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Understanding & Preparing for MACRA and MIPS

BY GE HEALTHCARE CAMDEN GROUP
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When Congress finally repealed the much-maligned sustainable growth rate (SGR) and its proposed payment cuts, medical groups rejoiced. But the new payment system would present its own challenges.

The Medicare Access and CHIP Reauthorization Act (MACRA), in the form of a proposed rule from the Centers for Medicare & Medicaid Services (CMS), aims to encourage medical groups to pursue advanced payment models and accountable care. Understanding and preparing for MACRA and MIPS is no small task; this article is structured to be a comprehensive summary to understand and begin your MACRA and MIPS preparation:

1. Provide an Overview of MACRA and MIPS
2. Help you prepare to implement and manage MACRA by breaking down the MIPS requirements
3. Provide actions for you to take now to prepare for MACRA and MIPS

Overview of MACRA and MIPS:

MACRA replaces several Medicare reporting systems and creates two potential paths for medical groups:

- ***The Merit-based Incentive Payment System (MIPS):*** The MIPS program replaces and incorporates the former EHR incentive program (Meaningful Use), Physician Quality Reporting System (PQRS), and Value-based Payment Modifier program.
- ***Advanced Payment Models (APMs):*** The APM path is for groups that are willing to assume two-sided risk under new payment models, including select accountable care organizations (ACOs) and demonstration programs.

The APM track provides for a 5 percent annual incentive payment, while MIPS has upside and downside risk starting at as much as 4 percent in 2019 and increasing to as much as 9 percent by 2022. MIPS is budget-neutral, so there will be winners and losers.

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Understanding and Preparing for MACRA and MIPS (continued from page 1)

Both tracks begin to measure performance in 2017 and to impact reimbursement to groups in 2019. (However, the acting administrator of CMS recently told Congress the agency is considering a delay in the start of the reporting period in response to physician concerns.)

MACRA is currently a proposed rule, with CMS required to issue a final rule by Nov. 1. Although CMS has recently been willing to revise some rules based on comments submitted by providers, significant deviation from the proposed rule is not expected. Given that most groups will not be ready to start on the APM path by January, it is estimated that more than 90 percent of groups will start under MIPS in the absence of drastic changes to the proposed rule. As a leader in your medical group, how can you help ensure success under MIPS? How can your group benefit from incentive payments and avoid payment reductions? Let's first look at how performance is measured and how medical groups can succeed under MIPS.

Measuring MIPS Performance

Your medical group probably began reporting quality with the inception of the PQRS (formerly PQRI) program in 2007. Under this program you received credit, and financial rewards, simply for reporting, regardless of actual performance.

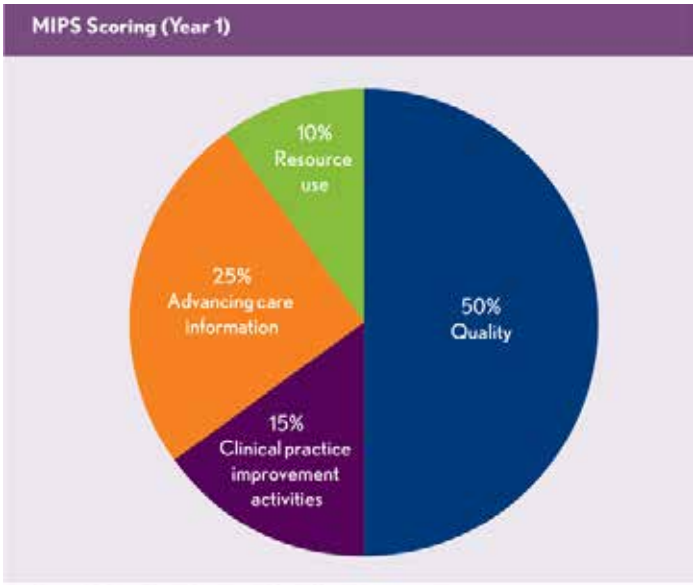
MIPS takes a different approach to measuring the performance of eligible clinicians, initially including physicians (MD/DO and DMD/DDS), nurse practitioners, physician assistants, and certified registered nurse anesthetists and, in 2019, expanding to include physical and occupational therapists, speech-language pathologists, audiologists, nurse midwives, clinical social workers, clinical psychologists, and dietitians/nutritional professionals. MIPS clinicians can elect to be measured individually or as a group under a common tax identification number. (For the purpose of this article, we will refer to individuals and groups collectively as MIPS clinicians.)

Eligible clinicians' performance in the four MIPS components will be assessed using a composite score on a 100-point scale. The four MIPS components:

1. Quality
2. Advancing Care Information (ACI)
3. Clinical Practice Improvement Activities (CPIA)
4. Resource Use

The weighting of the score for the first year of reporting is as illustrated below.

Preparing for MACRA_Part I_Exhibit 1(2)



The weighting of these categories is scheduled to change after 2017, with more emphasis on resource use (cost) and less on quality and meaningful use of technology.

MIPS maintains budget neutrality by grading on a curve. A MIPS clinician's score within each of the four categories is determined by benchmarking his or her results against other providers. Therefore, achieving fixed performance targets will not be sufficient to protect against payment reductions or to ensure bonuses. Clinicians must be among the higher-performing providers to maintain or increase their Medicare reimbursement.

The following provides more detailed information on the four MIPS components:

1. Quality: MIPS adopts many of the same measures as the PQRS and the Value-based Payment Modifier program, along with similar reporting methods. MIPS clinicians select six PQRS measures that they feel best represent their practice. CMS uses claims data to calculate an additional two population quality measures for individual clinicians or groups with less than 10 clinicians, or three additional measures for larger groups. Performance is measured on a 90-point scale.

2. Advancing Care Information: This component is a simpler and less burdensome version of the Meaningful Use program, which it replaces. The number of measures decreases from 18 to 11. MIPS clinicians receive 50 base points for providing numerator/denominators or answering yes/no for six meaningful-use objectives and their measures. An additional 80 points are based on performance in the areas of patient engagement and information exchange. Finally, one bonus point is awarded for reporting to one additional public registry. The total maximum score is 131, but clinicians need only 100 to receive full credit.

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3. Clinical Practice Improvement Activities: Performance is measured on a 60-point scale and is based on six sub-categories including expanding practice access, population management, and care coordination. MIPS clinicians must select three to six activities that total 60 points from among a list of 90 options. Examples of medium-weighted activities (worth 10 points each) include implementing regular care coordination training and establishing standard operations to manage transitions of care. Examples of high-weighted activities (worth 20 points each) include offering integrated behavioral health services and seeing new and follow-up Medicaid patients in a timely manner. Patient-centered medical homes receive the full 60 points, and participation in an APM earns 30 points.

4. Resource Use (cost): Performance is measured on a 20-point scale. There are no reporting requirements under this category. Instead, CMS will use claims data to assess MIPS clinicians' performance based on cost measures that account for different clinical specialties.

Preparing for MACRA: Breaking Down MIPS Requirements

The key to success in MIPS rests on a practice's ability to gather, quantify, and report on elements of patient care that exhibit improvement in outcomes and cost reduction. IT infrastructure, scalability, and continued development and process improvement are all necessary components of a MIPS strategy. Here we explore how a practice can achieve its goals, regardless of size or specialty, in the four defined areas of MIPS.

Quality (50 Percent of MIPS Composite Score)

Quality reporting under MIPS replaces the Physician Quality Reporting System (PQRS) program and uses basically the same measures and methods, with some modifications. Eligible providers (EPs) will select six measures across any combination of quality domains, as compared with nine measures currently required under PQRS. When choosing the six measures, the provider must include one outcomes measure or another high-quality measure, and one cross-cutting measure if the EP is patient facing. Additionally, the proposed rule requires CMS to calculate two (for physician groups of less than 10) or three (for groups of 10 or greater) population quality measures from claims data.

Instead of the six measures as described above, providers may choose to report a specialty measure set that is designed around specific specialties and conditions. The proposed rule allows for data submission of performance measures through registries, Qualified Clinical Data Registries, health IT developers, and certified survey vendors.

To succeed under the Quality domain, medical groups must take the following action steps:

1. Evaluate or implement electronic health record (EHR) use and reporting methodology:
   - Understand connectivity to area hospitals and networks
   - Explore partnering opportunities to offset capital investment
   - Gain understanding of data-registry and interoperability capability
2. Review measure selection:
   - If successful in past PQRS reporting, validate measure selection for 2017
   - Evaluate previous-year performance against benchmark
   - Adopt new measures based on previous experience and consider specialty-specific measure groups

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Sample MIPS Scorecard

Performance Category	Measure	Points
Quality (50%)	Quality Measure	10
	Quality Measure	10
	Quality Measure	10
	Quality Measure	10
	Cross-cutting Measure	10
	Outcome Measure	10
	Pop Health Measure	10
	Pop Health Measure	10
	Pop Health Measure	10
	TOTAL	90
Advancing Care Information (25%)	Base Score	50
	Performance Score	80
	Bonus Point (Public Health Registry)	1
	TOTAL	131
Clinical Practice Improvement Activities (15%)	Highly Weighted	20
	Highly Weighted	20
	Other Activities	10
	Other Activities	10
	TOTAL	60
Resource Use (10%)	Cost Measure	10
	Cost Measure	10
	TOTAL	20

Source: GE Healthcare Camden Group. Used with permission.

Published in HFMA's *Physician Business Adviser* e-newsletter, August 2016.

3. Monitor and track performance of measures:

- Understand performance against benchmarks to ensure the highest composite score
- Model scoring scenarios to ensure success
- Enroll in additional measures and monitor performance throughout 2017
- Create or redesign workflows and implement changes to address performance improvement

CMS has published PQRS results for the 2015 reporting year, along with benchmarks. These can be used to track performance and set high-performance targets. Given that CMS is allowing clinicians to choose the measures on which they will be evaluated, clinicians should be very intentional when selecting measures.

Resource Use (10 Percent of MIPS Composite Score)

CMS defines the scoring for Resource Use in MIPS as "comparing resources used to treat similar care episodes and clinical condition groups across practices." The calculations for this category replace the Value Modifier (VM) program and are based solely on claims data. The key change from the VM program is the addition of over 40 episode-specific measures to address specialty concerns. Although this category only accounts for 10 percent of the composite score in 2017, it eventually grows to 30 percent. Therefore it is imperative that physician practices understand how the calculations are occurring and what aspects of the spending formula they can control and influence.

Actions for medical groups include:

1. Review the Quality and Resource Use Report (QRUR) to determine relative position among peers
   - Use your Enterprise Identity Management System (EIDM) account to access and review the QRUR, which is published at https://portal.cms.gov
   - Use the QRUR to identify opportunities for improvement and to develop improvement plans
2. Review the 41 episodes to determine for which ones to consider a redesign of care management
   - If you are in a specialty practice, understand which episodes are applicable to your specialty and how to improve care design
   - There are no reporting requirements for this category.

Advancing Care Information (25 Percent of MIPS Composite Score)

Advancing Care Information replaces the Meaningful Use program and is less burdensome, with a smaller number of measures. The maximum score for this category is 131, although clinicians need only 100 points to receive full credit. Clinicians receive 50 base points for achieving the following six meaningful-use objectives:

- Protecting patient health information
- Electronic prescribing
- Patient electronic access
- Coordination of care through patient engagement
- Health information exchange
- Patient health and clinical data registry reporting

An additional 80 points will be awarded for performance in the areas of patient care and information access (and one bonus point is available for reporting to an additional public registry).

Actions for medical groups include:

1. Ask your IT vendor about its rollout plan for MIPS:

- Ensure your vendor has the ability to report measures
- Track measures by individual provider, and by group if applicable, to improve performance scores

2. Perform a review of current measure performance based on future targets
   - Identify deficiencies and redesign workflows to capture data, specifically focusing on measures involving portal usage, electronic exchange of transition of care, and direct messaging
3. Align with other providers, hospitals, and clinically integrated networks on health information exchange and interoperability efforts to share and build on relevant information
   - This category's factor in the MIPS composite score may decrease in future years once more users adopt EHR technology.

Clinical Practice Improvement Activities (15 Percent of MIPS Composite Score)

CPIAs comprise a new category. From a list of 90 activities, clinicians choose a combination of three to six activities that are most meaningful and applicable to their specialty and practice. Performance is measured on a 60-point scale with medium- (10 points) and high-weighted (20 points) activities. Patient-centered medical homes receive full credit for CPIA, while participation in an alternative payment model earns half-credit.

Subcategories include:

- Expanded practice access
- Beneficiary engagement
- Patient safety and practice assessment
- Care coordination
- Population management
- Participation in an APM
- Achieving health equity
- Emergency response and preparedness
- Integrated behavioral and mental health

Many medical groups have implemented some form of practice transformational effort such as chronic care management services, group visits, use of a prescription drug monitoring program, and

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providing 24/7 access for urgent and emergent care.

Going forward, medical groups should:

1. Evaluate current transformational efforts or initiatives to determine whether such efforts warrant points in this category
2. Assess efforts made by clinical staff and care management teams
3. Review participation in population health initiatives or with quality improvement organizations
4. Select activities that are aligned with the overall strategic direction of the practice (e.g., improving the patient experience, enhancing patient access and implementing telehealth services, implementing and optimizing the use of technology and registries)
5. Document improvement activities to substantiate efforts made

CPIA is probably the easiest category in which to score the maximum points, so clinicians should take advantage to increase their overall composite score.

Top 10 Actions to Take Now to Prepare for MACRA:

Each point counts under MIPS, and performance next year can result in a bonus or penalty of as much as 4 percent in 2019. Hence, clinicians must have a plan to prepare for 2017. CMS's goal is for 90 percent of Medicare fee-for-service payments to be tied to quality or value by the end of 2018, and commercial payers are being invited to match or exceed this goal. In that context, medical practices need to start now in an effort to promote care coordination and better patient outcomes.

Here are 10 actions your group should be taking now to prepare for MACRA.

1. Determine your path. The MIPS program replaces the former EHR Incentive (Meaningful Use), Physician Quality Reporting System, and Value-based Payment Modifier programs with four measures of cost, quality, information technology ("IT") use, and clinical practice improvement activities. How well your group performs on these measures compared to your peers will determine whether your Medicare payments are increased or cut by up to 9 percent by 2022. The APM path is for groups that are willing to take up- and down-side risk under new payment models, including select ACOs, medical homes, and bundled payments. APMs offer a 5 percent bonus payment. Many groups would rather avoid the reporting requirements, uncertainty, and potential payment reductions of MIPS. Unfortunately, qualifying for APM will be a challenge unless your group is already in a qualifying program – especially given the January 1, 2017 proposed start date. This aggressive timeline is one of the criticisms of MACRA, and CMS may push back the start date in the final rule. At this point, a vast majority (some projections are as high as 90 percent) of medical groups are expected to pursue MIPS, at least initially. Groups that start under MIPS can apply to move to APM in subsequent years.
2. Educate and engage your providers. Under the current performance based incentive programs, groups are rewarded for simply reporting data. If you start under MIPS, you will receive bonuses or pay cuts based on your actual performance against other groups. Active provider participation and engagement are imperative for improving your performance on the MIPS measures for cost, technology use, quality, and clinical practice performance. Start now by educating your providers on MACRA and the crucial role they play in your group's success. Inform them that their scores will be published on Physician Compare for public consumption. Evaluate your physician compensation plan to ensure that incentives are aligned with your MACRA objectives.
3. Assess your current technology. Health IT ("HIT") is foundational to MACRA, which requires participants to use certified electronic health records technology ("CEHRT"). While the number of meaningful use measures has decreased, groups may have HIT challenges relating to interoperability and the exchange of information. Although vendors have made great advances in recent years, gaps still exist, and the development of new capabilities and analytics continues. To meet MACRA requirements specifically relating to the collecting, monitoring, and reporting measures and scores, groups may require additional IT capabilities beyond the CEHRT. Additionally, there is an increase in the use of Qualified Clinical Data Registries ("QCDR") to collect clinical data to better manage the delivery of care, ultimately improving the quality.
4. Know your quality measures. APMs typically have a prescribed set of measures based on the program whereas, under MIPs, providers have the option to select measures. However, MACRA does require that quality measures used in APMs be comparable to those used in MIPS. Knowing your quality measures, and if applicable, selecting the right measures, is key as your group's performance will be determined based on how you compare to peers. It is important that you identify the measures applicable to your group, considering your provider specialty mix and patient population, and then create workflows to support the data capture of such measures. A good place to start is the Quality and Resource Use Report ("QRUR") since this report compares your scores relative to your peers by calculating the standard deviations from the national mean for both quality and cost. There is also a high-risk bonus adjustment that is based on ICD-10 coding, so accurate diagnosis coding assignment is critical.
5. **Track provider performance.** Monitoring your group's performance at an individual provider level on a consistent basis is vital since every point matters. Groups need to track performance monthly and compare the values to peers as well as targets. Your exceptional performance scores do not guarantee success since your current performance is compared

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to future benchmarks, which are unknown at this time. Also, CMS has allocated millions of dollars to reward high performing providers who land above performance thresholds, so aiming high may get you additional dollars.

6. **Form a steering committee.** Whether you pursue APM or MIPS, it will be important that your group is strategically aligned and that your efforts are coordinated. Much work will be necessary to ensure that your group has capabilities for measure selection, data capture and reporting, workflow analysis and/or development, training, and performance monitoring. A multidisciplinary steering committee consisting of physicians, management, IT, other providers, and staff can be a powerful way to align the group and to address the broad array of tasks. The steering committee will be charged with creating the MACRA strategy and a high level work plan. Members will oversee the plan's progress, timeline adherence, and provide direction for resolution of any obstacles impacting the plan.

7. **Implement a change management program.** Success under MACRA will require strategic and operational changes; change can be difficult to implement and even more difficult to maintain. Consider using a formal change management program that will combine a well-executed plan for change with the leadership needed to sustain that change over time. When executing tactical plans and projects, many groups focus solely on technical change strategies, while change management, like GE's Change Acceleration Process ("CAP)" program, focuses on both the technical changes and change leadership. Change leadership is an essential, but often overlooked aspect of change strategy; it addresses the human or cultural component that provides the spark needed to activate change. Change leadership will align, mobilize and motivate all stakeholders with a shared vision to support the MACRA program, making success a reality.

8. **Consider partnership opportunities.** APM and MIPS both present challenges, especially to smaller groups, that might be easier to overcome with partners. APMs require a group to take downside risk. Groups that do not have experience with risk or have a small patient population can benefit from joining an independent practice association ("IPA"), physician-hospital organization ("PHO"), clinically integrated network ("CIN"), or ACO that can provide care management capabilities, as well as spreading actuarial risk over a larger population. Success under MIPS will require technology resources, care management, and practice operational capabilities that may not be financially sustainable for small groups. Medical groups that have patient-centered medical home ("PCMH") status receive full credit for achieving the MIPS Clinical Practice Improvement Activities measure, so groups should consider joining a network or hiring an MSO that can provide resources or capabilities to support a PCMH.

9. **Develop care management capabilities.** Success under MACRA will require that groups deliver value by improving quality, outcomes, and patient experience while reducing costs. Use data to understand how your group performs today and where there are specific opportunities to improve. Then work with your physicians and staff to develop and implement care management capabilities that support higher performance. You should also look outside the walls of your group to partner with other providers, community resources, and your patients to more effectively manage the health of your population.

10. **Create a roadmap in 2016.** MACRA reporting is scheduled to begin in January 2017; hence, the time is now to create a plan and roadmap. Understanding your group's current challenges will be important as you develop your roadmap. Once you activate your plan, monitor your progress monthly and make any updates based on the final rule. Even if MACRA reporting is delayed, you will have a head start.

If groups take these 10 actions, they will be in a better position to transform the care that is delivered based on the Triple Aim of better care, better experience, and lower cost. And they will be rewarded financially under MACRA.

CAREER Corner

BY VICKIE AUSTIN

Suzanne Lestina

*This issue of "Career Corner" focuses on **Suzanne Lestina** Vice President of Revenue Cycle Innovation for Avadyne Health. Suzanne is also a past president of the First Illinois HFMA Chapter and a former employee of the Healthcare Financial Management Association where she was the director of revenue cycle MAP.*

Q: What was your first job?

A: My first job was working for Katie's Country Candy Store, an old-fashioned candy store at Lake Street Mall in Oak Park. My first professional job was as a biller at West Suburban Hospital in Oak Park.

Q: What had you choose healthcare as a career?

A: I didn't choose healthcare–it chose me. I was going to school part-time at Triton College and I took the job because I needed the money. Our hospital was a beta site for Blue Cross Blue Shield which was then the Medicare fiscal intermediary and we were working on a new direct data entry process as well as electronic eligibility. The experience was amazing. The job changed constantly and I could see that there was a tremendous opportunity to grow.

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

A: Barbara Ortiz and Lorraine Cherry were the BCBS representatives who were working on the beta, developing the system that's in place today. My job was to challenge them, which I did, and I learned so much from them.

Bobette Gustafson was the person who introduced me to speaking. She saw potential in me and never allowed me to question my own capabilities. Bobette got me involved on the National Uniform Billing Committee (NUBC) and also got me my first speaking engagement. Her confidence in me was so straight-forward. She said, "You should and you will," so I did! I never would have seen myself as a speaker and now it's a huge part of my work and my life.

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

A: When I initially started in billing we were affectionately known as "the back end" of healthcare. We were installing Meditech and billing dictionaries reside in admitting, so my boss moved me to "the front end" to become manager of admitting. On my second day as manager, we had a patient being admitted to the cardiac unit, a direct admit from the doctor's office. The staff said she needed a bed but I overruled them and said no, she can sit in the lobby like the other patients until her bed is ready. The next day, the head of cardiology came in. He looked at me and said, "If you ever, ever make one of my patients sit in the lobby, I will have your job. My patients come first and they will always come first. Do you understand?" I said, "Yes, I understand." This was a very humbling experience and it completely changed my mindset. Before I took that job I had the notion that the people on the "front end" didn't care about their impact to "back end" processes. This made me see the pressure they are constantly under, as well as their contribution and commitment they make to come to work every day.

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

A: Every opportunity is a stepping stone to something greater, even if you don't know it at the time. Be open to the fact that even with a pro-con list, you may not have thought of something [that could be valuable to your career]. Listen to your instinct and be open to making choices. Sometimes those pro-con lists are just a way to stay within our comfort zones.

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

A: That's such a loaded question! Through my work as chapter president for the First Illinois HFMA I ended up volunteering for national HFMA. I worked with Scott Johnston who invited me to be on a national advisory council, and I also got to know his boss, Rick Gundling and the rest of the executive team. When Scott left to take another job, he said Rick wondered if I would take on some of Scott's responsibilities while they were looking for a replacement. Later I thought, "Maybe I could do this job," so I called Scott. He said they were just going to call me to recruit me. I got the job and worked for HFMA for 8 years.

And oh, the connections! I cannot tell you how those connections still influence me today. I learned many of my leadership skills as an HFMA volunteer: diplomacy, the ability to listen to others and hear their ideas, and the ability to facilitate.

Q: What are you reading?

*A: Right now I'm reading Brené Brown's book **Daring Greatly.** I also love murder mysteries.*

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

A: Don't stop asking questions and challenging the way things get done.

Vickie Austin

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CMS Bundled Payments Program Expands

BY DANIEL M. GRAUMAN, IDETTE ELIZONDO, AND MEGHAN CORCORAN

Just one year ago, the Centers for Medicare & Medicaid Services (CMS) announced the creation of a mandatory bundled payment program for major joint replacement: Comprehensive Care for Joint Replacement (CJR). Now, CMS has proposed regulations that add cardiac episodes as well as "other hip and femur procedures" to the list of mandatory bundles for hospitals in many markets.

CMS' new proposed rule mandates that healthcare organizations in 98 metropolitan statistical areas (MSAs) participate in a bundled reimbursement model for both acute myocardial infarction (AMI), managed either medically or with procedural intervention, and for coronary artery bypass Idette Elizondograft (CABG).

Organizations that already are participating in the voluntary Bundled Payments for Care Improvement (BPCI) program in cardiac or other hip and femur bundles can continue with their current bundles/episodes, but others in the MSA will be required to adopt the mandatory bundles. Hospitals in the CJR regions will be required to add "other hip and femur procedures" to their bundles.

The actual MSAs will be selected when the final rule is published this fall. All of the new mandatory episode payment models will begin on July 1, 2017, and continue through December 2021.

As with the CJR program, the cardiac and hip/femur mandatory initiatives include:

- Patients with Medicare Part A and B, but not Medicare Advantage patients
- Ongoing payments based on the traditional payment model, with periodic reconciliation (comparison of actual costs with target costs, factoring in a discount to CMS—see below)
- Gainsharing allowed on both internal costs and episode costs

The primary differences between BPCI and the new mandatory bundles (CJR, hip and femur, and cardiac) are:

- No choice of bundle length—90-day bundles are required.
- The target price is partly based, as before, on three years of historical cost, but is based more heavily on regional averages than with BPCI (the fourth and fifth year prices are based 100 percent on regional averages), increasing cost pressure on higher-cost organizations.
- Payments are contingent on meeting specified quality performance targets, including clinical outcome and patient satisfaction; those with higher quality scores will have lower discounts.
- There will be no discounts to CMS in year 1 and the first quarter of year 2; discounts will range from 0.5 to 2.0 percent in the remainder of year 2 and year 3, and from 1.5 to 3.0 percent in years 4 and 5.

- There are more exclusions for conditions not related to the initial index admission, such as unrelated hospital readmissions.
- Stop-loss and gain provisions provide for no downside risk in the first year and gains or losses of not more than 5 percent of their actual total episode costs in the second year, 10 percent in the third year, and 20 percent in the fourth and fifth years.
- There will be two risk-sharing tracks, contributing to the ability of participating physicians to qualify for payment under an advanced alternative payment model (APM) under the Medicare Access and CHIP Reauthorization Act of 2015.

CMS also has proposed an incentive program to test the effectiveness of outpatient cardiac rehabilitation programs in preventing readmissions and improving outcomes. The program adds an incentive payment of $25 to providers' payment for each of the first 11 rehab sessions per episode (in addition to whatever payment would normally be received) and an incentive payment of $175 per session thereafter. CMS rapid expansion of mandatory bundled payment programs suggests that bundled payment models are here for the foreseeable future.

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2017 Health Insurance Marketplace Update:

Struggling Obamacare Plans Increase Calls for a Public Option

BY JIM WATSON, PARTNER, PBC ADVISORS, LLC

Without question, the Health Insurance Marketplace (FKA/AKA Exchanges) has increased coverage in Illinois and nationally. Coupled with Medicaid Expansion nationally, the uninsured rate in the U.S. is the lowest it's ever been. So in that regard, the ACA (or "Obamacare" as some affectionately refer to it), has been a huge success. And while some may argue there are massive problems with the Health Insurance Marketplace and its products (and there are), this train has left the station. So the question becomes: Where is it going and what's next?

Overview of 2017 Illinois Marketplace Plans

Insurers submitted their 2017 product and rate plans for Illinois in April, but this data was not released publicly until late July, as required by the federal government. Final rates will be "negotiated" (the carriers have final say on rates), and the 2017 Open Enrollment begins November 1, 2017.

As of this writing, the Illinois Marketplace will have six carriers in 2017 offering over 400 different health insurance plans. Aetna and UnitedHealthcare are exiting at the end of 2016, and Land of Lincoln Health exited the market as of 10/1/16. In Cook County, choices will be slim with only three carriers offering products. CIGNA has filed rates for plans to be offered on-exchange in the Chicago area in 2017. Below is a summary of rate increases proposed from the carriers who have indicated that they intend to offer products on the Illinois Health Insurance Marketplace in 2017:

- Celtic Insurance Co. (Ambetter): 18.6% or 22.3%, depending on whether the plan includes dental and vision
- Coventry: 20% average increase proposed for Coventry Health Care of Illinois, and 10.3% proposed increase for Coventry Health & Life Insurance Company
- Harken Health Insurance Company: Harken is a product offered through Midwest Security Life, a UnitedHealthcare subsidiary. Harken is staying in the Illinois exchange in 2017, despite United's departure. Their proposed rate increase is 38.4%
- Health Alliance Medical Plans, Inc.: 28.37% rate increase proposed
- Health Care Service Corporation (Blue Cross Blue Shield): 23-45% rate increased proposed
- Humana Health Plan, Inc.: 46.3% rate increase proposed

Increasing Support for a "Public Option" Could Ultimately Lead to "Single Payor"

With insurers increasingly backing away from Marketplace products (and for good reason—they've been a financial disaster for them, many of which are publically traded), there is increasing support to proposals by President Obama and Democratic presidential candidate Hillary Clinton to establish public option plans (effectively a "Medicare For All" model). Obama recently proposed creating public plans in areas where

competition is limited, while Clinton has laid out a broader proposal to launch government-run plans to compete against private insurers and to encourage states to seek waivers to create such plans.

All things considered, the Public Option makes the most sense. The objective is for all Americans to have equal access to high quality, affordable healthcare. Most Marketplace plans simply do not pass that "sniff test." To pay $300-$800 per month, and have $6,000-$12,000 deductibles, but not be able to access some of the more "brand name" providers in the market; well that's simply not good insurance coverage. So a public option could open the door to a new dialogue around universal healthcare, or single payor system, as the means to the end objective of equal access.

Government to Insurers: You Can't Have Your Cake and Eat It Too

At a federal level, there is increasing action toward requiring insurers to offer Marketplace products if these same insurers want to contract with the government for other government-funded health insurance plans. Nevada's state-run insurance exchange already ties exchange participation to its contracts with Medicaid managed care plans.

The Center for American Progress (CAP) is exploring the legality and operational details of establishing a linkage between participation in exchange markets and other public healthcare programs. A core

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2017 Health Insurance Marketplace Update: Struggling Obamacare Plans Increase Calls for a Public Option

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objective is to ensure that insurers offer a genuine competitive Marketplace product rather than just filing plans in order to be able to continue offering Medicare and Medicaid products.

Things may get more interesting in 2018 based on the 2016 Presidential Election

Let's not forget that the ACA passed without a single Republican vote, at a time when the Democrats controlled both houses of Congress. Let's not forget that since it was passed, Republicans have been angling to have it repealed. If Donald Trump wins, the strategy will likely be "repeal and replace." If Hillary Clinton wins, it would be very difficult to repeal, but it will be hard for her to maintain status quo, so perhaps a middle of the road solution is to "restructure."

What this means to healthcare providers

As we enter the fourth year of the Marketplace plans, we are becoming familiar with the challenges of these health insurance products:

- Higher patient out of pocket expenses equate to greater patient bad debt amounts
- Additional administrative costs in managing these products
- New operational requirements in Revenue Cycle management
- Increasing number of products, many of which are "narrow networks"

A few "best practices" can help you be successful in managing these and other managed care plans:

- Ensure compliance with "front end" process requirements: confirm eligibility and benefits, obtain referral and pre-authorizations, understand in which products and networks you are a "participating provider." Discipline around these front end processes can reduce reimbursement and denial problems on the back end.
- Increase your front-end "point of service" collections: The best time to collect patient fees is at the "front end" when patients arrive for appointments. In addition to ensuring collection of co-payments at time of service, collection of outstanding balances, co-insurance and deductibles at time of service greatly increases the probability of collection, and also decreases billing/collection costs and amount of bad debt write-offs.
- Create a "Contract Matrix" that specifies those plans that you participate in, and a brief summary of important operational/administrative requirements of each product.

2017 will be a pivotal year in the ongoing evolution of the ACA Health Insurance Marketplace. Stay tuned as healthcare will be front and center again on the national political stage.

Sources:

Healthcare.gov 8/1/16
Healthinsurance.org 8/18/16

Jim Watson is a Partner at PBC Advisors, LLC, an Oak Brook, Illinois-based healthcare consulting firm. You can reach Jim at Jim_Watson@PBCGroup.com or at 630-928-5233.

President's Message

In February, HFMA will be hosting our Managed Care Symposium in Chicago. This program is very popular and an important healthcare event to keep you up to date with annual managed care changes and one that you won't want to miss. Be on the lookout for a "Save the Date" postcard in the next couple of weeks.

The national HFMA leaders challenged the local HFMA chapters with one innovation strategy this year. The three areas of innovation the local chapters were asked to consider are: Early Careerists, Women in Healthcare and Physicians. The First Illinois Chapter chose to focus on Early Careerists due to an overwhelming amount of support from the FIHFMA leadership towards mentoring and career development of our members. The Early Careerists started with a networking session at the Fall Summit with FIHFMA leaders. Also, a select group of Early Careerists will be chosen to participate in a mentoring program. The mentoring program will start in 2017, and we are hoping to help form the healthcare leaders of the future.

Lastly, I would like to take a moment to thank all of our sponsors. We appreciate all of your time, resources, and commitment to the First Illinois HFMA Chapter. You have helped to make FIHFMA the strong organization it is and allowed us to continue our mission of being Chicagoland's healthcare finance resource.

Mary Treacy Shiff
2016-2017 FIHFMA President

Could the Collapse of Land of Lincoln Health Been Avoided? A View From One of the Founders

BY JASON MONTRIE, FORMER PRESIDENT & CEO, LAND OF LINCOLN HEALTH

Almost every day I'm asked one of the following questions: "What really happened to Land of Lincoln Health (LLH)?" or "Is there any hope for the Affordable Care Act (ACA)?" Over the past few weeks I've had time to reflect on these questions and also on the question I ask myself each day "Could the mid-year liquidation of LLH have been avoided?"

To answer the first question one could read some of the many stories that have been written on LLH and the COOP program in general. It is easy to find articles describing and detailing the challenges that led to more than 70% of the COOPs failing in the first three years of the program, but its failure really boiled down to two things: lack of access to capital, and the risk adjuster program.

It was made impossible for LLH to survive when the federal government (CMS) refused to pay over $70MM owed to LLH under the risk corridor program. Risk corridor was a regulatory failure that was compounded by CMS' refusal to allow LLH to pursue any alternative sources of capital when it did not amend several extremely burdensome regulations in the law which were simply designed to ensure that COOPs could never be privately funded.

Since LLH's demise, lawsuits have been filed over the failed risk corridor funding by a number of health plans including LLH. Perhaps seeing the challenges the funding regulations created, CMS has since relaxed the restrictions to private capital for COOPs, unfortunately not in time for LLH.

As far as the risk adjuster program is concerned, this is a much more serious topic because the first issue can really be attributed to COOPs and other new market participants in 2014-2016. The risk adjuster program however is designed to stay forever.

There are some significant flaws in the actuarial and structural architecture of the ACA, many of which are acknowledged by the industry and administration alike. There is progress being made on a number of topics contributing to these flaws such as: the 'gaming of the system' for special enrollment, the age band restriction on pricing being at 3:1, and other nuanced administrative changes. I'm very encouraged that the administration seems to be listening to the industry on these concerns as some of the changes are material to the future success of the ACA.

However, the single biggest threat to the success of the ACA lies in the implementation of the risk adjuster program, a complex actuarial formula designed to help spread risk among the carriers in a state's marketplace. Given the fact that health insurance is now guaranteed issue, the drafters of the law wanted to protect consumers from insurance carriers intentionally or otherwise avoiding the enrollment of the individuals with pre-existing conditions, those who need the care the most. The risk adjuster mechanism is a very important component of the ACA and conceptually is needed for market stability, the

problem however lies in the formula itself and the exceptions it allows.

It has been acknowledged that the formula has a disproportionately negative effect on new, rapidly growing health plans like LLH and the COOPs. There are fixes underway for some of these flaws, and my assumption is more fixes will be required and implemented. What is impossible to reconcile, and eventually dealt the fatal blow for LLH, is that the risk adjuster program works on the hypothesis that the market is a single risk pool, or in other words everyone is counted. Unfortunately that is not what happened in many states.

Most people can remember President Obama's now infamous *"If you like your plan you can keep it"* speech. The unintended consequence of that speech is the administration allowed for non ACA transitional plans called grandmothered or grandfathered plans to exist. This was done mainly due to the politically charged environment that existed after that speech, and the recognition from the administration that his words were not necessarily going to be true.

Some states recognized that allowing these transitional plans to co-exist with the ACA plans would create two risk pools and fundamentally destroy the risk adjuster program. Illinois, for understandable reasons, allowed the transitional plans to exist, and eventually had some of the highest percentages in the country of people who chose to stay in the old grandfathered plans. The most recent data showed approximately one third of individuals and more

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Could the Collapse of Land of Lincoln Health Been Avoided? A View From One of the Founders

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than half of small groups chose to stay out of the ACA plans through 2015.

What was the result of this? The result was that insurance companies were financially incented through the risk adjuster formula to send the less healthy members to the exchanges and keep the healthy individuals out of the exchanges. Only those customers in the exchanges would count towards the risk adjuster program. This would make their ACA exchange population appear less healthy than the overall population really is.

Since LLH was a new organization participating only on the exchange, they were essentially comparing LLH's entire population against a hand-selected group from their competition. The result was that for 2015 LLH was told it would owe over 20% of its entire collected premium, or $32MM to the program!

This was the eventual reason LLH had to shut down in the middle of the year harming over 50,000 members unnecessarily.

In all of the charged debate on ACA and risk adjuster, keeping in mind it would be absolutely expected for the winners to say the program works fine and the losers to cry foul, I have yet to hear **any** expert describe how a risk adjuster program can co-exist with transitional plans, it simply cannot.

Unfortunately despite several attempts to share this concern with CMS and after formulating a mitigation plan that was supported by our state regulators to lessen the impact of the risk adjuster program due to the allowance and high percentage of transitional plans in Illinois and thereby protect LLH members from a mid-year collapse, CMS determined that any change to the risk adjuster program would be unfair to the market. The Department of Insurance of Illinois was then forced to shut LLH down in July of 2016.

Today it would appear that the primary indictment of the ACA is that it has failed to create stable, competitive marketplaces in many parts of the country. Consumers are left with little or no choice at all in some cases as insurance companies are exiting the marketplace. That is why it is important to understand I share these things not to cry foul or lament LLH's demise and point fingers, but rather to point out the substantive changes that will be required to establish a healthy marketplace in the future. These changes include making it easier for new entrants to enter the market to provide competition, and fixing the underlying structural and actuarial flaws of the ACA including the risk adjuster program.

Despite all that we went through I remain optimistic that the ACA can and will work. I believe we are a better society when access to healthcare is a right for our citizens, and that we can and must have meaningful dialogue and substantive changes to this law in order to encourage and establish a healthy marketplace for consumers.

I also believe the future of health insurance will be in developing true partnerships and collaboration between the insurance community and the healthcare providers, and that new innovative companies will begin to emerge into the marketplace. That was the business model behind LLH and I remain more confident than ever that the future of health insurance lies in that spirit of redefining the role of the health insurer to benefit the consumer.

I want to close by saying "thanks". Thanks to the countless healthcare providers who put their trust, and in some cases names behind LLH. We never could have accomplished what we did without you. Thanks also to the most talented and hard working group of people I have ever had the honor to work with. It was truly a dream come true to be able to lead LLH surrounded by a group of people who were as passionate and resilient as any group I have ever seen. Finally, thanks to our members. To the more than 100,000 people who at some point trusted their health insurance to LLH, please know that every day we came to work committed to doing everything in our power to serve you.

Ultimately it was not enough. Could any of this have been avoided? I'm not sure. The only way to know that would have been to never have tried in the first place. I'm proud of the work we did. I'm proud of the company we created. As Abraham Lincoln is quoted as saying, *"The best way to predict the future is to create it."* 'm proud that we played a role in creating the future of healthcare, and I am looking forward to the next chapter, for we have much work left to do.

ACOs that Garner Shared Savings Increase

BY RICH DALY, HFMA SENIOR WRITER/EDITOR

Data indicate certain ACOs are more likely to either thrive or struggle under the program.

The share of Medicare accountable care organizations (ACOs) earning shared savings increased 3 percentage points in 2015—to nearly one-third—among other improvements noted in recently released data.

In performance year 2015 (PY15), 31 percent of ACOs (120 out of 392 ACOs) generated savings above their minimum savings rate (MSR), according to the latest ACO data from the Centers for Medicare & Medicaid Services (CMS). This is a small but steady improvement from the two previous years, during which 28 percent (92 out of 333) had shared saving in PY14 and 26 percent (58 out of 220) had shared savings in PY13.

However, the still-low share of ACOs generating shared savings drew concerns from some industry advocates. For instance, the National Association of ACOs (NAACOS) said it was "disappointed" in the 2015 shared savings because it means few ACOs are getting repaid for the substantial investments they have made to coordinate care and lower healthcare spending.

"We are a little surprised more didn't get over the hurdle," Jeffrey Spight, president of Collaborative Health Systems (CHS), a division of Universal American, said in an interview.

The results for CHS' partner ACOs, which are primary care physician operated, were better than the national average, with 10 out of 24 garnering shared savings and another eight achieving lower levels of savings in 2015. The latest CMS data identified 83 ACOs that reduced healthcare costs compared to their benchmark, but they didn't qualify for shared savings because they didn't meet the minimum savings threshold.

Premier saw 13 of the 26 ACOs it works with obtain shared savings, although smaller ACOs (with around 20,000 beneficiaries) had wider variation in their results, said Seth Edwards, principal of population health. "You can have a very high cost case that can skew your spending for the overarching group," Edwards said. The shared savings results came as ACOs face a $1.6 million average cost, according to a June NAACOS survey of 144 Medicare ACOs.

Despite the low overall rate of shared savings, industry observers expect the appeal of ACOs to increase.

Leading health systems "are seeing it as a way to really differentiate themselves in a very competitive marketplace," said Andrei Gonzales, MD, director of value-based reimbursement initiatives at McKesson Health Solutions. "Without these sorts of measures, it's hard to say how good a health system is or a provider practice is at managing their patients." Sixty-three percent of the 350 hospitals McKesson surveyed earlier this year are now part of an ACO, and another 47 percent of hospitals that are not in an ACO are expected to join one within five years.

Among other new ACO results was that half of the 12 remaining Pioneer ACOs garnered shared savings. However, four Pioneer ACOs generated losses, and the losses of one were large enough that the ACO owed money to Medicare.

CMS touted results that showed ACOs with more experience in either the Pioneer ACO model or the Medicare Shared Savings Program (MSSP) tend to perform better over time. In PY15, 42 percent of ACOs that started in 2012 garnered shared savings, compared with 37 percent that started in 2013, 22 percent that started in 2014, and 21 percent that started in 2015.

In addition, 45 percent of practices in the ACO Investment Model garnered shared savings. The test model offers select Shared Savings Program ACOs pre-paid savings. The shared savings rate of all other ACOs was only 29 percent.

Overall Savings

Medicare's more than 400 ACOs generated their largest savings yet for the federal government in 2015, with more than $466 million in total. That was a 36 percent increase from overall savings in 2014.

MSSP ACOs generated $429 million in savings, whereas Pioneer ACOs generated $37 million in total model savings. No Track 2 MSSP ACOs, which face two-sided risk, owed CMS losses. The Pioneer results followed the introduction of new financial benchmarks that compared the ACOs' spending to their initial years in the model. Among the quality results were that all 12 Pioneers improved their quality scores from the first performance year—four years ago—by more than 21 percentage points.

MSSP ACOs that reported quality in 2014 and 2015 improved on 84 percent of the quality measures that were reported in both years.

How They Did It

Spight, of CHS, said his ACOs achieved savings through reduced admissions, readmissions, and emergency department (ED) use. That echoed the findings of an August study in JAMA Internal Medicine, which found enrollment in a Medicare ACO was linked to reductions in health spending, as well as fewer ED visits and hospitalizations.

Although some ACOs are focusing on improving the quality of their post-acute networks, most ACOs have derived savings from reducing overall utilization, as opposed to just changes in the sites of care.

"I wouldn't credit most of the savings to provider steerage," Spight said. "More of it is that we're just getting our hands around people who are chronically ill." Conversely, Premier sees its members obtaining ACO savings from reduced length of stay and lower average cost of hospital stay per day, as well as from improved post-acute networks. "Utilizing care management and other steps can help beneficiaries receive care in places

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ACOs that Garner Shared Savings Increase (continued from page 13)

that are most appropriate for their condition," Edwards said.

The largest shared savings, nearly $42 million, were garnered by the Memorial Hermann ACO, which brought its three-year shared savings to nearly $200 million. Nishant Anand, MD, physician-in-chief at the ACO, credited care management, coordinated care, and better data use for the savings. Specific savings sources included reduced year-over-year admissions and ED use.

The latest results provide continued confirmation of some key takeaways from the earlier Medicare Physician Group Demonstration project, said Francois de Brantes, executive director for the Health Care Incentives Improvement Institute. Specifically, already efficient medical groups face disadvantages in producing significant incremental savings from their baseline, and physician group practices unaffiliated with hospitals can generate more savings because they don't worry about facility revenue reductions.

"The ACO program simply confirms these findings," de Brantes said in emailed comments. An initial analysis by Premier found the percentage of an ACO's savings was somewhat related to the size of its historical benchmark. "In groups that have smaller populations, as well as lower benchmarks, it can be very challenging," Edwards said.

Similarly, an analysis by Ashish Jha, a Harvard health policy researcher, concluded that per capita benchmarks for the ACOs that garnered savings were $10,580 and their actual spending was $10,140. Meanwhile, ACOs that didn't garner savings had average benchmarks of $9,601 and actual spending of $9,901. In June, CMS finalized rules to allow ACOs to benchmark their results to regional Medicare spending, rather than national, but only after their first three-year contract.

Edwards said he expects the benchmark changes will be very helpful to those ACOs with lower benchmarks. But even with those changes, the Medicare ACO model will continue to tighten the benchmarks, Anand noted. To address those increasing cost pressures, his ACO hopes to derive new savings from increased efficiencies in its post-acute care network. "We'll have to get even deeper into [post-acute] to be successful," Anand said in an interview.

CMS said it has received "strong interest" from providers to participate in a second MSSP agreement period starting in 2017.

New and renewing ACOs will be announced near the end of 2016.

Rich Daly is a senior writer/editor in HFMA's Washington, D.C., office. Follow Rich on Twitter: @rdalyhealthcare

From the HFMA Newswire

National HFMA President Joe Fifer Among '100 Most Influential People in Healthcare'

BY RICH DALY, HFMA SENIOR WRITER/EDITOR

For the second time in three years, HFMA President and CEO Joseph J. Fifer, FHFMA, CPA, was named to Modern Healthcare's list of the 100 Most Influential People in Healthcare. The annual ranking recognizes those who are considered by their peers and the senior editors of Modern Healthcare to be the biggest influencers in the healthcare industry. Modern Healthcare cited the thought-leadership work that took place during Fifer's tenure as chair of the HFMA Board of Directors in 2006-2007, when he led an initiative to make pricing more understandable and transparent to consumers. That work served as the foundation for the consumerism-related initiatives that Fifer—and HFMA—have become known for in the years since he took the helm as HFMA's president and CEO in 2012. Fifer, who ranked 80th on the top-100 list, previously served as CFO at Spectrum Health in Grand Rapids, Mich.

HFMA Joins National Patient Safety Foundation (NPSF)

The National Patient Safety Foundation (NPSF), a central voice for patient safety since 1997, has welcomed the Healthcare Financial Management Association (HFMA) to the NPSF Patient Safety Coalition. The NPSF Patient Safety Coalition is a growing community of stakeholders from across the continuum of care aligned in the mission to make health care safer for all. The NPSF Patient Safety Coalition was created to align diverse stakeholders from across the continuum of care in a unifying mission of making health care safer for patients and the workforce. Membership is open to myriad groups, including solutions providers working to address patient safety challenges, professional associations, advocacy organizations, and other similarly committed organizations. Coalition members gain valuable opportunities for networking, learning, and knowledge sharing through quarterly webinars, an annual member meeting, special projects and events, and other high-value activities.

"One of the goals of the coalition is to bring diverse stakeholders together to share expertise and learn from each other," said Tejal K. Gandhi, MD, MPH, CPPS, president and CEO of NPSF. "Many health care organizations now recognize that having the finance professionals' perspective is increasingly important to patient safety initiatives. We are very pleased to welcome HFMA into the coalition."

With more than 40,000 members, HFMA is the country's leading professional organization of health care finance professionals. By providing education, analysis, and guidance to its members, HFMA aims to improve health care by identifying and bridging gaps in knowledge and best practices. "People may not readily equate finance and patient safety, but we have seen a shift in recent years toward greater recognition that safe, high quality care is really tied to an organization's financial health," said Joseph J. Fifer, FHFMA, CPA, president and CEO, HFMA. "Joining the NPSF Patient Safety Coalition reflects our belief in the need for finance professionals to learn more about patient safety and their own organization's goals for advancing safe care."

For more information about the NPSF Patient Safety Coalition and how to join, contact David Coletta, senior vice president, at dcoletta@npsf.org.

Improve Performance Throughout the Revenue Cycle with HFMA's MAP App

HFMA's web-based MAP App helps hospitals, health systems, and physician practices improve performance throughout the revenue cycle. Compare your performance to peer groups and the industry and align your goals with the industry's best practices. Nearly 600 facilities use MAP App to:

- Display critical revenue cycle metrics in a dashboard to quickly compare performance
- Deliver case studies, expert insight, and events directly from HFMA
- Provide trending data across each of the MAP Keys
- Enable users to select criteria for their peer group
- Be alerted when performance changes

For more information or to schedule a demo, contact the HFMA MAP App team at mapapp@hfma.org.

Study Puts Numbers on Narrow Network Savings (by Andis Robeznieks, HFMA Contributing Writer)

A warning is issued that savings generated by narrow networks shouldn't come from penalizing patients who need more care.

While questions remain regarding the effect narrow provider networks have on patient access and choices, researchers identified how much they can save: from 6.7 percent to 13 percent on silver plan premiums. In a new study published in Health Affairs, University of Pennsylvania researchers used data from all the silver plans offered on the government-run marketplaces in all 50 states and the District of Columbia to calculate the cost of premiums based on the size of the physician network offered.

Other research, such as a McKinsey & Co. analysis, have defined narrow networks as including no more than 70 percent of an area's hospitals, but a University of Pennsylvania team looked at how many physicians were in the network. They categorized the networks as extra-small (less than 10 percent of physicians in an area participating), small (10 percent to 24 percent), medium (25 percent to 39 percent), large (40 percent to 59 percent), and extra-large (60 percent or more).

The average silver plan's network includes 30 percent of a service area's physicians, costs $266 each month, and has an average annual deductible of $2,774 and a $32 copay per primary-care visit, according to the study.

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The difference in cost was 13 percent between an extra-small and an extra-large network and 6.7 percent between an extra small and a large network. There were no significant differences in cost between the other plans, leading the researchers to conclude that this "suggests that very restrictive plans do not tend to be cheaper than moderately restrictive plans."

The 6.7 percent difference was calculated to equal an annual savings of $212 for a 27-year-old single individual, $339 for a 50-year-old individual, and $692 for a young family of four. Linda Blumberg, a senior fellow with the Urban Institute's Health Policy Center, thought the 6.7 percent figure might be a little low and said she's heard others suggest the difference was closer to 10 percent—which she said adds up for consumers. "When you're talking about an insurance premium costing thousands of dollars, 10 percent is a lot of groceries," Blumberg said.

The study's authors went further and linked successful implementation of narrow networks to success for the government policy objective of expanding health insurance coverage. Citing how silver plan premiums are often supported by government subsidies, they also linked narrow network savings to reduced government spending.

"Given the subsidy structure within the marketplaces, the benefits of lower premiums not only accrue to the consumer but also generate savings for the taxpayer," the authors wrote. "Thus, the lower premiums from narrow networks help reduce the number of uninsured people and reduce the cost of achieving that policy objective." Blumberg agreed, and she described narrow networks as "an important piece of the healthcare landscape that could catalyze lower costs."

Narrow networks still, however, are not always viewed positively despite their ability to offer insurance at a lower price. Blumberg said this might be a lingering effect of the chaos surrounding the 2014 roll out of the marketplace. "There was enormous confusion with physicians themselves not knowing whether they were in a network or not," Blumberg said. "I haven't heard much of that lately."

To this point, the study authors cited a 2014 study in which 26 percent of consumers were unaware of how narrow the network was for the plan they chose. Surveys suggest the vast majority of consumers are satisfied with their marketplace plan's physician network, according to a Health Affairs health policy brief published in July. But anecdotal complaints have "proliferated" mainly due to some plans excluding high-profile hospitals from their networks and these exclusions generating media coverage.

Hospital choice is particularly valued by older consumers. In Massachusetts, 60-year-olds were willing to pay $1,200 to $1,400 more for plans with a broader network, according to a 2015 report published by the American Economic Review and cited by the University of Pennsylvania researchers. Blumberg warned that there can also be access and cost issues for high-need patients who may have to go out of their network for needed services. She believes that these individuals should not have to pay the higher out-of-network price for services their plan is not providing. "Just because you're in a narrow network doesn't mean you're in a bad network," Blumberg said. "But, if plans are not providing appropriate care or appropriate access, then some intervention is required."

Two basic ways of lowering spending are to lower prices and lower utilization, but "when reducing use, you have to make sure you're not penalizing people who need more services," Blumberg said. She added that there should be honesty about where the savings are coming from. "We shouldn't have illusions that we can contain costs without taking money away from providers," Blumberg said. David Harlow, principal of the Harlow Group healthcare consulting firm, wrote in a 2013 blog post that "we've been kidding ourselves" by pretending that managed care can work without managing networks—which often means limiting them. Harlow stands by this opinion. "Managed care can save money, but only if care is actually managed," Harlow said in an e-mail. "One aspect of that effort is creating narrow networks."

"More of it is that we're just getting our hands around people who are chronically ill." Conversely, Premier sees its members obtaining ACO savings from reduced length of stay and lower average cost of hospital stay per day, as well as from improved post-acute networks. "Utilizing care management and other steps can help beneficiaries receive care in places.

Provider-Sponsored Health Plans: Valuation Considerations

BY BRIAN GORE, CFA, AND DAN PLATTEN, CPA, ABV

Providers contemplating the acquisition of health plans should not proceed without a full understanding of all the nuances involved with health plan valuations.

The healthcare industry is undergoing its biggest transformation since the 1990s. With the implementation of the Affordable Care Act (ACA) several years removed and continued movement from fee-for-service models to fee-for-value models, healthcare providers increasingly have been exploring the strategy of sponsoring their own health plans.

Many articles have outlined the strategic considerations for providers that are contemplating the viability of such a strategy. But once a provider has decided to pursue the development or acquisition of a provider-sponsored health plan (PSHP), it must turn its attention to tactical considerations related to valuation of the health plan, which must be addressed both before due diligence efforts commence and after the deal closes.

Before the agreement is finalized (whether the provider is launching a new health plan or acquiring one), the provider should perform a careful financial analysis of the potential value of all PSHP opportunities, given that health plans are subject to a unique set of value drivers. Only through such an analysis can the provider make an informed decision based on a clear understanding of the PSHP's true potential value.

After the deal, the provider must account for the acquisition in compliance with prevailing U.S. Generally Accepted Accounting Principles (U.S. GAAP). In particular, the provider must ensure the health plan's assets and liabilities are fair valued and reported appropriately, based on a clear understanding of the unique nature of those assets and liabilities.

Brief Overview of the Movement Toward PSHPs

The 1990s saw a large number of providers move into the health insurance market. But for the most part, these initiatives failed, and most of the providers exited the market. The reasons for failure were mostly operational and related primarily to particular nuances of the health insurance business, which most providers had not experienced previously. For example, challenges included the need to maintain sufficient levels of capital, a lack of functional expertise unique to insurers (e.g., actuarial and underwriting proficiency), and the difficulty of competing with incumbent commercial insurers.a

A number of themes have emerged over the past several years signaling the re-emergence of PSHPs, primarily as a result of the shift in focus from fee for service to value-based care—a trend that was solidified with the enactment of the ACA. Initial attempts by providers to holistically manage the care of their patients have included new delivery methods, such as accountable care organizations (ACOs) and the use of narrow networks. Both forms of healthcare delivery involve providers partnering with health plans for the benefit of the consumer.

PSHPs are a natural extension of this trend. Owning a health plan gives providers the ability to control all elements of healthcare delivery in an integrated manner that cannot be matched by an ACO or a narrow network. And the secret is out: Today, 13 percent of all U.S. health systems offer health plans in one or more markets, covering approximately 18 million members, or roughly 8 percent of all insured lives across 39 states. Moreover, acquisitions of health plans by providers have proliferated in the past 12 to 24 months, with the following being noteworthy examples:

- U.S. Health and Life Insurance Company acquired by St. Louis-based Ascension Health
- QualChoice Holdings, Inc., acquired by Denver-based Catholic Health Initiatives
- Riverside Health, Inc., acquired by the Baltimore-based University of Maryland Medical System
- PreferredOne Insurance Company acquired by Minneapolis-based Fairview Health Services, Inc.
- Piedmont Community Health Plan, Inc., acquired by Lynchburg, Va.-based Centra Health, Inc.
- HealthPlus of Michigan acquired by Detroit-based Henry Ford Health System

To avoid a repetition of the 1990s, providers considering ownership of PHSPs should be prepared to meet the associated tactical and operational challenges. The list of health plan valuation nuances is long, but provider executives must understand them all to be able to accurately value a health plan targeted for acquisition. To understand how health plan valuations differ from provider valuations, it is helpful first to review the nuances of the latter.

Nuances of Provider Valuations

The following factors constitute the primary nuances involved with valuation of provider organizations with respect to both pre-deal and post-deal analyses.

Pre-deal provider valuation. Transactions in the provider space are subject to regulations such as Stark Law, the anti-kickback statute, and tax-exempt laws, which require healthcare entities (with some exceptions) to pay no more than fair market value (FMV) for the assets or equity ownership received. The most significant requirement in these regulations is that the consideration or payment must not incorporate the value or volume of referrals.

For example, if a hospital purchases a physician practice for more than FMV in anticipation that the physician practice will generate referrals, the transaction would be in violation of these regulations because the above-FMV purchase price may be construed as an inducement for physician referrals. To avoid such a situation, the acquiring organizations must fully understand and analyze its cash flows in a valuation within the context of healthcare regulatory guidance. It is beyond the scope of this article to provide details regarding how to estimate FMV, other than to note that there are three primary valuation approaches that should be considered: income approach, market approach, and asset-based approach.

(continued on page 18)

 (continued from page 17)

Post-deal provider valuation. To comply with U.S. GAAP requirements under Accounting Standards Codification (ASC) Topic 805, Business Combinations, an acquirer must record the acquired assets and assumed liabilities at fair value, as defined in the FASB's ASC Topic 820, Fair Value Measurement. Given the capital intensive nature of healthcare providers, the largest acquired assets typically are the plant, property, and equipment. However, there are unique intangible assets to consider in establishing the opening balance sheet, as presented in the exhibit below.

Intangible Assets and Related Key Considerations in Provider Valuations:

INTANGIBLE ASSETS AND RELATED KEY CONSIDERATIONS IN PROVIDER VALUATIONS

Intangible Asset	Description	Considerations	Approach
Certificate of Need (CoN)	This certification is aimed at restraining healthcare facility costs and allowing coordinated planning of new services and construction. Its purpose is to reduce overall health and medical costs.	CoNs are: › Maintained by 36 states › Variously difficult to obtain, depending on state and specialty › Subject to moratoriums– explicit or implicit	Income or cost approach, depending on qualitative assessment considerations
Medicare License	CMS requires a provider to be certified before providing and billing for services rendered to Medicare- or Medicaid-eligible patients.	CMS may impose a moratorium on the enrollment of new Medicare providers.	Income or cost approach, depending on qualitative assessment considerations
Trade Name	The trade name is the registered or unregistered name of the company or facility.	Availability of third-party licensing rates of provider trade names is limited. Value derived from a provider's trade name is often limited due to the underlying element that drives health care (e.g., access and quality).	Income, market, or cost approach depending on qualitative assessment considerations
Other	Other intangible assets include: › Contractual and non-contractual relationships › Non-compete agreements › Developed technology › Favorable/unfavorable contracts	It is critical to evaluate the healthcare-specific regulations when assessing whether such items are identifiable under ASC 805.	Varies

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Unique Considerations of Health Plan Valuations

INTANGIBLE ASSETS AND RELATED KEY CONSIDERATIONS IN HEALTH PLAN VALUATIONS

Intangible Asset	Description	Considerations	Approach
Customer Relationships	Customers—also referred to as members, subscribers, enrollees, etc.—often represent a predictable, recurring source of premium income.	› Analysis should evaluate the average lapse (i.e., attrition) rate, which could vary by coverage type. › Profit margins are likely vary by coverage type.	Income approach—multi-period excess earnings method (MPEEM)
Provider Contracts	These contracts represent then networks of providers with which health plans contract for their customers to receive health care services.	› The cost of rebuilding the provider network should be considered, including direct expenses incurred in identifying, negotiating, and contracting with providers; indirect expenses to support those efforts; and opportunity costs. › Costs vary by provider type (hospitals, physicians, specialists, etc.).	Cost approach
State-Sponsored Contracts	State-by-state contracts to participate in government-sponsored managed care markets provide access to populations of participants who either voluntarily or involuntarily seek government health coverage. These contracts are common in managed Medicaid markets.	› The likelihood of renewals/extension should be evaluated. › In some cases, plan management may equate the probability of losing a contract with the probability of the business failing, which could suggest an indefinite life is the appropriate term to consider when valuing these contracts.	Income approach; MPEEM
Other	Other intangible assets include: › Trade name › Non-compete agreements › Developed technology › Favorable/unfavorable contracts	› Valuation of these assets requires an understanding of the economics and drivers of a health plan's value.	Varies

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Health plans present their own unique set of challenges from a valuation standpoint. Accordingly, once a provider has weighed the strategic considerations and opted to acquire a health plan or enter into a joint venture with one, the provider must begin to deal with the valuation issues that follow.

Like providers, health plans operate under a unique regulatory framework (made even more complex by state-by-state oversight), and both parties strive to ensure their customers receive high-quality and affordable care. But health plans and providers have inherently different operating models. Simply stated: While providers attempt to maximize the utilization of their assets, health plans attempt to minimize the amount by which their members utilize provider assets.

Because of these inherent differences, the valuation challenges differ between provider organizations and health plans, to the point that provider executives may feel they are venturing into uncharted territory in valuing a health plan. It therefore is incumbent on provider executives contemplating a health plan acquisition to familiarize themselves with the valuation issues unique to health plans that must be addressed before and after such an acquisition.

Pre-Deal Health Plan Valuation

The approaches to valuing health plans before the deal resemble approaches that providers use in valuing other providers. The traditional methods of valuation described previously still apply.

Discounted cash flow (DCF) analysis. Generally speaking, the DCF analysis of a health plan will attempt to estimate the future free cash flow (FCF) and then discount the FCF to present value using a risk-adjusted discount rate. But the fundamental drivers of FCF for a health plan are significantly different from those for a provider.

For one, provider forecasting focuses on projecting asset utilization. Providers make capital investments and then generate revenue from those investments by increasing the utilization of capital. Increasing revenue will generally translate into higher returns on capital due to operating leverage, and, in turn, value. Providers have a relatively high amount of operating leverage (i.e., high ratio of fixed costs), and their capital investments are made in tangible assets.

By contrast, the FCF for health plans starts with revenue that can come from multiple sources, under multiple and different payment models. Operating expenses are mostly variable, with the amount of a health plan's largest expense dependent on the degree of utilization by a plan's members. With a more-variable expense structure comes relatively lower operating leverage, but health plans must make capital investments that satisfy health and insurance regulators, thus restricting what would otherwise be FCF. Further discussion of the key drivers of FCF for a health plan is provided below.

Revenue. Revenue earned by a PSHP can come from multiple sources. Commercial health plans will generally receive premium income from individuals or employer groups that have purchased health insurance coverage. Government-sponsored health plans (e.g., managed Medicaid or Medicare Advantage) may receive income from a combination of members, federal government agencies, or state government agencies. Health plans that can increase their enrollment will generally increase their revenue, but increasing enrollment requires offering competitive rates that are commensurate with the underwriting risk of enrollees. Adverse selection was one of the causes of the failure of PSHPs in the 1990s, as was competition by incumbent commercial plans. Obtaining enrollees is subject to fierce competition among health plans, and these market dynamics must be understood when making revenue projections.

(continued on page 19)

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Expenses. Health plan expenses may pose a particular challenge for providers to manage and understand when performing a health plan valuation. Health plans have less operating leverage (i.e., more variable costs) than providers, meaning incremental revenue does not automatically translate into incremental operating profits.

Medical benefits expenses represent the single largest category of expenses for a health plan. Medical benefits, or claims, are subject to factors both in and out of a health plan's control. Negotiating rates with providers and proactively managing the utilization of health care to ensure insurance beneficiaries are receiving high-quality care are two examples of strategies commonly used to manage medical claims. However, the best-laid plans are not always successful, as evidenced by the withdrawal of prominent health insurance organizations from the ACA health insurance exchanges in 2016 and 2017.

In addition, with the onset of the ACA, many types of healthcare coverage are now bound by minimum medical loss ratios (MLRs)—approximately equal to medical expenses divided by premium revenue—generally ranging from 80 to 85 percent depending on the nature of the coverage. During a given coverage period, premium income is relatively known, but medical expenses are uncertain, making the management of medical expenses just as important as managing enrollment, if not more so.

Apart from medical benefit expenses, health plans have other expenses that are not trivial. If a health plan uses third-party brokers or benefits consultants to assist with the generation of new business, such parties will generally charge up-front commission expenses. These expenses can cause an earnings drag, leading to operating losses for health plans that are ramping up or growing at high rates due to enrollment growth. For providers acquiring small health plans with the intent to grow rapidly, having adequate liquidity to fund early operating losses from these expenses is paramount.

Health plans also incur underwriting and actuarial expenses, expenses related to provider contracting and maintaining provider relationships, and other administrative-related expenses, all of which must be covered by the narrow margin remaining after paying medical expenses.

Statutory reserve. For providers, after expenses are paid, management has discretion to determine how to allocate remaining profits. For health plans, sufficient capital must be retained in liquid assets to meet prevailing statutory reserve (or capital) requirements, which generally are set on a state-by-state basis. Some states require a constant percentage of premium income to be retained as capital, whereas others use risk-based capital models that are more commonly used by larger health insurers. Either way, a buyer of a PSHP must understand the specific requirements relevant to the markets in which it operates and ensure sufficient capital investment is factored into the forecast, because every dollar of capital that is required reduces available cash flow.

Pre-deal valuation wrap up. It is critical for provider executives to understand all of the above drivers when analyzing the prospective financial results of a health plan and when estimating the health plan's value. Proper analysis of these factors will ensure acquiring providers are prudently investing their capital and setting themselves up for success in the PSHP market.

Post-Deal Health Plan Valuation

Once the decision has been made to acquire a health plan, and the transaction has closed, a new set of valuation issues arise related to accounting for the transaction under U.S. GAAP, just like the requirements that would exist in a provider-to-provider transaction. However, several assets and liabilities that are material to a health plan's balance sheet are unique to health plans and require an appropriate understanding to value appropriately.

Medical claims payable. Medical claims payable represents the largest liability on a health plan's balance sheet and accounts for reserves held for future medical claims payable. Such reserves are usually short-tailed, meaning the amount of time between when the claim is incurred and ultimately settled (paid) is relatively short. Reserves may fall into different categories, such as claims that have been reported but not paid as of a measurement date, and claims that have been incurred but not reported (IBNR). IBNR claims are subject to a significant amount of actuarial expertise and analysis to estimate properly.

Other intangible assets. The types of intangible assets that are commonly analyzed for a health plan are shown in the exhibit on page 5, namely:

- Intangible Assets and Related Key Considerations in Health Plan Valuations
- Key Considerations in Health Plan Valuations
- Making the Best of an Exceptional Opportunity

The decision to enter the PSHP market is not one to be taken lightly. From strategic inception, to due diligence, to execution, to integration, the challenges that provider executives can face will be trying and require careful judgment and expertise. Providers considering PSHP acquisitions should familiarize themselves with the nuances of health plan valuation to ensure an exciting opportunity starts on the right foot.

Brian Gore, CFA, is managing director, Duff & Phelps, LLC, Chicago.

Dan Platten, CPA, ABV, is director, Duff & Phelps, LLC, Milwaukee, and a member of HFMA's Wisconsin Chapter.

Footnotes

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Healthcare Consumerism Study Shows Patients Need Financing Options

BY BRUCE HAUPT, PRESIDENT AND CEO OF CLEARBALANCE, CYNTHIA PORTER, PRESIDENT PORTER RESEARCH

Where patient satisfaction was once solely measured from a clinical standpoint, patients now regard the financial side of the house as an important part of the overall experience. Increasingly, they're judging and rating their satisfaction with healthcare organizations by the amount of repeat business and referrals they bring.

A study we recently conducted to measure awareness, loyalty and satisfaction with consumer-friendly patient loan programs and the role they play in creating a positive hospital experience for patients reveals some not-so-surprising insights.

The second annual Healthcare Consumerism Study was built on an effective model established in 2015 by the Lavin Entrepreneurship Center at San Diego State University. This year, healthcare market specialist Porter Research designed and administered the survey. In addition, the advice of the CFO from a major health system was also solicited in this year's study

The survey was completed by more than 2,700 patients, representing a 78 percent completion rate. This statistically significant response rate provides the survey data with a 95 percent (+/-2%) confidence rate.

Among respondents, healthcare cost is undeniably a concern: 79 percent say it is a factor when selecting a physician, and 81 percent confirm the same when choosing a healthcare provider.

Relative to their cost concerns, 91 percent of survey respondents regard healthcare as a "big ticket" expense that requires financing or some sort of payment plan of 12 months or more. In fact, one out of every three consumers would delay care if a loan program wasn't made available to them. This is an increase from our 2015 Healthcare Consumerism study, when 26 percent of respondents said they would delay care. Moreover, the finding compares with a recent study by the Commonwealth Fund, which shows 40 percent of adults with deductibles equal to 5 percent or more of their income said they would not seek care due to cost. Experience shows that most patients are willing to pay their portion of care. They just want options to make repayment affordable.

One survey respondent said, "It's helpful not to have to pay a large, unexpected medical bill all at once."

Loyalty is an important barometer of future business. According to The Advisory Board Company, patients who return to a healthcare organization within 18 months generate six times more revenue for that provider. Making care affordable through a loan program is a clear benefit that will enhance goodwill, loyalty and referrals within a healthcare provider's consumer and community base. According to the survey, 90 percent of respondents likely will return to the healthcare provider that offers a loan program, and 88 percent would likely recommend the healthcare provider to friends and family.

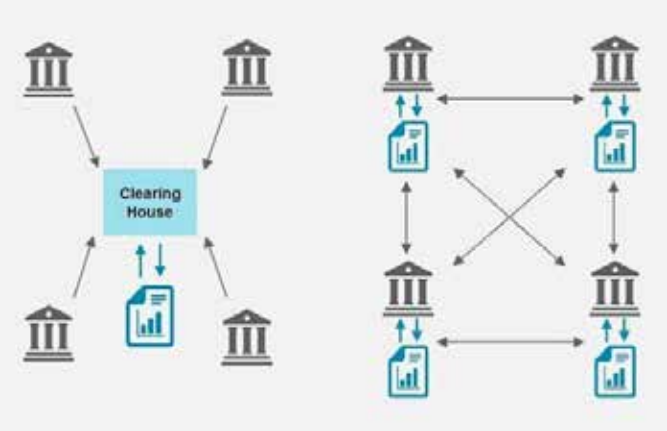
"I'm happy there's a reasonable payment method to manage medical debt versus being turned over to a collection agency," said a survey respondent.

Each interaction during a patient episode is an opportunity to create a longer-lasting relationship. It's important to remember that an episode isn't solely made up of the patient's experience inside of the hospital's four walls. Your outreach to patients before service and your follow-up for reimbursement are activities that impact their decision to return to your facility in the future.

For more information on consumer-friendly patient loan programs please contact Bruce Haupt, President and CEO, ClearBalance at bhaupt@clearbalance.org or Cynthia Porter, President, Porter Research at cporter@porterresearch.com.

Can "blockchain" Technology be Used in Healthcare?

BY STEVE OMANS



Most people will recognize "Bitcoin" before recognizing that it's run on a platform called "blockchain." As healthcare transparency, value and the care continuum become more important, blockchain may hold some important value in this process.

Today, more than 40 top financial institutions are using blockchain.

What is blockchain?

A blockchain is a data structure that makes it possible to create a digital ledger of transactions and share it among a distributed network of computers. It uses cryptography to allow each participant on the network to manipulate the ledger in a secure way without the need for a central authority.

Once a block of data is recorded on the blockchain ledger, it's extremely difficult to change or remove. When someone wants to add to it, participants in the network — all of which have copies of the existing blockchain — run algorithms to evaluate and verify the proposed transaction. If a majority of nodes agree that the transaction looks valid — that is, identifying information matches the blockchain's history — then the new transaction will be approved and a new block added to the chain.

The term blockchain today usually describes a version of this distributed ledger structure and distributed consensus process. There are different blockchain configurations that use different consensus mechanisms, depending on the type and size of the network and the use case of a particular company. The bitcoin blockchain, for example, is public and "permissionless," meaning anyone can participate and contribute to the ledger. Many firms also are exploring private or "permissioned" blockchains whose network is made up only of known participants. Each of these blockchain implementations operate in different ways.

Guardtime, a company that sells blockchain-based products and services to enterprises and governments including Ericsson AB and the country of Estonia, explained its approach like this:

Assume an organization has 10 transactions per second. Each of those transactions receives its own digital signature. Using a tree structure, those signatures are combined and given a single digital fingerprint — a unique representation of those transactions at a specific time. That fingerprint is sent up the tree to the next layer of infrastructure, such as a service provider or telecom company. This process happens for every organization in the network until there is a single digital fingerprint that encompasses all the transactions as they existed during that particular second. Once validated, that fingerprint is stored in a blockchain that all the participants can see. A copy of that ledger is also sent back to each organization to store locally. Those signatures can be continuously verified against what is in the blockchain, giving companies a way to monitor the state and integrity of a particular asset or transaction.

Any time a change to data or an asset is proposed, a new, unique digital fingerprint is created, Guardtime said. That fingerprint is sent to each client node for validation. If the fingerprints don't match, or if the change to the data doesn't fit with the network's agreed-upon rules, the transaction may not be validated. This setup means the entire network, rather than a central authority, is responsible for ensuring the validity of each transaction.

Using blockchain in healthcare

Blockchain is being used to migrate clinical data together in one centralized location.

One such company, **Gem Health Network** is working with Phillips Blockchain Labs.

Gem Founder and CEO Micah Winklspecht told Bitcoin Magazine, "A lot of healthcare companies started reaching out to us." Further, "a lot of companies were suffering from these same pain points—working with siloed data that we could bridge together. Use cases of distributed ledger technology span the entire healthcare continuum, a whole range of processes from wellness and prevention to billing and claims. We need a patient centric model for healthcare and particularly how to secure clinical data."

"One of the most interesting groups that reached out to us when we started talking about the blockchain and healthcare were physicians themselves," added Winkelspecht. Many of them see the problems," added Winkelspecht. "Many of them see it with today's technology and are fed up with the current system. Physicians want to help. And so we want to create platform for all the different stakeholders to collaborate."

Blockchain also has the ability to get rid of the middleman. The architecture allows a group of computers to reach consensus without the need for a central authority like a clearing house. Is it possible that blockchain might be able to offer providers a chance to create their own self-insured risk networks? Transactions could be approved automatically in seconds or minutes, claims processing and transparency to the patient would be seamless through the internet.

It's only a thought, but it could be that change has to happen in increments.

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

2nd Annual Women's Golf Outing
Held August 26 at Eagle Brook Country Club

BY SUE W. MARR, CHAIR, FIHFMA WOMEN'S GOLF COMMITTEE

The 2nd Annual Women's Golf Outing, co-sponsored by FIHFMA and CHEF, was held on Friday, August 26, 2016, at Eagle Brook Country Club. There were over 30 golfers in attendance, with golfing skills ranging from collegiate golf athlete to ones who haven't held a club for years. The participants were a great mix of FIHFMA members and associates, along with CHEF members and associates. There were representations from hospitals, healthcare providers and vendor partners, including Advocate, Presence, Rush, Lurie Children's, Palos Community, Covenant Retirement, AMA, and many more.

Participants had the option to play a game of scramble or attend a "Golf Clinic." At the clinic, professional golf instructors provided a tutorial on golf strokes and course etiquettes, and then led the attendees through a few holes of real golf. Lunch featured an inspirational speech by Michelle Rathman, CEO of Impact! Communications. The format of the event allowed attendees the opportunity to network, learn, and relax in the beautiful surroundings of the Eagle Brook Country Club. The day was beautiful and sunny, the perfect "fair golf weather," and fun was had by all.

Below is a summary of some of the "awards."

Golf Results

- Longest Drive: Jori Brink
- Longest Putt: Fran Dean
- Closet to Pin: Jen Draudt Scully
- Longest Drive (3-holer): Elizabeth Londo
- Team with Lowest Score: Andrea Dreher, Teresa Djukic, Jennifer Vanden Bergh, and Katie White
- Golf Trivia: Jen Draudt Scully

A special thank you to the Event Sponsors:

- Mulligan Cards: Avastone Health Solutions
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- Golf Balls: Lubaway, Masten and Co.
- Longest Drive: Bank of America
- Longest Putt: Crowe Horwath LLP
- Closest to Pin: Strategic Sourcing Results
- Lunch Sponsor and Fore Caddy: PBC Advisors, LLC

I will leave you with one of my favorite golf quotes from Jack Nicklaus, "I never hit a shot, not even in practice, without having a very sharp in-focus picture of it in my head."

HFMA Event Summaries Cont'd

2nd Annual Women's Golf Outing Held August 26 at Eagle Brook Country Club (continued from page 22)

Women's Golf Outing Photos

Attendees absorb the good vibes from Michelle Rathman, Impact! Communications

Elizabeth Londo, Paula Gallagher, Margaret Smith, Debbie Sieradzki

Karen Galivan Jori Brink Jenny Han Fran Dean

Katie White, Teresa Djukic, Jennifer VandenBergh, Andrea Dreher

Mary Treacy Shiff, Jennifer Draudt-Scully, Lauren Gorski, Donna Jansen

Patti Eddy, Tracey Coyne, Jennifer Ittner, Catherine Hennessy

New Member Profile

Sam Mahmood

I am currently a second year master's student, working as an Administrative Project Assistant at Rush Health, where I provide analytic support for Rush Health's value-based care programs. As an HFMA volunteer, I'm a new member of the First IL HFMA Chapter and a member of the Early Careerist Committee.

Questions:

How long have you been in healthcare?

I have been working in healthcare in some capacity for over four years. I began working in the field of healthcare as a pre-med student in undergrad, volunteering in the Emergency Department and the Intensive Care Unit for several years at Scripps Memorial Hospital in La Jolla, California. After completing one year of medical school, I decided I wanted to improve the quality of care patients receive on a systemic level and decided to obtain my master's degree in Health Systems Management at Rush University. As a first year master's student, I worked as an administrative project assistant in the Financial Planning and Decision Support Department of Rush University Medical Center.

Favorite class in college?

My favorite class as a student in the Health Systems Management program at Rush University would be the Care Coordination and Population Health course I took during spring quarter of 2016. My classmates and I were given a unique opportunity to work with the administrative staff of Orr Academy High School in West Garfield Park, to develop a proposal to improve access to mental health resources and increase career development opportunities for the student body.

Passions?

I am passionate about improving access to healthcare services for the underinsured and vulnerable in our communities. The Affordable Care Act increased access to healthcare services for millions of Americans, however many citizens still cannot afford to utilize healthcare services in their communities.

Millennial, GenXer or Baby Boomer?

Millennial

What's your favorite "brand" and why?

I can say after working for more than a year at Rush University Medical Center (RUMC), the Rush brand in the field of healthcare is my favorite. The employees of Rush, whether clinical or administrative, are always working to improve patient care and develop partnerships with the surrounding communities.

Welcome New Members

Matthew Anderson
The Claro Group
Analyst

Mohammad Ashraf
Health Care Consultant

Donnica Austin
Holy Cross Hospital
VP Operations

Joel Avila
CVS Health

JP Bader
Next Health Choice
President

Tim Barry
Village MD
Chief Executive Officer

Lee Burstein

Szu-Chun Chen
Optum360
Senior Analyst

Max Collopy
PwC
Consultant

Jim Crawford
BNY Mellon

Deborah Davisson
Holy Cross Hospital
CNO

Hani Elias
Procured, Inc.
Chief Executive Officer

Franya Esquivel
RSM US LLP
Audit Manager

Katherine Evans
Advocate Shared Revenue Cycle Organization
Learning and Development Specialist

Margaret Frodin
The Claro Group

David Gifford
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LLC VP Business Development

Lauren Hall
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Jon Hanessian
Evolent Health
VP, Partner Development

Carianne Johnson
University of Chicago
Executive Administrator

Jay Keltner
Advocate Health Care
Director Marketing-System

Jack Lacy
Veralon Partners
Analyst

Anthony Lesser
Deloitte
Senior Manager

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Consultant

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University of Illinois at Chicago
Grants & Contracts Administrator II

Lauren Wedding
The Claro Group
Analyst

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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.

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January 2017	December 10, 2017
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