Officer’s Corner

How Long is a Year?

Michael D. Myers
Immediate Past President
Vice President, Regulatory Reporting & Reimbursement
Lifebridge Health

Those of you who are avid readers of the quarterly Maryland Chapter Newsletter may also recognize that the Summer newsletter is the final opportunity for the newly appointed Immediate Past President to reflect a little on the experience of not only being Chapter President, but of the HFMA leadership experience as a whole. So, while I’m certain that by the end of this short-story no one will mistake my prose for Hemingway, here it is….

I had settled into my hotel room during the 2015 HFMA Leadership Training Conference in San Antonio, Texas and was in a few moments of relative solitude contemplating my imminent commitment to serve as the Maryland Chapter President. It was, frankly, a little unnerving. My thoughts ping-ponged back-and-forth between an internal debate regarding how long a year really is. In one respect it seemed an almost eternity given the uncertainty of the demands and expectations I was sure to be subjected to in the role of President – would I be able to add another major commitment and continue to balance my “day-time job” and the on-going personal needs of my family? As quickly as that thought raced through the recesses of my mind, it was retracted by an at least equally strong one that quantified one year as completely inadequate to accomplish the numerous initiatives that I believed would allow the Maryland Chapter to continue on a successful path, both in the immediate year, as well as the foreseeable future. If this on-going conflict of thoughts wasn’t enough, I was also acutely aware of the resounding success our Chapter has realized, and I felt a strong sense of obligation to not let down those former leaders whose volunteer efforts had laid such a path.

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Hello Region IV HFMA members. I wanted to take a moment and thank you for a great 2015-2016 HFMA year while I served as Regional Executive for Region IV. It was truly an honor to serve the chapters, their members and leaders during my term. I was able to visit each chapter at least one time while serving as Regional Executive and each visit provided an opportunity to observe both the similarities and differences among the five chapters in Region IV. I had a great time meeting many of you along the way and sharing with your chapters. Thank you for the hospitality! The commonalities that come to mind as I look back on my experiences with the different chapters are passion, pride, quality, integrity, excellence, fun, loyalty, dedication and commitment. As I worked closely with the chapter presidents and presidents elect of Region IV, and interacted with leaders from other regions, it was clear to me that Region IV truly stood out from the others and was clearly one of the best HFMA regions in the country.

Well, as they say, the proof is in the pudding. I am proud to say that during the 2015-2016 HFMA year, Region IV was the only region in the country to have all of its chapters achieve a score of 100 on their Chapter Balanced Scorecards. This means that each chapter met or exceeded goals in: 1) Total Education Hours and Education Hours per Member; 2) Membership; 3) Membership Satisfaction; 4) Certification; 5) Days Cash on Hand; 6) Timely Reporting of Chapter Events and Newsletters; and 7) Provider Board Composition of 40% and above. This is a true indicator of the quality leadership and volunteers within Region IV that strive each day to provide the very best in education and networking events for HFMA members. Congratulations on a job well done!

As we begin the 2016-2017 HFMA year I ask that you please welcome my replacement, Okey Silman, as your Regional Executive for Region IV. Okey is a past president of the West Virginia Chapter and he is truly passionate about HFMA. Okey will honorably serve the needs of each chapter and the leaders within Region IV as they strive to meet and exceed their goals for this next year. Okey will also serve as a liaison between the Region IV chapters and the national office of HFMA, providing insight and feedback for both sides of the equation. Okey will do an outstanding job this year and I know that you will all make him feel at home as he visits the chapters.

The Region IV presidents, presidents elect and chapter board members for 2016-2017 are a great group of leaders. Please support their efforts and volunteer within your chapter any way that you can.

I wish you all the best in the coming year and I know that the Region IV chapters will have a great year!

Sincerely,

Tom Henderson
2015-2016 Region IV Regional Executive
By Bruce Haupt
President, ClearBalance

Millennials raised in the digital age with the convenience of online services are driving healthcare providers to change how they engage with patients and improve the customer service aspect of care. While older generations value in-person communication and cultivating relationships with medical professionals, millennials desire a different approach.

Accustomed to instant gratification, millennials don’t want to phone in for an appointment and then wait weeks to see a doctor. Nor do they like to be locked in to health plan network restrictions. They often will search online for healthcare information, even before seeing a doctor.

A key finding in a global survey of over 3,000 people is that millennials tend to select doctors based on referrals from family and friends. But while older patients express dissatisfaction directly to doctors, millennials share unsatisfactory experiences with friends, often on a social network. The survey also revealed that this generation is likely to trust social feedback, handing providers another challenge. Not only do providers need an online presence, they must monitor and manage their social reputation.

Millennials aren’t tied to the notion that they must have one specific doctor; they don’t develop personal relationships with them. For standard checkups and consultations, some don’t feel the need to see a doctor at all, opting instead to see a physician assistant or nurse practitioner.

They don’t want to spend hours at a doctor’s office for minor medical complaints. Part of this is due to millennials being generally healthy; pressing health concerns typically are for accidents or injuries rather than chronic illnesses. But it’s also reflective of how they consume goods and services. Why shop at the mall when online is more convenient and expedient?

As degreed professionals in executive positions, millennials have good private insurance. However, with rising healthcare costs and patient pay responsibility, they are covering more of the bottom line for medical services, like everyone else. As a result, they are extremely price conscious and demand the best care. According to a report from PwC’s Health Research Institute, millennials age 18 to 34 are most likely to ask for a discount, ask for a cheaper treatment option, request a price check or appeal an insurance decision.

In order to stay competitive, providers need to focus on attracting this population. Their spending power, behaviors and choices have set the stage for digitally oriented generations to come.
Planning for the Unknown: Triple Aim

By Ritchie Dickey, CFA, Vice President with Lancaster Pollard (rdickey@lancasterpollard.com) and Jason Beakas, Assistant Vice President with Lancaster Pollard (jbeakas@lancasterpollard.com).

“In preparing for battle I have always found that plans are useless, but planning is indispensable.”

This quote attributed to Dwight Eisenhower is good advice for strategizing in an environment where one knows that the conditions will change. Such is the case with the future of revenue for health care providers in America.

U.S. health care is a $2.9 trillion complex and adaptive system of entities including insurance companies, hospitals, pharmaceutical companies, medical equipment manufacturers, technology companies and increasingly more stakeholders. Until recent years, the federal government had largely been a reactive participant since the advent of Medicare. For many Americans, the system has worked relatively well, with the average consumer enjoying access to quality care, state-of-the-art technology and a fair amount of options. However, the Medicare system has some glaring flaws that make it unsustainable as the population ages. The primary flaws include the unacceptably large percentage of the population without insurance and costs growing much faster than the rate of overall inflation, which led to the adoption of the Patient Protection and Affordable Care Act (ACA).

While the ACA aimed to accomplish several things, perhaps the single biggest long-term change was the creation of the Center for Medicare and Medicaid Innovation (CMMI). CMMI is intended to drive changes through new payment models and performance metrics. Currently, CMMI is testing innovative payment and delivery system models that show important promise for maintaining or improving the quality of care in Medicare, Medicaid and the Children’s Health Insurance Program (CHIP), while slowing the rate of growth in program costs.1 In order to prepare for the impending changes, a hospital’s management and board should carefully reconsider its organization’s mission and role in the community.

The New Health Care Paradigm – Incentives Matter

Historically, hospitals in the United States were paid on a fee-for-service (FFS) model. While this method has some merit, it can create perverse incentives. The new paradigm, called “triple aim,” seeks to better align incentives through improving the patient experience of care (including quality and satisfaction), improving the health of populations and reducing the per capita cost of health care.

None of these goals are controversial, but there exists a major challenge in getting the various stakeholders to coordinate in achieving these goals. At best, many of the key players have worked independently to form a high-quality and cost-effective system. Often, entities have battled over revenue arrangement such that health of populations’ vis-à-vis access is compromised. Recognizing the incentive problems with FFS, CMMI is pushing a number of models that will challenge all participants in the American health care system. The biggest change is a shift to value-based reimbursement, which is a search for better health outcomes at a lower cost. According to Standard and Poor’s (S&P) Rating Service, “it’s probably the single most significant factor now fueling health care reform.” In a fee-for-value system, the emphasis changes to paying providers for stronger preventive care and early detection, instead of paying them to treat an illness through episodic care, as they would under FFS models.2 This shift is still in its infancy, as the majority of reimbursement remains in a FFS model. Consequently, creditors and financial analysts have to look beyond historical financial statements to determine if a particular organization is set up to handle the future.

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1 Guterman S, Davis K, Stremikis K, Drake H (June 2010). “Innovation in Medicare and Medicaid will be central to health reform’s success”.


“In PREPARING FOR BATTLE I HAVE ALWAYS FOUND THAT PLANS ARE USELESS, BUT PLANNING IS INDISPENSABLE.”

~DWIGHT EISENHOWER
Linker Mills, FHFMA, CRCR
Maryland Chapter Certification Contact

I am proud to announce that we had four members pass the Certified Healthcare Financial Professional (CHFP) modules in the past few months:

- Terri Taylor, Senior Budget Analyst at Anne Arundel Medical Center
- Thomas Glenn, Business Development Analyst at LifeBridge Health
- Zack Royston, Director at Union Hospital of Cecil County
- Nancy McCarthy, Controller at the Casey Health Institute

We want to extend our congratulations to these members on their great accomplishment!

If you missed the one hour CHFP overview webinar on June 16th, please feel free to email me. I’ll be glad to send you the link so you can watch the recorded version. We also hope to have this on our website in the near future.

A reminder that if your employer does not pay for the CHFP certification program, your Maryland HFMA chapter will reimburse Maryland Chapter members once you become certified.

If you have any questions relating to certification, please feel free to call me at 443-777-7949 or email me at linker.s.mills@medstar.net

Upcoming HFMA Community Service Events

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<tr>
<td>Friday, August 19, 2016</td>
<td>Collection drive on behalf of St. Vincent’s Villa</td>
<td>Sheppard Pratt Conference Center during The Healthcare “Three R’s”</td>
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<tr>
<td>Saturday, September 24, 2016</td>
<td>Marian House 5K</td>
<td>Lake Montebello, Baltimore</td>
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Note:

If you are interested in being apart of any of HFMA community service events or learning how you can help reach out to Arin Foreman - arinforeman@KPMG.com.
Save the Date

Maryland Healthcare Financial Management Association’s Fall Institute
October 5th-7th 2016
Evolving in a Dynamic Healthcare Environment

Featured Social Events:
Enjoy a round of Golf or attend a local Brewery Tour & Tasting!

Hyatt Regency Chesapeake Bay Golf Resort, Spa, Marina
100 Heron Boulevard at Route 50, Cambridge, Maryland 21613

Visit us online at
WWW.HFMAMD.ORG
for upcoming events, industry news and more!
Officer’s Corner

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My eternal thought conflict and any uneasiness were quickly put into perspective when I participated in one of my first “official” activities as Chapter President. During July, on an early Saturday morning, a group of HFMA members and friends came together at the Maryland Food Bank for a morning of service designed to help others. And as no one will be surprised to hear, the experience was far more rewarding than the sacrifice of a weekend morning during the Summer. I quickly connected the commitment of the Maryland Chapter and its many volunteer leaders to helping our Maryland Chapter members gain the most from their HFMA affiliation through educational resources, networking and the building of personal relationships, including allowing opportunities to support our communities that extend beyond the boundaries defined by the healthcare finance profession.

In addition to the numerous local charities which our Maryland Chapter supports, we made financial contributions to assist in the recovery efforts following the floods in South Carolina as well as the national Promise of a Pencil. Our local Maryland Chapter continued its long-standing history of offering quality, affordable, educational opportunities—returning to Western Maryland and Rocky Gap for a truly amazing Annual Institute that had more than 200 participants, moving our multi-day Spring program to Annapolis, creating a new physician focused education program and of course the always well attended HSCRC Workshop. Along the way we had numerous opportunities to connect with each other in fun ways while recognizing many of our volunteer leaders, past and present, including conferring our highest award to George Bayless. As a leadership team, we spent considerable time learning and discussing how to keep our organization viable by engaging early careerists (millennial) and advancing the use of technology to connect with our members.

Any of you who might still be awake or otherwise reading into the last paragraph of this commentary may be wondering if I’ll give some profound answer to my title, “How Long is a Year?”, I will probably disappoint you here. I have no profound or philosophical explanation that defines a year beyond the normal time parameters we place upon it. I will say, however, it was more than long enough for me to develop not only an appreciation, but admiration, for the leadership team who tirelessly committed countless hours of time to ensure our Chapter members received the most from their affiliation with the Maryland Chapter of HFMA. It was also not nearly long enough to accomplish the numerous aspirational initiatives I had aimed to achieve. But in the end I’m satisfied recognizing the current and new leaders will continue to further the success of our Chapter, and honored by the privilege of having served in the role of President for one year.

Upcoming HFMA Education Events

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<td>Friday, August 19, 2016</td>
<td>The Healthcare “Three R’s”</td>
<td>Sheppard Pratt Conference Center</td>
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<tr>
<td>Wednesday, October 5, 2016</td>
<td>2016 Maryland HFMA Fall Institute</td>
<td>The Hyatt Regency Cambridge</td>
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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. The following is a link to the website if you are interested:
Planning for the Unknown: Triple Aim

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Medicaid Expansion and the Power of Technology

The most widely reported aspect of the ACA is the expansion of insurance to millions of Americans. Partly through insurance exchanges, over 11 million more people now have insurance. While this is an unalloyed positive development in achievement of the “triple aim”, the expansion brings new challenges. Medicaid is the primary source of reimbursement for the newly insured and it is generally considered to be an inferior payor source. Many physician groups do not accept Medicaid; thus, patients wind up visiting the local emergency room (ER) for care. ERs in many communities were already stressed, and the influx of new patients has further stretched the resources at many facilities.

Creditors and financial analysts recognize the potential benefits of more efficient facilities, including the potential for additional admissions or procedures at the hospital. However, the temptation to expand must be tempered by the risk incurred by overleveraging a hospital’s balance sheet. Carrying too much debt can make a hospital’s credit profile too fragile in an uncertain environment.

Perhaps the biggest opportunity and greatest challenge facing health care providers is the use of technology. Technological improvements are nothing new, of course, but a government mandate for Electronic Health Records (EHR), along with market demands to improve efficiency and accuracy, make this area a paramount strategic and operational focus for every organization. The promise of a well-executed IT strategy is better population health, with more accurate and complete data, more efficient billing and reduced cost. The difficulty is often in the implementation, as a lack of resources and poor training can lead to delayed projects and an unwillingness to embrace the full power of innovation. From an analytical point of view, some important questions are: does a hospital have a reasonable plan for integrating technological systems? And what has been its recent experience with major projects? Often, the answers are disappointing, which ties into another major consideration for all health care providers—affiliation.

M&A – Strength in Numbers

Mergers and acquisitions (M&A) and affiliation agreements are a dominant theme for financial analysts. It is generally understood that the health care delivery system has to be more efficient. The improved use of technology is one aspect of the operational efficiency that ties in with value or risk-based health plans. Through the use of “big data,” insurers and government payors have a much better means to track population health and pinpoint costs. In addition, affiliations or business combinations offer an opportunity to, “bolster scale, scope and diversify; boost profitability; enter new markets; and enhance their competitiveness.”

From an analytical and creditor’s perspective, it is crucial that organizations clearly articulate the current and future states of their affiliation strategy. For some providers, the only viable option may be a merger. Many health care systems have expanded through horizontal integration by the acquisition of other health care operations, in addition to combinations with strategically targeted hospitals. Generally, from an analyst or creditor’s point of view, the fewer providers in a market the better. Fewer providers leads to better buyer power when negotiating with payors and vendors. For now, independent hospitals can survive, but it will be increasingly difficult to manage the health of a population without being part of an integrated network of providers.

Putting it All Together

Improving the overall wellness of the population is the main goal of stakeholders in the health care system. Physicians and hospitals are on the front line in the effort to improve access, while at the same time reducing cost and improving the patient experience. A welcome change in recent years is the push for community programs designed to better educate the population regarding health issues. It is important for providers to identify and describe initiatives to improve the wellness in their community. While risk-based payment programs designed to better educate the population regarding health issues. It is important for providers to identify and describe initiatives to improve the wellness in their community. While risk-based payment programs represent a very small proportion of the payment plans now (less than 5%), it is undeniable that payments tied to health of a population are a growing force.

The challenges mentioned in this article and the context where market driven reforms dovetail (or sometimes collide) with

Ibid.
regulatory changes can be daunting. Until recently, it was generally accepted for hospital management to respond with a blithe dismissal when asked about the impact of reform. No longer can a hospital board or management get by with vague assurances to questions about planning for a vastly different payment structure.

For now, rating agencies and financial analysts continue to examine the historical operating performance of a health care organization. Debt service coverage, cash to debt and operating margins are still important. However, the examination goes deeper with an increased focus on underlying metrics (ie: FTEs per occupied bed) that provide signals of operating efficiency. The market-driven and government mandated reforms will place increasing pressure on operating costs.

While operating efficiency is the most important piece of the puzzle, creditors and analysts are placing a greater emphasis on the strength of hospital boards and management. Importantly, hospitals need to understand that a complex adaptive system cannot be predicted, so risk management is difficult. Organizations that can adapt by implementing robust processes and systems will have the best chance to survive and thrive.

Hearkening back to the Eisenhower quote, creditors and analysts are more interested in seeing that an organization is planning than knowing the details of the plan. Key questions are: how is the organization set up for value and risk based reimbursement? What is the organization’s affiliation plan? What is the organization’s track record and plan for implementing new technology? And what is the organization doing to connect to its community? Organizations that can demonstrate a thorough and consistent examination of these questions will be well-prepared for the future.
The HFMA Maryland Chapter has many exciting committees that would welcome your participation. If you are interested, please contact one of the Committee Chairs below:

<table>
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<tr>
<th>Committee</th>
<th>Chairperson</th>
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