The Chesapeake Bay Line

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In this Issue...

In this issue of the Maryland HFMA newsletter, we have included some highlights from both the November "CFO Dinner," included in President-Elect Craig Masters' Officer's Corner section, as well as some highlighted talks from the January 2018 HSCRC Workshop. And in addition, we've included an article about telemedicine and fair market value that was published by Chris David of Health Value Group, an out-of-state colleague from Colorado!

OFFICER'S CORNER

Featuring Craig Masters

Happy belated new year, everybody! I hope you had a relaxing holiday and a chance to decompress for a moment. Knowing all the hard work that is expected of us during the year, it is nice to pause and think about what we want to accomplish. To help get my "strategic energy" flowing, I try to accumulate as many inspirational quotes as possible to reflect on when I need a boost. Brian Tracy's quote above struck me as appropriate when thinking about the rapid changes facing our health care world in this new year.

"Think continually about what you want, not about the things you fear." – Brian Tracy

2018 has already experienced major changes in legislation and public policy, and our health systems are under constant pressure to improve quality and reliability while becoming more affordable. We are also experiencing growth in chronic conditions, advancing technology, and new models of patient care. These environmental changes create questions about our strategic plans and whether our capital investments are being made in the right place. Also, there is the added stress of your family and neighbors bringing you their concerns about high deductible plans and finding the appropriate care when the time comes. This situation can make it difficult to keep from becoming overwhelmed and cynical about the future.

However, I am lucky enough to be part of the HFMA community, where we provide an opportunity to be inspired by ideas and solutions to these issues. Our speakers bring thought leadership and case studies that address the innovation created both nationally and right here in Maryland to drive healthier populations and more affordable care. While many industries have limited communication among their peers due to proprietary rules and limitations, the beauty of healthcare is that we are all in this together and can speak in a this forum. During November, our Chapter sponsored two strong events geared toward partnering for change. The first was "The Influence of Payers in an All-Payer Model", an education session that highlighted the integrative work of both providers and payers to improve value based care. There were also presentations on Maryland consumerism, as well as highlighting social and economic influences on health outcomes, and many more topics. This Payer-Provider event is an important initiative for our Chapter, as we are trying to have as much open dialogue between **ALL** our evolving healthcare stakeholders, not just the hospital perspective.

Our second November event was our annual "CFO Dinner" which included a panel discussion of industry leaders representing the physicians, the payers, the non-acute providers, and the hospitals. The speakers focused on how our organizations can work together to accomplish the Triple Aim and meet CMS' expectations of the Maryland Waiver. While the discussion could be brutally honest about the risks, all four speakers provided their perspectives on how things are changing for the positive. In particular, John Ellis from GBMC spoke about our next generation of leaders and how impressed he is with the fresh ideas and energy being generated to move us forward.

While there is much work to be done, I believe our health care teams are focused on the right issues: access, quality, affordability, prevention, partnership. I encourage all of you to be more involved with our Maryland HFMA Chapter to not only be more informed of these important issues, but also collaborate to influence change; focusing on what we want out of our health care system, and not be afraid of the risks. It certainly won't be easy, as I will leave you with one more inspirational quote from my collection:

"The only place where success comes before work is in the dictionary."- Vidal Sassoon

FOURTH QUARTER 2017 MARKET REVIEW

Prepared by India Suter

Economic Environment & Events

In the U.S., third quarter real GDP growth was 3.2% (annualized), the fastest pace since the first quarter of 2015 and following similarly robust second quarter growth (+3.1%). After-tax corporate profits rose 4.7% (9.8% year-over-year), consumer spending gained 2.2% and business equipment spending soared 10.8%, the fastest in three years. Labor markets remained tight with the unemployment rate at 4.1%; the lowest since 2000, but average hourly earnings growth continued to languish at 2.5% for the trailing year (as of November). Fueled by high consumer confidence and a robust job market, U.S. retail sales in the holiday period rose at their best pace since 2011, according to Mastercard SpendingPulse, which tracks online and in-store spending. Manufacturing continued to show strength; the ISM manufacturing sector index exceeded 50 (indicating expansion) for 15 consecutive months through November. Inflation remained benign with headline CPI at 2.2% in November (y-o-y) and Core CPI (ex-food and energy) at 1.7%. Headline CPI was fueled by a 16.5% y-o-y leap in the price of gasoline. Prices of goods, however, fell 0.9% y-o-y with declines broad-based. The Fed's favored measure, the Core PCE price deflator, gained 1.5% y-o-y, remaining below the 2% target. As expected, the Fed hiked the Fed Funds target by 25 bps at its December meeting to 1.25% - 1.50%. This move marked the third increase of 25 bps during the year. Markets are pricing in an additional three hikes in 2018, while Fed projections are for rates to end 2018 between 2.0% and 2.25%. President Trump nominated Jerome Powell to become the next Fed Chair, replacing Janet Yellen, whose term expires in February 2018.

Non-U.S. developed economies continued to gain momentum. Third quarter GDP growth in the euro zone was 2.6% (y-o- y) while inflation remained low (1.5% y-o-y as of November). The European Central Bank (ECB) upgraded its 2018 forecast for growth from 1.8% to 2.3%, though growth in the U.K. is expected to slow given the yet-undetermined effects of Brexit. As expected by markets, the ECB kept its interest rates on hold in the fourth quarter, but it confirmed that it plans to reduce asset purchases to €30bn a month in January 2018, down from the current rate of €60bn. Unemployment in the euro zone fell to 8.8%, below 9% for the first time since 2009. Unemployment in Germany fell to a record low of 3.6%. Outside of Europe, Japan's economy continued to grow and unemployment reached a 24-year low at 2.7%. The Bank of Japan is expected to continue its stimulus measures in an effort to stimulate inflation (Core CPI +0.9% y-o-y in November).

Closing Thoughts

In spite of various simmering concerns, we ended 2017 the same way we started - with U.S. stock markets at record highs and volatility at historic lows. Meanwhile, there are no shortages of potential headwinds that we might encounter in

2018 and valuations across most asset classes remain stretched by many measures. It is impossible to predict what may spark volatility (bitcoin, Brexit, China, geopolitics, domestic politics, or, most likely a nebulous "other"). As a result, we still caution investors to temper return expectations, to maintain a long-term perspective, and to adhere to prudent asset allocation with appropriate levels of diversification.

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2018 HSCRC WORKSHOP SUMMARIES

Relevant Topics in Performance Measurement

Update on current policies and what's ahead in new Total Cost of Care model – Traci La Velle, Dianne Feeney

Summary by Peter May

With a new Total Cost of Care (TCOC) model fast approaching, policies and programs are currently under development to shift a greater focus onto the quality of care in Maryland. Two of the main components to the new TCOC model are potentially avoidable utilization savings (PAU) and readmission reduction programs. While neither of these two components are new to Maryland Healthcare, improvements to the current models and more aggressive performance targets will be implemented with the goal of improving population health. Expanding the definition of PAU through new approaches, and decreasing readmission rates to the national average are just some of the steps being taken to ensure better quality of care for patients.

Implementing such a model does not come without challenges. Firstly, there are multiple design considerations for the TCOC model, including quality measures, performance benchmarks, and revenue adjustments. Secondly, the components and measures of the model must continually adapt over time to ensure that the quality of Maryland's healthcare is keeping up with the equivalent national programs. The Maryland Hospital Association (MHA) has outlined complication policy goals to potentially address some of the aforementioned considerations, with a focus on clinically relevant measurements, and national complications to create a clearer perception of Maryland's hospital quality.

This combination of improving current healthcare quality components with aggressive performance targets, a greater focus on measuring what matters, and ensuring that Maryland's Healthcare quality stays on par with the nation will pave the way for greater quality of care of patients.

Inter-Hospital Cost Comparison Overview

Alan Pack

Summary by Dave White

Since the suspension of the Reasonableness of Charges Calculation (ROC) in 2011 and the subsequent suspension of the Inter Hospital Cost Comparison Model (ICC) in 2015, the HSCRC has strived to develop a new methodology to measure the price efficiency of Maryland hospitals. At the Maryland HFMA HSCRC work shop Alan Pack, the director of population based methodologies at the HSCRC, gave an update of the new efficiency modeling being completed and highlighted some of the changes being considered.

First, the new ICC methodology excludes non-ECMAD revenue, chronic revenue, and categorical revenue from the calculation as well at one-time revenue and Shock Trauma. This takes into account the impact that chronic/categorical patients have on the efficiency of a hospital when compared to its peer group, and also recognizes the issues when creating an accurate charge per ECMAD with cycle billed service lines. This included revenue in the ICC is then adjusted for social goods and costs beyond a hospitals control. Social goods (i.e. training residents and doctors) should not be punished and so the revenue associated with these programs are stripped out from the ICC calculation. In the same way, where a hospital is located impacts the hospitals revenues, so the HSCRC has implemented a regional specific labor market adjustment with three regions reflecting the wage variations across Maryland.

These stripped revenues are then converted to cost by stripping profit and applying a productivity adjustment. These two revenue adjustments so far have been controversial. Currently the profit strip is based on regulated profit, which punishes hospitals for reinvesting profits into the unregulated domain (i.e. population health initiatives). Perhaps the revenue adjustment should be based on total profit to reflect these community initiatives and not hold hospitals accountable for their reinvestments. The productivity adjustment, based on excess capacity from FY2010 – FY2017 has also been a source of tension and Alan Pack suggested potentially using MHCC data to look at licensed beds and average daily censuses rather

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TELEMEDICINE AND FAIR MARKET VALUE: WHAT YOU NEED TO KNOW

By Chris W. David, CPA/ABC, ASA, HealthValue Group

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

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

The American Telemedicine Association (ATA) defines telemedicine as "the use of medical information exchanged from one site to another via electronic communication to improve a patient's clinical health status."[1] Simply stated, telemedicine allows patients to connect remotely with physicians via phone or video conference to address healthcare concerns. This treatment method has been used for several years to conduct specialty consultations in rural areas with patients who have limited access to doctors.

Telemedicine services are typically divided into three categories: a) store and forward b) video conferencing and d) remote patient monitoring

Store and Forward

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

Video Conferencing

Video conferencing uses two-way interactive audio-video technology to connect users when a live, face-to-face interaction is necessary. Video devices can include video conferencing units, peripheral cameras, video scopes, or web cameras. Display devices include computer monitors, LED TVs, LCD projectors, and even tablet computers. Video conferencing provides a cost-effective way for patients to receive care.

Video conferencing is the most common form of telemedicine practiced today. It is an effective tool for a variety of applications, including emergency room and intensive care unit support.

Remote Patient Monitoring

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

Demand for Telemedicine

30% of Medicare payments are now tied to alternative payment models (APMs). The Department of Health and Human Services (HHS) plans to raise the percentage by 50% by the end of 2018. Many healthcare providers are looking for ways to increase quality of care and patient access while keeping costs down. The Medicare Shared Savings Program (MSSP) is an alternative payment model that recognizes telemedicine services as a clinical practice improvement activity, which is one of four components required for incentive payments. Physicians who provide patients with

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[1] http://thesource.americantelemed.org/resources/telemedicine-glossary

FOURTH QUARTER 2017 MARKET REVIEW

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Preliminary Returns for Various Periods Ending 12/31/18

	Last Quarter	Year to Date	**Last Year**	Last 2 Yrs	Last 3 Yrs	Last 5 Yrs	Last 7 Yrs	Last 10 Yrs	Last 15 Yrs
US Broad Market									
Russell: 3000 Index	6.34	21.13	21.13	16.86	11.21	15.58	13.50	8.60	10.25
Large Cap									
Russell: 1000 Index	6.59	21.69	21.69	16.77	11.23	15.71	13.66	8.59	10.18
Mid Cap									
Russell: Midcap Index	6.07	18.52	18.52	16.13	9.58	14.96	12.76	9.11	12.07
Small Cap									
Russell: 2000 Index	3.34	14.65	14.65	17.93	9.96	14.12	11.62	8.71	11.17
Non-US Equity									
MSCI: EAFE US$	4.23	25.03	25.03	12.38	7.80	7.90	6.04	1.94	8.11
MSCI: Emrg Mkts	7.44	37.28	37.28	23.55	9.10	4.35	2.56	1.68	12.31
Fixed Income									
Bloomberg: Aggregate Index	0.39	3.54	3.54	3.09	2.24	2.10	3.20	4.01	4.15
Bloomberg: Gov/Credit Long	0.49	4.00	4.00	3.52	2.38	2.13	3.43	4.08	4.20
Bloomberg: Long Crdt A	1.05	6.18	6.18	5.90	3.63	3.24	4.81	5.42	5.22
Bloomberg: Corp High Yield	0.47	7.50	7.50	12.21	6.35	5.78	7.04	8.03	8.98
Bloomberg: Global Agg ex USD	1.63	10.51	10.51	5.90	1.77	(0.20)	1.05	2.40	4.25

The information contained in this review is based upon data produced by Asset Strategy Consultants and Callan Associates.

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2018 HSCRC WORKSHOP SUMMARIES

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than the current methodology.

The development of an ICC methodology to compare the efficiency of Maryland Hospitals is a complex and difficult task that must account for several uncertainties in the cost of care market. Not only is the HSCRC measuring price efficiency, but also attempting to capture volume only complicating the process. As such, the process remains unfinished with several workgroups being established to analyze the methodological approaches taken by the HSCRC and voice opinions on the matter. What ultimately results from this long process one can hope will be a fair and accurate measure of hospital efficiency.

How to Leverage Your Part B Providers to Manage Total Cost of Care

Cathy Zito and Gabriella Gold

Article by Elizabeth Moriarty

Two representatives from Lighthouse Healthcare Advisors, Cathy Zito and Gabriella Gold, presented on how to leverage Part B providers to better manage total cost of care at Friday's HSCRC meeting. They began with a brief background of Part B reimbursement, the shift from volume to value, and the impact of the all-payer model. Zito and Gold then bridged how these industry components have helped lead to the new Total Cost of Care Model, with the focus on improving health and quality of care, encouraging care redesign, and providing new incentive programs and resources for primary care physicians.

Zito and Gold provided four key areas of focus to help develop a successful care redesign program. These include data capture, workflow, patient engagement, and analytics. These four tools can be leveraged in either the hospital or medical group setting. For example, a hospital can utilize the CRISP server to determine readmission rates. Similarly, a medical group can leverage CRISP reporting services to find out ED usage. Efficient work flow is important in any setting, but can be especially helpful with patient registration, optimizing the electronic medical record, and capturing quality metrics. In terms of patient engagement, both hospitals and medical groups can connect with their patients using an interactive portal. Patient navigators or care coordinators can help facilitate the engagement even further. Analytics is a particularly critical tool in care redesign. It can not only help a hospital or medical group compare how it is performing to its peers, but can give them an idea of what rates are higher than should be. Leveraging all of these tools can help either a hospital or medical group to excel in this period of transition.

The Lighthouse Advisors then directed the focus on how specifically these tools can be implemented for Part B providers, a concept that becomes increasingly important as Maryland shifts to the idea of a health community. Again, by utilizing technology, through centralized reporting systems, shared care plan development, and referral tracking, physicians can engage their patients and more swiftly coordinate their care. Care management is the next natural segue in this process, as managers can help to educate their patients and keep them on track. Given these ideas, it becomes extremely beneficial to negotiate contracts that follow suit. For example, compensating providers on RVUs may no longer make sense if there is encouragement for the provider to have a greater emphasis on quality and documentation improvement.

The tools of success presented by Zito and Gold are extremely relevant for providers here in Maryland looking to not only improve patient experience, but to not leave any dollars on the table. By committing to quality data capture, improved workflow, patient engagement, and analytics, hospitals and physician groups alike will face less of a challenge as the industry continues to focus on value and total cost of care.

TELEMEDICINE AND FAIR MARKET VALUE: WHAT YOU NEED TO KNOW

By Chris W. David, CPA/ABC, ASA, HealthValue Group

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free equipment for remote monitoring are now eligible for fraud and abuse waivers under recent changes to the MSSP program.

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

Telemedicine Reimbursement

Medicare

Medicare first began to reimburse telemedicine services after the Balanced Budget Act of 1997 was passed. As of January 2017, Medicare reimbursement only includes video conferencing services under very specifi¬c circumstances. Store and forward, or asynchronous services, are not permitted for reimbursement (except for federal telemedicine demonstration programs in Alaska or Hawaii, as stated by the Center for Medicaid and Medicare Services).[2] Medicare claims for telemedicine services are billed using Current Procedural Terminology (CPT®) codes, along with the appropriate telemedicine modifier code "GT."

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

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

- Provider offices
- Hospitals
- Critical access hospitals (CAHs)
- Rural health clinics
- Federally qualified health centers
- Hospital-based or CAH-based renal dialysis centers (including satellites)[3]
- Skilled nursing facilities
- Community mental health centers

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

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

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

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

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

[2] "Telehealth Services." Center for Medicaid and Medicare Services. Medicare Learning Network. December 2015. < https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf>

[3] "Telehealth Services." Center for Medicaid and Medicare Services. Medicare Learning Network. December 2015. < https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf>

Medicaid

Coverage of telemedicine services under Medicaid is determined on a state-by-state basis.[4] The off¬icial policy indicates that states may reimburse for telemedicine under Medicaid as long as the service satisfies federal requirements of "e¬fficiency, economy, and quality of care." This policy enables states to have unique standards for what services they deem appropriate for reimbursement, which causes gaps in the system due to a massive lack of uniformity. This results in differing reimbursement policies for each state. Recently, the Center for Medicaid and Medicare Services granted states flexibility to define their own telemedicine policy.

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

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

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

Private Payers

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

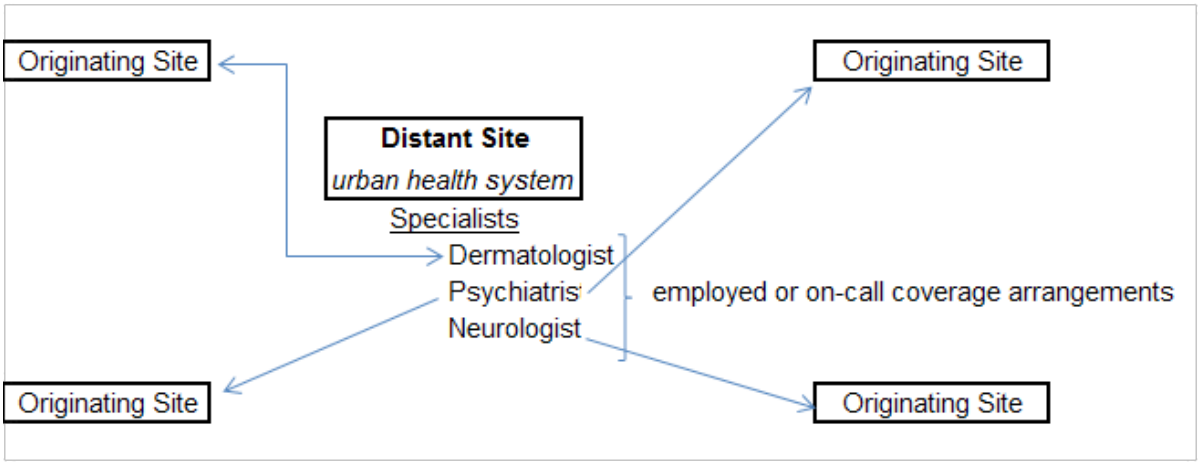
These laws often have restrictions, caveats, and limited applicability. These qualifying clauses may set up certain conditions where an insurer has the flexibility to restrict telemedicine reimbursement within their contract. For example, many states limit their coverage requirement to live video real-time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

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

Basic Model

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

[4] www.medicaid.gov/Medicaid/benefits/telemed/index.html



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

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

Fair Market Value (FMV) Concerns

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

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

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

Although the services offered under telemedicine arrangements may be similar to traditional on-call arrangements, determining the fair market value (FMV) of compensation for telemedicine requires a firm grasp of the legal and regulatory landscape surrounding these services. A provider's ability to bill and collect for telemedicine services must be taken into account to be properly compensated.

CERTIFICATION NEWS

By Chuck Cronauer, FHFMA | Maryland Chapter Certification Contact

Congratulations to the following individuals who have passed the CHFP exam for the period October 2017 through February 2018:

Deborah L Nealon/Group Practice Administrator/Horizon Surgical Group, PA

Cheryl Rochford/Business Plan Manager/Adventist Healthcare

Jeffrey D. Roumm/Manager/Myers & Stauffer

If your employer does not pay for the certification process, our Maryland HFMA chapter will reimburse you for one set of the materials upon successful completion both certification modules.

If interested, please visit the HFMA national website for a free webinar on the CHFP certification process. https://www.hfma.org/Content.aspx?id=46005. Also, continue to watch this section of the newsletter for updates and additional information.

If you have any questions concerning certification, please email me at linker.s.mills@medstar.net and I will be happy to assist you!

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UPCOMING EDUCATION EVENTS

Date	Event	Location
Monday, March 5, 2018	Maryland HFMA 5th Annual Spring Institute	**The Westin Annapolis** **100 Westgate Circle, Annapolis, MD**

Note: In addition to webinars hosted by the Maryland Chapter, the HFMA National organization sponsors numerous complimentary webinars on a wide variety of current industry topics. Please visit their website for more information.

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