to see these patients on an in-network basis. In Illinois, eight (8) health plans have been awarded contracts with CMS and Illinois HFS to provide benefits to the MMAI population.

State of Illinois Medicaid Expansion and Reform: Under ACA, states are offered funds to expand eligibility for Medicaid, so that additional people who don't know they qualify for Medicaid would qualify. At the same time, Illinois (like many states prior to this) is mandating that Medicaid enrollees receive their health insurance benefits through a contracted managed care plan. The state has awarded contracts to nine (9) health insurers to provide coverage under the Integrated Care Program (ICP) in 2014, with populations of enrollees being rolled into the program throughout 2014 so that by the legislatively mandated date of 1/1/15, 50% of all Illinois Medicaid recipients are enrolled in a managed care plan.

Additionally, the state has awarded several "Accountable Care Entity" (ACE) designations. ACEs will function much like the CMS Accountable

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Care Organization (ACO), and will first attribute and then enroll patients to the ACE. The ACEs will be provided quality initiatives and shared savings opportunities, and full risk after 18 months. These ACE contracts will become operational by 8/1/14, although this date is subject to change. These ACEs will function as both providers of care and a health plan payor.

What is also notable with respect to both the HIX plans and the Medicaid/ACE plans is that patient eligibility for each program will likely change across a benefit plan year or years. As a result, we are seeing HIX plans and Medicaid/ACE plans forming network and product alliances to provide easier transitions across products based on eligibility for patients, and allow payors to retain members across the product spectrum as their eligibility for these different programs change over time.

Potential challenges and Impact on your practice:

Where do we begin? Obviously there is hyper-change in the marketplace and it is going to be messy.

Let's walk through the key points on being ready for these changes by asking these key questions:

- Do I have a contract with this plan for this patient (am I in network)?
- Is the patient eligible?
- What referral processes are required?
- How do I manage the Grace Period?

Now let's discuss the key points of readiness in core practice areas:

The front-end (Registration):

- It will be very important to identify the HIX and new Medicaid plan patients, and many practices and hospitals are setting up separate Insurance Codes in their Practice Management systems to do so.
- You will need to get samples of all the HIX and new Medicaid Plan ID cards and train your staff to identify and register these patients (after confirming that you are contracted with the HIX or new Medicaid plan and the member is eligible).
- It is recommended that you verify eligibility and benefits for the patient for each and every appointment or visit, given the uncertainty of eligibility and the "Grace Period" requirements.
- And like all managed care plans, the HIX and new Medicaid plans will have a variety of pre-certification, referral, and authorization protocols you will need to know and manage to, or risk claims denials.

The back-end (Billing):

- You will need to make sure you bill electronically or send the bills to the correct address, and upon payment validate insurer payment versus patient balance.
- The HIX plans tend to have high deductibles and co-insurance amounts, so you will want to know that and follow up promptly with patients to collect balances. Every practice should develop and implement an upfront collection process for collecting co-payments, co-insurance and deductibles at time of service.
- You will also need to work with each HIX plan on managing their "Grace Period" policy and procedure.

We've already seen with the HIX plans that networks and network education around how to identify, treat and bill for HIX patients and plans lagged, resulting in considerable uncertainty at a practice level with this population. We are seeing the same with the first phase of Medicaid expansion. So it is critical that you proactively work both the "front-end" (Registration) and the "back-end" (Billing/Collection) of your practice revenue cycle.

Tactics & strategies to prepare & position your practice in the changing marketplace:

To reiterate a key message from the beginning of this article, 2014 is going to continue to be a year of unprecedented change in health insurance, and you need to understand what's coming and what you need to do. Things will not get any easier toward the end of 2014 or into 2015 (more ACA, MA changes and implementation and ICD-10). So you are best served to get on this now, and proactively manage these changes throughout the second half of 2014.

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Below is a summary of key strategies for your practice to best prepare and position for the changing health insurance marketplace:

1. Understand what is happening: The ACA (or "Obamacare" as it is referred to) is massive, complex and being implemented quickly. At the same time there are changes to Medicare, Medicare Advantage, and Public Aid that also need to be understood and managed accordingly.
2. The importance of your managed care payor agreements: As noted above, all four of your patient segments will be migrating to health insurance plans controlled by commercial managed care companies. You need to assess impact on your access to patients via your existing managed care contracts:
   a. Are you in these new networks or do you need additional or separate contracts?
   b. Are you being automatically added ("deemered") into agreements/networks, and do you want to be in these new products/networks?
   c. Are there "narrow networks" that you are being excluded from, and what is the impact to your practice in that scenario?
   d. Will you participate in these new contracts/products/plans via direct agreements with the payors, or via your IPA/PHO agreements? Do you have all bases covered?
3. Referral pattern impact: You will need to know, from the payor or from your IPA/PHO contracts, are there changes to referral policies and/or providers you can refer to? This is especially important in some of the newer plans/network configurations (narrow networks, tiered networks, risk/attributed patient networks).
4. Manage your revenue cycle: This is worth repeating: Your front-end (Registration) and back-end (Billing/Collection) both need to be on top of this. Also, there will be additional incentives and/or penalties related to the coding aspects of your billings.
5. Stay tuned in: As we move into 2014 and then into 2015, the volume of questions and the development/refinement of operational processes, network configurations and new products will intensify. It will be important for your office staff to stay on top of these changes and react accordingly.
6. Have a Plan: To borrow that famous quote from "Jaws": We're gonna need a bigger boat! What we mean by that is many of today's independent physician practices are not equipped for the task at hand in navigating the transformation underway in the U.S. healthcare system. Most practices consider their options as follows:
   - Merge together with other practices to form bigger independent groups
   - Become employed by a hospital or health system
   - Develop a "concierge" practice
   - Retire

Each of these options has pros and cons, and some may not be an option for you. The important thing is to understand what the changes in U.S. healthcare mean to you, be proactive in managing these changes in the short term, and have a solid plan for the long term.

Feel free to call Cathy at 630-571-6770 if you'd like to discuss any of this information in further detail.

Cathy Johnson

Cathryn Johnson is a Senior Healthcare Consultant with PBC Advisors, LLC. Cathy provides excellence to hospitals and medical groups with managed care, reimbursement, operations, contract strategy and negotiations. Cathy has in-depth knowledge of complex and various reimbursement methodologies and in data, billing and governmental issues related to managed care and governmental health plans.

President's Message

As our new year begins, I think about the lasting friendships and experiences I have developed through HFMA. Healthcare has changed since I joined the First Illinois Chapter over 25 years ago, but the association has been a steady influence, and continues to be the indispensable resource for healthcare finance. I am honored to be the leader of the First Illinois Chapter for the next year. With a very strong board and officer team, and a robust volunteer base, we are well positioned to continue to provide high quality education, networking opportunities and exposure to world class resources and services.

I thank outgoing President Dan Yunker for his tireless leadership and innovative ideas. He has been a change agent and created an environment of growth and opportunity for the chapter. Mighty big shoes to fill. I also thank outgoing board members Michelle Holtzman, Brian Washa and Tim Manning. They have given us thought leadership and many hours of time to help the chapter execute its strategic plan. I thank Tracey Coyne, outgoing Past-President. She is at the end of a five year commitment that has propelled the chapter forward as evidenced by a remarkable member satisfaction improvement. And finally I thank Mike Nichols as he leaves his post as Regional Executive. He has lent a steady hand over many years as the voice of reason for the board.

As I look forward I ask all of you for your thoughts and ideas to help us fulfill our commitment to the chapter. Take a look at our strategic plan on the chapter web site for insight into our direction for the year. We are over 1440 members strong and have the resources to stay at the forefront of the issues facing healthcare finance today. There is opportunity for each of you to get involved, join a committee, share your time and skills, and help us stay ahead of the challenges we will be confronted with. I can assure you that this year your chapter is committed to providing high quality education, collaboration, networking and a lot of fun along the way. I will see you at the Fall Summit in October and call or email me along the way.

Contact Carl at 312-906-6063; cpellettieri@impacths.net

Carl Pelletieri
2014 – 2015 First Illinois, HFMA Chapter President

A New Paradigm for Technology

BY KIMBERLY MOORE, FIRST AMERICAN HEALTHCARE FINANCE &
STEVE FEHLINGER, FHFMA, SR. CONSULTANT, LUBAWAY, MASTEN AND CO., LTD.

The Triple Aim

As health care organizations pursue the Triple Aim vision, they need to explore every facet of their care delivery systems. Reliance on technology, the vehicle for reform, requires organizations to take a fresh look at how they view technology assets. This paper briefly explores a new paradigm for technology acquisition and lifecycle management that aligns with improving patient care, reducing health delivery costs, and improving population health.

An old strategy in a new environment

Historically, most health care organizations viewed technology like an emerging nuisance–with reluctant providers preferring pen and paper. Technology equipment was not regarded with the same esteem as equipment used to deliver direct patient care, nor could a direct line be drawn to the bottom line. Therefore, in many health care organizations, an efficient and cost-effective strategy was never developed to acquire and manage the lifecycle of technology, resulting in costly maintenance and repairs over time.

What has changed?

HITECH and the PPACA (do these need to be spelled out?) have created an environment where technology is critical in improving patient care, enhancing the patient experience, and reducing health delivery costs. Electronic Health Records (EHR) utilization incentives and penalties are directly tied to an organization's financial performance. New regulations and new technology require new strategies. While holding on to outdated technology may have been an option in the past, employing this strategy today will hinder performance, competitiveness and the bottom line.

What makes this so different?

2014 is a pivotal year in health care:

- Decreases in reimbursements
- Technology incentives drying-up
- Introduction of insurance exchanges
- Unpredictable government regulations (ex: ICD-10)

These changes are decreasing cash flow, aging accounts receivables, and challenging even the largest and strongest institutions. This is the new normal; health care organizations are trying to become comfortable with being uncomfortable.

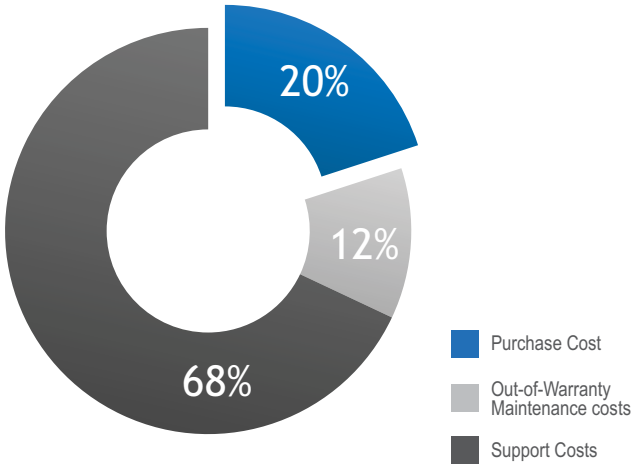
It is time to rethink the paradigm

A strategic commitment to keeping technology current is essential for health care organizations to achieve the Triple Aim, remain competitive and, ultimately, to survive. Embracing a routine refresh cycle utilizing lease financing enables you to:

- **Lower acquisition costs:** Low, fixed payments made over the lease term will cost less than purchasing the equipment outright.
- **Reduce indirect costs:** Technology is a rapidly changing commodity with a short useful life; aligning terms with useful life and maintenance coverage will significantly reduce support and out-of-warranty maintenance costs.
- **Stay current and flexible:** As technology changes, health care organizations can easily refresh equipment to keep pace with innovations in technology.

Leasing is not a decision based on whether or not you use your cash. It is a strategic financing method organizations use to manage the life cycle of their equipment.

Total Cost of IT Ownership Breakdown



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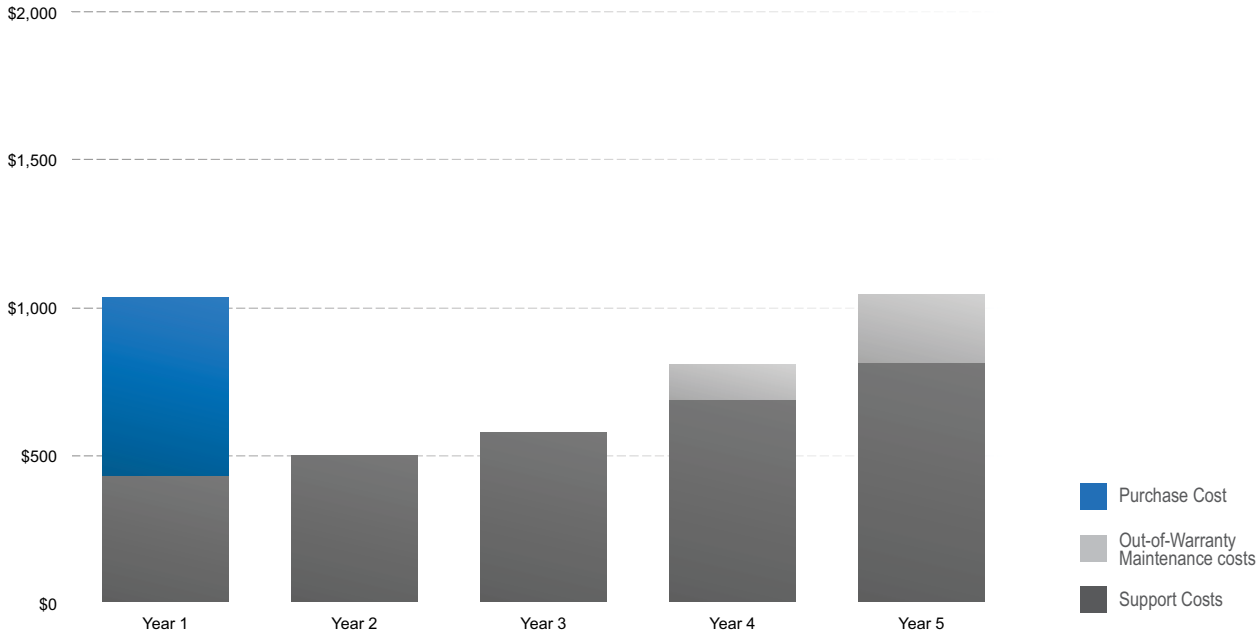
Total Cost of Computer Purchase



What has changed?

Unlike traditional for-profit businesses, non-profit hospitals do not experience the tax savings created by the depreciation of assets (a tax shield). Leasing is the only tool that will allow hospitals to experience savings from the tax shield. In a true lease, the leasing organization is able to depreciate the equipment, resulting in tax savings that will pass through to the health care organization.

Conclusion

Budgeting for technology in this era involves a new paradigm for how we acquire and maintain equipment. The solution to technology management challenges facing health care today starts with rethinking the way we view technology and its increasing importance in our pursuit of the Triple Aim. Organizations must make a strategic commitment to technology and create an environment that is able to adapt to change.

Works Cited

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The Fair Market Value Implications of Health Systems:

Losing Money on Their Employed Physicians

BY TIMOTHY SMITH, AMERICAN APPRAISAL

Introduction

The recent cycle of physician employment by hospitals and health systems has resurrected one of the perennial questions in healthcare valuation: can the compensation paid to employed physicians be fair market value ("FMV") when hospital systems lose money on their physician practices? A related question is whether it is commercially reasonable for health systems to lose money on their employed physicians.[1] In thinking about these critical compliance questions, it may be a helpful starting point to examine the causes of financial losses in hospital-owned practices ("HOPs"). Understanding the economics of HOP losses can provide a context for assessing FMV compliance. Since these economics are driven by a variety of factors, multiple answers are possible in examining the question of FMV for HOPs operating in the red.

It is worth looking at publically available data on HOPs in comparison to physician-owned practices ("POPs") to gain a general understanding of market trends relative to practice losses. Data from the 2012 Medical Group Management Association ("MGMA") *Cost Survey* for single specialty and multispecialty practices are presented in Charts 1 and 2 below.[2] The charts report the net income or loss per full-time equivalent ("FTE") physician for practices owned by hospitals/integrated delivery systems ("IDS") and by physicians.

What is readily apparent from these charts is that, for the HOPs included in the MGMA *Cost Survey*, losses per FTE physician are the norm. Indeed, some of these losses are substantial. In citing this survey, however, it should be noted that the data was not gathered using statistical sampling methods; it is based on voluntary responses to a trade group's annual survey. Whether the above data is fully representative of all HOPs in the United States is not known. What is nonetheless striking about this data is that POPs do not report similar losses. It is here – the absence of losses in POPs – where the inquiry into the FMV implications of losses in HOPs begins.

Earnings-Based Compensation: The Historical Paradigm for Physician Compensation

When evaluating issues related to physician compensation, it is important to understand how physicians have been traditionally paid. Most physicians in the United States have historically worked in POPs, primarily comprised of one to two physicians.[3] In this practice setting, physician compensation is determined based on the net practice earnings generated by the practice, *i.e.,* collections for services rendered less the cost associated with generating the services. In today's marketplace, this model is known as "eat what you catch" or "eat what you treat" or the ironic "eat what you kill" (which is hopefully not the patient). Such net earnings from services rendered, or earnings-based compensation, has been the

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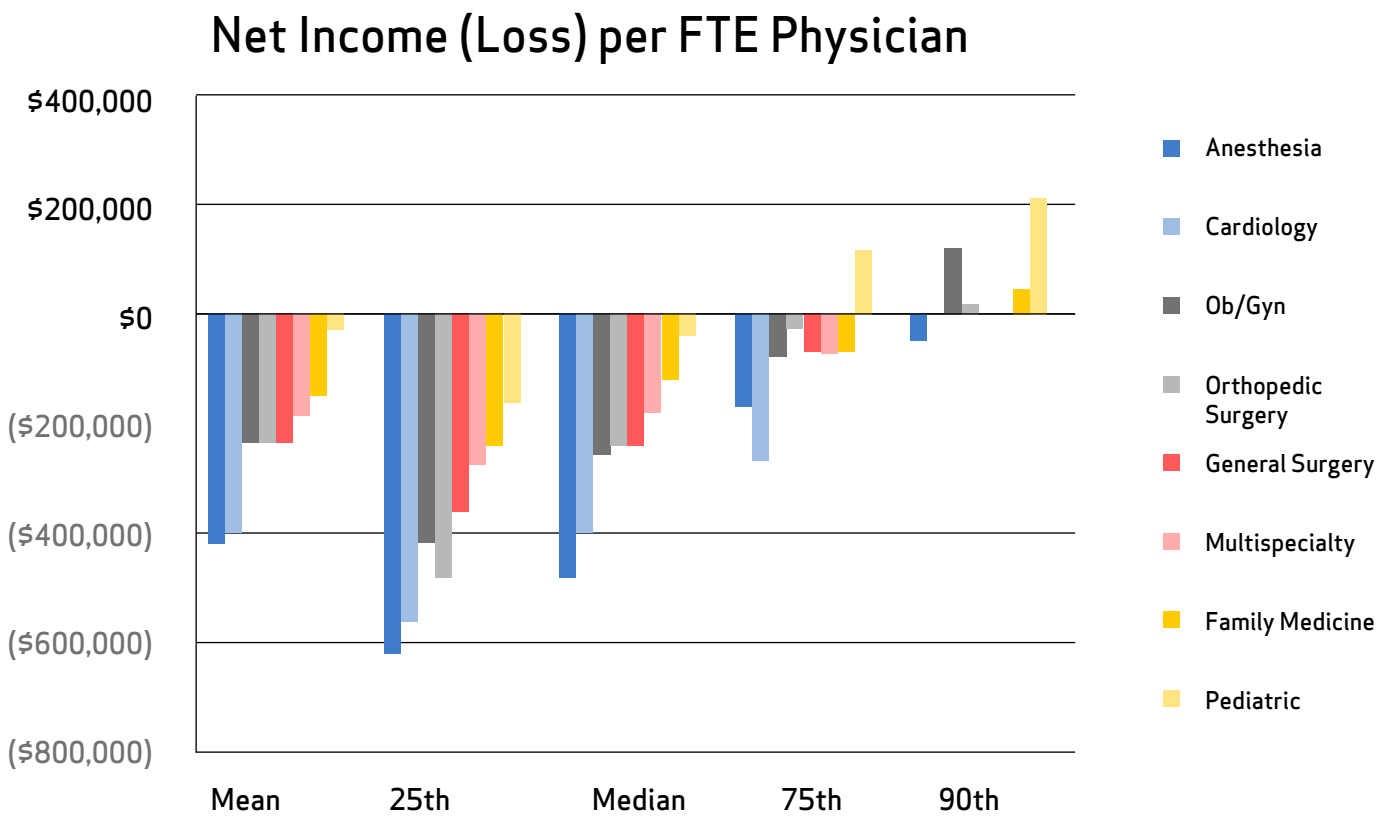
Chart 1: Net Income/(Loss) per FTE Physician for Hospital/IDS-Owned Practices



The Fair Market Value Implications of Health Systems: Losing Money on Their Employed Physicians

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historical paradigm for physicians compensated in the United States. Indeed, earnings-based compensation is a long-established concept for determining the value of professional services, including those of physicians, attorneys, accountants, and consultants. In other words, the value or compensation for professional services is the revenue received from providing the services less the cost to generate the services.[4]

Earnings-based compensation is an "elegant" concept because it simplifies the complexity of economic factors in a physician practice into a single value. It consolidates the impact of multiple variables on the economics of physician services in the healthcare marketplace. Net practice earnings result from the range of services provided by a physician, including the service mix of medical procedures, as well as other services, including compensated hospital call coverage, medical directorships, research, and other professional services. It also reflects the physician's productivity, and more importantly, reveals the value of medical services in the local market viz-a-viz the reimbursement paid for services by insurers. This value indicator is critical: physician services are paid at varying levels by payers from one market to the next, and indeed, within a local market.[5] Embedded in net practice earnings, therefore, is an indication of the local market value of physician services, albeit one that might be hidden beneath the "noise" of poor revenue cycle management by the physician's practice.

Earnings-based compensation also indicates a physician's economic efficiency: at what cost did the physician use resources in providing services. Physicians are not created equal with respect to their overhead spending and support levels. Some physicians are high resource utilizers when it comes to support staff, office space, supplies, and other operating expenses. Other physicians, by contrast, may require less staff and space to produce the same level of services as their higher consuming colleagues. Physicians with high economic efficiency make more money, given the same levels of productivity and reimbursement, than their less efficient peers.

Physicians have historically understood these practice dynamics and economics.[6] They made operational decisions in relation to improving their practices in terms of increasing revenues and lowering costs, while maintaining quality patient care. Their horizon of decision-making consisted of their individual practices and net practice earnings. The impact of operational changes, moreover, was immediate and direct. Increased productivity or revenue meant increased compensation; increased overhead meant reduced compensation. Compensation based on net practice earnings was self-adjusting and self-leveling. Increased net practice earnings generally allowed for higher compensation. Conversely, reduced earnings usually required a reduction in compensation. In short, "eat what you catch" created a natural boundary for compensation. Consequently, earnings-based compensation generally explains why POPs in the MGMA data do not show net losses.[7] The critical question now becomes: Why do HOPs lose money?

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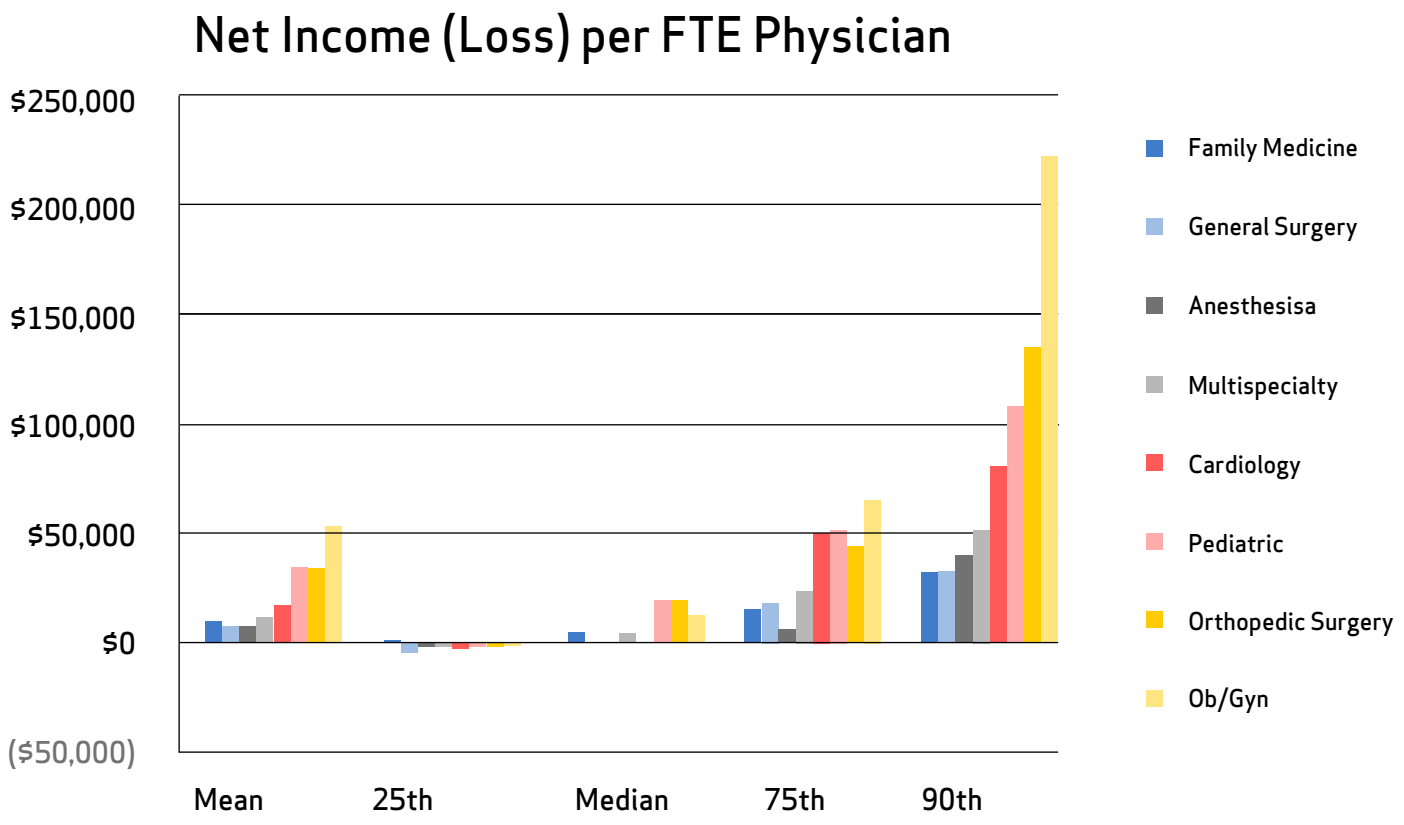
Chart 2: Net Income/(Loss) per FTE Physician for Physician-Owned Practices



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Losses Arising from Employer and Physician Performance Issues

In examining the causes of HOP losses, one should not fail to note a common cause of losses in many business endeavors: shortcomings in management and employee performance. Sometimes mistakes and misjudgments are made in the course of a hospital system operating a physician practice. Many hospital systems underestimate the complexity of issues involved in operating physician practices. At the same time, physicians and experienced practice managers may not be prepared for the difficulties associated with organizational integration. Often, these mistakes occur as part of the transition of a practice from physician to hospital system ownership. Typical issues that can go poorly in a transition include:

- Obtaining new third-party payer provider numbers,
- Timely credentialing with commercial payers,
- Converting to new health IT systems for billing/collections or electronic health records ("EHRs"),
- Transfer of "back office" functions to centralized management or service centers,
- Negotiation of favorable reimbursement rates with commercial payers,
- Changes in participation in networks or in referral patterns from other physicians in the community,
- Changes in practice location sites after being acquired,
- Assignment of contracts.

In addition, the transitioning of physicians from entrepreneurs to employees who are paid on base salaries or guaranteed compensation may not provide an environment with sufficient incentives for productivity. One of the key lessons from the prior market cycle of integration in the 1990s was that the motivations for highly productive physicians can change once a physician is no longer at risk under "eat what you catch." Depending on the compensation structure, practice losses may simply result from physicians not producing commensurate with their historical levels, while hospitals continue to compensate them at historic levels or higher.

Another potential cause results from productivity-based compensation that is not tied to operational cost considerations. If physicians are allowed to increase their resource utilization in order to generate higher productivity, but have no compensation consequence for using more resources, losses can accrue in the practice. A prime example is the extender use of nonphysician providers ("NPPs"), where the NPPs do not perform independent patient encounters but rather are used to reduce physician contact time with patients. Under a productivity-based compensation plan where there is no offset for the incremental cost of the NPP, physicians can increase their productivity and resulting compensation at the expense of the employer.

The Unintended Consequences of Hospital- Physician Integration

The ownership and operation of physician practices by hospital systems can affect the underlying services and economics of physician practices in ways that are distinct from POPs. The reason for this difference is that ownership by other types of healthcare entities can introduce business and operational considerations that are not intrinsic or related to the economic and operational optimization of a practice. The larger concerns and objectives of a healthcare organization can override goals and plans that would maximize physician practice earnings. As part of a larger healthcare organization, physician practices become one resource or service line within a larger continuum of services and product lines. Optimization of the organization can take precedence over that of the practice in terms of the healthcare entity's goals, strategies, and priorities. For example, IDS considerations can influence decisions related to the number of providers, the type and specialty/subspecialty of providers, practice locations, and the level and extent of hospital emergency department and inpatient call coverage. Such changes can affect practice operations and economics in ways that are both favorable and unfavorable from the singular perspective of the physician practice.

As part of integration, a practice becomes a participant in the hospital system's economics in terms of access to contracts, resources, policies, practices, and corporate culture. Such participation can have an impact on both the revenues and overhead of a practice. A review of these factors can be summarized as follows:

Participation in Payer Contracts: Studies have shown that large health systems can have greater leverage on commercial payers in a local market, providing a practice with higher reimbursement on commercial patients.[8] On the other hand, some hospital systems lack experience in negotiating physician fee schedule rates, or they may sacrifice physician rates for gains in other areas for the system.

Centralized Billing and Collections: Billing and collections for a practice are often moved to a centralized office or absorbed into the hospital's billing and collection function. This move could negatively affect the practice's revenue cycle if the centralized function is inefficient or inexperienced with respect to physician practices.[9]

Payer Mix: When a physician practice is owned by a hospital system, it may be required to expand its payer mix to less favorable payers or locations, thereby decreasing practice revenues on a per unit of service basis.

Technical Component / Ancillary Services: Hospital systems frequently move or consolidate technical component or ancillary services from physician practices into existing hospital facilities in order to maximize reimbursement and/or to eliminate duplicative services. A potential effect, however, of converting these services to provider-based status is to create operating losses in physician practices. The effect occurs when physician compensation levels, whether established by market survey data or by historical practice net

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earnings, include the net earnings from in-office ancillaries provided by physician groups, for those specialties in which ancillaries are usual and customary.[10] Once those earnings streams are removed from the practice, physician compensation levels can generate losses.

Corporate Pay Grades for Support Staff: Hospital systems and large healthcare organizations often have formal and structured pay grades for employees. These rates can exceed those paid by smaller physician groups or solo physicians for the NPP staff of a practice, causing overhead to thereby increase.[11]

Employee Benefits: Smaller physician-owned practices often do not offer benefit packages that are comparable to larger, corporate organizations in the employment marketplace. As a result, benefit costs for the practice staff can increase after integration.

In summary, ownership of physician practices by hospital systems can alter the operations and economics of these practices in ways that reduce revenue or increase cost. As a result, the net earnings from a practice may not be optimized from the perspective of the practice as an operational and accounting unit. HOP losses may result from operating dynamics that do not relate to the actions of physicians or their compensation. They simply result from the choices made by the hospital system in how to best utilize practice resources within the IDS.[12]

The Move to Survey- Based Compensation using wRVUs

The migration of physicians into employment arrangements with health systems has produced a move away from earnings-based compensation towards the focus on physician compensation surveys. Indeed, survey-based compensation appears to have become a prevailing paradigm for establishing physician compensation in many employment deals.[13] Some of the key factors in this paradigm shift include the following:

- Recommended use of the survey data as a "prudent practice" in the commentary to the Stark Phase III regulations,[14]
- Availability of various physician compensation surveys to the general public,[15]
- Wide use and acceptance of survey-based compensation by valuators, consultants, and health systems,
- The apparent objectivity of using survey data,
- The belief that the survey data is a reasonable or fully accurate reflection of the physician marketplace.

Concomitant with the use of the surveys is a particular focus on physician work relative value units ("wRVUs") as the sole means of applying survey data to subject physicians in employment arrangements.[16] A major contributor to this trend is the fact that

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wRVU-based compensation models are usually the compensation structure of choice for this recent cycle of hospital-physician consolidation. It was natural, therefore, to apply and utilize physician compensation survey data in terms of wRVUs and wRVU-related benchmarks. More importantly, wRVUs reflect a universal scale by which the productivity of all physicians could be measured and ranked. Using wRVUs, compensation can be assigned using the concept of productivity-matched compensation: a physician should be paid commensurate with his or her level of productivity. A critical presupposition of this approach is that wRVU productivity fully accounts for compensation levels in the marketplace.

The uninformed use of survey data, however, can be one potential cause of losses in HOPs. The reason such use causes losses is that many common methods of applying survey data can ignore critical elements in the economics of physician services relative to the subject physician in the local marketplace. Under survey-based compensation, physicians are usually paid based on the range of compensation reported in a survey using various economic models that range from picking a given percentile as FMV to matching percentiles of compensation with percentile benchmarking of wRVUs. Such methods, however, can ignore the full array of economic drivers of value for physician services. The financial reality of physician services is that their value is a function of several key factors, including productivity, reimbursement, service mix defined as both clinical and nonclinical services, and resource or cost utilization.[17] Ignoring these factors and focusing solely on wRVU productivity and/or median compensation, for example, can lead to losses in a particular practice under certain circumstances.

A prime example is the failure to take into account local market reimbursement in a compensation analysis. One of the key drivers of value in physician services is local market reimbursement. Two published analyses have demonstrated the impact of reimbursement rates on physician compensation. A ground-breaking article in 2008 modeled the impact of different payer mixes and commercial rates on physician compensation based on RVUs. It showed the significant impact that reimbursement rates can have on compensation per RVU rates. This analysis also noted how exclusive reliance on survey data can lead to results that are not reflective of local market conditions.[18]

Another recently published analysis used the data from the Center for Studying Health System Change ("HSC") to analyze the impact of reimbursement rates on physician compensation. Until recently, reliable data on commercial reimbursement levels across the country was not readily available to the public. A recent study by HSC, however, provided this data for eight different U.S. markets. This study shows a wide range of commercial reimbursement rates for physicians across various local markets in the United States and within those local markets.[19]

The analysis applied reimbursement rates from the HSC study to a model cardiology group constructed from the 2010 RVU values for an actual nine-physician cardiology group. Assuming a simplified payer mix and an overhead level based data from the MGMA *Cost Survey,* expected revenues and practice net earnings were estimated for each reimbursement level by market.[20] The analysis also included a national average. The resulting practice net earnings were converted to a compensation-per-wRVU rate and compared to the MGMA median compensation per wRVU for invasive-interventional cardiology. The difference in the two rates was multiplied by the group's total wRVUs to compute the total difference in compensation between the median and the net practice earnings. As shown in the Table on the following page, paying the physicians the median produces practice losses for over half of the reimbursement levels.[21]

A key implication of this analysis is that ignoring local market reimbursement in compensation-setting practices may result in significant losses on employed physicians. Certain compensation levels are not economically sustainable or viable in various markets because reimbursement levels cannot support these levels of physician pay, at least not without generating material red ink in the practice. Alternatively, if employed physicians are in a high reimbursement market, one may be underpaying what the market can afford by failing to recognize these local economic dynamics. Divorcing physician compensation from the local market raises the specter of high practice losses, or alternatively, undercompensated physicians.[22]

Many attempt to factor local market conditions into their valuation analysis by using regional or state data as a better approximation of local market conditions.[23] However, review of the HSC study and its implications indicates that it is unlikely that the survey data can be applied with any meaningful degree of precision to reflect the dynamics of any one particular market. Variations across a region, or even within a state, may not allow a reasonable level of specificity to a given market.[24] In the state of Texas, for example, there is a material difference in physician reimbursement between Houston and the Dallas/Fort Worth area.[25] There is also a significant variance between reimbursement levels in Northern California markets in comparison to Southern California.[26]

Perhaps the most precise statement one can make about the surveys is that they reflect the markets of those who responded. Since the respondents are not included based on statistically valid sampling techniques and since the surveys do not report data by individual market, it is indeterminate as to what markets are represented in the survey data. This reality should give pause in the use of survey data to establish physician compensation levels in employment arrangements. Failure to recognize these characteristics of the survey data can be one source of potential losses in HOPs.

A third recently published analysis has also called into question the commonly held idea that wRVUs are the definitive driver of compensation levels in the physician marketplace. This analysis used linear regression to study the relationship between compensation and wRVUs in the MGMA data over a five-year period (2008 through 2012 surveys) for 28 individual specialties representing surgical, medical, and hospital-based specialties, along with primary care. The analysis

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showed that wRVUs were found to explain or be predictive of only 30 to 40 percent of compensation levels in these specialties, based on the R-squared values of the regression lines.[27] While wRVUs certainly explain a material percentage of compensation, the question becomes whether these levels are sufficient to warrant the exclusive use and reliance on wRVUs alone to establish compensation for physicians. The reality of the MGMA data is that 60 to 70 percent of compensation is not explained by wRVUs.[28]

While much could be debated and discussed about the use of survey data, it is perhaps sufficient to say that the use of survey-based compensation has certain limitations and disadvantages. Survey-based compensation-setting practices can be imprecise in view of the variety of factors that can affect physician compensation in the marketplace because they may not take these factors into account. In general, the physician compensation surveys do not usually include information on local market reimbursement or other key factors that would allow the data to be applied to specific physicians with greater precision.[29] Note that these limitations are not necessarily cause for abandoning survey data in establishing FMV compensation. Rather, these limitations frequently necessitate the use of additional valuation methods and techniques that use the concept of earnings-based compensation under the cost and income approaches. Use of these methods can mitigate the limitations experienced in using survey data.[30]

Implications for Fair Market Value

The foregoing discussion has provided three potential factors that can contribute to losses in employed physician practices: over-reliance on survey-based compensation-setting practices; integration into hospital systems; and ordinary mistakes and shortcomings on the hospital or physician side of the practice equation. It is also possible that a combination of these various factors, even in relatively small increments, can be the culprit in physician losses. For hospital systems with practice losses, the pressing question is what implications for FMV compliance can be drawn from identifying the specific causes of the losses. Are there some causes for losses that render the compensation paid to employed physicians to be inconsistent with FMV?

Defining Fair Market Value

FMV for healthcare regulatory purposes has been defined by two sets of federal healthcare regulations. The federal physician anti self-referral law and regulations, commonly known as the "Stark Law," define FMV as follows:

> Fair market value means the value in arm's-length transactions, consistent with the general market value. "General market value" means the price that an asset would bring as the result of *bona fide* bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the service agreement. Usually, the fair market price is the price at which *bona fide* sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition, or the compensation that has been included in *bona fide* service agreements with comparable terms at the time of the agreement, where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals.[31]
>
> In addition, the regulations promulgated under the federal anti-kickback statute include a definition of FMV that is specific to the leasing of real estate and equipment:
>
> Note that for purposes of paragraph (b) of this section, the term fair market value means the value of the rental property for general commercial purposes, but shall not be adjusted to reflect the additional

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Market/Rate Level	Revenue per wRVU	Model Compensation per wRVU	MGMA Median Compensation per wRVU	Variance per wRVU	Total Difference in Model and Median Compensation
Milwaukee, WI - 75th %tile	$122.44	$80.40	$52.41	$27.99	$2,399,017
Milwaukee, WI - Standard	$99.79	$57.75	$52.41	$5.34	$457,549
Cleveland, OH - 75th %tile	$98.62	$56.58	$52.41	$4.17	$357,262
San Francisco, CA - Standard	$97.54	$55.50	$52.41	$3.09	$264,688
Indianapolis, IN - 75th %tile	$96.47	$54.43	$52.41	$2.02	$172,972
Richmond, VA - 75th %tile	$92.83	$50.79	$52.41	($1.62)	($139,034)
Miami, FL - 75th %tile	$90.07	$48.03	$52.41	($4.38)	($375,610)
National Average	$87.05	$45.01	$52.41	($7.40)	($634,472)
Los Angeles, CA - Standard	$82.26	$40.22	$52.41	($12.19)	($1,045,052)
Richmond, VA - Standard	$79.52	$37.48	$52.41	($14.93)	($1,279,914)
Indianapolis, IN - Standard	$78.07	$36.03	$78.07	($16.38)	($1,404,202)
Miami, FL - Standard	$77.15	$35.11	$52.41	($17.30)	($1,483,061)
Cleveland, OH - Standard	$76.45	$34.41	$76.45	($18.00)	($1,543,062)

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> value that one party (either the prospective lessee or lessor) would attribute to the property as a result of its proximity or convenience to sources of referrals or business otherwise generated for which payment may be made in whole or in part under Medicare, Medicaid and all other Federal health care programs.[32]
>
> Note that for purposes of paragraph (c) of this section, the term fair market value means that the value of the equipment when obtained from a manufacturer or professional distributor, but shall not be adjusted to reflect the additional value one party (either the prospective lessee or lessor) would attribute to the equipment as a result of its proximity or convenience to sources of referrals or business otherwise generated for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs.[33]

Depending on whether the regulations apply to a subject arrangement, these definitions should be used to determine FMV for compliance purposes.

In practice, however, many appraisers will also incorporate the "classic" definition of FMV as established by various authoritative bodies in the professional practice of appraisal.[34] They will also use standard appraisal methodology as understood and practiced by professional appraisers across multiple valuation disciplines.[35] They incorporate the classic FMV definition and standard appraisal methodology because they think that regulations under the Stark Law and the anti-kickback statute do not provide sufficiently detailed and systematic guidance for the credible determination of FMV.[36] Where standard appraisal methodology appears to conflict with healthcare regulations related to the determination of FMV, appraisers make a jurisdictional exception and cede to the regulatory requirements.[37]

As part of this composite definition of FMV, professional appraisers will generally focus on a key element of the classic definition, which is the idea of the exchange price between a hypothetical buyer and seller in a transaction. For example, the International Glossary of Business Valuation Terms defines FMV as follows:[38]

> The price, expressed in terms of cash equivalents, at which property would change hands between a hypothetical willing and able buyer and a *hypothetical* willing and able seller, acting at arm's length in an open and unrestricted market, when neither is under compulsion to buy or sell and when both have reasonable knowledge of the relevant facts.

The idea of the hypothetical buyer and seller is readily convertible into the healthcare regulatory definition of FMV that excludes the value or volume of referrals by assuming that the hypothetical buyer and seller are at arm's length without any referral relationships. Thus, the FMV analysis does not take into consideration referrals because the analysis is based on hypothetical parties who are not in a position to refer. This adjustment or addition to the classic definition, in which the hypothetical parties are assumed not to have a referral relationship, affords a significant reconciliation and bridge between the two definitions of FMV. For purposes of this article, the adjusted definition will be used to examine the issue of FMV as it relates to the various causes of losses in HOPs.[39]

Losses Resulting from Performance Issues

In looking at the FMV implications of various causes of losses in HOPs, some causes are easier than others to analyze from the perspective of FMV. Perhaps the most straightforward case is the one in which a hospital system simply makes mistakes in transitioning or operating the practice. Bumbled operations are not usually part of the expectations between the hypothetical buyer and seller for a transaction. The hypothetical buyer and seller are assumed to have reasonable operational ability consistent with typical buyers and sellers in the marketplace. Thus, the hypothetical buyer of the services (the employer) would be expected to operate the practice in a reasonable manner, and the hypothetical seller of the services (the physician) would expect compensation to be commensurate with reasonable operation. Any downside resulting from operational errors would accrue to the party at fault, which in this case in the hospital system. The fact that a particular health system dropped the ball does not alter the fundamental FMV analysis between the hypothetical parties.

Losses resulting from physicians with poor productivity or performance outcomes raise a different set of issues. In these fact patterns, the compensation was typically established based on historical productivity, which was significantly higher than the current level. The question of FMV becomes focused on expectations relative to the employee. Would the hypothetical buyer of services expect to pay compensation at the current level based on the physician's current level of productivity or performance? If the downturn in productivity or performance relates to the physician, it may be difficult to argue that productivity from years past is determinative of current or prospective FMV compensation.

Losses Resulting from Integration

A similar line of reasoning can be applied to the unintended consequences of hospital-physician integration. If losses are the result of a particular hospital system's integration of a practice to further the goals and strategies of that individual system, one can argue that such losses do not impact the FMV analysis of the hypothetical parties. The hypothetical or typical employer may not necessarily operate a physician practice in the way that the specific hospital has. Thus, the losses are a function of what a particular buyer did with a practice, not what the hypothetical buyer would do.[40]

One might raise the objection that market expectations exist for integration changes. While the market is certainly riding this most recent wave of integration, one cannot effectively argue that the current marketplace of employers for physicians is comprised solely of health systems. POPs still exist. In addition, not all HOPs experience adverse financial consequences from integration issues. Moreover, the typical health system may or may not decide to operate its physician practices the same way that a particular health system has.

It is difficult to argue, therefore, that the hypothetical buyer and seller exist in a marketplace defined solely by HOPs which, in effect, operate physician practices for the greater good of the IDS in the manner that

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a particular health system has done. Similar to the case of operator mis-management, it can be argued that hospital system changes that serve to benefit the IDS at the expense of the practice relate to the particular system only. The hypothetical seller or physician would not expect to give up compensation merely for the greater good or profitability of the IDS.[41]

Losses from Compensation- Setting Practices based on Survey Models

Situations where losses have resulted from the uncritical use of survey-based models can give rise to questions about whether such compensation is consistent with FMV. The fundamental question is whether FMV compensation can be established by ignoring local market factors and conditions, such as those related to reimbursement. It may be difficult to justify compensation levels, and any related losses, when these drivers were ignored in light of the recent studies and data that have emerged in the professional literature showing that local market factors produce varying physician compensation levels.

Moreover, one should also not fail to note that the Stark regulations point to location as one of the factors that should be considered in determining FMV for regulatory compliance purposes.[42] In short, there are significant arguments to be made that losses from narrowly conceived compensation models call into question the FMV of the underlying compensation.

It may be possible to make an argument in defense of past compensation and losses along the following lines of reasoning: Until the aforementioned studies and data related to the impact of local market reimbursement and physician compensation were made publicly available, the impact of reimbursement, for example, was not fully understood by the marketplace. As a result, the marketplace believed that survey-focused compensation practices had a greater degree of precision and validity than was actually warranted by the data. Yet, this argument may not suffice for future compensation in many arrangements, now that better information on use of the survey data is available. For these reasons, losses generated by certain survey-based valuation methods may present a FMV risk for health systems because they did not take into account the full array of factors that affect physician compensation in the local market setting.

At the same time, one should not fail to note the potential difficulties that hospital systems can have in implementing new compensation-setting practices that return to earnings-based compensation. Putting a practice back on a hypothetical basis before the impact of integration may be difficult. It requires identifying relevant operational areas for adjustment and calculating the financial impact of integration decisions. It may also involve complex regulatory and legal issues, such as those relating to the compensation value of ancillary services. One alternative is to use multiple surveys and multiple methods to determine FMV compensation using more sophisticated valuation methods and techniques.[43]

Conclusion

The causes of losses in HOPs can be varied, ranging from the unintended consequences of integration to survey-based compensation practices that were inadequate to address the range of factors affecting the economics of physician practices. Ordinary mishaps and physician disincentives can also be causes. Losses resulting from some causes may be more defensible than other causes from an FMV perspective. The critical factor for FMV is to be able to identify these causes and evaluate them along the lines of analysis discussed in this article. It should be noted that there have not been any recent and known lawsuits or investigations related to this specific issue of FMV compensation in HOPs with losses. With physician employment by health systems on the rise, however, the regulatory concerns related to this issue should be given thoughtful consideration.

Timothy Smith *is the national director of American Appraisal's healthcare valuation practice. Mr. Smith has over 19 years of experience in the healthcare industry, including more than 14 years at Hospital Corporation of America, Inc. ("HCA"), the nation's largest hospital company. During his tenure at HCA, he worked on hundreds of physician practice acquisition, divestiture, and employment deals. He also completed regulatory compliance reviews on hundreds of appraisals for acquisitions, divestitures, and compensation arrangements.*

Following his HCA tenure, Mr. Smith has worked in the appraisal profession with a focus on physician compensation arrangements. He has emerged as a thought leader in the area of healthcare compensation valuation ("CV"). He authored the first systematic account of the theory and practice of CV in the BVR/AHLA Guide to Healthcare Industry Compensation and Valuation, which he co-edited with Mark O. Dietrich. Mr. Smith is the most extensively published author on the newly emerging appraisal discipline of CV in the healthcare industry today.

He holds the Accredited in Business Valuation ("ABV") certification from the American Institute of Certified Public Accountants ("AICPA") and is a licensed CPA in two states. He can be reached at 214-459-6411 or tsmith@american-appraisal.com.

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Endnotes

1 The topic of commercial reasonableness raises a secondary but critical set of issues that revolve around the definition of commercial reasonableness and its relation to FMV that are beyond the scope of this article. For an in-depth discussion of these issues, see "BV, CV and the Relationship Between Fair Mark Value and Commercial Reasonableness" (Chapter 9), *BVR/AHLA Guide to Healthcare Industry Compensation and Valuation*, by Mark O. Dietrich, pp. 179 to 192.

2 For a copy of this survey, see www.mgma.com/ store/mgma-surveys/.

3 *Physicians Moving to Mid-Sized, Single-Specialty Practices,* Tracking Report No. 18, August 2007, and *A Snapshot of U.S. Physicians: Key Findings from the 2008 Health Tracking Physician Survey*, Data Bulletin No. 35, September 2009. www.hschange.org. These articles provide some analysis of the trends in physician practice size.

4 *Reasonable Compensation: Application and Analysis for Appraisal, Tax, and Management Purposes*, by Kevin Yeanoplos and Ron Seigneur, Business Valuation Resources, LLC (BVR), 2010, pp. 7-10.

5 See *Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power,* Research Brief, No. 16, November 2010, Center for Studying Health System Change, www.hschange.org.

6 See Medical Group Management Association, www.mgma.com for more information on phy¬sician practice dynamics.

7 It should be noted that for certain hospital-based specialties – such as anesthesiology, radiology, neonatology, or hospitalists – cover¬age payments or subsidies from hospitals are frequently needed to supplement the profes¬sional fees that such groups collect for providing coverage at a facility. Otherwise, such groups would only be able to pay below-market compensation levels, and would eventually be unable to provide services at the facility. The economics of hospital-based spe¬cialties, however, should be distinguished from those of office-based physician specialties. Thus, some of the points made in this article may not be fully applicable to the valuation of hospital-based coverage arrangements. For an in-depth discussion of this issue, see "An Introduction to Physician Services and Specialties" (Chapter 13), *BVR/AHLA Guide to Healthcare Industry Compensation and Valuation,* by Timothy Smith, section 4.0, Distinguishing Between Office-Based and Hospital-Based Physician Specialties, pp. 338-41.

8 *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, Robert A. Berenson, Paul B. Ginsburg and Nicole Kemper, *Health Affairs*, Vol. 29, No. 4, 2010. *Rising Hospital Employment of Physicians: Better Quality, Higher Costs?* Ann S. O'Malley, Amelia M. Bond and Robert A. Berenson, *Issue Brief*, No. 136, August 2011, Center for Studying Health System Change, www. hschange.org.

9 One of the lessons of the 1990s wave of physi¬cian practice acquisitions and employment by hospitals was that hospital systems frequently did not understand physician billing and col¬lection issues and performed poorly in this area in comparison to the pre-acquisition practice.

10 For example, diagnostic testing through echo¬cardiograms, EKGs, and nuclear camera studies are routinely provided in cardiology practices as part of the continuum of patient care services. Imaging modalities, such as MRI and CT, as frequently offered in orthopedic groups, while chemotherapy is part of most medical oncology practices. Primary care practices frequently provide basic lab and radiology (X-ray) services to patients. Most ob/gyn practices provide ultrasound services as part of prenatal care.

11 Based on the author's experience over two decades in reviewing rates for small and large organizations.

12 The Economics of Health System and Integrated Delivery System Practices (section 2.11), "The Economics of Physician Clinical Services and Compensation" (Chapter 14), *BVR/AHLA Guide to Healthcare Industry*

13 This shift is implicit in various presentations made at conferences and webinars in the past few years for various healthcare-related orga¬nizations or valuation societies. The content of most presentations about establishing FMV for employed physicians in HOPs usually focuses on the use of survey data.

14 Medicare Program; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Phase III), 72 Fed. Reg. 51015, September 5, 2007.

15 Popular surveys include those published by the Medical Group Management Association, ("MGMA"), www.mgma.com/store/mgma-surveys/, American Medical Group Associations ("AMGA"), www.ecommerce.amga.org/ iMISpublic/Core/Orders/product.aspx?catid=3&prodid=2330, Sullivan Cotter and Associates, ("SCA"), www.sullivancotter. com/surveys/physician-compensation-and-productivity-survey/, and Hospital and Healthcare Compensation Service, ("HHCS"), www.hhcsinc.com/hcsreports.htm.

16 Physician wRVUs are part of the Resource Based Relative Value Scale ("RBRVS") estab¬lished by the Centers for Medicare & Medicaid Services ("CMS"). They are intended to rate the time, mental effort, judgment, technical skill, physical effort, and stress associated with providing a specific medical procedure or service.

17 For a complete discussion of the economics of physician services, see "An Introduction to Physician Services and Specialties" and "The Economics of Physician Clinical Services and Compensation" (Chapters 13-14), *BVR/AHLA Guide to Healthcare Industry Compensation and Valuation*, by Timothy Smith, pp. 331 to 370.

18 See "Evaluating RVU-Based Compensation Arrangements," Health Lawyers Weekly, November 14, 2008, Mark O. Dietrich and Gregory D. Anderson and "Evaluating RVU-Based Compensation Arrangements" (Chapter 36), *BVR/AHLA Guide to Healthcare Industry Compensation and Valuation*, by Mark O. Dietrich and Gregory D. Anderson, pp. 835-41.

19 See *Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power*, Research Brief, No. 16, November 2010, Center for Studying Health System Change, www.hschange.org.

20 The market rates reported included the stan¬dard fee schedule and the 75th percentile negotiated rates, stated as a percentage of Medicare.

21 For a detailed account of the assumptions and analysis used in this example, see "How Reimbursement and Physician Compensation Vary by Market" (Chapter 37), *BVR/AHLA Guide to Healthcare Industry Compensation and Valuation*, by Timothy Smith, pp. 843-55.

22 While the latter outcome may not trigger sig¬nificant FMV compliance concerns, it certainly puts any potential employer of phy¬sicians, whether health system-owned or physician-owned, at a competitive disadvan¬tage for hiring, especially when other competitors in the market recognize these local dynamics.

23 Regional data is particularly used since such data is usually available with significant respondent sizes. Moreover, the surveys often publish summaries indicating material differ¬ences in regional compensation. Users frequently take these regional analyses and trends to be applicable to their local market.

24 For a detailed analysis of the impact of local market conditions, see "Healthcare Market Structure and its Implication for Valuation of Privately Held Provider Entities – An Empirical Analysis" (Chapter 3), The *BVR/ AHLA Guide to Healthcare Valuation, Third Edition*, by Mark O. Dietrich, pp. 99-129.

25 Based on the author's experience in both mar¬kets and on information provided by parties with significant knowledge of these markets.

26 As indicated in the HSC data and based on the author's experience.

27 For a detailed account of this study, see "An Analysis of the Relationship Between Productivity and Compensation in the MGMA Data and Its Implications for Valuation and Compensation-Setting Practices" (Chapter 39), *BVR/AHLA Guide to Healthcare Industry Compensation and Valuation*, by Timothy Smith, pp. 869-89.

28 This outcome is consistent with the findings of the previously discussed analysis of reim¬bursement and compensation and the work of Dietrich and Anderson.

29 For a presentation of alternative valuation methods, see "Valuing Physician Employment Arrangements for Clinical Services: Cost- and Income-Based Valuation Methods" (Chapter 24), *BVR/AHLA Guide to Healthcare Industry Compensation and Valuation*, by Timothy Smith, pp. 573-610.

30 For a discussion of such methods and analysis, see "Valuing Physician Employment Arrangements for Clinical Services: Cost- and Income-Based Valuation Methods" (Chapter 24), *BVR/AHLA Guide to Healthcare Industry Compensation and Valuation*, by Timothy Smith, pp. 573-610.

31 42 C.F.R. § 411.351. The Stark law is also known as the Ethics in Patients Referrals Act.

32 42 C.F.R. 1001.952(b)(6).

33 42 C.F.R. 1001.952(c)(6).

34 Examples include IRS Revenue Ruling 59-60 and the International Glossary of Business Valuation Terms, www.bvresources.com/ FreeDownloads/IntGlossaryBVTerms2001.pdf.

35 Professional appraisers are those valuation consultants who practice pursuant to an appraisal credential given by a professional appraisal organization, such as the American Society of Appraisers or the American Institute of Certified Public Accountants. Standard appraisal methodology considers the use and application of the market, cost, and income approaches and arrives at a conclu¬sion of value based on a synthesis and reconciliation of all applied approaches.

36 For further discussion of this issue, see "Complying With the Healthcare Definition of FMV in Appraisal Practice" (Chapter 6), *BVR/AHLA Guide to Healthcare Industry Compensation and Valuation*, by Timothy Smith, pp. 127-54.

37 Such deference to regulatory considerations is part of the standard appraisal methodology. See the jurisdictional exceptions provided under the Uniform Standards of Professional Appraisal Practice ("USPAP") and the Statement on *Standards for Valuations Services 1: Valuation of a Business, Business Ownership Interest, Security, or Intangible Asset,* issued by the American Institute of Certified Public Accountants.

38 The International Glossary was developed and adopted by the four major U.S. business appraisal professional societies (American Society of Appraisers, American Institute of Certified Public Accountants, Institute of Business Appraisal, and the National Association of Certified Valuation Analysts) along with their Canadian counterpart (Canadian Institute of Chartered Business Valuators).

39 For an in-depth discussion of reconciling the regulatory and classic definition of FMV, see "Complying With the Healthcare Definition of FMV in Appraisal Practice" (Chapter 6), BVR/AHLA *Guide to Healthcare Industry Compensation and Valuation*, by Timothy Smith, pp. 127-54.

40 Under the International Glossary of Business Valuation Terms, the value to a specific buyer or seller is deemed to be investment value, not FMV.

41 The hypothetical seller of the service, i.e., the physician, has alternatives in the marketplace, possibly including remaining in private practice or seeking employment in physician-owned pri¬vate practices.

42 Medicare Program; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Phase II), 69 Fed. Reg. 16107, March 26, 2004, and 72 Fed. Reg. 51015, September 5, 2007.

43 For a discussion of such methods and analysis, see "Valuing Physician Employment Arrangements for Clinical Services: Market-Based Valuation Methods" (Chapter 23), *BVR/AHLA Guide to Healthcare Industry Compensation and Valuation*, by Timothy Smith, pp. 537-72.

Healthcare in Transition: Retail Opportunities Abound

BY STEVE FEHLINGER, FHFMA, SR. CONSULTANT, LUBAWAY, MASTEN AND CO., LTD.

Healthcare costs are approaching 20 percent of GDP, outstripping inflation and economic growth with significantly more services provided to the aging baby boom generation. While health care is an important contributor to the economy, many feel 20 percent of GDP is not sustainable.

Healthcare spending in the United States was $2.6 trillion in 2010. By 2021, healthcare expenditures will reach $4.8 trillion or about one-fifth of the economy.[1] For American families in 2012, healthcare costs exceeded $20,000 for the first time.[2] For many families, this easily exceeds the cost of a mortgage premium and property taxes. For those employees whose healthcare premiums are paid by their employers, more costs are being passed on to employees making them consumers.

The Patient Protection and Affordable Care Act implemented in 2010, has created more consumers by embedding in law the concept of high deductible health plans. Although new federal tax subsidies will help reduce health insurance rates for many consumers, many individuals and families do not qualify. For those individuals and families that do qualify, others make up this subsidy in the form of higher taxes or some other cost transfer. These first-dollar-no-coverage policies make these people into consumers.

This creates an expanding market opportunity. With more patients in control to manage their own health care dollars it is in a consumer's best interest to shop around, compare prices and providers to select the medical services that are best fit their needs. Therefore, providers are encouraged to repackage and re-price their services, competing for patients based on price and quality.

The healthcare market is ripe for market encroachment by other industries eager to tap this large GDP healthcare segment. For example, Walmart, Costco, Target, CVS and others have expanded into the prescription drug business by offering low cost generic drugs and significant marketing influence. Other sectors of the healthcare sector will follow.

A case in point is Walgreen. Walgreen is the largest drugstore chain with fiscal 2013 sales of $72 billion and provides six million customers cost-effective pharmacy, health and wellness services and advice each day. The company operates 8,209 drugstores in 50 states, the District of Columbia, Puerto Rico and the U.S. Virgin Islands. The company's vision is "to be the first-choice in health and daily living for everyone in America, and beyond."[3]

In 2013, Walgreen expanded further into the health care system, becoming the first retail chain to offer diagnosis and treatment of chronic disease such as diabetes, asthma and hypertension. That same year, Walgreen was approved by CMS for three accountable care organizations.[4]

Walgreens is not stopping with retail clinics. On January 14, 2014, the Deerfield, IL company announced a relationship with Inovalon, Inc., a large scale data and analytics technology company to implement a patient assessment tool at more than 400 of their Walgreen Healthcare Clinic locations. By integrating data analytics of more than 8.3 billion medical events, the system will enable their nurse practitioners and physician assistants to play a greater role in the patient's experience.

Keith Dunleavy, M.D., president and CEO of Inovalon, recently stated, "Bringing advanced analytics to the point of care in real-time is a powerful benefit for patients being seen in today's highly complex healthcare environment." According to Inovalon ePASS (Electronic Patient Assessment Solution Suite) is expected to support patient assessments with individualized predictive analytics. This advanced insight is expected to and improve continuity of care, patient assessment and documentation, and score accuracy. The ePASS system supports Medicare Advantage, the commercial insurance exchange, and state Medicaid.[5]

Healthcare reform is expected to increase demand for primary care. Early on, retail clinics were deemed a threat to hospitals and Primary Care Physicians (PCPs). The landscape is fundamentally different today. Many hospitals and PCPs are operating at or near capacity. With capacity constraints, hospitals are developing relationships with retail clinics. Similarly, PCPs are developing relationships with retail clinics. These relationships allow hospitals and PCPs to off-load low acuity cases to free up capacity to deal with more complex, higher reimbursement cases. Accenture (a large multinational management consulting company) predicts that retail clinics will double from roughly 1,400 to more than 2,800 in three years. By moving patients to less expensive retail clinics, the consulting firm estimates that this will save $800 million dollars annually.[6]

The next retail innovation will be further cost reduction driven by the cost conscious self-service mindset, which lead to self-serve gas pumps, ATM's, and store checkouts. So why not self- service healthcare? Picture a kiosk or iPhone app with a diagnostic plugin purchased off the shelf at Walmart (or Walgreen) with diagnostic inputs for body mass, blood pressure, blood glucose, A1C hemoglobin, cholesterol ratio, temperature, and heart rate. The results are directed to your PCP for further follow up if necessary.

The cost of healthcare will continue to attract innovation and competitive pressure, which will drive down cost and drive price transparency because expanded consumer choice will demand it. This change will be disruptive and no one knows how our organizations will be impacted 10 years from now. This change will engender the need for metrics, financial reporting, financial accountability and guidance, which is what financial folks know how to do. While disruption often brings discomfort, with change comes opportunity. However, the financial traits that lead to success will not change. These include being flexible, working collaboratively with others, having a focus on results, and connecting with client, customers, patients and perhaps IBM's Wilson.

1 Centers for Medicare and Medicaid Services, National Health Expenditures Projections 2011-2021. **www.cms.gov/Research-Statistics-data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf**

2 2012 Milliman Medical Index.

3 Walgreens Newsroom: Walgreens Named Best-Integrated Mobile Experience in the 18thAnnual Webby Awards, April 30, 2014.

4 Chicagotribune.com. *Business-Walgreen Clinic*, April 4, 2013.

5 Walgreens Newsroom: Walgreens Brings Bid Data Analytics to Healthcare Clinics through Expanded Relationship with Inovation, January 30, 2014.

6 Accenture: Insight Driven Health, *Retail Clinics: From Foe to Friend?*, 2013

Price Transparency: A Growing Trend, but It Will Take A Village

BY DANIEL T. YUNKER, SVP, MCHC / CEO LAND OF LINCOLN HEALTH AND FIRST ILLINOIS HFMA'S PAST PRESIDENT

Until recently, patients rarely knew the cost of services until after receiving care. Consensus is growing, however, that better communication of medical costs will empower consumers to make more informed health care decisions. And while price transparency alone cannot transform the U.S. health care system, consumer advocates, employers, health plans and some providers are pushing for greater reporting and availability of the prices of health care services as a way to encourage consumers to choose low-cost, high quality providers and to promote competition based on the value of care.

Accordingly, the Healthcare Financial Management Association recently convened a task force made up of health plans, providers, consumers, employer groups and physician groups to prepare and release Price Transparency in Health Care, a report outlining guiding principles and recommendations for improving price transparency in health care. The key recommendations of this report included: health plans are in the best position to help their members find out the total estimated price of the service; hospitals should serve as a price information resource for uninsured people; consumers should receive price information in an easy-to-understand format, so they can make the most of the price information resources at their disposal; and employers can play a role in price transparency by encouraging their employees to be engaged in their health care decisions.

Amid growing calls for price transparency in health care, U.S. Health and Human Services Secretary Kathleen Sebelius in May 2013 ordered the release of fiscal year 2011 pricing data for the 100 most common hospital services and 30 common outpatient services. Then, in May 2013, the Centers for Medicare & Medicaid Services (CMS) released prices charged for 130 of the most commonly performed medical procedures at more than 3,000 hospitals. Finally, on April 9, 2014, CMS released on the agency's website data about the numbers and type of services that individual physicians and other health care professionals have delivered. All three releases put a spotlight on the drastic price differences for health care services in hospitals nationwide, as well as within communities, noting that consumers are largely unaware of the wide-ranging costs.

Over the past decade, efforts to raise price transparency through state legislation have also been on the rise. To date, 27 states, including Illinois, have enacted legislation related to transparency and disclosure. Last year, North Carolina passed one of the strongest state laws in the country, requiring the state's hospitals and ambulatory surgical centers to publicly disclose on a state website what they are paid by public and private insurers for 140 medical procedures and services. Thirty-four states require hospitals to report certain charges and payment rates, and lawmakers in more than 30 states have introduced legislation to increase the availability of rates charged at hospitals. Illinois law requires the state to collect, analyze and disseminate health care cost information in a uniform system. In addition, the state law requires that Illinois publish a consumer guide and for hospitals to provide prospective patients with the normal costs of services prior to treatment.

Additionally, hospitals are generally supportive of legislation that would allow individual states to determine price disclosure rules. The American Hospital Association agrees that consumers need useful information when making health care-related decisions for themselves and their families, which includes providing understandable information about health care costs.

Physicians have a responsibility to be aware of the costs of services, laboratory fees and drug costs and to help patients explore various treatments, as well. The physician community is embracing the notion that cost should be a factor in delivery, but only in conjunction with considerations about quality of services provided.

As consumers take more control of their health care dollars, consumerism will drive patients to pay more attention to price as part of the formula to define the value of the health care services they receive. Insurers have been working to make this sort of data more accessible and understandable to potential customers. Some insurance plans have recognized the trend toward price transparency, and are now offering fixed costs – copays – for physician visits, diagnostics and prescription drugs. Another trend to watch closely is the growing prevalence of narrow network insurance products. It is well documented that the consumer will trade broad access for cost, but they still have their preference of where they want to receive their care. These narrow network products can offer value to the consumer as long as the network of the product that the consumer is buying is transparent when they are making the purchasing decision.

It is critical that consumers have access to meaningful, transparent price information. Despite the release of a significant amount of information, it is still difficult to determine simple prices for medical procedures.

While the nation's health care system has made significant strides in publicly reporting data on provider performance and quality, more work still needs to be done to help pricing information flow freely, both overall and for specific services. A number of obstacles to achieving this goal exist, including the complexity of the health care marketplace itself.

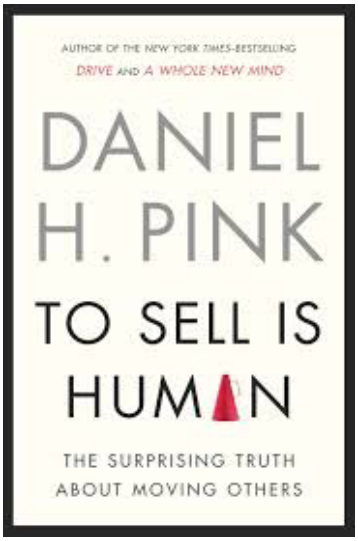
The process will continue gradually, since many of the proposed solutions have drawbacks and leave no easy answers. With so many critical allies in place, it is unlikely that transparency initiatives will lose momentum anytime soon. Only the future will determine what vertical(s) of the industry take(s) the leadership role in making it a reliable reality.

Welcome to the World of Sales

BY VICKIE AUSTIN

We are all in sales.

We may turn our noses up at the notion. The word "sales" makes us think of used car salesmen, hucksters or, if you're of a certain age, the Fuller Brush Man going door-to-door, hawking his wares. We shrink from the notion that we may be in the same category as those smarmy guys from the movie, "Glengarry Glen Ross," or the hapless Willy Loman in Arthur Miller's famous play "Death of a Salesman." Still, according to author Daniel Pink, we are all in sales.



Mr. Pink, a keynote speaker at this past June's ANI 2014, has written a brilliant book called To Sell is Human: The Surprising Truth About Moving Others which arose from his own assessment that he himself is a salesman. After cataloging how he spent his time, including meetings, e-mails and conversations with family, friends and colleagues, he surmised that he spends the majority of his days trying to coax others to part with their resources. "Pitching colleagues, persuading funders, cajoling kids," he writes... "We're all in sales now."

To prove his hypothesis, Mr. Pink commissioned a study with Working with Qualtrics, a research and data analytics company, to uncover how much time and energy people devote to moving others. The What Do You Do at Work? survey found that people now spend about 40 percent of their time at work engaged in what Mr. Pink calls "non-sales selling"—persuading, influencing and convincing others in ways that don't involve anyone actually buying anything. The respondents considered this aspect of their work critical to their professional success, "even in excess of the considerable amount of time they devote to it."

How about you? What are you selling? Perhaps you are among the number of HFMA members who proudly wear the actual title of salesman or saleswoman, representing one of the many excellent companies that support the world of healthcare financial management. And if so, please know that first paragraph meant no disrespect! But if you're a hospital CFO, aren't you selling every day, too? You're peddling influence, engaging in the persuasive act of helping the hospital spend—or save—its precious resources. You're selling great ideas up the ladder to the CEO, the board of directors or shareholders, or pitching a project to your peers or team. Your career success is directly proportionate to your ability to influence and inspire others.

Other factors support this premise that we're all in sales. The burgeoning of the entrepreneur economy is one of them. Research estimates that 30 percent of American workers now work on their own and by 2015 that number of non-traditional workers—freelancers, contractors and consultants—will reach 1.3 billion. Another factor is what Mr. Pink calls "elasticity," the new breadth of skills demanded by established companies. That means everyone from the call center employees to the engineers now have some responsibility for understanding and meeting customers' needs.

And the third factor Mr. Pink credits to this wave of non-sales sales jobs is the growth of the industry sector he calls "Ed-Med." The education and health services sector has risen "like a rocket" according to the analysis of U.S. Job Growth by Industry Sector sourced by the Bureau of Labor Statistics. As the number of manufacturing jobs has plummeted, jobs in education and medicine have peaked to become the largest job sector in the U.S. economy. And that sector of Ed-Med professionals has one mission in common: to move people. The ability to influence, persuade and to change behavior is key to success for those in the "white coat/white chalk" economy. That Ed-Med economy is, of course, where all HFMA members live.

Also, the Internet has shifted the balance of power from the seller to the buyer, or at least it has leveled the playing field. Ask any physician and you'll know that the role of the patient has morphed from one who blithely accepted a physician's diagnosis to someone who enters the doctor's office armed with loads of data. "Today's educators and health care professionals can no longer depend on the quasi-reverence that information asymmetry often afforded them," Mr. Pink says. "When the balance tilts in the opposite direction, what they do and how they do it must change. Ed-Med, beware."

Now that we know we're in sales, read "How to Be" and "What to Do," the sections in the book that provide us with new ways of thinking around our jobs. Driven by a sense of purpose and a desire to serve, we can sharpen our skills and refine our conversations in a way that truly moves people, improving their health, their lives and their futures. And in this brave new world of selling, that's everyone's job.

Vickie Austin

Vickie Austin is engaged in non-sales selling as a business and career coach and founder of CHOICES Worldwide. She helps individuals and organizations with marketing and strategic planning and she's a frequent speaker at HFMA chapters around the country. Follow her blog at www.vickieaustin.com or you can connect with her at vaustin@choicesworldwide.com, 312-213-1795, @Vickie_Austin and LinkedIn, www.linkedin.com/in/vickieaustin.

FI HFMA Spring Summit Recap

BY DAN YUNKER, PAST PRESIDENT, FI HFMA, SVP, METROPOLITAN CHICAGO HEALTHCARE COUNCIL, CEO, LAND OF LINCOLN HEALTH AND KATY ELDRIDGE, DIRECTOR OF ORTHOPEDICS/MSK, DUPAGE MEDICAL GROUP

A new model aims to help hospitals determine the ROI of their eThe FI HFMA 2014 Spring Summit was held April 10-11, 2014, at the Eaglewood Resort & Spa in Itasca, Illinois. Over 400 attendees enjoyed two days of learning, networking and socializing with healthcare industry leaders in an exceptional setting. Below are a couple of perspectives on the program. Be on the lookout for upcoming information for the FI HFMA 2014 Fall Summit, to be held October 30-31, 2014.

So much to talk about, so little time

The common themes that ran through the April Summit presentations were those we all experience every day: challenge, conflict and change. Skillful navigation through these turbulent waters will result in financial sustainability and will support the seismic shift from volume to value and from episodic care to a systemic approach driven by wellness and prevention.

The challenges are many and profound. Decreasing reimbursement, increasing costs, finite resources and an aging population make doing business in the current environment challenging. Looking ahead to the realities of increased risk drive home the need for sweeping change. Dr. Will Faber and Lucy Zielinski of Health Directions outlined the importance of cost avoidance through reduced readmissions, meaningful use penalties, no-pay events and the need to reduce costs associated with staff and staff turnover. Dr. Faber also encouraged organizations to focus on those things which they can control – improving patient experience and engagement, providing care in less costly settings and providing coordinated preventive services.

Executives and their teams are now faced with conflicting incentives and contract models, as well as contradictory philosophies in how they should manage the financial well-being of their organizations. As we shift to providing the right care for the patient in the right place at the right time, that translates into empty hospital beds. Greg Snow, VP Corporate Solutions for Conifer, stated that there are 1,900 fewer hospital IP admits per day in the Chicago area. Coupled with a "fragmented payment system and inefficient health reform implementation," this creates financial instability and a poor long-term outlook within the current financial framework.

Interestingly, Snow also stated that contrary to pre-reform predictions, ED (need to spell out ED?) use has not decreased with the increase in the number of patients with insurance. Patient visits to EDs have increased due to the shortage of PCPs, creating a new roadblock to patient access. Ironically, those who now have insurance are paying more for co-pays to be seen in the ED than they would in a PCP office. We are in a precarious time as structures are created to appropriately match demand and the shift begins away from higher cost treatment but before shared savings are being realized and distributed.

Dan Michelson, CEO of Strata Decision Technology, tells us that, "Things change and the fringe becomes the center." We see this most profoundly as population health management now takes center stage, as ever-increasing risk changes the fundamental way in which we do business. We are also seeing finance, which has traditionally been viewed as a back-office function, move to the forefront to partner with clinicians. With the need to control spending for services, we also need to work to control costs within the system.

An additional new pressure is being applied by consumers, many of whom are currently in high-deductible health plans, and are demanding pricing transparency. This is definitely a big change for all of health care. Berni Bussell of Beecher Carlson may have summed it up best: "Survival does not belong to the fittest, but to the most adaptive." The less time we spend fretting over the current state of things and focus on how best to create and implement sustainable strategies in these new and uncertain times, the greater our chances for long term success.

Technology Transforming AR Performance

Technology used to stabilize and transform market performance in the wake of the global financial crisis has made its way into healthcare AR management and was showcased at the First Illinois HFMA Spring Summit, where the President of ARxChange, Jim Zadoorian, engaged attendees with a presentation on how today's advanced analytical computing power is being leveraged to deliver market-based trade exchange methods. These methods are fueling national on-line accounts receivables marketplaces, or accounts receivable exchanges, where CFOs can instantaneously convert patient AR to its fair-market cash equivalent.

Here's how the technology works. Hospitals feed patient accounts into the system's advanced computing network that mines and improves data quality with the same investment-grade precision used throughout the financial services sector. Search engine technology scans these data looking for billable insurance opportunities and charity care eligibility. It then interprets any remaining account balances relative to their expected performance by correlating patient information, risk factors, and payment attributes from a range of financial databases.

Account balances are graded and categorized according to their fair-market value. They are then run through an array of performance scenarios that reveal "strike-points" where CFOs can extract optimal value on the AR exchange for their patient balances as they age through the revenue cycle. Accounts placed on the exchange are serviced under highly compliant and hospital-sanctioned safeguards. The net result is 20/20 visibility into the performance of today's patient receivables along with extended transparency into tomorrow's.

With over $12 billion in market activity, AR-based trade exchange technology is rapidly becoming an essential performance partner in the Affordable Care Act era—not as a temporary departure, but rather as a structural transformation and lasting change. It has taken hold across

(continued on page 21)

FI HFMA Spring Summit Recap (continued from page 20)

the U.S., in states like Georgia where the hospital association is actively working to enroll its membership in the marketplace. More recently, the Metropolitan Chicago Hospital Counsel also announced its rollout of this type of technology with ARxChange.

For additional information on the technology, please contact the First Illinois HFMA Chapter to access material presented at the Spring Summit.

Dan Yunker and Andrew Boron

Craig Greenberg and Angela Williams

Dr. Ralph Wuebker

Mike Nichols

HFMA Upcoming Events

Save the Date:

First Illinois Chapter HFMA Night
U.S. Cellular Field, Tuesday, August 26

Please join us for a First Illinois Chapter HFMA Night at U.S. Cellular Field on Tuesday August 26, as the White Sox take on the Cleveland Indians! Game time is 7:10 p.m., with the pre-game festivities beginning at 5:40 p.m. in the Miller Lite Extra Base Suite. This is a premier event that will include:

- Admission to the White Sox vs. Indians game starting at 7:10 pm
- Admission to HFMA Pre-Game Party in the Miller Lite Extra Base Suite
- Food buffet and drinks throughout the game
- Spectacular left field corner bird's-eye view
- Plasma TVs
- Climate-controlled air conditioning and private restrooms
- Private outdoor balcony seating

This event usually sells out fast. Be on the lookout for registration information in the next couple of weeks.

Fall Summit
October 30& 31

Joe Fifer, HFMA President and CEO will be one of the keynote speakers!

Presenting your FI HFMA 2014-2015 Officers & Board of Directors

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Secretary: Mary Treacy Shiff, Vice President Finance, Advocate Good Samaritan Hospital

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Kim McMahon, Senior Vice President, First Midwest Bank

Leading The Change:
HFMA National Theme for the 2014-2015 Chapter Year

As you can see in our new masthead, Leading The Change is this year's chapter theme from HFMA's national office. The theme is described in the context of the historical and unprecedented transformation in the U.S. healthcare system, and the need for financial leaders to lead the change. Below is a summary of this year's theme, as detailed on the HFMA national website (www.hfma.org):

Finance is at the heart of this transformation. We understand the money flow, structure, processes, payment methodologies, and resource utilization that will lower costs, improve care coordination, reward value, and create a positive patient experience.

Seizing this opportunity requires that healthcare finance professionals lead in a number of key ways:

- We need to chart the course. We need to show a bold and better future and the realistic steps to get there.
- We need to inspire. We need to show how to rise above the uncertainty and frustration of today and to be positive about a better future. We need a sense of urgency to change the delivery model!
- We need to empower. None of us can make big changes alone. Transforming healthcare requires that we develop great teams. That means being mentors to less experienced professionals and demonstrating trust by giving team members increasing levels of responsibility.
- We need to lead the change from the outside in and also from the inside out! We need to lead legislative reform, payer reform and delivery reform. Our leaders have great intelligence and experience and we need to leverage that and transform our industry!

If we lead with optimism and innovation, we can lead the healthcare transformation that our country needs!

Annual CFO Symposium and Invitation Golf Outing Held

The First Illinois Chapter held its Annual CFO Symposium and Invitational Golf Outing at Eagle Brook C.C. in Geneva, Ill. More than one hundred HFMA members, including more than 60 provider-based executives, gained thought-provoking insights from the keynote presentation on "*Medical Practice in America: Past, Present, and Future,*" delivered by Kurt Mosley, Vice President of Strategic Alliances for Merritt Hawkins. A highlight of the day came on the course when Jennifer Moon sunk a Hole-In-One on Hole #5! Way to go Jennifer!

The keynote was followed by a panel moderated by the FI HFMA Chapter President Dan Yunker, that included distinguished healthcare executives Steve Scogna, CEO at Northwest Community Healthcare, Vince Pryor, EVP/CFO at Edward-Elmhurst Healthcare, Michael Englehart, President at Advocate Physician Partners, and Dr. Bryan Becker, Associate VP for Operations at University of Illinois Hospital. The panel openly shared their perspectives on our transforming industry and market.

The afternoon included a social-filled afternoon of golf, prizes and a well-attended networking reception. The 2015 Symposium will be held at Eagle Brook C.C. on May 11, 2015. Provider-based members and First Illinois Chapter or 2015 Symposium sponsors interested in participating in this invitational event should mark their calendars and contact Pat Moran at patrick.moran@coniferhealth.com to express your interest.

CFO Golf Outing Co-Host Pat Moran with Tracy Packingham

Hole in One Winner Jennifer Moon, with Barb Lear and Patt Vilt.

FI HFMA Wins Big at HFMA Annual National Institute (ANI) Held in Las Vegas June 22-24, 2014

Your First Illinois Chapter received seven national awards at the annual Chapter President's Dinner held June 23, 2014, held annually at the national HFMA Annual National Institute (ANI).

HFMA's Awards and Recognition Program is designed to provide incentives and recognition of chapter activities to achieve results as defined by the Davis Chapter Management System (DCMS) policy. It is intended to focus chapters on important activities that add value for members or the Association while simultaneously encouraging innovation and improvement. Six award groups are identified:

- The Robert M. Shelton Award for Sustained Chapter Excellence
- The Helen M. Yerger Special Recognition Award
- The C. Henry Hottum Award for Educational Performance Improvement
- Awards of Excellence for Education, including: The Sister Mary Gerald Bronze Award of Excellence for Education
- The John M. Stag Silver Award of Excellence for Education
- The Charles F. Mehler Gold Award of Excellence for Education
- Award of Excellence for Improved Chapter Performance
- Awards of Excellence for Certification: Bronze, Silver and Gold Levels
- Awards of Excellence for Membership Growth and Retention: Bronze, Silver and Gold Levels

FI HFMA was recognized for the following awards and achievements, including four (4) Yerger Awards:

- **Outstanding Performance Innovation:** For the FI HFMA Spring and Fall Summits.
- **Performance Improvement:** For applying project management to increase the collaboration between the chapter and outside organizations.
- **Member Service:** By mobilizing certification study groups and organizing over 3,700 hours dedicated to exam preparation.
- **Improving Member Satisfaction:** By reducing emails and developing a chapter communications plan.

FI HFMA also received the following awards and recognition:

- **Hottum Award for Educational Performance Improvement,** by exceeding the chapter education hour goal by 64%.
- **Bronze Award for Excellence in Certification,** as 5.8% of our members are now certified.
- **Bronze Award for Excellence in Education,** by achieving 15.5 education hours per member.

Congratulations to Dan Yunker for his tireless leadership as Chapter President this year, and the entire FI HFMA board and officers. A special thank you to all of you who volunteered your time and talent to make this happen! We wouldn't be who we are without all the chapter volunteers who commit to our success. Thank you! We had a truly outstanding year that was clearly recognized by HFMA National. Being recognized at the National Institute made us all proud, and we are continuing to find ways to improve our service to our members.

Webinar Committee Announcements

HFMA - First Illinois Chapter would like to thank our past webinar committee chair Adam Lynch and committee members for their countless number of hours creating an exceptional virtual learning experience to our members! Concurrently, we would like to welcome our current committee chair Kauser Karwa, with some new and some past committee members. Below is a current listing of our webinar committee members.

Jennifer Johnson
Spiro Hountalas
Mary Corbett
Linda Klute
Bryan J Eckert
Sandra Sawyer
James DiGiorgio

We want to hear your thoughts!

The current tentative webinar schedule is outlined to the right. We would to hear from you on the topics that may be of interest to you. Please email your thoughts and suggestions to:

Kauser Karwa, Webinar Committee Chair
kauser.karwa@mcgladrey.com

Tentative Webinar Calendar		
July	15	W
	29	W
August	12	Tu
	21	Th
September	4	Th
	16	Tu
October	7	Tu
November	4	Tu
	18	Tu
December	3	W
	16	Tu
January	13	Tu
	27	Tu
February	10	Tu
	24	Tu
March	10	Tu
	24	Tu
April	7	Tu
May	5	Tu
	27	W

Dear Educators and Sponsors:

Do you have a healthcare education topic that you have been wanting to get in front of healthcare professionals, specifically, key stakeholders? I have some great news for you! I am pleased to invite you to present on a wide range of healthcare education topics relevant to our chapter members virtually via webinars. These topics are a great way to create awareness on pressing issues in healthcare, as well as provide CPE credits to our members. Please submit your topics by visiting the link (http://firstillinoishfma.org/resources/webinars/webinar-application/) and completing the webinar application.

Sincerely,

Kauser Karwa

Webinar Committee Chair
kauser.karwa@mcgladrey.com

Carl and FI HFMA leadership at 2014 LTC (from left: Rich Franco; Kevin Weinstein; Carl Pellettieri; Adam Lynch; Brian Katz and Katie White. Photographer, not pictured: Mary Treacy Shiff)

Certification Update

From the Certification Committee, it is with pleasure that we report that the chapter hit our benchmark for number of members certified. This metric is based on the percentage of members who are Certified Healthcare Finance Professionals (having passed the CHFP exam). As of the end of the 2013-14 year, our chapter had 5.6% of its members who were certified.

Thank you to all members who have gone through the rigorous process of preparing and taking the exam. It is quite an accomplishment. The chapter received a Bronze Award from National HFMA for Excellence in Certification. Our existing Certification Committee Chair, Tim Stadelmann, Director of Finance at Advocate Sherman Hospital, has been a key driver in our member certification efforts. We are excited to have Bart Richards, Managing Director of The Claro Group, join Tim as a co-chair of the committee.

As you might expect, the bar has already been set higher for this year. Bart and Tim will be seeking out members who are looking to enhance their careers with this prestigious certification. HFMA certification is widely recognized among healthcare finance professionals and their organizations. A growing number of organizations are requiring HFMA certification for their finance leaders.

Becoming certified distinguishes you as a leader, as well as a role model in the healthcare finance community. The CHFP credential enhances your credibility, supports your professional development, demonstrates a high level of commitment to the field, and validates your skills and knowledge. If you are interested in learning more about the process, please email Bart (brichards@theclarogroup.com), and we will put you in touch with the right person. Also, contact Bart for more information on how you can qualify for full reimbursement of exam expenses.

Our initial plans include continuing the exam prep class at the Fall Summit as we did last year. So look out! You might receive a phone call later this year from a Certification Committee member asking about your interest in improving your career.

Welcome New Members

Nsikak Akpakpan

Paul Altman

Jennifer Arrant
Manager, Denials Management, Northwest Community Healthcare

Matthew T. Barron
Healthcare Consultant

Casey Bartolucci
Director
HealthScape Advisors

Robin Cheskin
Finance Director
Accretive Health

Chris Cochran
Director, U.S. Bancorp

Heather Daas
Manager, Northwestern Memorial Hospital

Christie Davis
SVP/Relationship Manager
Wells Fargo

Steven P. Fuernstahl
COO Firsel Law Group, Ltd.

Nick Gialessas
Investment Banking Associate, U.S. Bancorp

Punkaj Gupta
Abbvie, Inc.

Amanda Holland
Senior Manager, Deloitte Consulting

Justin Tyler Howard
Director, Expense
Humana

Martin Leiter
Director, Expense Reduction Analysts

Joseph Malas
Executive Finance Director-Shared Revenue Cycle
Advocate Health Care

Keith Martino
Abbvie, Inc.

Jason Noggoh
Abbvie, Inc.

Michael G. Richardson
Vice President of Sales, Northern Region,
Hollis Cobb Associates

Keith Shindler
Attorney, The Shindler Law Firm

Jill Syftestad
Business Analyst
American Hospital Association

Karen Thier
Director HIM
Palos Community Hospital

Terry Wilson
Director Patient Financial Services
Copley Memorial Hospital

The First Illinois Chapter Sponsors

The First Illinois Chapter wishes to recognize and thank our sponsors for the 2013-2014 chapter year. Thank you for all your generous support of the chapter and its activities.

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Conifer
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Healthcare Insights
Impact Healthcare Services
Mcare
Medical Business Bureau
Lubaway Masten
Medical Business Associates
MiraMed
Pavillion Group
Performance Services
ProAssurance
SS & G
State Collection
Strategic Reimbursement
Tatum

First Illinois *Speaks*
HFMA's First Illinois Chapter Newsletter

Publication Information

Editor 2013-2014
Jim Watson ..... 630-928-5233 jim_watson@pbcgroup.com

Official Chapter Photographer
Randy Gelb ..... 847-227-4770 rgelb@mbb.net

Sponsorship
Chad Preston .....615-414-1025 cpreston@avectushealth.com

Design
DesignSpring Group, Kathy Bussert kbussert@designspringinc.com

HFMA Editorial Guidelines

First Illinois Speaks is the newsletter of the First Illinois Chapter of HFMA. *First Illinois Speaks* is published 4 times per year. Newsletter articles are written by professionals in the healthcare industry, typically chapter members, for professionals in the healthcare industry. We encourage members and other interested parties to submit materials for publication. The Editor reserves the right to edit material for content and length and also reserves the right to reject any contribution. Articles published elsewhere may on occasion be reprinted, with permission, in *First Illinois Speaks*. Requests for permission to reprint an article in another publication should be directed to the Editor. Please send all correspondence and material to the editor listed above.

The statements and opinions appearing in articles are those of the authors and not necessarily those of the First Illinois Chapter HFMA. The staff believes that the contents of *First Illinois Speaks* are interesting and thought-provoking but the staff has no authority to speak for the Officers or Board of Directors of the First Illinois Chapter HFMA. Readers are invited to comment on the opinions the authors express. Letters to the editor are invited, subject to condensation and editing. *First Illinois Speaks* does not promote commercial services, products, or organizations in its editorial content. Materials submitted for consideration should not mention or promote specific commercial services, proprietary products or organizations.

Style

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
October 2014	September 10, 2014
January 2015	December 10, 2015
April 2015	March 10, 2015
July 2015	June 10, 2015