hfma

new mexico chapter

NM HFMA 2023 Fall Conference

FUTURE OF HEALTHCARE: BECOMING AGENTS OF CHANGE

Thank you to our Business Partners!

Healthcare Industry Trends

- Presented by:
- Jennifer Boese, Director of Health Care Policy & Innovation-CLA (CliftonLarsonAllen)

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Jennifer Boese is the Director of Health Care Policy & Innovation at CLA. She has worked in state and federal government as well as the private sector. She has decades of public policy, government relations and health care knowledge, which affords her a deep understanding of the health care market, health care organizations and stakeholders. Her role at CLA is to provide thought leadership, policy analysis and strategic insights to providers across the continuum related to the industry's ongoing transformation. A key focus of that work is on market innovations and emerging payment models. Her goal is to help CLA clients navigate and thrive in an increasingly dynamic environment.

Health Care Industry Trends

What we're watching and how to respond

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Learning Objectives

- Learn Details On Six Macro Trends
- Understand How These Impact Health Care
- Consider Steps To Take In Response

Health Care Trends to Monitor

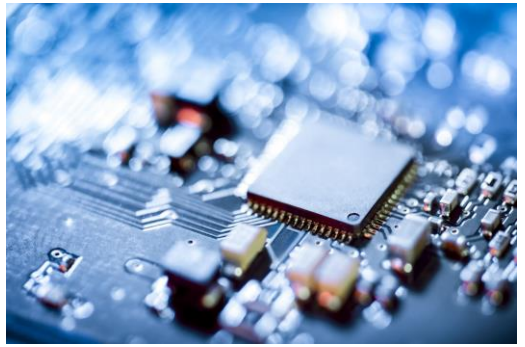
Labor, labor, labor

Regulatory Environment

Mergers,
Acquisitions
Private Equity

Capitol Hill Agenda

Technology



Economy

Economy

CLA Economic Outlook (Q3) Executive Summary

Half full

- GDP growth continues
- Inflation continues to fall
- Fed rate hikes nearing an end
- Strong projected company profits
- Consumer spending remains robust

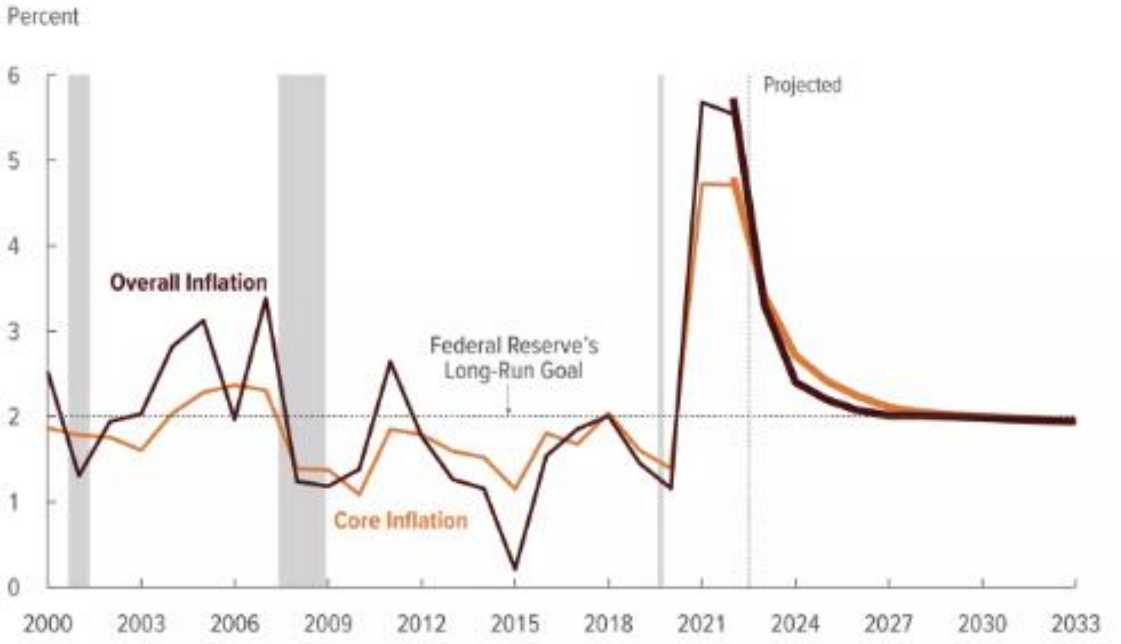
Half empty

- Relatively high interest rates
- Tight labor markets
- Inflation still above the Fed's 2% target
- Real estate is softening
- Falling labor productivity

https://www.claconnect.com/en/events/2023/2023-economic-outlook-third-quarter-update

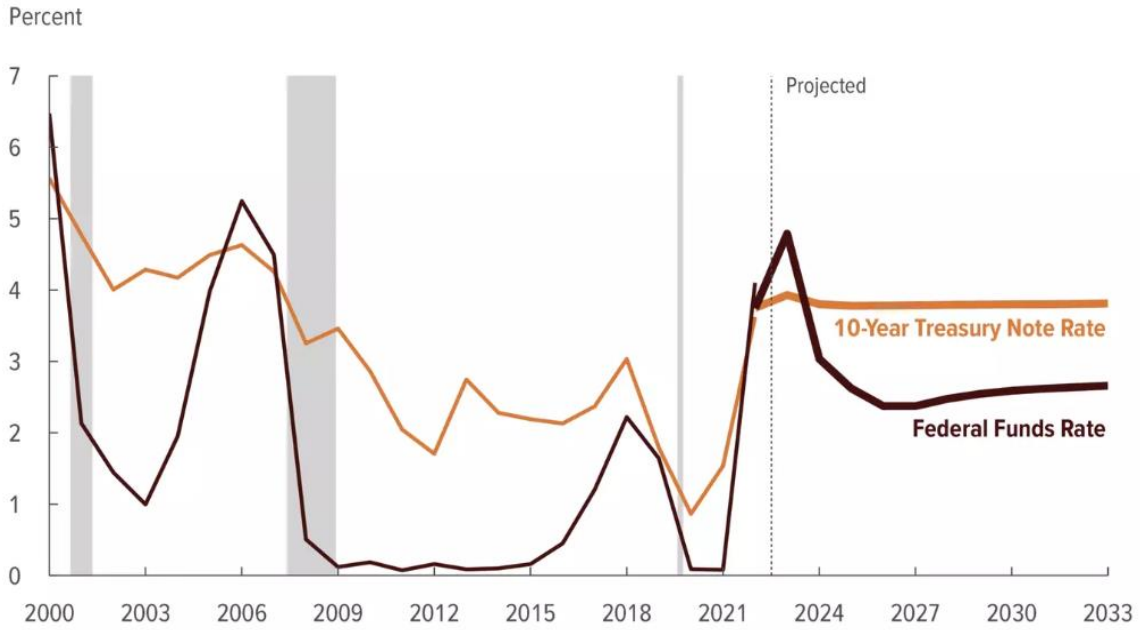
Congressional Budget Office - 2023

Inflation



In CBO's projections, inflation declines in 2023 as pressures ease from factors that, since mid-2020, have caused demand to grow more rapidly than supply. That decline continues until 2027, when the rate of inflation reaches the Federal Reserve's long-run goal. (Inflation is measures by price index for personal consumption expenditures.)

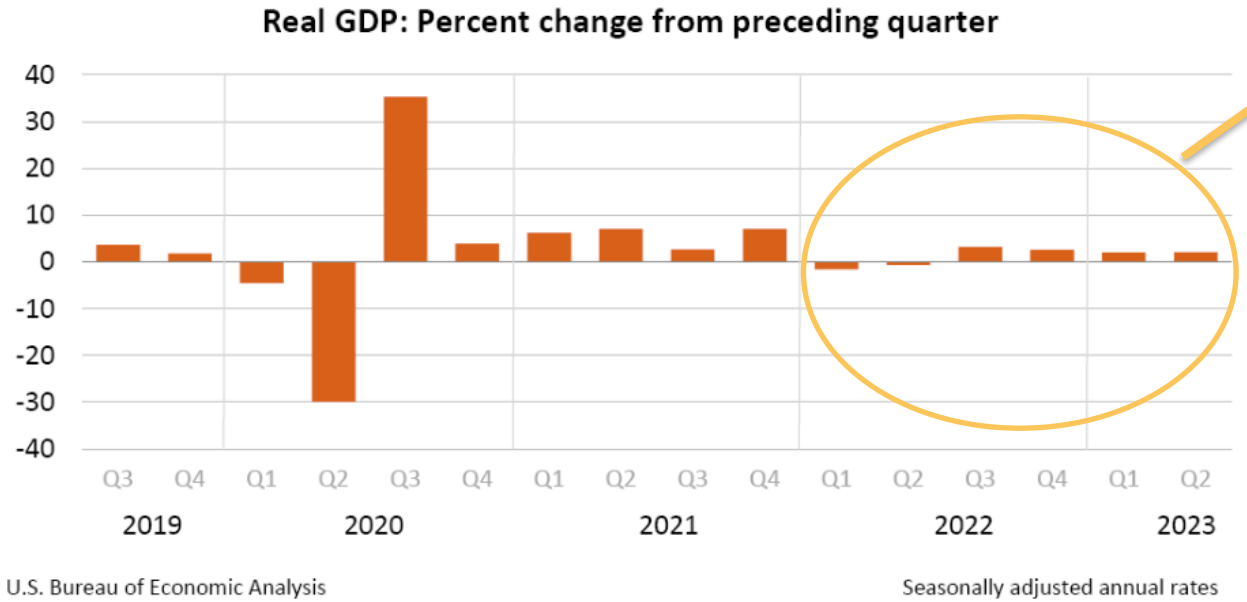
Interest Rates

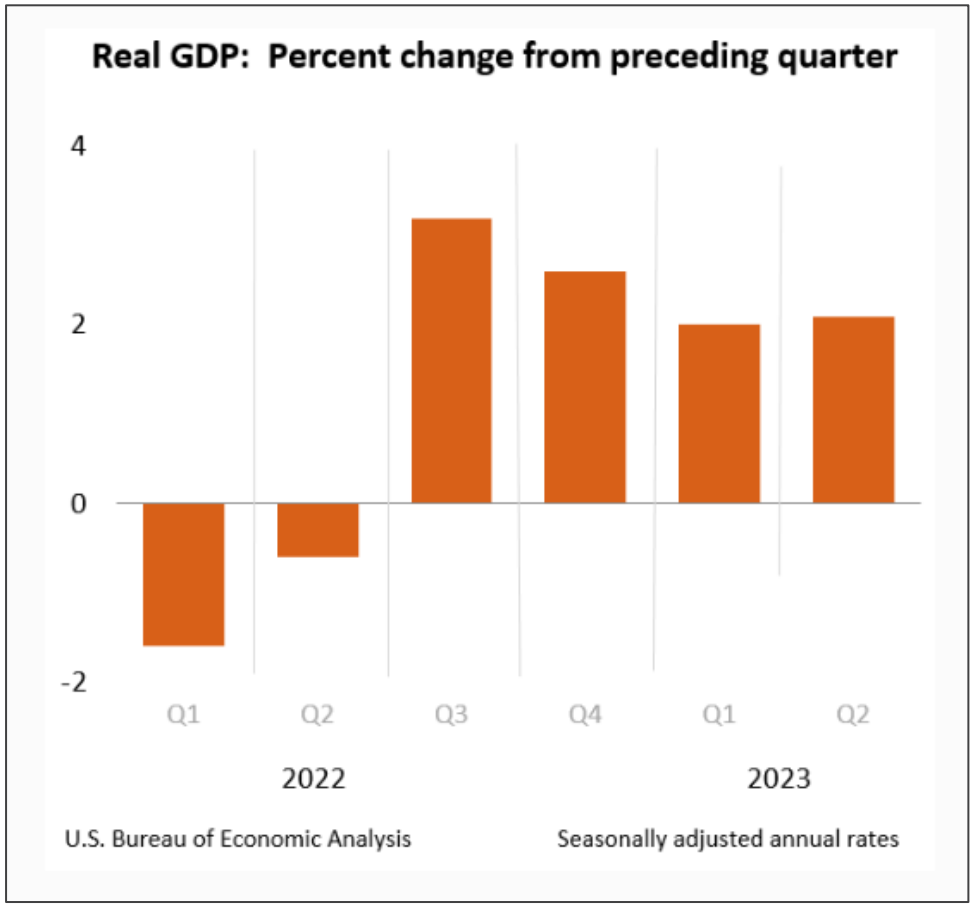


In CBO's projections, the Federal Reserve further increases the target range for the federal funds rate in early 2023 to reduce inflationary pressures in the economy. That rate is projected to fall in 2024, as inflation slows and unemployment rises. The interest rate on 10-year Treasury notes, however, remains at 3.8 percent from projection period.

Source: https://www.cbo.gov/publication/58952

National GDP Growth

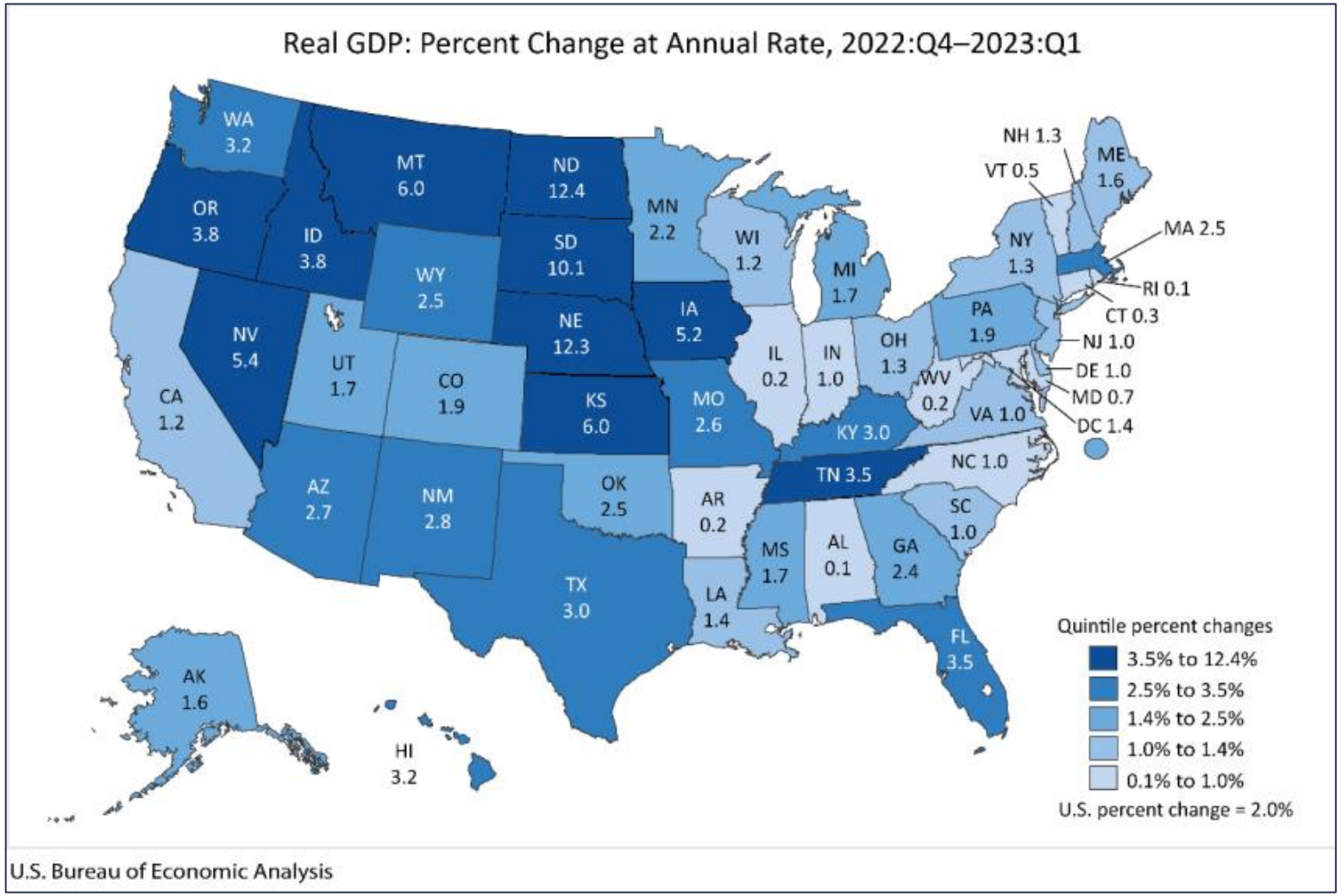




2.1% in Q1 2023
2.0% in Q2 2023

Gross Domestic Product, Second Quarter 2023 (Second Estimate) and Corporate Profits (Preliminary) | U.S. Bureau of Economic Analysis (BEA)

New Mexico Economy



New Mexico in real GDP growth = 2.8%

U.S. Bureau of Economic Analysis

Economy

Macro

- Interest rates and inflation are still high but trending down
- Economy is growing slowly

Health Care

- Economic conditions continue to negatively impact health care
- Debt, borrowing, purchases, tight labor market an ongoing issue
- Still recovering from pandemic

Actions

- Back to the basics of efficiency, and service line performance (understand it, drive changes as necessary)
- Utilize financial modeling that incorporates multiple scenarios to enhance planning and strategic direction
- Grow efficiently

Workforce/Labor Issues

Labor Market

Nationally

- 8.8 million job openings
- 6.4 million are unemployed
- An average of 76 available workers for every 100 jobs
- Unemployment = 3.8% (up from previous months)

New Mexico

- Unemployment rate = 3.6%
- New Mexico has 67 available workers for every 100 jobs

Understanding America's Labor Shortage: The Most Impacted States

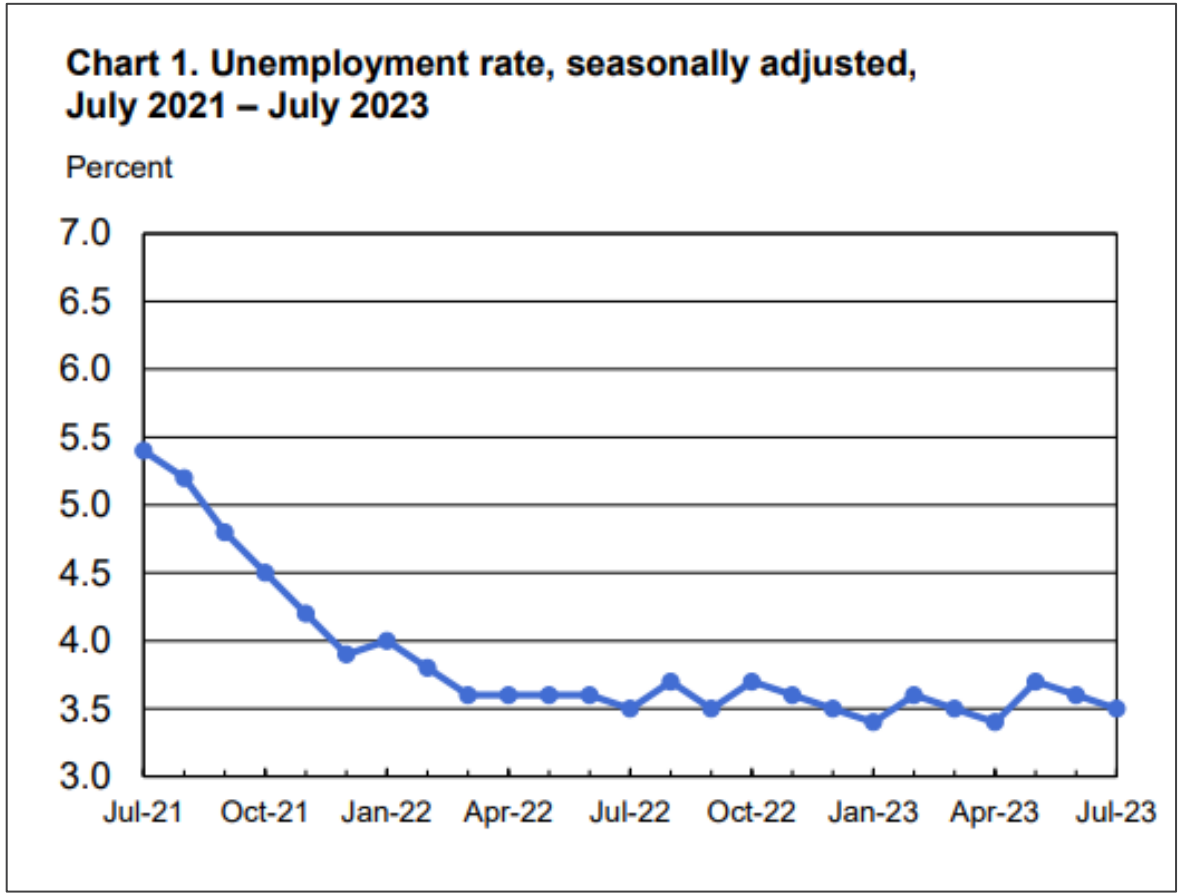
America Works Data Center | U.S. Chamber of Commerce (uschamber.com)

Job Openings and Labor Turnover Summary - 2023 M07 Results (bls.gov)

Employment Situation Summary - 2023 M08 Results (bls.gov)

Health Care Employment

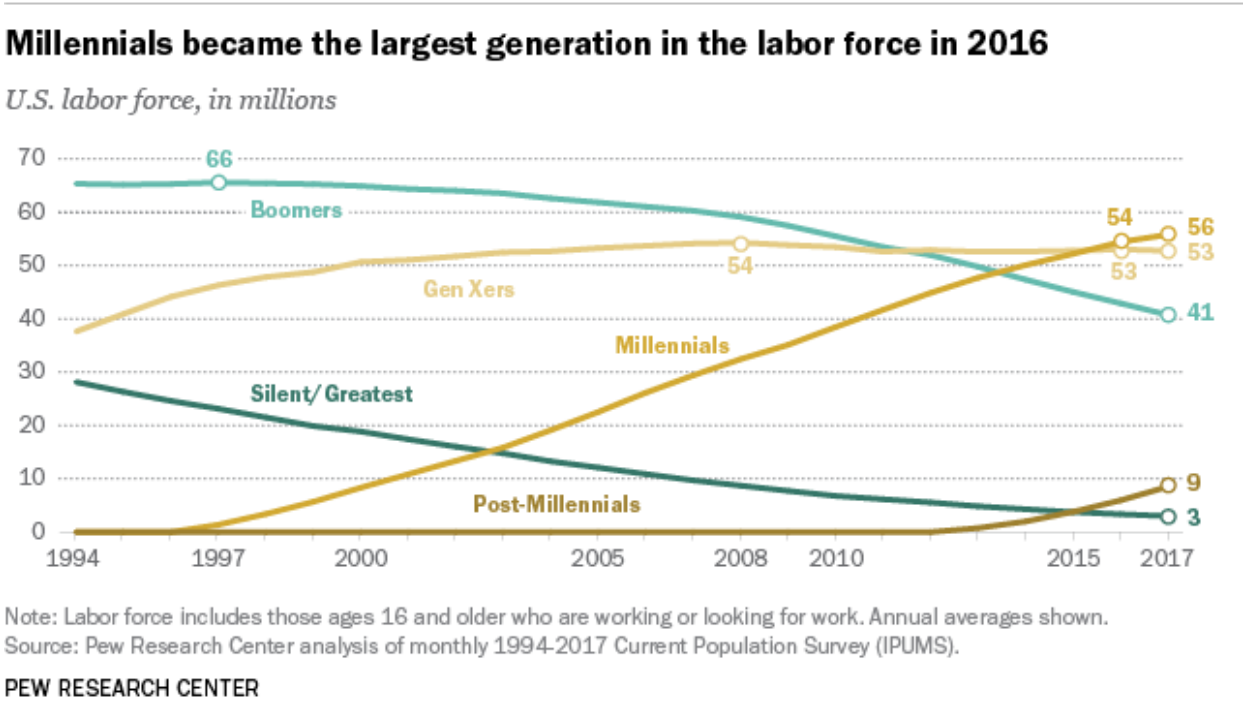
- Health care added 71,000 in August and 63,000 jobs in July.
- The average monthly gain prior had been 51,000 over the past year
- Largest job growth occurred in ambulatory health care services (+40,000), nursing and residential care (+17,000) and hospitals (+15,000)

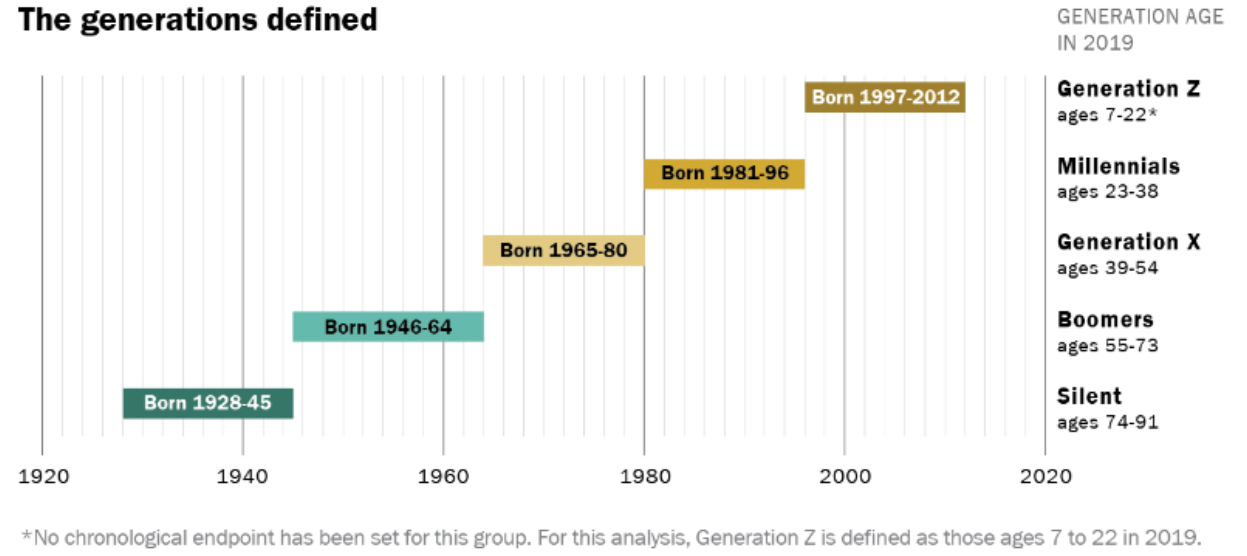


https://www.bls.gov/news.release/pdf/empsit.pdf

Generational Cohorts

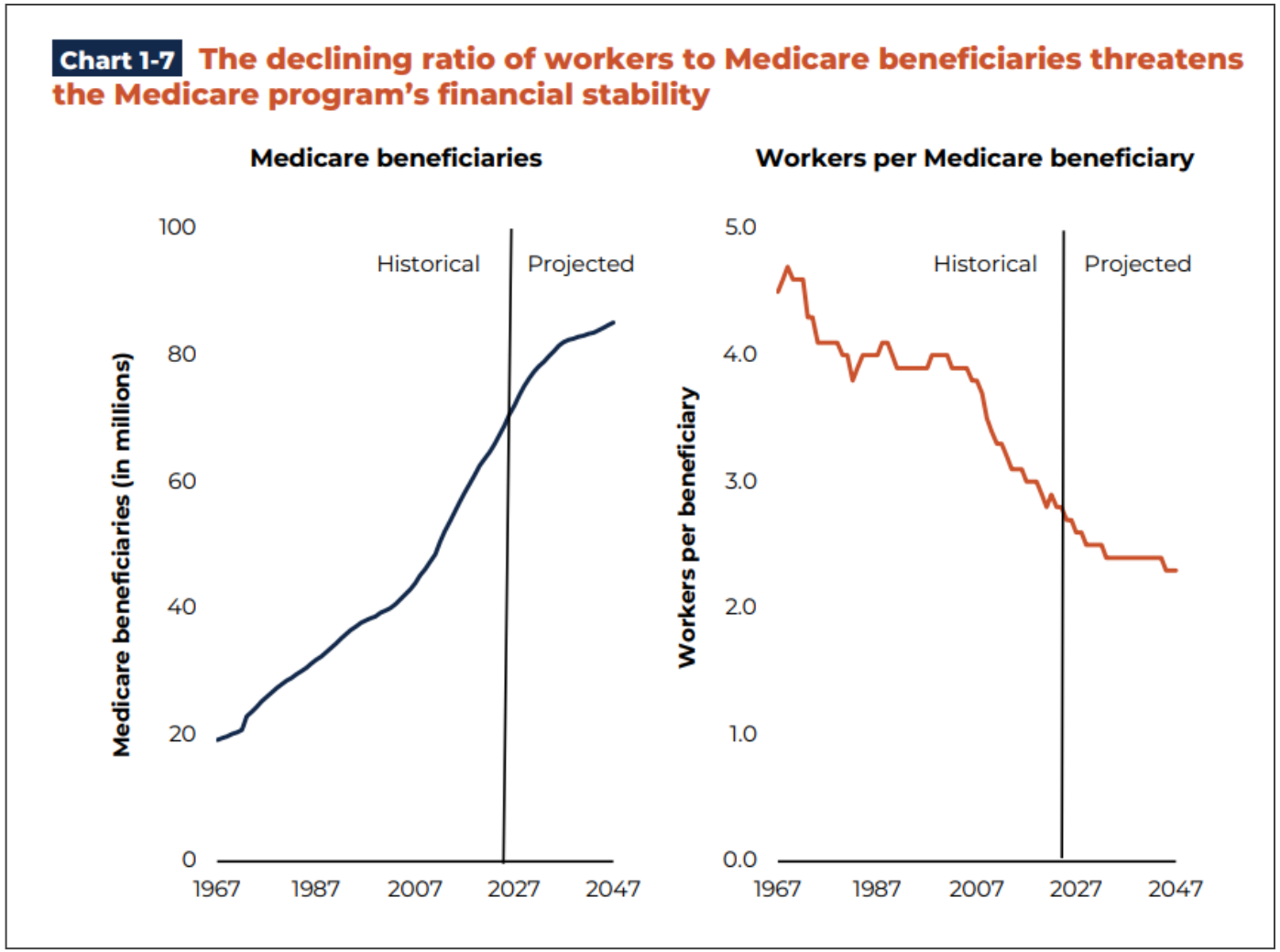
- **Silent/Greatest**: 47 million, few still in workforce
- **Boomers**: 76 million, majority still in workforce, 10,000 turn 65 daily
- **Gen X**: 55 million
- **Millennials (Gen Y)**: 75 million, largest cohort in workforce
- **Gen Z**: 72 million, moving into workforce





Sources: Pew Research Center, Millennials are largest generation in the U.S. labor force | Pew Research Center, Where Millennials end and Generation Z begins | Pew Research Center

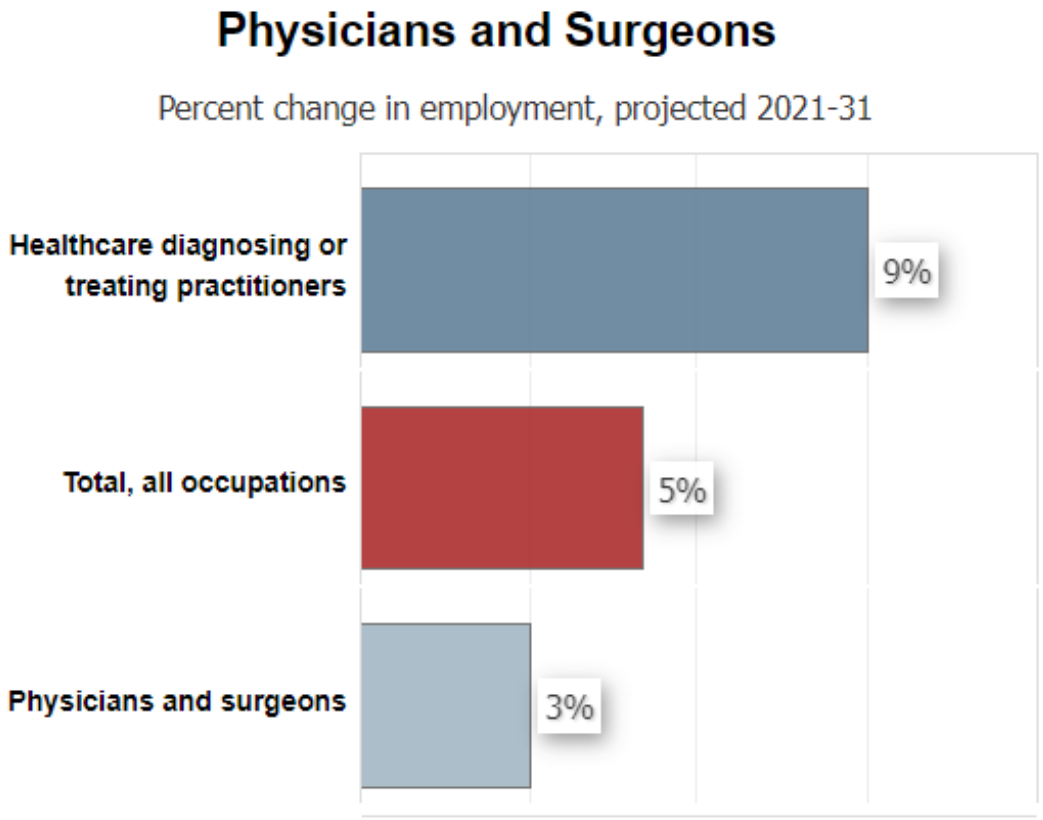
Medicare Funding: Baby Boomers, Younger Generations



- By 2029, all baby boomers will have reached the age of eligibility for the Medicare program, and 75 million beneficiaries are expected to have Medicare Part A Hospital Insurance—up from 65 million beneficiaries in 2022
- Medicare Part A Hospital Insurance is largely financed by workers' Medicare payroll taxes
- Workers have declined from 4.5 workers per Medicare beneficiary (1967) to 2.9 workers per beneficiary in 2022 and projected to fall to 2.5 workers per beneficiary by 2029

2023 MedPAC Data Book Available at July2023_MedPAC_DataBook_SEC.pdf

Job Outlook



Note: All Occupations includes all occupations in the U.S. Economy.
Source: U.S. Bureau of Labor Statistics, Employment Projections program

"Despite limited employment growth, about 23,800 openings for physicians and surgeons are projected each year, on average, over the decade. Most of those openings are expected to result from the need to replace workers who transfer to different occupations or exit the labor force, such as to retire."

Example: Physician Demand

- Pandemic impacts (burnout, retirements etc)
- Increasing levels of demand (aging population); U.S. population projected to grow 10.6%;
- National projected physician shortage by 2034:
  - A shortage of primary care physicians of between 17,800 and 48,000
  - A shortage across the nonprimary care specialties of between 21,000 and 77,100 physicians

Employment projections data for physicians and surgeons, 2021-31

Occupational Title	SOC Code	Employment, 2021	Projected Employment, 2031	Change, 2021-31	
				Percent	Numeric
Physicians and surgeons	—	761,700	783,100	3	21,400
Physicians	29-1210	701,300	720,700	3	19,400
Anesthesiologists	29-1211	34,100	34,500	1	400
Cardiologists	29-1212	20,300	20,900	3	600
Dermatologists	29-1213	10,100	10,400	3	300
Emergency medicine physicians	29-1214	39,500	40,800	3	1,300
Family medicine physicians	29-1215	112,200	115,900	3	3,700
General internal medicine physicians	29-1216	63,700	65,000	2	1,300
Neurologists	29-1217	7,800	8,000	3	200
Obstetricians and gynecologists	29-1218	23,600	24,000	2	400
Pediatricians, general	29-1221	36,800	37,200	1	400
Physicians, pathologists	29-1222	12,100	12,600	4	500
Psychiatrists	29-1223	27,900	30,300	9	2,400
Radiologists	29-1224	32,400	33,600	4	1,200
Physicians, all other	29-1229	280,800	287,500	2	6,700
Surgeons	29-1240	60,400	62,400	3	2,000
Ophthalmologists, except pediatric	29-1241	12,000	12,800	6	800
Orthopedic surgeons, except pediatric	29-1242	16,800	17,300	3	400
Pediatric surgeons	29-1243	900	900	2	0
Surgeons, all other	29-1249	30,700	31,500	3	800

SOURCE: U.S. Bureau of Labor Statistics, Employment Projections program

* *Sources: AAMC,* The Complexities of Physician Supply and Demand: Projections from 2019 to 2034 | AAMC BLS, Physicians and Surgeons : Occupational Outlook Handbook: : U.S. Bureau of Labor Statistics (bls.gov);

Example: Advanced Practicing Provider Demand

Employment projections data for physician assistants, 2021-31

Occupational Title	SOC Code	Employment, 2021	Projected Employment, 2031	Change, 2021-31	
				Percent	Numeric
Physician assistants	29-1071	139,100	177,500	28	38,400

SOURCE: U.S. Bureau of Labor Statistics, Employment Projections program

Employment projections data for nurse anesthetists, nurse midwives, and nurse practitioners, 2021-31

Occupational Title	SOC Code	Employment, 2021	Projected Employment, 2031	Change, 2021-31	
				Percent	Numeric
Nurse anesthetists, nurse midwives, and nurse practitioners	—	300,000	418,700	40	118,600
Nurse anesthetists	29-1151	45,200	50,500	12	5,300
Nurse midwives	29-1161	8,100	8,700	7	600
Nurse practitioners	29-1171	246,700	359,400	46	112,700

SOURCE: U.S. Bureau of Labor Statistics, Employment Projections program

Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook, Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners, on the Internet at https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm; Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook, Physician Assistants, on the Internet at https://www.bls.gov/ooh/healthcare/physician-assistants.htm

- Nationally, employment projected for nurse anesthetists, nurse midwives, nurse practitioners projected to grow 40% from between 2021-2031.
- Nationally, employment for physician assistants is projected to grow by 28%.
- Growth due to higher demand for services (aging population), physician shortage, focus on chronic/primary care

Labor Trends

Macro

- Lots of available jobs but not enough workers
- Low unemployment rates
- Still coming out of COVID impacts

Health Care

- Post-pandemic impacts continue for health care
- Burnout, mental health, rising wages, work-life balance, lower stress jobs
- Tight job market may decrease appetite to leave existing job

Actions

- Retain your workers (understand their commitment, needs, wants)
- Assess benefits, wages, schedules, organization culture (but manage permanent wage scale adjustments)
- Create new, find new, reinforce workforce pipelines

Regulatory Landscape

Robust Regulatory Landscape (HHS, DOJ, FTC…)

Anti-Trust
Stark

Hospital Consolidation

340B

Price Transparency

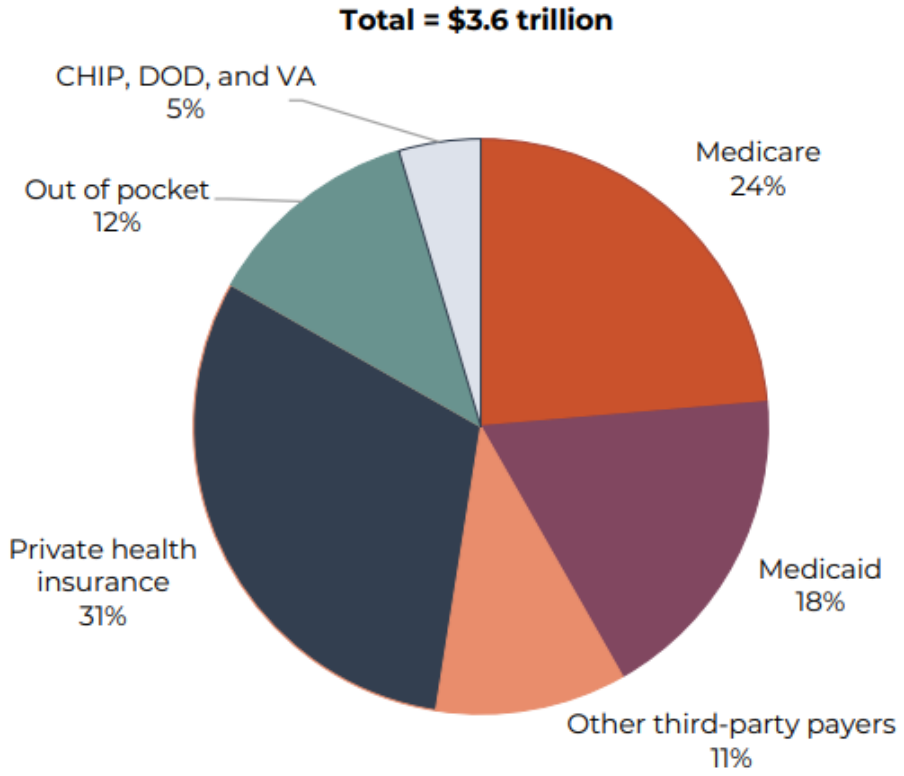
No Suprises Act

Medicare
(including Medicare Advantage)

Medicaid

Spending Overall

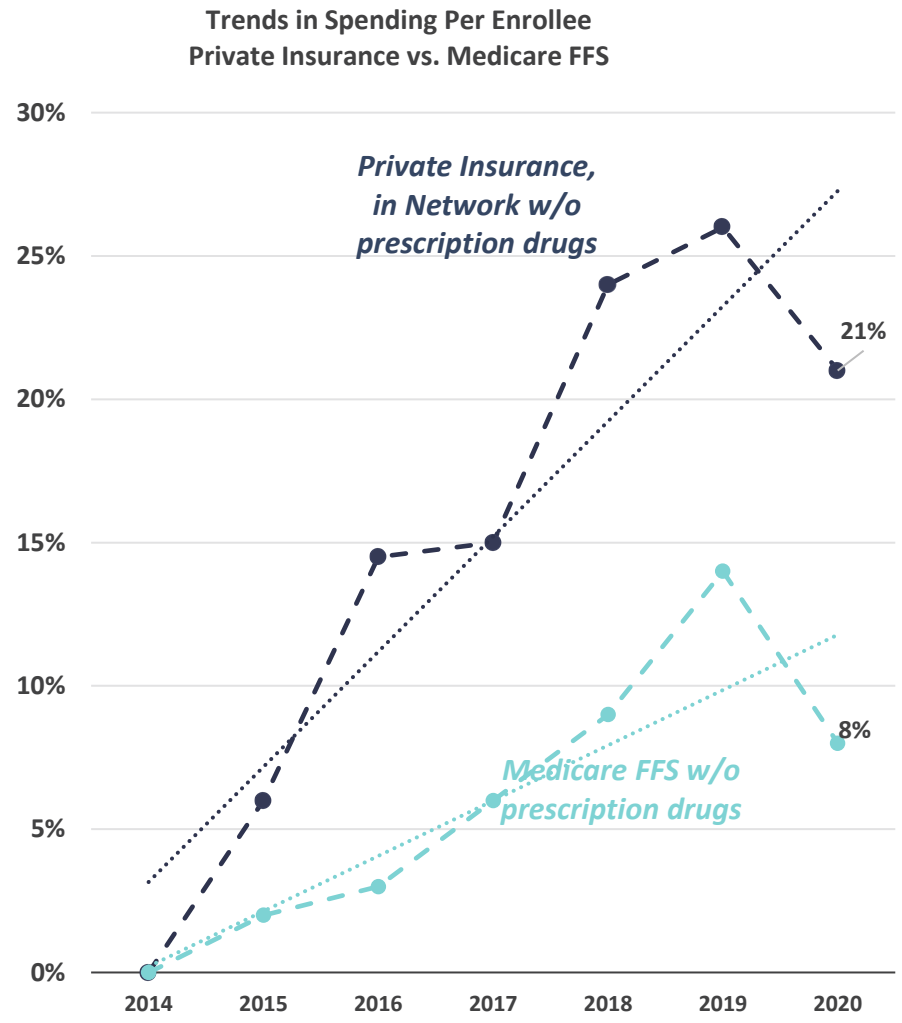
Chart 1-1 **Medicare was the largest single purchaser of personal health care in the U.S., 2021**



- Of the $3.6 trillion spent on personal health care in 2021, Medicare accounted for 24%, or $840 billion
- Private health insurance plans financed 31% of total personal health care spending
- Consumer out-of-pocket spending (not including premiums) equaled 12%

2023 MedPAC Data Book Available at July2023_MedPAC_DataBook_SEC.pdf

Health Care Spending Per Enrollee*



- Growth in health care spending for those with private insurance has increased proportionately faster than Medicare FFS spending.
- As depicted at left, from 2014 to 2020, private insurance spending per enrollee has grown at a rate of 21% compared to 8% for Medicare FFS**.
- Price increases were largely responsible for spending growth in private insurance.
- Hospital & physician consolidation is believed to be the cause for high prices as consolidation creates increased provider market power, which in turn leads to greater leverage in contract negotiations.

** Source: 2023 MedPAC Data Book, based on 2021 data, available at www.medpac.gov/document-type/data-book*

** * Spending includes payments to providers from health insurance and patients, but not from other sources (e.g. workers compensation or auto insurance. Spending for retail prescription drugs was not available and therefore not included.*

IPPS Hospital Margins

Chart 6-6 **IPPS hospitals' all-payer operating margins continued to vary across hospital groups in 2021, including all-time high among for-profit hospitals**

	All-payer total margin						
				2020		2021	
Hospital group	2017	2018	2019	With relief funds	Without relief funds	With relief funds	Without relief funds
IPPS	5.9%	5.9%	6.4%	5.3%	1.9%	8.7%	7.2%
Location							
Metropolitan (urban)	6.0	6.1	6.6	5.3	2.0	8.6	7.3
Rural micropolitan	4.9	3.9	5.2	6.2	1.9	9.2	6.8
Other rural	2.1	0.2	0.7	3.4	–1.5	7.6	3.0
Ownership							
For profit	10.5	11.4	12.2	12.6	10.4	15.1	13.9
Nonprofit	5.9	5.5	6.1	4.7	1.2	8.2	6.8
DSH and teaching							
Both	5.7	5.8	6.2	4.8	1.4	8.4	6.9
DSH only	5.5	5.6	6.3	6.2	2.8	8.9	7.3
Teaching only	8.8	8.7	7.7	6.0	4.1	7.7	6.7
Neither	9.0	9.1	10.1	8.4	6.0	13.5	11.8
CAH	2.3	1.7	2.4	5.0	0.4	10.8	6.0

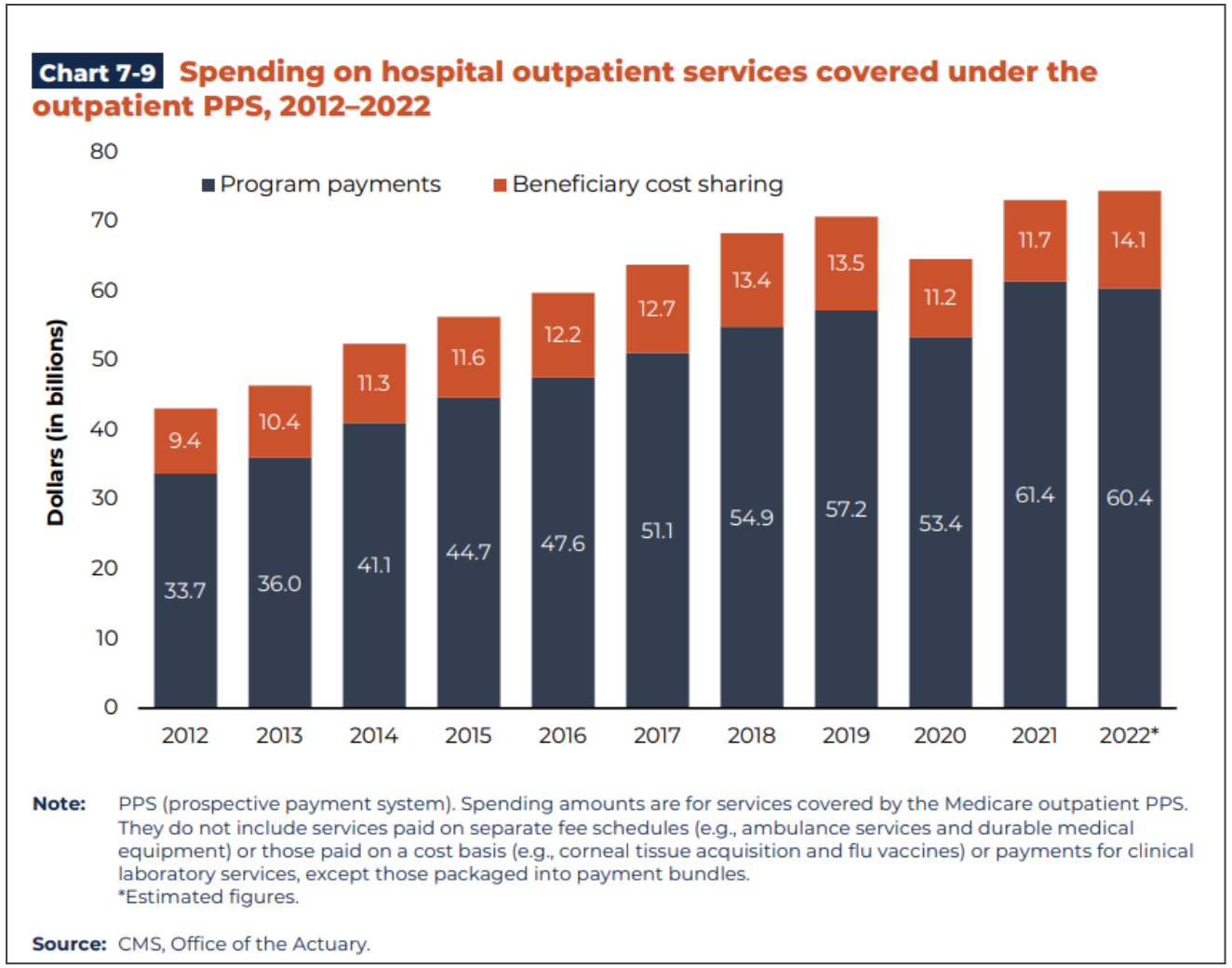
Note: IPPS (inpatient prospective payment systems), DSH (disproportionate share hospital), CAH (critical access hospital). "Relief funds" refers to Provider Relief Fund payments and Paycheck Protection Program forgiven loans recorded on hospitals' cost reports. Hospitals' margin is calculated as aggregate payments minus aggregate allowable costs, divided by aggregate payments. "All-payer operating margin" includes payments from all payers, excluding revenue from investments and contributions and, for 2020 and 2021, is reported with and without reported federal relief funds. Metropolitan (urban) counties contain an urban cluster of 50,000 or more people; rural micropolitan counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." Data are for IPPS hospitals that had a cost report with a midpoint in the specified fiscal year and was complete as of our analysis. Given that not all hospitals are reporting the same 12-month period, the 2020 and 2021 data reflect varying numbers of months of COVID-19 impacts.

Source: MedPAC analysis of hospital cost report data from CMS and Census data on metropolitan and micropolitan areas.

- Significant variation among hospitals but, in aggregate, operating margins continued to be higher among for-profit hospitals and those that were not teaching hospitals or DSH hospitals
- Operating margins continued to be lower among hospitals in rural non-micropolitan areas
- Due to pandemic funds, the difference in all-payer operating margin between rural and urban hospitals was smaller than pre-pandemic
- Critical Access Hospital all-payer operating margin reached a record high in 2021

2023 MedPAC Data Book Available at July2023_MedPAC_DataBook_SEC.pdf

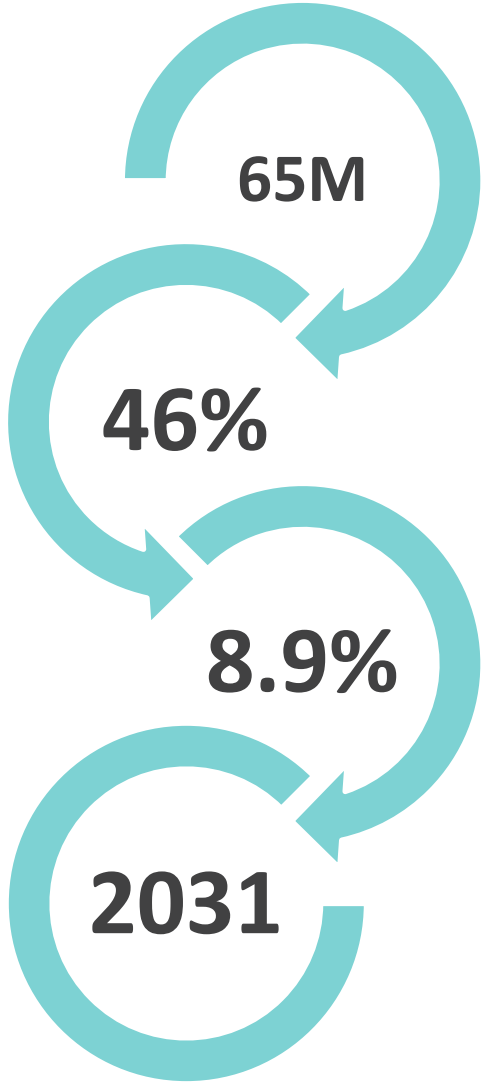
Hospital Outpatient Services



2023 MedPAC Data Book Available at July2023_MedPAC_DataBook_SEC.pdf

- Office of the Actuary estimates spending under the outpatient PPS was $74.5 billion in 2022 ($60.4 billion in program spending, $14.1 billion in beneficiary copayments)
- MedPAC estimate outpatient PPS accounted for about 6.5% of total Medicare program spending in 2022.
- From calendar year 2012 to 2022, overall spending for hospital outpatient services covered under the OPPS increased by 73%.
- The Office of the Actuary projects total spending to increase an average of 8.9%/year between 2022 to 2024

Medicare Insolvency Looming



Covers roughly 65 million individuals

Beneficiaries in Medicare Advantage

Projected average growth rate for expenditure over next 5 years

Trust Fund is solvent until this date

Medicare Trustees Report, 2023 Medicare Trustees Report (cms.gov)

Medicare Advantage in Pictures

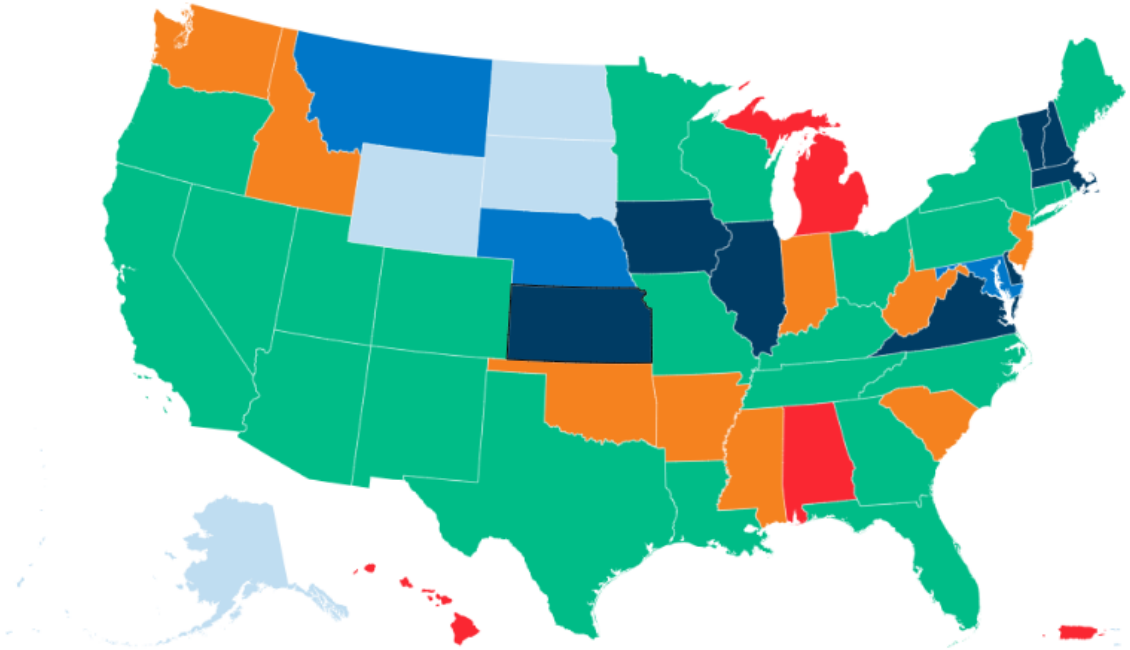
Figure 6

Share of Beneficiaries Enrolled in Medicare Advantage in 2023, by State

Click on the buttons below to see enrollment data for 2013 and 2023:

2013 2023

< 20% 20%–30% 30%–40% 40%–50% 50%–60% ≥ 60%



NOTE: Includes only Medicare beneficiaries with Part A and B coverage.
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files and March Medicare Enrollment Dashboard, 2013 and 2023. • PNG

KFF

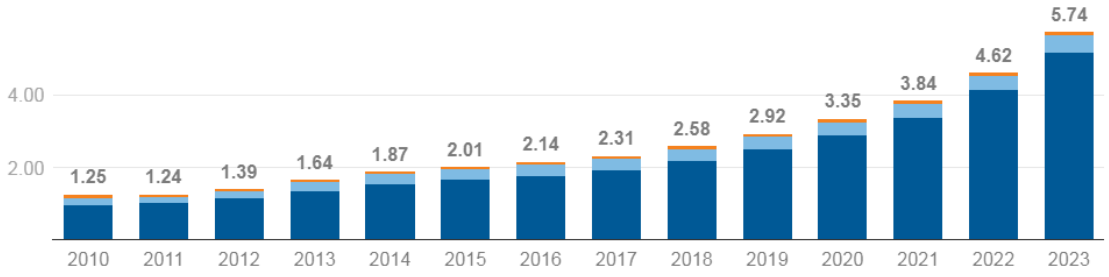
Source:: Medicare Advantage in 2023: Enrollment Update and Key Trends | KFF

Figure 5

Number of Beneficiaries in Special Needs Plans, 2010-2023

In millions

Dual Eligible Special Needs Plans (D-SNPs) Chronic or Disabling Conditions (C-SNPs) Institutional (I-SNPs)

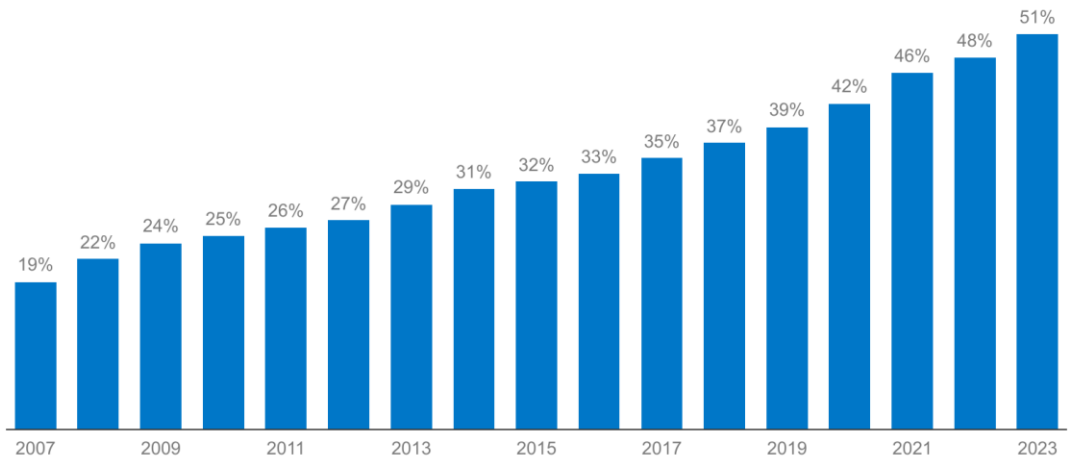


NOTE: Numbers may not sum to the total due to rounding.
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2023. • PNG

KFF

Figure 1

Total Medicare Advantage Enrollment, 2007-2023



NOTE: Enrollment data are from March of each year. Includes Medicare Advantage plans: HMOs, PPOs (local and regional), PFFS, and MSAs. About 60.0 million people are enrolled in Medicare Parts A and B in 2023.
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2023; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2016; CCW data from 20 percent of beneficiaries, 2017-2020; and Medicare Enrollment Dashboard 2021-2023.

KFF

But…Medicare Advantage Growth Elicits Scrutiny

HHS OIG released a report on Medicare Advantage denials, prior authorization

- In a one-week period (2019), sampled top 15 MA plans
  - 13% of prior authorization requests met Medicare coverage requirements were denied
  - 18% of payment claims that met coverage and billing requirements.
- *OIG annualized the impact*
  - *Prior authorization denials in that week (1,631) would equal 84,812 denied beneficiary requests for services that met Medicare coverage rules that year*
  - *Payment denials in that week (28,949) would equal 1.5 million payment requests that met Medicare coverage and billing rules*

HHS OIG Recommendations

1. CMS should issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews.
2. CMS should update its audit protocols to address the issues identified in this report, such as MAO use of clinical criteria and/or examining particular service types.
3. CMS should direct MAOs to take additional steps to identify and address vulnerabilities that can lead to manual review and system errors

CMS concurs with recommendations

There's the MA risk-adjustment rule (RADV) which will recoup some $5 billion. Lawsuit already filed.

**** Source:*** ***https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf***

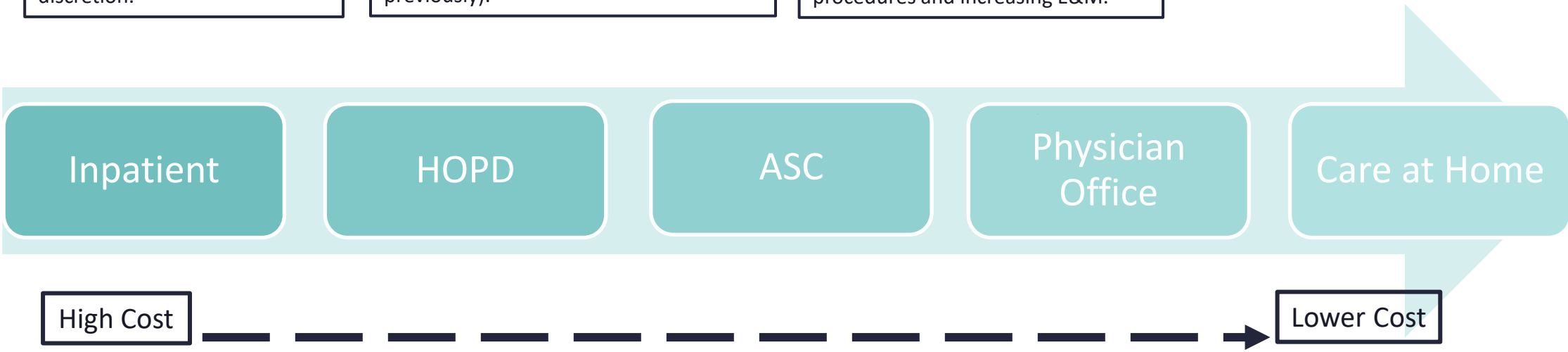
Medicare Continues to Push Site-of-Care Shift

Medicare has moved some types of procedures from IP only to Hospital OP; leaving site-of-service up to physicians' discretion.

Hospital OP Rule adds procedures to list of procedures that can be performed in an ASC, including Total Hip Arthroplasty (Total Knees Arthroplasty added previously).

Physician Fee Schedule rule expands care management, virtual care environment, and rebalances physician payments by reducing procedures and increasing E&M.

Home Health rule expands reimbursement to include payment for infusions delivered at home.



The shift to lower cost settings results in lower costs for Medicare program, out-of-pocket costs for consumers, which becomes a competitive factor to understand and plan around.

Accountable Care Organizations (ACOs)

- There are various models of ACOs in Medicare, Medicaid and in the commercial market
- ACOs held responsible for providing high quality care and a cost-effective manner
- ACO model set-up dictates quality or performance requirements along with payments
- Largest ACO to date is MSSP

Shared Savings Program Fast Facts – As of January 1, 2023

CMS | SHARED SAVINGS PROGRAM

SHARED SAVINGS PROGRAM INFORMATION

PROGRAM CHARACTERISTICS (as of January 1st of each year)

Performance Year	ACOs	Assigned Beneficiaries
2023	456	10.9 million
2022	483	11.0 million
2021	477	10.7 million
2020	517	11.2 million
2019	487	10.4 million
2018	561	10.5 million
2017	480	9.0 million
2016	433	7.7 million
2015	404	7.3 million
2014	338	4.9 million
2012 / 2013	220	3.2 million

PERFORMANCE YEAR (PY) RESULTS

Performance Year	Total Earned Shared Savings	Average Overall Quality Score
2021	$2.0 billion	91%
2020	$2.3 billion	97%
2019	$1.5 billion	92%
2018	$983 million	93%
2017	$799 million	92%
2016	$700 million	95%
2015	$645 million	91%
2014	$341 million	83%
2012 / 2013	$315 million	95%

2023 SHARED SAVINGS PROGRAM ACO INFORMATION

ACO TRACKS

	ACOs	Percent
One Sided (33% of ACOs)		
BASIC Track Levels A&B	151	33%
Two Sided (67% of ACOs)		
BASIC Track Levels C&D	19	4%
BASIC Track Level E*	125	28%
ENHANCED Track*	161	35%

*Qualifies as an Advanced Alternative Payment Model (APM)
Note: tracks 1, 2, and 1+ are no longer applicable as of PY 2022

ACOs BENEFICIARY ASSIGNMENT METHODOLOGY

	ACOs	Percent
Prospective	171	37%
Preliminary Prospective with Retrospective Reconciliation	285	63%

2023 MEDICARE BENEFICIARY DEMOGRAPHIC DISTRIBUTION

Enrollment Type	Beneficiary Person-Years	Percent
Aged Non-Dual	9,120,038	85%
Disabled	918,762	9%
Aged Dual	614,163	6%
End Stage Renal Disease (ESRD)	46,183	<1%

ACO COMPOSITION

HIGH / LOW REVENUE ACOs

	ACOs	Percent
High Revenue	204	45%
Low Revenue	252	55%

Skilled Nursing Facility (SNF) AFFILIATES & SNF 3-DAY RULE WAIVER

ACOs approved for a SNF 3-Day Rule Waiver	160
Total number of SNF affiliates	2,290

ACO PARTICIPANT LIST COMPOSITION

Participant TINs	15,539
Physicians and non-Physicians	573,126
Hospitals	1,450
Federally Qualified Health Centers (FQHCs)	4,409
Rural Health Clinics (RHCs)	2,240
Critical Access Hospitals	467

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Value-Based Models

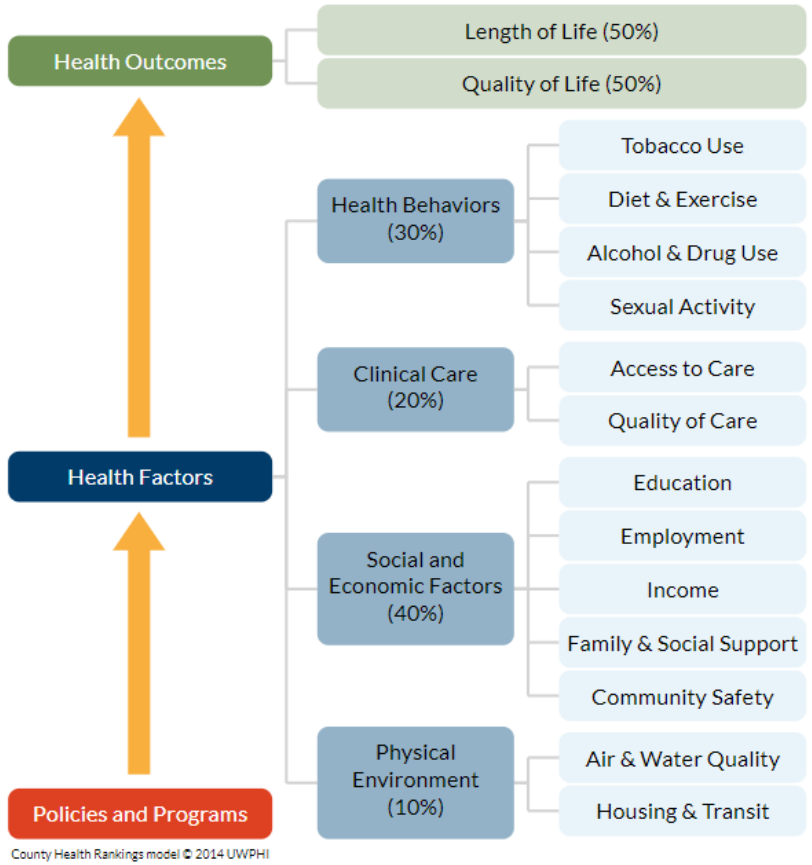
MSSP

- $1.8 billion in Medicare savings in 2022
- Second highest since beginning of MSSP
- Sixth consecutive year of savings
- MSSP is permanent, not a CMMI model

CMMI Models

- CMMI releases strategy refresh
- Fewer models
- More focus on health equity
- Newer models
  - REACH ACO
  - Making Care Primary
  - GUIDE (dementia care model)

Emerging Focus: Social Drivers of Health, Health Equity

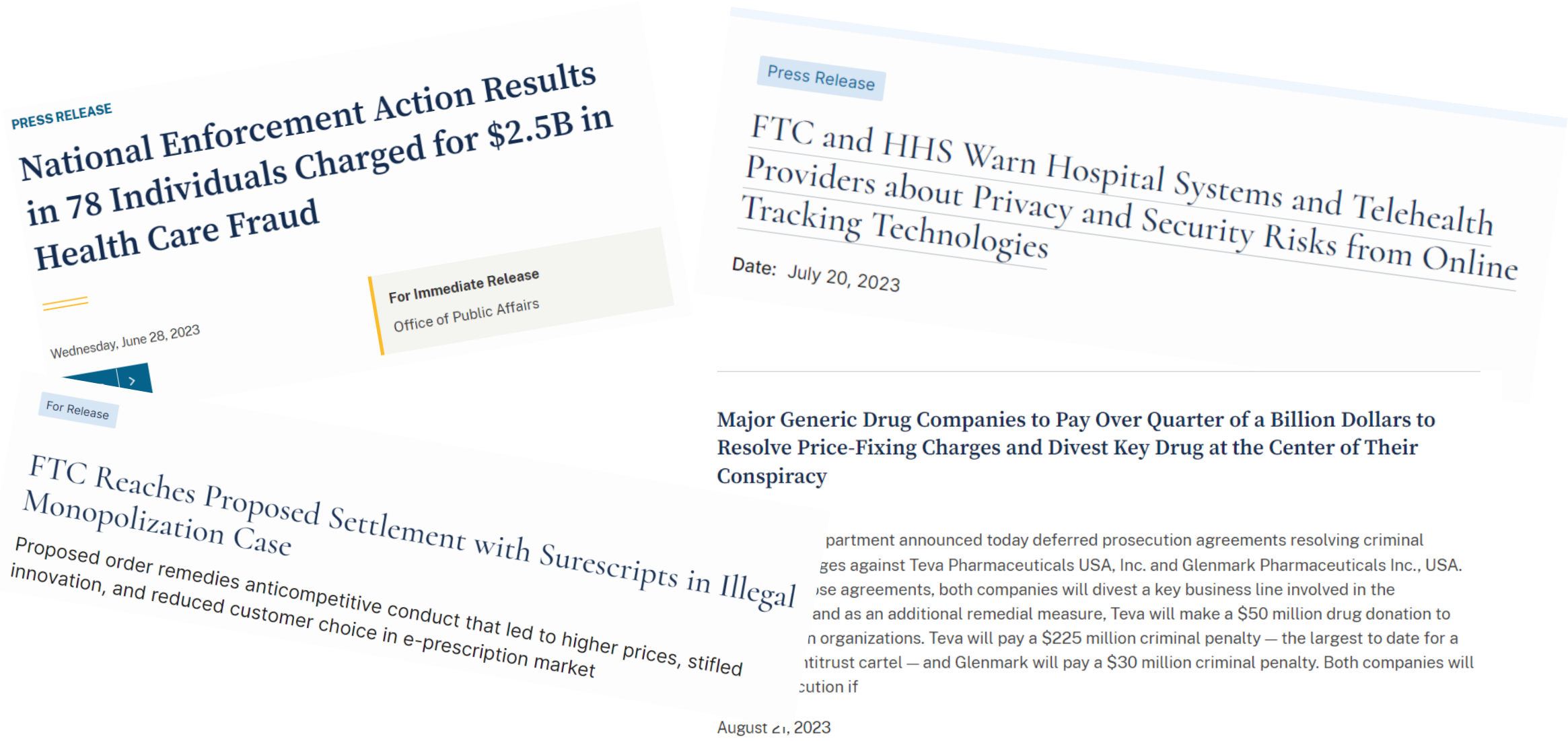


Framework for County Health Rankings

Source: University of Wisconsin-Population Health Institute, Robert Wood Johnson Foundation, https://www.countyhealthrankings.org/explore-health-rankings

- Focus on SDoH on the rise
  - Medicare Advantage can now offer/pay for certain interventions (ex: an air condition for an individual with asthma)
  - Medicare payment systems and APM/VBP models includes health equity
  - Z-codes
- Desire to get upstream to impact health outcomes before the acute stage
- Desire to ensure underserved populations are addressed with Medicare payments

Robust FTC, DOJ, FBI Activities



PRESS RELEASE

National Enforcement Action Results in 78 Individuals Charged for $2.5B in Health Care Fraud

Wednesday, June 28, 2023

For Immediate Release

Office of Public Affairs

For Release

FTC Reaches Proposed Settlement with Surescripts in Illegal Monopolization Case

Proposed order remedies anticompetitive conduct that led to higher prices, stifled innovation, and reduced customer choice in e-prescription market

Press Release

FTC and HHS Warn Hospital Systems and Telehealth Providers about Privacy and Security Risks from Online Tracking Technologies

Date: July 20, 2023

Major Generic Drug Companies to Pay Over Quarter of a Billion Dollars to Resolve Price-Fixing Charges and Divest Key Drug at the Center of Their Conspiracy

partment announced today deferred prosecution agreements resolving criminal
ges against Teva Pharmaceuticals USA, Inc. and Glenmark Pharmaceuticals Inc., USA.
se agreements, both companies will divest a key business line involved in the
and as an additional remedial measure, Teva will make a $50 million drug donation to
n organizations. Teva will pay a $225 million criminal penalty — the largest to date for a
titrust cartel — and Glenmark will pay a $30 million criminal penalty. Both companies will
cution if

August 21, 2023

FTC, DOJ, Proposed Merger Guidance

1. Mergers should not significantly increase concentration in highly concentrated markets
2. Mergers should not eliminate substantial competition between firms
3. Mergers should not increase the risk of coordination
4. Mergers should not eliminate a potential entrant in a concentrated market
5. Mergers should substantially lessen competition by creating a firm that controls products or services that its rivals may use to compete
6. Vertical mergers should not create market structures that foreclose competition
7. Mergers should not entrench or extend a dominant position
8. Mergers should not further a trend toward concentration
9. When a merger is part of a series of multiple acquisitions, the Agencies may examine the whole series
10. When a merger involves a multi-sided platform, the Agencies examine competition between platforms, on a platform, or to displace a platform
11. When a merger involves competing buyers, the Agencies examine whether it may substantially lessen competition for workers or other sellers
12. When an acquisition involves partial ownership or minority interests, the Agencies examine its impact on competition
13. Mergers should not otherwise substantially lessen competition or tend to create a monopoly

U.S. DOJ & FTC Draft Memo with 13 guidelines for Merger & Acquisition Activity dated July 19, 2023 at
FTC and DOJ Seek Comment on Draft Merger Guidelines | Federal Trade Commission

Regulatory Landscape

Macro

- Heightened regulatory environment
- Total health care spend is high and growing
- Medicare population growing but paying for program a bigger problem

Health Care

- Driving down/moderating costs in Medicare a priority
- Scrutiny crosses many segments of health care (nursing homes, hospitals etc)
- Specific attention on mergers, acquisitions, private equity involvement

Actions

- Elevate compliance & risk management programs, use internal audits and more
- Pay attention to and monitor emerging regulations as well as agency enforcement actions
- If care moving to OP and more care management (VBP), reassess how you're positioned

M&A, Private Equity

Mergers, Acquisitions, Bankruptcies

Hospital Mergers & Acquisitions

- Lots of activity across the health care ecosystem
- Cross market hospital mergers increase
  - Advocate Aurora /Atrium
  - Kaiser & Geisinger (Risant Health)
- Billings & Logan Health
- Froedtert & ThedaCare

Market Moves

- Payers becoming much more vertically integrated
  - United acquisition of Signify, Change, and Amydesis
- Amazon plays
- Walgreens, CVS, Walmart etc

Bankruptcies

- Uptick in hospital bankruptcies
- Mercy City Hospital (IA) filed for bankruptcy (U. of Iowa signed letter of intent to purchase)
- Spectrum Health Kelsey Hospital (MI) closing
- Martin General Hospital (NC) closed

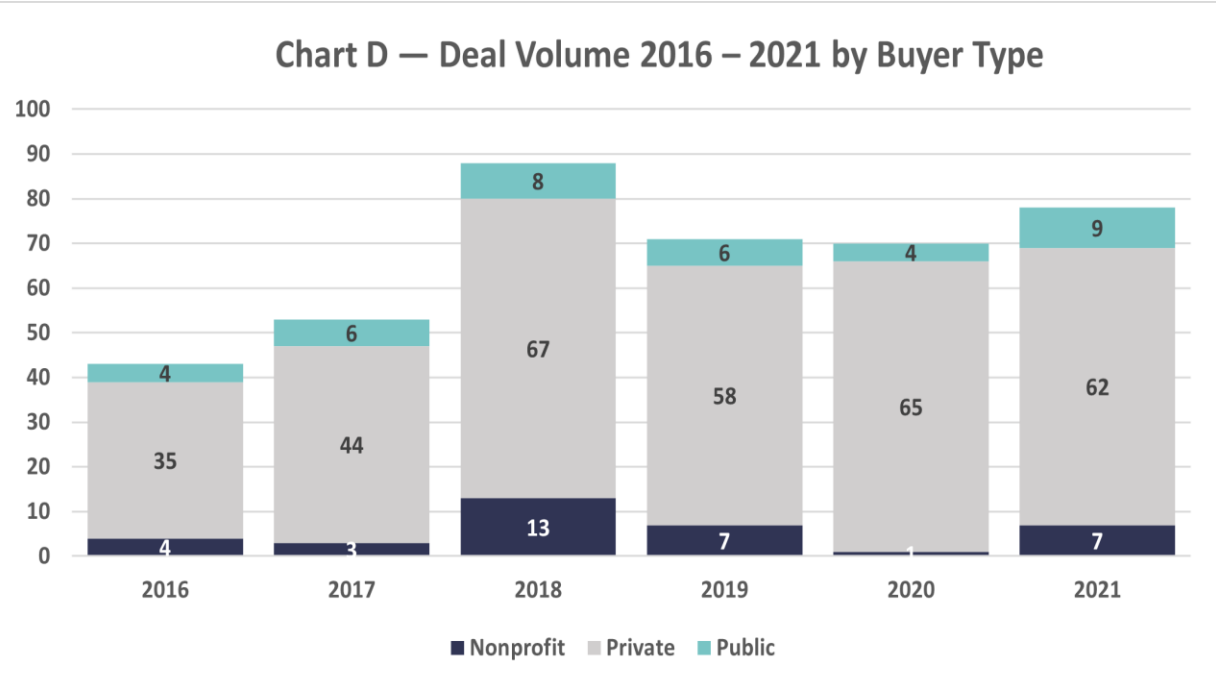
Oversight

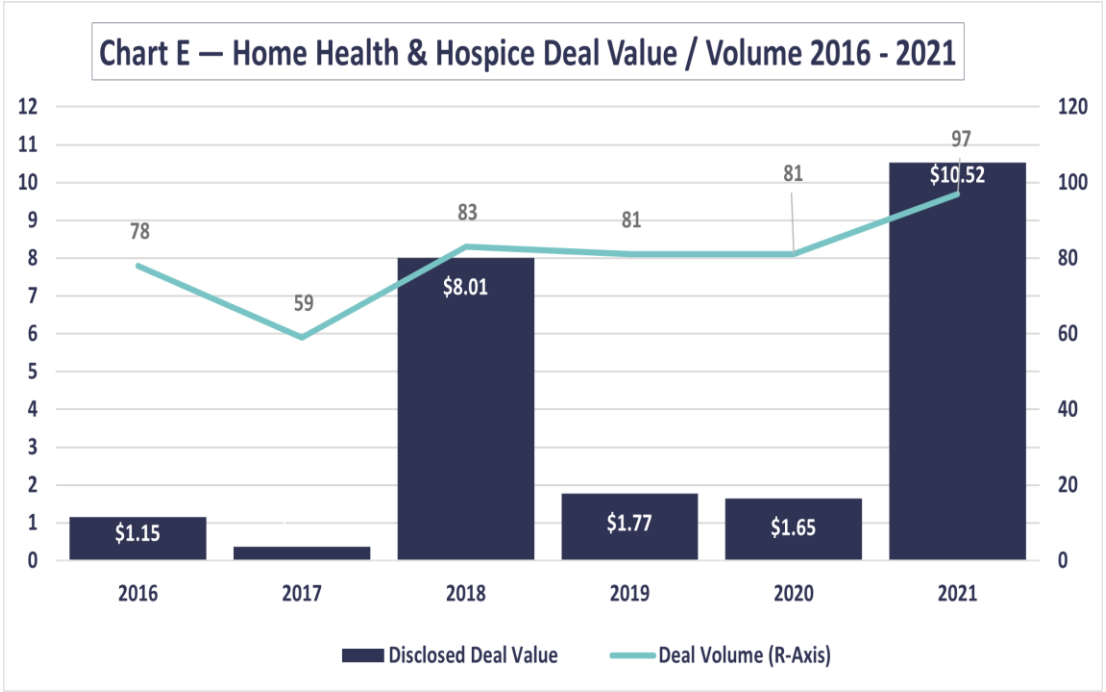
- Amount of activity stoking interest from Congress
- FTC/DOJ/ state involvement causes deals to fall through
  - Fairview Health & Sanford
  - Hackensack Meridian & Englewood Health
  - United's acquisition of Amydesis

Private Equity Influence

"Recent years have seen a surge of innovation in health care, driven by investments from private equity firms, family offices, and other sources. This elevated interest – particularly in fragmented specialties, home-based care and behavioral health – is creating growth opportunities throughout the health care sector."

- Jed Cheney, CLA Principal*



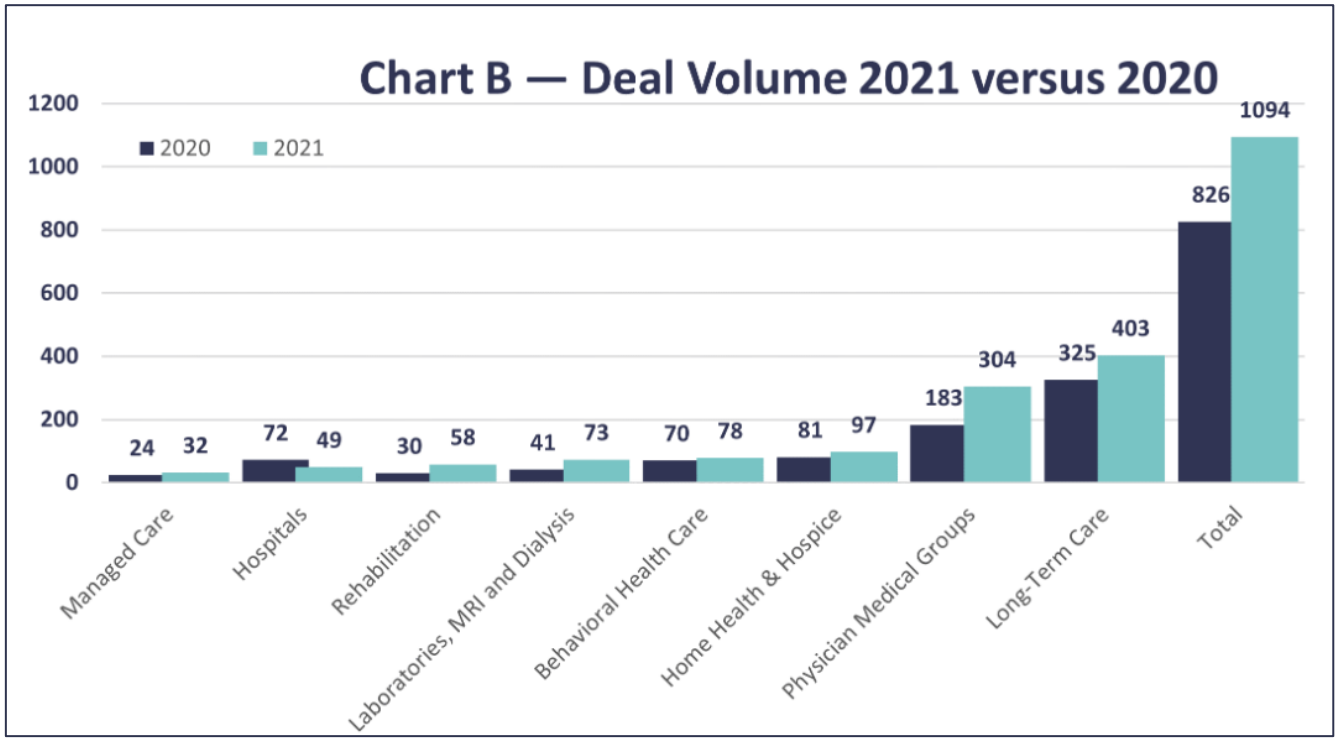


**** Source: CLA Article "Transaction Trends in Health Care Deal Making" by Jed Cheney, Principal dated March 2022; charts reproduced with permission from Deal Search Online, www.healthcaremanda.com, all rights reserved.***

Long-Term Care Leads the Way

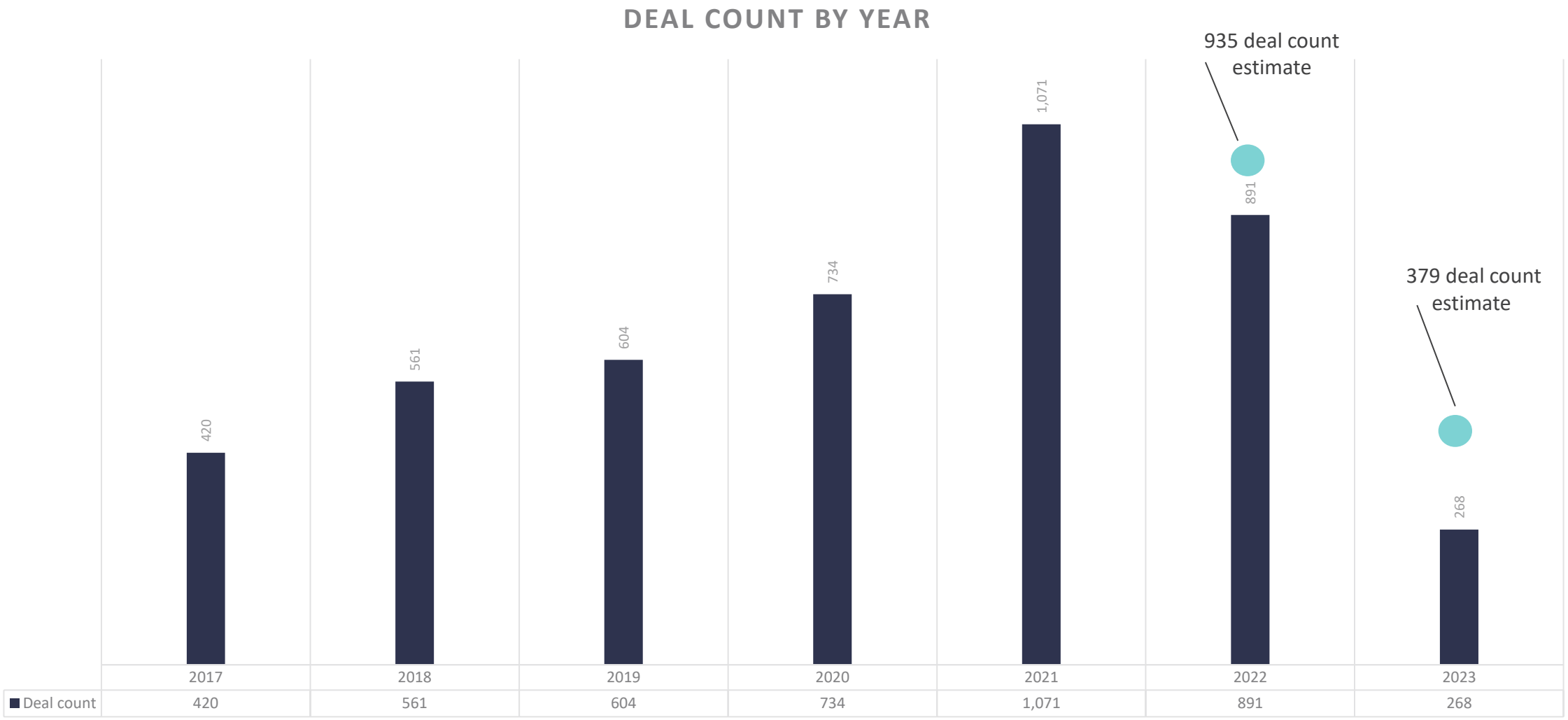
Some central themes:

- Private buyers reflecting private equity and strategic buyers are driving the M&A environment due in part to record levels of capital raised, representing nearly 80% of the buying market.
- Long-term care continues to be the highest segment in terms of volume, followed by physician practices, home health and hospice, and behavioral health providers.
- Geographically, the distribution of deals has a high concentration throughout the Sun Belt region and California.



** Source: CLA Article "Transaction Trends in Health Care Deal Making" by Jed Cheney, Principal dated March 2022; charts reproduced with permission from Deal Search Online, www.healthcaremanda.com, all rights reserved.*

Pitchbook (Q2, June 2023)



https://pitchbook.com/news/reports/q2-2023-healthcare-services-report

A Few Reasons For Decline?

M&A, PE Activity

Macro

- Still an active market
- Lots of dry powder out there to invest

Health Care

- Consolidation in health care ongoing
- Deals (especially digital health) will face more scrutiny by buyers

Actions

- Understand these trends and why
- Determine how/if these deals impact you locally and/or globally long-term
- Consider your options in response – acquire, merge, strategic partnerships…

Very Complicated Congressional Landscape

Capitol Hill Agenda?

Prescription Drug Prices

Physician Payments

Appropriations Federal Budget

Debt Ceiling Implications

340B Legislation

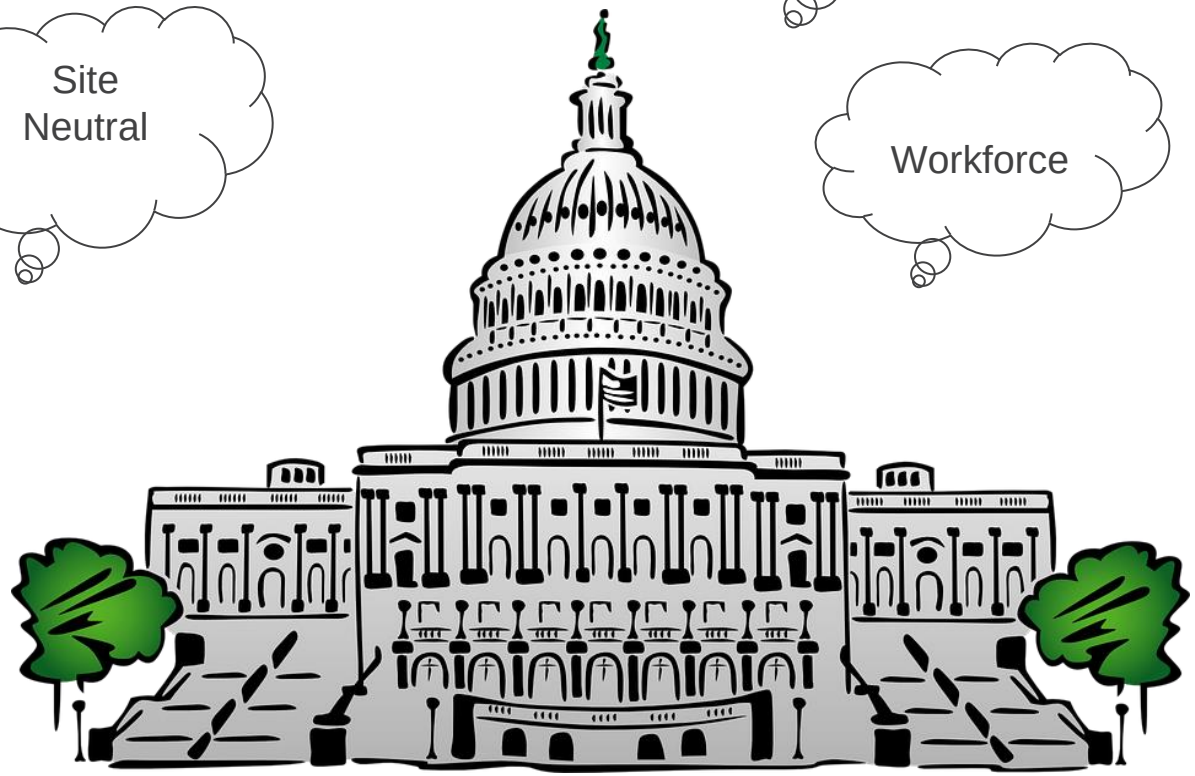
Site Neutral

Workforce

Telehealth

Pharmacy Benefit Managers

Hospital at Home



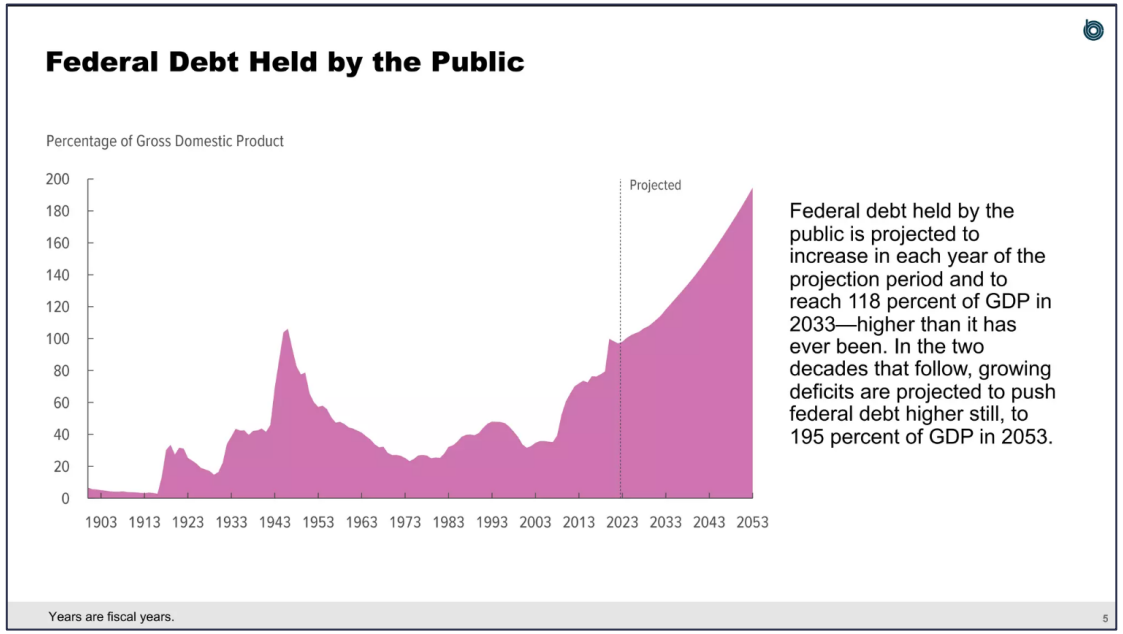
Federal Political Environment

- Split control of Congress, each Chamber has a small majority
- Democrat President, Administration (agencies)
- Major financial issues (debt ceiling, govt funding) and deficit
- Significant difficulty in moving legislation
- End of federal Public Health Emergency but some policies continue to wind down

Federal Budget, Financial Environment Not Positive

Two Types of Federal Debt

1. Debt held by public. Mostly in the form of securities issued by the Treasury and held by investors such as individuals, the Federal Reserve, mutual funds, and financial institutions. Currently accounts for majority of debt ($24+ trillion).
2. Debt held by government (intergovernmental debt). Accounts for roughly $6.87 trillion of existing debt.



CBO projects increase in federal debt held by public. As of January 2023, it costs the government $261 billion to maintain its debt. That is 14% of total federal spending

Source: Congressional Budget Office, *https://www.cbo.gov/publication/58952*
Source Treasury Department, https://fiscaldata.treasury.gov/americas-finance-guide/national-debt/

Federal: Running $1.394 T Deficit

Budget Outlook, by Fiscal Year

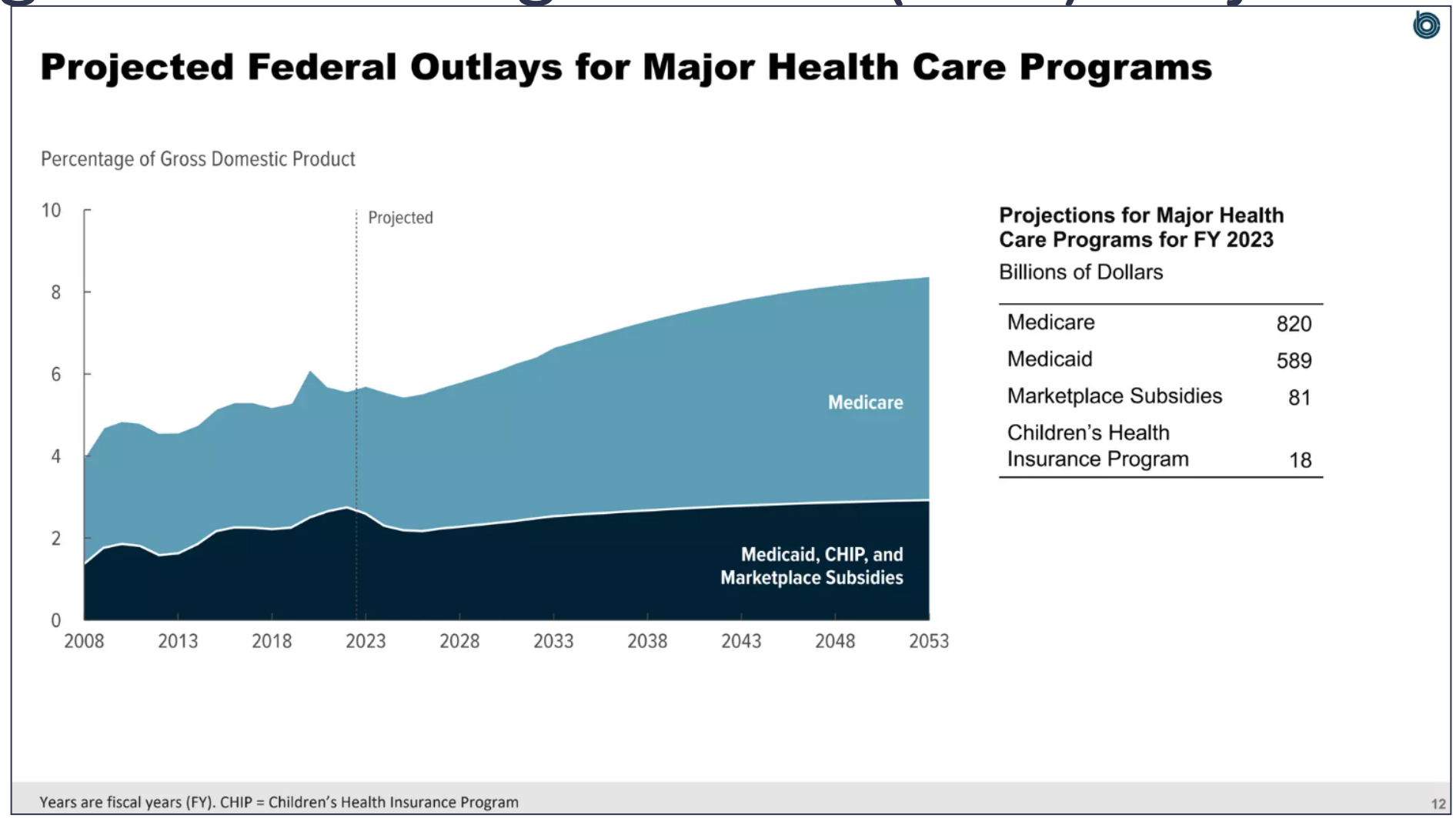
	Percentage of Gross Domestic Product					Billions of Dollars			
	Average, 1973–2022	Actual, 2022	2023	2024	2033	Actual, 2022	2023	2024	2033
Revenues, Total	**17.4**	**19.6**	**18.3**	**17.7**	**18.1**	**4,896**	4,812	**4,838**	7,098
Individual income taxes	8.0	10.5	9.6	9.0	9.7	2,632	2,523	2,467	3,803
Payroll taxes	6.0	5.9	6.0	6.0	5.9	1,484	1,562	1,633	2,307
Corporate income taxes	1.8	1.7	1.8	1.8	1.4	425	475	479	539
Other	1.6	1.4	1.0	1.0	1.1	356	251	260	449
Outlays, Total	**21.0**	**24.8**	**23.7**	**23.8**	**24.9**	**6,208**	6,206	**6,493**	9,799
Mandatory, subtotal	10.9	16.3	14.6	14.3	15.3	4,076	3,825	3,885	5,997
Social Security	4.4	4.8	5.1	5.3	6.0	1,213	1,336	1,450	2,355
Major health care programs	3.3	5.6	5.7	5.6	6.7	1,404	1,508	1,528	2,629
Medicare, net of offsetting receipts	2.0	2.8	3.1	3.3	4.1	710	820	894	1,623
Medicaid, CHIP, and marketplace subsidies	1.2	2.8	2.6	2.3	2.6	695	688	634	1,005
Other	3.2	5.8	3.7	3.3	2.6	1,459	981	908	1,014
Discretionary, subtotal	8.0	6.6	6.6	6.9	6.0	1,657	1,741	1,869	2,373
Defense	4.3	3.0	3.1	3.1	2.8	746	800	848	1,105
Nondefense	3.8	3.6	3.6	3.7	3.2	910	941	1,022	1,269
Net interest	2.0	1.9	2.4	2.7	3.6	475	640	739	1,429
Deficit, Total	**-3.6**	**-5.2**	**-5.3**	**-6.1**	**-6.9**	**-1,312**	**-1,394**	**-1,655**	**-2,702**
Deficit, Primary	-1.5	-3.3	-2.9	-3.4	-3.2	-837	-755	-916	-1,273
Debt Held by the Public	46.9	97.0	98.0	100.4	118.2	24,257	25,716	27,370	46,445

Source: CBO: https://www.cbo.gov/spstem/files/2023-02/58848-Outlook.pdf

2023 Must Pass Legislation

- ✓ Debt ceiling agreement passes but has impacts on FFY budget
- ✗ Federal budget funding ends 9/30

Congressional Budget Office (CBO) Projections



Source: Congressional Budget Office, *https://www.cbo.gov/publication/58952*

Hospitals In Congressional Crosshairs

Site Neutral

- Multiple bills include polices to equalize payments across settings
- Savings would range from $3 billion to $120 billion depending on the policy
- Bipartisan support

Tax-Exempt Status

- Attention focused on whether hospitals are contributing enough uncompensated care/charity care to warrant tax-exempt status
- Congressional hearings on topic have included medical debt and charity care requirements
- Bipartisan issue, including four Senators asking IRS to engage (this is a new tactic/approach)

Price Transparency

- Congress supports price transparency
- Belief that exposure to prices/costs will result in better consumer knowledge
- Congress pushing legislation to codify existing price transparency regulations into statue

Consolidation

- Congress watching and concerned by it
- Multiple hearings have focused on the issue and impact on how they contribute to rising health care spending/costs
- Role of private equity in hospital acquisitions

Example: Site Neutral Legislation

Medicare site-neutral for all off-campus HOPDs ($30-$40 billion)	• Health Care Fairness for All Act • SITE Act
Medicare site-neutral for all off-campus HOPD drug administration ($4 billion)	• Health Care Price Transparency Act • PATIENT Act
Separate NPI for each off-campus HOPD ($2 billion)	• Primary Care and Healthcare Workforce Expansion Act • Transparency in Billing Act
Commercial market site-neutral HOPD payment caps ($120 billion)	• Primary Care and Healthcare Workforce Expansion Act

Ex: Tax-Exempt Status Scrutiny

"We are alarmed by reports that despite their tax-exempt status, certain nonprofit hospitals may be taking advantage of this overly broad definition of "community benefit" and engaging in practices that are not in the best interest of the patient. These practices – along with lax federal oversight – have allowed some nonprofit hospitals to avoid providing essential care in the community for those who need it most."

- Letter from Senators Warren (D-MA.), Warnock (D-GA.), Cassidy (R-LA), Grassley (R-IA)*

Example Cited in Letter:

- 56 NY hospitals filed liens on nearly 5,000 people's homes w/nearly 80% of liens occurring in counties with incomes < 300% of FPL.
- Mosiac Life, MO, charging full fees for patients who should have received free or reduced fee care.
- Methodist Le Bonheur Hospital, TN brought > 8,300 lawsuits against patients or employees for unpaid medical bills.
- UV Health System filed 36,000 lawsuits for > $106M over a 6-year period that involved "relentless" debt collection efforts.

NY Times article reporting that:

- Providence Health pursued a strategy to "wring money" out of patients to "pressure them to pay" for services when those patients were eligible for free care.
- Allina Health System, MN reportedly receives $209M > than was spent on providing charity care, having a policy of denying medical care from patients with unpaid medical bills.

****Source: Bi-Partisan letter to The Honorable Daniel Werfel, Commissioner Internal Revenue Service & The Honorable Edward T. Killen, Commissioner Tax Exempt & Government Entities Division dated August 7, 2023 at www.warren.senate.gov/imo/media/doc/letters.***

Congressional

Macro

- Congress is just generally cranky
- Difficult environment to pass legislation
- Government shut-down a possibility

Health Care

- Congress focusing in on hospitals and PBMs
- Site neutral a real possibility to find offsets
- Expiring policies still unfinished (CHCs, DSH, GME…)

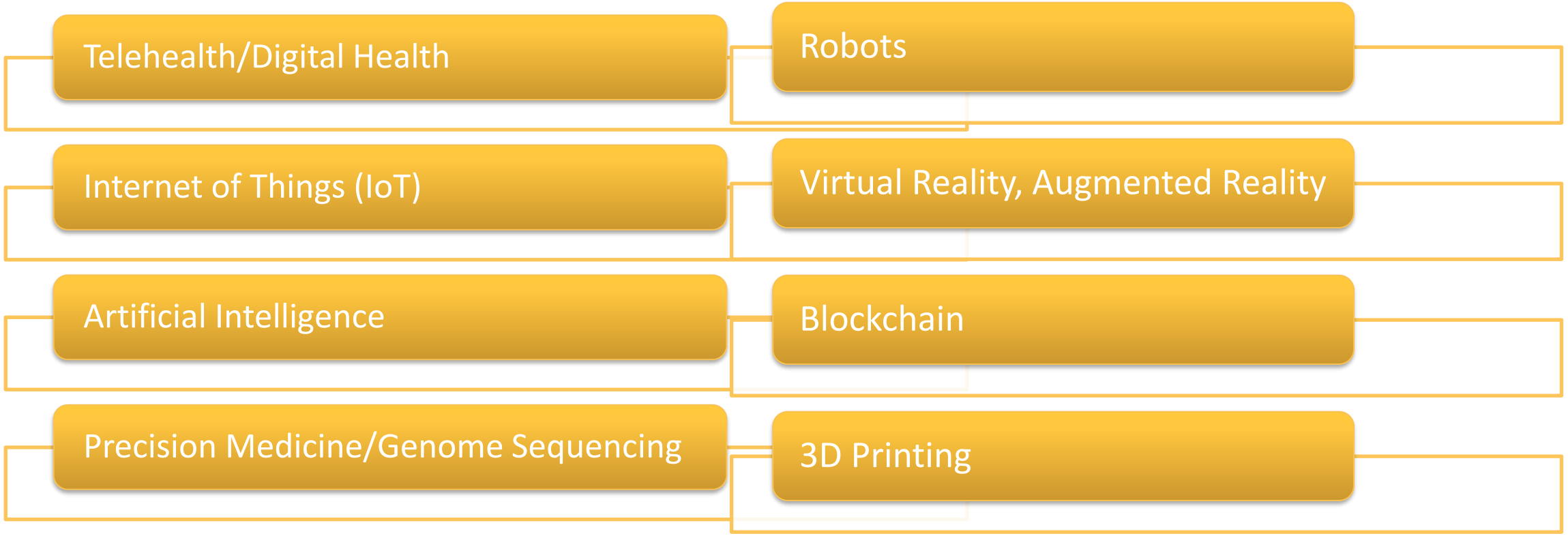
Actions

- Understand what Congress feels care and payment should be going
- Understand your potential vulnerability with site neutral and have a plan
- Grassroots advocacy always an option (legislators need to know how policies impact their constituents)

Digital, Technology

Technological Trends: Industry 4.0

Advances and innovations in the following are helping drive this future …



And many more…

Telehealth/Digital Health

Adoption/Acceptance

- COVID spurred adoption on exponentially
- Use has come down but will not go to pre-COVID levels
- Use is now well-accepted
- Consumers expectations are shifting to favor its availability for some services

Deals/Investments

- Deal volume has generally been going up for the past decade, spiked in 2021 but then was half that volume in 2022. (Rock Health)
- 2023 is starting off muted. To be seen whether deals will increase.
- Pandemic ending, inflation, economy and related issues may cause less volume

Higher Use

- Telehealth has been used by some 80% of individuals (Rock Health)
- Telehealth in Medicare (FFS) rose 63-fold in 2020 from 840,000 in 2019 to 52.7M (ASPE/HHS)
- Telehealth, audio-only use, Remote Patient Monitoring are highest used
- Primary care, behavioral health

Near Future Trends

- Ongoing growth, interest and adoption as a part of normal patient care options
- More physicians will embrace
- Primary care access point (ACOs, new entrants)
- Digital therapeutics

Artificial Intelligence (AI)

What

- Where a computer models or emulates human behavior or intelligence
- Many types of AI, such as machine learning, deep learning, natural language processing, intelligent user interfaces, robotics, computer vision….

Use Case Examples

- Medical imaging/diagnosis
- Patient education,
- Patient monitoring
- Medical coding, Chart review
- Research, data analytics
- Virtual assistant/chatbots
- Automating revenue cycle/other processes

Higher Health Care Use

- Revenue cycle
- Repeatable tasks
- Chatbots
- Predictive analytics

Future Trends

- Generative AI (ChatGPT) applications
- Pharmaceutical development
- Clinical applications and diagnosis
- Use in virtual and augmented reality for clinical applications

Technology Spending & Cybersecurity

Technology Spending Increases

- Hardware
- Software
- Replacements
- Cybersecurity

Statistics

- FBI's Internet Crime Complaint Center (IC3) 2021 report, found complaints went from 301,500 totaling $1.4 billion to over 800,500 complaints totaling $6.9 billion in past five years
- Ransomware one of the top five crime types, most common was through phishing emails, Remote Desktop Protocol (RDP) exploitation, and exploitation of software vulnerabilities.

Common Cybersecurity Risks

- Ransomware
- Phishing/smishing/vishing
- IoT, legacy systems
- Data breaches

Future

- Increased cyber risk
- Increased cybersecurity costs
- Increased focus on technology that aligns and integrates with existing systems (like EHRs) and provides efficiencies, higher productivity
- Increased technology budgets

Digital/Technology

Macro

- Technology is advancing at a very rapid pace
- Will continue to be a growing issue

Health Care

- Cyber actors are focused on health care due to the data it has
- Artificial intelligence will be a focus in coming years

Actions

- Create or revisit your digital strategy and align with enterprise strategic plan
- Invest in cybersecurity
- Digital/tech tools can provide your organization with efficiencies, productivity and more

Thank You!

Jennifer Boese
Director, Health Care Policy & Innovation
Jennifer.Boese@CLAconnect.com
608-662-7635

CLAconnect.com

CPAs | CONSULTANTS | WEALTH ADVISORS

Thank you to our Business Partners!

9:30AM-
9:45AM

Refreshments available in Ocotillo Meeting Room

Top 10 Opportunities in Revenue Cycle

- Presented by: **Kris N. Brumley, SVP, Chief Operating Officer- Revenue Enterprises, LLC**

Kris N. Brumley, SVP, Chief Operating Officer-Revenue Enterprises, LLC

As SVP/COO of Revenue Enterprises, Kris Brumley is a collaborative partner within the executive team and a leader for operational functions across the organization. Kris productively shares vision, drives innovation, and supports those around her in a way that elevates them and fosters continuous improvement and results. She has helped create a supportive environment for clients resulting in 98% client retention and a 65% NPS score for all clients and 75% for top clients by revenue.

Kris possesses an MBA in data analytics and has twenty-five years' experience in the healthcare industry, with 19 specifically in revenue cycle. She brings a wealth of customer service experience to her role and has worn many hats at Revenue Enterprises including Director of Business Development, EBO Division Director, and VP of Client Experience Management.

In her personal life, Kris is as busy outside of work as inside. She values spending time with her family, and enjoys fishing, hiking, traveling and interior decorating and design.

TO[illegible]PORTUNITIES IN R[illegible]UE CYCLE

2023 Fall HFMA Presentation

revenue enterprises

OBJECTIVES

We will explore the top 10 opportunities that healthcare organizations can leverage to optimize their revenue cycle management. The healthcare revenue cycle is a complex process that involves various stages, from patient registration and insurance verification to claims submission and reimbursement. During the presentation, we will delve into each opportunity in detail, providing specific strategies and best practices to maximize revenue and improve financial performance.

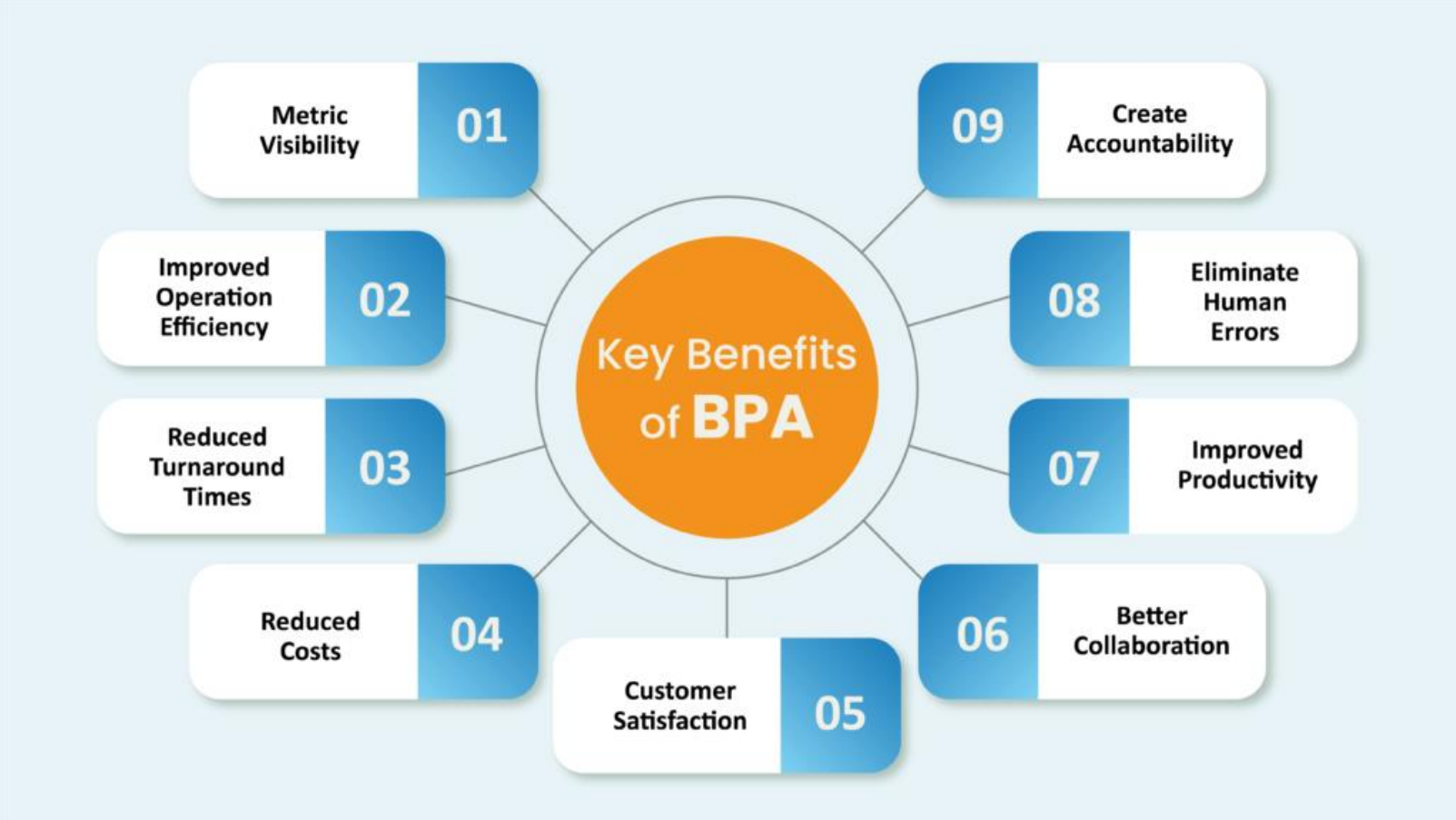
By the end of this presentation, you will have a comprehensive understanding of the top opportunities in healthcare revenue cycle management and be equipped with actionable insights to drive financial success in your organization.

- Automation of manual processes: Implementing technology solutions to automate repetitive tasks can significantly improve efficiency and reduce errors in the revenue cycle.
- Streamlining patient registration: Improving the patient registration process by implementing self-service options, electronic forms, and real-time eligibility verification can reduce administrative burden and enhance data accuracy.
- Enhancing coding and documentation: Ensuring accurate and complete coding and documentation practices can optimize reimbursement and minimize claim denials.
- Implementing revenue integrity programs: Revenue integrity programs help identify and address potential revenue leakage points, ensuring accurate billing and reimbursement.
- Improving claims management: Implementing robust claims management systems and processes can reduce claim denials, accelerate reimbursement, and improve overall revenue cycle performance.

- Enhancing patient financial experience: Providing transparent and convenient payment options, financial counseling, and price transparency tools can improve patient satisfaction and increase collections.
- Leveraging data analytics: Utilizing advanced analytics tools to analyze revenue cycle data can identify trends, patterns, and areas for improvement, leading to better financial outcomes.
- Optimizing payer contract management: Effective management of payer contracts, including negotiation, analysis, and monitoring, can maximize reimbursement rates and minimize underpayments.
- Strengthening revenue cycle staff education and training: Investing in ongoing education and training for revenue cycle staff can enhance their skills and knowledge, leading to improved performance and outcomes.
- Embracing value-based care models: Transitioning to value-based care models can incentivize quality outcomes and improve financial performance by aligning reimbursement with patient outcomes.

#1 – AUTOMATION OF MANUAL PROCESSES

Implementing technology solutions to automate repetitive tasks can significantly improve efficiency and reduce errors in the revenue cycle.



BPA = Business Process Automation

#1 – AUTOMATION OF MANUAL PROCESSES

Implementing technology solutions to automate repetitive tasks can significantly improve efficiency and reduce errors in the revenue cycle.

RCM software that can automate patient registration, insurance verification, claims processing and billing and can integrate with your EHR to streamline data flow.
Advanced **Analytics and Reporting Tools** can provide insights into revenue cycle performance, helping healthcare organizations identify areas for improvement and optimization.
Claims management software that can automate the creation, submission and tracking of insurance claims typically result in faster reimbursement
Denials management solutions can help identify and address claim denials more efficiently, reducing the revenue lost due to denied claims
Appointment scheduling and reminder systems help reduce no-shows and improve revenue by ensuring that appointments are kept and billed for
Robotic process automation (RPA) can be used to automate repetitive, rule-based tasks such as data entry, claims submission, and payment posting
Machine learning and AI technologies can be employed for predictive analytics, fraud detection, and optimizing reimbursement strategies

#2 – STREAMLINING PATIENT REGISTRATION

IMPROVING THE PATIENT REGISTRATION PROCESS BY IMPLEMENTING SELF-SERVICE OPTIONS, ELECTRONIC FORMS, AND REAL-TIME ELIGIBILITY VERIFICATION CAN REDUCE ADMINISTRATIVE BURDEN AND ENHANCE DATA ACCURACY.

#2 – STREAMLINING PATIENT REGISTRATION

Improving the patient registration process by implementing self-service options, electronic forms, and real-time eligibility verification can reduce administrative burden and enhance data accuracy.

Online Pre-Registration: Offer patients the option to pre-register online before their appointment. This can include filling out demographic information, insurance details, and medical history through a secure patient portal. This not only saves time during in-person registration but also reduces errors.

Mobile Registration Apps: Develop mobile apps that allow patients to complete registration tasks on their smartphones or tablets. These apps can be integrated with your electronic health record (EHR) system for seamless data transfer.

Self-Service Kiosks: Install self-service kiosks in your healthcare facility's waiting area. Patients can use these kiosks to check-in, update personal information, and verify insurance details. Kiosks can significantly reduce wait times and staff workload.

Appointment Reminders: Send appointment reminders via SMS, email, or phone calls that include instructions on what patients should bring with them for registration. This reduces the chances of missing required documents.

Insurance Verification Tools: Implement automated insurance verification tools to quickly verify patients' insurance coverage and eligibility. This reduces registration delays and billing errors.

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#3 – ENHANCING CODING AND DOCUMENTATION

Ensuring accurate and complete coding and documentation practices can optimize reimbursement and minimize claim denials.

#3 – ENHANCING CODING AND DOCUMENTATION

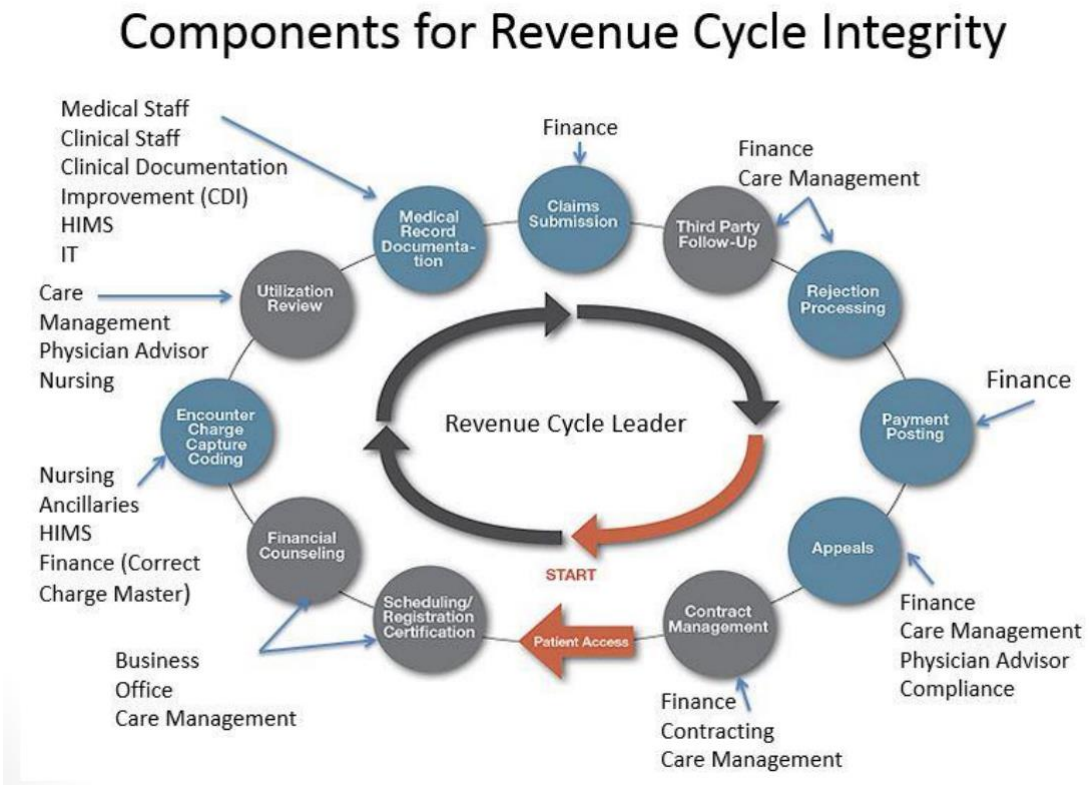
Ensuring accurate and complete coding and documentation practices can optimize reimbursement and minimize claim denials.

1. Ensure accurate NPI is used
2. Participate in payer listservs
3. Don’t apply one payer’s rules to other payers
4. Ensure you have at least one “good” contact with each of your payers
5. Have a consistent process to alert staff and physicians of coding updates
6. Catalog your communication regarding coding updates
7. Verify insurance every visit
8. Ensure you have necessary preauthorization
9. Correct and submit denied claims within 24 hours
10. Know which commercial payers will recognize consultation codes

#4 – IMPLEMENTING REVENUE INTEGRITY PROGRAMS

Revenue integrity programs help identify and address potential revenue leakage points, ensuring accurate billing and reimbursement.

A strong revenue integrity program requires commitment – ongoing monitoring, and dedication to improving process to ensure accurate billing, regulatory compliance and financial stability.



#4 – IMPLEMENTING REVENUE INTEGRITY PROGRAMS

Revenue integrity programs help identify and address potential revenue leakage points, ensuring accurate billing and reimbursement.

Leadership and Governance:

Assign a dedicated team or revenue integrity officer responsible for overseeing the program.

Develop a clear governance structure with defined roles and responsibilities.

Assessment and Gap Analysis:

Conduct a comprehensive assessment of your current revenue cycle processes, including coding, documentation, billing, and compliance.

Identify gaps, vulnerabilities, and areas for improvement.

Regulatory Compliance:

Stay up-to-date with healthcare regulations, including Medicare, Medicaid, and private payer requirements.

Develop and maintain policies and procedures to ensure compliance with regulations.

Education and Training:

Provide ongoing education and training to staff on coding guidelines, documentation requirements, and compliance with billing regulations.

Offer specific training for staff involved in revenue cycle processes.

#4 – IMPLEMENTING REVENUE INTEGRITY PROGRAMS

5. Coding and Documentation Improvement:

Implement strategies to improve the accuracy and completeness of clinical documentation.

Conduct regular coding audits to identify areas for improvement and provide feedback to coders and providers.

6. Charge Capture:

Ensure that all billable services and items are captured accurately and in a timely manner.

Implement charge reconciliation processes to identify discrepancies.

7. Denial Management:

Establish a denial management program to identify and address claim denials promptly.

Analyze denial trends and implement preventive measures.

8. Pricing Transparency:

Comply with price transparency regulations by providing patients with clear and accessible pricing information.

Implement tools and processes to estimate and communicate costs to patients.

#4 – IMPLEMENTING REVENUE INTEGRITY PROGRAMS

Reimbursement Optimization:

Analyze payer contracts to ensure you're maximizing reimbursement rates.

Negotiate favorable contracts with payers when possible.

Technology and Automation:

Invest in revenue cycle management software and automation tools to streamline processes and reduce manual errors.

Utilize data analytics to identify areas for improvement

Documentation Review and Improvement:

Conduct periodic reviews of clinical documentation to ensure accuracy and completeness.

Provide feedback and education to providers to improve documentation practices.

Charge Description Master (CDM) Maintenance:

Regularly review and update the Charge Description Master to ensure accurate pricing and coding for services and procedures.

Compliance Audits:

Perform regular compliance audits to identify and address potential compliance risks.

Develop corrective action plans for any identified issues.

#4 – IMPLEMENTING REVENUE INTEGRITY PROGRAMS

Financial Counseling and Patient Access:

Provide financial counseling to patients to help them understand their financial responsibilities and options.

Streamline the patient access process to improve upfront collections and reduce bad debt.

Performance Metrics and Reporting:

Define key performance indicators (KPIs) to measure the effectiveness of your revenue integrity program.

Generate regular reports to track progress and identify areas requiring attention.

Enforce consequences for non-compliance or errors as necessary.

Continuous Improvement:

Establish a culture of continuous improvement within your organization.

Regularly review program outcomes, solicit feedback, and make adjustments as needed.

External Audits and Reviews:

Consider engaging external auditors or consultants periodically to provide an independent assessment of your revenue cycle processes.

#4 – IMPLEMENTING REVENUE INTEGRITY PROGRAMS

Communication and Collaboration:

Foster collaboration between revenue cycle teams, clinical staff, compliance, and finance departments to ensure alignment and cooperation.

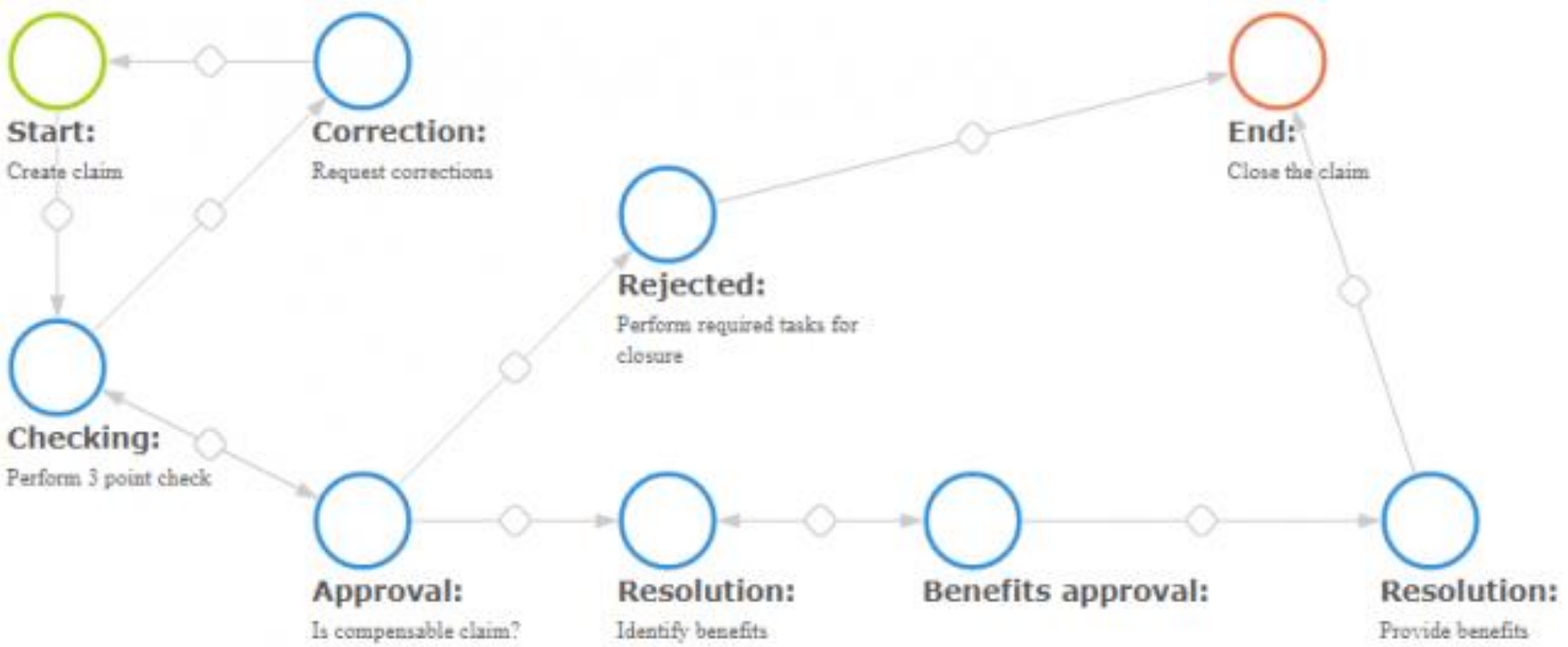
Documentation of Policies and Procedures:

Document all policies and procedures related to revenue cycle processes and compliance.

Ensure that staff have access to these documents and are aware of the processes they outline.

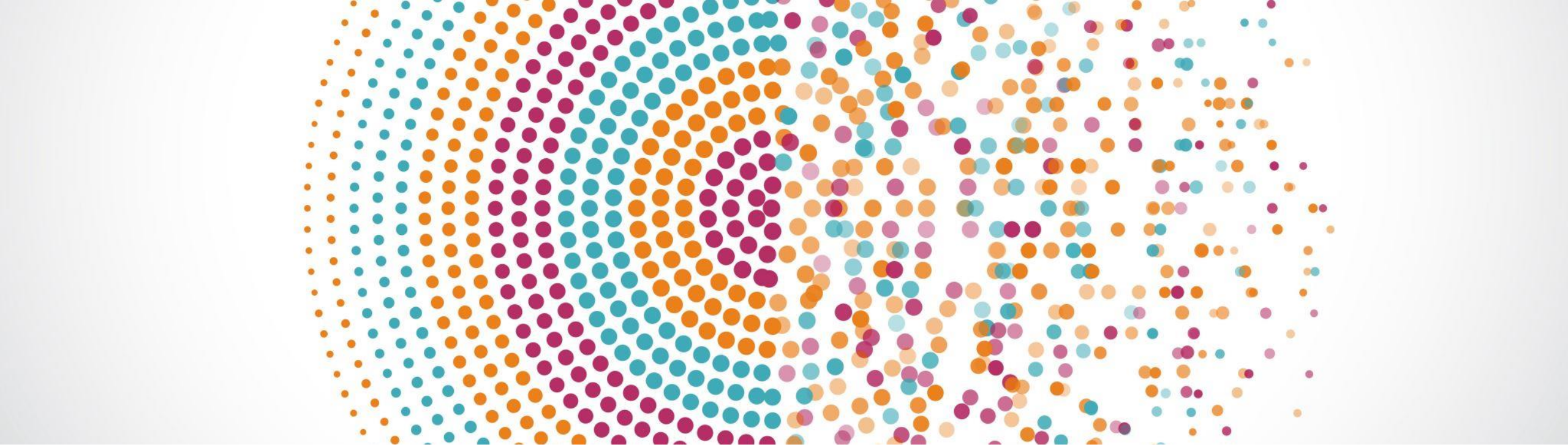
Monitoring and Enforcement:

Implement monitoring mechanisms to ensure that revenue cycle processes and compliance measures are consistently followed.



#5 – IMPROVING CLAIMS MANAGEMENT

Implementing robust claims management systems and processes can reduce claim denials, accelerate reimbursement, and improve overall revenue cycle performance.



#5 – IMPROVING CLAIMS MANAGEMENT

A recent study shared by *HealthLeaders* says that the average health system saw 11,000 claims denied due to prior authorization and other factors in 2022.

Denials rose to 11% of all claims last year, up nearly 8% from 2021, according to a recent study.

Prior authorization denials on inpatient accounts were a key driver behind the dollar value of denials increasing by 67% in 2022.

- Collecting accurate patient data
- Improving first-pass yield
- Ensuring clean claims submissions
- Minimizing coding errors
- Promptly handling rejected and denied claims
- Updating your claims management software
- Tracking payer trends and financial performance

https://www.healthleadersmedia.com/revenue-cycle/cost-denials-saw-67-increase-2022

#6 – ENHANCING PATIENT FINANCIAL EXPERIENCE

Providing transparent and convenient payment options, financial counseling, and price transparency tools can improve patient satisfaction and increase collections.

#6 – ENHANCING PATIENT FINANCIAL EXPERIENCE

Providing transparent and convenient payment options, financial counseling, and price transparency tools can improve patient satisfaction and increase collections.

1. Educate your patients on the revenue cycle process up front – to help set expectations
    a. What will you need from them?
    b. What can they expect to pay?
    c. What are their options for payment?
    d. What are next steps?

2. Communicate digitally and offer mobile-friendly options
    a. Registration
    b. Payments
    c. Access to statements
    d. Progress of their claims/claims status

3. Before investing, ask them what they want!

#7 – LEVERAGING DATA ANALYTICS

Utilizing advanced analytics tools to analyze revenue cycle data can identify trends, patterns, and areas for improvement, leading to better financial outcomes.

SAMPLE REVENUE CYCLE EXPLORER EXECUTIVE DASHBOARD.

1. Revenue cycle management detail tabs (e.g., account receivables, collection rates, denial management)
2. KPIs : MTD, YTD (current versus prior year)
3. Current accounts receivable aging
4. Payer mix percentages
5. rended accounts receivable days
6. Trended net collection rates

#8 – OPTIMIZING PAYER CONTRACT MANAGEMENT

Effective management of payer contracts, including negotiation, analysis, and monitoring, can maximize reimbursement rates and minimize underpayments.

#8 – OPTIMIZING PAYER CONTRACT MANAGEMENT

1. Clarify ALL the details about your payer reimbursement including impacts on modifiers and multiple procedures.
2. Understand all terms and targets within your contracts
3. Forecast and prepare – remember that your patient payments are as important as your payer payments for maximum recovery of revenue
4. Perform a cost analysis
5. Understand and minimize administrative burden and manual processes
6. Read the fine print and know what it says!
7. Take action

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#9 – STRENGTHENING REVENUE CYCLE STAFF EDUCATION AND TRAINING

Investing in ongoing education and training for revenue cycle staff can enhance their skills and knowledge, leading to improved performance and outcomes.

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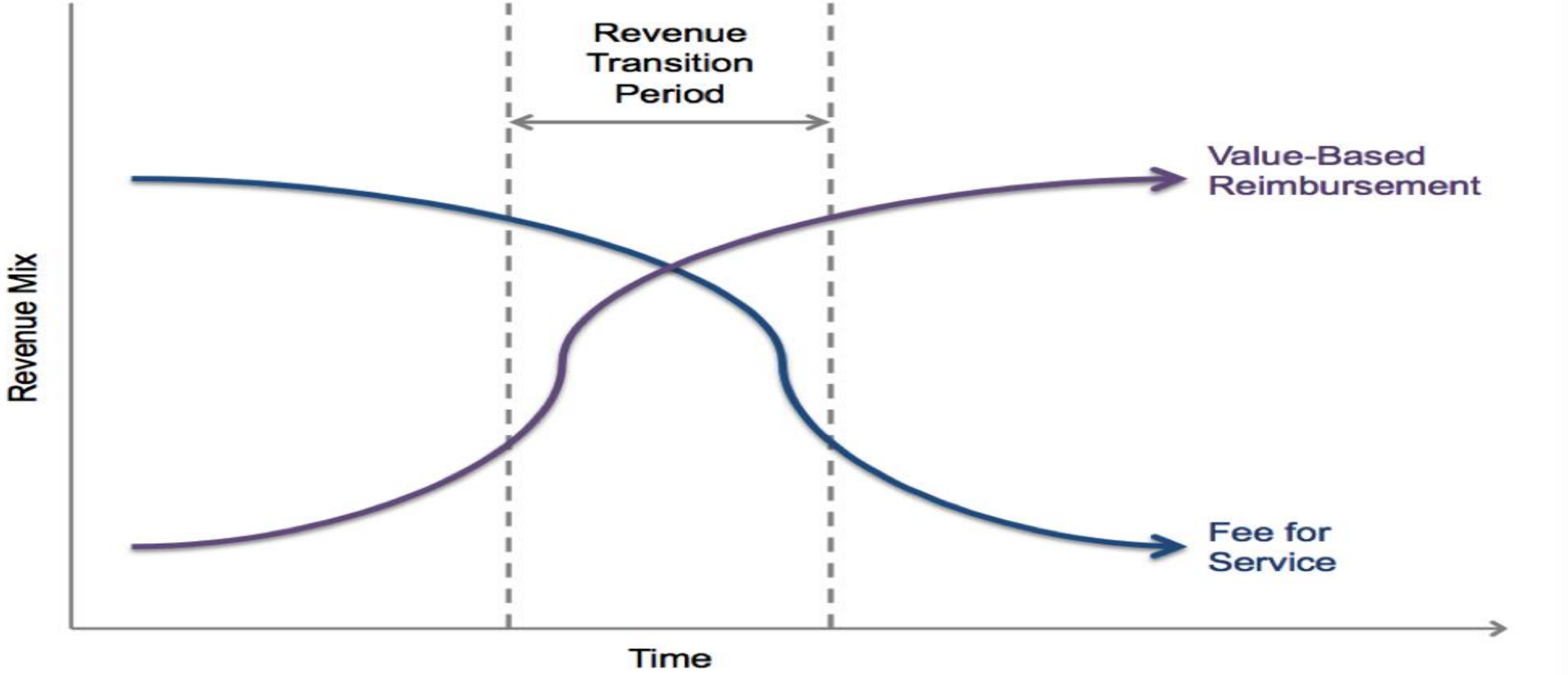
#9 – STRENGTHENING REVENUE CYCLE STAFF EDUCATION AND TRAINING

Invest in your most valuable resource – your people!

- Inexperienced "Green" Representatives
  - Introduction to Healthcare Revenue Cycle (for ALL Rev Cycle Employees)
  - Help them to understand *why* what they do is important and how each step feeds the next
- Customer Service Skills
  - Smile
  - Put on your game face and remember that there is a person affected by everything you do



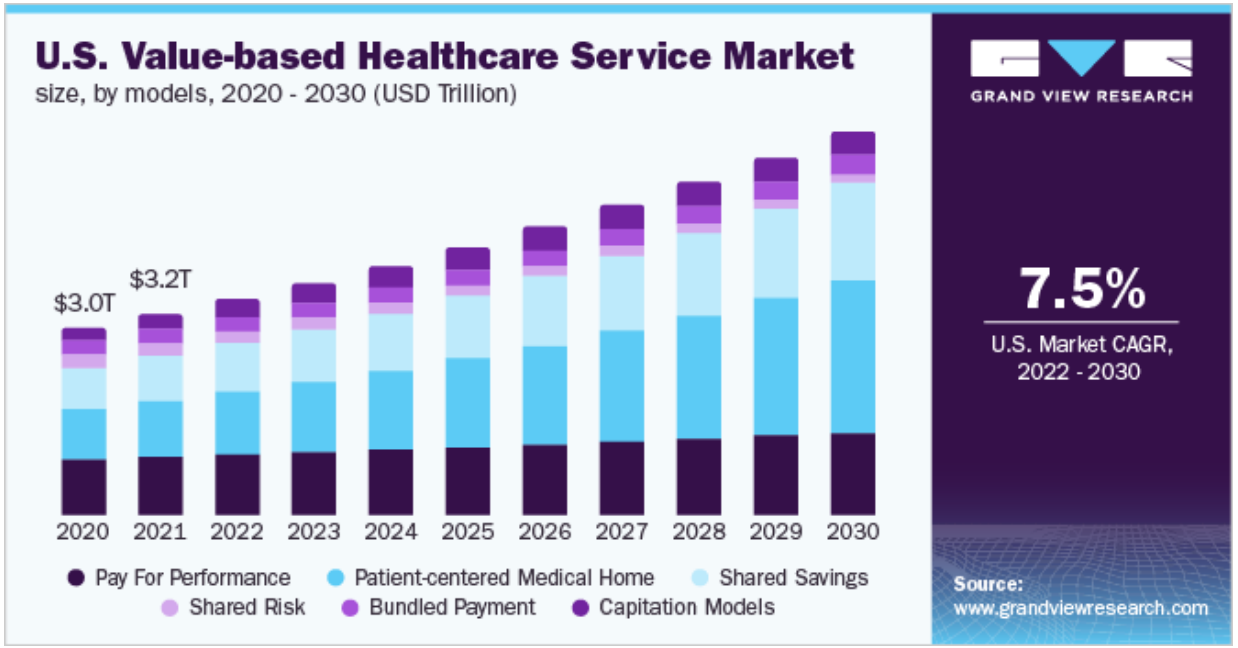
#10 – EMBRACING VALUE-BASED CARE MODELS

Transitioning to value-based care models can incentivize quality outcomes and improve financial performance by aligning reimbursement with patient outcomes.

#10 – EMBRACING VALUE-BASED CARE MODELS

Transitioning to value-based care models can incentivize quality outcomes and improve financial performance by aligning reimbursement with patient outcomes.

1. **Takes time.**
2. **Requires streamlined data management to gather and track outcomes.**
3. **Requires commitment and buy-in from providers, executive leadership and all support staff, with a clear understanding of why accuracy of data tracking is important, and what it means for the facility and for your patients.**



"Pay for performance accounted for the largest market share revenue of over 28.00% in 2021 due to the rising shift from traditional fee-for-service toward payment for value-based healthcare programs. Furthermore, to reduce costs and improve healthcare for patients and society, the government has provided incentives that have driven payers to establish value-based pay-for-performance programs."

https://www.grandviewresearch.com/industry-analysis/us-value-based-healthcare-service-market-report

THANK YOU

KRIS BRUMLEY, MBA
SVP/Chief Operating Officer
Revenue Enterprises, LLC

720-626-7405

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Thank you to our Business Partners!

Cures Act

- **Presented by:**
- **Kristen Borth, MS, RHIA, Chief Operating Officer- Primeau Consulting Group**

Kristen Borth, MS, RHIA, Chief Operating Officer- Primeau Consulting Group

Kristen Borth is a health information and informatics professional with over 10 years of experience in consulting in acute and ambulatory services. While transitioning from private to public sector consulting, she has always stayed in the realm of Health Information Management and Health Informatics. This has helped to broaden her foundational knowledge regarding the crossover and similarities in both arenas.

Kristen has a bachelor's and graduate degree from Loma Linda University in health information and informatics. She has three children (two boys and a girl), a Great Dane and Corgi, a cat, and a wonderfully supportive husband to keep her life outside of work fun and busy. She loves to bake and cook. Cycling and running are her stress relievers and she has just recently moved back to her home state of Arkansas.

21st Century Cures Act
UNTANGLING THE CONFUSION

Kristen Borth, MS, RHIA

COO, Primeau Consulting Group, INC

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Agenda

- Review the legislation impacting interoperability
- Understand the Information Blocking rules
- Review industry definitions of EHI
- Discuss challenges in defining EHI with the DRS and LHR
- Review how governance can address healthcare transformation for today and the future

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2020 Cures Act Final Rule

Purpose

To implement certain provisions of the Cures Act that will advance interoperability and support the access, exchange and use of electronic health information (EHI)

CMS Companion Rule: Patient Access and Interoperability

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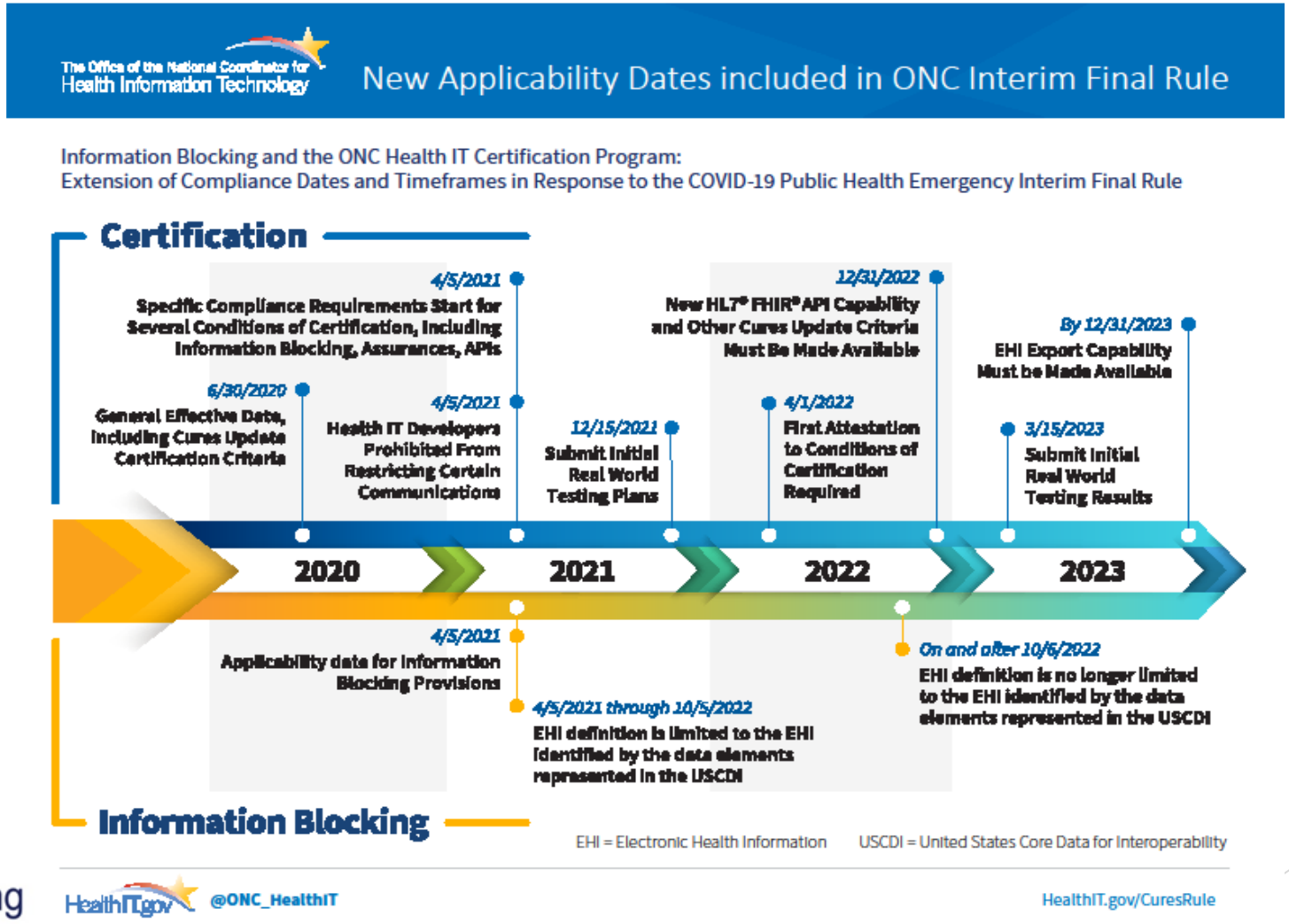
Updated Timeline



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Industry Interoperability Initiatives

- HITECH Act
- 21st Century Cures Act
- TEFCA

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Interoperability in Healthcare

- The ability for various healthcare information technologies (HIT) to exchange, interpret and use data cohesively
- Stakeholders are working together to move toward interoperability with EHRs
- Sharing EHI still remains a challenge
- Landscape is moving quickly!!

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Electronic Health Information (EHI)—Definitions

- ePHI, as defined in HIPAA to the extent ePHI, is included in the **designated record set.** Excludes:
  - Psychotherapy notes
  - Information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding
- November 2, 2020 - October 5, 2022
  - **USCDI** must be available for access, exchange and use
- October 6, 2022
  - **Full EHI** is ePHI to the extent it is included in the designated record set
    - This definition is applicable whether the actor is a covered entity or not.

Great resource
https://library.ahima.org/doc?oid=104008#.YxjdhKHMI2w

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EHI Task Force

- AHIMA, co-convenor: technical and policy input from HIM community and health system perspective
- AMIA, co-convenor: technical and policy input from clinical informatics, health IT standards, and health system perspective
- EHR Association, co-convenor: technical and policy input from health IT developer and standards implementer perspective.

Objective: Develop consensus recommendations on how to standardize expectations for data classes related to the definition of the DRS and EHI

AHIMA
American Health Information Management Association®

AMIA
INFORMATICS PROFESSIONALS. LEADING THE WAY.

EHRA
HIMSS ELECTRONIC HEALTH RECORD ASSOCIATION

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Approach

- Examined data classes commonly contained in health IT and exchanged today
- Examined data classes less frequently exchanged
- Identified from
  - USCDI
  - ONDEC
  - Health IT developer lists of data classes
  - Best practice previously developed by AHIMA

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Data Universes under HIPAA and Information Blocking

- Definition
  - PHI – 45 CFR 160.103
  - DRS – 45 CFR 164.501
  - ePHI – electronic subset of PHI
  - EHI – intersection of ePHI and DRS
- Challenges
  - DRS to some extent is fluid by implementation, thus scope of EHI can change by actor, even though it may involve the exact same data set, ePHI, available

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Key considerations: Status conditions

- Certain data classes may not be considered EHI depending on their “status”
- Task Force identified several status conditions
  - Unvalidated data
  - Draft data
  - Duplicative data
  - Data that does not meet the ePHI definition

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Status condition: Unvalidated Data

- Examples
  - External records prior to clinical review or reconciliation
  - Device readings not reviewed or checked by a clinician
  - Patient-generated data that is submitted prior to clinical review of reconciliation

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Status condition: Draft Data

- Examples
  - Clinical note or report in progress that may be written or edited but not signed
  - Pre-charting
  - Data used in teaching workflows, provided a medical student begins the work and it is later taken over by other authors

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Status condition: Duplicative Data

- Examples
  - Audio transcription files and/or transcribed text of lab result information that is both in the lab system and the EHR

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Status condition: Data does not meet the ePHI definition

- Definitions of ePHI and IIHI indicate that the context of collection and HIPAA definitions play a role in defining EHI
- Information must be collected by a covered entity (CE) or business associate (BA) when they are acting as a CE or BA and not as an employer or in other capacities to be considered EHI
  - Employee health service
- De-identified data or data that is not patient identifiable is not considered EHI

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Data Class & Next Steps

- Whether a data class is considered EHI will evolve over time
- Standardizing expectations around the definition of EHI important to the operationalization of Cures Act Final Rule
- Task Force Next steps
  - Seek feedback from stakeholders
  - Refine consensus understanding of what data classes are EHI including follow-up actions by the federal government and/or private sector to operationalize the definition of EHI
  - Exploration of whether common characteristics across covered entities could yield a common interpretation of the DRS to serve as a template

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Federal Information Technology Plan

- Trusted Exchange Framework and Common Agreement (TEFCA)
- Payer to Patient Access Application Provider Interface
- Provider to Patient Access API Requirement
- Payer to payer EHI Sharing Requirement
- HL7 Da Vinci Project

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Top Trends in Healthcare

1. Interoperability is progressing
2. Almost all EHR vendors have improved connections
3. Ambulatory clinics and smaller hospitals are connecting to share data now more than ever before
4. High costs and lack of EHR vendor technical readiness make interoperability harder for half of the providers
5. Networks have been steadily increasing since 2017. Providers consider private and public health information exchanges the most valuable sharing method
6. Patient-facing app use is still in the early stages, it is growing. Apple is the most common third party being used. Providers that are not using patient-facing apps are in the process of certifying with Apple to start using FHIR

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Top Trends in Healthcare

7. Large health systems make up the majority of organizations adopting FHIR application programming interfaces, primarily for patient-record exchange, clinician-enabling tools, and patient-facing tools
8. About one-third of providers with FHIR APIs said they are too early in their interoperability process to rate their satisfaction with the technologies
9. Proprietary APIs, such as patient-record exchange, patient-facing tools and clinician-facing tools are proving to be valuable among provider organizations
10. Over the next two to three years, providers want their vendors to focus on improving patient-record exchange by making it bidirectional and enhancing population health capabilities.

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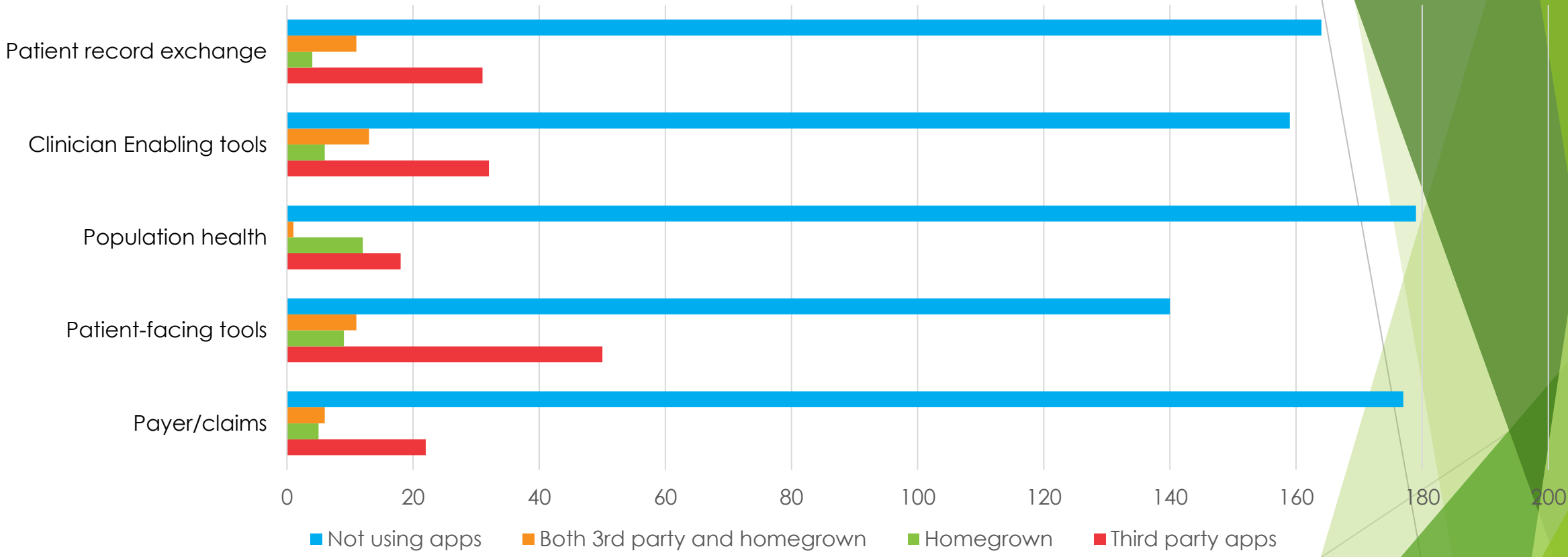
Types of Apps Being Used



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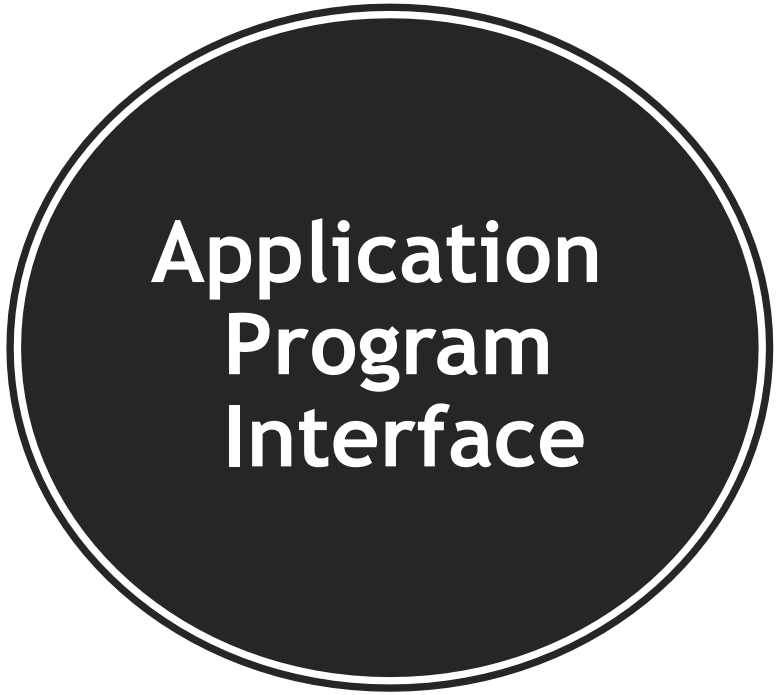
Application Program Interfaces for Healthcare



- APIs help applications talk to each other
- Transition to value-based care
- From EHR implementation & adoption to interoperability
- Challenges accessing and sharing data as we migrate to the cloud
- FHIR can make it easier to use and share data

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Four Levels of API Integration

- **Read:** Extract Data from the EHR and send it to another application
- **Read and write**: Extract data and send different data back to the EHR
- **Read, write and change**: Extract, send data, and change existing data in the EHR
- **Read, write, change and add**: All of the above and bring in third party data to both the EHR and the other application

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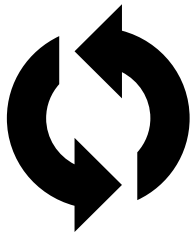
Interoperability & Information Governance

Establish policy

Determines accountabilities for managing information



Promotes objectively through robust, repeatable processes

Protects information with appropriate controls

Prioritize investments

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Conduct a Risk Assessment

Staff

- **HIM**
- **IT**
- **Compliance/Quality**
- **Revenue Cycle**
- **Informatics**
- **Vendors/Business Associates**
- **Ancillary Departments**

Current Process

- **ROI**
- **API interfaces and third-party linkage**
- **Payer & other external party requests**
- **Amendments**
- **Patient portal**
- **Other exchanges – HIEs**

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INTEROPERABILITY & INFORMATION GOVERNANCE

- How is interoperability incorporated into our overall Information Governance plan?
- How does my organization access, exchange or use EHI?
- What other organizations request EHI, ie; patients, providers, payors, attorneys, HIEs?
- What processes need to be revised to ensure interoperability?
- How do I incorporate the Information Blocking Exceptions into my policies and procedures?
- How are patients accessing/using the portal?
- How do I educate patients regarding access, exchange and use of EHI?
- How do I respond to a request for EHI?
- Is there anything that limits my response to an EHI request?

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INTEROPERABILITY & INFORMATION GOVERNANCE

Assess Processes for Compliance and Operational Efficiencies

- The United States Core Data for Interoperability (USCDI)
- Data elements to be included in the designated record set
- Designated record set definition
- Data segmentation (as necessary) for sensitive EHI
- Unsigned or incomplete documents
- Lab/test results that require review before availability
- Approvals of 3rd party apps
- Patient identification and matching accuracy

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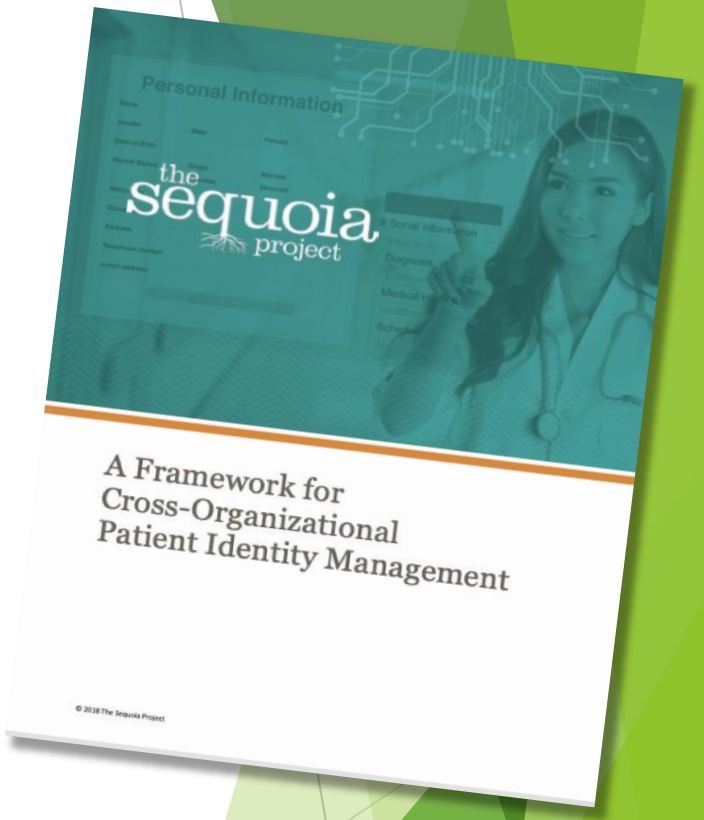
Implications of Old Technology

- This is not good for compliance with the 21st Century Cures Act!
- 70-90% cross-organization matches fail*
- *Why?*
  - Same as the reasons why we have duplicates
  - Different data standards and data quality at different providers

**ONC & The Sequoia Project Research*



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Data Standards & Data Quality Matter

- Data standard differences are caused by software, training, priority of data quality, and protocols of each provider
- Data standard differences include
  - Using middle initials instead of middle names
  - Data formats
  - Normalized vs. not normalized
  - Handling of compound-names (space, no space, punctuation)
  - Historical data or lack thereof

https://journal.ahima.org/page/patient-identification-ahima-naming-policy

Provider	DOB	First Name	Middle Name	Last Name	SSN	Cell Number	Street Address	Street Address 2
Big Hospital System	02/07/1975	CHUNG	HEE	KIM	998-45-7832	555-123-3421	456 S. Sentator Drive #5	
Local Provider	07/02/1975	CHUNGHEE		KIM	9985557832	5551233421	456 Senator	Apt. 5

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Interoperability & MPI Search

- Historical patient address, telephone, other names are more important now
- Be aware of missing data
  - Not all providers collect the same information
    - Full employer data, NOK or guarantor full name and contact data are often different between providers
    - Different types of patient names: nickname, other names, preferred names, aliases, names as registered before
- Lack of a universal patient ID

USCDI v1 Summary of Data Classes and Data Elements

Allergies and Intolerance			
• Substance (Medication)	• Substance (Drug Class)	• Reaction	
Assessment and Plan of Treatment			
Care Team Members			
Clinical Notes			
• Consultation Note	• Discharge Summary Note	• History & Physical	• Imaging Narrative
• Laboratory Report Narrative	• Pathology Report Narrative	• Procedure Note	• Progress Note
Goals			
• Patient Goals			
Health Concerns			
Immunizations			
Laboratory			
• Tests	• Values/Results		
Medications			
• Medications	• Medication Allergies		
Patient Demographics			
• First Name	• Last Name	• Previous Name	• Middle Name (including middle initial)
• Suffix	• Birth Sex	• Date of Birth	• Race
• Ethnicity	• Preferred Language	• Current Address	• Previous Address
• Phone Number	• Phone Number type	• Email Address	
Problems			
Procedures			
Provenance			
• Author Time Stamp	• Author Organization		
Smoking Status			
Unique Device Identifier(s) for a Patient's Implantable Device(s)			
Vital Signs			
• Diastolic Blood Pressure	• Systolic Blood Pressure	• Body Height	• Body Weight
• Heart Rate	• Respiratory Rate	• Body Temperature	• Pulse Oximetry
• Inhaled Oxygen Concentration	• BMI Percentile (2-20 years)	• Weight-for-length Percentile (Birth - 36 months)	• Head Occipital-frontal Circumference Percentile (Birth - 36 months)

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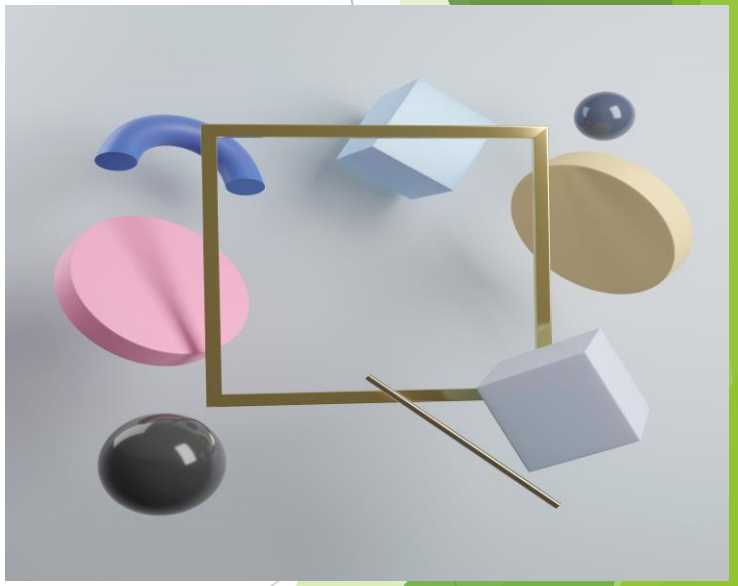
Learning from Our Mistakes

- Significant costs and patient safety issues can be partially attributed to EHR search limitations
- We no longer can do three-letter & DOB only searches!
- We can *Avoid Repeating the Same Mistake* again
- AHIMA Recommended Data Elements for Capture in the MPI



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Name provided at Registration	Legal Name Verified on Government ID	First Name Field	Middle Name Field	Last Name Field
Harvey Garcia Rodriguez	Harvey Davis Garcia-Rodriguez	Harvey	Davis	Garcia-Rodriguez
C Nguyen	C N Nguyen	C	N	Nguyen
Wayne Martinez	R D Wayne Martinez	RD	Wayne	Martinez
George Jones	George 7 Jones	George	7*	Jones
Elena Lusk	Elena Lusk			Lusk
Patty Anderson		Patty		Anderson
Madonna	Madonna	Madonna		Madonna

Note: Health IT systems should be evaluated for inclusion of numeric values in name fields.

Suffixes

Legal Name Verified Government ID	Data Entered in First Name Field	Data Entered In Middle Name Field	Data Entered in Last Name Field	Data Entered in Suffix Field
James R. Billings Jr.	James	Randolph	Billings	JR
Charles Wayne Miller III	Charles	Wayne	Miller	III

Sex and Gender

- Patient Identified Sexual Orientation
- Sex Assigned at Birth
- HL7 International Standard Publication
- FHIR Standards & Mapping Guidelines
- Ensure Registration Procedures include patient self-identified
- Sex assigned at birth (separate field)
- Legal sex (government-issued ID)

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Best Practices, Policies, and Procedures

- From paper to electronic
- Standardized demographics
- Review, update and implement patient access, interoperability, API and information blocking related patient request workflows, policies, procedures and forms
- Review and revise P&Ps as necessary to meet the information blocking requirements

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Leading with Interoperability

- EHR Interoperability is here and expanding rapidly
- Patient facing APIs and requests will continue to grow
- Assessing your current state will help you begin your journey
- Focus on data integrity and governance
- MPI & demographic accuracy are crucial to patient safety & compliance

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Conclusion

- ePHI and PHI are considered EHI
- EHI is defined per HIPAA as DRS
- LHR and DRS may or may not be the same– Must be defined by the organization
- Changes are coming, be prepared

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Actionable Trends

- 21st Century Cures Assessment
- Assist Providers with chart completion
- Work with your EHR Vendor
  - Ensure they are ready for 12/31/2023
  - Understand how segmentation and confidential information is stored
  - Be prepared for API connectivity
- Update policies
- Create a DRS policy – hint: use the USCDI

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QUESTIONS?

THOUGHTS?

Concerns?

References

- file:///C:/Users/dprimeau/Documents/Presentations/AHIMA%202021%20Virtual%20Conference/Trends-in-EMR-Interoperability_CHIME_KLAS.pdf
- https://www.nextgen.com/blog/2020/january/integrated-care-interoperability
- Federal Register :: 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program (Information Blocking examples – proposed rule)
- CARIN Alliance Code of Conduct: https://www.carinalliance.com/our-work/trust-frameworkand-code-of-conduct/
- ONC Model Privacy Notice: https://www.healthit.gov/topic/privacy-security-andhipaa/model-privacy-notice-mpn
- More information visit https://www.cms.gov/Regulations-andGuidance/Guidance/Interoperability/index

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- file:///C:/Users/dprimeau/Documents/Presentations/AHIMA%202021%20Virtual%20Conference/HealthIT_EnhancedPatientMatching_Report_FINAL.pdf
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- https://www.cms.gov/files/document/scoring-methodology-fact-sheet-2021.pdf

Thank You!

Kristen Borth, MS, RHIA

Feel free to contact us:

info@primeauconsultinggroup.com

Primeau Consulting Group

Thank you to our Business Partners!

Lunch Presentation - Regional update - What HFMA can do for you.

hfma healthcare financial management association

Presented by:

Lisa Kirk, Regional Executive 2 / VP Sales- HFMA Region 10 - Professional Credit

Lisa Kirk, Regional Executive 2 / VP Sales- HFMA Region 10- Professional Credit

Lisa has been a member of the Idaho Chapter of HFMA for 15 years, serving as President for the Chapter in 2017-18. She joined HFMA's Region 10 Regional Executive (RE) team in 2022 and currently serves as RE 2. In her "day job" Lisa leads a sales team for Professional Credit, an HFMA Peer Reviewed debt collection agency. In her free time, Lisa stays busy attending her 11-year old son's baseball and football games and 7-year old daughters baseball and dance classes. When not watching her kid's activities, Lisa enjoys snow skiing together with her kids and husband.

HFMA Regional Update

What HFMA can do for you

hfma™

Lisa Kirk

- 15 years experience in patient accounts recovery
- Region 10 Region Executive Team (2022-2025)
- Member of Idaho Chapter, President (2017-18)
- Recipient of the Bronze Follmer, Reeves Silver and Muncie Gold Merit Awards, Medal of Honor

LISA KIRK
PROFESSIONAL CREDIT

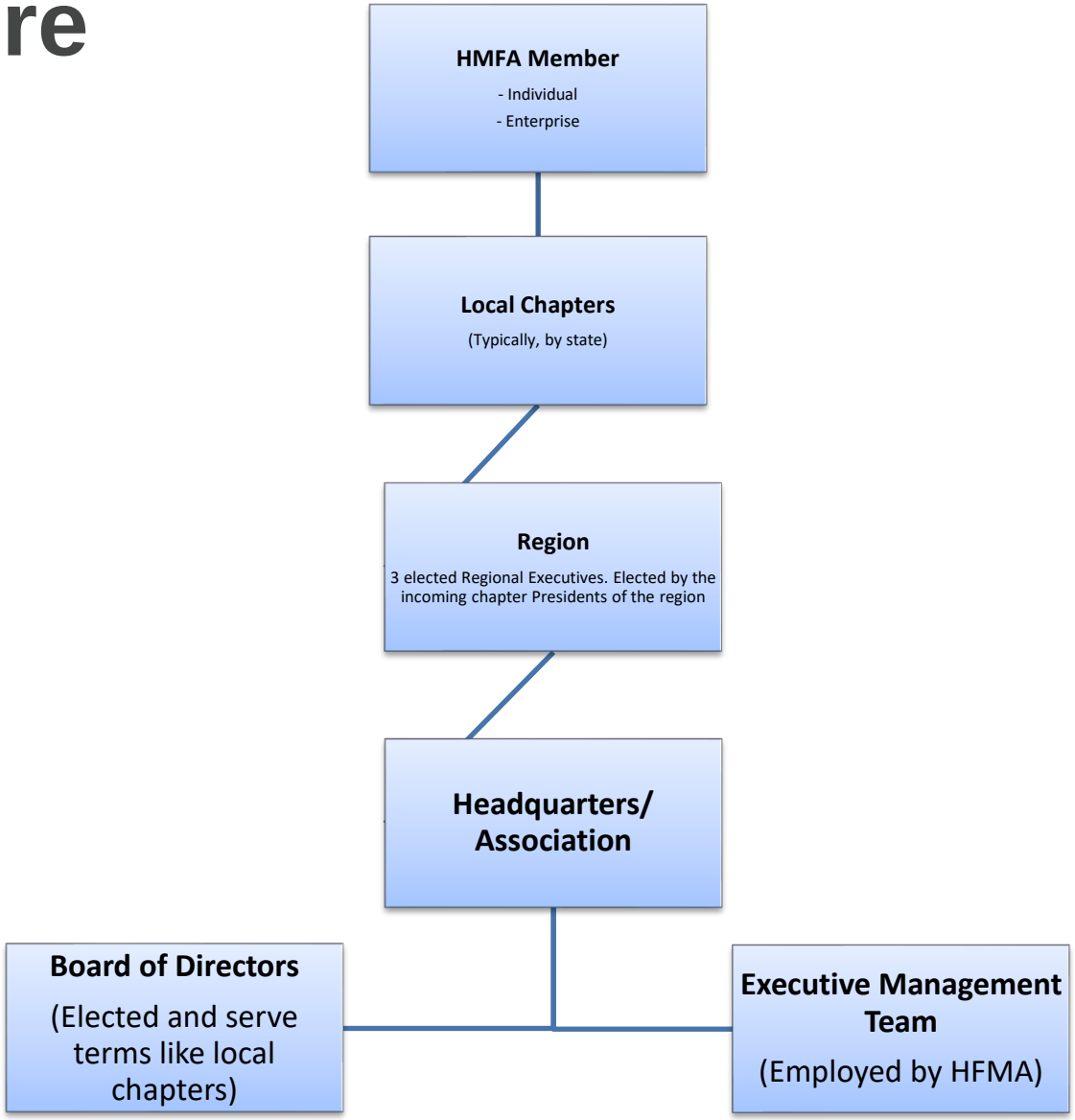
Vice President of Sales

360-567-4985
Lkirk@professionalcredit.com

Today’s Presentation

1. HFMA Organizational overview
2. Regional Executive Role
3. HFMA initiatives
4. Western Region Symposium 2023-Region 10 & 11 Joint Conference

HFMA Structure



Professional Membership Association – serving both individuals and organizations

103,000+

MEMBER COUNT AS OF APRIL 2023

95%

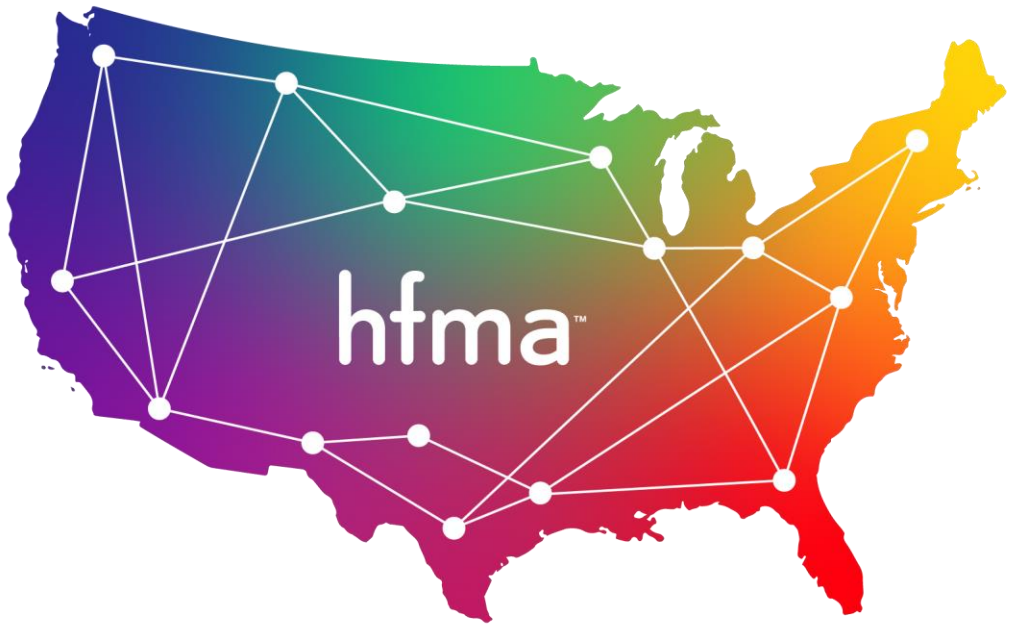
ENTERPRISE MEMBERSHIP RETENTION RATE AS OF FEBRUARY 2023

88%

MEMBERSHIP GROWTH FROM JUNE 2020 TO FEBRUARY 2023

Our Members Belong to 59 Local Chapters

Chapters and Regions



REGION 1
- Connecticut
- Massachusetts-Rhode Island
- Northern New England

REGION 2
- Empire New York
- Metropolitan New York
- Puerto Rico
- Rochester Regional

REGION 3
- Central Pennsylvania
- Metropolitan Philadelphia
- New Jersey
- Northeastern Pennsylvania
- Western Pennsylvania

REGION 4
- Kentucky
- Maryland
- North Carolina
- Virginia DC
- West Virginia

REGION 5
- Alabama
- Florida
- Georgia
- South Carolina
- Tennessee

REGION 6
- Central Ohio
- Michigan Great Lakes
- Northeast Ohio
- Northwest Ohio
- Southwestern Ohio

REGION 7
- Greater Illinois
- First Illinois
- Indiana Pressler Memorial
- Wisconsin

REGION 8
- Greater Heartland
- Iowa
- Kansas (Sunflower)
- Minnesota
- Nebraska
- North Dakota
- South Dakota

REGION 9
- Arkansas
- Lone Star
- Louisiana
- Mississippi
- Oklahoma
- South Texas
- Texas Gulf Coast

REGION 10
- Arizona
- Colorado
- Idaho
- Montana
- New Mexico
- Utah
- Wyoming

REGION 11
- Hawaii
- Nevada
- Northern California
- Oregon
- San Diego – Imperial
- Southern California
- Washington - Alaska

Region 10-Regional Executive Team

Chad Krcil
Regional Executive
Colorado Chapter

Lisa Kirk
Regional Executive II
Idaho Chapter

Kelly Akkerman
Regional Executive III
Montana Chapter

Regional Executive Role

The Regional Execute is a key volunteer leadership position that exists to:

- **Serve as the primary volunteer leader between volunteers at the local level and foster dialogue with Association**
  - Monthly calls with Chapter leaders and Association Staff
  - Live in person meetings at Volunteer leadership meeting, LTC and Western Region Symposium

- **Assist chapter leaders in serving members**
  - Work with chapters on strategic planning on important initiatives through development of Chapter Success Plan
  - Best practice discussions on Member Engagement, Volunteer Engagement, Succession Planning
  - RE visits to Chapters for engagement with Chapter officers, board members and Chapter members
  - Promote Chapter Success Award submission to celebrate Chapter successes

- **Lead change efforts to drive HFMA's strategies and represent Chapter leaders at REC and with National Board and staff**
  - Involvement in REC monthly calls with all Region's REs and Association staff
  - Live meetings with all Region's REs, Association staff and Association Board members and offices
  - Development of Davis Chapter Management System Policy
  - Update the Chapter Success Dashboard

- **Encourage chapters to collaborate and help other chapters**
  - Monthly meetings with Chapter leaders discussing best practices by Chapters
  - REC meetings with all Region leaders with discussion on Region successes and implementing actions in all Chapters

- **Promote Regional Events and Multi-Region Events**
  - Western Region Symposium (WRS)-RE 10 & 11 Joint Collaborative Multi-Region Event
  - Region 10 Webx Series
  - Rural Health Conference held in July 2023 and now planned for Annual Virtual Conference
  - Promote Certification Program both at Chapter levels as well at Multi-Region Events through bootcamp certification sessions
  - Promote Region Success Award submission to celebrate Region Chapter collaboration successes

HFMA

Ann Jordan

President and Chief Executive Officer, HFMA

Membership Benefits

Included with HFMA Membership

Professional Certifications

E-Learning Courses + Webinars

Community

E-Newsletters

Member-Only Content

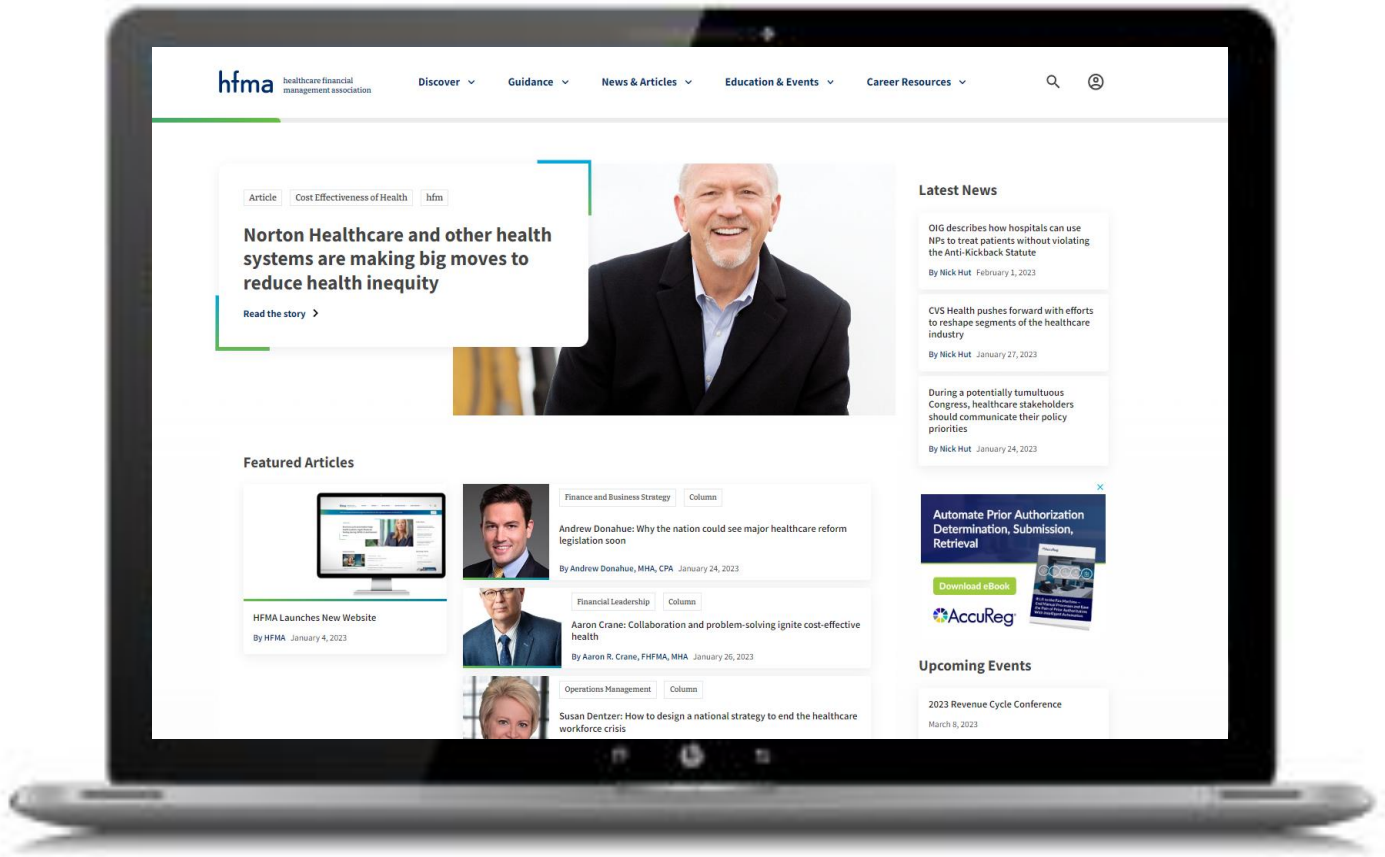
Certifications

Why get HFMA certified?

- Establishing and maintaining a clear competitive edge is a prerequisite for today's changing economy
- Gain and demonstrate your edge by enhancing your knowledge and proving proficiency with HFMA's certification program
- Explore and choose your area of focus from the wide-range of certification options available to you.
- Increase credibility - An HFMA credential validates that you have the education needed to succeed in your field
- Position a person for advancement - Show your manager you are committed to staying up to date in your profession.
- Differentiate an earner in the job market - Maintain the proficiencies leaders in the field are seeking to meet their organizational goals

Online Member Home

- New website launched January 2023
- Bold new layout and design
- Updated navigation
- Enhanced search
- Personalized experiences when logged in



hfma.org/newsite

News, Strategies, Insights

hfm magazine

- Health systems are making big moves to reduce health inequities
- The role of community partnerships in reducing cost of care and improving health outcomes
- How to support underserved patients through in-home care
- Susan Dentzer: A national strategy is needed to end the healthcare workforce crisis
- Jill Geisler: Resolve to upgrade your communication in 2023

Read the current issue

Winter 2022

November 2022

October 2022

September 2022

Summer 2022

May 2022

April 2022

March 2022

Download app to read on your device.

GET IT ON Google Play

Download on the App Store

E-Newsletters

- HFMA Daily
- Revenue Cycle Insights
- Cost Effectiveness of Health Report
- Leadership
- Healthcare Finance Strategies

Guidance: Reports + More

Regulatory and Accounting Resources

Healthcare Dollars & Sense

Value Project

Patient Friendly Billing

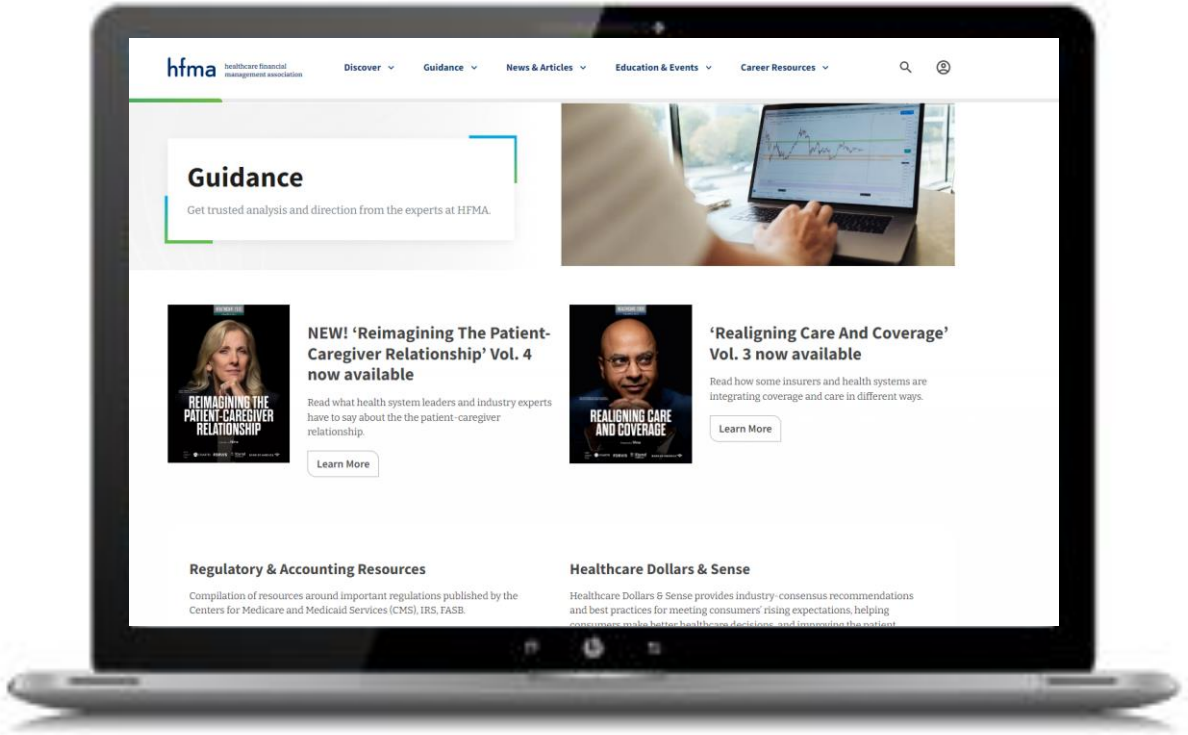
Healthcare 2030

Consumerism Maturity

Research & Trends

Claim Integrity

Special Reports from HFMA's Thought Leadership Retreat



Data + Insights

Salary + Compensation Data

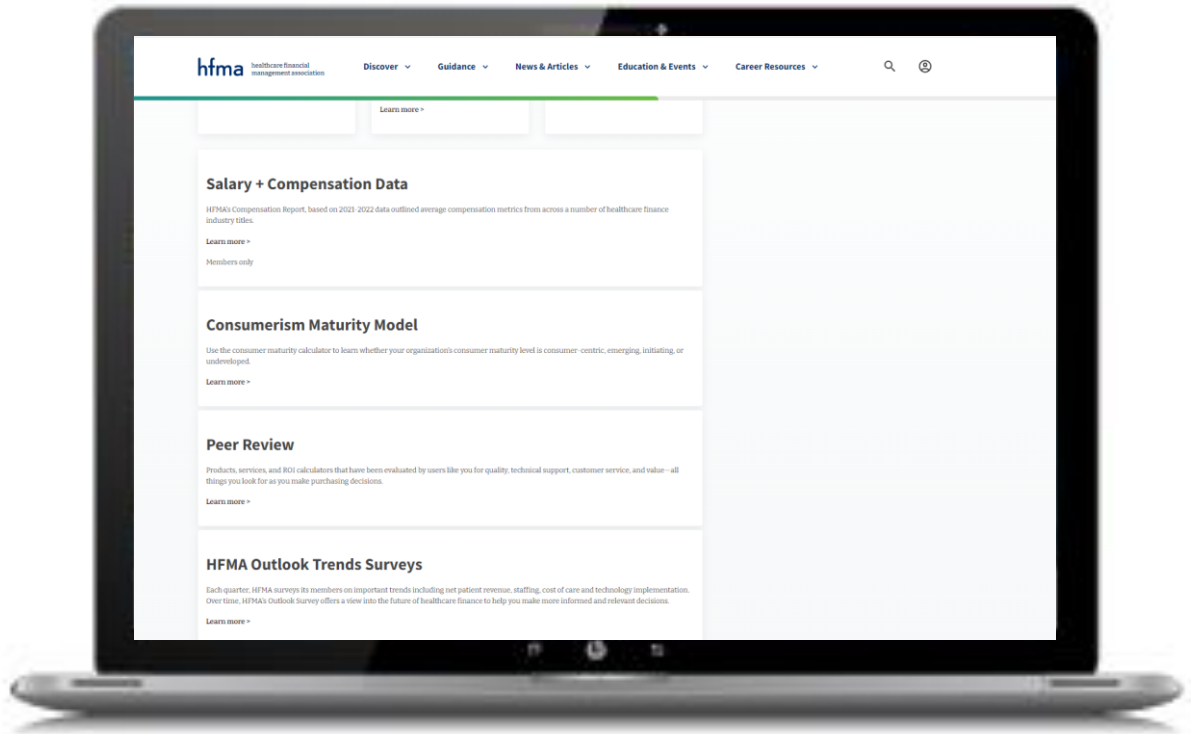
Consumerism Maturity Model

MAP Award Score Calculator

HFMA's Peer Review

Outlook Trend Surveys

+ more

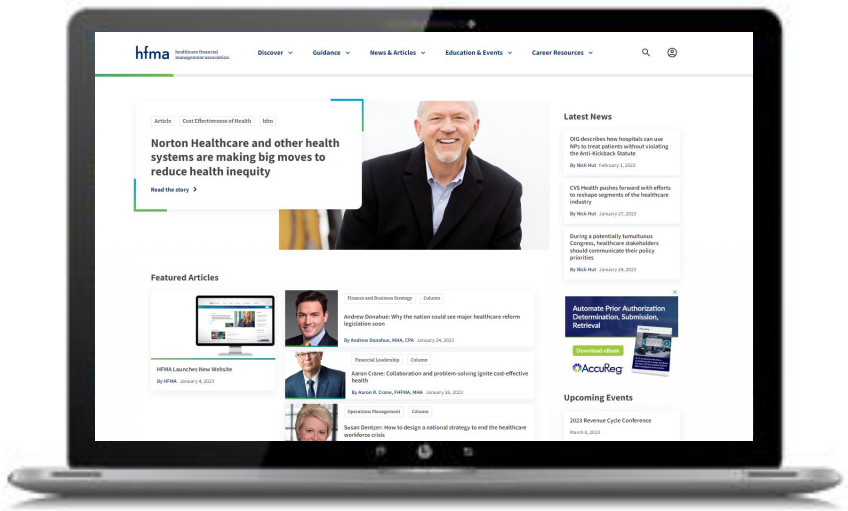


HFMA's Podcast Series

Insights from leading experts on a range of topics in healthcare finance

hfma.org/podcast

Connect: Stay in Touch



hfma.org

HFMA Daily

Community

Social Media

2023-24 Initiatives

One HFMA

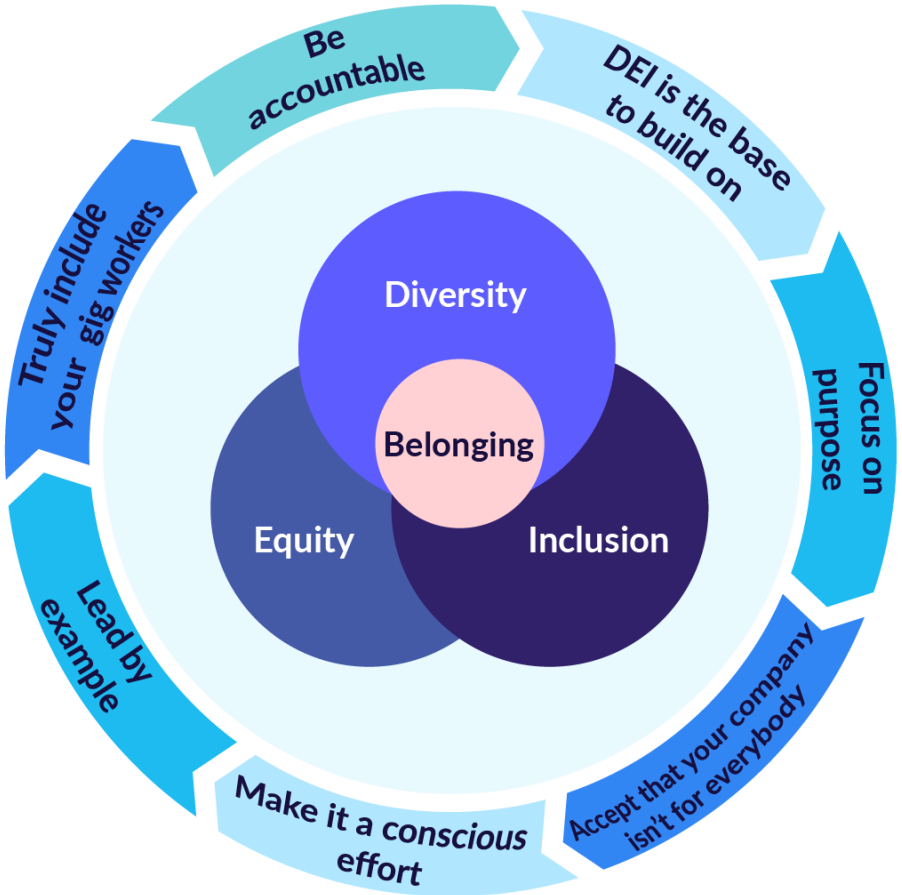
- Ensuring a consistent volunteer experience
- Reduce duplication of efforts between Chapter Volunteers and Association staff
  - Pre-Conference-Event creation, webpage, social media ad
  - Event Support-Technology Support
  - Post Conference-Feedback Survey, Certificate of Attendance, Attendee list
  - Conference App Assistance
  - Contract Review
  - Sponsorship Assistance
  - Networking Event
  - Marketing and Communication
  - Website Creation
  - Chapter Ballots
  - Chapter Engagement Awards
- Chapters focus on innovation, collaboration and increased member value

Greater Focus on DEI at the Chapter Level

Diversity, Equity, Inclusion and Belonging (DEIB) at Organizations

Welcoming and representation of different dimension of diversity

Feeling accepted as members of a group, valued, and connected with the company



Ensuring that all individuals have access to the same opportunities and that they are treated fairly

Building a work environment where everyone's thoughts, ideas, and perspectives matter

AIHR ACADEMY TO INNOVATE HR

hfma

DEI Task Force

Findings, Recommendations & Changes

Findings

1. HFMA membership reflects the racial composition of the nation as a whole.
2. Nearly eight in 10 (78%) of members believe their workplace culture fully embraces/is actively working toward better DEI.
3. Consistent with the survey findings on workplace culture, 82% of members describe their position on DEI as supportive/engaged.
4. Overall, 93% of members believe that HFMA members from all backgrounds and with a range of identities have equitable access and ability to use HFMA's membership resources.
5. HFMA is perceived as cultivating a welcoming and inclusive environment for all members.

*Based on over 5,000 surveys results from HFMA members

Recommendations

1. Encourage belonging at the local, regional and association level.

- Outline and share guiding principles to guide local efforts.
  - Discipline, courage and perseverance
  - Growth movement for everyone as an association
  - Emphasis on equity and inclusion
  - Equity equals access to resources to be a success in life
  - Continue to focus on healthcare finance and revenue cycle

Recommendations / Changes

2. Encourage engagement (e.g., attendance at meetings, volunteer opportunities, broader participation)
   - Create awareness and sharing key takeaways and considerations to help local chapters.
     - Outreach and partner with minority associations/institutions on programming (examples include though not limited to: the National Association of Health Services Executives, National Association of Latino Healthcare, National Association of Hispanic Healthcare Executives, Black Directors Health Equity Agenda)
     - Encourage diverse speakers
       - Diverse subject matter experts
     - Inspire emerging leaders Student engagement (share best practices)
       - Succession planning
     - Promote leadership awareness
       - Not DEI training –continue focus on finance, revenue cycle, etc.
       - A current topic could include workforce challenges
     - Incorporate into Chapter Success Plan
       - Add element
       - Submit initiative to Regional Executive (at the Association level)
       - Capture data to determine future recognition
     - Facilitate data collection and better practice sharing
       - Encourage targeted data collection to gain insights on chapter level inclusion efforts
       - Encourage better practice sharing (e.g., toolkits) among chapters to build on successful practices vii. Continue dialog with Regional Executive Council by having regular discussions on agenda. The Board Liaisons and staff to the Regional Executive Council will bring pertinent areas of consideration to the HFMA Board of Directors, as needed.

Recommendations / Changes

3. Identify barriers in our existing structure

- **Below are issues identified that can be addressed over time (these were not prioritized by the Task Force/Regional Executives at this time)**
    a) Membership dues
    b) Risk of politicization of the issue
    c) Lack of tools and resources
    d) Sharing of chapters' better practices should be considered
    e) Budget and volunteer burden
    f) Turnover and transfer of knowledge
    g) Acceptance
    h) Current culture
    i) Lack of data
    j) Provider scholarship –Sponsors only want decision makers
    k) Requirements for succession at the local and regional level
    l) No accountability –Consideration to build into Chapter Action Plan
    m) In-person vs. Meet-up opportunity (virtual, webinar or other)

2023-24 Initiatives

- **Membership Growth (Individual and Enterprise)**
  - Focus on Individual growth and incentives for membership such as certification, growing professional network and developing marketable professional skills and knowledge
  - As Enterprise membership continues to grow Chapters must find ways to engage these members to be active and meet the organizations goals
- **Engagement (Member and Volunteer)**
  - Enhance engagement activities-Networking, live even planning, on-line education, certification programs
  - Rethink the volunteer experience with new opportunities for involvement with a more concise path to Chapter leadership
- **Succession Planning**
  - Identification of volunteers wishing to become Chapter Leaders –Volunteer interest survey, volunteer coordinator
  - Knowledge transfer instruments and documentation
  - Identification of new members and their volunteer aspirations

Get Involved

Get Involved!

- Attend local and national educational events
- Take advantage of networking opportunities
- Write an article
- Speak at an HFMA local or national event
- Participate in national workgroups
- Volunteer for your local HFMA chapter and pursue leadership opportunities
- Contribute to the HFMA online community
- Get certified
- Refer your colleagues

Why Volunteer?

Volunteering for your professional association is a great way to enhance your career, expand your connections and have fun!

Other reasons to volunteer include:

- **Learn and develop new skills**: Enhance leadership, communication and relationship-building skills by engaging with others.
- **Gain valuable experience:** Volunteer experience shows employers that you are a respected, contributing member of your professional community.
- **Expand your network:** Meet like-minded professionals and build long-term personal and professional relationships.
- **Increase your visibility:** Participating as a volunteer exposes you to others in the industry, including hiring managers and recruiters.
- **Strengthen your resume:** Volunteer experience always bolsters a resume and reinforces your commitment to the profession.

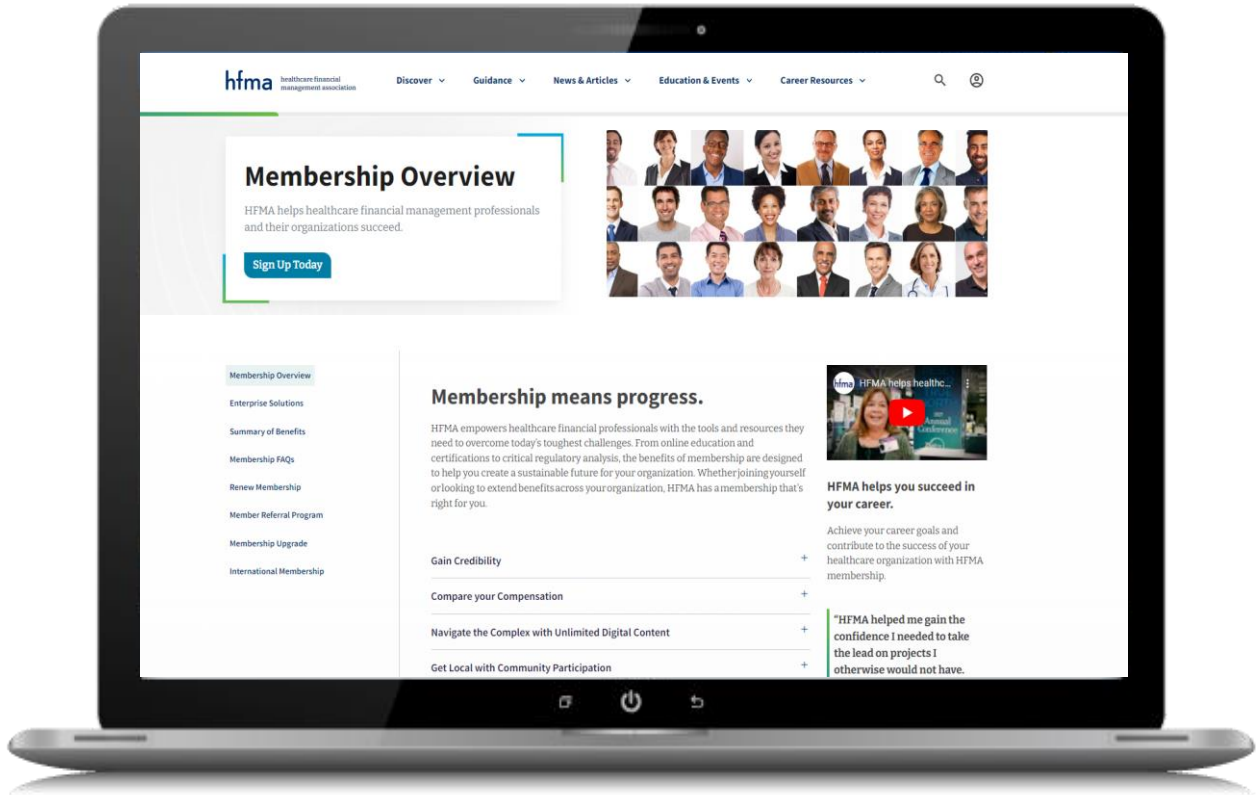
When you belong to HFMA

Easily find & discover
relevant information

Access
what you need when you need it

Navigate
the complex healthcare environment

Belong & engage
Collaborative opportunities & communities to actively



hfma.org/membership

Western Region Symposium

Western Region Symposium

25th Annual Western Region Symposium

Educate **Connect** **Motivate**

- Amazing networking opportunities
  - 2023 WRS had over 900 attendees
  - Over 40% of attendees where decision makers from healthcare providers
  - Connect with peers from hospitals, health plans, physician practices and others in the healthcare setting
- Relevant and compelling Education
  - Keynote Speakers
  - Revenue Cycle Track
  - Finance Track
  - Critical Access Hospital
- Sponsorship-One of the largest exhibition areas for Business Partners to showcase product and services through booth presence and individual sponsorship opportunities
  - Increase brand recognition
  - Promote product and services
  - Generate leads and position your organization as thought leaders
  - Spark new conversations with possible new customers

WRS-Provider Incentives

hfma.org

Thank you to our Business Partners!


DRAWINGS