First Illinois Speaks
hfma healthcare financial management association
HFMA's First Illinois Chapter Newsletter
October 2015

GO BEYOND

Highlights and Recap First Illinois Chapter Events begin on page 18

News, Events & Updates

In This Issue

Healthcare Liability Insurance: Is Your Hospital Addressing Current and Emerging Challenges?

BY PAUL SULASKI, PROASSURANCE VICE PRESIDENT, HOSPITALS & FACILITIES

Healthcare is dynamic by its very nature, but rarely has U.S. healthcare experienced change on the scale of the past two years, with:

- over 10 million* people who have enrolled and paid for health insurance coverage through the Affordable Care Act (as of March 2015)
- an unprecedented number of hospital and medical group consolidations
- urgent care centers, retail clinics, and other outpatient facilities proliferating
- rapid adoption of electronic health records and an increasing number of healthcare data breaches
- a growing shortage of physicians

How will these trends affect healthcare liability and what can hospitals do to prepare? You can help your organization meet the challenges of an evolving healthcare environment by clarifying what's most important. You also must understand coverage options and the balance of risk and control. This two-pronged approach of knowing what's most important and understanding risk/control options will help you ensure the right fit for your hospital's needs.

What Is Most Important to Your Organization?

To be effective, your healthcare liability insurance program must align with your hospital's objectives, systems, and risk tolerance. This means your important control is respected—control over how the program is structured, how claims are handled, and strategies for containing costs.

You can help ensure program alignment with hospital objectives by considering:

- **Cost**—How can you utilize economies of scale, loss control strategies, and alternative options to reduce your hospital's healthcare liability insurance premium? Can your insurance provider bundle coverages to lower costs and deliver a single-source solution (such as umbrella, D&O, E&O, cyber liability, etc.)?
- **Risk tolerance**—What level of risk is your organization willing to assume? Can your insurance provider structure a risk sharing program that addresses both budgetary constraints and your organization's comfort level?

(continued on page 2)

Healthcare Liability Insurance: Is Your Hospital Addressing Current and Emerging Challenges?

(continued from page 1)

- **Control**—How can you help ensure your hospital retains important control over claims handling and key program parameters?
- **Mergers, acquisitions, growth**—What options are available to help make it easier to address coverage issues associated with consolidating new physicians and healthcare providers into your organization?
- **Loss control**—Does your hospital's current approach address emerging healthcare liability risks? Would your risk management team benefit from added assistance and resources?

Many large healthcare organizations work with an insurance broker when deciding how to handle liability insurance. They then review how established insurance companies can offer expertise and resources to meet their needs, along with:

- **Financial strength and ratings**—Does the company have a history of proven financial stability?
- **Experience insuring hospitals and large healthcare entities**—Does the insurer have extensive experience with a track record of successfully serving this complex market?
- **Ability to provide alternative and customized insurance programs**—Traditional healthcare professional liability coverage may not meet the needs of many of today's complex healthcare organizations. Large organizations may wish to retain risk and, potentially, share in good outcomes. Can the insurer provide alternatives tailored to your organization's unique needs?
- **Level of transparency**—Does the insurer provide straight facts, respect your expertise and knowledge, and work to help you fully understand how your insurance program could be structured and what services are included?
- **Ease of doing business**—Is the insurer vigilant in anticipating and helping you solve problems? Do they make it as easy as possible for you to secure coverage and services to fit your organization's criteria?
- **Claims defense**—Does the insurer commit to providing the level of claims handling you want for the level of risk you are willing to assume?

Alternative Options

Hospitals and large healthcare organizations increasingly seek more sophisticated and customized alternatives for managing and financing losses associated with risk. Options within alternative risk include numerous methods of retaining, transferring, or financing risk. Advantages of these options include a high level of control and the opportunity for cost savings.

Another alternative for organizations large enough to support necessary start-up costs (generally those with premiums of $1 million-plus) is a self-insurance program. These programs allow the hospital

(continued on page 3)

(continued from page 2)

to directly assume the risk of claims. Various types of self-insurance are allowed under federal law, including:

- Risk Retention Groups (RRGs) are corporations or limited liability associations that are organized for, and whose primary activity consists of, assuming and spreading some or all of the liability exposure of its members. An RRG must be owned by its members or by an organization that is owned by members of the group. Members contribute capital, and membership is limited to individuals engaged in similar activities. RRGs are not subject to state regulatory requirements, and their members are not protected by their state's guaranty fund should the group become insolvent.
- Risk Purchasing Groups (RPGs) are formed by a group of individuals or entities with similar or related liability risks to purchase liability insurance coverage on a group basis. This is not an insurance company. The RPG does not underwrite its risks, but instead purchases coverage for its members, usually from an established insurance company licensed in at least one state.
- Captive Insurance Company—Captive insurers are alternative risk vehicles that allow organizations to form an insurance company subsidiary to finance retained losses in a formal structure. Common types of captives include single parent, association, group, agency, and rent-a-captives. Healthcare organizations can use a "cell" of an existing captive facility for much easier captive-option access. Captives are not licensed by individual states, and many are formed "offshore" at locations where regulation is not as stringent. This entity does not qualify for protection under state guaranty funds and retains responsibility for all dollar losses accruing from claims.

Unique solutions that address the needs of growing and merging healthcare organizations also are in demand. Innovative insurers are providing flexible protection, consultation, and service options to create the optimal program for a hospital's situation and preferences. For example:

- Hospitals can purchase unique joint hospital/physician professional liability coverage
- Hospitals can allow acquired physician practices to maintain their own insurance and seamlessly merge risk into the hospital's insurance program through risk transfer or retention layers

Traditional Options

Healthcare organizations that do not meet premium levels necessary for self-insurance or that find such arrangements outside their comfort zone may benefit from traditional options. Insurance companies that are experienced with hospitals and healthcare entities can work with you to craft a policy with the coverage you desire. For example, you may save money through deductibles, retrospective rating, or staff participation in specific risk reduction activities or training. You also can take advantage of the insurance company's risk resources and expertise to augment your patient safety efforts.

Expertise is Key

Whether you take an alternative or traditional approach to mitigating risk, it's vitally important you are clear about your healthcare organization's needs and are comfortable with the company you choose. Working with insurance experts who have proven experience and success in healthcare liability insurance and risk options—along with selecting a stable and expert carrier—will net the best result.

*U.S. Department of Health & Human Services, press release June 2, 2015, http://www.hhs.gov/news/press/2015pres/06/20150602a.html

This article is not intended to provide legal advice. *ProAssurance is a national provider of healthcare liability insurance and risk resource services. For more information, visit ProAssurance.com.*

President's Message

HFMA: A BETTER VERISON OF FANTASY FOOTBALL

Today, 56 million Americans and Canadians are estimated to play fantasy sports according to Fantasy Sports Trade Association[1]. First Illinois members are not immune to the appeal. Many enjoy playing fantasy football or rotisserie baseball. Some of us are in leagues together or meet up to draft players, watch important games and exchange awards over lunch or drinks.

If you are one of the 56 million of us that enjoy playing fantasy football, then I think you will love volunteering with HFMA. I know you're saying to yourself, "okay, that's a stretch," but just hear me out.

Playing a fantasy sport gives you the opportunity to compete against friends and strangers. Each week you might earn or lose money or, more importantly, bragging rights. The connection seems fleeting.

Let's compare that experience to volunteering with First Illinois HFMA. We are still engaged in competition but instead of this being an individual effort, we focus on team goals. We are seeking to outperform the 68 other local chapters by: 1) offering more education, 2) increasing member satisfaction and 3) growing our membership. I'm biased, but I think we're always at the top of the leaderboard.

Both endeavors require a little work. For fantasy sports, a great deal of time (maybe too much, according to my wife) is spent analyzing player statistics and match-ups. Through volunteering with HFMA, the contribution of time and effort relates directly to your profession and has the added benefit of being actually productive.

Fantasy sports are just plain fun, and it makes watching sports more appealing. That's probably why 56 million people play. I know I have a skewed idea of fun, but organizing an education event and seeing my industry colleagues is very satisfying. Like I mentioned in the last newsletter, being a part of HFMA has locally and nationally expanded my friendships.

I sincerely doubt that many fantasy accounts will be deleted in favor of volunteering for HFMA as a result of this article. My desire is simply for HFMA volunteering to be considered in a different context. In doing so you may experience greater personal growth and, dare I say, a little fun.

Who am I kidding, HFMA absolutely offers personal growth, but it can't compare to being a team "owner" of Team Tickle Me Al-Mo or My Favorite Marshawn. What I really need is for someone to trade me for the New Orleans Saints defense. Seriously – anyone?

Adam Lynch
2015 – 2016 First Illinois,
HFMA Chapter President

[1] http://fsta.org/research/industry-demographics/

Outsourced Healthcare Call Centers: Hallmarks of Excellence

BY BRIAN BAUGHMAN, MCKESSON BUSINESS PERFORMANCE SERVICES

As more hospitals and health systems embrace the concept of value-based care, patient satisfaction is becoming for them an ever more important measurement of success. Patient satisfaction is driven by positive encounters at every point of contact within an organization. This includes telephone encounters, whether the issue is something as simple as requesting directions, or as complex as a Spanish-speaking patient calling about a bee sting.

To help drive up patient satisfaction scores, some two-thirds of U.S. hospitals utilize call centers to support patients. Call centers are used for nurse advice, pre-admission education, disease management programs, post-discharge follow-up, appointment scheduling, medication refills, marketing campaigns, referrals, triage, billing and collections. The cost of maintaining in-house call centers is increasing as call volumes go up. And as physician and hospital reimbursements decline, it's no wonder that hospitals are seeking to improve call center efficiency.

While one approach to reduce call volume and achieve efficiency is to offload calls to online and automated systems, research shows that people want to connect with live human beings when they need help and that just two bad telephone experiences greatly diminishes their opinion of a service provider.

The trend, therefore, among hospitals and hospital systems that want to increase patient satisfaction, is moving toward centralizing and outsourcing call centers to reduce costs and maintain the human connection. Theoretically, this is an excellent idea, but actual results can vary. Many third-party call center providers are too specialized, offering only a few services, or not specialized enough, serving multiple industries generally. This results in frustrated callers who either don't connect with someone who can help them or who feel as though the agent at the other end of the line doesn't know enough to help them.

Hallmarks of Excellence

However, a centralized, outsourced call center solution that delivers both efficiency and a positive patient experience is one that displays these 10 hallmarks of excellence:

1. Broad, deep healthcare expertise, with extensive healthcare experience and knowledge that enables the delivery of call center services across a wide range of hospital functions. Representatives are able to determine quickly what kind of help each caller needs and have the expertise to offer that help or know who else does.
2. Personalized attention and accountability. A truly effective call center takes time to adapt to the unique circumstances, personality and experiences of the hospital's personnel, capabilities and community mix. As a result, they feel and act as if they are an extension of the hospital's own staff.
3. Extended availability. An outsourced call center should deliver the level of availability required by a hospital's community, whether it's Monday through Friday from 7 a.m. to 7 p.m. or 24 x7.
4. Transparency. A hospital should have complete visibility – real-time and historical – into all activity and performance of the outsourced call center.
5. Scalability. The call center should be prepared to adjust its representative base to match the hospital's needs as the hospital grows and develops over time.
6. Security. A call center provider must have the technology and certifications to ensure uninterrupted service and secured individual lines of communications for maximum patient privacy.
7. Robust infrastructure, with back-up power to ensure availability within seconds of any interruption.
8. Quality. A call center should provide much more than a set of warm bodies reading from scripts. Representatives should have skills such as compassion and empathy as well as call center experience and fluency in the same languages as the hospital's patient population. The call center provider should offer regular, ongoing training for all its representatives.
9. Investment in representatives. The call center provider should treat its employees well, providing attractive benefits and paid time off, so that they will feel valued and will work harder to make callers feel that way as well.
10. Affordability. An outsourced call center provider should provide the hospital significant savings over building and maintaining an in-house call center.

Benefits of the Right Call Center Solution

A healthcare call center that provides these hallmarks of excellence will provide hospitals and health systems a wide range of benefits, including:

- Patients will receive the information and services they need faster.
- Patients will spend less time on hold.
- Hospitals will be seen as more responsive.
- Patient satisfaction will rise.
- Hospitals will achieve greater call center efficiency.
- Hospitals will save money over their in-house call centers.

Brian Baughman is the Territory Vice President for the Northeast & Midwest with McKesson Business Performance Services, which provides a comprehensive array of services available to help hospitals and physicians adapt to the post-reform environment. McKesson BPS helps organizations optimize revenue, reduce operational costs and minimize audit risk. In addition, McKesson BPS works with hospitals and physician groups nationwide to implement new care delivery models and payment systems, helping to deliver the tools and resources to effectively manage patient populations while continuing to deliver the highest level of care. Brian may be reached at Brian.Baughman@McKesson.com or at 724-777-1316.

Career Corner

BY VICKIE AUSTIN

*This new column features a First Illinois HFMA Chapter member's career journey. This quarter's column profiles **Shane Ramsey,** senior director of Enterprise Solutions at Healthgrades and co-editor of "First Illinois Speaks!"*

Shane Ramsey

Q: What was your first job?

A: My first job after college was selling copiers and fax machines. After a year, a senior healthcare sales executive, Robin Schroder-Janonis—someone who is still a friend and mentor 15 years later—took a chance on me. She hired me as a sales account executive, partnering with hospitals for mobile MRI, CT and PET/CT services.

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

A: My mother. I witnessed her helping people her entire life. Co-workers, elderly neighbors or family members, friends and every stray animal in town… I think she just feels compelled to help. I also grew up helping my hero, my grandfather, a World War II Navy veteran by honor and a mechanic by trade. He would spend his evenings and weekends fixing cars for people who couldn't afford to have their cars fixed. I guess that's where my mother got it.

Q: What had you choose healthcare financial management?

A: I've always loved numbers: I have a bachelor's degree in business with a major in finance [from Eastern Illinois University], and an MBA [from Loyola]. My previous roles in healthcare technology sales led me to the job I'm doing now for Healthgrades. I made a conscious decision to be part of the future of healthcare solutions. I knew I wanted to get involved with strategy and marketing and this job gets me much closer to the healthcare consumer. I want my daughters Brooke (5) and Avery (4) to grow up in a healthier world.

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

A: One of my most humbling moments was my first meeting with a customer in Michigan. When I learned several executives were coming to the meeting I felt like a big shot. As it turns out, they showed up just to point out all the things we were doing wrong! The executives spent a total of three hours letting me have it. I walked out with my tail between my legs and with 10 pages of notes to help resolve their issues. Fortunately, to this day I've stayed connected with several people from that system.

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

A: You have to constantly remind yourself of why you're doing what you are doing. My reasons include: my family, helping patients and consumers and making a difference. One of my favorite quotes is by Abraham Lincoln who said, "It's better to remain silent and let people think you are a fool than to open your mouth and prove them right." The lesson is to listen, not speak.

Q: I noticed on your LinkedIn profile that you are co-founder of The Patrick Foundation, Inc. What is that?

A: On Thanksgiving morning in 2004 I received a phone call from my closest friend's mother telling me that my friend, Pat, had been killed earlier that morning. He was a police officer for the Burbank Police Department and he was on his way to his family's Thanksgiving celebration where he was going to tell them he was engaged to be married. Even though he was off-duty, Pat had pulled over on I-55 in a snowstorm to help a family get their van out of a ditch. While helping this family another vehicle hit a patch of ice and struck and killed Pat.

His family, friends, fellow officers and I created The Patrick Foundation, Inc., to raise funds to support groups that meant a lot to Pat. We've given scholarships for graduates seeking degrees in community service and supported local sports teams that can't afford their gear—Pat loved sports. We've also sent several police officers to Washington, D.C., for National Police Memorial Week so they can pay respect to their fallen sisters and brothers in blue.

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

A: While the education events are amazing, the biggest contribution that HFMA has made to my career is in the networking and friendships. I'm relatively new to the association and I can see how partnerships and friendships have been established and maintained for decades. I can't even think of First Illinois HFMA and not think of Dan Yunker and Jim Watson. There's a quality of sincere concern and willingness among members to support fellow HFMA members.

Q: What are you reading?

*A: The last three books I read were **10% Happier** by Dan Harris, **The Other Wes Moore** by Wes Moore and **American Sniper** by Chris Kyle, Scott McEwen, and Jim DeFelice. Right now I'm reading **Strong Fathers, Strong Daughters** by Meg Meeker. **Mindfulness** by Mark Williams and Danny Perlman is next on my list.*

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

A: Work hard and focus on your goals. Never forget what is most important to you and remember what you can offer. Don't be afraid to get outside of your comfort zone. Stay positive and be happy!

Vickie Austin

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

How The Municipal Advisor Rule Affects Hospital Bond Financing

BY GRANT GOODMAND, VICE PRESIDENT, LANCASTER POLLARD

Hospital bond financing is a complex undertaking that can present a number of unique challenges. That is why finding an investment bank with experience as a financial advisor and underwriter is important. An investment bank with these credentials should have a clear understanding of the borrower, underwriter, and investor perspectives, and as a result, know how to negotiate with each party.

But with the introduction of the Municipal Advisor Rule, selection of an investment bank may now also be influenced by reviewing the investment bank's compliance with the rule's legal standard for municipal advisors. This standard governs a municipal advisor's conduct, recordkeeping, registration and qualifications. According to the rule, a municipal advisor has a fiduciary duty to act in the best interest of their client. But there are various aspects and options related to the Municipal Advisor Rule that can influence how a hospital might identify a suitable municipal advisor and receive advice for their planned bond transactions.

Origins of the Municipal Advisor Rule

The Municipal Advisor Rule was rooted in Section 975 of the 2010 Dodd-Frank Wall Street Reform and Consumer Protection Act, which required municipal advisors to register with the Securities and Exchange Commission (SEC). In the fall of 2013, the SEC adopted new municipal advisor registration rules that were created by the Municipal Securities Rulemaking Board (MSRB). On July 1, 2014, the MSRB's Municipal Advisor Rule went into effect, requiring municipal advisors to register with the MSRB and the SEC. The rule codified a professional qualification standard for municipal advisors, outlined business policies and procedures, and allowed for examinations by enforcement agencies and regulatory organizations to ensure rule compliance. The Municipal Advisor Rule was designed to prevent fraud and pay-to-play practices, eliminate conflicts of interest and require financial advisors to place the welfare of their clients' assets ahead of their own interests. If a municipal advisor is found to be in violation of the rule, penalties can include fines, restitution and suspension, or prohibition from engaging in municipal advisor activities or other securities business.

In short, the Municipal Advisor Rule is a regulatory action that oversees the practices of municipal advisors who counsel municipalities on financial issues such as bond offerings. It demands that municipal advisors have an explicit fiduciary responsibility to their client and ultimately protects municipal entities from financial advisors who may have a self-interest in a financial deal.

On a side note, the MSRB also issued Rule G-17 which focused on regulating underwriters during the issuance process for municipal securities. Unlike a municipal advisor, an underwriter is not required to act in the issuer's best interests. An underwriter does, however, have a duty to purchase and sell securities at a fair price. Because the underwriter's function is to negotiate the purchase price, interest rate and other terms of the bonds with the issuer, and then resell those bonds to investors, there is a natural division of financial interest between the issuer of the bonds and the underwriter.

For a hospital seeking to enter into a municipal bond transaction, the Municipal Advisor Rule provides some guidance. Based on the rule, it may make sense to identify investment banks who are:

- SEC- and MSRB-registered municipal advisors
- Experienced financial advisors and underwriters
- Proven negotiators in bond financing

This approach may result in finding investment banks that can fulfill their fiduciary obligation to bond issuers. Investment banks with this profile should also be equipped to undertake bond financing negotiations based on their experience in debt underwriting and their ability to understand borrower, underwriter and investor perspectives.

Options When Using A Municipal Advisor

If a hospital wants to receive advice from a market participant, they will need to hire a municipal advisor to represent them as an Independent Registered Municipal Advisor (IRMA) and satisfy the following IRMA exemption requirements:

- The IRMA must be a registered municipal agent.

(continued on page 8)

How The Municipal Advisor Rule Affects Hospital Bond Financing (continued from page 7)

- The IRMA cannot have had an association for the past two years with the market participant(s) seeking the exemption.
- The market participant(s) seeking to rely on this exemption must receive a written statement from the hospital explaining that the hospital is represented by and will rely on the advice of the IRMA.
- The market participant(s) seeking the exemption will provide written disclosures to the hospital and the IRMA that they are not a municipal advisor and are not subject to the fiduciary obligations of a municipal advisor.

The IRMA exemption allows the IRMA to help the hospital evaluate financial advice from other market participants and identify potential conflicts of interest. Before hiring an IRMA, hospitals should:

- Make sure the IRMA meets all licensing and regulatory requirements
- Confirm that the IRMA is listed as a broker-dealer on FINRA.org
- Check the IRMA's references

If a hospital wants a broker-dealer to serve as the bond underwriter, the following conditions should be fulfilled to meet the Municipal Advisor Rule's underwriter exclusion:

- The broker-dealer is engaged to provide advice for a specific issuance of municipal securities.
- An engagement letter is executed and approved of by the hospital requesting the broker-dealer's underwriting services for a specific issuance of municipal securities.

Because this exclusion is limited to servicing a specific transaction, it is not an option for hospitals that haven't decided on their financing plan. Also, hospitals can only receive advice from broker-dealers retained for a specific transaction who meet the underwriter exclusion requirements. It's important to note that a broker-dealer that is acting as a municipal advisor for a hospital is prohibited from switching to the role of underwriter for the same issuance of municipal securities by MSRB Rule G-23.

A hospital can also obtain advice from a municipal advisor by writing a request for proposal (RFP) seeking input on specific objectives. The RFP exemption requirements are:

- The RFP is sent to at least three firms or is publicly posted on the hospital's website
- The RFP is open for a specified amount of time (six months is considered reasonable)

If the hospital is interested in soliciting ideas from pre-screened or pre-qualified market participants, "mini RFPs" can target those participants. Mini RFP requirements include that:

- The RFP be open for a specified amount of time (three months is considered reasonable).
- The RFP be sent to either the entire pool or at least three of the pre-qualified market participants.

A Municipal Advisor Case Study

The Loma Linda University Medical Center (LLUMC) located in Loma Linda, California provides an example of the role a municipal advisor can play in hospital bond financing. LLUMC operates six hospitals and began a campus transformation plan for 2016 by targeting debt consolidation with a focus on long-term sustainability. Serving as their municipal advisor, Lancaster Pollard worked with LLUMC's executive team to identify the best financial strategy. The firm strategized with LLUMC on their 2014 bonds to support the optimization of the existing debt structure. The refunding leveraged favorable market conditions to secure long-term capital ahead of LLUMC's scheduled campus redevelopment plans.

The project resulted in the placement of $683.3 million in Series 2014 refunding revenue bonds, qualifying it as one of the largest "BBB" rated health care transactions in the history of the municipal bond market. Acting in its fiduciary role as the municipal advisor, Lancaster Pollard coordinated and handled negotiations with various third parties to create efficiencies resulting in cost savings for the hospital. In a final review of the project:

- LLUMC's debt was refunded
- Funding was provided for additional capital expenditures
- New permanent debt structure included a long-term, low fixed-interest rate
- A lower debt service resulted in substantial savings for LLUMC

The Bottom Line

The regulatory changes of the Municipal Advisor Rule have the potential to safeguard hospitals that are planning bond transactions. Hospital leadership should consider educating themselves on these new regulations and using them to their benefit as appropriate. Identifying investment banks with a record of success in bond financing negotiations is a necessary first step. Experience in debt underwriting and an ability to understand borrower, underwriter and investor perspectives gives an investment bank serving as a municipal advisor the ability to fulfill their fiduciary obligation to the hospital, align their fees to the transaction, and focus on a mutually beneficial outcome.

Grant Goodman

Grant Goodman is a vice president with Lancaster Pollard in Newport Beach, California, and is the lead health care banker in Northern California and Nevada. Over the course of his career, he has underwritten and advised on transactions in excess of $750 million. He earned a bachelor of business administration degree with a concentration in management from the University of San Diego. Additionally, he holds an investment banking representative license (Series 79) and general securities representative licenses (Series 7 & Series 63).

Using Marketing's Playbook to Engage Patients Financially

BY KRISTEN JACOBSEN, DIRECTOR OF MARKETING

Revenue cycle leaders at the HIMSS Revenue Cycle Solutions Summit in Chicago talked about key challenges facing the industry. They tackled tough topics, including ICD-10 and the growing complexity of collecting patient balances. They talked with consistency about the need for change, the goal of patient centricity and the importance of metrics to track payment performance.

It struck me that many proven tactics marketers use to engage potential consumers can help financial leaders improve results in the patient-pay revenue cycle. Marketers consider demographics, personas, channels, messaging, conversion rates and more to tailor communications that drive results. That model can prove effective for patient financial engagement as well, leading to better experiences for patients and better financial results for the provider.

Consider the following:

Segment your audience

Marketers seek to understand common needs and behaviors of their audience because different segments are moved to action for different reasons. That's true, too, of patients. No two patients are the same. Each has distinct financial needs or preferences that have an impact on how, when and if they choose to pay their healthcare bill. Understanding common needs, motivators and payment patterns within your patient population—and building common profiles for those segments—is the first step in building a more effective financial communication framework.

Optimize your messaging

Segmentation allows you to vary messages to patients to achieve the best results. For example, you might emphasize the availability of online payments for a demographic segment that's inclined to pay in the moment. Or, you might tailor messages in printed bills, text communications and online payment portals based on the balance due, past payment tendencies or cycle. The right channel of communication can be as important as the right message. Therefore, you can establish messaging strategies that connect with patients where and when they choose to pay.

Measure conversions and results

Marketers measure success in conversions: a web view to an inquiry, then an inquiry to a sale. Through tracking, testing and analysis, marketers can pinpoint the various messages, communication channels and campaign processes that drive the highest conversion rates. Healthcare financial leaders can similarly focus on key "conversion"

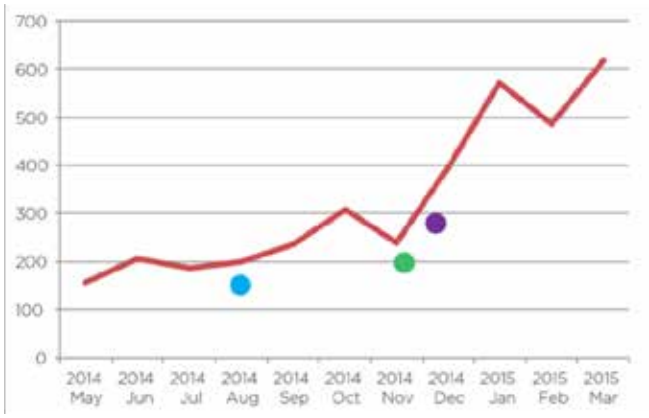
Using Marketing's Playbook to Engage Patients Financially (continued from page 9)

points—understanding what mix of messages, timing, billing and payment channels work best for each patient segment.

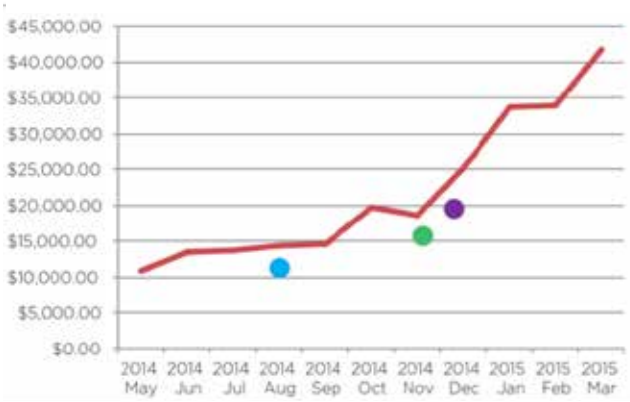
Putting it all together

The following metrics show one provider's results applying this type of approach. The colored dots indicate messaging changes over time. By targeting messaging, testing the results and fine-tuning for improvements the provider realized a significant increase in dollars collected. This patient population was inclined to pay online, so with the right message to inspire online payment "conversions," the provider saw a significant increase in dollars collected—nearly quadrupling during the course of the analysis.

Online Payments Made



Dollars Collected



Marketers seek to grow revenue by striving to understand how and why their customers buy. Similarly, healthcare financial leaders can gain insight into how each patient population pays and what messaging strategies drive the best results. By taking a page from the marketer's playbook, providers can build flexibility into how they connect with patients where and when they choose to pay and find new solutions to improve financial results and strengthen patient relationships.

Throughout her career, Kristen Jacobsen has held strategic marketing roles in organizations focused on strengthening customer relationships through analytics and communication technologies. Her experience spans a wide range of industries, including healthcare.

Key Questions Focus Attention on Healthcare Real Estate

SYDNEY SCARBOROUGH, MANAGING DIRECTOR, JLL, CHICAGO

Property, plant, and equipment occupancy costs are typically the third largest operating expense and represent almost 40 percent of a hospital's balance sheet. Reducing them not only improves flexibility, but frees up more funds for clinical improvements.

The Affordable Care Act (ACA) has had considerable financial, operating, and regulatory impact on hospitals and health systems. There is no real dispute among executives to its influence on patient accessibility. Yet there has been little attention paid to its effect on providers' real estate portfolios. The following are critical issues and trends related to the ACA and important questions to ask from a real estate perspective.

Reimbursement Changes and Cost Control

A variety of factors are converging to change healthcare payment processes and generally lower rates from Medicare/Medicaid, the public and private exchanges, and commercial payers. There is an unprecedented need to restructure healthcare organizations to meet demands by consumers, employers, and the government to provide greater value, but at a lower cost.

Property, plant, and equipment occupancy costs are typically the third largest operating expense and represent almost 40 percent of a hospital's balance sheet; so they impact finances tremendously. Reducing them not only improves flexibility, but frees up more funds for clinical improvements.

Healthcare organizations are collaborating and forming alliances to increase purchasing power, consolidate services, and cut costs. The same can be done for real estate. By streamlining and restructuring operations through centralization and standardization of real estate practices and processes, providers can reduce risk and increase efficiency.

For example, Adventist Health developed a strategy to reduce the number of vendors for soft services (e.g., environmental services, security, grounds/landscaping, linen, and supplies) by partnering with vendors who are leaders in their respective industries. Adventist Health's spend for these soft services is approximately $60 million annually. By building a consistent program in each area with the same protocols, products, and methods, the health system will not only achieve a 15-25 percent savings when fully implemented, but quality will improve and compliance risks will decrease.

With 545 properties spread across four states, there are some instances where a single vendor is not practical for Adventist. For example, there is not a single vendor who can service all four states for linen services. Yet by regionalizing linen services, a 13 percent savings has been achieved.

Healthcare finance leaders should consider the following questions regarding their real estate cost control:

Can you document what your system spends on occupancy costs?

Occupancy cost—or the total of all space expenses associated with operating and maintaining owned and leased properties—is rarely well tracked because these costs are dispersed across multiple cost centers and buried in other operating costs.

Are we managing our portfolio in a consistent fashion across all locations? Too often, especially in the wake of expansion through mergers and acquisitions, real estate management is inconsistent. Managing a portfolio in a centralized manner with established best practices can reduce waste and variability. These best practices include:

- A culture of ongoing innovation
- Functional operational risk management programs
- Consistent procedures throughout the provider's system and at each facility location
- Empowered employee work groups to drive service delivery improvements
- Annual operations audits of safety performance

(continued on page 13)

Are we partnering with facility/project management organizations for services outside our core competency? Looking beyond common vendors, such as food service and cleaning, to experts who can drive value in facility management, lease administration, transaction services, and project management can bring state-of-the-art technologies, processes, systems, and personnel to the organization.

Capital Allocation Challenges

The past decade has seen fierce competition for available healthcare capital. Potential uses all are compelling: investing in medical equipment technology, acquiring leading edge electronic health record systems, updating or replacing aging hospital infrastructure, and others. Compounding the problem, some investor analysts have assigned the healthcare sector a negative outlook since 2008. This makes it even tougher for hospital leaders to acquire capital at the best rates.

With negative outlooks from the traditional bond market analysts, many hospital executives have been limiting real estate investment to critical infrastructure maintenance and improvement programs. This has resulted in a steady increase in the average age of plant. From 2011 to 2014, the median age of hospitals increased from 10.5 to 11.3 years, according to data reported in the February 2015 hfm magazine. Any level at or above the 10-year mark is a concern to rating agencies.

Even if a system offers the latest medical technology and treatments, patients will take notice if the buildings housing them are aging and not well maintained. Health care is becoming much more retail focused. The front door matters.

Some alternative financing options are available, such as credit-tenant leases and sales of real estate assets. Developing relationships with healthcare real estate investors can pay off.

- Healthcare real estate investors appreciate the stable income-producing qualities of healthcare real estate.
- Healthcare real estate offers higher investor returns relative to other traditional property types (i.e., office, industrial, retail). For example, on a particular day earlier this month, public healthcare REIT dividend yield was 5.49 percent versus office/industrial REIT dividend yield at 4.72 percent, according to a recent update from Dividend.com.
- Continued low interest rates help fuel increased pricing.

Healthcare finance leaders should ask the following questions related to capital allocation:

Have we done a thorough risk assessment of our capital assets? What is their serviceable life expectancy? What is the risk of equipment failure?

Is the look of our facilities consistent with the level of our services? Does it convey the message we desire to patients?

Are our environments comfortable and inviting for both patients and staff? A clean, safe, pleasant working environment adds to patient and employee satisfaction and can have an impact on HCAHPS patient satisfaction scores.

(continued on page 14)

Have we considered real estate financing options to increase capital availability? Some alternatives include owning with mortgage debt, owning with tax-exempt debt, tax-exempt synthetic leasing, long-term sale leaseback, joint venture, and build to suit to own or to lease. Considerations will include cash proceeds, the cost of capital, ease of completion, control, and flexibility.

Consumer Choice

Consumers are exerting more influence on healthcare purchasing decisions due to changes in the reimbursement model. Convenience of location and facility appearance will play a role in these decisions.

Like other consumer services, healthcare systems will be measured on the basis of overall value as a combination of quality, price, and location. The "look and feel" of a hospital—which often takes a back seat to the focus on medical attention—will drive consumer decisions. Hospitals and health systems are evaluating their appearance to be perceived as leading edge, accessible, and easily identified by patients.

For example, Reliant Medical Group in central Massachusetts used a strategic real estate assessment to develop a real estate plan for the group's primary care operations. The plan included the following objectives:

- Evaluating the performance of facilities and identifying opportunities to better use capacity
- Measuring the system's readiness to handle an increase in patient visits
- Determining if the current locations were optimal for serving the current patient base and identifying future locations needed to serve targeted growth areas

The analysis revealed variances in performance across the group, as well as opportunities for growth within the existing facilities. Reliant developed a three-pronged strategy to address future growth:

- Leverage the current network, filling it to capacity before adding new space.
- Secure new markets in selected additional sites and expand into growth markets to the greatest extent possible, while remaining on REIT leases at some present locations for several years.
- Consolidate current locations into optimal site configurations as leases expire or—worst case—renegotiate.

Healthcare finance leaders might ask the following questions related to improve patient satisfaction:

Where do we realistically stand in terms of quality, price, and convenience versus our competitors? A thorough inventory of your current locations relative to your competitors and population demographics is a starting point. Location intelligence services offered by healthcare real estate firms can provide data and analysis.

How does this align with where we want to be? In essence, what is our system's brand, and what do we want to be in the minds of consumers?

How convenient are our access points to our target market? For example, for patients with chronic illnesses, are physical locations close enough to the community served so patients with chronic illnesses don't have to travel long distances?

Targeted Attention

Your organization's real estate deserves close scrutiny because it is a major factor in supporting your operations and mission. Asking the questions above will help tighten the focus on this important area.

Sydney Scarborough is managing director, JLL, Chicago, and is a member of HFMA's First Illinois Chapter.

More Hospitals Hit by Readmissions Penalty

BY RICH DALY, SENIOR WRITER & EDITOR, HFMA WASHINGTON, D.C. OFFICE

Although the latest round of rules for the program includes some tweaks urged by hospitals, major impacts of socioeconomic factors remain unaddressed.

The number of hospitals hit by readmissions penalties will increase by 28 to 2,666 in FY16, according to estimates by the Centers for Medicare & Medicaid Services (CMS).

The estimated readmissions penalty totals also will increase by $6 million to $420 million, as hospitals' base-operating DRG payments are reduced by their proxy FY16 hospital-specific readmissions adjustment, according to the recently issued final rule for the inpatient prospective payment system.

The latest estimate of $414 million FY15 penalties was smaller than the $428 million CMS had projected in the final rule implementing the current year's cuts.

The FY16 penalties for the four-year-old hospital readmissions reduction program (HRRP) are based on a hospital's risk-adjusted readmission rate during a three-year period for five conditions: acute myocardial infarction, heart failure, pneumonia, total hip and total knee arthroplasty, and chronic obstructive pulmonary disease.

The penalty is a reduction in the base operating DRG payments by a hospital-specific adjustment factor that accounts for the hospital's excess readmissions. It uses an excess readmissions ratio that is the ratio of actual readmissions over expected readmissions for the five conditions.

The latest penalties followed a January analysis published in hfm of the 2,225 facilities penalized under the HRRP based on the FY14 IPPS final rule. It found 502 would have benefited by at least $100,000 from eliminating excess readmissions, while other hospitals would have had a smaller positive financial impact. Additionally, the analysis found that only a relatively small improvement in readmissions performance was required to reduce readmissions penalties.

Longstanding Concerns

Some longstanding and new provisions of the program have raised significant hospital concerns.

One of the most serious issues raised by hospital advocates is that HRRP largely ignores the impact of sociodemographic status (SDS). Hospitals have urged CMS to risk-adjust HRRP results to reflect specific inpatient populations and to account for sociodemographic factors—including income, education level, and poverty rate—that could drive readmission. Without an SDS adjustment, large hospitals, major teaching hospitals, and recipients of higher disproportionate share hospital payments are more vulnerable to HRRP cuts due to factors

(continued on page 17)

outside of their control.

"These cuts disproportionately affect safety-net hospitals, which already face daunting financial challenges as the primary source of care in many economically struggling communities," said Chad Mulvany, director of healthcare finance policy, strategy and development, at HFMA.

CMS officials have long downplayed the effect of SDS on hospitals' readmission performance.

"While we appreciate these comments and the importance of the role that sociodemographic status plays in the care of patients, we continue to have concerns about holding hospitals to different standards for the outcomes of their patients of low sociodemographic status because we do not want to mask potential disparities or minimize incentives to improve the outcomes of disadvantaged populations," agency officials wrote in the final rule.

In addition to ongoing, statutorily mandated research by the U.S. Department of Health and Human Services on the impact of SDS on quality measures, resource use, and other Medicare measures, the National Quality Forum has launched a two-year study of whether SDS factors should be added to each HRRP measure.

Coming Expansion

Mulvany also expressed disappointment that CMS moved forward with a modified expansion of the population subject to the HRRP's pneumonia readmissions measure beginning in FY17. The modified measure will include patients with a principal discharge diagnosis of pneumonia or aspiration pneumonia, and patients with a principal discharge diagnosis of sepsis with a secondary diagnosis of pneumonia coded as "present on admission."

No longer included are patients with a principal discharge diagnosis of respiratory failure or patients with a principal discharge diagnosis of sepsis if they are coded as having severe sepsis. CMS eliminated those categories in the final rule after hospitals raised concerns that counting such patients, who arrive seriously ill and at grave risk for readmission, would skew their results.

However, the change left unaddressed the concern of some hospital advocates that patients with a diagnosis of sepsis and secondary diagnosis of pneumonia have a higher predicted mortality and readmission risk, and often have multiple co-morbid conditions that are prone to exacerbation during the initial admission.

"These changes to penalize facilities for readmission of patients who arrive at the hospital already seriously ill will disproportionately affect facilities serving the poorest communities," Mulvany said. Additionally, HFMA had urged CMS not to finalize the revised pneumonia readmission measure for inclusion in the HRRP until it was endorsed by the National Quality Forum, as required by the ACA.

HFMA Upcoming Events

(click logo below to register for events)

CHFP Certification Practicum at the Fall Summit

Have you ever wanted to pursue that coveted Fellow designation? Did you know that certification is a key step in becoming a Fellow? The Board of Directors and chapter officers support and encourage all members to become certified by HFMA. Members are invited to prepare for the Certified Healthcare Financial Professional (CHFP) examination with this 8-hour practicum on November 12, 2015, at the Fall Summit.

This session will review healthcare finance, risk mitigation, evolving payment models, healthcare accounting and cost analysis, strategic finance, and managing financial resources. Collaborate with peers on case studies under Christoph Stauder, FHFMA, CPA, of Stauder Consulting, LLC. Christoph has a proven track record of appropriately preparing students for the exam and focusing on what is important. He teaches the course for HFMA nationally.

As a Fall Summit attendee, committing to attending the practicum and taking the exam gives one access to Christoph's study guide, HFMA national's study materials, and reimbursement for the cost of the exam. The value to each candidate is over $900. Please reach out to Bart Richards, BRichards@TheClaroGroup.com, or Tim Stadelmann, Tim.Stadelmann@AdvocateHealth.com, of the Certification Committee for more information.

Thank you to those members who have already committed. This year's candidates are from organizations including:

- Adventist GlenOaks Hospital
- Advocate Health Care
- Centegra Health System
- Crowe Horwath LLP
- Edward-Elmhurst Health
- Grant Thornton LLP
- MacNeal Hospital
- Northwestern Medicine
- The Claro Group
- The Guava Group

Starting this year, HFMA has restructured the CHFP exam. Check out the information below to learn more about the new CHFP process.

Changes to HFMA's CHFP Certification Program

HFMA's strategic vision characterizes the current healthcare business environment as the transformation of care to achieve value. Providers, physicians, and payers are all confronted with new business challenges. The nature of the business environment and its impact on industry stakeholders supply both the demand for and elements of a new approach to the CHFP.

New CHFP program features

A learning program designed to build comprehensive industry understanding and sharpen business skills, CHFP has a two-module structure:

- HFMA's Business of Health Care - Healthcare finance overview, risk mitigation, evolving payment models, healthcare accounting and cost analysis, strategic finance, and managing financial resources
- HFMA's Operational Excellence exam - Healthcare Industry Stakeholder's Business Challenges; exercises and case studies on the application of business acumen in health care

Why is the certification program changing?

The healthcare reform environment has caused the industry's key stakeholders—providers, payers and physicians—to fundamentally rethink existing business models. Care transformation is business transformation. The necessary success factor for finance professionals today is change-oriented business acumen. The existing certification program focuses narrowly on applied finance and financial reporting and does not address the business environment.

Earning the CHFP

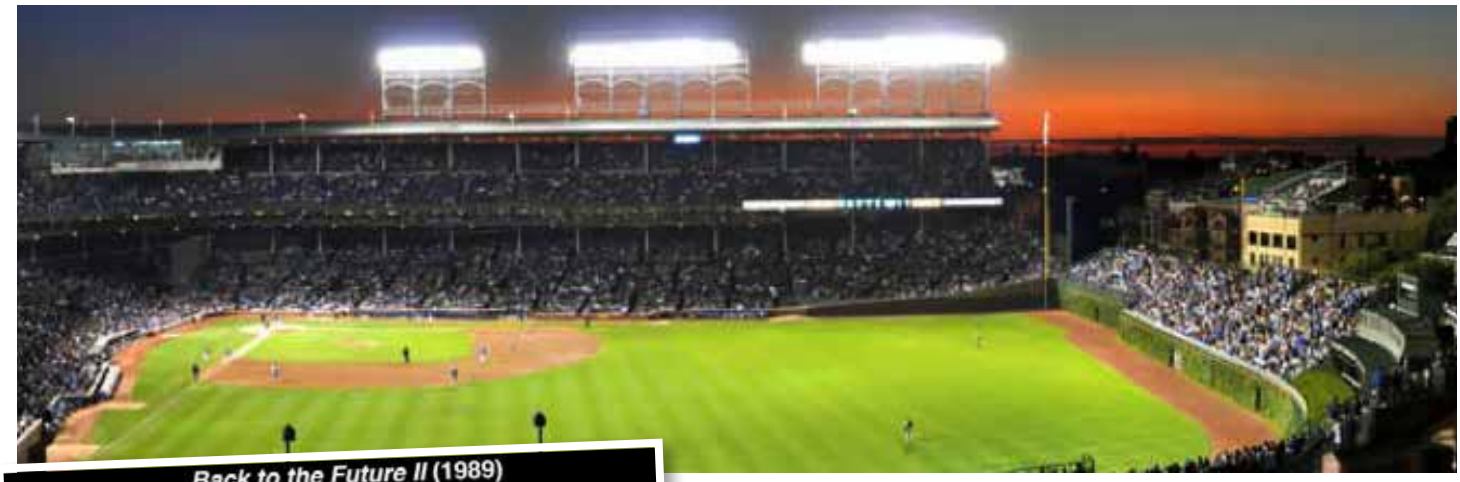
It is important to note that the CHFP credential is awarded upon successful completion of the module I end-of-course assessment and module II case study exercises and exam. HFMA membership is required for module II.

CHFP and FHFMA Certification Holders

Individuals who have earned the CHFP [and Fellowship] prior to 2015 are not affected. Also, the new CHFP and how the program integrates with the Fellowship (existing FHFMA) are not affected. Both programs are on the same "knowledge – competencies" continuum. As such, they are integrated and not in opposition in three anchors: knowledge base, competencies-skills and currency-relevance.

HFMA Night at Wrigley Field

Chicago, August 20, 2015



Holy Cow! Who knew that the Cubs would end the season in the National League Championship Series? Die Hard Cubs Fans and FIHFMA. That's who.

On August 20, First Illinois HFMA had another successful networking event while enjoying watching the Cubs top the Braves 7-1 from the first class venue with amazing foods, drinks and views at the Ivy Legends Rooftop Suite.

The Cubbies won, the weather was beautiful and as always the networking was enjoyed by all attendees.

Who knows, maybe some of us will be able to say we attended a Cubs game the year the finally won the series again after over 100 years! Back to the Future II predicted it in 1989 (not that that matters) but it seems to be talk of the town, along with that colossal Kyle Schwarber home run!

So whether your Northside or Southside, enjoy October baseball in Chicago! We don't get the opportunity very often.

(Editors Note: At press time, the Cubs were scheduled to begin the NLCS on the road against either the New York Mets or LA Dodgers. https://pbs.twimg.com/media/CQvsE_JXAAAtfQf.png Will it be Back to the Future or Back to the Drawing Board? …. We look forward to concluding this story in our next edition…)

Welcome New Members

Declan Frye

Gary P Wagner
Network Manager
Beacon Health Strategies

Michael J Farrell
Treasurer

Michael Walker
ZirMed

Janelle Haslett-Brousse
Senior Consultant
Nell Haslett-Brousse

Brian Seiwell
Client Executive
Healthcare Solutions
TransUnion

Cathleen Bimmerle
Clinical Assistant Professor
University of Illinois at Chicago

Nikhil Mehta

Hank Thompson
Senior Consultant
Navigant Consulting Inc.

Aaron Hosansky

Scott Manson
Principal
Frost Ruttenberg & Rothblatt, PC

Ellen M Schultz
Senioor Reimbursement Auditor
Health Care Service Corporation

Elena Slavcheva
Senior Analyst
Optum360

Kari Kosog
Analyst
The Claro Group

Hugh Brennan
Chief Financial Officer

Nicholas Kladouris
Senior Financial Analyst
Advocate HealthCare

Maria Thompson
Health Policy & Economics Director
Ethicon US, LLC

Soniece Curin
Accounting Supervisor
Advocate Health Care

Jinal B Thakkar
Senior Consultant
McGladrey

Ron Ralph
Healthcare Partner
Crowe Horwath

David Manco
Assistant Controller
Universal Health Services, Inc.

Jake Donahue
Etyon Inc

Aristotelis Archos
Senior Staff Accountant
Advocate Healthcare

Deb Kozlowski, CRCR
Senior Associate
McGladrey

Rosana Auk
Reporting Specialist
Advocate Health Care

Lilian Grinnstead
Reporting Specialist
Advocate Health Care

Chris Wyatt

Stan Jaworski
Board Member
The Boulevard Medical Respite Care Center

Tammy Sanchez
Revenue Cycle Manager
Wheaton Eye Clinic

Marshall Sied
Emtec

Kayla L Moore
Outpatient Clinical Documentation Improvement Analyst
The Claro Group

Brendan Henry
Blue Cross Blue Shield of IL

David Brady
Manager
Sebis Direct

Chris Albright
Sr. Financial Analyst
Advocate Health Care

Tracy Wilson
Director
Northwest Community Hospital

Jesse Sanchez
VP of Business Development
Stoneleigh Recovery Associates

The First Illinois Chapter Sponsors

The First Illinois Chapter wishes to recognize and thank our sponsors for the 2015-2016 chapter year. Thank you for all your generous support of the chapter and its activities.

Platinum Sponsors

Harris & Harris
PNC Bank
Principle Valuation

Gold Sponsors

Array Services
Besler
Citi
Crowe Horwath
Enable Comp
Fifth Third Bank
GE
OST
PBC Advisors, LLC
Plante Moran
UCB
Vaughn Holland

Silver Sponsors

American Appraisal
Clear Balance
Capio Partners
Emdeon
Grant Thorton
McGladrey
MDS
Parallon
Passport
Triage
Wells Fargo

Bronze Sponsors

Amerinet
Mcare
Medical Business Bureau
Performance Services
American Express
Avadyne Health
Bank of America
Bottom Line Services
Cirius Group
Conifer
DGA Partners
Doxo
EY
HBCS
Healthcare Insights
HealthCare Payment Specialists
Impact Health Services
Lubaway Masten
Medical Business Associates
MiraMed
On Plan
Pavillion Group
ProAssurance
SS&G Healthcare Chicago, LLC
State Collection
Strategic Reimbursement
Tatum

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

Publication Information

Editor 2015-2016
Jim Watson ..... 630-928-5233 jim_watson@pbcgroup.com
Shane Ramsey ..... 312-515-7854 sramsey@healthgrades.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. All rights reserved. *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
January 2016	December 10, 2016
April 2016	March 10, 2016
July 2016	June 10, 2016
October 2016	September 10, 2016