The Newsletter of the Massachusetts-Rhode Island Chapter

Advisor

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MA - RI Chapter

Healthcare Financial Management Association

PHYSICIAN PRACTICE MANAGEMENT

- How Healthy Is Your Practice? It's Time for the Annual Check-Up
- How to Find Cash Under Your Own Roof
- All Co-Management Arrangements are Not Created Equal: Understanding True Value-Drivers
- The Ins and Outs of References

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On the Cover

Pictured from Left to Right: Jonathan Gorski, Mark Toso, Annamarie Monks, Jonathan Richman, Amy Guay, John Droney, Linda Burns

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President's Message

As summers ends, we start to embark on new beginnings whether at work, school , or in our personal lives; now is the right time to THRIVE!

Thrive is the HFMA National Chairperson's theme for 2016-2017, and it certainly is something our Chapter has consistently achieved. We have had successes last year, and we plan to build on these and accelerate these accomplishments in the coming year.

Healthcare continues to be in a state of transformation that will continue to play out over the years to come. During times of change, we can set our sights low and seek only to survive, or we can choose to make the most of a challenging situation – CHOOSE TO THRIVE!

Our chapter has the ability, the talent, and the presence of so many forward-thinkers to be able to keep abreast and, oftentimes, ahead of the changes and needs that our industry faces. It is a credit to our HFMA predecessors who made the Massachusetts-Rhode Island Chapter as strong as it is today to deal with the constant fluctuations and challenges of healthcare and to help our members meet these demands.

As I think about the coming year as President, I have confidence that we can build on our past successes and continue to excel. The Mass.-RI Chapter is often a step-ahead in technology, ideas, innovation and talent. What we need to do now is to take advantage of these attributes and put them into action.

I see a number of opportunities where we can thrive by offering innovative and exciting events. Planning is already under way for the following:

- Creating a women's conference
- Expanding our Revenue Cycle program to a day and a half
- Growing our young professional membership
- Capitalizing on social media for the purposes of growth, communications, and marketing

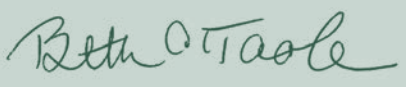
The Chapter's success is driven by members' involvement and satisfaction. Providing opportunities for participation and putting our ideas and people into motion will drive our success this year. A simple invitation or a tap on the shoulder is sometimes all it takes to get colleagues involved in our Chapter offerings. So, why not invite someone to join you at the next HFMA event and see how contagious getting others involved can be?

Now is the time to become involved in the Chapter by attending events, joining a committee, sharing your ideas and talents, and suggesting new and innovative topics for our education sessions. Members' participation is a key factor to our success.

Our Spring Awards night recognized many of our colleagues and their achievements, especially Jerry Vitti, who was presented with the Hernan Award. The Region 1 conference at Mohegan Sun in late May was another opportunity to network with our colleagues from neighboring states and attend some outstanding educational sessions. Our most recent event at Granite Links golf course provided members the opportunity to golf with friends, take in the spectacular views of the city, share laughter and a delicious clambake. I look forward to the coming months with some of our Cornerstone events listed on the back page of HFMA Advisor.

As I begin my year as President, I want to acknowledge and thank the incredible members of the Board of Directors, the committee chairs, and all of you that I have had the pleasure to serve with over the years. I want to especially thank my immediate predecessor Tim Hogan for his guidance and direction to make last year so successful.

As Maya Angelou stated "My mission in life is not merely to survive, but to thrive; and to do so with some passion, some compassion, some humor, and some style." With this mind, I look forward to achieving great things in the year ahead in collaboration with you, the Chapter members.



Beth O'Toole
President

Advisor

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HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

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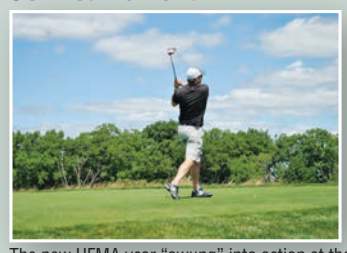

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Innovative Responses to Payment Reform: Not Getting Soaked When You Have One Foot in the Boat and One Foot on the Dock!

By
Mark E. Toso, CPA, CGMA

This year's Physician Practice Management meeting addressed how **"Innovation"** can support the move from "Fee-for-Service (FFS)" payment systems to "Alternative Payment Models (APM)". The speakers and panelists indicated that the goals of population health management have not changed i.e. the changing payment systems will focus on improving quality, reducing per capita health care costs and improving the coordination of care. The ques-

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Linda A. Burns, MHA, MBA demonstrating conference theme of one foot on the boat and one foot on the dock

Innovative Responses to Payment Reform:

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tion health care professionals continue to address is: How are health care provider systems, insurers, and the government responding to meet those goals and what may or may not be innovative?

Importance of Data Analytics

William Marder, PhD of Truven Health Analytics addressed the drivers of spending growth for privately insured patients which provided information on health spending by service, by disease, and by type of patient. This type of data analytics allow health care professionals

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Exhibit 1

Impact of Payment System on Conditions Driving Costs

System Type	Pre-vention	Delivery	Diabetes +	Biologics	Behavioral Health
Fee-for-Service	N/A	Complex	Why we are here today	Rapid adoption and very costly	Prices too low for adequate supply
Bundled Payment	N/A	Long history	Hard to define	Hard to define	Hard to define
Payment for Outcome/Performance	N/A	N/A	Patient role	Promising	Hard to define outcome
Accountable Care Organizations Patient-Centered Med. Homes	N/A	Vaginal v C-section	Potential	Hard to know	Hard to know
Capitation	N/A	Long positive history	Promising in concert with delivery system	Potential	Hard to know

TRUVEN HEALTH ANALYTICS

Innovative Responses to Payment Reform:

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to understand the implications of decisions they make with respect to their organizations. Exhibit 1 on page 6 provides an interesting summary of how the changing payment systems impact drivers of cost. Dr. Marder also provided a summary of the Alternative Payment Models when compared to the FFS model, see Exhibit 2.

Exhibit 2

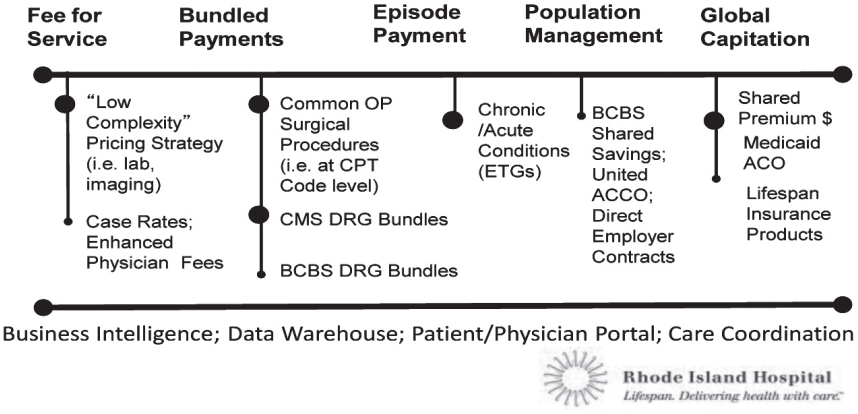
Pluses and Minuses of Payment Systems

System Type	Positives	Negatives
Fee-for-Service	• Well-known, no incentive to undertreat	• Likely to overtreat, costly
Bundled Payment	• Good history - OB for delivery • Simplified purchasing	• Depends critically on definition of the bundle • Potential to undertreat
Payment for Outcome/Performance	• Only pay if it works • Provides clear incentive to provider	• Hard to define and measure good endpoints • Who is responsible for outcome • Responsiveness to small incentives may be weak
Accountable Care Organizations Patient-Centered Med. Homes	• Patient-centered view • Quality focus • Voluntary	• Uncertainty about what will happen as cost controls hit • Inadequate quality measures
Capitation	• Has been wonderful where it works – Kaiser etc.	• Hard to replicate • Potential to undertreat

TRUVEN HEALTH ANALYTICS

Exhibit 3

Inventory of Alternative Payment Models (APM)- Potential Contracting Related Initiatives



Rhode Island Hospital
Lifespan. Delivering health with care.

Health Systems Perspectives - Growth in Large Systems Continues

Dr. Jeff Smith of UMass Memorial Medical Center and Margaret Van Bree, President of Rhode Island Hospital, discussed the growth of their systems to respond to the changing payment systems. UMass Memorial is the largest employer in Central Massachusetts and Lifespan is the largest health system and private employer in Rhode Island. *The growth of the large systems is being driven by, in part, the ability to absorb risk under the new payment systems; the cost of the information technology to manage under the new systems; and fixed costs can be spread over a larger base thus reducing per unit costs*. The movement towards the APM by Lifespan is shown in the attached Exhibit 3.

BXBS and CMS Perspectives - Growth in APM Continues

Renee Richard of Centers for Medicare and Medicaid Services (CMS) Region I and Sean Murphy, Senior

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Innovative Responses to Payment Reform:

(continued from page 7)

Annamarie Monks, Rosemary Rotty, Roger Price, and Krista Katsapetses; Front Row: Conference Speakers Jeffery A. Smith and Margaret M. Van Bree, Linda Burns

Director of Blue Cross Blue Shield of Massachusetts ("BXBS") discussed the payers' perspective with respect to the growth in APM's. CMS continues to move toward APM's across it's many programs as is shown in Exhibit 4 on page 27.

Ms. Richards summarized the various programs around the country being implemented by CMS most of which had a common theme, transform how CMS pays for health care services to emphasize quality, cost control and coordination of care:

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Conference Speakers Sean Murphy and Renee Richard

Steven Strongwater, MD, Roberta Zysman, and Rick Markello

Photos courtesy of Tony Slabacheski, Regional Medical Waste

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The Massachusetts-Rhode Island Chapter congratulates the following members on becoming Certified Healthcare Financial Professionals (CHFPs) in the past year:

Michael Baker
CHFP, CSAF

Peter R. Johnson
CHFP

Jason E. Brown
CTS, CHFP

Stacey Lee
CHFP

Robert Guadagno
CHFP, CSMC, CSBI

Emily Anne Nolte
CRCR, CHFP

If you're interested in becoming certified in the coming year, additional details are available at http://www.hfma.org/chfp/ or you can contact John Reardon (johndreardon@hotmail.com) for more information.

Welcome New Members!

The following members recently joined. We welcome you to the Chapter and encourage you to take advantage of the many professional development, networking and information resources available to you at HFMA. Other HFMA members are a terrific resource for your everyday professional challenges – we encourage all members, current and new, to get involved with HFMA committees and social activities. And… use the Membership Directory – *it's a great resource!* We value your membership, so please send us feedback or questions on your HFMA experiences to admin@ma-ri-hfma.org.

New Massachusetts-Rhode Island Chapter Members

August 1, 2016 through August 31, 2016

Diana Allen,
PPS Harvard Medical Faculty Physicians

Robert Bentinck-Smith,
Lahey Health System

Melissa Chausse,
Steward Health Care

Jeffery Clardy,
University Emergency Medicine Foundation

Christine Conway,
Audit Billing Center

Samuel Cordeiro

Linda Crump, CPA,
Prima CARE, PC

Lynne Guerard,
Craneware Inc.

Meghan Kearney

Mary Beth Molloy,
Faculty Practice Foundation, Inc.

Kayla Mudge,
Hospital Assn. of Rhode Island

Conor O'Brien,
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Samantha Reilly,
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Melvin Smith,
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Ryan Whiteleather,
Addison Group

How Healthy Is Your Practice? It's Time for the Annual Check-Up

By
Jonathan Gorski and Christopher Swain

Physicians recommend that patients undergo annual physical examinations. They advocate preventive medicine both to affirm a patient's health and also to proactively manage potential problems. Patients may balk at the time commitment, but recognize the value of yearly examinations. Likewise, a physician's practice will benefit from an annual check-up, even though the daily clinical, financial, and operational demands of the practice may make it difficult for physicians and managers to devote the time to ensure that the business is healthy. Still, the annual practice check-up is meant to reassure physicians and leaders that many aspects of the practice are running well and serves to identify areas of opportunity. With all the legal, regulatory and industry challenges, it has never been more important to perform this annual check-up.

Metrics specific to a physician's practice or specialty may be required, but at a minimum, the annual practice check-up should examine:

- Operations
- Billing
- Financial Management
- Human Resources

Additionally, important benchmarks should be monitored throughout the year to keep the practice on track and to facilitate performing subsequent yearly check-ups. (See sidebar.)

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Operations

A practice assessment starts by taking a fresh look at provider scheduling. A recent client complained about her staff that constantly ran 20 minutes late even at the outset of the day. We determined that although the physician was prepared to see patients at 8:00 a.m., the first patient did not actually enter the examination room until 8:15 a.m. because of the time necessary to check insurance coverage and collect a co-payment, among other administrative tasks. The simple solution was to book the first patient for a 7:45 a.m. appointment so that the doctor could begin the physical exam at 8:00 a.m. This was a simple solution, and a practice will likely find many "simple" efficiency improvements when conducting an assessment.

Addressing daily operations also includes staffing metrics and workflow efficiencies. Evaluating staffing costs is critical. Total staff expense should be benchmarked as a percentage of net revenue. This benchmark varies by specialty and practice style, but we recommend it be less than 35 percent. If a practice spends 35 cents on staff for every dollar generated, remedies are available, such as tracking and eliminating overtime, cross-training employees, tightening check-in and check-out procedures, and re-engineering telephone workflow.

Other measures include ensuring **evaluations of employees** are performed annually with no exceptions and comparing staff compensation to outside data (staff is doing so). Compare benchmarks of support staff per full-time-equivalent (FTE) physician to control overhead. Also, do not be afraid to differentiate and reward staff who over-performs.

Regarding **overtime**, investigate using enhanced technology. For example, does the practice use insurance card scanners and/or automated appointment reminders? Does the practice track referrals via a software program? Is the current phone system state of the art? Is the practice making full use of the features in the Electronic Medical Records (EMR) software?

Another way to enhance operations is to **cross-train** staff. Flexibility and payroll cost reduction opportunities are two important by-products of cross-training. Determine if efficiencies are available in daily protocols for check-in, check–out and telephone workflow. Consider customer-

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(How Healthy Is Your Practice? - *continued from page 12)*

service training. Not many practices employ this type of training, but those that do reap the benefits of increased patients' satisfaction. Many forms of provider compensation that will soon have a patient service component associated with patients who receive quality service will also become a premier source for marketing.

Billing

Most medical practices can manage their expenses within benchmark. Medical practices, however, have greater risk on the revenue side. Getting paid for the work being done is critical. The health care system is evolving, so it is vitally clear how to get the revenue deserved and remain compliant. Ensure those dollars are billed and collected appropriately after the service is provided.

To accomplish that goal, a fee-schedule analysis is a must-do every year. Ensure that the full charge is not collected. If it is, a fee increase may be warranted. Track allowable payments by comparing them to actual payments. And remember, payers make mistakes, so it is the practice's responsibility to ensure it is receiving the allowable payment negotiated for each current procedural terminology (CPT) code. Fortunately, most practice management systems offer this kind of tracking. It is also a good idea to perform a billing cost analysis by calculating total billing cost as a percentage of collections. Benchmark this figure to your specialty's average and high-performing practices and there may be opportunities to re-engineer.

It is important to review licenses and certifications every year as well. Although it seems second-nature to do so, make sure a protocol is in place to avoid missing a license of certification renewal.

Make sure an audit of the billing process is performed by tracking several patients from check-in through claim adjudication. Pay attention to aspects such as:

- charge entry lag
- charge capture
- services documented but not charged
- services charged but not documented
- claim denial rate
- top denial reasons
- co-payment and referral success rate

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(How Healthy Is Your Practice? - *continued from page 13)*

Finally, do not overlook investigating potential ancillary services. Practices should always explore additional revenue streams, and, thus, practices may consider devoting an entire brain-storming session to this topic.

Financial Management

Financial management of a practice demands a significant amount of time, but certain aspects are often overlooked. Do not neglect to review internal communications. For example, are the financial and billing reports needed to manage effectively being received? Is staff informing management of problems so they can be adequately addressed?

Once a budget is prepared, adhere to it throughout the year by identifying variances. A budget-to-actual report should be reviewed at least quarterly.

Another component of financial management concerns reviewing a practice's line of credit and other loan terms. Are there opportunities to refinance or adjust terms? Always maintain an open dialogue with a bank representative.

Another key evaluation is reviewing physician costs, such as malpractice policies, physician compensation amounts and structure (especially non-owner provider bonus structures), and other related benefits. Additionally, scrutinize higher vendor costs, such as office supplies, clinical supplies, answering service, cleaning service, and insurance policies. Practice cost accounting by analyzing major procedures, by CPT code, to ensure profitability. Pay attention to lab tests, pharmaceuticals/vaccines administered, and ancillary services.

Human Resources

Human resources is also an area that is sometimes paid short shrift. Although cost-savings may not be easily captured from this review, the benefit of avoiding future legal action alone justifies human resources as a crucial area to examine.

Begin this check-up by evaluating the practice employee handbook. Is it current? Do all employees receive it as a matter of course? To ensure compliance with ever-changing laws, the handbook should be referenced

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often. And of course, pay attention to the changing regulatory environment, complying with the myriad requirements of all regulatory agencies regarding such laws as Health Insurance Portability and Accountability (HIPAA), Occupational Safety & Health Administra-

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Just as a comprehensive yearly patient physical employs charts to record various body system functions and results of lab tests, the annual practice examination involves numerous calculations found in the following checklist of measures that should be tracked and reviewed year over year.

1. Days in total AR
2. Days in patient AR
3. Total AR gross collection rate
4. Patient AR gross collection percentage
5. Percentage of AR exceeding 90
6. Percentage of more than 90 days patient AR
7. Percentage of patient AR to total AR
8. Claim denial rate
9. Charge entry lag
10. Collection per procedure/patient visit
11. Charge per procedure/patient visit
12. Payer mix
13. Coding curve
14. Collections per FTE provider
15. Procedures/visits per FTE provider
16. Relative Value Unit (RVU)/Worked RVU per FTE provider
17. Overhead rate
18. Total staff expense as a percentage of revenue
19. Employee benefits as a percentage of revenue
20. Billing cost as a percentage of revenue
21. Support staff FTE's per FTE provider
22. Provider compensation to market
23. Provider benefits to market

(How Healthy Is Your Practice? - *continued from page 15)*

tion (OSHA), etc. Reassess employee benefits including the most important ones such as health insurance - use a benchmark contribution percentage, disability and life insurance and retirement plans.

While this article cannot possibly cover the unique needs of every practice specialty, it is meant to reinforce the importance of completing an annual exercise and what can be accomplished if implemented. This will assist with finding improvements and identifying necessary changes that will lead to a stronger, financially healthier practice. ❑

About the Authors

Jonathan Gorski, CPA, MBA is a Partner at Edelstein & Company with over 20 years of experience advising owners, CEOs, CFOs, controllers and managers of privately-owned businesses of all sizes. Jonathan has a particular expertise in the healthcare sector, helping physician practices and other healthcare organizations manage their business and financial operations, in addition to tackling the specific challenges facing healthcare practices today.
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How to Find Cash Under Your Own Roof

By
Donald Hilker, CPA, CVA

If there were thousands of dollars sitting in your building, would you look for it? Of course you would! A cost-segregation study can provide tremendous tax benefits and improved cash flow, leading your organization to find money right under your own roof.

What is a cost-segregation study?

A cost-segregation study identifies assets and their costs, and classifies those assets for federal tax purposes. Cost-segregation enables the owner to reallocate real property under IRS Code Sec 1250 to personal property under IRS Code Sec 1245. Commercial buildings are depreciated over a 39-year life. A cost-segregation study breaks out the components of the building. Certain costs that may be classified as 39-year property can instead be classified as personal property or land improvements, with a five, seven, or 15-year life. These costs can then be depreciated using accelerated methods. A cost-segregation study allows the owner to depreciate the structure in the shortest amount of time permissible under current tax laws, saving tax dollars.

Advantages of a cost-segregation study

The primary benefit of a cost-segregation study is an immediate increase in cash flow. Taxes are deferred resulting in current tax savings. The time-value of money is the idea that money available at the present time is worth more than the same amount in the future, due to its earning potential. Because of this, there is a great advantage of these front-loaded deductions compared to the deductions spread over a long period of time. In addition, there could be additional tax savings when deductions are taken during high tax bracket years versus possible lower tax brackets in future years, such as retirement years.

Disadvantages of a cost-segregation study

A cost-segregation study does come with costs. The cost

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(How to Find Cash under Your Own Roof - *continued from page 17)*

of the engineering study and the triggering of depreciation recapture and understatement penalties for taxpayers that use cost-segregation too aggressively can be considered disadvantages to pursuing the study.

What are the circumstances for a cost-segregation study?

The three prime circumstances for using a cost-segregation study are:

1) Newly constructed building
2) Purchase of an existing building
3) Major renovation of an existing building

The cost of the building, renovations that are taking place, and highly specialized buildings are all important considerations for cost-segregation studies.

How do you know if your organization should undertake a study? The general rule of thumb is a cost of $1 million dollars or more for a cost-asset value segregation to be worthwhile. Medical practices typically have very specialized features such as plumbing, electrical systems, and cabinetry and countertops that may warrant conducting a cost-segregation study.

The Bottom Line

Cost-segregation studies can be a valuable tax strategy for owners of commercial real estate. A commercial cost-segregation study creates an opportunity to defer taxes, reduce the current tax burden, and free capital by improving cash flow. Owners of commercial real estate should always consider and evaluate the benefits of a cost-segregation study when purchasing or renovating a building. ❑

About the Author

Donald Hilker, CPA, CVA, is the Physician Services Team Leader of WithumSmith+Brown, PC's Healthcare Services Group. He can be reached at (732) 379 5206 or email at dhilker@withum.com.

All Co-Management Arrangements are Not Created Equal: Understanding True Value-Drivers

By
Nicole Montanaro

The trend towards improved quality and transparency in healthcare is shifting hospitals' critical success factors from financial performance to efficiency and quality performance that are on par with national and industry standards. In order effectively to elevate performance and keep up with these standards, many hospitals and health systems are involving physicians by integrating them into governance and leadership positions.

It has become abundantly clear that healthcare payment is making the shift from volume to value. As a result, physicians' participation is vital for hospitals and health systems to achieve performance outcomes related to quality.

Introduction to Co-Management Arrangements

The quintessential co-management arrangement is a strategic agreement between a hospital and a group of physicians in order to align the physicians with the hospital for the physicians' provision of improved quality and efficiency performance in exchange for compensation payable by the hospital. These arrangements can range in scope from a specific service

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line to an entire hospital or even multiple hospitals within a health system. They are most commonly seen for service lines such as orthopedic surgery and cardiology, but can be customized for nearly any service line or hospital program, from obstetrics/gynecology to neurosurgery to wound care.

There are two primary arrangement types. The first is the direct contract co-management model, in which the physicians can be individually engaged or engaged as a group. The other co-management model is the limited liability company ("LLC") model. In the LLC model, instead of the hospital contracting directly with the physicians, the hospital contracts with a management company, the LLC, which has been formed for the purpose of co-managing the subject service line. This LLC can be owned wholly by the physicians or jointly by the physicians and the hospital.

Whether engaged directly or through a management company, the services provided by the physicians and the accompanying fee structure in co-management arrangements are relatively consistent throughout the market. Services can be categorized into two buckets:

- Hourly-based, and
- Performance-based

The hourly-based services are administrative in nature, such as as clinical management, program development, committee meeting attendance, etc. The performance-based services are clinical in nature and are provided via the achievement of certain pre-determined quality outcomes related to the performance of the subject service line. The fee structure corresponds with the services provided and is typically comprised of the following components:

- A fixed fee, and
- A variable fee

The fixed fee is usually an hourly rate payable to the physicians for their time spent performing the hourly-based duties described above. The variable fee is at-risk compensation payable to the physicians

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based on their achievement of certain service line performance thresholds, as described above. The at-risk compensation amount is variable in that, based on the service line performance, the physicians may receive any compensation amount from $0 up to a maximum incentive compensation amount typically determined by a third-party valuation firm. The following discusses the importance of setting compensation amounts that are consistent with Fair market Value (FMV).

The Need for Fair Market Value

According to the Internal Revenue Service ("IRS") Revenue Ruling 59-60, FMV is defined as:

FMV, in effect, is the price at which the property would change hands between a willing buyer and a willing seller when the former is not under any compulsion to buy and the latter is not under any compulsion to sell, both parties having reasonable knowledge of relevant facts.

As it relates to the healthcare industry, and physician compensation arrangements in particular, federally mandated fraud and abuse legislation consider FMV the standard of value for physician arrangements. Therefore, the documentation and analytical process associated with an FMV opinion are crucial to have on record if an arrangement or facility is audited by government authorities. Specifically, since Medicare, Medicaid, or any other government program funding could trigger a review of transactions between referring parties (such as hospitals and physicians), legislation such as the anti-kickback statute, which prohibits compensation in exchange for patient referrals, and the Stark self-referral law, which limits certain physician referrals, guide healthcare's legal and regulatory environment. The anti-kickback statute is a criminal offense, with some intent or some level of knowledge of wrongdoing, while the Stark self-referral law is a civil offense punishable by monetary fines. As a high-level overview, this legislation seeks to prevent payments to physicians based on the volume or value of referrals.

Regulatory Guidelines & Compliance Tips

Due to the tightly controlled environment that

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surrounds the healthcare industry, compliance and regulatory guidelines should never be an afterthought, especially when it comes to co-management arrangements. In order to develop a compliant co-management program, hospital management should consider working closely with counsel and third-party consultants and be able to explain reasons for pursuing a co-management agreement. Specifically, the following summarizes the main regulatory guidelines to adhere to when paying for quality.

General Program Guidelines

- The hospital should monitor the program and implement safeguards to ensure patients' access to care is not limited due to participation in the program
- All eligible physicians should be asked to participate in the program
- The hourly-based and performance-based services and the payments associated with these services do not overlap and are not duplicative with any other arrangement
- The hourly-based and performance-based services are required for the efficient operation of the facility or service line and/or based on community need
- The arrangement is the best fiscal option, absent referrals
- The arrangement makes sense commercially.

Metrics Guidelines

- The metrics should be clearly and separately identified
- The metrics should be proven to impact patient care based on credible medical evidence
- The metrics were determined with particular consideration of the subject service line or facility's patient population.

Compensation Guidelines

- Compensation should be determined by a third-party valuation firm and be within FMV;
- The incentive compensation for quality should be

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paid based on performance thresholds, which consider historical performance and national/industry benchmarks;

- The incentive compensation quality ranges from no payment to a maximum amount based on level of performance;
- The maximum FMV incentive compensation for quality should be paid only if superior performance (typically consistent with the national/industry top decile) is achieved under all metrics.

What to Know About Quality Metrics

From a valuation firm's perspective, the quality metrics are the true value drivers in determining the maximum FMV variable fee payable to the physicians and the distinguishing factor in creating a meaningful quality improvement program. Therefore, the selection of the metrics to be measured, the determination of the associated benchmarks and stretch goals, and analysis of historical performance all play a large role in the determination of the FMV incentive compensation for quality.

Based on analysis of quality payments to physicians in the market, as well as analysis of hospital pay-for-performance programs funded by both governmental and commercial payors, the following summarizes the major types of value drivers typically observed in the market when incentive dollars are rewarded for quality:

- Metric Type (outcomes versus process)
- Metric Benchmarking Source
- Number of Metrics
- Performance Threshold for Payout
- Historical Performance
- Likelihood of Achieving Maximum Payout
- Physician Responsibility to Impact metrics

Additionally, various other more qualitative value drivers related to quality payments in the market have been observed, such as patient acuity, experience/expertise of the physicians, qualities of the physician organization, etc.

With adherence to the aforementioned guidelines and in-depth consideration of the true value drivers, the quality metrics of the program, a meaningful and compliant quality improvement program can be within reach. ❑

About the Author

Nicole Montanaro is a Senior Analyst in the Professional Services Agreements division at VMG Health, LLC in Dallas, Texas and has performed over 100 quality incentive compensation valuations. Her area of expertise is dedicated to performing valuations of compensation agreements within the healthcare industry; specifically, co-management agreements, purchased services agreements, and management services arrangements. Additionally, she has experience in performing clinical compensation valuations, on-call coverage analysis, and analysis related to subsidy payments or collections guarantee models. (nicolem@vmghealth.com)

The Ins and Outs of References

By
Jeff Zegas and Lida Junghans

Career Corner: *HFMA Advisor is pleased to offer this third edition of our new Career Corner feature. We welcome readers' comments and questions about career development topics and will work to address questions in future issues.*

Linda A. Burns, MHA, MBA and
Kate Stewart, Esq., co-editors, HFMA Advisor

Providing references when you apply for a possible new opportunity is a standard practice. Nobody intentionally provides the name of someone who would provide a questionable or bad reference, but are the people you name as references able to provide the best information about you and your skills? As a health care executive search firm, we are retained by clients to find leaders for their organizations. We speak with many individuals who provide references and focus our conversations in order to learn as much as we can about a candidate's strengths and weaknesses. Knowing more about how we approach a reference conversation may help you evaluate whom you ask to serve as your references.

What do we aim to learn from references and how do we go about it?

First of all, it is important for us to understand the perspective of the person giving the reference. How long has he been in his role? How long and in what ways has he known you? We often open a conversation with: "Before we start talking about X, could you please give me

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(The Ins and Outs of References - *continued from page 24)*

a quick overview of your own career?" This provides us with a background for the reference's perspective.

- How long and in what contexts have you known X?
- How would you describe him/her?
- What were your first impressions of X and how have those changed over time?
- How would you describe his/her leadership style?
- Can you tell me about his/her interpersonal style?
- How does s/he deal with colleagues, administrative staff, executives senior to him/her, board members?

What is the candidate's leadership style?

Leadership style is critically important, with certain styles fitting better with certain cultures, organizations and positions than others. Examples and probing questions help us define more clearly a candidate's style and management methods.

- How does s/he bring people together towards a goal?
- How creative and strategic a leader is X? Can s/he see the big picture and not get bogged down in the details?"
- How is X viewed in his/her field? What is his/her reputation and the quality of his/her clinical work?
- The portfolio of this new position is substantial. Can you comment on X's ability to "scale up" to such a big job?

What are the candidate's accomplishments?

We expect that the person giving the reference will be able to comment in some detail on the candidate's accomplishments and the process of leading these initiatives.

- What stands out to you as his/her notable accomplishment(s)?

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(The Ins and Outs of References - *continued from page 25)*

- What was challenging about that accomplishment? What skills did it take to meet the challenge?
- Can you describe a difficult management or budget challenge s/he faced and how s/he addressed it?
- What experience does s/he have in leading major organizational change – e.g. a department merger or redesign? Please describe his/her role in carrying it out and the project's final outcome.
- Can you describe his/her interdisciplinary work or initiatives? Do you see this as a priority in his/her professional career?
- Could you provide an example of a difficult situation and how s/he handled it?

Nobody is perfect.

We also want to know what this person does less well.

- What would a fair-minded critic say about him/her?
- Do you think that X is ready for this job?
- Have you seen him/her in a situation where s/he didn't get along with someone? How did s/he deal with it?
- Is there anything that you are aware of in X's personal or professional life that could cause embarrassment, be considered an impropriety or have material impact on his/her candidacy should it be made public?

Lastly, there is "the doorknob question", the question we ask as we are getting ready to close the conversation, with a hand on the metaphorical doorknob: "Is there anything else you can tell us about X?" ❑

About the Authors

Jeff Zegas is CEO and ***Lida Junghans***, PhD is Senior Search Associate at ZurickDavis, a retained executive search firm exclusively serving health care organizations.
www.ZurickDavis.com, @ZurickDavis

Innovative Responses to Payment Reform:

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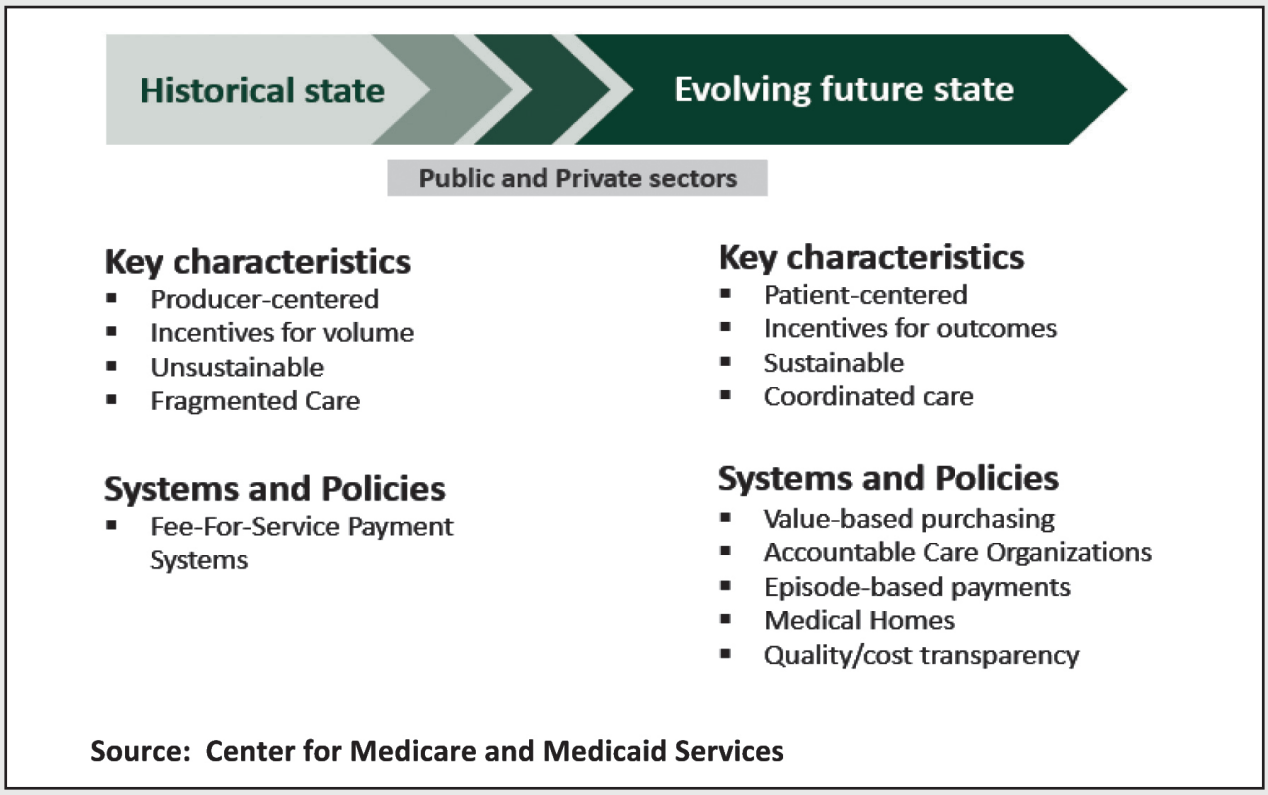
Exhibit 4



1. Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)
2. Accountable Care Organizations
3. Independence at Home Demonstration
4. Comprehensive End-Stage Renal Disease (ERSD) Care
5. Comprehensive Primary Care
6. Next Generation Accountable Care Organization (ACO) Models
7. Bundled Payments for Care Improvement
8. Oncology Care Model
9. Comprehensive Care for Joint Replacement
10. Medicare Advantage Value Based Insurance Design Model
11. Medicare Part D Enhanced Medication Therapy Management Model
12. Medicare Care Choices Model

Sean Murphy from BCBS elaborated on the changes being made to the "Alternative Quality Contract" (AQC) which was implemented in many hospitals over the last several years. The expansion of the AQC to include the Preferred Provider Organization (PPO) population and the comparisons are summarized in Exhibit 5 on page 28.

Health Systems Perspectives - Atrius New MD Payment Models

Dr. Steve Strongwater, President of Atrius Health, provided the perspective of the largest multi-specialty medical group in the Northeast with respect to the new physician payment models. The following list nearby identifies the existing models to the APM's which are evolving in today's environment.

MD Payment Models (72% of Physicians are Employed)

1. Fee-For-Service (FFS)

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Innovative Responses to Payment Reform:

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2. Salaried (w/wo performance incentives)
3. Upside Incentives

   -Care Coordination. Medical Home

   -Pay for performance (PQRS, Meaningful Use)
4. Financial risk **(physician compensation may have 10% based upon quality; patient satisfaction; productivity (Work RVU's) and outcomes)**

   -Value Based Payments. Hared Savings

   Condition Specialist/case rate (risk)
   Episode of Care (EOC)
   Bundled Payment
   Accountable Care Organization

   -Full capitation (global Payment)

   Alternative Payment Model (BCBS-AQC)

*84% Mass. Primary Care Providers are in 8 Largest Provider Networks**

Partners (PCHI)	1,165
Steward Health Care	559
Atrius Health	518
New Eng Qual Alliance	365
UMass Memorial	347
Boston Medical Center	347
Baycare Health Partners	301
The Pedi Phys Org at Children's	294
Lahey Health	167
Mt. Auburn	111
South Shore	93
Lowell General	93

Dr. Strongwater has observed that ***physicians do not enjoy the practice of medicine*** and this will change the way physicians practice medicine i.e. Concierge

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Exhibit 5

HMO/PPO Model Comparison

	HMO/AQC	PPO
Attribution Logic	Member-selected Primary Care Physician (PCP)	Claims based algorithm attributes member to a PCP
Attribution Timing	N/A	Reporting: Concurrent during performance year. Settlement: Retrospective as of 12/31 of performance year (with 4 months run-out)
Budget	Prior year claims history used as baseline Per Member Per Month (PMPM)	
Incentive Payments	One lump sum settlement based on efficiency and quality performance in prior year	Year 1 performance earns a performance-based PMPM)(+/-) paid in year 3
Reporting	Broad set of data and reports (daily, monthly, quarterly, bi-annual, annual) to support ongoing improvement on cost, quality and outcomes	
Risk Share	Quality-based risk share	
Trend	Regional Network minus Total Medical Expense (TME) trend target	Average Regional Network TME trend
Trend Adjustments	Adjusted for PO's changes in relative health status and member pharmacy benefits	
Quality Measures	Quality metrics and (and thresholds) will largely be the same for HMO & PPO – depression measure will be excluded from PPO	

Innovative Responses to Payment Reform:

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Medicine; Telehealth; CVS...etc. However, he believes the best hope is the evolving value based system:

- **Best Practice: elimination of unjustified variation**
  Improve care reliability (shift from *laissez faire medicine* to best practice)
  Diagnostic errors: close care gaps; unclosed care loops
- **Pay for value not volume: P4P, VBP**
  Incentives/disincentives for clinical outcomes/ complications
  Alternative Quality Contract; PQRS; Bundled Payments; Prometheus
- **Better Care Coordination**
  Medical home, navigators, etc.
  Data analytics to identify and manage disease sensitive conditions; prevent ED visits & re/ hospitalizations

Health Systems Perspectives - Steward Strategic Approach

John Polanowicz, Executive Vice President of Steward Health Care provided his assessment of how to manage under APM's. Steward's model focuses on value, integrated care delivery and greater ownership of outcomes.

- Expand network and investment in care integration
- Embrace global payments to remove economic barriers and create/align economic incentives
- Invest heavily in IT, particularly EHR
- Expand access points through acquisition of hospitals, physician practices, ASC's, imaging assets and urgent care partnerships
- Continue investment in market-leading facilities
- Invest in programs to improve quality and brand
- Supply chain optimization
- Consolidate back-office operations

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Innovative Responses to Payment Reform:

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In addition to looking at the overall strategy, it became clear that the Steward Business Model needed to focus on improving operational efficiency, not just at the 75th percentile but at the 90th percentile.

Historical Challenge

- Salaries Wages & Benefits (SW&B) constitute over 50% of total operating expenses across the hospital group. The inability to match staff shifts to fluctuating patient census resulted in excess costs.
- Hospital teams were reactive, reviewing financial impacts of coding, volume, staffing and length of stay at month's end.
- Difficulty in predicting census and the need to satisfy union requirements have been the biggest challenges to reducing SW&B.

Efforts to Date

- In 2014, a new predictive model was implemented to match staffing to volume; staffing costs per patient day decreased. Model was run manually and opportunities were managed closely by corporate office. In addition, a new initiative to control length of stay was launched and run centrally
- In 2015, Steward developed a proprietary IT tool to help hospital operational teams manage LOS, staffing and volume in real time.

Next Phase (2016)

- Enhance predictive capabilities of proprietary tool to achieve maximum savings and operational efficiencies:
    1. Push opportunities to end users, highlighting action items needed to achieve savings
    2. Actively and algorithmically match staff to volume
    3. Specifically target and track cost per hour
    4. Integrate the length of stay tool algorithm to minimize labor cost per unit of care delivered

Importance of Data Analytics - Next Generation of Population Health and Chronic Care Management

Deepak Damodaran, Director of PwC and Shashank Karnik, Manager of PwC elaborated on the struggle to bridge the gap between fee-for-service medicine volume driven model to the value based model and the key operational questions to answer to accomplish this goal. They provided an outline of strategic issues and operational considerations to accomplish this goal followed by some in depth analysis which focused on the importance of detailed information evaluated using predictive analytics.

Key Strategic Questions

1. How can we get the senior executive team and key stakeholders aligned on a common goal?
2. What scale and assets are needed to effectively execute population health?
3. Over what period of time and with what payer classes can we implement population health?
4. What partnerships are required to successfully deliver population health?
5. How do we balance performing population health with potential revenue impacts?

Key Operational Questions

1. What organizational structure is needed for population health to operate effectively and are the right structures in place today?
2. How much investment is required in technology and care management infrastructure?
3. What physical location is optimal to deploy population health (e.g., physician offices, hospitals, etc.)?
4. How can we gain market share and enhance competitive positioning using population health?
5. How can we align the physician community across primary care and specialty areas?

Where is Population Health (They believe health care organizations are not there yet.)

1. Don't understand "how to" cross the volume to value "valley of death".
2. "Experimental" mode and lack of "industrial grade" planning.

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3. Suboptimal operating model for population health.
4. Perception that population health and care coordination are the same thing.

Physician Compensation Models in a Value Based Environment

Dr. Bruce Hamory, the CMO of Health and Life Sciences for Oliver Wyman, concluded the session with an assessment of physician compensation models under Alternative Payment Models. Physicians have experienced cost pressures, hospital consolidations, price transparency, and increased physician employment as the move to APM's have been implemented. Dr. Hamory believes that physician compensation models must reward physicians based upon attaining the organization's mission as shown in Exhibit 6 below.

The general guiding principles according to Dr. Hamory are simple

- Physician Compensation should be adequate to attract and retain quality physicians
- Physician Compensation must be market competitive and affordable
- Physicians should be able to impact their compensation through their performance
- Physicians who contribute more, should earn more
- (Based upon an analysis of Work RVU's v. Panel Size it was determined that Panel Size was not a good indicator of productivity with respect to total compensation)
- Factors other than financial productivity must be recognized and rewarded

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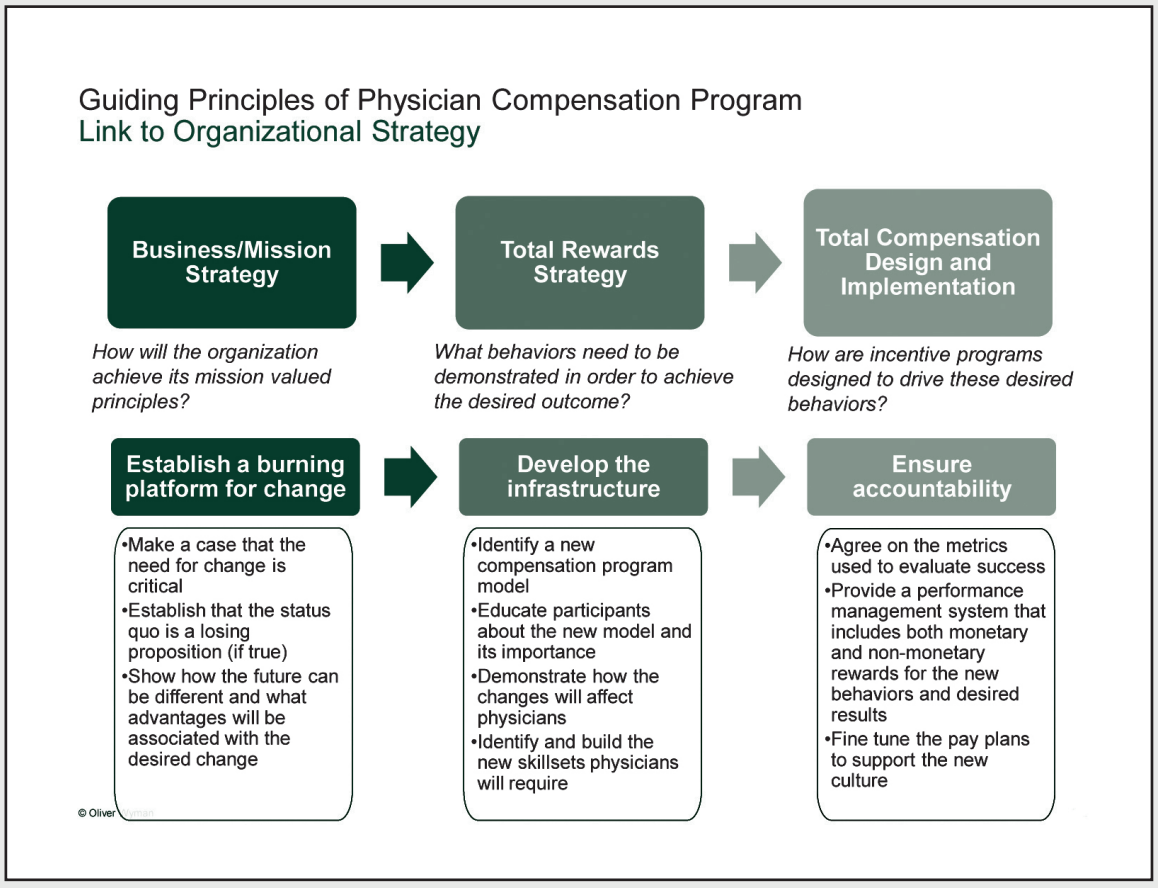
Exhibit 6



Source: Oliver Wyman, Dr. Bruce Hamory

HFMA Annual Summer Golf Tournament

By
Emily Anne Nolte, CRCR, CHFP

The new HFMA year "swung" into action at the annual golf tournament and clambake at Granite Links Golf Club. The weather was perfect for a round of golf, the views of Boston were breathtaking, and the lobster was simply delicious. Many foursomes competed but in the end the team made up of Young Joo, Justin Spencer, Sean Swiatek and Michael Monsegur took the first place prize with a score of 60. Well done guys! In addition to prizes for the top golfers, the annual raffle offered some great gift cards as well as a wide variety of golf apparel from shirts, to practice gear, swing analyzers, new clubs and even emoji golf balls.

After a long morning on the golf course (made even more enjoyable thanks to the beverage cart), the

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HFMA Annual Summer Golf Tournament (continued from page 32)

golfers were joined by their non-golfing buddies for a delicious clambake. Everyone enjoyed a hearty and fun lunch meeting new members, connecting with old friends, and even teaching some new to New

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Photos courtesy of Stephanie Moore, Wentworth-Douglass Health System and Tony Slabacheski, Regional Medical Waste

HFMA Annual Summer Golf Tournament (continued from page 33)

England the correct way to crack a lobster. If the bucket full of lobster claws is any indication, the day was a huge success.

Thanks to all of our volunteers, sponsors, golfers and friends for making this another successful event!

Winners

1sr Place	Young Joo	Justin Spencer	Sean Swiatek	Michael Monsegur
2nd Place	Paul Fitzpatric	Mike Koziol	Kevin Dwyer	Mark Stewart
3rd Place	Jennifer Cunningham	SarahModine	Michael Gale	Bob Feldmann

Innovative Responses to Payment Reform:

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Exhibit 7 shown below summarizes what has been seen or recommended in compensation plans discussed over the last several years.

Innovation to Respond to Payment Reform

The definition of "Innovation" per the dictionary and other sources is as follows:

- Innovation is defined simply as a "new idea, device, or method". https://en.wikipedia.org/wiki/Innovation - cite_note-1
- **However, innovation is often also viewed as the application of better solutions that meet new requirements, unarticulated needs, or existing market needs. This is accomplished through more-effective products, processes, services, technologies, or business models that are readily available to markets, governments and society.**
- The term "innovation" can be defined as something original and more effective and, as a consequence, new, that "breaks into" the market or society.

The second definition would appear to best meet the definition of what health care organizations are trying to accomplish as the road from FFS to APM is implemented. The presentations indicated in part that innovation is being accomplished through the following means:

1. Data Analytics and Predictive Analytics is being used to understand how patients utilize resources, what diseases cost, what services cost and ultimately what drives Total Medical Expenses (TME).
2. Consolidations are continuing at a rapid pace in order to transfer risk to provider organizations.
3. Physician Compensation Models are evolving to meet the changing environment. ❑

Exhibit 7

Align the Plan with the Organization's Goals

- Pay for what we want people to do
- Goals can be individual or group
- Establish a proportion of variable compensation to align payment with goals
  - Proportions of total compensation range from 5-50% in incentive
  - IRS regulations for not-for-profits typically limit incentive to 25% or less
- Potential Incentive Goals include:
  - Financial- beating budget
  - Access
  - Patient Satisfaction
  - Quality- use "bundles"
  - Project work- use completion dates
  - Academic/Teaching performance

Goals should be numerical, stated in writing in advance, and measured with frequent reporting to the physician

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hfma 2016 - 2017

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2016 - 2017

PROGRAM & SPECIAL EVENT SCHEDULE

Date	Event	Location	Coordinator(s)
10-21-2016	Accounting & Regulatory Technical Update	Four Points Sheraton Norwood, MA	Joanna Kroon
11-15-2016	Capital Finance Program	Boston Convention & Event Center Boston, MA	Karen Kinsella and Michael Lutz
12-09-2016	Compliance Update	Doubletree Hotel Westborough, MA	Matthew Smith, FHFMA and Kate Sullivan
01-20-2017	Revenue Cycle Conference	Gillette Stadium Foxborough, MA	Patrick McDonough, Dennis Scott, and James Jacobi
03-10-2017	Enterprise Performance Management & Physician Practice Management Joint Meeting	Four Points Sheraton Norwood, MA	Roger Price, Krista Katsapetses, Amy Guay, CHFP & Gary Janko
06-02-2017	Managed Care Program	Four Points Sheraton Norwood, MA	Kimberly Carlozzi and Karen Granoff

Education/Program Administration Committee, Chair: Rosemary Rotty, FHFMA, UMass Memorial Health Care Inc.

NOTE: Please keep in mind that the themes listed for the programs are general. The programs themselves address current issues pertaining to these themes.