The Chesapeake Bay Line

Volume 2017/2018 | Issue 1, November 2017

Annual Institute Edition

The Maryland Chapter of HFMA is happy to introduce to you our new newsletter format! This special edition of the newsletter highlights the 2017 Fall Annual Institute, which took place between October 4 and October 6 at the Princess Royale hotel in Ocean City, MD. The event included fascinating talks on the state of Maryland healthcare and nationwide healthcare trends, as well as a full day of recreation when members either played golf or joined a distillery tour at the local Seacrets Distillery. Talks included everything from an update from the Health Services Cost Review Commission and presentations on Maryland's provider landscape to a presentation from Matt Stover, ex-Baltimore Ravens Kicker, on his transition from the world of professional football to the world of business.

In this Issue...

OFFICER'S CORNER

Featuring James Case, KPMG LLP, Maryland Chapter HFMA Vice President

"Where Passion Meets Purpose" is the theme the Chair of HFMA, Carol Friesen, chose to guide chapter leader's pursuits this year. As a millennial, I've heard those words written and spoken many times to describe designing the ideal lifestyle. Surely this is the Chair's tactic to connect with our generation. It's a tactic we shouldn't meet with skepticism. It's a tactic to help us connect with a community of people who just may have something to teach us about passion and purpose.

When I think of passion, I think about friendship. I think about confidence. I think about joy. Passion may be any one of these strong emotions, but it is almost always associated with people. Early in my career, I leapt into HFMA and I've been lucky to see firsthand the passion the Maryland Chapter was built upon by prior leaders of this chapter. Friendship, confidence, and joy are all emotions these leaders shared and developed in the HFMA community. As those leaders pass the baton, that passionate community is what the new leaders of the Chapter are trying to build, that is what we are trying to recreate.

When I think of passion, I think about friendship. I think about confidence. I think about joy. Passion may be any one of these strong emotions, but it is almost always associated with people.

But they didn't build it without a purpose in mind. They built it because they needed it. They built it because our careers require community to fulfill our greater purpose. I'll tell you a secret. It's the greater purpose that you hear talked about in books and social media. It's the greater purpose that you're searching for.

What we chose to do is hard, but it's worthwhile. It sounds dorky, but we can make a difference in the lives of others if we help our organizations effectively manage their finances. Whether that means improving the financial management of our organizations, or providing our executive teams the information to make strategic plans to prepare for an uncertain future. That's HFMA's purpose, the purpose that many in our HFMA community share, and it very well may be your purpose too. But if you don't have it, you won't find it if you sit on the sidelines. You are going to need the educations and social interactions the chapter provides to spark that passion or to find that greater purpose and a meaningful career.

I hope you find this year ignites the passion and purpose you have in your career. I can think of no better place than in the community of the Maryland Chapter of HFMA to do it. Come join us.

40 YEARS AND COUNTING: MARYLAND'S INNOVATION IN HEALTHCARE REIMBURSEMENT

by Angela Wells-Sims, Director of Finance, National Medicare Finance, Kaiser Permanate

Many of us grew up saying that we wanted to become a doctor, engineer, lawyer, or some other profession that appealed to us based on what we perceived as a meaningful or important career. That dream job for me was to be a biomedical engineer, because it combined the excitement of innovation with medicine. Needless to say, I didn't become a biomedical engineer, but I did end up in healthcare reimbursement, which has been ever evolving. Maryland reimbursement, where I began my career, is a great example of how integration of policy, finance, and industry collaboration has resulted in hospital sustainability, equitable access to care, and shifts in care delivery.

Maryland began its unique method of reimbursement 40 years ago through a Center for Medicare & Medicaid Services (CMS) demonstration project, which became known to many as Maryland's Medicare waiver. The intent of a demonstration project is to introduce new approaches that will drive efficiency and improve care that can ultimately be implemented on a larger scale. Some of Maryland's influence can be seen in national payment models. The rollout of prospective payment systems (PPS) and other bundled payment models changed the national expense trends jeopardizing Maryland's waiver. In lieu of transitioning to CMS' PPS, Maryland moved forward with looking for opportunities to modernize its payment model.

Healthcare in the US began as a sick-care model with a fee-for service reimbursement structure. That model recently shifted to outcome driven care, which has essentially made those of us in healthcare finance "healthcare financial engineers." In addition to the regular financial functions, our jobs require understanding population health, analyzing utilization, evaluating care delivery methods, and fully engaging all stakeholders to collectively address improving health costs. In 2014, the State of Maryland and CMS entered a new demonstration initiative which Princeton University health care economist Uwe Reinhardt called the "boldest proposal in the United States in the last half century to grab the problem of cost growth by the horns."

What's the Biggest Difference in the Old Waiver and the New All-Payer Model?

The original Medicare waiver of 1977 "required the HSCRC to (1) constrain hospital costs; (2) ensure access to hospital care for all citizens; (3) improve the equity and fairness of hospital financing; (4) provide for financial stability; and (5) make all parties accountable to the public.[1]" No longer is the focus just on reducing the rate of expense growth. The new agreement focuses on the triple aim of health care: reducing per capita costs, improving health of communities, and improving the experience of patient care.

Have Hospitals Made Progress Under the New Model?

Hospitals have made significant progress on metrics established for the first phase of the New All-Payer Model, but this phase is just one piece of the redesign. "To truly transform health care, it will take collaboration and buy-in from the entire health care continuum. This will include physician gainsharing and other initiatives that bring providers in line with the goals of the CMS agreement.[2]"

What Will Be Necessary for Continued Success?

Collaboration across all stakeholders is critical to achieve the triple aim. The triple aim are linked goals which will require "partnership with individuals and families, redesign of primary care, population health management, financial management, and macro system integration.[2]"

Continued on page 11

ECONOMIC AND MARKET REVIEW

Prepared by Asset Strategy Consultants

Economic Environment and Events

While the U.S. entered its 96th month of expansion, economic data was uninspiring. First quarter GDP growth was revised up to 1.4% (annualized) and was the weakest in three quarters. Personal consumption expenditures grew 1.1%, but this was the smallest advance since the second quarter of 2013. After a strong 2016, light vehicle sales were down nearly 2% in June (year-over-year) with passenger car sales off 13% over the past year. Pending home sales and housing starts were also softer going into quarter-end, but the median price of a new home jumped 17% year-over-year to a record $345,800. While unemployment fell to a 15-year low of 4.3%, declining workforce participation continues to play a role in that metric. Consumer spending continues to be a driver of growth, but its pace of growth has also slowed. Expectations for 2017 U.S. GDP growth were cut by the International Monetary Fund from 2.3% to 2.1% in response to lowered expectations for fiscal stimulus, including tax reform. Inflation remained stubbornly low. Headline CPI was 1.9% as of May (year-over-year) while Core was 1.7%. The Fed's favored measure, the PCE price index, gained 1.4% (year-over-year) still below the 2% target. While growth appears to have moderated, the Fed believes that the upward trajectory is intact and consequently raised the Fed Funds rate by 25 bps, as markets expected, to 1.0% - 1.25%. Markets are currently divided as to whether we will see another hike this year. More significantly, however, was the Fed's announcement that it will begin to reduce the size of its $4.5 trillion balance sheet. While timing remains uncertain, the Fed made clear the process by which it intends to begin the tapering process. It will begin to allow U.S. Treasuries and mortgages to mature each month, up to a set amount, or cap, that will rise over time. Proceeds from maturities in amounts over the cap will continue to be reinvested. This approach is both more moderate and more transparent than investors expected and while the timing is uncertain, markets were unfazed.

A number of notable events occurred overseas on the political front. Populism appeared to lose favor as both the Netherlands and France declared centrist victories - Italy is up next with its election in spring of 2018. In the U.K., a surprising result came out of the snap election called by Prime Minister Theresa May; her Conservative Party lost its majority in the House of Commons, thus increasing the likelihood of a "softer" Brexit. First quarter GDP growth was 2.3% (annualized) for the euro zone, exceeding expectations and the best in two years. Unemployment dropped to 9.3%, the lowest since 2009. The European Central Bank kept rates unchanged, but it also removed language that suggested rates would continue to decline. Comments in late June by ECB President Mario Draghi hinted at a normalization/reduction of bond buying caused yields to rise; markets have priced in a near 100% probability of an ECB rate hike over the next twelve months. The euro and the pound strengthened significantly versus the U.S. dollar over the course of the quarter, up about 7% and 4%, respectively, on mixed economic data and uncertainty over the political climate. Inflation in the U.K. hit a four-year high of 2.9% (year-over-year) in May, leading to hawkish rhetoric from the Bank of England's chief economist. The post-Brexit decline in the pound has been a key culprit in rising inflation. Japan's first quarter GDP growth was 1.3% (annualized). While lower than expected it was the fifth quarter of economic expansion, the longest in more than a decade, and above Japan's long-range potential of roughly 0.7%. China exceeded expectations with a 6.9% annual growth pace in the first quarter and, more recently, unexpectedly strong manufacturing data.

Closing Thoughts

We entered 2017 with U.S. stock markets at record highs and historically low volatility. Not much has changed although geopolitical risks have not abated and the previously envisioned pro-growth policies sought by enthusiastic market participants remain elusive. That said, economic news has brightened outside of the U.S. with global economies seemingly on steadier footing and the prospect of reflation on the horizon. While consensus is that valuations remain stretched across asset classes, it is impossible to predict what will thwart this Goldilocks environment. We caution investors to temper return expectations and, as always, Callan encourages investors to maintain a long-term perspective and prudent asset allocation with appropriate levels of diversification.

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ANNUAL INSTITUTE SHOWCASE SESSIONS

The 2018 Annual Institute offered many educational and interesting sessions. Members have summarized some of these sessions for you. Enjoy!

Click on the below topics for a summary of each session!

MARYLAND'S INTEGRATED CARE NETWORK - HEADING INTO YEAR

Summary by David White
Presentation by Katie Wunderlich, Principal Deputy Director, HSCRC and Chris Peterson, Principal Deputy Director, HSCRC

In 2014 the HSCRC and the Maryland Department of Health and Mental Hygiene established a workgroup to develop ideas on how to improve care coordination between providers and support Maryland's All-Payer model. As David Finney explained in his presentation on Maryland's Integrated Care Network (ICN), CRISP was tapped to enhance data synthesis and data sharing capabilities in order to connect providers and payers in Maryland at the point of care, by care managers and coordinators, by population health teams, and for patients.

Fiscal Year 2016 saw the planning and foundation being laid for the ICN and importantly established a "Patient Care Overview" in the workflow that allows clinicians and care managers access to high-value information about patients through CRISP. The improvements made to the ICN in FY2017 focused more on Hospital Care Coordination and providing care management information to clinicians directly in the hospital setting. This information includes things like contact information for the patient, who their care coordinator is, and who the primary care provider is. The system allows for patients to be effectively tracked and notify their care managers if, for example, a patient who has an Anne Arundel Medical Center primary care physician shows up in the ED of Baltimore Washington Medical Center. Additionally, FY2017 focused on creating an alert system which provides ED clinicians with care alerts and patient information, for example: "Mrs. XYZ pain medications are managed by Dr. Smith. Contact her prior to prescribing any controlled substances."

The results from the improvements made in FY2017 have been remarkable. 72% of high needs Medicare patients now have a primary care physician known in CRISP, an improvement from 40% at the beginning of FY2017. Additionally, 27% of these patients have a care coordinator known in CRISP, an improvement from 1% at the beginning of F2017. There are over 15,000 care alerts in Crisp, taken from 26 hospitals and 3,700 of these care alerts are for high needs Medicare patients.

Another key part to Maryland's ICN is the Medicare Analytics Data Engine (MADE) which allows for the analysis of patient and hospital data to improve the management of complex and chronically ill patients. This data engine consists of three analytic parts; population analytics, episode analytics, and pharmacy analytics and is all based on Claim and Claim Line Feed data which consists of all data pertaining to Medicare FFS parts A, B, and D claims. MADE allows hospitals to easily identify patients of interest and provides detailed reports for healthcare spending associated with a high needs patient.

Synthesizing data and sharing it between providers and payers in a way that is useful and beneficial to clinicians and patients is a complex task that requires coordination on a variety of fronts. Through CRISP, Maryland has taken great strides in creating a system that allows information to flow between entities with the goal of helping track patients and their needs and delivering the appropriate type of care in the appropriate setting. This Integrated Care Network will prove to be effective in helping reduce healthcare costs in the state as patient information becomes more easily accessible.

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POST-ACUTE PROVIDERS: THE ADVANTAGES OF STRONG RELATIONSHIPS

Summary by Elizabeth Moriaty
Presentation by Pattrick V. Trotta, CPA, CHC, Partner & Director of Healthcare Consulting Group, Hertzback & Company, P.A.

Patrick Trotta, partner at Hertzbach and Company, presented on the critical factors in different types of post-acute providers and the advantages and disadvantages of contractual partnerships. With the rapid growth of the population over 85 years old, there will be a great opportunity for quality long term care in the very near future.

As post-acute care is not being provided by family members, there is a need for facilities to provide this service. This can include long term care hospitals, inpatient rehabilitation facilities, home health agencies, skilled nursing facilities, or other assisted living facilities. The patient makeup in terms of the severity of illness varies type to type. Therefore, the key differences between these facilities includes the specific type of care they can provide. In recent years, skilled nursing facilities have been the go-to location for post-acute hospital discharges. Yearly spending among all long term care facilities has reached $275 billion, with Medicare's share at $60 billion alone.

Looking to the future, there will be added importance for strengthened relationships between post- and acute- care providers. Additionally, there will likely be a care shift from hospitals to home health and other population health activities. With payment and care models constantly changing, post-acute strategies will have the opportunity to deliver greater value. Key strategies to help achieve this is to establish realistic goals, engage in collaborative relationships, and develop a deeper understanding of the industry. Additionally, it is important to weigh the decision to own or partner. However, the partner must be chosen critically, to ensure there is a mutual understanding and dedication to value based care and data driven decisions. Through these successful relationships, there will be a clear opportunity for the industry to increase the quality of post-acute care and ideally decrease readmissions.

BEYOND POLITICS: THE SHAPE OF THE NEW HEALTHCARE ECONOMY

Summary by David White
Presentation by Merrill Goozner, Editor Emeritus, Modern Healthcare

When the GOP retook the majority of the United States House of Representatives in the 2010 midterm elections, the repeal of the Affordable Care Act seemed to be at the top of their legislative agenda with over 50 votes being called for bills that repealed the law. With the 2016 election, Republicans took control of all three branches of government and the scrapping of the Affordable Care Act seemed imminent. However, the proposed replacement for the ACA, the American Health Care Act (AHCA) failed to garner enough support to pass the Senate, mostly for the same reasons that the GOP criticized the ACA; it was written in secret without bipartisan input. The AHCA was also very unpopular as it would have repealed employer mandates, repealed premium and cost sharing subsidies, turned Medicaid into a per capita block grant system, and would have cost tens of millions of Americans their insurance coverage. Once the CBO scored the bill, it had slim public support.

With the passage of the ACA (and the failure of the GOP's repeal efforts) the United States Healthcare Economy was dramatically transformed. The ACA has reduced the uninsured rate to 9% through the expansion of Medicaid and the creation of insurance exchanges, which allowed 11 million people to purchase healthcare coverage. Of importance is the way that the ACA transformed delivery systems and payment systems. Following the passage of the ACA the number of Medicare Accountable Care Organizations rose from 330 in 2014 to 400 in 2015. Additionally, incentive programs were established to reward or punish hospitals based on readmissions; value based purchase; and Hospital Acquired Conditions. These incentive programs have led to reductions in readmissions and hospital acquired conditions, however more hospitals are being penalized in 2016 based on the Value Based Purchasing program then in 2015. Healthcare spending growth has slowed in the United States partially as a result of the ACA, however it is unclear how much of the growth slowdown can be attributed to the law and how much structural economic changes contributed to the slowdown.

Since the Affordable Care Act, the debate over healthcare in the United States has shifted to the left of the political spectrum. The preservation of the Medicaid expansion seems to be a permanent demand as any bill that would end it would receive a score showing millions of people losing healthcare, making the bill toxic. The Trump administration has made the ACA popular amongst the public and has reversed the animosity that generally existed in the public. Single-Payer systems are even starting to gain more support following the 2016 elections. It is unclear what actions the administration will take to weaken the ACA, but they have slowed down the programs to incentivize people to sign up for insurance on the exchanges and have limited the enrollment periods.

The political debate aside, the facts are clear that the United States is an aging society and healthcare costs will continue to rise, especially Medicare costs as the next generation qualifies for coverage. Providers are already taking steps to slow cost growth (shifting inpatient services to outpatient services, moving services to less costly settings, etc.) however cost growth will remain a key concern in the American Economy as healthcare spending as a percent of GDP continues to grow. The data shows that costs can be kept below overall economic growth trends however. CMS projected that National Health Expenditures would be 19% of GDP by 2016, it was 18% in 2016. What needs to change to control this growth as the population ages is expectations about end of life care and how to pay for that long term care. If those issues can be addressed, the rise of Healthcare spending could be mitigated.

WELCOME TO THE BLINDSPOT ZONE! WHY GOOD PEOPLE MAKE BAD CHOICES

Summary by Peter May
Presentation by Kevin McCarthy, Trainer, Author and Coach, Making Better Happen, LLC

There are two different roads we can go down in life. The first is the wide, well-traveled road that's comfortable, easy, and results in no change in a person's life. The second is the narrow, less-traveled road where one must ask the hard questions, cut out unhealthy relationships, and strive for change in one's life. And with that thought, Kevin McCarthy concluded his presentation on blind spots and what they mean in our lives.

Kevin spent 33 months in federal prison, during which he realized what he truly valued in his life and how his hidden blind spots had led him to commit a crime he did not even know he was committing. In this case, Kevin is not referring to a visual blind spot but rather a mental one. These blind spots hide in assumptions, expectations, intuitions, our emotional state, our character, our values, and our communication styles to name a few. It is by understanding where these blind spots lie that Kevin believes will help answer those hard questions on the narrow road.

Perhaps one of the most critical blind spots to address in the professional world is communication style. Miscommunication resulting from two different communication styles can often times leads to conflict between two or more people. But by recognizing the triggers, differences in style, and empathizing with one another, we can learn to remove these blind spots. An invaluable blind spot tool that Kevin provides us with is this: Stop. Think. Process. Sometimes we act on emotion and by taking the time to stop, truly think about what is happening, and process the information, we may be able to act more logically and with more clarity.

Kevin left the audience with the small task of taking the Implicit Social Attitudes test to help identify blind spots. It can be found at this link: https://implicit.harvard.edu/implicit/

PANEL: BEST PRACTICES FOR MITIGATING CLINICAL DENIALS

Summary by Peter May
Moderatored by Edward Niewiadomski, MD, President, Physician Advisor On-Call, LLC
Panelists: Paul Nicholson, Sr. VP and CFO, UM St. Joseph Medical Center
Susan Mani, MD, FACC CQO/Chair of Medicine, Northwest Hospital and VP/Medical Director of Clinical Transformation, LifeBridge Health
David Krajewski, Executive VP/CFO, LifeBridge Health
Cydney T. Teal, MD, CMO, Union Hospital of Cecil County

Learning different approaches to managing population health is one of the key methods to reducing overall healthcare costs. During this panel several programs were described that intend to solve the problem on how to properly manage population health. These programs target different areas of healthcare such as reducing readmissions, improving the transition from hospital to home, creating partnerships with local community organizations, and streamlining CRISP workflows.

One of the biggest questions that healthcare providers are currently asking is where does healthcare end and individual/family care begin? No such clear line seems to be defined, but one of the goals of many programs is to create strong partnerships with local community organizations. These partnerships will allow for a more fluid transition from hospital to home, providing patients with an additional healthcare resource while at the same time potentially reducing readmissions.

One such program aims to use health coaches to work one on one with patients to improve their overall health. A particular example that was given was how a healthcare coach worked with an illiterate patient with diabetes to improve their diet. The health coach made a picture book of medication directions and foods at the grocery store that the patient should be consuming to maintain their overall health.

This is just one example of how healthcare providers are attempting to bridge the gap between the hospital and home. However, there are other examples of programs such as the Bay Area Transformation Partnership and the programs offered by Nexus Health. These programs offer promising services that intend to reduce overall healthcare costs but more importantly improve the population health.

INFLUENCING BEHAVIORS

Summary by Elizabeth Moriaty

Presentation by Edmund A. Tori, D.O., Associate Director of MedStar Institute for Innovation (MI2) and Director of The Influence Center at MI2

Edmund Tori is the Associate Director of the MedStar Institute for Innovation (MI2) and the Director of the Influence Center at MI2. Tori began his morning session with the conundrum of the title of his talk, "Influencing Behaviors." Was the focus to be on behaviors that influence us or how to influence behaviors? Throughout his presentation, he brought to light ways to master both.

Tori described how The Influence Center at MI2 focuses on things that rarely change- how to influence people. One key case study they performed was with OB operating room personnel. They noticed the pattern that most staff recognized right away when there was a problem or medical error, but no one would speak up. The Center organized a simulation to mimic this realistic situation. The least senior nurse in the room noticed the error immediately, though it took her several minutes to mention something was wrong. Through this simulation, they were able to pick up on a few changes in body language including covering her neck with her jacket, shifting her vision, and biting her lip. Tori identified these as common actions for someone who is nervous or uncomfortable. Another key case study Tori performed was how to increase responses to email solicitations. He found that by simply changing the email subject to all lowercase letters led to nearly a 100% response rate. People were more likely to actually open the email because the grammatically incorrect subject line felt more personal. These examples, among others, brought Tori to his main conclusion. Just listening or telling people what to do isn't enough. To optimize your efforts, you have to look to ways to influence people by changing their moods first and their minds will follow.

Tori has established six simple rules for influencing behaviors. The first is to manage your own state. This includes your mood, emotions, and perfecting your game face. You can only get so far if you have the wrong attitude. The second is to make them comfortable. People generally respond more positively when they are at ease. With that leads to the third principal, to remove their objections early. You must address patterns of limiting beliefs and the little voice screaming in their head. These include the common expressions like "I can't", "It's always," etc. Next is to move people with what already moves them. Tori recounted an example of how he got one of his patients to quit smoking, by proposing it in a way that would be a gift to his wife. Next is to remark about the unremarkable, particularly using the power of the third party. For example, kids are far more likely to eat their vegetables if they overhear their parents talking about how it's only an "adult food." Lastly, is to design in the desired and design out the undesired. This can be accomplished by actually taking a moment to fix what people say "happens all the time," and altering the way you demonstrate things.

Tori's experiences at the Influence Center and his six principal rules were not only fascinating, but applicable to all in the room. His advice clearly comes from heavy observation of human behaviors and patterns. In a dynamic industry such as healthcare, mastering something that rarely changes such as how to influence behavior, can be an extraordinary tool.

40 YEARS AND COUNTING: MARYLAND'S INNOVATION IN HEALTHCARE REIMBURSEMENT

by Angela Wells-Sims, Director of Finance, National Medicare Finance, Kaiser Permanate

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What's Next?

Depending on who you ask, the answer could vary. What we all know is there are factors contributing to uncertainty, but there are ways to help us prepare. To provide opportunity for dialogue and education, the Maryland Chapter of HFMA will be hosting its inaugural payer-provider collaborative educational conference to discuss The Influence of Payers in An All-Payer Model. Join us on Friday, November 17th for this opportunity to engage with hospital, payer, physician and policy leaders from the region.

The discussions will range from "Innovative Collaborations and Partnerships for Managing Health Needs" to "Enabling the Data Driven Healthcare Enterprise with Self-Service Visual Analytics."

Some of our dynamic speakers include:

- Patricia M.C. Brown, Esquire, Johns Hopkins Medicine & Johns Hopkins HealthCare LLC
- Abhishek Sharma, M.D, PricewaterhouseCoopers LLP
- Brian Sims, Maryland Hospital Association
- Destiny-Simone Ramjohn, Ph.D, Kaiser Permanente
- Michael Yannick, FSA, MAAA, Optum
- Andy De, Tableau Software
- Bradley Herring, Ph.D, Johns Hopkins Bloomberg School of Public Health
- Long Thai, Mid-Atlantic Permanente Medical Group

For a full overview of the day's agenda, and to register, visit https://hfmamd.starchapter.com/meet-reg1.php?id=138

[1] Robert Murray, "Setting Hospital Rates to Control Costs And Boost Quality: The Maryland Experience" Health Affairs September/October 2009 vol. 28 no. 5 1395-1405

[2] Carmela Coyle, "Maryland's Progress On The Path To The Triple Aim" Health Affairs Blog November 12, 2015

[3] Donald M. Berwick, Thomas W. Nolan and John Whittington, "The Triple Aim: Care, Health, And Cost" Health Affairs May 2008 vol. 27 no. 3 759-769

CERTIFICATION NEWS

By Chuck Cronauer, FHFMA | Maryland Chapter Certification Contact

Congratulations to the following individuals who have passed the CHFP exam for the period April through September 2017:

Thomas A. Werthman/ Senior Managing Consultant/ Berkeley Research Group

Kristen R. Henry/ Manager, Financial Planning & Analysis/ Gerald Champion Regional Medical Ctr.

Barbara A. Makowiecki/ Director, Finance & Business Analytics/ Medstar Franklin Square Medical Ctr.

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 call me at 410-550-7185 or email me at ccronau1@jhmi.edu and I will be happy to assist you!

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ECONOMIC AND MARKET REVIEW

Prepared by Asset Strategy Consultants

Preliminary Returns for Various Periods Ending 06/30/17

	Month Ending 6/30/17	Month Ending 5/31/17	Last Month 4/30/17	**Last QTR**	Last 2 QTRS	Last 3 QTRS	**Last Year**	Last 3 Years	Last 5 Years	Last 10 Years	Last 15 Years
Broad Market											
Russell:3000 Index	.90	1.02	1.06	3.02	8.93	13.52	18.51	9.10	14.58	7.26	8.66
Large Cap											
Russell:1000 Index	.70	1.28	1.06	3.06	9.27	13.46	18.03	9.26	14.67	7.29	8.62
MidCap											
Russell:Midcap Index	.99	.91	.77	2.70	7.99	11.45	16.48	7.69	14.72	7.67	10.50
Small Cap											
Russell:2000 Index	3.46	(2.03)	1.10	2.46	4.99	14.26	24.60	7.36	13.70	6.92	9.19
Non-US Equity											
MSCI: EAFE US$	(0.18)	3.67	2.54	6.12	13.81	13.00	20.27	1.15	8.69	1.03	6.31
MSCI: Emerg Markets	1.01	2.96	2.19	6.27	18.43	13.50	23.75	1.07	3.96	1.92	10.60
Fixed Income											
Bloomberg: Aggregate Index	(0.10)	0.77	0.77	1.45	2.27	(0.77)	(0.31)	2.48	2.21	4.48	4.48
Bloomberg: Gov/ Credit Long	.76	2.02	1.55	4.39	6.03	(2.28)	(1.07)	5.28	4.26	7.58	7.23
Bloomberg: Long Credit A	1.10	2.10	1.52	4.80	5.94	(0.11)	1.68	5.70	5.25	7.16	6.99
Bloomberg: High Yield Cash Pay	0.13	0.87	1.15	2.16	4.92	6.75	12.68	4.47	6.88	7.68	8.98
JPM: Emer Mkt Bond	(0.38)	0.62	2.16	2.40	6.27	0.62	3.75	4.78	4.97	7.19	9.80

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

ASSET STRATEGY CONSULTANTS

UPCOMING EDUCATION EVENTS

Date	Event	Location
Friday, November 17, 2017	The Influence of Payers in an All-Payer Model	**Sheppard Pratt Conference Center** 6501 N. Charles Street, Towson, MD
Wednesday, November 29, 2017	HFMA Maryland Chapter CFO Dinner	**Center Club** Harbor Room, 16th Floor 100 Light Stree, Baltimore, MD
Friday, December 8, 2017	2018 Charge Master Open Door Forum	**Maryland Hospital Association** 6820 Deerpath Road, Elkridge, 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.

Attention all members, sponsors and friends of the Maryland HFMA Chapter!

Have something to say to the chapter?

Itching to share your thoughts with others?

Then write an article for our newsletter!

Email your articles for consideration to:
newsletter@hfmamd.org

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