First Illinois Speaks hfma
HFMA's First Illinois Chapter Newsletter

March 2020

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2020 Trends: The National View from the J.P. Morgan Healthcare Conference

BY J.P. MORGAN PUBLIC FINANCE HEALTHCARE TEAM

More than 10,000 registered participants attended the 38th annual J.P. Morgan Healthcare Conference in San Francisco in January 2020. The Not-for-Profit Healthcare track featured 27 of the country's leading NFP health systems, who shared their insights and strategies with standing-room-only crowds.

For those who were not in San Francisco, below are the top themes from the Not-For-Profit presentations.

1 **Health care is not just hospital care –** Health systems have explicitly broadened their focus areas – including housing, food security, domestic violence, mental health – as core elements of their mission fulfillment; addressing social determinants of health is no longer just an ancillary community benefit, but rather a core strategic imperative. Intermountain Healthcare set the tone for the conference, challenging systems to embrace a wider array of community needs and recalling the legacy of Bernard Tyson, the late CEO of Kaiser Permanente, who extolled the imperative for NFP systems to address social determinants of health.

2 **Affordability and access are paramount –** With healthcare costs the #1 cause of personal bankruptcy in the United States and price transparency highly visible in the national debate, leading systems are disrupting themselves to improve affordability and enhance access. Civica, the not-for-profit generic drug and pharmaceutical company, now has eighteen drugs in the pipeline with the expectation to grow to more than 100. It already serves an astounding 1/3 of hospitals beds in the nation. "Right care at the right time in the right place" and ambulatory strategies (such as OSF's Urgo platform) were consistent themes; several NFP systems are also designing coverage models to specifically meet the needs

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of underserved populations more effectively, virtually or through outreach programs like Seattle Children's efforts in Alaska and UC Health's partnerships to better serve rural Californians.

3 **The appetite for financial risk for populations is growing –** While the shift to value based care may have been slower than some anticipated, a growing willingness to take on financial risk for populations was evident this year. This was true not only for organizations with large scale insurance platforms, but also for regional and academic systems who understand that managing and scaling risk effectively will be a necessary capability for future success. For instance, Providence St. Joseph Health stated their strategic intent to take "full insurance risk at scale," with at least 30% of business in capitated arrangements.

4 **Primary care redesign is at the heart of population health –** NFP health systems are taking innovative steps to reimagine the nature and shape of consumer relationships with their healthcare providers – including rethinking productivity based measures for clinicians by redesigning workflow to lengthen appointment times, slow caregivers down and incorporate multi-disciplinary teams (including mental health) in standard care. For vulnerable populations, Geisinger aims to create a "community center meets activity center meets doctor's office." Or – as Henry Ford Health System put it – "Primary care is the primary focus." All systems have embraced virtual care strategies that allow patients to access care remotely, for example, Cottage Health offers CareNow E-visits with fast online diagnosis for common conditions.

5 **Successful systems are growing meaningfully –** The ability to attract new partners and integrate these assets is a key success factor as consolidation continues. Many of our participants are actively seeking growth opportunities, with the intention of being successful multi-market consolidators. Advocate Aurora Health countered the notion that NFP mergers do not realize their intended benefits, stating that cost and quality measures have improved since their merger.

6 **Growth in adjacent businesses –** Several of our presenters have embarked on strategies that explicitly increase the scope of their organizations – for instance, ProMedica's integration of the ManorCare acquisition explicitly elevates post-acute as a core strategy for the organization. Jefferson Health's mantra of seeking to be a 195 year old academic medical center "acting like a startup" challenges the status quo and motivates fresh, innovative thinking about the intersection of industries as seemingly disparate as fashion and healthcare.

7 **Democratization of expertise –** Systems are broadening their care delivery network through programs and partnerships by leveraging specialized knowledge. Hospital for Special Surgery has partnerships with like-minded organizations, providing access to the Hospital's top musculoskeletal providers. City of Hope's partnership with Amazon provides a range of enhanced cancer support services to US employees, including a dedicated phone line staffed by oncology nurses, specialized support for complex cancers and diagnosis and treatment plan review

8 **Commercialization of IP & capabilities creates value –** The dialogue around growth has evolved dramatically, with a focus expanding beyond the acute care footprint to an increasing focus on building and scaling services businesses. For instance, Bon Secours Mercy Health's sale of a majority stake of Ensemble, their revenue services company, for more than $1.2B highlights the potential value of these services businesses at scale. In a similar vein, more AMCs are effectively monetizing intellectual property, enabling reinvestment in core research and delivery missions – like Children's Hospital of Philadelphia's Center for Applied Genomics.

9 **Strides in technology are enhancing experience and efficiency –** Ascension shared the work they are doing with Google to make the EMR and all patient data searchable with an intuitive interface – a development that could meaningfully streamline the way caregivers access patient records. Baylor Scott & White Health is providing a personalized, on demand experience with its 'MyBSWHealth' App. NYU Langone is optimizing patient throughput across its health system in a 'Command and Control Model' which monitors system-wide capacity and alleviates bottlenecks; the resulting reduction in ED boarders and transfer delays has improved patient flow and satisfaction. Likewise, NorthShore's Clinical Analytics Prediction Engine has reduced response time by 62% and mortality by 20%, while a study at Northwestern suggests that a Google artificial intelligence system can predict breast cancer more accurately than human experts.

10 **Data analytics central to success –** almost every system that took the podium reinforced the notion that leveraging patient data more effectively is central to success. Mass General Brigham's Center for Clinical Data Science advances the potential for truly personalized treatment plans and disease identification. The Mayo Clinic also announced at the conference its partnership with a healthcare data analytics firm to build out an AI powered engine that will collate its years of clinical research and pathology work into a searchable platform. In

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addition, OHSU discussed its partnership with the University of Oregon for a joint center in biomedical data science to attack cancer and other diseases with big data.

11 **Modernizing business structure to align with strategy –** Several organizations discussed how they are reshaping themselves to enhance focus on their customers and the services they seek to provide. For some of the largest organizations in the country, like CommonSpirit, this means cascading a single operating model throughout a massive network; for Providence St. Joseph Health, it has meant "deconstructing" the health system to reorganize as a service line while diversifying the business and digitizing the patient experience.

12 **Partnering is an essential element of growth –** while many NFP organizations have long espoused the notion of partnership with other companies, it is clear this strategy has been widely embraced by leading systems. Partnerships with for-profit companies abound, particularly in the ambulatory space; this year we learned more about NFP partnerships yielding results, like the coordinated effort at Seattle Cancer Care Alliance. Navitus, SSM Health's fully pass-through PBM, is another avenue for this type of partnership among systems.

13 **NFP healthcare's role in reducing the nation's divisiveness –** There is no denying the polarized and fractured climate in which we live, and yet many of our presenters chose to focus on how health systems can be a change agent in healing these divisions through extraordinary care and personal connection. ChristianaCare's message that if one "leads with love, excellence is unavoidable" resonated deeply. These leading health systems have willingly embraced a broader focus to support well-being and meet the complete needs of a person and community. With the quality of leadership on display at the conference, the audience left inspired by the notion that compassion and business excellence can be symbiotic objectives.

"You can't separate the clinical and the financial – not anymore."

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Message From Our Chapter President

BY LANA DUBINSKY, PRESIDENT, FI HFMA

Dear Friends and Colleagues,

We work in a field that is constantly delivering unexpected challenges COVID-19 being just the latest unexpected one. But as a national issue directly tied to the nation's health, we can emphatically expect there will be health finance questions to deal with in the aftermath (even if we don't yet know what those questions are). Isn't it great to know we have a support system and colleagues in our First Illinois HFMA chapter that will help us navigate the unexpected? That valuable support is delivered in face-to-face chapter events, but it's also always there online, even when we cannot meet.

With COVID-19 recommendations for closures and restricted activities now in place statewide, our future chapter events have been temporarily suspended. Be assured we will inform you as soon as our regular HFMA calendar resumes. Your First Illinois HMFA website is always a place to go for such information.

http://firstillinoishfma.org/

During this time of increased working from home and suspended group gatherings, please also remember these other online sources for answers to questions, ideas and information sharing: your First Illinois chapter Facebook page, HFMA National's Facebook page, and the #hfmacommunity platform.

https://www.facebook.com/FirstIllinoisHFMA/

https://www.facebook.com/hfmaorg/?tn-str=k*F

https://twitter.com/hashtag/HFMACommunity?src=hashtag_click

Your feedback is always helpful to keep the chapter moving forward, and we sincerely thank those who provide feedback. As you check email in the coming weeks, be alert for a one question survey coming from HFMA National in April. They will be asking whether you believe your chapter is doing an excellent job. If your answer is anything but an enthusiastic "10," I strongly encourage you to email me directly with thoughts on where you think the chapter focus is weak. This is your chapter, and we want it to meet your needs. Click **HERE** and you can find the feedback button on the right side to contact us.

The Annual HFMA Conference is scheduled for June 28 to July 1 in San Antonio, Texas. The conference theme of "Navigate Complexity" could not be timelier. This year's conference will be the place to find actionable solutions to the issues and climate that U.S. healthcare faces. HFMA is monitoring how COVID-19 developments might impact the conference, but as of now, it is going forward. You can follow developments and register online below.

https://annual.hfma.org/2020/Public/Content.aspx?ID=1426

Here's a piece of exciting news. First Illinois was selected to host the Region 7 Midwest Conference this year. Please save the date; it will take place October 25-27, at the Hilton Chicago/Oak Brook Resort & Conference Center in Oak Brook, IL. We are honored to be hosting our colleagues from First Illinois, McMahon-Illini, Southern Illinois, Indiana and Wisconsin chapters. The presence of many of our own chapter members will help make it a memorable and valuable event for all. There will be much more information coming out on this, so please watch for it. (See link below.)

www.hfmaregion7.com

Proposed price transparency regulation for both group and individual health plan markets remains a concern that HFMA is monitoring closely. The Illinois Health and Hospital Association's (IHA) sent a letter to the CMS speaking for its member organizations and asking for retraction of some of what's proposed. You can see that January 29, 2020, letter on IHA's website, below, as well as their Principles for Commitment to Price Transparency.

https://www.team-iha.org/finance/price-transparency

Thank you to all our First Illinois HFMA members who faithfully step up in the ever-changing and challenging world of healthcare finance to deliver value to their organizations and care for their constituents. You are the best! We look forward to seeing you in person again at a First Illinois HFMA event later this year.

Lana Dubinsky
2019-2020 FIHFMA President

Telemedicine's New Relevancy in an Age of COVID-19

BY JIM WATSON, PRINCIPAL, BDO USA, LLP AND NICOLE CHANNELL, SENIOR MANAGER, BDO USA, LLP

Telemedicine has long been promised as a tool that could be used to leapfrog advances in access to care. Makes total sense; bringing healthcare into the same convenient media platforms that we've grown to know and love: our cell phones, pads and TVs. Over recent years the utility of telemed has been clearly demonstrated, yet its progression into the mainstream has been stalled as payors struggled with finalizing details around coverage and reimbursement. More recently, healthcare providers and healthcare payors have found ways to provide telemedicine coverage, often via an add on or carve out on a per visit basis (i.e., the Teledoc model). As of January 1, 2020, telebehavioral health coverage was mandated for ACA plans. In many ways, this primed the pump and set the stage for what is now an almost overnight phenomenon driven by COVID-19.

Telemedicine has arrived: Medicare and Commercial Insurance Coverage & Payment

As the coronavirus spread across the country, the demand for tele and virtual visits increased. And as it became clearer that this was going to evolve into a pandemic, the federal government and commercial payors moved with unprecedented speed. Beginning on March 6, 2020, Medicare and Medicare Advantage Plans began temporarily paying clinicians to provide telehealth services for beneficiaries residing across the entire country. Shortly after this announcement, HCSC/BlueCross BlueShield announced that they, too, would immediately begin coverage for telemedicine visits. All major insurers followed suit. *(see COVID-19 National Payor Grid on pages 10 & 11)*

Summary of Medicare's Telemedicine Value Proposition & Opportunity:

- **Expanded telemedicine coverage via COVID-19 public health emergency:** Effective for services starting March 6, 2020, and for the duration of the COVID-19 public health emergency, Medicare will make payment for Medicare telehealth services furnished to patients in broader circumstances.
- **Expanded telemedicine coverage via expanded sites of service:** Starting March 6, 2020, and for the duration of the COVID-19 public health emergency, Medicare will make payment for professional services furnished to beneficiaries in all areas of the country in all settings (previous Medicare coverage was limited to very specific settings). Medicare will make payment for Medicare telehealth services furnished to beneficiaries in any healthcare facility and in their home.

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- **Considered same as in-person visits and paid at same rate:** These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits.

- **No costly technology required:** The new waiver explicitly allows the HHS Secretary to authorize use of telephones that have audio and video capabilities for the furnishing of Medicare telehealth services during the COVID-19 PHE. In addition, effective immediately, the HHS OCR will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency. So, appointments can be conducted over a smartphone with video capability or any device using video technology (i.e., a tablet, laptop). For some appointments a simple check-in over the phone without video capabilities may suffice.

- **Patient cost share waiver:** The Medicare coinsurance and deductible would generally apply to these services. However, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost sharing for telehealth visits paid by federal healthcare programs. To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.

Immediate Questions to be Answered and Communicated:

1. What does it mean to deliver telemed services, i.e., do I need equipment?
2. Can we bill and get paid for telemed services?
3. What do patients know about telemed?

Let's take these questions individually:

1. What does it mean to deliver Telemed services; i.e., do I need equipment?

There are three types of visits: *(see page 9 table for summary)*

1. Medicare Telehealth Visits
2. Virtual Check Ins
3. E-Visits

This legislation, although labelled "temporary," removes previous confusion related to "approved technology" through which clinicians may perform telemed visits. The new waiver explicitly allows the HHS Secretary to authorize use of telephones that have audio and video capabilities for the furnishing of Medicare telehealth services during the COVID-19 PHE. In addition, effective immediately, the HHS OCR will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the nationwide COVID-19 public health emergency. So, appointments can be conducted over a smartphone with video capability or any device using video technology (i.e., a tablet, laptop). For some appointments a simple check-in over the phone without video capabilities may suffice.

2. Can we bill and get paid for Telemed services?

Yes, Medicare has issued codes and reimbursement amounts for all three (3) levels of care. BCBSIL has done the same. See below "Billing & Payment" section for complete details. Attached are tables with the billing codes and reimbursement amounts, where available

3. What do patients know about Telemed?

Most of the large health insurers have sent communication this week to their members related to COVID-19 and coverage for Telemedicine and testing. As time passes more and more of your patients will be interested in Telemed. This may become a prime revenue generator in the near term, during this period of office closures. You are well served to understand Telemed, and be proactive in the education of your patient base, in addition to the deployment of the service itself.

Billing & Payment:

- Clinicians can bill immediately for dates of service starting March 6, 2020. Telehealth services are paid under the Physician Fee Schedule at the same amount as in-person services.

- Medicare telehealth services are generally billed as if the service had been furnished in-person.

- For Medicare telehealth services, the claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional telehealth service from a distant site.

- Medicare coinsurance and deductible still apply for these services. Additionally, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

- To read the CMS Fact Sheet on this announcement visit: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet. To read the Frequently Asked Questions on this announcement visit: https://www.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

- To view the HCSC/BCBSIL Telemed Coverage announcements, visit www.bcbsil.com

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Telemedicine's New Releveancy in an Age of COVID-19 (continued from page 7)

Strategic Considerations:

- During the pandemic, broad deployment of Telemedicine is more of a civil defense/infection control strategy than a business strategy, but in the long run Telemedicine is both a care delivery strategy and a business strategy.
- Do we want patients/consumers becoming accustomed to the cheap, quick, convenient model of Virtual Check Ins and E-Visits?
- How will this affect competition across Independent Physicians, Employed Medical Groups and even payors who will likely enter this space as a cheap means to control revenue streams and referral patterns?
- How will the broader industry trend of Private Equity (PE) investment impact the evolution of Telemedicine?
- How do we balance activating/engaging our patient base to Telemed, while needing to protect the revenue levels of historical in person visits?

Telemedicine Visits:

Medicare patients may use telecommunication technology for office, hospital visits and other services that generally occur in-person.

- The provider must use an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient at home.
- Distant site practitioners who can furnish and get payment for covered telehealth services (subject to state law) can include physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals.
- CMS is waiving the requirement that you have a prior existing relationship with the patient, and waiving cost share as well.

VIRTUAL CHECK-INS: In all areas, established Medicare patients in their home may have a brief communication service with practitioners via a number of communication technology modalities including synchronous discussion over a telephone or exchange of information through video or image. We expect that these virtual services will be initiated by the patient; however, practitioners may need to educate beneficiaries on the availability of the service prior to patient initiation. Medicare pays for "virtual check-ins" (or brief communication technology-based service) for patients to communicate with their doctors and avoid unnecessary trips to the doctor's office.

- **Virtual check-ins are for patients with an established (or existing) relationship with a physician or certain practitioners where the communication is not related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours (or soonest appointment available).**
- **The patient must verbally consent to receive virtual check-in services.**
- **The Medicare coinsurance and deductible would generally apply to these services.**

Doctors and certain practitioners may bill for these virtual check-in services furnished through several communication technology modalities, such as telephone (HCPCS code G2012). The practitioner may respond to the patient's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal. Standard Part B cost sharing applies to both. In addition, separate from these virtual check-in services, captured video or images can be sent to a physician (HCPCS code G2010).

- **HCPCS code G2012:** Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
- **HCPCS code G2010:** Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment.

E-visits:

In all types of locations including the patient's home, and in all areas, established Medicare patients may have non-face-to-face patient-initiated communications with their doctors without going to the doctor's office by using online patient portals. The services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable.

- These services can only be reported when the billing practice has an established relationship with the patient.
- For e-visits, the patient must generate the initial inquiry and communications can occur over a 7-day period.
- The patient must verbally consent to receive virtual check-in services. The Medicare coinsurance and deductible would apply to these services.

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Telemedicine's New Releveancy in an Age of COVID-19 (continued from page 8)

Medicare Part B also pays for e-visits or patient-initiated online evaluation and management conducted via a patient portal. Practitioners who may independently bill Medicare for evaluation and management visits (for instance, physicians and nurse practitioners) can bill the following codes:

- 99421: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes
- 99422: Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 11– 20 minutes
- 99423: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes.

Clinicians who may not independently bill for evaluation and management visits (for example, physical therapists, occupational therapists, speech language pathologists, clinical psychologists) can also provide these e-visits and bill the following codes:

- G2061: Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes
- G2062: Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11–20 minutes
- G2063: Qualified non-physician qualified healthcare professional assessment and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes.

Telemed Services Summary (referenced on page 7)

Type of Serivce	What is the Service?	HCPCS/CPT CODE	Patient Relationship with Provider
Medical Telehealth Visits	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth services include: • 99201-99215 (Office or other outpatient visits) • G0425-G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406-G0406 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs). For a complete list: **https://www.cms.gov/Medicare/Medicare-General-information/Telehealth/Telehealth-Codes**	For new* or established patients. *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.
Virtual Check-in	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommuncations device to decide whether an office visit or other service is needed. A remote evaluation or recorded video and/or images submitted by an established patient.	• HCPCS code G2012 • HCPCS code G2010	For established patients.
E-Visits	A communication between a patient and their provider through an online patient portal.	• 99421 • 99422 • 99423 • G2061 • G2062 • G2063	For established patients.

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COVID-19 National Payor Grid (referenced on page 6)

Payer	COVID 19 testing patient responsibility waived	COVID 19 covered services	Telemedicine
Aetna	Yes	Co-pays for all diagnostic testing related to COVID-19 will be waived. This policy covers the test kit for patients who meet the CDC guidelines for testing and can be done in any approved laboratory location. These member costs associated with diagnostic testing at any authorized location will be waived for all Commercial, Medicare and Medicaid plans	Yes
BCBSIL	Yes	"Covering testing to diagnose the 2019 Novel Coronavirus (COVID-19) for most members with no prior authorization needed and no member copays or deductibles. For treatment of COVID-19, we cover medically necessary health benefits, including physician services, hospitalization and emergency services consistent with the terms of each member's benefit plan."	Yes
Cigna	Yes	"Will reimburse COVID-19 testing without customer copay or cost-share. Kits approved through the CDC and/or the FDA are eligible for reimbursement and billed with one of the following codes: U0001 (CDC kit), U0002, or 87635 (FDA). Phone calls for COVID-19 related care (e.g. virtual visit with or without video with the licensed health care provider)"	Yes
Humana (as of 3/10/20)	Yes	Humana will waive out-of-pocket costs associated with testing for COVID-19 for patients who meet CDC guidelines at approved laboratory locations. This includes Medicare Advantage, Medicaid and commercial employer-sponsored plans.	Yes
United Health Care (as of 3/18/20)	Yes	UnitedHealthcare will waive costs for COVID-19 testing provided at approved locations in accordance with the CDC guidelines. Will also waive copays, coinsurance and deductibles for visits associated with COVID-19 testing, whether the care is received in a physician's office, an urgent care center or an emergency department. This coverage applies to Commercial, Medicare Advantage and Medicaid.	Yes

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COVID-19 National Payor Grid (referenced on page 6, continued from page 10)

Telemedicine updates / fee to patient	Limitations	Payer resources
"Cost sharing will be waived for all virtual visits through the Aetna-covered Teladoc offerings as well as in-network providers delivering synchronous virtual care (live video-conferencing) for all Commercial plan designs. Aetna is also extending its Medicare Advantage virtual evaluation and monitoring visit benefit to all Aetna Commercial members as a fully-covered benefit."	Self-insured plans will be able to opt-out of this program at their discretion.	**https://www.aetna.com/health-care-professionals/provider-education-manuals/covid-faq.html**
Temporarily lifting cost-sharing for medically necessary health services delivered by an in-network provider via telehealth for eligible fully insured members.	Self-insured plans will be able to opt-out of this program at their discretion.	**https://www.bcbsil.com/provider/education/covid-19-preparedness.html**
"Code 99241 will be reimbursed for all other synchronous real-time virtual visits when billed with Place of Service 11. Reimbursement will be made according to applicable benefits and related cost share for non COVID-19 services."		**https://www.cigna.com/health-care-providers/**
Costs for telemedicine visits for urgent care needs for the next 90 days will be waived by Humana. This includes Medicare Advantage, Medicaid and commercial employer-sponsored plans and is limited to in-network providers delivering synchronous virtual care (live video-conferencing).	Self-insured plan sponsors will be able to opt-out of the program at their discretion.	**https://www.humana.com/provider/coronavirus**
"Temporarily waiving the CMS originating site restrictions, where applicable, for Medicare Advantage, Medicaid and commercial members. Providers will be able to bill for telehealth services performed while a patient is at home. This change will apply immediately and be effective until June 18, 2020. These policy changes apply to members with benefit plans covering telehealth services. Will reimburse both participating and non-participating care providers who submit appropriate telehealth claims according to the terms of applicable member benefit plans."	Self-insured plan sponsors will be able to opt-out of the program at their discretion.	**https://www.uhcprovider.com/en/resource-library/news/Novel-Coronavirus-COVID-19.html**

Regulatory Corner

BY BRIANNA ENGESETH

We know how much you value regulatory updates and hot topics so we will continue to bring those to you. Feel free to check out the Library at www.hfma.org on a monthly basis or subscribe to any folders you want to receive content updates on.

Key Hospital Financial Statistics and Ratio Medians 2019 Hospital ratio data in this document include operating margin, days in accounts receivable, average length of stay, and capital expense. https://www.hfma.org/content/dam/hfma/Documents/industry-initiatives/key-hospital-financial-statistics-ratio-medians-2019.pdf This and the other hospital financial statistics from previous years can be found at: https://www.hfma.org/topics/research_reports/1114.html

Comprehensive Care for Joint Replacement Model Proposed Rule Executive Summary

CMS released a proposed rule that would revise certain aspects of the Comprehensive Care for Joint Replacement (CJR) model, including the episode of care definition, the target price calculation, the reconciliation process, the beneficiary notice requirements and the appeals process.

https://www.hfma.org/industry-initiatives/regulatory-and-accounting-resources/fact-sheets/comprehensive-care-joint-replacement-model-proposed-rule-exec-summary.html

To access this summary and other regulatory materials and accounting guidance, go to: https://www.hfma.org/industry-initiatives/regulatory-and-accounting-resources.html.

"We Were Completely Wrong": How Henry Ford Health System Won a Major Direct Contract

BY RICH DALY, HFMA SENIOR WRITER AND EDITOR

- **Henry Ford won a direct contract with GM that started in 2019**
- **The five-year contract includes increasing downside financial risk tied to financial and health-quality measures.**
- **The shift to physician employment has helped Henry Ford's performance under the contract.**

When General Motors executives gathered to consider direct-contracting bids solicited from three Michigan health systems, none was willing to bet on Henry Ford Health System.

However, the subsequent review of the providers' bids revealed that only Henry Ford could meet the direct-contracting requirements of the large national employer. "We were completely wrong. Every single one of us," Sheila Savageau, U.S. healthcare leader at General Motors (GM), said in a recent presentation to congressional staff.

The Henry Ford deal, which launched at the start of 2019 as one of the coverage options for 23,000 GM beneficiaries in the Detroit area, is the auto manufacturer's only direct contract with a provider. In five other value-based arrangements it operates for employees across the country, health plan intermediaries are involved.

The GM direct-contracting initiative is part of a larger trend, with the share of large employers contracting directly with health systems and providers in local markets planned to reach 10% in 2020 and another 21% considering undertaking them in the next two years , according to the National Business Group on Health.

Factors that helped Henry Ford win the GM direct contract i ncluded its:

- Ability to drive care delivery changes
- Experience with measurable, quality-driven contracts
- Ability to manage large amounts of data
- Comprehensive clinical and administrative connectivity and interoperability
- Ability to meet network requirements
- Ability to take on growing financial risk and quality requirements over the term of the contract
- Ability to provide "concierge" service

What type of contractual experience was considered important?

Part of GM's review of the contract application included comparisons of the applicants' performance in models from the Centers for Medicare & Medicaid Services (CMS), such as the Next Generation Accountable Care Organization program.

Next, the manufacturer examined performance on CMS quality measures, such as those tracking hospital-acquired conditions. Applicants' scores on the Hospital Consumer Assessment of Healthcare Providers and Systems survey also were compared.

Capacity to take on downside risk was deemed critical

The ability of Henry Ford to take on open-ended downside financial risk as part of the contract was "absolutely critical," Savageau said. GM rejected at least one direct-contract proposal that requested to cap the provider's financial risk at $1 million. The manufacturer established a five-year contract with the health system because Savageau anticipated it would take three years or more to begin realizing the desired financial and clinical benefits.

Although the contract includes increasingly stringent health-quality outcomes and financial benchmarks, Savageau said the carmaker still may offer performance bonuses if Henry Ford meets the health goals but narrowly misses the financial goals. The model measures the system's performance using 19 quality measures. "Because to me, the quality is more important," Savageau said. "The other thing we've seen over time is whenever quality improves, costs actually go down." In exchange for an anticipated patient volume increase, the health system agreed to use a "Medicare-plus pricing model."

Operational details that make a difference

The large number of employed physicians at Henry Ford improves the functioning of the model, GM has found."That's the biggest, most significant factor that you can have with a health system," Savageau said. "If we have a physician issue that arises, I pick up the phone and I call one person and that one person is contacting the physician."Savageau said it also was important for GM to determine whether the health system's senior leaders were committed to the contract. "You have to go all the way to the board of the health system and ask, 'Is this really your mission?'" Savageau said.

The model has gotten off to a somewhat modest start, enrolling 11% of eligible employees this year. But Savageau was optimistic that up to 90% in the area eventually may enroll.

About the Author

Rich Daly is HFMA senior writer and editor, in our Washington, D.C. office

Follow Rich on Twitter: @rdalyhealthcare

https://www.hfma.org/topics/news/2019/12/we-were-completely-wrong-henry-ford-health-system-won-major-direct-contract.html


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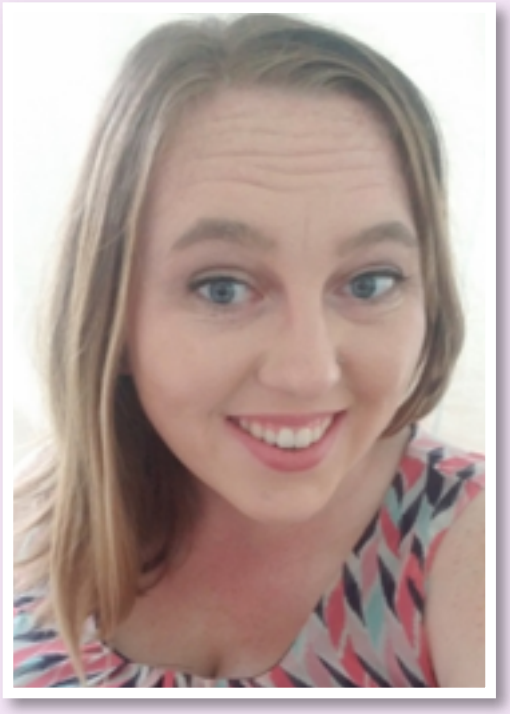

Meagan Edgren MSA, CHFP

Corporate Finance, Revenue Accounting
Northwestern Medicine

Questions:

What was your first job?

Revenue Cycle Claims Analyst at Healthcare Financial Resources LLC *(HFRI),* an Illinois based Account Receivable *(AR)* Recovery & Resolution vendor. They were my first step into the healthcare industry while I was completing my MS in Accountancy from Aurora University. Working for HFRI helped me to grow my understanding of the healthcare industry, healthcare finance and, ultimately, opened many doors towards future career opportunities.

Why Healthcare Finance?

It was love at first sight – I know that sounds cliché. But after gaining such valuable experience early in my career I cannot see myself in any other industry. I very quickly fell in love with the constant change and new challenges that the healthcare industry and finance bring. Each new client while working for a vendor, or new assignment while at Northwest Medicine, has presented its own unique set of challenges to overcome. It's exciting and rewarding to investigate and conquer them.

Career Perspective:

For me, growing my career has been about finding organizations whose core values align closely with my own. An organization's values, mission and vision say a lot about their goals and senior leadership. I held several positions at HFRI before transitioning to Northwestern Medicine where I have been able to continue my career growth. At both organizations I have had the opportunity to work for some truly amazing leaders. Their embodiment of a servant leadership style has inspired me to keep aiming my career goals high.

Why HFMA?

HFMA has been a great opportunity for me to grow my professional network and hear some incredible presentations at their events. It has been very rewarding both personally and professionally to volunteer on the HFMA Certification Committee. I look forward to meeting others who share my passion for healthcare finance and helping them achieve their goal of becoming a Certified Healthcare Financial Professional (CHFP).

What are you looking forward to in 2020?

I look forward to being more involved in HFMA. I recently joined the Membership Committee to encourage other finance professionals to join the chapter and benefit from what HFMA offers. I am also sitting for my first section of the CPA exam, so most of my summer will be spent studying for that. But I hope to spend some time traveling and hiking with my boyfriend and our dog.

Welcome New Members

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Mediclinic City Hospital

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First Illinois Chapter HFMA Editorial Guidelines

First Illinois Speaks is the newsletter of the First Illinois Chapter of HFMA. *First Illinois Speaks* is published 3 times per year. Newsletter articles are written by professionals in the healthcare industry, typically chapter members, for professionals in the healthcare industry. We encourage members and other interested parties to submit materials for publication. The Editor reserves the right to edit material for content and length and also reserves the right to reject any contribution. Articles published elsewhere may on occasion be reprinted, with permission, in *First Illinois Speaks*. Requests for permission to reprint an article in another publication should be directed to the Editor. Please send all correspondence and material to the editor listed above.

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Style

Articles for *First Illinois Speaks* should be written in a clear, concise style. Scholarly formats and styles should be avoided. Footnotes may be used when appropriate, but should be used sparingly. Preferred articles present strong examples, case studies, current facts and figures, and problem-solving or "how-to" approaches to issues in healthcare finance. The primary audience is First Illinois HFMA membership: chief financial officers, vice presidents of finance, controllers, patient financial services managers, business office managers, and other individuals responsible for all facets of the financial management of healthcare organizations in the Greater Chicago and Northern Illinois area.

A broad topical article may be 1,000-1,500 words in length. Shorter, "how-to" or single subject articles of 500-800 words are also welcome. Authors should suggest titles for their articles. Graphs, charts, and tables **(PDF or JPG only)** should be provided when appropriate. Footnotes should be placed at the end of the article. Authors should provide their full names, academic or professional titles, academic degrees, professional credentials, complete addresses, telephone and fax numbers, and e-mail addresses. Manuscripts should be submitted electronically, on computer disk or by e-mail as a Microsoft Word or ASCII document.

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Publication Scheduling

Publication Date	Articles Received By
June 2020	May 1, 2020
September 2020	August 1, 2020
February 2021	January 4, 2021