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MASS MEDIA

MA - RI Chapter

Healthcare Financial Management Association

MANAGED CARE

- A Three-Phased Approach to Creating a Sustainable Patient-Centered Medical Home
- Health IT as a Utility Part 2: How to Implement Health IT as a Utility
- Health IT as a Utility: Part 3 Does Health IT as a Utility Make Sense for Your Organization?
- Consolidating Stop Loss Reinsurance Programs Benefits Health Care Providers

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On the Cover

***Cover picture left to right: Richard Twomey**, Consultant, **Jim Donohue**, ECG Management Consultants, **Karen Rosania**, Merck, **Kevin Jourdain**, Sisters of Providence Health System, **Marilyn Perna**, BIDPO, **Jan Costa**, Senior Whole Health, **Radha Radhakrishna**, Partners Healthcare System, Inc., **Kim Carlozzi**, PricewaterhouseCoopers LLP, **Linda Guerra**, BIDPO, **Rick Wichmann**, PricewaterhouseCoopers LLP, **Miriam Jost**, Harvard Vanguard Medical Associates, **Dan Willis**, Winchester Hospital, **Emma Mandell**, ECG Management Consultants, **Woody Woodward**, Senior Whole Health*

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President's Message

With the fall season upon us, your HFMA Chapter continues to offer a full schedule of events. Back-to-School for our Chapter traditionally means that it is time for our New to Healthcare Program at Simmons College. This year, as in prior years, we had strong interest in this program. I would like to thank Karen Hart and Judy Johnson as well as Gerry O'Neil all from Winchester Hospital, along with Kevin McNeil from Lowell General Hospital, for once again organizing a most successful program. Special thanks also go out to Erik Lynch, Rosemary Sheehan, Daniel Willis and Tim Hogan for serving as our expert faculty.

On September 30, we closed out the month with a wonderful day of golf on beautiful Cape Cod. We all know that the Cape is a special place at this time of year, and our golf tournament at Bayberry Hills with overnight accommodations at the Red Jacket Resort in West Yarmouth was outstanding. We tried something different this year as we created an "End of Summer" golf event and moved the outing to the Cape. We hope that you welcomed a change in venue; please let us know what you think. We are especially grateful to Kathleen Maher and Beth O'Toole along with their dedicated team of volunteers for organizing a great day of golf.

Also in September, I attended the HFMA Region 1 Fall President's Meeting with other HFMA chapter presidents from around New England. At this meeting, we discussed issues of common interest among the chapters including the planning for the 2014 Region 1 Conference. As in prior years, our Region 1 Conference will be held in May at Mohegan Sun. We also received a briefing from HFMA national at this meeting. You will be pleased to know that HFMA membership continues to grow, and for the first time has now surpassed 40,000 members nationwide. National HFMA leadership believes strongly that our organization remains well positioned to play a unique role as a credible convener of ideas, strategy, data, and informed points of view with respect to healthcare finance. On a day to day basis, the national HFMA organization works with each local chapter to ensure alignment around four key goals – member participation in education programs, membership growth, member satisfaction, and certification. Your HFMA Board and Program Committees here in the MA/RI Chapter are focused on these objectives in order to further enhance the value of your HFMA membership. The topic of HFMA certification is receiving more emphasis these days, and you will be hearing more about this in the coming months.

As we look ahead, our **Capital Finance Program** is scheduled for the afternoon of Thursday, November 21 at the Boston Convention Center, and our annual **Compliance Program** is scheduled to be held on Friday, December 6 at the Doubletree Hotel in Westboro, MA.

I look forward to seeing you at our upcoming events.

Sincerely,

Roger Boucher
Chapter President

MASS MEDIA

HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

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New Massachusetts-Rhode Island Chapter Members
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MASS MEDIA is a publication of the Massachusetts - Rhode Island Chapter of the Healthcare Financial Management Association devoted to keeping membership current on national & local healthcare financial topics. Opinions and views expressed in the articles and features of the publication are those of the author(s) and do not necessarily reflect the position of the Massachusetts-Rhode Island Chapter or The National Chapter of Healthcare Financial Management Association. Articles submitted are subject to editorial changes made by the committee. Article submissions, comments and requests for further information and advertising rates may be forwarded to: Jean Schuster and Rosemary Rotty, HFMA Massachusetts-Rhode Island Chapter, 411 Waverley Oaks Road, Suite 331B, Waltham, MA 02452, admin@ma-ri-hfma.org

ANNUAL MANAGED CARE CONFERENCE

June 7, 2013

By:
Jim Donohue, MBA

This year's conference Massachusetts Rhode Island HFMA Managed Care Conference was held on June 7, 2013 and titled Healthcare's Puzzle Cube - Aligning Cost, Quality and Reform. The conference discussions and presentations focused on the delivering the promise of the Triple Aim in our market which has seen significant realignment of provider networks, the development of new care delivery models and rapid shift in payment models toward value-based methodologies. The meeting was once again held at the Doubletree Hotel in Westborough and attracted 166 attendees.

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Committee members Jim Donohue, ECG Management Consultants, Jan Costa, Senior Whole Health, and Radha Radhakrishna, Partners Healthcare System, pose with speaker Thomas Lee, MD, Partners HealthCare System

Morning Panel: Strategies for Managing Total Medical Expense While Improving Quality in Light of Reform

Afternoon Panel: Global Payments, New Products and Health Care Reform: How Will It Be Different This Time?

Photos courtesy of Tony Slabacheski, Apollo Health Street

A Three-Phased Approach to Creating a Sustainable Patient-Centered Medical Home

By:
Emma M. Mandell and
Charles A. Brown

Key Takeaways

- The patient-centered medical home (PCMH), an emerging model of care delivery, focuses on comprehensive, coordinated, and integrated patient care, as well as greater efficiency.
- Simply implementing a PCMH is not enough to ensure its success. A sustainable transition to a PCMH involves a three-phased process: implementation, evolution, and integration.
- Health systems considering the transition to a PCMH need to align the model with their strategic objectives before they begin implementation.
- Subsequently, in the evolution phase, health systems must adapt their processes and culture to fit the model. During integration, health systems align with payors and other medical providers to develop innovative payment methods while delivering the best possible patient care.
- Health systems that fail to adopt an effective PCMH model are at risk of falling behind on the opportunity to transform their organizations to a more value-based system of care.

Introduction

Increasing pressure to improve the value of healthcare has led to innovative models of care delivery such as the PCMH. This structure emphasizes comprehensive, coordinated, and integrated patient-centered care that aims to improve health outcomes. At the same time, the PCMH model encourages greater efficiency, resulting in reduced waste and lower costs.

However, simply implementing a PCMH is only the first step in a transformative process. Following implementation, health systems' procedures and cultures need to evolve to support the new model. The PCMH can then be aligned and integrated with external medical services and supported by innovative reimbursement models. To make this process successful, health systems must focus on both maintenance and continuous improvement. It is equally important for health systems to fully leverage the PCMH model to improve patient care, better manage populations, and reduce healthcare costs.

This *Diagnostic* examines each of the three phases of the transformation process – implementation, evolution, and integration – and how they form the basis of a successful PCMH. Using these three steps as a guide, health systems can move beyond the implementation of their PCMH model and ensure its long-term sustainability.

PCMH: Key Features

The PCMH fundamentally redesigns the way care is delivered. The following are the key components of an effective PCMH model:

- *Team-Based Care* – Seamless, comprehensive care is provided by a team of physicians, nurses, medical assistants, case managers, pharmacists, social workers, nutritionists, and other healthcare professionals.
- *Patient- and Family-Centered Care* – Care is patient- and family-centric, as care teams partner with patients and families to understand care needs and make informed decisions.
- *Comprehensive Care* – The PCMH provides or coordinates access to all services to meet a patient's care needs. The primary care physician is responsible for managing a patient's care from start to finish.
- *Coordinated Care* – A PCMH team coordinates the patient's full continuum of care (i.e., primary

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(**Sustainable Patient-Centered Medical Home -** *continued from page 6)*

care, specialty care, hospitals, home health care, and community services). The PCMH ensures seamless transitions between different types of care and clear communication among care providers.

- *Access to Care* – The PCMH model ensures access to care, services, and information as determined by patient population needs. This model provides alternative means of care delivery and communication (e.g., telephone visits, group visits, patient portals, extended hours, urgent care).
- *Care Management* – Care teams proactively use population health management, wellness promotion, disease management and prevention, and patient engagement and education to manage their patients' health.
- *Health Information Technology (IT)* – Important infrastructure is in place to support the PCMH, including electronic medical records, a patient portal, decision support, predictive modeling, electronic prescribing, a patient registry, and reporting capabilities.
- *Quality, Safety, and Performance Improvement* – Successful PCMHs commit to the highest standards of quality, safety, and performance by engaging in continuous improvement activities and utilizing best practices and standardized processes.
- *Payment Reform* – Reimbursement is restructured to appropriately recognize the added value provided to patients who are part of a PCMH.

The Three-Phased Approach

Overview

Although many health systems are beginning to adopt a PCMH model, they often lack the resources and knowledge to leverage the model for best results. Our three-phased approach provides a framework with which to implement a PCMH, adapt current systems to fit the new model, and integrate clinical services while supporting the model with innovative financial arrangements. By following this approach, organiza-

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(Sustainable Patient-Centered Medical Home - *continued from page 7)*

tions have a structured means of transforming the way they deliver patient care.

Moving left to right, the following graphic depicts this three-phased approach as a continuum, from implementation to evolution to integration (see chart below):

Implementation

Although the PCMH model has great potential as the future of healthcare delivery, transitioning to a PCMH can be a daunting prospect for any healthcare organization. Many health systems are not yet ready for the transformation: they lack essential change management capabilities, time, or financial capital, or they are not prepared for the substantial cultural or infrastructure changes required.

Those systems that are positioned to move to a PCMH model need to answer some critical strategic questions

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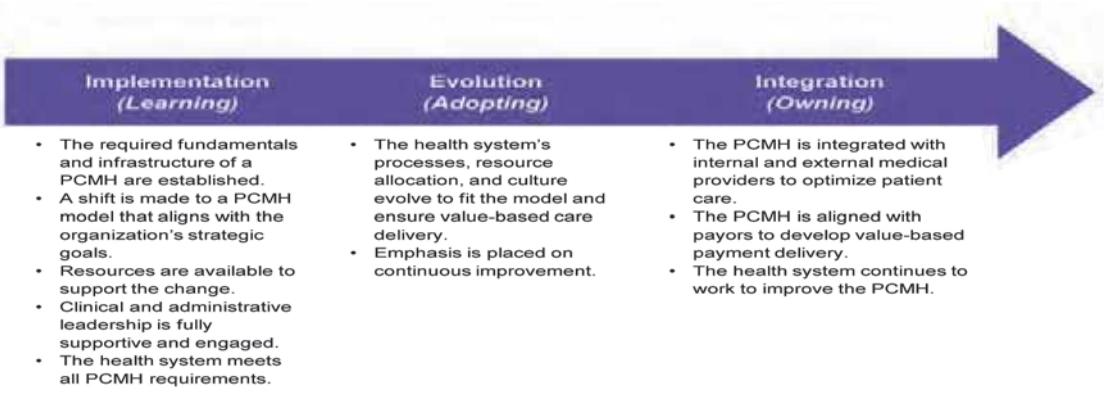

(Sustainable Patient-Centered Medical Home - *continued from page 8)*

before they take action at the tactical level:

- How does the model support the health system's strategic goals and vision?
- How does the health system ensure clinical and financial alignment with the model?
- What infrastructure is required to support the model and other care redesign initiatives over time?
- What are the desired outcomes of the model?

Once the strategic issues are addressed, health systems can move forward with implementation. At its core, the PCMH model will include the aforementioned key components (e.g., patient-centered care, comprehensive and coordinated care, health IT). While the specifics of how to proceed will depend on the capabilities and culture of the organization, a successful implementation will have at its foundation the following elements:

- The commitment and support of clinical and administrative leadership.
- Ongoing clinical engagement.
- Alignment with the health system's mission, vision, values, and goals.
- Payment methodologies designed to support the delivery of enhanced, value-based care services.
- Staff and leadership with change management skills.

By considering both the strategic and tactical implications of a transition to a PCMH, health systems will be better able to develop a sustainable medical home that provides improved care and services to patients.

Evolution

If the implementation phase is about lining up the pieces needed to operationalize the PCMH, the evolu-

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(**Sustainable Patient-Centered Medical Home -** *continued from page 9)*

tion phase is about achieving provider organization and physician buy-in of the PCMH model and having it become a part of the culture and daily processes. Below are some ways that practices can smooth the evolution to a PCMH model and ensure its long-term success.

- *Cultural Change* – Understand the substantial cultural transformation necessary for PCMH adoption and educate providers on the nontraditional practices of medicine that the model requires.
- *Continuous Improvement* – Determine the resources and tools necessary to maintain continuous support, development, and improvement of the model.
- *Daily Work Flows* – Redesign work flows, policies, and procedures to support the model.
- *Time* – Consider the additional time needed for the transformation and the impact this will have on provider schedules and patient volume.
- *Resources* – Determine the additional resources needed to support the model.
  - — Training programs for staff.
  - — Educational resources for patient engagement.
  - — Tracking and reporting tools.
  - — Appropriate staffing levels (e.g., physicians, case managers, nurses, medical assistants, other support staff).
  - — Healthcare IT infrastructure and optimization.

When taken together, these actions help ensure that the introduction of the PCMH model will be as seamless as possible. A smooth transition is beneficial not just for the health system but patients as well – the sooner the PCMH model is fully embraced by providers, the sooner patients will begin to experience improvements in care.

Integration

Integration is the natural next step after evolution. In the evolution phase of the continuum, procedures, culture, and behaviors evolve to integrate the PCMH model within the health system. The integration process goes beyond the health system itself to include providers across the continuum of care, such as hospitals, specialty care, and subacute care. At the same time, the PCMH also aligns with payors to take advantage of innovative payment methods that reward value-based care. We examine below how integration can make a positive difference for both clinical care and payment reform.

Clinical Care Integration

While initially the PCMH model addressed primary care medicine, today it focuses on the patient's total health picture. Toward this goal, the model emphasizes communication and collaboration among all of a patient's medical providers, including primary and specialty care, hospitals, home health facilities, nursing facilities, and behavioral health.

By coordinating a patient's comprehensive care needs, the PCMH model integrates the previously fragmented and inefficient healthcare system. The results are threefold:

1. Patient care is improved as physicians work together to develop best practices and standardized ways of practicing medicine.
2. Health systems can better manage patient populations, operate more efficiently, and keep costs down, improving long-term viability.
3. Health systems can position themselves in the competitive healthcare market as high-quality, high-value organizations.

With better integration, health systems and payors are already seeing improved clinical and financial outcomes, including the following:

- Reduced unnecessary ER visits.
- Reduced unnecessary readmission rates.
- Reduced per member per month (PMPM) costs.
- Increased patient satisfaction.
- Reduced patient wait time and improved access to care (i.e., availability of appointments).
- Improved patient outcomes for chronic conditions (e.g., diabetes, cardiovascular disease, hypertension).

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(**Sustainable Patient-Centered Medical Home -** *continued from page 10)*

The table below presents the clinical and financial improvements already experienced by various PCMH pilots.

Financial Integration

Transitioning to a PCMH model also means moving from current volume-based to value-based payment methodologies, where the focus is not on the number of procedures performed but patient outcomes. A successful PCMH model will include reimbursement processes that promote high-value care delivery and improved outcomes, while still lowering the total cost of care.

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PCMH Clinical and Financial Improvements[1]

Pilot	Number of Patients	Incentive	Results		
			Hospital Reduction (Percentage)	ER Visit Reduction (Percentage)	Total Savings Per Patient
Colorado Medical Homes for Children	10,781	Pay for Performance (P4P)	18%	N/A	$169 to $530
Community Care of North Carolina	> 1 Million	PMPM Payment	40%	16%	$516
Geisinger Health System	TBD	P4P; PMPM; Shared Savings	15%	N/A	N/A
Group Health Cooperative	9,200	TBD	11%	29%	$71
Intermountain Healthcare	4,700	P4P	4.8% to 19.2%	0.0% to 7.3%	$640
MeritCare Health System and Blue Cross Blue Shield (BCBS) of North Dakota	192	PMPM; Shared Savings	6%	24%	$530
Vermont Blueprint for Health	60,000	PMPM	11%	12%	$215

(Annual Managed Care Conference - *continued from page 5)*

In what is becoming a tradition, the conference began a presentation on national legislative developments delivered by Alexandra Calcagno, Director, Federal Relations at the Massachusetts Medical Society. This year's topics included the implications of the budget sequestration, the implementation of the Affordable Care Act, Medicare physician payment reform and other key challenges and opportunities facing congress in 2013.

Committee members Emma Mandell, ECG Management Consultants, Sean Murphy, Blue Cross Blue Shield of Mass, and Daniel Willis, Winchester Hospital

Following the legislative update, was Thomas L. Lee, M.D., Network President, Partners HealthCare System, titled The Era of Delivery System Reform Begins. Dr. Lee outlined three phases of health reform, which include Phase 1 - Insurance Reform, followed by Phase 2 - Payment Reform and Phase 3 - Delivery System Reform. He described that we are just now beginning to enter Phases 2 and 3 which will be disruptive, create pressure for integration among hospitals, physician and payors. Dr. Lee also suggested that the work of thought leaders Michael Porter, Atul Gawande, MD and Richard Bohmer provide guidance for how organizations can overcome the resistance to disruptive change.

The morning session concluded with panel discussion titled Strategies for Managing Total Medical Expense While Improving Quality in Light of Reform. The discussion was moderated by Dr. Richard Parker, Chief Medical Officer, Beth Israel Deaconess Care Organization LLC, and featured panelists Dominic Delmonico, FHFMA, CPA, Senior Vice President for Managed Care Contracting and Network, Care New England; Win Whitcomb, MD, Chief Quality Officer, Baystate Health Systems; Emily DuHamel Brower, Executive Director, Accountable Care Programs, Atrius Health; and Lisa Whittemore, Vice President, Performance Measurement Improvement, Blue Cross Blue Shield of Massachusetts. The discussion focused on the work conducted by providers and health plans to respond the increasing demand to balance the management of costs and improvement of quality in the health care system.

The afternoon session began with a presentation by David Seltz, Executive Director of the Massachusetts Health Policy Commission. Mr. Seltz provided the described the legislative history that led to the passage of Chapter 224 in Massachusetts and the creation of the Health Policy Commission. He then continued to outline the structure, governance and goals of the HPC and the work it will be conducting over the coming years. The conference concluded with the afternoon panel, titled Global Payments, New Products and Health Care Reform: How Will It Be Different This Time? and was moderated by Nancy Turnbull, Senior Lecturer on Health Policy, Associate Dean for Educational Programs, Harvard School of Public Health. The panelists included Amy Whitcomb Slemmer, Executive Director, Health Care For All; Jeffrey I. Lasker, MD, Chief Executive Officer, New England Quality Care Alliance; Paul Kasuba, MD, Chief Medical Officer, Tufts Health Plan; Rick Weisblatt, Ph.D., Senior Vice-President for Provider Network; and Product Development, Harvard Pilgrim Health Care and Lynn Kohrs, Manager of Health Benefits & Programs, GE Aviation. In this discussion, Ms. Turnbull and the panelists examined the how and why the current health reform initiatives can be successful where efforts in past decades have failed.

New President Roger Boucher, Bank of America Merrill Lynch, welcomes attendees

We extend special thanks to each of panelists and presenters who shared their time and perspective to help make the conference a success. We are also grateful to PricewaterhouseCoopers, LLP for once again donating Red Sox tickets for the raffle and to the Managed Care Committee for all their work to put together another outstanding conference.

Health IT as a Utility Part 2:
How to Implement Health IT as a Utility

By:
Jennifer Vanegas

Many health care providers prefer to outright purchase their IT assets. But in Part 1 of this series, we explored the problems, both short- and long-term, that owning IT assets can cause.

Is there a better approach?

Proponents of the "health IT as a utility" approach contend that the acquisition of IT assets should be treated as any other utility expense; that is, technology should be treated as a regular, ongoing operating expense, similar to such other utilities as electricity, heating, etc. But how does an organization go about implementing this concept?

In this Part 2, we consider how a health care organization would develop a framework in which technology expenses can be treated as operating expenses rather than capital expenses.

Specifically, we will look at one of the easiest, most straightforward approaches to implementing this concept: the lease-based technology refresh program.

What does leasing technology entail?

A technology lease program is an **operating lease**. A technology lease is not like traditional bank financing. Nor does it bear any implication on the financial condition of your organization or your availability of capital or funding sources.

In a technology lease program, your organization rents (rather than owns) its IT equipment. As the equipment ages, you return the old equipment and receive new equipment. When you return the old equipment, the leasing partner is able to access whatever residual value may remain in the old IT equipment – typically through the resale of the old equipment or its parts.

Leases for IT equipment can be obtained primarily from three sources:

"Traditional Bank" leasing. Most commercial banks offer equipment leasing. However, they typically are not well suited for technology leases. Specifically, banks are not set up to handle the old equipment that will be returned at the end of the lease, so they may not want to get involved with the refresh cycle – a critical component of the technology lease. They also may be less willing to finance software and service costs.

Captive leasing companies. Many manufacturers, such as Dell, Cisco, etc., offer financing options for their equipment. However, they usually provide financing only for their own equipment; an organization that procures equipment from a variety of manufacturers may need to patch together separate leases with each vendor. Additionally, organizations may find it difficult to switch manufacturers.

Independent leasing companies. These companies (some of which are bank-owned or affiliated, which is ideal) put the focus on the customer, not the product. They are not tied to individual manufacturers, and they can provide leases for all of the varied equipment an organization may need. They can also provide administrative efficiencies, such as combining separate leases with different refresh cycles (such as one lease for networking equipment, a second lease for desktop computers, etc.) into one master lease with a single consolidated invoice.

The residual value of the old equipment is the key component that drives down the cost of a technology lease program. In fact, the cost to lease the equipment is less than the cost to outright purchase the

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equipment – a point we will explore in the third part of this series.

But more to the point of this paper, the lease expense is an operating expense. This expense comes out of the hospital's operating budget, just as any other utility expense, like heat, water, electricity, etc.

Because your technology expense becomes an operating expense, your organization can avoid many of the problems with treating the purchase of IT assets as capital expenditures.

And finally, the refresh component of a technology lease program is yet another strong point in favor of leasing. In the lease-based technology refresh program, the refresh cycle is written directly into the structure of the lease. As a result, your organization regularly and predictably receives new IT systems and devices to address market or regulatory demands to stay updated.

How does a lease-based technology refresh program work?

Length of the terms

The leasing partner will start by working with you to identify which equipment is best suited for this program. Typical targets include computer hardware, tablet devices, networking equipment such as storage and servers, wireless infrastructure, printers, etc.

During this assessment process, the leasing partner will estimate the useful life of the assets. Networking equipment, for example, tends to have a five-year useful life. In this case, a five-year refresh cycle might make sense, meaning your organization would receive new servers every five years. On the other hand, desktops and laptops typically become obsolete more quickly, so an organization might prefer a shorter three-year refresh cycle for these devices.

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Whatever the circumstance, customized lease solutions can be built to address your organization's specific assets as well as your organization's preference for holding onto existing equipment.

Lease rate

Three criteria will determine the rate of your lease:

1. The overall interest rate environment (usually measured against U.S. Treasury notes)
2. The creditworthiness of your organization
3. The leasing partner's estimates of the equipment residual value (which varies by equipment type)

As stated, the key to leasing – what makes it a financially viable model – lies in the residual value of the equipment. The ideal leasing partner has precisely the experience and the resources needed to tap into this residual value and remarket the old equipment or its parts. The more residual value the leasing partner believes will exist at the end of the lease, the more attractive terms your organization will receive.

Repairs and maintenance within a technology lease

Typically, the lease will be structured so that your equipment is always under warranty, which is not affected by the lease. If repairs are needed, your IT department simply contacts the warranty service company directly.

Should the equipment not be under warranty, your organization is responsible for the repair. If the equipment is beyond repair, your organization will have to replace it with "like-kind" equipment – not necessarily new equipment, but a replacement comparable to the original.

Returning equipment at the end of the lease

When the lease ends, the process is straightforward: Your organization simply packages the old equipment (original packaging is not required) and sends it back to the leasing partner. The lease can be structured to make this process as easy as possible. For example, the leasing partner may provide:

+ Pack and ship services, where the leasing partner brings in a team to package and palletize the equipment for your organization.
+ Asset management software, so your IT department can easily track all the assets covered by the lease. More sophisticated tracking systems even include mobile device apps and barcode scanning ability, so equipment can be accounted for directly in the field.

New equipment orders

Now comes the best part: obtaining your new equipment. Your leasing partner should assign a Project Manager who will work with your IT department to manage the ordering process. In this case, your IT director selects the vendor of choice (maybe under GPO guidance) and the specific equipment your organization needs, and then submits quotes or specifica-

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(**Health IT as a Utility Part 2: -** *continued from page 15*)

tions to the Project Manager. The Project Manager handles all of the administrative aspects of ordering the equipment, and he/she will also be able to provide consultative services to help the IT director make the most cost-effective purchasing decisions.

Next in the series…

A lease-based approach to technology provides organizations with a simple, structured platform to treat health IT as a utility. But although we can talk anecdotally about the benefits of leasing, the proof will naturally lie in the actual costs. Do the numbers support the leasing of IT assets? Is there a business case for change at your organization?

We answer these questions (and more) in "Does Health IT as a Utility Make Sense for Your Organization?" — the third and final installment of our three-part paper, "Health IT as Utility." ❑

About First America Healthcare Finance

First American Healthcare Finance is a $25-billion direct lender. Jennifer serves customers in MA, NJ, CT and RI from her office in Fairport, NY. First American's equipment financing services are HFMA Peer Reviewed and exclusively endorsed by the American Hospital Association (AHA).

About the Author

Jennifer Vanegas is a healthcare technology finance specialist with First American Healthcare Finance (*www.fahf.com*). Working from the corporate office in New York, Jennifer can be reached at (585) 643 3377 or at *jennifer.vanegas@fahf.com*. Jennifer is an active member of the New Jersey Chapter of HFMA.

LOGIXHealth

Making intelligence matter

LOGIXTIP#061

For 2014, CMS adjusted the Observation time requirements (from 24 hours to "two midnights") changing the qualifications for inpatient status and further incentivizing throughput efficiency.

LogixHealth provides expert coding and billing for top hospitals, emergency departments and office-based practices nationwide, processing over 6 million visits annually. Located in Bedford, Massachusetts, in a state of the art facility, our staff of over 400 people service approximately 5,000 providers in over 30 states.

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8 Oak Park Drive, Bedford, MA 01730 phone: 781.280.1736 www.logixhealth.com

Health IT as a Utility: Part 3

Does Health IT as a Utility Make Sense for Your Organization?

By:
Jennifer Vanegas

Traditionally, health care organizations treat technology assets as capital assets. Technology purchases are included in the capital expenditures budget, and these assets are outright owned by the organization.

Increasingly, though, the cost-effectiveness of this approach is in question. In our three-part paper, Health IT as a Utility, we are analyzing the business case for this approach.

In part one, "Is Owning IT Assets Inefficient?" — we identified how the capital approach can be inefficient and expensive. In part two, "How to Implement Health IT as a Utility" — we analyzed how a lease-based technology refresh program might work.

In this third and final part, we look at the numbers behind technology leasing to help you determine whether

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Your chance to win a $100 gift card AND earn educational credits for the Chapter!

How do you win?

Read all four articles in this issue of *Mass Media* and answer five questions for each article to be entered into a random drawing for the $100.00 gift card.

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First, read the four articles in this issue:

1. **A Three-Phased Approach to Creating a Sustainable Patient-Centered Medical Home**
2. **Health IT as a Utility: Part 2: How to Implement Health IT as a Utility**
3. **Health IT as a Utility: Part 3: Does Health IT as a Utility Make Sense for Your Organization?**
4. **Consolidating Stop Loss Reinsurance Programs Benefits Health Care Providers**

Next, follow this link to a survey with the article questions:
http://survey.constantcontact.com/survey/a07e8ef14vehn3fxne7/start

Finally, answer the questions and provide your name and HFMA ID number (you *must* be an HFMA member to qualify for the drawing). We will close the survey 60 days after the newsletter is released. The winner will be notified soon after and the $100 gift card will be delivered.

Good Luck!

Consolidating Stop Loss Reinsurance Programs Benefits Health Care Providers

By:
Richard D. Twomey

As government programs and private health insurance companies increasingly transfer the financial responsibility for claims costs to health care providers through accountable care organizations, bundled payment mechanisms, and other reimbursement mechanisms, health care providers would do well to consider consolidating the financial risks into one stop loss policy.

With greater frequency health care providers (IPAs, Medical Groups, PHOs) are forced to participate in a smorgasbord of managed care contracts characterized by annual budget targets, claims cost exposure, quality metrics, and patient experience feedback measurements. While there are opportunities to share in upside savings, there is also the possibility of significant financial losses. It's not a coincidence that almost all of the Medicare Shared Savings Program ACOs elected to sign on to the Track 1 model, which rewards savings without penalizing losses. Although many of the managed care contracts include some form of stop loss reinsurance, there is a good chance that the cost, and

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(**Consolidating Stop Loss Reinsurance -** *continued from page 20)*

the policy terms, do not meet the price, and risk tolerance requirements of the healthcare provider.

It is easy to understand why health care providers purchase stop loss reinsurance as part of the managed care contract:

- it is expedient
- there may be insufficient funds in the existing budget to purchase stop loss in the commercial marketplace
- the initial membership numbers start out small

But in the longer term, purchasing stop loss reinsurance which combines the risk of all of the managed care agreements makes more sense.

Purchasing stop loss reinsurance is an important decision which can have a significant impact on the bottom line. The coverage needs to be tailored to the price, and risk tolerances of the health care provider, and provide reasonable protection for the risk assumed in the managed care contracts. The reinsurance coverage offered by governmental programs and private insurance companies is generally a one size, one price, fits all proposition. While the coverage is specific to the terms of the managed care contract, the coverage offerings are often very limited, and the pricing is often based on the risk pool of the insurer, not the experience of the individual health care provider. While a particular health care provider may have much better claims management/cost management experience than the health care providers in the risk pool, the stop loss rates may not reflect this efficiency. As the price of the stop loss reinsurance is not vetted in a competitive bidding process, the price may be too high, and fluctuate significantly from one year to the next. On the other hand the commercial stop loss reinsurance marketplace offers significant flexibility in policy terms and risk assumption designs. The price is based on industry wide claims experience, tested in the competitive marketplace, and refined over many years.

In consolidating the reinsurance programs, health care providers should be diligent to purchase coverage that takes into account:

- the financial exposure of each managed care contract
- the range of covered services
- the negotiated contractual reimbursement schedule
- the impact of the contracted provider network
- the number and value of high cost claims
- the total medical expenses

Each health care provider has a unique set of stop loss requirements based its size, composition, and the number, and type of managed care contracts. Detailed claims expense analysis may indicate that while one health care provider may seek protection from a few very expensive claims, others may seek financial protection from an unusually large number of moderately costly claims. Claim specific stop loss protects against high cost individual claims whereas; aggregate stop loss protects against high utilization of services. But each situation needs close scrutiny, as illustrated by the following examples:

- An IPA responsible for the cost of both physician and hospital services may purchase stop loss reinsurance to limit losses on expensive hospital claims, but not purchase coverage for physician services, which can be managed within the IPA.
- A fledgling IPA may want to purchase a comparatively low hospital services deductible, a more mature IPA may want to purchase a higher hospital services deductible
- An established PHO may feel comfortable self-insuring the in-network hospital and physician covered services, but seek protection for transplants, out-of-area services, and retail pharmacy coverage

Price is also a serious consideration. When the stop loss reinsurance is spread over a number of different managed care policies, the health care provider does not receive the purchasing power economies of scale in either price, or program flexibility. Commercial reinsurers are attracted by larger numbers of covered lives. Generally, the greater the number of covered lives, the more competitive the bidding process, and the better the pricing. Plus, government programs and health insurance companies have no compelling reason to

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(**Consolidating Stop Loss Reinsurance -** *continued from page 21)*

offer the most competitive stop loss rates. It's not their core business; it's more of an accommodation, or a token of good faith in bargaining. The thinking is to let the commercial reinsurers take the large risks.

Over time, as health care providers sign additional managed care contracts containing stop loss reinsurance, and the membership numbers increase, new problems arise:

- The deductible and coinsurance terms of the stop loss coverage becomes out-dated
- Administration of the various reinsurance policies, renewal dates, and prices becomes burdensome
- There is a lack of consolidated management reports which identify overall financial exposure
- The annual stop loss reinsurance settlement calculations may reveal unexpected large financial losses

The commercial reinsurance market has tremendous flexibility of terms of coverage provisions and contract riders. Common commercial policy riders, favorable to the insured include:

- A 30 day carry forward provision, which allows covered services incurred during the last 30 days of a policy, which did not reach the deductible in the policy period, to be applied to the satisfaction of the deductible in the next policy period. In this case the health care provider must renew the policy with the same reinsurer.
- Refund provisions which return a portion of the premiums to the insured if at the end of the policy period, the claims are less than 60% or 65% of the total premium
- Multiple risk groups may have policy terms, and premium rates by class, common classes include commercial, Medicare and Medicaid
- Additional managed care contracts may be added to the existing policy

The advantages of negotiating a consolidated reinsurance policy in the commercial marketplace are:

- The best price by taking advantage of the buying power of the full membership, and competitive bidding by commercial reinsurers
- One administration process for all claims reporting and filing
- Consolidated financial reporting of the claims payments, payment requests, and pending claims
- Coverage that is specifically designed to meet the organizations risk tolerance
- Better cash flow because specific claims payments are made as soon as a deductible is reached, not the end of a settlement period
- One renewal process for all stop loss coverages
- The ability to switch reinsurers for pricing considerations every 12 months
- The ability to negotiate the managed care agreements with the insurance companies without the distraction of reinsurance coverage
- Access to the significant cost savings programs negotiated by large reinsurers, including transplants networks, neonates networks, hospital audit programs,
- Expansive stop loss policy terms and riders
- Newly signed managed care contracts can be incorporated into the existing policy

As health care providers move into the business of not only providing accessible, high quality health care services, but also taking on the financial responsibility for those services, they should seriously consider consolidating their stop loss reinsurance to obtain the best price, and policy terms.

About the Author

Richard Twomey has over 28 years of managed care experience ranging from underwriting and brokering provider stop loss and HMO reinsurance products, to developing strategic business plans,and conducting buyer decision making and competitive analysis for HMOs and health care providers.

Welcome New Members!

The following members recently joined the Massachusetts-Rhode Island Chapter of HFMA. 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

August 1, 2013 – September 30, 2013

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Culbert Healthcare Solutions, Inc.

Mary Jane Anderson
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Nicole Calisi
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Erin Dimick
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Nancy Medina
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Sean P. O'Neill
Steward Medical Group, Inc.

Olugbenga A. Osho
MASS HEALTH

David Peck
Environmental Systems, Inc.

Sharat Rastogi
Cognizant Technology Solutions

Donna Rizzardini, CRCR

Charles Saponaro
Medical Record Associates, LLC

Kate Signorelli

Kimberly Tran
Beth Israel Deaconess Med Ctr

Patrick Uyesaka

(**Health IT as a Utility Part 3: -** *continued from page 18*)

this approach might make sense for your organization. However, before you can advocate any specific position on the issue, you must understand the broader technology environment within your organization.

Questions to consider

+ *As technology evolves, has your organization changed how you budget and procure it?*
+ *Are you satisfied with your ability to embrace & implement the newest technology?*
+ *Does budget uncertainty limit your ability to keep your IT environment up to date?*
+ *Does the current technology at your facility meet the expectations of your patients and staff? Are budget constraints preventing that?*
+ *Does your IT department spend enough time thinking about strategic IT initiatives and ways to leverage technology to improve the health care experience, or is the IT department focused on general IT maintenance, upkeep and support?*

In the pages that follow, as we assess the financial implications of a lease-based technology program, we will help you define the answers to these questions.

Financial implication #1: Predictable, stable budgets

As we discussed in part two of this paper, a technology lease program is an operating lease. This operating lease brings with it a predictable, manageable operating expense.

Whereas organizations that own their technology typically allocate purchases from the capital budget, lease

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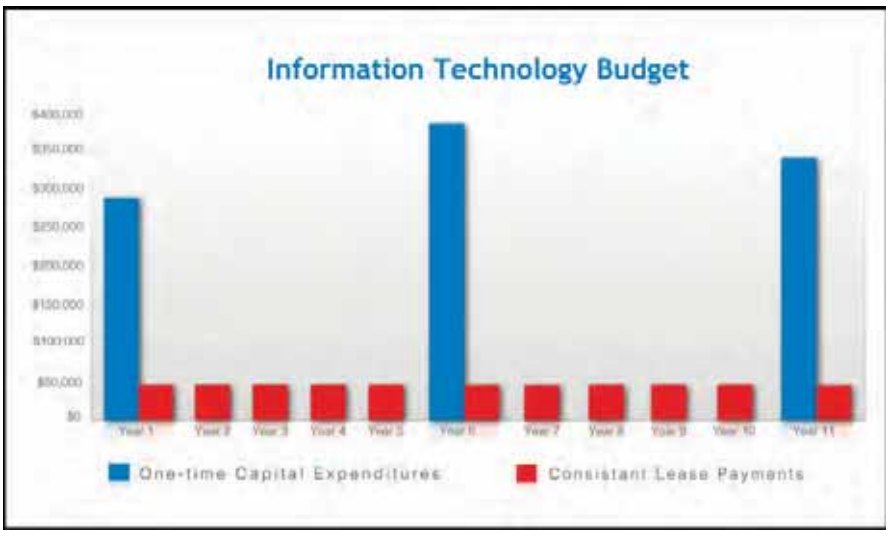
(**Health IT as a Utility Part 3: -** *continued from page 24*)

payments come from the operating budget. This simplifies the acquisition of IT assets significantly. In fact, the lease payments are often small enough to fall within the spending authority of department managers.

Because the lease payments are fixed, predictable operating expenses known ahead of time, budget peaks and valleys are eliminated. Working capital is freed up to finance growth and expansion — as it should.

In part one, we showed you the typical budget for technology capital expenditures. See how lease-based IT budgeting changes the picture: (chart at right)



A lease-based technology program smooths out the IT budget, relieves the stress associated with the IT planning process, and relieves the unpredictability that occurs when IT assets are owned and treated as capital expenditures.

Financial implication #2: Potential lower total cost of ownership

In part one of this paper, we showed you that the maintenance cost of a five-year-old laptop is more than double that of a one-year-old laptop. With a lease-based refresh program, your organization receives new, updated equipment on a regular cycle. As a result, your organization does not have to incur the expense of maintaining obsolete equipment.

But how do the numbers compare in a real-world example? Consider this scenario: Say your organization needs to acquire 500 desktop computers, which will most likely become outdated within four years. Let us compare the cost of purchasing 500 PCs against the cost of leasing 500 PCs.

Owning the Technology

To calculate the total cost of ownership, we can use current market conditions to quantify the direct and indirect costs of purchasing 500 computers:

The two bottom charts at right represent total ownership costs over four years. To bring these costs into today's dollars:

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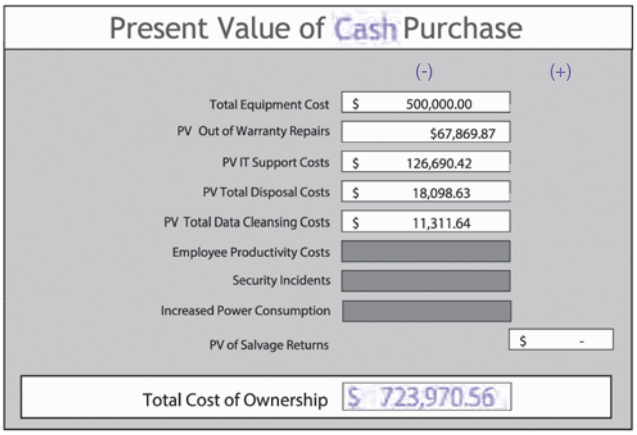
Direct Costs

Useful Life	4 Years
	(-)
Equipment Cost/ Unit	$ 1,000.00
Number of Units	500
Shipping Costs	$ 10,000.00
Sales Tax (%)	0.00%
Total	$ 510,000.00

Indirect Costs

Opportunity Cost of Capital (%)	2.50%	
	(-)	(+)
Salvage Value Assumption		
Out of Warranty Repairs	$ 75,000.00	
IT Support Costs	$ 140,000.00	
Disposal Costs	$ 20,000.00	
Data Cleansing Costs	$ 12,500.00	

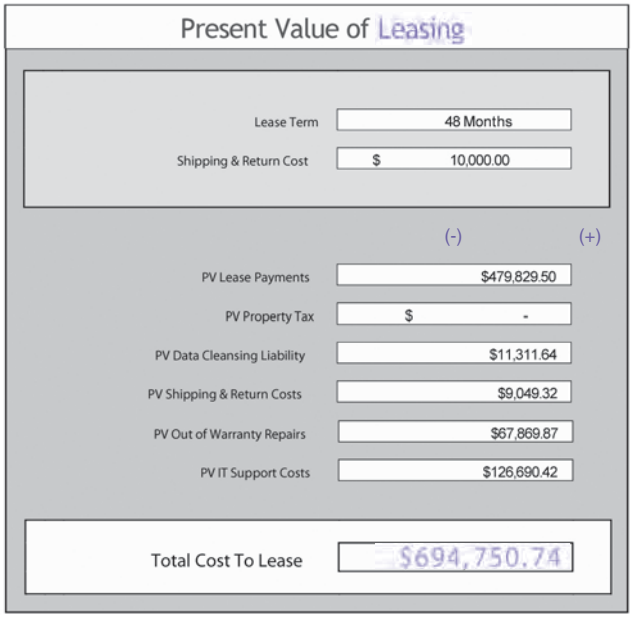
(**Health IT as a Utility Part 3: -** *continued from page 25)*



Notice that this figure — $723,970 — does not include ancillary expenses such as loss of employee productivity, potential security threats and increased power consumption which are typical of older, less efficient equipment. In other words, the total cost of ownership could be even higher than $723,970.

Leasing the Technology

Now suppose we structure a lease program for these PCs with a four-year refresh cycle. Using the same current market conditions, we can calculate the present value of the expected cash outlays over the life of the lease as:



Compare $694,750 for the total four-year cost of leasing 500 desktops to $723,970 (or more) for the total four-year cost of owning 500 desktops. Food for thought.

Financial implication #3: Consistently high IT standards

Leasing IT equipment, rather than purchasing IT equipment, enables your organization to consistently obtain the most sophisticated current technology. The implications here are immense.

> 65% of the respondents to a 2005 survey by the Equipment Leasing Association said that having the latest equipment is the number one benefit to leasing.[1]

Because a lease-based technology refresh program ensures that your organization regularly disposes of old, outdated equipment, the IT department is no longer forced to play the role of repairman. As this support burden is relieved, the CIO is able to switch the focus of the entire IT department expertise from operations – which frequently involve solutions — to the more appropriate strategic use of emerging technologies.

The technology lease, in essence, codifies you organization's commitment to technology.

Leasing technology ensures that your organization is forward thinking, rather than reactive. Your organization becomes nimble, more competitive, and well positioned to take advantage of new developments as they appear on the horizon.

Financial implication #4: Hassle-free equipment disposal

It is not unheard of to find ancient, dusty computers hiding in the storage closets of an organization's IT department. Equipment breaks down or gets replaced, and the department has nowhere to put the old pieces … and so the equipment eventually piles up in corners and becomes part of the scenery.

The alternatives are not compelling, either: shipping the old equipment off to a landfill, or paying someone to come and dispose of the equipment in an environmentally friendly manner.

After all, your organization is in the business of providing health care. It is not in the business of disposing of old and outdated IT equipment.

This is where the right leasing company makes all the difference.

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(**Health IT as a Utility Part 3: -** *continued from page 26*)

The predictable refresh cycle allows the IT department to adequately plan for end of lease returns. Additionally, the leasing company should help make the process of equipment disposal straightforward and painless. The lessor may even provide asset tracking software that allows the IT department to easily identify every piece of leased equipment out in the field. And with add-ons such as pack and ship services, and Department of Defense-level data cleansing services, the logistics of the returns become instantly manageable.

Furthermore, leasing is green. An experienced technology leasing company will be able to remarket 100% of your old equipment. By putting the old equipment back into use rather than ending up in a landfill, leasing is not only hassle-free — it also supports your organization's sustainability initiatives.

Financial implication #5: Improved marketability

When IT assets are owned, the tendency is for an organization to hold on to the assets beyond their useful lifecycle. However, a technology lease program makes the refresh cycle automatic, so the technology your organization offers is always up-to-date. This commitment to technology presents you with a remarkable angle to differentiate yourself.

Innovative thinking goes a long way toward attracting more patients and star faculty. Many hospitals and health systems are getting creative with how they use technology to stand out in a crowded market.

How might the better use of technology attract world-class physicians, enhance service offerings and help your organization stand out in the market?

Ultimately, by treating health IT as a utility, your organization can better manage the challenges of short-life technology. A lease-based technology refresh program achieves that goal with a simple, straightforward framework.

Where to go from here?

To start reaping the benefits of treating health IT as a utility, the first step is to decide which technology and IT equipment at your organization can be treated as a refreshable commodity and which are better suited for ownership.

From there, the next step is to consider how frequently your organization will want to renew these assets. And finally, you are ready to discuss the program options available with an AHA-endorsed and HFMA Peer-Reviewed leasing partner.

About the Author

Jennifer Vanegas is a healthcare technology finance specialist with First American Healthcare Finance (*www.fahf.com*). Working from the corporate office in New York, Jennifer can be reached at (585) 643 3377 or at *jennifer.vanegas@fahf.com*. Jennifer is an active member of the New Jersey Chapter of HFMA.

Works Cited

[1] Peter Alexander, "Should you lease or buy your tech equipment?" Entrepreneur, October 2005.

(**Sustainable Patient-Centered Medical Home -** *continued from page 11)*

Too often, health systems explore PCMH models and payment delivery options separately, exacerbating the misalignment of clinical and financial initiatives. Healthcare leaders must instead work closely with payors to devise value-based payment methodologies that benefit both parties and support the PCMH's near- and long-term strategic goals.

When implementing a PCMH model, organizations should consider the following steps to ensure that payment methodologies are supporting value-based care:

- Review current managed care contracts to understand whether they appropriately support value-based care delivery.
- Determine the local, regional, and/or national market trends regarding reimbursement methodologies for a PCMH.
- Determine the organization's available and needed financial capital to support the model.
- Understand how new payment models will: (1) support the PCMH transformation, (2) affect provider compensation, and (3) help incentivize behavior.
- Begin discussions with payors to design collaborative value-based contracts.

When it comes to implementing a PCMH payment reform strategy, a healthcare organization could include one or a combination of any of the following payment mechanisms:

- Grants.
- Infrastructure support and funding.
- Care management payments.
- P4P.
- Shared savings.
- Global budget or risk-based arrangements.
- Enhanced payments for care services.

It is important to note that, depending on each health

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(Sustainable Patient-Centered Medical Home - *continued from page 28)*

system's needs, the PCMH model requires varied levels of financial investment to fund both the initial implementation and the long-term viability of the model. Government and private payors, such as BCBS, UnitedHealthcare, and Cigna, are experimenting extensively with initial funding and reimbursement methodologies to support the PCMH model.

The Three-Phased Approach in Visual Terms

The graphic below illustrates how the three phases – implementation, evolution, and integration – support a successful PCMH.

Risks of Inaction

As market forces spur practices toward value-based care delivery, health systems that postpone care redesign will struggle to remain viable in the future. Some potential risks of not moving to a PCMH model are described below.

- Future incentives and cost-saving opportunities might be unavailable to medical practices that do not have active PCMHs. Examples include the following:
  - — Investment in further development of PCMH capabilities and infrastructure.
  - — Payment for system performance in managing the health of a patient population.
- Payors are seeking to partner with providers to undertake population health management initiatives and are using PCMHs as a proxy to identify qualified participants.
- Some payors are designing benefit packages that waive co-payments if patients seek care at a certified PCMH, which could result in decreased patient volume for non-PCMH organizations.
- Inadequate monitoring and coordination of care can result in lost opportunities (e.g., referral leakage).

In short, health systems that fail to adopt the PCMH model risk missed opportunities and lost revenue over time.

Conclusion

With the PCMH model, health systems can become more efficient, lower costs, improve the way care is delivered, and, most importantly, give patients better experiences and outcomes. In order for a PCMH to be successful and sustainable, it must be done right.

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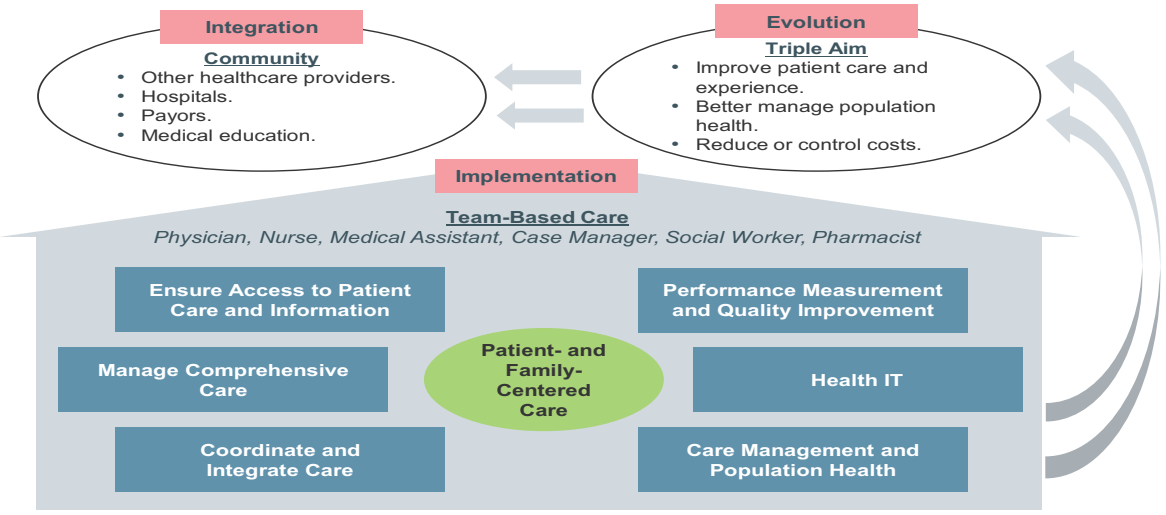

(**Sustainable Patient-Centered Medical Home -** *continued from page 29)*

This Diagnostic has proposed a three-phased approach – implementation, evolution, integration – to help health systems transition to a PCMH as smoothly as possible while aligning the interests of patients, providers, payors, and other medical services.

Ultimately, the measure of a PCMH's success is not how well it functions, but the impact it makes. With an effective PCMH in place, healthcare providers can at last focus on what really matters: delivering value-based care that is truly *patient-centered*. ❑

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About the Authors

This Diagnostic was written by ***Ms. Emma M. Mandell***, Senior Consultant, and ***Mr. Charles A. Brown***, Senior Manager. To learn more about the PCMH, innovative care delivery models, and other related topics, please contact Ms. Mandell at *emandell@ecgmc.com* or Mr. Brown at *cbrown@ecgmc.com*.

[1.] Source: D. Fields, E. Leshen, and K. Patel, "Driving Quality Gains and Cost Savings Through Adoption of Medical Homes," Health Affairs, May 2010; 819-826"

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Stephen J. Doneski
Director
SteveD@fdcpa.com
617.456.2449

Erik W. Lynch
Director
ErikL@fdcpa.com
617.456.2446

Douglas J. McGregor
Director
DougM@fdcpa.com
617.456.2402

Christopher J. Previte
Director
ChrisP@fdcpa.com
617.456.2481

HFMA Massachusetts-Rhode Island Chapter
411 Waverley Oaks Road, Suite 331B
Waltham, MA 02452

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2013 - 2014 Program & Special Event Schedule

Date	Event	Location	Coordinator(s)
11-21-2013	Capital Finance Program	Boston Convention & Event Center Boston, MA	Roger Boucher & Jeffrey Dykens, CPA
12-06-2013	Compliance Update	Doubletree Hotel Westborough, MA	Christopher Gingras, CHFP & Matthew Putvinski
01-24-2014	Revenue Cycle Meeting	Gillette Stadium Foxboro, MA	Ames Ryba, & Jennifer Samaras
03-28-2014	Enterprise Performance Management & Practice Management Joint Meeting	Four Points Sheraton Norwood, MA	Karen Hart, Stephen Saudek, Caryl Beison & Annamarie Monks
05-14-2014 thru 05-15-2014	Region 1 Conference	Mohegan Sun Uncasville, CT	Region 1
05-29-2014	HFMA Massachusetts-Rhode Island Chapter Annual Awards Banquet	Downtown Harvard Club Boston, MA	Roger Boucher and Garrett Gillespie
06-06-2014	Managed Care Program	Doubletree Hotel Westborough, MA	James Donohue, MBA & Jan Costa

Education/Program Administration Committee, Co-Chairs: Deborah Wilson, CPA & Catherine Robinson-Skeen dwilson@lawrencegeneral.org Cathy.Skeen@steward.org

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