Fine Print

THE OFFICIAL NEWSLETTER OF THE WESTERN NEW YORK CHAPTER OF HFMA

Winter 2017

President's Message

Ryan Caster
2016 - 2017 Chapter President

First off, I want to wish everyone a Happy New Year! I hope everyone had a safe and happy holiday season. A new year always brings with it a sense of excitement – whether it's a resolution to start the new year or an opportunity to hit the reset button. This year is undoubtedly no different, but with this new year also comes uncertainty around our industry as we welcome the 45th President to the White House. While it is still unclear as to what the change in Presidency will mean to the industry, one thing is certain, we will have plenty to contemplate in the coming months.

We have completed another successful sponsorship campaign! I would like to thank those organizations that continue to sponsor the Western New York chapter, as well as to welcome the new sponsors. Without your support, we would not be able to offer the number of education and social events that we do! I would also like to thank Joe Romano and Chirico Rozsa for coordinating this year's campaign!

Speaking of education events, our Empowering Your Personal Brand session was held on January 19th at the Foundry in Buffalo. Somewhat of a different event for us – attendees were treated to sessions on self-transformation, stress management and personal branding, topped off with massages and a happy hour! Thank you to Steve Chizuk, Chelsey Kelchlin and the rest of the education committee for putting on this event!

On Wednesday, January 25th, we will be having our annual CDM Update session. This year's event will once again be at Classics V. Jean Russell and her team from Epoch Health will once again be the facilitators of the session.

In addition to these live sessions, we also have a number of upcoming webinars. As a reminder, these are all free of charge and are an easy way to bank CPE hours without having to leave the comfort of your office! Please check the website for dates and times.

Finally, I just want to wish everyone one last happy new year and I look forward to the second half of my year serving as the Chapter's President!

Ryan E. Caster, President

Welcome New Members!

Catherine Ackerson
Regional Sales manager
Commercial Banking
Wells Fargo

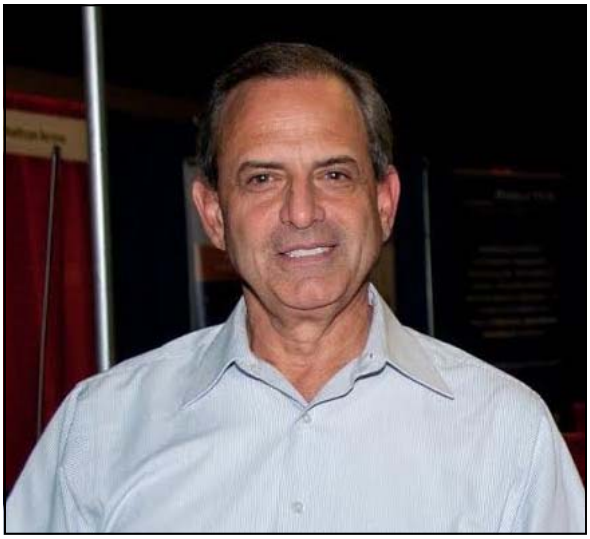
Brandon Biskup
Senior Accountant
Dent Neurologic Institute

Donna Hopkins
Professional Billing Manager
Erie County Medical Center

Kayla Kaufman
Executive Assistant to CEO
Invision Health

On December 22nd, one of our WNY HFMA Chapter members retired.

Suzanne Roccisano



Russ Previte, FHFMA, CPA has been a member of HFMA since 1990. He has always been an active voice in HFMA, an advocate for so many of the important issues that have faced us. He has been a mentor and for all of us, a great resource when we needed help. Many of us remember Russ from his days at Blue Cross where he was the Director of Contracting and also Provider Reimbursement. Back then, it was unusual for someone from an insurance company to be a part of the Chapter. But then, in 2000 Russ left Blue Cross and joined the ranks of Director of Reimbursement and Budget at Mount St. Mary's. He will leave his job with the Catholic Health System as Director of Reimbursement.

Russ has been tireless in his involvement with our chapter. He has served as Co-chair of the reimbursement committee for many years. He was President of our chapter in 1998-1999. In addition, he received the second Paul Sweet Memorial Award in 2015 as well as the Medal of Honor in 2005.

Russ will be leaving healthcare to spend time with his family. He has 2 new grandchildren on the way. And, did you know.....that Russ performs in 3 bands in the WNY area? You can usually find him performing with either Penelope, Everyday People, and New2LA .

The following notes are from Joe Romano, Reimbursement Manager, Eastern Niagara Hospital:

> One thing about Russ is, he was always willing to help you, no matter how busy he was, he always made time for his family, friends and co-workers. He was very dedicated and loyal, and always wanted to learn more, no matter how accomplished he was. He had earned the respect and admiration of his peers, whether it was as an Assistant Director at Blue Cross Blue Shield, or in his position as Director of Reimbursement at Mt. St. Mary's Hospital or at the Catholic Health System. He was also a very down to earth person, and probably one of the easiest individuals to sit down with and have a conversation with. In addition to enjoying time with his family and friends, he is a passionate musician and an avid runner. He enjoys running on a daily basis, and on any given weekend you will find him running in a variety of 5K's throughout the area. He is going to be missed and will leave an indelible void in the western New York health care community!

If you want to send Russ your good wishes, his home email is Russs595@aol.com and cell phone is 909-1075. Russ, you are a kind and gentle soul. Your knowledge and your helpful nature will be missed. We all wish you well in your retirement. You have earned it. And thank you for your service to HFMA.

Annual Institute and Holiday Party

Steve Chizuk & Chelsey Kelchlin

This year's Annual Institute and Holiday Party was hosted at Templeton Landing on December 1st. The event had a very similar setup to last year as we paired it with our holiday party. It was an all-day event comprised of many topics. Russell Davis of The Advisory Board Company gave an annual State of the Union. Unfortunately, with the election just being held a month before, there was little in the way of solid facts. The unexpected win of Donald Trump left many of his colleagues amazed and unprepared for what is ahead. A lot of the discussion was based on hypotheticals of what could be. It will make our jobs very interesting in the next year or so. I want to thank Freed Maxick for their generosity in sponsoring The Advisory Board Presentation.

Sanath from Freed Maxick followed The Advisory Board with a Cyber Security Update. I appreciated him bringing complicated technical matters down to the level that we could understand. Reinforcing it with real life example portrayed in the news brought on a sense of alarm. Technology has brought us both immense benefits and threats.

After lunch and vendor fair we changed gears and had a comedic speaker talking about Communication Bleeps and Blunders. We typically don't have a speaker of this nature but I thought it was a refreshing pick me up after what usually comes from weighing yourself down after lunch. I want to give a special shout out to those who discovered how anal retentive they really are.

Continuing the event was Christian from Salucro with his presentation "When did the Front-End Get all the Cool Tools?" The presentation was in a case study format and gave a nice look into real organizations and what they had to do in order to succeed in the world of Revenue Cycle. Personally being outside of that world I still thought the examples he provided got you thinking about the unique challenge the front-end has pulling everything together.

The last speaker of the day was Jeff Gold from HANYS giving a New York State Update. Similar to the Advisory Board there was still the fear of the unknown. I personally enjoy his open dialogue and candid comments. His ability to take a political conundrum to a number of talking points is an art.

Thank you for all that could attend. I hope that you got something out of the day. For the members that could not attend, we missed you and hope that you can find time to attend next year. The event isn't just about education but also a chance to connect with your colleagues in the industry. The chance to share knowledge and cooperate is way to enhance our not only ourselves but our field.

I want to especially thank the sponsors of the event. Without you and your continuing commitment we wouldn't be able to provide the educational commitment we are in business for.

Annual Institute and Holiday Party Photos

Steve Chizuk & Chelsey Kelchlin

Reimbursement Committee Update

Joe Romano, Committee Chair
Jim Stabel, Committee Co-Chair

The Western New York HFMA Reimbursement Committee will be dealing with several reimbursement issues over the next few months.

2015 ICR Audit Tool

KPMG expects to commence fieldwork February 2017 after the completion of the DSH Audits. However, they have suggested to providers that they could commence field work as early as November 2016 ahead of the start of the DSH work, if providers would prefer that.

2013 Medicaid DSH Audit Tool

Hospital access to the on-line tool began November 1, 2016 and the deadline for the DSH Tool completion and submission of supporting documentation was November 30, 2016. KPMG expects to commence audits on December 1, 2016 with completion anticipated by January 31, 2017.

FFY 2018 Medicare Wage Index

Medicare is currently auditing the 2014 wage index, which will be used for FFY 2018 rates. February 17, 2017 is the deadline for Hospitals to submit requests for either 1.) Corrections to errors in the January PUF's due to CMS or MAC mishandling of the wage index data, or 2.) Revisions of desk review adjustments to their wage index data as included in the January PUF's. MAC's must receive the requests and supporting documentation by this date.

For further information regarding any of the above activities, contact Reimbursement Committee Chair Joe Romano at 514-5881 or JRomano@enhs.org or Co-Chair Jim Stabel at 828-3751 or jstabel@chsbuffalo.org.

The Future of Rural Health Care: Challenges and Solutions

Brett Murphy, Vice President, Lancaster Pollard

Few topics are as emotional and personal as health care. Imagine your child breaking an arm playing football in the backyard, your mother calling to relay some bad news about your father's health after a visit to the doctor or your sibling telling you about an upcoming battle with cancer. Fear, anger, sorrow, uncertainty and other emotions flood over you instantly. It's inevitable that everyone will face health care issues in one form or another.

But rural Americans are suffering unique health care challenges that urban residents typically do not face. Simply accessing health care can be a significant hurdle for many. Even more challenging may be finding affordable care.

Defining Rural

The U.S. Census Bureau identifies two categories of urban areas: the first is an urbanized area of 50,000 or more people, including cities and metropolitan areas; the second is an urban cluster of at least 2,500 and less than 50,000 people, including suburbs and large towns. Rural encompasses all population, housing, and territory not included within either of the designated urban area definitions. According to 2010 census data, approximately 20% to 25% of the U.S. population lives in rural areas.

Typical demographic trends of rural areas include lower median incomes, a high proportion of seniors, higher acuity levels and lower life-expectancies. Based on 2010 census data, per capita income is on average $7,417 lower in rural areas than in urban areas, and rural Americans have a higher likelihood of living below the poverty level. According to the Rural Health Foundation, nearly 24% of children in rural areas live in poverty. And as younger residents leave home to attend colleges and universities, or seek employment in urban centers, the remaining population in the rural communities they leave behind becomes older. The fastest growing age cohort in rural America are residents 85 years old and above.

Rural populations typically have high numbers of lower income and aged residents, and there are specific ailments that impact these communities at a higher rate than urban communities. Obesity, lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease are statistically more common in rural areas. Finally, the gap between urban and rural life expectancies is growing. According to a 2014 study published in *American Journal of Preventive Medicine*, consistent overall increases in U.S. life expectancy was noted during the past 40 years, from 70.8 years in 1970 to 78.7 years in 2010. However, the study reveals the rural-urban gap widening from 0.4 years in 1969 to 1971 to 2 years in 2005 to 2009.

To make matters worse, the providers of rural health care suffer alongside the populations they serve. From reimbursement cuts to a suffocating regulatory environment, smaller facilities located outside urban and suburban population centers have a more difficult path to managing cash flow and scaling fixed costs. This article will focus on two of the primary challenges that both residents and providers face in rural communities.

Challenge One: Access to Health Care

In most U.S. cities, access to physicians and hospitals is a quick drive, a cheap public transit fare, or a taxi ride away. However, people in rural settings are likely to live further away from health care providers, particularly specialist services. Additionally, the deficiency of dependable transportation can be a barrier. Transportation services that exist in urban areas are often lacking or non-existent in rural areas.

Besides the geographical barriers to accessing health care, there are fewer providers. As noted earlier, about 20% to 25% of the population is rural; however, only about 10% of physicians practice in these communities.2 Ask any rural hospital or skilled nursing CEO to list the top issues in the industry; most would likely tab finding qualified staff as a key concern. Per *Healthy People 2010: A Companion Document for Rural Areas*, a project funded by the Office of Rural Health Policy, more than 33% of rural Americans live in “health professional shortage areas,” and nearly 82% of rural counties are classified as “medically underserved areas.”

Compounding these issues is the rate at which rural health care facilities are shutting down. The National Rural Health Association recently teamed with the University of North Carolina and iVantage, a health analytics firm, to conduct a study that identifies current and potential rural hospital closures. The ultimate goal is to identify potential closings before they occur. The research targeted approximately 2,000 rural hospitals across the country, and labeled 210 as "most vulnerable" with another 463 labeled as "at risk." Those dubbed “most vulnerable” could close any day, while “at risk” ratings are reserved for hospitals that may only last another few years without adjustment. Ultimately, closing these sites will not only have a negative impact on the access to care in the service area, but also eliminate a top employer in the community.

Challenge Two: Affordability

With a new presidential administration on the horizon, the future of the Affordable Care Act (ACA) is unclear. The general purpose of the ACA was to create more affordable health insurance for the uninsured, thereby reducing the drain on the health care system created by caring for uninsured. According to *The Affordable Care Act and Insurance Coverage in Rural Areas*, a 2014 report, rural populations have a larger proportion of low-income residents who could potentially benefit from the ACA to receive health insurance coverage.

However, approximately 66% of uninsured rural individuals live in states that chose not to expand Medicaid. In some states that chose to expand, the enrollment has far exceeded the projections, which has caused strain on the Medicaid funds from the state. Additionally, several national insurers have pulled out of the ACA state exchanges as their losses piled up. In some cases, to offset losses, premiums on employer-provided insurance plans have increased, creating strains on small businesses subsidizing these plans to employees. Limited employment opportunities combined with mounting health care premiums continue to drive costs higher. Ultimately, these factors equate to rural individuals having fewer affordable health insurance choices.

Aside from the ACA complications, Medicare payment systems and reimbursement practices typically do not acknowledge the distinctive situations of small and rural hospitals. These hospitals are disproportionately impacted by the continual cuts to Medicare reimbursements, including the bad-debt program and disproportionate-share hospital payments. At some facilities, the average age of plant for health care and hospital facilities far exceeds acceptable levels. Improvements to the physical plant and the demand for new information systems climbs, yet access to capital financing can be limited. Reinvesting in the facility is difficult with dwindling revenues and limited financing options.

Solutions and Paths Forward

Though the landscape seems bleak, not all hope is lost. Many rural health facilities are using rural clinics, allowing them to open smaller yet impactful health care facilities across their service areas. This model allows for easier access to general care, but still limits the ability to access specialty care, such as cancer treatment centers or heart specialists. Accessibility is also being driven by new delivery methods, like telehealth, online prescription subscriptions, delivery services and 24/7 on-call doctors via the internet. Supplementing hands-on care with technology should allow greater access as long as communities become connected.

Health care organizations must also address affordability in expense reductions. Specialized consulting groups, such as Health Care Resource Group, focus on working with smaller rural facilities to navigate through difficult waters and improve operations.

A thoughtful capital structure is a good way for hospitals to address expense reductions through minimizing debt service payments. Several financing programs are available to rural hospitals that can address the need to reinvest their facilities through expansion, acquisition, rehabilitation, or even a modern replacement facility and meet the needs of the community. The USDA Community Facilities Program is reserved for rural non-profit organizations, including hospitals and skilled nursing facilities, and provides below market fixed-rate, long-term, non-recourse financing for construction and refinance. Other non-recourse financing solutions include the Federal Housing Administration (FHA) Sec. 242 mortgage insurance programs, which also provide agency-insured, long-term, fixed-rate debt at relatively high leverage points.

The aforementioned challenges in rural communities impact a significant portion of the U.S. on a daily basis. Simply accessing affordable health care is something the majority of the nation may take for granted. Without strategic financial action, our rural health care system will continue to face obstacles that severely inhibit community members from receiving necessary care.

Brett Murphy is a vice president with Lancaster Pollard in Chicago. He may be reached at bmurphy@lancasterpollard.com.

Upcoming Events Calendar - Region 2 Webinar

Visit our website at www.hfmawny.org for registration information.

February 3, 2017	**Joint Replacement Bundles**
February 7, 2017	**The New AP Strategy: Leveraging Automation and Working Capital Optimization to Generate Revenue**
February 16, 2017	**HCC Risk Adjustment - Revenue Concepts**
February 22, 2017	**OCR and HIPAA Updates 2017**
March 8, 2017	**How to Build the Business Care for AP Automation**
March 23, 2017	**Transforming CDI - The New Paradigm for Value Based Performance**
April 13, 2017	**How to Turn AP Into a Profit Center**

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For information on committee chairs and co-chairs, please visit our website at http://hfmawny.org/Directory.aspx

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If you have any questions or comments or would like to contribute to future editions of *Fine Print*, please contact: Jill Johnson (jjohnson@lumsdencpa.com) or Elizabeth Krause (ekrause@lumsdencpa.com).

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healthcare financial management association

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