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Data-Driven Patient Engagement: Self-Advocacy with the Help of a Personal Healthcare Portfolio

BY REBECCA BUSCH, RN, MBA, CCM, CFE, CPC, CHPA-IV, CRMA, CICA, FIALCP, FHFMA, AND PETER ELIAS, SENIOR DATA ANALYST

Patients often find themselves forced to make healthcare and financial decisions during the course of a healthcare episode. However, there is a distinct lack of comprehensive, technology-driven tools on the market that can truly be said to empower patients to make data-driven healthcare decisions.

When it comes to managing one's health, the concept of managing a financial portfolio can provide useful parallels. In finance, a portfolio is a collection of one's assets, typically categorized by type and accompanied by an assessed value. Examples of these assets may include stocks, bonds, cash, real estate and other alternative investments. A financial professional may be utilized to consult on financial goals customized for each individual. A financial portfolio provides the ability to manage and navigate one's personal wealth.

A healthcare portfolio is similar, except that it is an investment in our own human capital. Our ability to navigate our human capital requires a focus on receiving information impacting health and wellness across multiple categories, such as chronic conditions, surgical history, risk factors, allergies, etc. As a parallel to the financial professional, an evolving health infomediary specialist may be the ideal resource to assist patients in developing a personal health care portfolio. A health infomediary specialist is a professional who has training in understanding health information, respective financial billing statements, and navigating payer environment, and has an ability to research health access and delivery options.

The Personal Healthcare Portfolio Model[1]

The Personal Healthcare Portfolio (PHP) should be, at its core, patient-centric. The model should encompass a health data management guide and be optimized by the use of technology, in particular the technology that captures, stores and converts health information

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into actionable analytics. Many patient tools do exist, and organizations like The American Health Information Management Association (AHIMA) provides a list of resources that address some element of data collection. At minimum, a PHP should be used to create, manage, validate and update the patient's most critical health information. Doing this not only allows patients to identify their objectives, it also serves as a useful tool to measure and ensure they meet these objectives.

There are numerous benefits of data-driven health information management, including:

- Patient self-advocacy in a meaningful and productive way
- Helping patients arrive at the best informed healthcare decision(s)
- Selecting the right resources, at the right time, at the right price
- Avoiding adverse health events

A patient-centric, data-driven information management system (such as the PHP) allows the patient to accomplish many things, such as self-managing provided care, minimizing the risk of adverse events by being informed, and asking the right questions at the point of care to better manage costs. As healthcare professionals evolve in their use of EHR tools to manage patient care, offerings of patient tools and technology should be a parallel effort.

Assessing Data Management Capacities

Data-driven information management is a long and continuous process; thus, it is important to assess the data management capability of the patient. This provides an opportunity to evaluate the patient's readiness to manage their own health data. Understanding a patient's level of engagement, knowledge and ability to manage their own care can be a complicated process. But the strategic use of workflow charts, assessment tools and inventories of key stakeholders can make it much easier.

In general, patients find themselves categorized in any of the below mentioned data readiness categories depending on their scores from a gap assessment. The end goal is to reach the top categories where the patient understands how to navigate through an encounter and make data-driven decisions.

1. **Uninitiated –** When the patient is not clear on how to use the health plan provisions and does not have a knowledge of health and wellness status.
2. **Conceptual –** The patient is in initial planning stages with a basic knowledge of their current providers and history of care.
3. **Developmental –** Patient engagement is underway; the patient has fair knowledge of their current providers and has a documented history of care and ongoing treatments.
4. **Defined –** The patient is aware of the available tools, maintains their known medical history, and understands the healthcare plan-based offerings in relation to their personal needs.
5. **Achieved –** The patient has a comprehensive understanding of demographic information, history of payment activities and policy coverages and has often demonstrated the capacity to manage the process of maintaining a PHR.
6. **Enhanced –** The patient demonstrates behaviors consistent with being a healthcare data-driven consumer with an understanding of how to successfully navigate an episode of care.

Engaging Health Data Management

The next step in the data-driven *health management process is to identify a health data management strategy*. A good data management strategy is well documented, and objectives are identified by the patient to promote self-advocacy in collaboration with healthcare stakeholders (anyone influencing or directing care) and with consideration of resources and technology utilization. The data management strategy will define how the objectives are measured and evaluated and is a key to achieve data-driven health care management.

Collecting healthcare records is an important step and usually plays a significant role in identifying the *plan of care.* A patient can create an active wellness program that will help them establish a health financial plan. This enables a patient to assess and monitor their ongoing health care needs from a clinical and financial perspective.

Once the patient develops a data management strategy and defines the plan of care, the focus must be on establishing a PHP. A *health data management program* allows a patient to establish a PHP, and the health information collected by the patient allows them to establish and develop a portfolio. It is important that the PHP is updated regularly to empower the patient to effectively use the data in managing their plan of care.

Often, there are times when the patient might need additional assistance from other stakeholders like providers, specialists and financial advisors during the course of care. It becomes important for the patient to develop a *health data governance* plan to manage the access to their protected information. A health data governance plan allows patients to determine and validate a stakeholder's access to the patient's personal health information and other related content. Any PHP system should incorporate the patient's ability to define levels of access with each stakeholder involved in managing their care and information.

It is important to have a mechanism in which the patient can control levels of access to their personal health information. An effective PHP tool should be seamless from a user perspective on how the *health data architecture* enables patients to identify, define and govern their data.

Technological Framework

Technology plays a crucial role in managing a patient's health data. As such, a technology strategy needs to be defined and validated. It is important for a patient to identify the technological tool and data management strategy to effectively use their health data. Since the quality of collected data significantly drives decisions, it is important

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that the patient's data quality follows well-defined standards and benchmarks.

Another key aspect of defining a technology strategy is to make sure the health information is protected. Risk planning and mitigation is important, and fail safe mechanisms are always warranted since health data is invaluable. If proper precautions are not taken, Medical Identity Theft (MIT) can occur and have serious consequences for the affected patient.

As a high-volume cash industry, healthcare provides many lucrative opportunities for fraud, such as false billings, false claims, professional misrepresentation, accident crime rings, "pill-mill" schemes, and more. When a patient has their identity stolen, though, it can result in loss of benefits, denial of access to future healthcare services, exposure to medical errors (due to integration of the perpetrator's health data into the victim's health data) and unwarranted litigation, among other effects.

Key Takeaway

A successful data-driven patient requires the use of a PHP to self-advocate. The role of an infomediary specialist or case manager can facilitate the introduction of a PHP. A patient-focused healthcare data management system, in addition to a clear understanding of all defined objectives, improves the efficiency of the system greatly. Assessment of a patient's willingness and readiness to manage their personal health data is the first step towards achieving patient-centric, data-driven self-care.

About the Authors

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[1]Busch, R "Patients Healthcare Portfolio: a Practitioner's Guide to Providing Tools for Patients" CRC Press Taylor Francis Group 2017 Boca Raton Florida

The State of Nursing Innovation by 2025

BY KAREN MEADOR, M.D., SENIOR PHYSICIAN EXECUTIVE AND MANAGING DIRECTOR & GINA TAPPER, CLINICAL FELLOW AND DIRECTOR IN THE BDO CENTER FOR HEALTHCARE EXCELLENCE & INNOVATION

Produced by The BDO Center for Healthcare Excellence & Innovation in partnership with the University of Pennsylvania School of Nursing

When Diane Spatz first began working to more effectively promote breastfeeding vulnerable infants, it's unlikely she thought of it as an act of innovation.

Yet, innovating is exactly what she was doing when she turned her own extensive clinical experience as a nurse into a 10-step solution for improving the care of our most vulnerable infants starting life in the neonatal intensive care unit (NICU).

The process developed by Spatz, PhD, RN-BC, FAAN, Professor of Perinatal Nursing, and Helen M. Shearer, Term Professor of Nutrition at the University of Pennsylvania School of Nursing and Director of the Lactation Program at Children's Hospital of Philadelphia, has now been implemented in hospitals around the country and the world.

And it's proved successful. Before implementation, the percentage of NICU infants at Children's Hospital of Philadelphia receiving human milk at discharge was about 30 percent. In 2014, six years after it was implemented, more than 86 percent of NICU infants were discharged on human milk.

Spatz, and other nurses like her, are proof that nursing innovation—unleashed through human-centered design, expanded scope of practice, advanced education and executive leadership—is already happening.

We also know this to be true through our team of clinical and business innovation leaders who have seen nursing innovation gain speed over the course of their careers. We've worked with clinicians practicing at advanced levels and advising companies on product development, leaders of global research initiatives around social determinants of health, and advisers to some of the top health systems in the country. And nurse innovators have been by our side all along the way.

But nursing innovation has yet to be fully unleashed, as I've seen firsthand in my 25 years as a physician.

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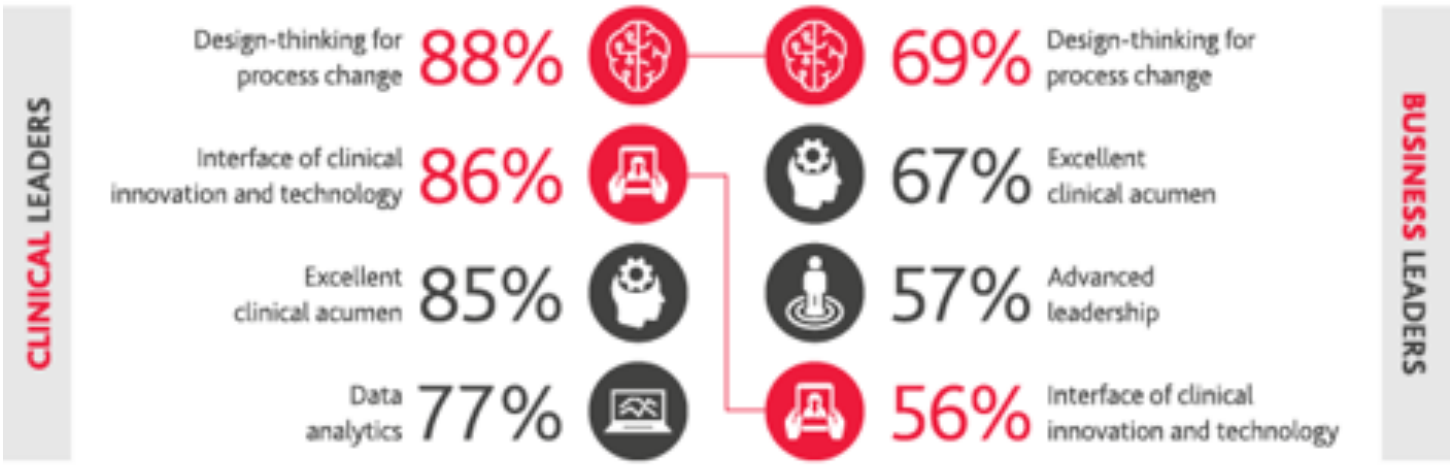
TOP 4 MOST VALUABLE SKILLS FOR NURSE INNOVATORS BY 2025



The State of Nursing Innovation by 2025

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That's why, together with Penn Nursing, BDO embarked on a mission to find out how nursing innovation is being unleashed today—and what health systems and communities need to change to create a future where nurse innovators are all practicing at their full scope.

To do this, we surveyed clinical and business leader stakeholders themselves—including at hospitals, post-acute providers, payers, biotech and med device companies—on where they'll find the most value from nursing innovation by 2025.

What we found is that organizations across the system are already looking to nurses for individual-level innovation and clinical acumen skills. But they're missing out on the opportunity—including improved patient outcomes—that comes from bringing nurses into innovation at the leadership level.

If true care transformation is to take shape, health systems and businesses must recognize that nursing can and must extend well beyond the bedside and the community—and into the boardroom. Nurses are already leading sweeping innovations at larger, systemic levels within clinical and business organizations. They're just having to navigate around certain roadblocks to do it.

To create a consumer-centric health system capable of addressing perplexing health issues like the opioid crisis, caring for the aging population and chronic care management, roadblocks need to be removed and systems must embrace nurses as leaders in innovation.

Unleashing nurse innovators is a care imperative and a business imperative.

To learn more about the innovation and clinical skills nurses are bringing to their organizations today—and how those organizations plan to elevate nurse innovators by 2025—read Unleashing Nurse-Led Innovation.

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Formula for Understanding Employed Physician Losses, Developing Stronger Management Strategies

BY RANDY BIERNAT, CPA, PARTNER, BKD NATIONAL HEALTH CARE GROUP

The health care industry's complex reimbursement landscape coupled with physician contracting has left hospital and health system leaders without critical intelligence into physician profitability and losses. According to the American Medical Group Association (AMGA) 2017 Medical Group Operations and Finance Survey, physician losses increased 7.5 percent between 2016 and 2017 to $140,856 per physician.

Understanding physician practice economics is crucial, and the following formulas and methodologies will outline common analyses and highlight a stronger option for improving physician profitability, preparing for risk-based contracts and reducing physician burnout.

What Are the Existing Physician Practice Economics?

Physician services are reimbursed through Medicare's Part B Physician Fee Schedule (PFS), and other payors often set physician fees in relation to Medicare's PFS. Medicare bases PFS amounts on its defined Total Work Relative Value Unit (TRVU), which is associated with a Current Procedural Terminology (CPT) code and adjusted annually with a conversion factor rate that accounts for geographic area. One of the reimbursement components for the physician services provided is a work Relative Value Unit (wRVU), which represents the value of the physician's work and bears a strong correlation to time—but it's not an exclusive factor.

Understanding Marginal Profit and Controllable Losses

The first step in improving physician profitability is understanding loss—both controllable and uncontrollable. A controlled loss is fixed and **does not** increase on a per-unit basis, while an uncontrolled loss is variable and **increases** on a per-unit basis.

Figure 1. Baseline – Salary Compensation Model, Impact of One Additional Visit

	Total	Per Visit	Next Visit	New Total
Visits	4,000	n/a	+1	4,001
Revenue	$420,000	$105.00	+$105.00	$420,105
Expense – Fixed	300,000	75.00	+0.00	300,000
Expense – Variable	220,000	55.00	+55.00	220,055
Practice Net Income/(Loss)	($100,000)	($25.00)	+$50.00	($99,950)

Figure 1 is a straightforward characterization of practice expenses in fixed- and variable-cost pools and serves to illustrate marginal profit. As revenue increases, the per-unit fixed cost decreases and the per-unit variable cost remains constant.

The "Next Visit" column is the marginal visit and the key to effectively controlling losses. When marginal revenue exceeds variable costs, the marginal visit is profitable and reduces the practice loss. However, this simplistic example of a controlled loss is somewhat unrealistic because it fails to reflect the additional provider compensation for the additional physician work.

Because hospitals and health systems want to increase access to care and profitability, many physician compensation plans include productivity bonus paid on a per-unit basis. Figure 2 illustrates this more complex compensation and realistic payment structure by including a fixed and variable physician compensation component.

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Figure 2. Base + Productivity Bonus Model				
	Total	Per Visit	Next Visit	New Total
Visits	4,000	n/a	+1	4,001
Revenue	$420,000	$105.00	+$105.00	$420,105
Practice Expense – Fixed	150,000	37.50	+0.00	150,000
Practice Expense – Variable	170,000	42.50	+42.50	170,043
Practice Net Income before Physician Expenses	*$100,000*	*$25.00*	*+$62.50*	*$100,062*
Physician Expense – Fixed	200,000	50.00	+0.00	200,000
Physician Expense – Variable	-	-	?????	?????
Practice Net Income/(Loss)	*($100,000)*	*($25.00)*	?????	?????
Physician Compensation per Visit	*$50.00*			

For this example, the threshold for bonus compensation is set at 4,000 visits. Because the Total column also is 4,000 visits, no variable provider expense is included and physician compensation is effectively $50 per visit. **Figure 2** shows how total net income is affected by the marginal physician payment for their work for the last visit.

What's the Key to Managing Controlled Losses?

The structure of productivity bonus compensation is the key to controlling and predicting physician losses and is unfortunately overlooked. The following charts illustrate how an increase in physician clinical work effort impacts the practice financial performance, which is determined entirely by collection rates, operating leverage and the physician productivity bonus marginal rate.

COLLECTIONS RATE

A marginal rate needs to be sustained, but often declines as productivity rises.

OPERATING LEVERAGE

The mix of fixed and variable costs changes over time and at varying productivity levels.

PHYSICIAN PRODUCTIVITY BONUS MARGINAL RATE

A contractual arrangement that should set rates that create predictable "win-win" financial results for both the provider and the practice's economics.

The ideal goal is to create a productivity bonus compensation arrangement that keeps total variable cost per unit equal to or less than the revenue per unit. Uncontrolled losses are difficult to budget and occur when contribution margin is negative. Physician compensation arrangements that create negative contribution margins not only create uncontrollable losses and increase the practice's loss per unit level, they also create misaligned incentives that create myriad financial and compliance risks and contribute to physician burnout.

Complex Marginal Analysis

Figure 2 illustrates the effect of a simple productivity bonus structure and Figure 3 builds on the model by including

the cost of additional physician work effort in the analysis. **Figure 3** is built on the same assumption of 4,000 base visits.

Figure 3 illustrates a flat productivity incentive for all visits above 4,000 at $60 per visit ($55 in compensation + $5 per visit in related benefit cost). As the favorable payor mix declines, it reduces the marginal revenue, which is a common effect of productivity increases.

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Figure 3. Base + Productivity Bonus Model with 2,000 Visit Growth

	Total	Per Visit	Marginal
Visits	6,000	n/a	(visit 6,001)
Revenue	$600,000	$100.00	$95.00
Practice Expense – Fixed	150,000	25.00	-
Practice Expense – Variable	255,000	42.50	42.50
Practice Net Income before Physician Expenses	*$195,000*	*$32.50*	*$52.50*
Physician Expense – Fixed	200,000	33.33	-
Physician Expense – Variable	120,000	20.00	60.00
Practice Net Income/(Loss)	*($125,000)*	*($20.83)*	*($7.50)*
Physician Compensation per Visit	*$53.33*		

$60 for visits 4,000 > 5,000

$65 for visits 5,000 > 6,000

$70 for visits < 6,000

The marginal analysis in **Figure 4** highlights the exponential danger of these plans. Because the contribution margin is negative, the more the provider works, the greater the total practice loss, and the bonus tier model accelerates the loss with additional productivity. Effectively, the harder the physician works, the greater the total practice loss, and it incentivizes productivity levels that contribute to physician burnout—a key driver of turnover in employed physician groups.

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Figure 4. Base + Bonus Tiered-Increasing Model – Growth of 2,000 Visits			
	Total	Per Visit	Marginal
Visits	6,000	n/a	(visit 6,001)
Revenue	$600,000	$100.00	$95.00
Practice Expense – Fixed	150,000	25.00	-
Practice Expense – Variable	255,000	42.50	42.50
Practice Net Income before Physician Expenses	*$195,000*	*$32.50*	*$52.50*
Physician Expense – Fixed	200,000	33.33	-
Physician Expense – Variable	130,000	21.67	70.00
Practice Net Income/(Loss)	*($135,000)*	*($22.50)*	*($17.50)*
Physician Compensation per Visit	*$55.00*		

So What Does a Strong Model Look Like?

The solution to improving physician profitability is to work toward productivity compensation terms that have an inverse relationship between units produced and compensation per unit. Creating a sustainable contribution margin for that final compensation tier is the key to designing positive, controlled marginal practice income.

Figure 5 illustrates this arrangement by showing productivity bonus pay of:

$62 for visits 4,000 > 5,000

$57 for visits 5,000 > 6,000

$52 for visits < 6,000

Figure 5. Base + Bonus Tiered-Decreasing Model – Practice Growth of 2,000 Visits			
	Total	Per Visit	Marginal
Visits	6,000	n/a	(visit 6,001)
Revenue	$600,000	$100.00	$95.00
Practice Expense – Fixed	150,000	25.00	-
Practice Expense – Variable	255,000	42.50	42.50
Practice Net Income before Physician Expenses	*$195,000*	*$32.50*	*$52.50*
Physician Expense – Fixed	200,000	33.33	-
Physician Expense – Variable	119,000	19.83	52.00
Practice Net Income/(Loss)	*($124,000)*	*($20.66)*	*$0.50*
Physician Compensation per Visit	*$53.17*		

It's especially crucial to note that while the net practice income is substantially different under the three approaches, the physician compensation per visit is not.

Regardless of tiered amounts, setting a compensation cap limiting the productivity bonus to a sustainable percentage of collections at the margins can help further control losses.

Physician Compensation Examples Summarized per Visit

- Flat productivity: $53.33
- Increasing tiers: $55.00
- Decreasing tiers: $53.17

Investing in physician compensation redesign can produce more predictable, sustainable compensation terms with employed physicians. While it's not feasible to arrive at a positive marginal net income in every situation, a decreasing tiered production model can give you stronger control over losses and a more sustainable model.

If improving physician profitability or participating in a value-based payment model is on your priority list this year, contact Randy Biernat at rbiernat@bkd.com or your Trusted BKD Advisor.

Worksheet S-10 Is Here To Stay: A First Look at MAC S-10 Audits

BY KYLE PENNINGTON, CLIENT RELATIONS MANAGER AT SOUTHWEST CONSULTING ASSOCIATES

As a result of the Affordable Care Act, which was passed in 2010, the Federal Medicare DSH payment calculation was bifurcated, with 25% of the computed amount going directly to hospitals under the historical DSH formula and the remaining 75% establishing a fixed UC pool shared by qualifying hospitals nationally.

In its FY 2018 IPPS final rulemaking, CMS announced that it was phasing out the use of Medicaid and Medicare/SSI days and would begin incorporating data from Worksheet S-10 to calculate one-third of Factor 3, which determines a hospital's share of the federal uncompensated care pool.

Then in its FY 2019 IPPS rulemaking, CMS continued with the use of Worksheet S-10 and further transitioned to utilize charity care and bad debt costs reported on Medicare cost report Worksheet S-10 to calculate qualifying hospitals' federal uncompensated care reimbursement.

CMS advanced the time period of the S-10 data used in FY 2018 by one year to further phase-out the low-income days proxy by using two fiscal years of S-10 cost report data to calculate UC Factor 3:

FY 2013 low-income insured days and FY 2016 SSI data

FY 2014 uncompensated care cost per Worksheet S-10

FY 2015 uncompensated care cost per Worksheet S-10

In the most recent round of IPPS proposed rulemaking, CMS is proposing to abandon the average of three cost reporting periods as described above and use only one year of S-10 data from FY 2015 (or alternatively, FY 2017 data) for FY 2020 UC allocation purposes.

While Worksheet S-10 has been used for UC reimbursement purposes for only a short time, audits of the S-10 data to ensure its accuracy and consistency have been a high priority for hospital providers. During 2019 final rulemaking, CMS stated that due to the overwhelming feedback from commenters emphasizing the importance of audits, they would begin the inaugural audits in fall 2018, which they did.

CMS performed audit work on FY 2015 S-10 data for approximately 600 of the 2,400 qualifying hospitals. Now that these 2015 audits have been completed, it is important for hospitals to gain some insight into the inaugural audits, especially when considering that 100% of future UC payments (nearly $8.5 billion in FY 2020) will be derived solely from one year of S-10 data.

Inaugural Audits of S-10 Data

Hospitals nationwide received requests from Medicare Administrative Contractors (MACs) to provide data and detailed explanations supporting the charity care and bad debt data reported on their FY 2015 Medicare cost report Worksheet S-10. In many cases, the hospitals selected for audit were given a very short timeframe of two weeks to respond to the MAC's initial questions, and the requests for data, which were very extensive, included up to 18 required items.

Some of the notable components of the requests from MACs included:

1. A copy of the hospital's charity care policy and/or financial assistance policy (for both uninsured and insured patients), along with an explanation of how hospital personnel determine insurance status and charity care write-offs
2. Additional details to assist the auditor in understanding the financial assistance policies and how they are operationally implemented
3. Information on how the hospital's S-10 was actually populated
4. Patient-detailed charity care listings that tie to the cost report; these patient listings require hospitals to comprise approximately 20 data elements including name, dates of service, DOB, SSN, gender, and write-off date, as well as revenue codes, payments received and contractual accounts for every transaction related to the stay
5. A comparison of current year vs. prior year charity care charges from the hospitals' audited financial statements with an explanation for any significant changes between the years and a reconciliation if the detail listing does not agree to the amounts reported on S-10
6. Patient-detailed Medicare and non-Medicare bad debt listings (with similar elements to the charity care listings mentioned above) and a two-part reconciliation of the bad debt write-offs from the financial accounting records to the bad debts reported on line 26 of Worksheet S-10.

Audit Challenges

As one may assume, the inaugural S-10 audits posed a number of challenges for providers as they waded their way through the extensive request. One recurring theme came as a byproduct just from the sheer size of the audit request letter. Hospitals had difficulty in meeting the timeframe to submit the requested information. Providers were only given two weeks (or less) to compile all of the data, and from what we witnessed, not one provider had ALL of the data on hand prepared in the requested format and structure. Every hospital had to supplement the files they had previously prepared for their cost report filing in order to meet MAC requirements.

With regards to the charity care and bad debt patient listings, file size became a barrier hospitals had to overcome. For example, the letter requests every transaction and revenue code charge for each patient claimed on charity line 20, columns 1 and 2. For the average 100-bed hospital, the data set could easily be in the millions of records, and hospitals and MACs alike had difficulties handling the large files.

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Worksheet S-10 Is Here To Stay:
A First Look at MAC S-10 Audits

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Year-over-year comparisons and reconciliations were also challenging. Considerable time was spent by both sides to reconcile and understand the variances. Hospitals may have had a system conversion or turnover at their facility between the time of filing and the time of audit so providing an explanation for any variance was difficult.

Given the instructions to report charity charges at total charges and based on service date, some hospitals struggled to reconcile the detail to their financials where charity charges are based on the charity write-off amounts and their posting date.

Finally, and perhaps the most difficult item from the entire request, was the bad debt reconciliation.

Sampling and Audit Findings

Upon submission of the audit support, MACs began sampling the data, which generally included 40-60 patients covering four categories: insured, uninsured, inpatient and outpatient. Actual criteria for sampling varied by MAC. The required sample support primarily consisted of patient UBs, remittance advices, proof of income, charity applications and approval forms.

As you can imagine, providing documentation from three to four years prior to an auditor within the required tight time frame was tough. If any of the required items were missing or could not be provided, the hospital was then subject to extrapolations.

Upon sample completion, MACs presented hospitals with findings and proposed adjustments, and provided only one week response time in most cases. It also appeared that there were some inconsistencies with how auditors handled findings from what we were able to see.

What's Next?

While the inaugural round of FY 2015 S-10 audits hase concluded, it appears that CMS is continuing full steam ahead and moving on to FY 2017 data. In April, CMS instructed MACs to reach out to certain providers where their 2017 S-10 data appeared aberrant and asked the hospitals to justify its reporting fluctuations to the MAC, and if necessary, amend their 2017 report.

Regardless of which year CMS ultimately selects to use in its FY 2020 rulemaking, it is clear that S-10 will impact provider reimbursement for the foreseeable future. And, based upon the inaugural round of S-10 audits, hospitals must be able to provide support for each sampled patient during the audit that verifies the patient met the criteria stated in the hospital's financial assistance policy. As we witnessed in the audits, small sample sizes have the potential for large extrapolations so we recommend every hospital complete an audit readiness test to determine how they would fare not if, but when their hospital is selected for audit.

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Worksheet S-10 Is Here To Stay: A First Look at MAC S-10 Audits (continued from page 13)

S-10 programs should be top-of-mind for qualifying hospitals. It is important to keep in mind that if you are selected for audit, there may be no avenue which allows hospitals the opportunity to appeal adverse findings for purposes of the UC calculation. Hospitals should assume that any audit of S-10 data will be the only opportunity to have the correct S-10 data incorporated into the UC DSH calculation.

Looking forward, hospitals should place an absolute premium on getting the correct S-10 data into the as-filed cost report. Hospitals should have patient detail that ties to Worksheet S-10, that complies with the most recent reporting instructions, AND that is supported by the hospital's financial assistance policies. If not already doing so, hospitals should evaluate FFY 2017 data and submit revisions where appropriate.

And just a reminder, CMS will require hospitals to submit a detailed listing of charity patients for cost reports with periods beginning on or after October 1, 2018, or the report will be rejected. By far, one of the biggest issues we've seen in performing hundreds of S-10 reviews and seeing these audits firsthand is the difficulty many hospitals have had in obtaining the patient detail to support the filed S-10.

In conclusion, S-10 is here to stay, and it has significant reimbursement impacts for hospitals nationwide. It's driving a nearly $8.5 billion federal reimbursement pool, so hospitals should make every effort to analyze their UC data including a review of ALL transaction codes, a review of their processes for collecting and maintaining the data and, most importantly at this time, take a deep-dive look at their charity and other financial assistance policies and ensure they conform to the program requirements. These best practices will be absolutely critical to surviving MAC reviews.

About the Author

Kyle Pennington is a client relations manager with Southwest Consulting Associates where he currently focuses on the educational outreach efforts behind SCA's Medicare DSH and Worksheet S-10 Uncompensated Care practice. He has presented on Medicare DSH and Worksheet S-10 Uncompensated Care to various HFMA chapters, has been featured in HFMA Healthcare Business News, and was recently selected to speak on the S-10 topic at the 2019 HFMA Annual Conference in June. For an S-10 best practices guide, more in-depth detail about MAC S-10 audits, or what financial impact the 2020 IPPS proposed rule has on your hospital(s), email Kyle at kpennington@southwestconsulting.net. Learn more about Southwest Consulting Associates at southwestconsulting.net.

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ABOUT THE GOLF OUTING
Eagle Brook Country Club is a private country club in Geneva, Illinois with over 300 members containing a golf courses designed by Roger Packard and Andy North, swimming and tennis facilities and a newly renovated clubhouse.

THERE ARE TWO AVAILABLE FORMATS
(1) 9 - hole scramble or (2) start with a clinic led by the golf pro and finish with 3 holes of golf.

THE REGISTRATION FEE INCLUDES GOLF, CART AND LUNCH.
You will have the use of driving range, putting green, bag service, locker room facilities, and Pro-Shop services.

SAVE THE DATE

Monday, August 19, 2019
9:00 AM – 5:00 PM

Eagle Brook Country Club
2288 Fargo Boulevard, Geneva, IL 60134

8:30-9:00 ..... Registration
9:00-11:30 ..... Education
11:30-12:30 .... Lunch and Network
1:00-4:00 ..... Golf: 9-hole scramble, or Golf Clinic with 3-hole
4:00-5:00 ..... Awards and Social

DIRECTIONS
Eagle Brook is located 45 minutes west of Chicago, and is easily accessible via either 1-80 (exit Orchard), or 1-90 (exit South Randall Road).

The Metra departing out of Ogilvie Station has a stop in Geneva on the Union Pacific West Line. The stop is a 5 minute drive from the club. Taxi, Uber or Lyft are available from the station.

Fifth Annual Women in Leadership Golf Outing

BY SUE W. MARR, CHAIR, FIHFMA WOMEN IN LEADERSHIP COMMITTEE

The Annual Women in Leadership Golf Outing will be held on Monday, August 19, at Eagle Brook Country Club, in Geneva, Illinois. This year will mark the fifth anniversary of this fantastic event, and it has grown from an informal gathering to a well-organized annual event attended by 70 plus healthcare executives from the Greater Chicagoland area. Past tournaments have seen great representations from healthcare providers and vendor partners including Advocate, Northwestern Medicine, AMITA, Rush, Northwest Community, BDO, BKD, Claro, Plante Moran and many more.

This event is designed to be a fun and non-intimidating setting for female healthcare executives to be introduced to and enjoy the game of golf and the associated networking and social engagement benefits. Participants range from former collegiate golf athletes to ones who have not held a club for years.

Golfers have the option to play a game of scramble or attend a "Golf Clinic." At the clinic, professional golf instructors provide a tutorial on golf strokes and course etiquette, and then lead the attendees through three holes on the course. The format of the event allows attendees the opportunity to network, learn and relax in the beautiful surroundings of the Eagle Brook Country Club. Additionally, raffles will be held with the proceeds going to the chapter scholarship fund.

To celebrate the fifth year and to emphasize the importance of being our best selves, this year's theme is "Creating the Value of Taking Care of Yourself." We will start the morning with yoga and meditation to ensure we are both physically ready and mentally prepared to score those birdies on the course.

The speaker session, "How Unattachment Gets Results!" will be led by Gay Crain. Coach Crain had two successful careers in senior corporate management and commercial real estate business development before becoming an LPGA teaching professional and motivational speaker. She will share her unique perspective and elicit "aha" moments with her audience.

As a special treat for our participants, we will have several massage therapists staffed for the morning, so please arrive on time to reserve a massage session.

The golf shotgun start is scheduled for 1 p.m., following lunch and, as always, we anticipate a lot of competitive edges to be demonstrated on the course with various on-course games and proximity contests. The day will conclude with awards, social hour and plenty of laughs back in the clubhouse.

Look forward to seeing many familiar faces and meeting new ones on August 19. Please be on the lookout for event registration and spread the word. Register early to receive the coveted golf polo. Please contact me at sue.marr@plantemoran.com, regarding sponsorship opportunities, volunteering, questions, comments, and suggestions of polo color.

I will leave you with a quote from Dr. Bob Rotella, the world's preeminent sports psychologist and performance coach, "Golf is about how well you accept, respond to, and score with your misses much more so than it is a game of your perfect shots."

FALL SUMMIT 2019

First Illinois HFMA

OCTOBER 22-23, 2019

Drury Lane Conference Center
Oakbrook Terrace, IL

Format
Case Studies, Panels, Presentations by or with a Provider

Topic Areas
Healthcare topics, including key areas members want to hear from like Business Intelligence and data analytics, Managing and measuring the total cost of care, and Accounting and financial reporting issues related to emerging payment models.

Committee Participation
Interested in being part of the chapter's premier educational event committee? **We want to hear from YOU!** Email us at fallsummit@firstillinoishfma.org

SAVE the DATE!!

This year's 2019 Fall Summit, the First Illinois Chapter's premium educational event, is October 22-23 at the Drury Lane Conference Center in Oakbrook Terrace, Illinois.

The event features over 12 hours of continuing education hours including several CFO panels that will look at stand-alone hospitals opportunities and challenges of being independent, as well as the CFO of the future skills and resources needed.

Back by popular demand is our very successful Casino Night. It's an outstanding opportunity to network and sharpen your probability analysis skills! During the Fall Summit, you will also interact with our business partners who can help you find solutions to today's business needs. We are also looking for our past chapter presidents to join us at Tuesday's lunch.

Look for more information to arrive at your desk shortly as we continue to build this year's premier educational event.

Mark your calendars now for October 22-23!

Notes from 2019 Leadership Training Conference (LTC)

Facts learned about HFMA overall:

- All membership has moved to an all-inclusive membership (all benefits for a single price).
- Joe Fifer, FHFMA, CPA, HFMA's president & CEO, predicted that the percentage of members certified will grow significantly in the near future.
- Enterprise membership is here to stay and will continue to grow.
- HFMA is governed by a volunteer board.
  - Mike Allen, MHA, FHFMA, CPA is the new chairman of the board. Mike is the CFO of OSF Healthcare in Peoria.
  - Mike stressed the importance of being thought leaders, especially around the subject of artificial intelligence and automation in general.
  - Mike Allen succeeds Kevin Brennan, who was the CFO at Geisinger.
  - Kevin Brennan succeeded Carol Friesen, who is now the CEO of OSF North in Rockford, Illinois.

Notes from various programming tracks:

- Driving a greater sense of community will help the chapter overall. Some strategies to achieve this may include:
  - Need to have an emphasis on innovation and CFO involvement.
    - Members want cutting edge speakers and content.
    - Driving CFO engagement will enhance provider participation; suggested rotating events to be held on-site at major providers starting with Enterprise members as a benefit for that membership level.
  - We should investigate more digital programming options. Other professional organization are having much greater success here.
  - Need to continue to have an emphasis on provider-only networking opportunities free from vendor interests.
- We need to drive membership and embrace enterprise membership.
- The First Illinois Chapter has an annual sponsorship model whereby sponsors pay a single amount and receive a list of benefits. Those benefits vary by the level of sponsorship. Other chapters balance annual sponsorships with event sponsors as well.
  - Event sponsorship examples include:
    - Lanyards
    - WIFI
    - Speakers
    - Meals
    - Breaks

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Notes from 2019 Leadership Training Conference

(continued from page 18)

- National resources that we should leverage more:
  - National Education Committee
    - Each region has a dedicated contact that can recommend topics, speakers and technical solutions.
    - They can provide association speakers for certain topics; the only cost to the chapter is travel costs.
    - Chapter Dashboard
      - This provides chapter statistics on membership growth, value (quality and member satisfaction) and engagement.
      - These dashboard statistics determine chapter awards.
    - Programming ideas
      - HealthCare 101: An overview of the industry geared toward early careerists and non-members (ideally early careerist non-members) with networking afterward. Could be held periodically at providers/vendors to drive membership growth.
      - Collaboration with other chapters on events and speakers, and with other professional organizations to drive attendance (Wisconsin does this well).

Past Presidents Gather at 2018 Fall Summit Luncheon to Celebrate First Illinois Chapter HFMA 70th Anniversary

Back Row: Left to Right: James Heinking, Brian Katz, Mike Nichols, Suzanne Lestina, Carl Pellettieri, Pat Moran

Front Row: Left to Right: Eric Lundahl, Joe Parillo, Linda Klute, Cathy Jacobson, Dan Yunker, Guy Alton

At the 2018 Fall Summit luncheon, the First Illinois HFMA Chapter celebrated its 70th anniversary as a chapter. The chapter, officially chartered in the State of Illinois on October 15, 1948, was the first chapter of the newly formed American Association of Hospital Accountants (AAHA) now known as the Healthcare Financial Management Association (HFMA). Charles Warfield, chief accountant, Alexian Brothers Hospital, Chicago, served as the first president. While a few things have changed since then, the commitment and leadership of our members and volunteers has remained robust and true. We were honored to have many of our past presidents and former HFMA national chairs as special guests at this luncheon and look forward to continuing this new tradition.

Year	Past Presidents
2017-2018	Brian Katz
2015-2016	Adam Lynch
2014-2015	Carl Pellettieri
2013-2014	Dan Yunker
2011-2012	Pat Moran
2009-2010	Mike Nichols, FHFMA, CPA
2008-2009	Guy Alton
2005-2006	James Heinking
2002-2003	Suzanne Lestina, CPC, FHFMA
2001-2002	Eric Lundahl
1990-1991	Linda Klute
1983-1984	Joe Parrillo, FHFMA, CPA
Year	**Past National Chairs**
2009-2010	Cathy Jacobson, FHFMA, CPA
1999-2000	Rich Henley, FACHE, FHFMA

A few factoids about life in 1948

- Yearly iInflation U.S.A. 7.74%
- Average cost of new house $7,700.00
- Average wages per year $2,950.00
- Cost of a gallon of gas 16 cents
- Average cost of a new car $1,250.00
- Loaf of bread 14 cents
- Pound of hamburger meat 45 cents
- Movie ticket 60 cents
- First appearances & 1948's most popular Christmas gifts, toys and presents: Scrabble invented Slinky Jr.
- World changing event: Scientists at Bell Labs invented the transistor.
- National Health Assembly convened in Washington, D.C., by the Federal Security Agency. Final report endorsed voluntary health insurance but reiterated need for universal coverage.

First Illinois Chapter Partners

The First Illinois Chapter wishes to recognize and thank our 2019 Partners for all your generous support of the chapter and its activities. *Click here* to learn more about the chapter's robust partnership program.

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BKD CPAs & Advisors

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ATTORNEYS AT LAW

RSM

rh Robert Half

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TransUnion

Triage Consulting Group

VERALON

First Illinois Speaks hfma
HFMA's First Illinois Chapter Newsletter

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HFMA Editorial Guidelines

First Illinois Speaks is the newsletter of the First Illinois Chapter of HFMA. *First Illinois Speaks* is published 4 times per year. Newsletter articles are written by professionals in the healthcare industry, typically chapter members, for professionals in the healthcare industry. We encourage members and other interested parties to submit materials for publication. The Editor reserves the right to edit material for content and length and also reserves the right to reject any contribution. Articles published elsewhere may on occasion be reprinted, with permission, in *First Illinois Speaks*. Requests for permission to reprint an article in another publication should be directed to the Editor. Please send all correspondence and material to the editor listed above.

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Style

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

A broad topical article may be 1000-1500 words in length. Shorter, "how-to" or single subject articles of 500-800 words are also welcome. Authors should suggest titles for their articles. Graphs, charts, and tables **(PDF or JPG only)** should be provided when appropriate. Footnotes should be placed at the end of the article. Authors should provide their full names, academic or professional titles, academic degrees, professional credentials, complete addresses, telephone and fax numbers, and e-mail addresses. Manuscripts should be submitted electronically, on computer disk or by e-mail as a Microsoft Word or ASCII document.

Founders Points

In recognition of your efforts, HFMA members who have articles published will receive 2 points toward earning the HFMA Founders Merit Award.

Publication Scheduling

Publication Date	Articles Received By
September 2019	August 31, 2019
February 2020	January 31, 2020
June 2020	May 30, 2020