• 340B for Hospitals – Short & Long Term Strategies
• Myths Obstructing a Patient-Friendly Fiscal Experience
• A Funny Thing Happened on the Way to the Interview
• Revenue Cycle Conference Summary
On the Cover

Back row, left to right: Michael Friedberg, Janet Hodgdon, Julie Hall, Dennis Scott, Sara Sullivan, Jason Manfredi, Peter Panagakis

Front row, left to right: Annamarie Monks, Fred Romano, Glenn Morrissey, Jen Samaras, Patrick McDonough, Alyson West, Bob Cato

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You may remember an email request from me at the beginning of October to participate in HFMA’s Annual Chapter Membership Satisfaction Survey.

Today, I am thrilled to let you know that the results have been delivered...and Wow!

Seventy-seven percent of our responding members are “Extremely Satisfied” or “Very Satisfied” with the programs and services offered by the Massachusetts / Rhode Island Chapter. That is a 16% increase over the previous year, and 8% higher than the national results across all 68 chapters.

With 1,300 members in Massachusetts / Rhode Island, we are the third-largest HFMA chapter in the nation. Compared to similar chapters with 1,000+ members, our ratings outperformed other large-sized chapters by 7%.

In fact, the collective results for HFMA Region 1 (New England) demonstrate the best scores in the country. Our regional satisfaction ratings were 8% above the next highest region, which includes our neighbors to the west in New York. This impressive outcome reflects the cooperative and generous spirit that all the New England chapters have brought to shared efforts like our Region 1 Annual Healthcare Conference held at Mohegan Sun each year in May.

As a member-driven organization that is committed to continuous improvement, the annual survey process is an invaluable touchstone to make sure that we continue to meet your high expectations. I am so thankful that the hard work and dedication of our Chapter volunteers have resulted in our best ratings in years!

For example, 80% of respondents from Massachusetts / Rhode Island are Extremely Satisfied or Very Satisfied with the speakers at our educational programs. This validates the thought and attention that each organizing committee invests into carefully selecting industry experts and thought-leaders to speak at our events.

About half of respondents (52%) had attended a Chapter event within the past six months. This comes as no surprise because we provide more than 11,000 educational program hours each year. But we would love to see that number climb even higher.

Aside from the Region 1 Annual Healthcare Conference, our Chapter’s three most attended programs during 2015-2016 have been the Revenue Cycle Conference in January, Accounting & Regulatory Technical Update in October, and Enterprise Performance Management / Physician Practice Management in March.

Regarding your level of interest in specific program topics for the upcoming year, the most popular responses were: Trends and outlook for local healthcare industry (85%); State legislative and regulatory update (74%); and Transitioning to value-based payment models (74%).

The survey results also highlight where we have opportunities to advance further. For example, you want to see more improvement in networking opportunities. In fact, 25% of respondents selected this as the single most important area to improve. We hear you loud and clear, and we are taking action! This year, the newly formed Young Professionals Committee has organized two smash-success social events. In addition, our popular Annual Awards Dinner was recently identified by HFMA National as a networking “best practice” for other chapters to model. We are committed to offering a wider variety of meaningful opportunities to connect with new friends and colleagues.

I am grateful to everybody who took the time to complete and submit a survey. We take these results very seriously. In addition to the ratings, many of you also shared thoughtful ideas in the comments section. Your questions or suggestions are always welcome. You don’t have to wait until the next annual survey in October! Please do not hesitate to contact me directly at president@ma-ri-hfma.org or feel free to contact a member of the Board or Committees.

Timothy C. Hogan, JD, FHFMA, CHC
President
President's Message
I by: Timothy C. Hogan
Seventy-seven percent of our responding members are "Extremely Satisfied" or "Very Satisfied" with the programs and services offered by the Massachusetts / Rhode Island Chapter.

HFMA Hosts Young Professionals Night
Young professionals gathered at MGH for networking and insights from Richard Silveria.

340B for Hospitals – Short & Long Term Strategies
I by: Robert Gricius
The 340B program represents a crucial opportunity for hospitals and health systems to reduce costs in an environment that is demanding more cost-effective care.

Myths Obstructing a Patient-Friendly Fiscal Experience
I by: Candice Powers, MBA, CRCR, CRCA
As healthcare finance professionals, we are trained to identify issues and introduce performance-improvement initiatives.

Welcome New Members
New Massachusetts-Rhode Island Chapter Members March 1, 2016 through May 31, 2016.

CAREER CORNER:
A Funny Thing Happened on the Way to the Interview
I by: Ralph DiPisa
Five Guidelines for not Fumbling Your Next Career Opportunity.

Revenue Cycle Conference Summary
I by: Patrick McDonough
The HFMA MA -RI Chapter held its annual Revenue Cycle conference in January with 483 attendees with sessions focusing on revenue cycle, information technology, government payers, physician-related issues, and CFO-level issues in addition to keynote speeches.

Annual Social and Awards Night
As part of this wonderful evening of food and good cheer, Chapter President Timothy Hogan, FHFMA gave out a number of chapter awards.

Newsletter Committee
Linda A. Burns, MBA, MHA, Consultant, Ambulatory Care & Physician Services
Linda A. Burns, MHA, MBA Consulting & Physician Practice
Kate Stewart, Attorney, Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C.
On March 29, the Massachusetts-Rhode Island chapter hosted its third Young Professionals Event. The event, held at Massachusetts General Hospital, featured time for networking and a presentation by Richard Silveria, Vice President and Chief Financial Officer of Boston Medical Center. The presentation topic was “What is the Future of Healthcare Finance?” and included both perspectives on the industry as well as tips for those seeking to advance their careers. Mr. Silveria highlighted that the CFOs of today and tomorrow are called upon to be strategic advisors in an ever-evolving market.

Encouraging the involvement of young professionals in the organization is a goal of HFMA nationally and within our chapter. We were thrilled to have 89 attendees at the March event and look forward to additional young professionals events in the future. If you have any questions about the young professionals initiatives in the chapter or want to get involved, please contact Rosemary Sheehan (RRSheehan@partners.org) or James Jacobi (JJacobi@medixteam.com).
The Federal 340B Drug Pricing Program was created by Congress in 1992. The program is governed by the Office of Pharmacy Affairs (OPA) and Health Resources and Services Administration (HRSA). It was created to help a diverse group of tax-exempt hospitals, federal grantees and other safety-net providers’ stretch scarce federal dollars further to provide more care to more patients. The program requires pharmaceutical manufacturers to provide certain hospitals and clinics with discounted pricing on outpatient medications prescribed to eligible patients. This discounted pricing can range from 25-35% lower than the current baseline and can represent significant and material cost savings for a participating facility.

This article will focus on short and longer term strategies to employ in order to obtain initial qualification for the subset of acute care hospitals that are allowed to participate in this program (e.g. the program is not available to investor-owned hospitals) and steps to take to continue to stay qualified moving forward.

**Introduction**

The formula used to determine qualification for the 340B program is the same one that was used for Medicare Disproportionate Share (“DSH”) under the Pre-ACA regulations. Specifically it is as follows: (See Exhibit 1 on page 7.)

(continued on page 7)
The numerator on the left fraction (the Supplemental Security Income (SSI) ratio) represents Medicare Part A or Part C (Medicare Advantage) inpatient days where the member also was eligible for Federal financial assistance from Title XVI (SSI) and is not institutionalized.

The denominator of the left fraction represents the total Medicare Part A/C covered days.

The numerator on the right fraction (the “Medicaid” ratio) represents the total allowable Title XIX (Medicaid) days and the denominator represents the total acute care days.

If “Y” is greater than or equal to 27.32%, the hospital can qualify for the 340B Drug Pricing Program as a “DSH Acute-Care Hospital.

If “Y” is greater than or equal to 22.8% and <27.32%, the hospital can qualify for the 340B Drug Pricing Program if it’s an Rural Referral Center (RRC) or Sole Community Hospital (SCH).

The primary difference between the qualification categories is the exclusion of “orphan drugs” from the set of pharmaceuticals available for discounted pricing for the RRC/SCH 340B participants. This is a significant difference as many of these drugs are used in oncology and can be very expensive.

One of the key points is that Medicare/SSI days retain their substantially enhanced value over Medicaid days versus the current “Days Proxy” metric for Medicare DSH post-ACA Uncompensated Care Payment model. This has special relevance on the issue of retaining eligibility and taking a longer-term approach to qualifying. (continued on page 8)
**Application Process**

The first step in optimizing an initial year’s savings for a newly qualified or re-qualified hospital is to understand the compressed window of time in which a hospital can apply for 340B Program eligibility. There are four 15 day windows per year when applications are accepted; (the first 15 days of each calendar quarter (e.g. January 1-15; April 1-15, etc.). If the hospital is successful, the start of the program is the first day of the next calendar quarter. If a hospital misses any of these windows of opportunity those savings are not retroactively obtainable and the start of the program is deferred another three months.

**Increasing Year One Savings**

A hospital can gain an additional quarter of 340B Program savings by accelerating the filing of its cost report in order to take advantage of these application windows. As an example, if a hospital has a 12/31 year-end, the cost report would normally be filed on or around May 31. However, if the hospital believes it will qualify for 340B Program for the first time in its current fiscal year, there can be a significant gain by filing the Medicare cost report before April 14. If the hospital is accepted into the program, the first quarter of 340B savings would begin July 1, as opposed to October 1 (had the cost report been filed when due).

In order to take advantage of these application windows to add an additional quarter of savings, is critical to have concurrent visibility into Medicaid utilization trends so that a decision can be made early in the next fiscal year whether it makes sense to accelerate the cost report filing.

**Medicaid Utilization Visibility**

The key to obtaining accelerated qualification for the 340B Drug Pricing Program and maintaining compliance requires a fundamental switch from episodic to continual eligibility verification and visibility for all classes and related parties of government subsidized or paid healthcare. This governmentally sponsored population easily exceeds 60% of the insured lives in this country.

Exhibit 2 (above) illustrates the data flows and timing between data submissions by the facility to both In-State and Out-of-State Medicaid data warehouses and Medicare.

*(continued on page 9)*
Although most hospitals understand the need for In-State Medicaid data warehouse exchange for inpatients, we often are questioned on the rationale behind submitting Outpatient and Physician data (for employed physicians).

That rationale is due to the inconsistent data quality from many facilities when it comes to capturing the necessary demographic data that comprise the input file to all States Medicaid Data Warehouse’s (MDW).

In the classic example, if there is a transposition of two digits in the Social Security Number (SSN) or Medicaid recipient number or a changed/misspelled name or any other error in data captured as an inpatient, the hospital will send a bad record to the State for verifying eligibility. Without being able to compare the data from an inpatient stay to the data captured during an outpatient/physician encounter, the hospital has no way to know it is sending up incorrect data for verification. This incorrect data will not show a match for the hospital and the allowable Medicaid days are lost.

We see roughly 0.5% to 0.75% of additional Inpatient allowable Medicaid days by submitting outpatient demographic data that results in a matched eligibility record and tying the results back to an inpatient stay via Medical record number within a hospital or multi-hospital system.

Medicare eligibility, or lack thereof, is the driving factor behind concurrent submission of Medicare EDI queries (which now only goes back 12 months) and/or the use of the Common Working File to encounter data older than 12 months.

Out of State Medicaid can often comprise a significant number of incremental allowable Title XIX days and tangentially can also generate additional Medicaid revenue if done on a timely basis by focusing on patients that live in one State and obtain Medicaid coverage in another.  

(continued on page 10)
REVENUE CYCLE

(340B for Hospitals - continued from page 9)

Refer to the chart on page 32 (Exhibit 3)

This chart illustrates the month by month concurrent Medicaid and Medicare/SSI utilization metrics for a sample University teaching facility.

The blue section of the bar graph represents the Medicaid days from the pre-ACA program for this State. The red section of the bar graph represents the internally calculated concurrent SSI metrics based on State eligibility data, prior SSI data files (the LDS MedPar files through 2013), and concurrent utilization of those SSI members that are presumptively eligible under what is known as a compassionate care protocol or general SSA disability guidelines. The green section of the bar graph represents the days were attributable to Medicaid expansion in the State for the Hospital’s 2014 fiscal year.

One can see from the chart that the facility was very close to the DSH Hospital 340B Program threshold through the first nine months of its’ 2014 fiscal year using In-State Medicaid days only.

In conclusion the facility, given their concurrent utilization visibility, filed its’ cost report on an accelerated basis and increased its’ first year 340B Program savings by $2 Million.

Retaining 340B Program Eligibility

Getting into the 340B Program is only the first step in this cycle, the next challenge for all threshold hospitals is retaining eligibility for this critical cost savings Program.

Our focus for this facility was and is pro-actively managing their SSI metric which had previously moved up and down by more than 20% in a single year.

This is not to say that Medicaid Member utilization is not a necessary component of overall 340B (continued on page 27)
Myths Obstructing a Patient-Friendly Fiscal Experience

By
Candice Powers, MBA, CRCR, CRCA

Earlier this year, my seven-year old daughter was injured when she fell from a piece of playground equipment. As traumatic as the compound fracture of her forearm was, the complicated, convoluted, and confusing financial obstacle course that followed put much more strain on my family. My experience as a guarantor over the course of the five months following the injury is certainly more common than is acceptable in the healthcare financial industry. This single medical event has transformed a few of my beliefs that as a provider I had held as firm truths.

As healthcare finance professionals, we are trained to identify issues and introduce performance-improvement initiatives. The following narrative details what I have learned through the eyes of the patient/guarantor.

Myth #1: Demographic validation is done at the registration desk or bedside for every patient.

When a patient enters a hospital, particularly through the ambulance bay, he is neither given the opportunity to relay nor review information essential to activities post-discharge in any sort of organized fashion. When my daughter arrived in the emergency room, a nurse took the quick registration information of name, date of birth and allergies. Once my child was settled in the bay and just before the nurse left, I handed him the acci-

(continued on page 12)
dent form and my insurance card. The items were returned and stowed hastily as I was busy making attempts to comfort my child. At some point a registrar presented bedside and I hastily signed consents for treatment. I did not read these forms. My attention at that moment was focused on the well-being of my loved one.

My child was to be transferred to another facility for surgery. We would be asked to provide consent and the same information upon arriving at another facility. We arrived at the emergency department of the second facility where a pediatric orthopedist was available.

While waiting for a surgical bay, a very kind clerk approached my husband and me. At this point, 2:00 a.m., we were both exhausted and scared. She asked if I could verify my daughter’s demographic information. The address for my child was incorrect. I asked where the information was obtained; she explained that both the run-sheet and also accident form had our demographic information listed.

The after-school care provider had not updated our address in three years. The accident form given to me as we loaded into the ambulance was flawed. All other providers had assumed this to be the correct address. I corrected the demographic information with the registration clerk on the spot and thanked her for allowing me the opportunity to review my information. I knew at that moment that the road to correcting this information would be difficult as I had no idea how many providers we had seen.

Demographic verification technologies are only as reliable as the people utilizing the software and the procedures followed for ensuring compliance. Millions of dollars a year are spent by hospitals and other health facilities installing and maintaining these systems. However, if variances in the information are not validated and updated in real time, these investments are fruitless.

(continued on page 13)
In addition, in instances where a patient has likely not been properly validated, e.g. trauma patients arriving by ambulance, post-discharge phone and letter campaigns affording patients the opportunity to validate information regarding their visits or admissions would prove far less expensive than follow-up labor, re-billing attempts, and ultimately uncompensated care. Many facilities contact self-pay patients post-discharge, particularly ER patients, to revalidate their self-pay status and route them to appropriate resources. Other patient classifications could benefit from similar workflows. These efforts should focus on the areas creating the highest discrepancy rates.

A true “check-out” procedure or exit interview process also allows time for patients and their families to review information in an organized and less stressful environment. This concept is not new within revenue cycle initiatives; however, it is an area that needs continual monitoring to assess effectiveness and compliance with healthcare organizations’ policies. On paper, this quality assurance measure often looks quite different than in practice.

Myth #2: Patients are informed regarding services provided by physicians not employed by the hospital and for which the patients may receive separate bills.

Most facilities are not all-inclusive owners of every service provided in the hospital. Oftentimes, hospitals contract with, rather than directly employ, select providers to provide essential services not owned by the hospital to provide appropriate care to patients. Examples include radiologists, anesthesiologists, pathologists, hospitalists, and emergency physician groups, and their professional services are often billed separately. To healthcare professionals, this is not a foreign concept. Consents and statements often include a disclaimer explaining that the patient may receive bills from each of these entities. (See graphic on page 14) However, these providers may or may not be considered in-network (continued on page 14)
and that is rarely explained in a manner understood by patients/guarantors.

In an emergency situation, network status is not front-of-mind. Once a patient has been discharged (continued on page 15)

Graph 1.1: Illustrates the number of claims generated from a singular accident without consideration of incorrect billings, denials or appeals

SOME HONORS MEAN MORE THAN A TROPHY

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and begins to receive a plethora of explanations-of-benefits forms, the sorting becomes overwhelming. Most insurance plans have a RAP provision that essentially states that if an in-network facility is chosen for services, any out-of-network service received can be processed at in-network rates, if requested by the guarantor though some plans still consider the expense an out-of-network cost when calculating out-of-pocket maximum expenses. Most guarantors are oblivious to this loophole and are saddled with the hefty outpatient responsibilities in this situation. The difference in guarantor liability in my instance amounted to $1,500, but this amount could be vastly larger with a more complicated diagnosis or procedure.

Those who are contracting with supplemental providers for essential services must also be cognizant of the impact these complex agreements have on patients. While the facility certainly cannot dictate network participation, hospitals should consider which insurance plans contract with which physician groups when reviewing proposals.

In cases of incorrect demographic information as described above, corresponding statements may not arrive. In my daughter’s case, every provider facility was updated immediately. In each case, I was informed that the data feed to the “blind” providers had not been transmitted and that the corrected demographic information would be transmitted. This did not occur. If facilities rely on a singular data feed or a face-sheet to obtain demographic information and insurance, this process is severely flawed. The patient account is a living, evolving record and must be treated as such. As information changes for a patient, updates should be sent to the “blind” provider as well. If this cannot be achieved, remote access to view the initiating facility health information system becomes crucial. This access will allow billing staff an additional resource to locate the most updated information for the patient and to coordinate benefits.

(continued on page 16)

Walking the tightrope between volume and value?

A strong Clinical Documentation Improvement (CDI) program enables organizations to optimize revenue in the current fee-for-service system, while building a clearer picture of the population that will need care under value based payment methods.

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Myth #3: Insurance verification and coordination of benefits are completed at multiple points in the revenue cycle.

Insurance information and coordination of benefits can certainly change at any point in the revenue cycle. In my experience, the coordination of benefits (COB) was spelled out on the accident form. Despite that fact, three providers changed the COB order to list the third-party liability insurer as primary. While this is certainly the proper procedure the majority of the time, it was incorrect in this instance.

The COB issue coupled with incorrect demographic information for one blind service provider had resulted in the balance being transferred to patient responsibility with no activity on the account. Unfortunately, in healthcare finance, this lethal combination spells a bad debt transfer. In my case, a debt of nearly $1,000 would have been reported to the credit bureaus had I not been proactive. My experience as a Revenue Cycle Director for a decade coupled with years of billing and admissions proficiency granted me an advantage that the general public lacks.

I was able to locate the provider in question by a search of the National Provider Identification database from reviewing the secondary insurance denial for coordination of benefits. I had not received a statement. Most consumers would not be aware of the resources available to track down this information and the account would have been placed in collections. Healthcare consumers deserve better. Under the Federal Credit Reporting Act, any creditor reporting to a bureau must provide complete and accurate information. Creditors can be held liable and fined for non-compliance.

Many facilities are extremely adept at authenticating benefits and insurance priority on scheduled services. Pre-encounter validation is the ultimate area in which to operate to protect revenues.

(continued on page 17)
Similar logic proving successful on the front-end of a service must be employed for unexpected, non-scheduled services. Better tools, amplified awareness and an increase in provider engagement in the full patient experience can ensure full and accurate reimbursement for services provided.

**Myth #4 Patients, not staff, are ultimately responsible for understanding coverage, plan, and services.**

Historically, resources within financial departments of a facility or individual provider offices are pointed toward singular functions, e.g. billing, admissions, scheduling. I strongly recommend that at each point of contact within the revenue cycle, staff must be trained to comprehensively review an encounter, a patient, and a circumstance. Silos of functionality and process within all areas of healthcare will continue to produce sub-par results and drive costs ever higher. Just as in the clinical setting, better outcomes are realized by removing variance and reviewing multi-faceted circumstances.

As consumerism continues to drive healthcare, the quality of the fiscal experience will inevitably impact patient volumes and satisfaction. As healthcare professionals, we must redesign processes and train staff to understand more than just their primary functions within our organizations. In addition, the industry would be well-served by redefining financial counseling to include true financial advocacy for those utilizing services in a confusing and complex delivery system.

The days of patients being solely responsible for understanding plan documents and the application of those benefits are over. By following traditional models of interaction with patients, providers will predictably be underpaid and patient balances will be erroneous. In the current climate of acquisition, hospitals that own physician practices, in particular, are favorably positioned to lead the transition (continued on page 21)
The ROI Companies provides Patient Financial Services specializing in:

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- Legacy System A/R Conversion Services
- Medicaid Eligibility Programs
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ROI’s resources represent over 50 years of business experience addressing the professional needs of healthcare providers throughout the industry. Quality work, product development, and strategic acquisitions have positioned us as an industry-leading provider of full-service healthcare revenue cycle management services. We are dedicated exclusively to the healthcare industry.

With five operation centers – including one in Worcester, Massachusetts – and a qualified staff of over 500 providing support to more than 150 healthcare facilities nationwide, ROI has the capabilities to facilitate cash flow, reduce active receivables, and improve patient satisfaction for our clients.

Please consider THE ROI COMPANIES as a qualified option when reviewing outside assistance to improve your Patient Financial Services revenue.

Contacts:
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508-868-1209 • ekennedy@theroi.com

Sandra Magaw, Director of Business Development
508-453-2610 • smagaw@theroi.com
It’s Time to Renew!

If you haven’t already, don’t forget to renew your Membership with HFMA. HFMA provides many valuable benefits and services for healthcare financial management professionals. The following are benefits you receive as a Member of the Massachusetts-Rhode Island Chapter:

➤ Chapter meetings and webinars—a monthly occurrence—serve as an opportunity to hear speakers on topics such as Revenue Cycle, Managed Care, Physician Practice Management, Enterprise Performance Management and Compliance. Educational programs provide a wide range of opportunities to increase your knowledge on critical healthcare finance topics.

➤ Social events that allow you to network with your HFMA colleagues, and have some fun!

➤ Opportunity to participate in specialized committees which allow you to join colleagues with a common interest on a special issue. Not only will you expand your network of professional contacts, but you will also help shape the direction and actions of the Chapter through work on a committee.

➤ HFMA Advisor, our chapter newsletter—a several times per year publication that keeps you up-to-date on local issues in health-care finance, CFO interviews, announces chapter programs, and committee activities.

An investment in HFMA pays big dividends. But don’t take our word for it—see what your HFMA colleagues have to say about what HFMA means to them Renew today and continue to take advantage of the opportunities that can help you and your organization be successful. To reinstate your HFMA membership, visit the website at https://www.hfma.org/renew.

What HFMA Means to Me . . .

HFMA gives me the opportunity to network with my colleagues in healthcare finance. I have met so many wonderful people through HFMA and have made lifelong connections to people I value. I enjoy volunteering for such a fine organization.

- Laurie Nelle, FHFMA, MBA

The most important values that I receive from HFMA membership are the opportunities to meet and develop relationships with those who are passionate about and committed to the healthcare industry. This is closely followed by the learning opportunities offered through HFMA to stay current in this fast-paced and multi-faceted industry.

- Richard Russo

The most important value I get from HFMA is that it keeps me connected to health care providers and companies engaged every day in the hard and crucial work of taking care of patients and transforming lives.

- David Tolley
Welcome New Members!

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

### New Massachusetts-Rhode Island Chapter Members

March 1, 2016 through May 31, 2016

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<td>Pamela Russell</td>
<td>Varian Medical Systems</td>
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<td>University of New Hampshire</td>
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<td>Chris Shepard</td>
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<td>Lucy Silva</td>
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<td>Jennifer Surin</td>
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<td>Mike Trilli</td>
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<td>Lawrence Vernaglia,</td>
<td>Foley &amp; Lardner, LLP</td>
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<td>Craig Wild</td>
<td>Fidelity Investments</td>
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<td>Sheldon Wilson</td>
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<td>Vanessa Wong</td>
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<td>Jocelyn Zybert</td>
<td>Steward Health Care</td>
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to a true patient-friendly financial experience. No stakeholder holds a better position to advocate on behalf of their populations.

The possibilities to redesign the fiscal experience are numerous. This process begins with shadowing actual patients through the entire process with all stakeholders. Only when the experience is fully understood by staff and management can obstacles be removed and true progress be made toward streamlining the complex labyrinth of healthcare delivery within the confines of insurance coverage. While it sounds overwhelming, small improvements/initiatives can have a large impact.

Some healthcare entities are beginning to explore ways in which individual resources can be pointed toward patients to guide them through more than the clinical implications surrounding an occurrence of illness or injury. This is certainly a step in the right direction, yet much more room for improvement exists.

After my child’s accident, as we waited for the first ambulance, I looked down at my daughter’s tear-streaked face. She pleadingly asked, “Mama, when they fix it, is it gonna hurt?” With my sincerest resolve, I promised she would be asleep and not feel it. I had no idea that the fiscal resolution would be the most painful experience for our family. I was stunned that it was so difficult to settle, lasting months after she was medically cleared to resume normal activity. We as an industry can and must address the fiscal patient experience with the same compassion and tenacity inherent in the clinical setting when treating patients. The people looking to us for healing deserve at least that much.

After my child’s accident, as we waited for the first ambulance, I looked down at my daughter’s tear-streaked face. She pleadingly asked, “Mama, when they fix it, is it gonna hurt?” With my sincerest resolve, I promised she would be asleep and not feel it. I had no idea that the fiscal resolution would be the most painful experience for our family. I was stunned that it was so difficult to settle, lasting months after she was medically cleared to resume normal activity. We as an industry can and must address the fiscal patient experience with the same compassion and tenacity inherent in the clinical setting when treating patients. The people looking to us for healing deserve at least that much.

About the Author

Candice Powers is Director, Revenue Cycle, at Optim Healthcare, Savannah, Georgia, and can be reached at CPowers@optimhealth.com.
At HFI, our mission is to maximize revenue for our healthcare clients by advocating for their most vulnerable members.

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Healthcare Financial, Inc. is a proud sponsor of HFMA.
As soon as the eight of them sat down to dinner, David grabbed the wine list and loudly announced that he would be ordering for everyone at the table. He thought he was demonstrating leadership; they thought he was being presumptuous. He was hoping to impress them; they were hoping to relax with a new colleague.

David’s over-the-top boldness was the wrong tool for the wrong situation. There are times where you need to put a stake in the ground and step up as the man or woman in charge – this was not one of them. He misread the circumstances and pushed too hard on highlighting his capabilities at a time when he should have been developing relationships.

By the time dinner arrived, the CEO & board members had mentally moved on to candidate #2.

Understanding the Hiring Dance
In our many years of healthcare executive recruiting, we’ve successfully guided and counseled thousands of candidates through the search process gauntlet (David wasn’t one of them).

Little of what we advise is complicated. However much of it is subtle and counterintuitive, particularly to senior executives who don’t often find themselves on the selling side of the job search equation.

Interestingly, and more often than not, when a promising candidate is passed over late in the process, it’s usually because of simple, human errors as opposed to a weakness in the candidate’s skills or experience.

These errors are avoidable, provided you’re properly prepared. With that in mind, here are the five points we make with candidates in anticipation of the interview process:

1. Get in the Zone.
As a senior executive, you’ve got a lot of distractions during the course of the day – multitasking is part of your job. A job interview, on the other hand – particularly if it involves multiple people at the same time – is more like a performance. You need to be focused, attentive, and clearheaded if you’re going to shine.

Is your interview at the end of the day? Leave the office early and take the afternoon off. Go sit outside for a little while and get your thoughts together, like an athlete preparing for game day. Proper preparation is not something easily wedged between a barrage of phone calls and emails.

Are you coming in from out of town? Fly up the day before and give yourself a chance to get settled. Rushing in from the airport with your tie a little crooked and your shirt a little wrinkled won’t make you look important. Rather, it will make you look disheveled and frantic.

And please, shut off your electronic devices. A couple of years ago, we had a promising CFO candidate who casually checked her Blackberry – several times – in the middle of a meeting with the search committee. When I pointed out to her later that this had effectively killed her chances, she con-

(continued on page 24)
fessed that she was in the middle of a tense contract negotiation back at the office and couldn’t resist “checking in.” Needless to say, the search committee couldn’t resist hiring someone else.

2. Don’t Rely on Your History.
Unlike the stock market, past performance is very much a predictor of future job success. And so if you earned the right degree, have the right experience, and can point to the current opening as the next logical step on your career path, you’ve done what you need to do to set the table.

But that’s really just the beginning. What many candidates don’t realize is that the further along in the interviewing process they get, the more likely it is that whomever they’re competing with has an equally impressive set of credentials (if they didn’t, they’d already be out of the running).

Being successful in the interviewing process requires more than just pointing to what you’ve already done… you need to be selling. How do your past successes tie into the organization’s current challenges? What’s your approach to management and how will that mesh with your new colleagues? Why are you excited about this opportunity in particular?

Remember that search committees work for organizations that have challenges – they want to feel confident that you can solve them. Your job is to clearly and enthusiastically connect the dots and never lose sight of the fact that your history only gets you to the interview table.

3. Come with a Game Plan.
Prior to her first round of interviews for a CFO position with an academic medical center, Gail did plenty of research. She Googled every member of the search committee, searched her LinkedIn contacts for mutual friends, and tried to find as many points of connection with the organization as possible. She prepared different questions for each interviewer, printed out photos of the people she’d be meeting with, and pasted them on a hospital org chart, so she’d know and recognize everyone before she even shook hands. That’s preparation.

Successful candidates understand that the interview process is part information gathering and part beauty contest.

Sure, you need to have good answers to technical and strategic questions, but you also need to come across as prepared, confident, and likeable.

The more organized you are ahead of time, and the more thought and pre-work you devote to mapping out a strategy for getting the job, the better you’ll perform when you’re sitting across the table from the decision-makers. If you walk in the door expecting to just wing it, it’s likely that you’ll be walking out empty-handed.

4. Look Beyond the Interview.
The further along you get in the interview process, the more the members of the search committee will be looking for reasons not to offer you the position. They have to… it’s the only way they can narrow down the field of qualified, talented professionals to (continued on page 25)
a single candidate.

Successful executives realize this and work hard throughout the entire process, not just during the interviews themselves. Things like handwritten follow-up notes, interactions with the receptionist, and an awareness of how you’re conducting yourself during a dinner meeting all serve to nudge you ahead or behind of other equally qualified candidates.

By the same token, you’ll want to pay particular attention to how many of your personal stories and interests to share with the search committee. Yes, it’s fine to be involved in outside activities, causes, and hobbies. But be aware that some of these may be viewed as “over the line.” We worked with a candidate, for example, who was extremely well-qualified for a CNO position and who seemed on track for an offer… until she mentioned in passing that she has a few household pets – 20 of them. Right or wrong, that raised enough eyebrows to give them pause about her candidacy.

5. Win or Go Home.

The job interview process is not just grueling, it’s unforgiving. Unlike your current position, where compromise likely characterize much of a typical day, competing for a job is black and white – there is no prize for second place.

Some executives, however, particularly those who have amassed a winning track record over time, have adopted a defensive, “play not to lose” approach to their work. This may be a successful strategy within the day-to-day realities of a corporate environment, but when vying for a highly sought-after position in competition with other executives, nothing short of focus and clear determination is going to carry you over the finish line.

“Successful candidates understand that the interview process is part information gathering… and

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part beauty contest.”

We had a candidate, for example, who was in the running for a CFO position at a major academic center. The members of the search committee liked him, and he had the skills and experience they were looking for, but they couldn’t understand why he wanted to leave his current situation for this new opportunity — they were concerned that he wasn’t really committed.

Meanwhile, he knew he had the credentials. And so, while he did in fact want the position, he didn’t try very hard to convince them of his interest. In the end, they offered the position to a less qualified, but significantly more enthusiastic candidate who just seemed to want it more.

**Summary**

The job search process is a “sudden death” competition.

You need to win every round, and there are few second chances.

Successful candidates — the ones who make steady progress in their careers and who rise to the occasion when a suitable position comes available — are those who understand the nuances and subtleties of the interviewing process.

Keep these five guidelines in mind when your next opportunity arises. And remember, in a close race, it’s often the little things that make the difference.

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**About the Author**

Ralph DiPisa is a Partner at Phillips DiPisa.
utilization management, but only that with the impact of Medicaid expansion already reflected in the payer mix the biggest risk is a precipitous decline in the CMS published SSI ratio that many other hospitals face.

**SSI Ratio Management**

There are four phases for what is termed SSI Ratio Management

**Phase I** focuses on identification of the historic SSI ratio numerator composition

- Or said differently, historically, who has comprised the Medicare/SSI patient population

Phase 2 involves a correlation analysis of SSI enrollment status using State level Title XVI status

- Some, but not all States, provide insight via the aid category/program information determining whether a patient qualifies for SSI payments

However, it is important to understand the virtually no States segregate patients that received State Supplemental SSI payments versus eligibility for Federal SSI cash benefits; it is that Federal eligibility that is required for inclusion in this calculation.

Although it is tempting to rely upon these data values to calculate an internal SSI metric, the reality is that the submission of any cost report SSI value that is different than the most recently published CMS metric will result in an automatic restatement by the MAC to the last published value. That’s not to say that there is no value in this data, only that it is part of a larger model to track and manage this population.

**Phase 3** centers on concurrent tracking of dual-eligible SSI ratio trends.

Virtually all Medicare/SSI patients are also eligible for Medicaid as both programs are means tested and in many States people entitled to SSI benefits automatically qualify for Medicaid. Similar to the State provided insight into Title XVI (SSI) entitlement, this phase is a component of a larger model that looks to identify trends in utilization that can be identified and tracked to assist in the management of this population.

**Phase 4** concentrates on identifying existing hospital or system patients that are not now qualified for SSI but have a high probability for obtaining these cash benefits by enrolling in this program and who are already entitled to Medicare, or will soon be based upon their age or disability classification.

**Phase I: Identification of the historic SSI ratio numerator composition**

There is only one government file that is available to hospitals that identifies those patients that CMS believes comprises the detail behind what used to be known as the “SSI black box” before this claims level data was made available.

Exhibit 4 (see page 33) shows the content of this file that is available without charge to all hospitals, identifying whether or not they qualify for 340B or Medicare DSH or any other program.

(continued on page 32)
Revenue Cycle Conference Summary

By: Patrick McDonough

The HFMA MA-RI Chapter held its annual Revenue Cycle conference in January with 483 attendees with sessions focusing on revenue cycle, information technology, government payers, physician-related issues, and CFO-level issues in addition to keynote speeches.

The goal of the Revenue Cycle Committee was to identify educational sessions that would challenge the attendees' thinking on their current processes within their revenue cycle and/or to give attendees an entirely different perspective of the revenue cycle that they hadn’t previously considered.

Keynote speaker Dr. Jonathan Burroughs challenged attendees to use the lessons of the aviation industry to eliminate hospital-caused illnesses and injuries. In a particularly powerful segment of his presentation, he played a video clip of a woman whose daughter died unnecessarily as a result of inappropriate treatment.

The luncheon keynote was perhaps the most powerful presentation that has ever been made at the Revenue Cycle Conference. Despite the room being filled to standing-room-only capacity, one could hear a pin drop as New York Fire Department Captain Alfredo Fuentes recounted the events of September 11, 2001. He described in detail how he narrowly escaped the collapse of the first World Trade Center building by crouching next to a pillar in a parking garage, only to enter the second World Trade Center shortly before the building collapsed, fracturing his skull and breaking nine of his ribs. Captain Fuentes (continued on page 29)

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Revenue Cycle Conference Summary - (continued from page 28)
gave us all an important perspective on our jobs when he noted that he considers all people who work for hospitals to be heroes because they are all part of the delivery of services that save lives on a daily basis.

Closing speaker Jackie MacMullan of ESPN.com was as informative as she was entertaining, including stories ranging from Red Auerbach buying her an ice cream cone when he thought she was the cheerleading coach, to Moses Malone using some interesting language to explain that he wasn’t interested in doing a post-game interview, and to more serious subjects like ethics involved in making the decision of when to go forward with a story and when to hold off.

The HFMA Chapter extends its appreciation to Dennis Scott of PV Kent & Associates, Paul Fitzpatrick of IC System, and James Jacobi of Medix Staffing for their fantastic job coordinating the 54 vendors who exhibited at the conference, as well as creating the well-received “Operation” themed vendor game. Special thanks go out to all who helped coordinate speakers at the conference, including Board Liaison Rosemary Sheehan, Jono West of Cardon Outreach, Janet Hodgdon of Baker Newman Noyes, Larry Millner of Baker Newman Noyes, Larry Millner of Naveos, Josh Goldberg, Daryl Weldon of Jellyfish Health, Peter Panagakis of

(continued on page 30)
Revenue Cycle Conference Summary - continued from page 29

Action Collection Agency, Tom Symington of Experian Health, Gloria Perez of Lawrence General Hospital, Sheila DeStramp of Lawrence General Hospital, Jennifer Samaras of Patient Funding Alternatives.

Recognizing that Tom Brady was running short on receivers late in the season, our usual photographer, Tony Slabacheski, stepped out from behind the camera to volunteer his services.

Conference Speaker Kathleen Harris (Experian Health), presenting on “Powering the Revenue Cycle with Analytics.

Dr. O’Neill Britton (Chief Health Information Officer, Partners HealthCare, Inc.) and Rosemary Sheehan (V.P. Revenue Cycle Operations, Partners HealthCare, Inc.).

Closing speaker Jackie MacMullan, Chapter President Timothy Hogan (Boston Children’s Hospital), and Revenue Cycle Conference Co-Chairs Patrick McDonough (ParrishShaw) and Jennifer Samaras (Patient Funding Alternatives).

Conference speaker Jim Noga (Partners HealthCare System) and Gloria Perez (Lawrence General Hospital).

Photos courtesy of Tony Slabacheski, Regional Medical Waste

Manfredi of KForce Staffing, and Sara Sullivan of Boston Medical Center.

The afternoon panel on Section 501(r) compliance. From left to right: Brian Kozik (Compliance Officer, Lawrence General Hospital), Gregory Kanetis (Director of Patient Financial Services, Lawrence General Hospital), William F. Wyman, FHFMA (VP of Revenue Services, Lowell General Hospital), and moderator Janet Hodgdon, CPA (Baker Newman Noyes).
Annual Social and Awards Night

On May 12, 2016, the HFMA Massachusetts-Rhode Island Chapter celebrated its Annual Social and Awards Night at the Downtown Harvard Club. Chapter members enjoyed a four-course meal from Chef Jorge Lopes with wine pairings from California’s Cakebread Cellars.

As part of this wonderful evening of food and good cheer, Chapter President Timothy Hogan, FHFMA gave out a number of chapter awards. A full list of awardees is listed in the box to the right.

The chapter wishes to acknowledge the sponsors of the event and thank everyone for attending this year’s dinner.

HFMA Award Recipients:

**HERNAN AWARD**
Gerard A. Vitti
Healthcare Financial, Inc.

**MEDAL OF HONOR**
Jeffrey S. Dykens, CPA
Falmouth Hospital
Gary A. Rosenberg
Verrill Dana, LLP
Richard M. Wichmann
Cambridge Health Alliance

**GOLD**
David S. Szabo
Locke Lord LLP

**SILVER**
Karl Baker
CliftonLarsonAllen
E. Jill Barton, FHFMA, CSBI, CSPPM
Culbert Healthcare Solutions
Jill I. Batty, FHFMA, CPA
Cambridge Health Alliance
Karen L. Rosania, CHFP
Merck

**BRONZE**
Steven P. Davis, FHFMA, MBA
Roger Price
Cerner Health Services
Michael R. Souza, FHFMA
Hospital Association of Rhode Island

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Hernan Award recipient Gerald Vitti with his wife Erin and his children, Celia and Anthony

Chapter President Timothy Hogan and Gold Award recipient David Szabo

HFMA Advisor Co-Editor Linda Burns and her husband Dr. Richard Dennis

Medal of Honor recipients Jeffrey Dykens, Gary Rosenberg, and Richard Wichmann

Silver Award recipients Karl Baker, E. Jill Barton, Jill I. Batty, and Karen Rosania

Bronze Award recipient Roger Price and Chapter President Timothy Hogan

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Photos courtesy of Tony Slabacheski, Regional Medical Waste
The highlighted field “Post-ruling SSI days” contains the number of inpatient days for each Medicare admission that CMS, in conjunction with Social Security Administration data, uses to compile the numerator of the Medicare/SSI fraction.

If one sums these days and then divides by the sum of the “Covered days,” the quotient equates to the CMS published Medicare/SSI ratio published by CMS for the applicable Federal Fiscal Year (not, it is important to (continued on page 33)

Exhibit 3: Concurrent Visibility into 340B Metrics

Exhibit 4: Identification of the SSI ratio numerator composition

<table>
<thead>
<tr>
<th>Aid Category</th>
<th>Column A</th>
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3 Types of SSI Payments:
1. Federal SSI payments (Yes)
2. Optional State SSI payments (No)
3. Mandatory State SSI payments (No)

Eligibility for Federal SSI payments takes precedence over actual payments (in the event of a recoupment)

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note, for the Hospital fiscal year).

Phase 2: Correlation analysis of SSI enrollment status using State level Title XVI status

Exhibit 5 (shown at right) shows an actual example from the State of Pennsylvania that returns aid category/program information that would seem to indicate that this particular patient is entitled to SSI cash benefits (which he or she probably is).

As noted, there are 3 Types of SSI payments:
1. Federal SSI payments (Yes)
2. Optional State SSI payments (No)
3. Mandatory State SSI payments (No)

Of these three only item number one, Federal SSI payments, would qualify this individual to be included in the numerator of the Medicare/SSI fraction and we cannot tell solely from this aid category/program code description which SSI payment this patient is entitled to.

Exhibit 5: Correlation Analyst of SSI Enrollment status from the State Eligibility Files

What we do know is that the eligibility for Federal SSI payments takes precedence over the actual payment in the same way that eligibility for Medicaid takes precedence over payment.

Phase 3: Concurrent tracking of dual-eligible SSI ratio trends

• Virtually all Medicare/SSI patients are also eligible for Medicaid since both programs are means-tested, and in many States people en-
titled to SSI benefits automatically qualify for Medicaid.

• Similar to the State-provided insight into Title XVI (SSI) entitlement, this phase is a component of a larger model that looks to identify trends in utilization that can be identified and tracked to assist in the management of this population.

When we discuss the components of visibility into concurrent Dual-eligible SSI ratio trends, it’s not made to calculate an internal SSI ratio to be used in lieu of the most recent published CMS metric, but to determine how this metric is trending based on all the components noted. These include:

1. The number and type of pending SSI applications
   • This requires coordination with a 3rd party vendor or internal department who’s responsible for filing these applications for SSI and following up with the SSA and/or appropriate judicial body to assess the probability and timing of success.

2. Prior SSI Members Living and Non-Institutionalized
   • A relatively small subset of the Medicare/SSI patients for one year are re-admitted to the subsequent year. Although not comprehensive, it is another variable to consider when determining whether more or less resources are necessary to ensure an upward trending SSI metric.

3. State Aid Category – Program codes
   • These codes are obtained from the State as they pertain to the Federal SSI benefit payments and another variable to consider when performing multi-variable trend analysis.

4. Presumptively eligible- Compassionate Care Applicants
   • There are certain clinical conditions that

(continued on page 35)
presumptively qualify an individual for SSI entitlement.

i. An example would be newborns with a birth weight of less than 1200 grams.

ii. Unlike the Medicaid program for presumptively eligible newborns whose Mothers have Title XIX coverage when they deliver, this category of SSI presumptive eligibility requires a formal application on behalf of the newborn and is subject to the same processing timeframe as other presumptively eligible SSI individuals.

iii. The exceptions to this process are individuals who meet the “compassionate care” parameters who can obtain SSI benefits in a matter of weeks, not months.

Phase 4: Identifying existing hospital or hospital system patients that are not now qualified for SSI but may qualify in the future

This model is based on their clinical/demographic/payer/pharmaceutical profile and a predictive model that narrows this sub-group down to a manageable number for the SSI enrollment vendor.

Summary

The 340B Drug Pricing Program represents a crucial opportunity for hospitals and hospital systems to reduce costs by a significant and material amount in an industry environment that is demanding more cost-effective care. Dedicating the necessary resources to qualify and retain eligibility for this program in the face of an increased focus on compliance by OPA/HRSA will be an important requirement to effectively compete in this constantly changing environment.

About the Author

Robert Gricius, NAVEOS® Founder and CEO, is a nationally recognized authority and expert witness in the area of healthcare finance. For more information please contact NAVEOS® at info@naveosdata.com or call 888-550-2422.
**Program & Special Event Schedule**

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<td>New to Healthcare Seminar</td>
<td>Simmons College, Boston, MA</td>
<td>Gerry O'Neill</td>
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<td>10-21-2016</td>
<td>Accounting &amp; Regulatory Technical Update</td>
<td>Four Points Sheraton, Norwood, MA</td>
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<td>11-15-2016</td>
<td>Capital Finance Program</td>
<td>Boston Convention &amp; Event Center</td>
<td>Matthew Smith, FHFMA</td>
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<td>Karen Granoff</td>
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Education/Program Administration Committee, Chair: Rosemary Rotty, FHFMA, UMass Memorial Health Care Inc.

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