The vast majority of us are members of HFMA because someone we work with asked or maybe even told us to join. They recognized the value of HFMA to their own careers and actively promoted it. Do you remember who that person was for you? Have you benefited in some way from your membership?

With the new year underway, we all have our own goals for 2018 and hopefully yours are off to a solid start. As you tackle your professional goals, remember the value of HFMA that person shared with you and get involved. There are many opportunities to get involved as an HFMA member and make the most of your membership:

• Help the Association grow – share the same benefits with your colleagues and peers by encouraging their membership. The Member-Get-A-Member program is new for 2018 and provides rewards for referring new members.

• Write an article – consider authoring an article for the Chapter’s newsletter, maybe something you have knowledge or passion for or something you’ve done for work or school.

• Attend an education program or webinar. There are a large number of programs available locally and nationally to help you keep up with the latest information and at affordable prices. Take someone along with you!

• Speak at an educational program – whether locally or nationally, this is a great way to share your expertise.

• Volunteer for the Chapter – Become a leader in your HFMA chapter by volunteering. Whether you’re interested in serving on a committee, mentoring other HFMA members, participating on a task force, or serving as an officer, you’ll find that the time and expertise you offer are rewarded many times over through your:
  • Personal and professional growth
  • Influence on your chapter’s future
  • Broadening of your professional network

Talk to any of your current chapter leaders about your interest in volunteering as there are currently multiple positions available for the upcoming year. A list of chapter leaders can be found on pages 18 and 19 of this newsletter.

• Get certified – invest in your future by becoming a Certified Healthcare Financial Professional (CHFP)

• Check out our Social Media on Facebook, Twitter, LinkedIn and our FREE App on the App stores for the latest articles, events, and other posts from recently held events. Search NHVT HFMA to find the sites on their respective pages.

• Check out our website (www.nhvthfma.org) and National’s website (www.hfma.org) for the latest newsletters, publications and knowledge center to further keep abreast of healthcare financial developments.

• Attend an upcoming networking event. We will be holding an event during the Annual Meeting on March 22nd in Portsmouth. More details to come!
Welcome New Members

Thomas Jabro
Treasury Management Officer, PNC Healthcare

Jessica Landon
Assistant Director, Springfield Hospital

Kevin Wilson
Financial Systems Analyst, Catholic Medical Center

• Reach out to other members of HFMA for their experience and expertise, whether by phone or at a networking event.

HFMA can be a pretty powerful part of your toolkit in the new year. Put it to work for you by getting involved.

I am happy to help with any of the above opportunities or questions you may have and to hear the value HFMA has for you.

I hope to hear from you soon and let me know if you are looking into any of these opportunities.

Eric Walker,
CPA, FHFMA
2017-18
Chapter President

Continued from page 1

Most providers are aware that denials are a significant source – perhaps the most significant source – of lost revenue. Understanding this, many providers seek to navigate their claims’ denials more effectively, yet struggle to overcome the challenges of turning oceans of information into insight.

The result is not only the lost revenue of denied claims that are not successfully appealed, but the labor cost to work them and the opportunity cost of not working other claims that might require attention.

By using sophisticated data analysis and technology, providers can understand where they are in the sea of denials and get a good sense of where they want to go. But to reach that destination they must deploy the insight they have gained, and employ good change management techniques.

Payer denials are often ambiguous and inconsistent, and the sheer volume of denials that wash over the decks of the Patient Financial Services (PFS) ship can be overwhelming. The result is not only the lost revenue of denied claims that are not successfully appealed, but the labor cost to work them and the opportunity cost of not working other claims that might require attention.

An effective denials management process looks something like this:

Continued, next page
Benchmark the Problem

To better understand the impact of denials, it is important to define two waves in the process: initial denials and writeoffs (or adjustments.)

Initial denials are a payer response (paper remittance or electronic 835 file) indicating no payment or only partial payment for services.

Writeoffs are provider transactions to adjust balances off active AR and record the lost revenue on the general ledger.

There are commonly accepted benchmarks for both of these metrics. Most industry literature would suggest normal performance around a 10% initial denial rate and a writeoff rate of 1%. In other words, 90% of initial writeoffs can be corrected and only 10% are fatal errors.

However, most providers are in the range of 15%-20% initial denial rate (though few can accurately measure this metric), and 2-3% writeoff rate. Plus, as with most benchmarks, comparing these guidelines to actual performance comes with significant pitfalls.

Too often providers fool themselves into thinking they are close to sailing smoothly toward benchmark-level performance by redefining the inputs and moving process failures out of scope. For example, it is easy to assume a duplicate denial or a non-covered denial has no cash impact and therefore should not be included, but if those categories are in the benchmark then they should be included in the calculation. Furthermore, it is likely that some of those denials – even those that appear to have no cash value -- can be collected. It is not uncommon for a payer to inappropriately deny a claim as a duplicate when there are multiple services on the same day or if a modifier was left off. If a provider ignores these denials, they are ignoring lost revenue.

Another challenge in applying these benchmarks is the lack of specificity. Knowing your overall rate relative to 10% is useful information, but the next level of information – the breakdown by denial type – is even more useful. While variations in performance, payer mix, service mix, etc. means every facility is likely to have a different experience, a common breakdown of the 10% initial denial rate should look something like this:
Analyze the Root Cause

The previous table can help providers understand where they should be, but it doesn’t yet tell them where they are. Like a ship captain’s sextant and chronometer, providers need good tools to help sort through the constant flow of denials to identify not only where the biggest opportunities are but also the root cause of those problems.

For example, it would be easy to look at the payer with the highest number of denials, or even the largest denial type, and opportunity might pop up there. But it is equally likely that the payer with the largest number of denials is simply the largest payer. Looking at denial rates is a more valuable approach.

Example 1: In this chart, the height of the bar represents claim volume for a payer (left y-axis) and the height of the line represents the denial rate for that payer (right y-axis). In this case, “Payer #11” is denying disproportionately and needs to be investigated deeper.

The best analytical tools make it easy for users to quickly and logically drill deeper, peeling layers of the onion until the heart of the issue is revealed. The payer scorecard enables you to focus on payer-specific issues. Another technique is to compare volume and financial impacts in two dimension and observe the most significant impacts.

Example 2: In this chart, the position on the y-axis indicated the $ amount (charges) being denied and the position on the x-axis indicates the volume (count) of claims being denied. The size of the bubble is proportional to the % of claims denied for this reason. The red bubble in the top left portrays a significant $ impact caused by a very few “Clinical” denials.

Next, it is important to drill down into details with context. Denials come in many flavors and the various categories have their own details that need to be considered in context. For example, Eligibility, Coordination of Benefits and Authorizations denials reflect front end processes and should be analyzed with the context of who did the registration/verification, what service location did the patient arrive, etc. Medical Necessity and Non-Covered Service denials usually occur at the service level and require CPT Code level analysis. “Lacks Information” is a catch all the payers use to mean almost anything. Usually one or more remarks codes are used to describe in detail what is truly “lacking” for adjudication.
Example 3: Advanced analytical techniques allow you to integrate context by presenting visualizations using multiple dimensions simultaneously. The left chart shows proportionally how much ($) is denied by each payer. The right chart shows the mix of remarks codes. For demonstration, the black section making up about 25% of the pie chart is selected and the left chart shows that this remark (MA04 – secondary payment cannot be considered without primary payer information) is coming primarily from Payer #4 and Payer #13.

Finally, quantitative analysis is an important step to prioritize and find the most impactful opportunities, but also to get to the step of understanding root cause. To design better processes, you need detail and you need to look at real examples. Your analysis tool needs to provide a mechanism to peel the onion all the way to the heart – account examples you can review in detail.

Example 4: This “treemap” chart shows the relative amounts of denials by payer and then sliced by category. Using the toggle filters on the right, this chart is limited to just Type of Bill 131. Then the box representing “Procedure” denials from “Payer #2” is clicked to filter the detail line items below. The list includes all the details required to investigate – account number, Revenue Code, Denial (CAS) Code, CPT Code, etc. These are “procedure is inconsistent with modifier” denials. The next step would be to look at all the details of these charges being denied. Clicking the “…” in the top right of the drill-to-detail table allows for export to excel.
Upcoming Education and Events

We hope you will join us for one or more of these upcoming events. For more information, click the links below, or visit nhthfma.org/events.

<table>
<thead>
<tr>
<th>DATE</th>
<th>TOPIC</th>
<th>LOCATION</th>
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<tbody>
<tr>
<td>1/17/18</td>
<td>Excel Series, #3&lt;br&gt;Excel Pivot Tables</td>
<td>Webinar</td>
</tr>
<tr>
<td>1/25/18</td>
<td>Excel Series, #4&lt;br&gt;Transform Data in Excel without Formulas or Macros</td>
<td>Webinar</td>
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<tr>
<td>2/6/18</td>
<td>Cost Reporting: A Primer for Board Members</td>
<td>Webinar</td>
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<tr>
<td>2/13/18</td>
<td>Excel Series, #5&lt;br&gt;Excel Budget Ideas</td>
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<tr>
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<td>Webinar</td>
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<tr>
<td>2/27/18</td>
<td>Excel Series, #6&lt;br&gt;The Two Most Important Excel Functions for Accountants</td>
<td>Webinar</td>
</tr>
<tr>
<td>3/2/2018</td>
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<td>UNH Campus&lt;br&gt;Durham, NH</td>
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</table>
Engineer a Response

Once a common problem has been identified and a series of examples have been reviewed, the root cause problem should be clear. In the best case scenario, it might be an erroneous setting in the chargemaster or bill editor. These should be easily fixed. A more challenging obstacle might be a piece of information that is not being collected at the time of service or elsewhere in the process that is leading to payer denials.

In any case, once the failure point is identified, it is important to engineer solutions to get claims paid. For denials sitting in active Accounts Receivable (AR), it is important to make a quick determination on the likelihood of collection. For example, a billing error is almost certainly correctable, and even a relatively small balance is probably worth working. On the other hand, failure to obtain an authorization for a non-urgent outpatient procedure may be impossible, and even though the claim balance is much greater, the effort required to work it is probably not justified by the expected return.

But simply fixing denials as they occur is like trying to sail into the wind – you can do it, but it requires a lot of work for relatively little return. You can really put the wind in the sails of your collection efforts if you fix processes upstream to avoid the denials altogether. Avoiding initial denials eliminates the need for more resources in PFS, reducing costs while increasing (and accelerating) cash collections. However, it is easy to underestimate the degree of difficulty and the effort required to make those upstream changes.

But looking at a map and even drawing out a route doesn’t get you anywhere if you don’t hoist the sails, put a hand on the tiller, and take the helm. Identifying the problems is good, developing solutions is better, but you have to implement to really get any benefit.

Implement a Solution

Like any change management effort, implementing processes changes to improve denials requires buy in from stakeholders, but these stakeholders may be more challenging than most.

For process failures that are occurring upstream – likely in clinical areas or in patient access functions – potentially managed by clinical or other non-revenue cycle staff – fixes will require the assistance, or at least the approval, of a clinical resource, perhaps even a physician with administrative oversight. Those resources, particularly physicians, will likely not be satisfied with anecdotes or even best practices developed in other organizations – they will want to see hard facts and data.

By using the reporting capabilities that helped identify the problems, these resources can be converted from skeptics to enthusiasts, from obstacles to fellow navigators, who will help turn great solutions into tangible process changes and ultimately better performance.

Conclusion

Managing denials is not a new concept for providers. As payers have increasingly used denials as a mechanism to limit reimbursement, most organizations have made an effort to limit the revenue losses associated with denials.

While information about denials is readily available, improvement efforts have been hampered by a lack of insight, which makes it harder to identify areas of focus, harder to uncover root causes, and harder to win over stakeholders who are vital to not just overturning denials, but to eliminating them in the first place.

Providers seeking better performance should deploy business intelligence and analytic tools that help delve below the surface of the sea of denials to understand root causes. What services are being denied? Which payers use various codes to reflect what kinds of denials? What is the context for the various denial rates?

Analytic tools that help answer those questions are now available to those who seek performance improvement in these areas, and they can show the way to transit what are otherwise very treacherous waters -- even more effectively than a sextant and chronometer.

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Peter Angerhofer and Jeff Means are two of the three principals at Colburn Hill Group; Peter lives in NH, and Jeff is based in Chicago, IL. Colburn Hill Group is a Revenue Cycle consulting and tech-enabled solutions firm; CHG can be found on the web at www.colburnhill.com. Peter can easily be reached at pangerho@colburnhill.com.
Partnering with a Loan Program Vendor to Drive Patient Satisfaction and POS Collections

Chris Davis, Stacey Lee, Dave Harris

Executive Summary:
The trend of increasing patient responsibility has encouraged patients to demand price transparency regarding their healthcare services. An annual health and well-being survey conducted by PwC shows the share of medical plans with the highest enrollment steadily shifting to high deductible health plans. As this trend continues to increase, providers can consider offering a loan program to support patients in meeting their financial obligations. A loan program is a patient-friendly financing option that thereby improves collections and reduces A/R, allowing external financial specialists to manage, bill and collect payments from self-pay accounts. It also serves as a way to enhance billing transparency from point-of-service (POS) through balance resolution.

Key benefits to offering a loan program are as follows:

- **Accelerated cash flow driven by up-front payment of a percentage of self-pay balances**
- **Reduced A/R and bad debt due to higher total collections from self-pay patients**
- **Increased patient loyalty through reputation as a caring provider with zero-interest or low-interest payment plans**
- **Improved regional recognition as a result of marketing through co-branded advertisements**

Loan Program Background – How it Works:
The process for how a loan program works is fairly standard across the industry. It begins with the vendor analyzing the provider’s current portfolio of self-pay accounts. The provider needs to determine the portion of their self-pay A/R that they would like the vendor to manage. The most common options include the following: 1) all existing self-pay A/R plus new A/R moving forward; 2) only new A/R moving forward; or 3) a subset of existing and/or new A/R moving forward as determined by criteria such as patient balance thresholds.

If it is determined that the vendor will be responsible for all or a portion of existing self-pay A/R balances, the vendor pays the provider a percentage of each account balance up-front (% based on each account’s default risk and payment plan), creating an immediate cash increase for the provider. Once the future state qualifying account criteria is established, the vendor manages payment resolution of these accounts based on the payment plan terms determined by the provider (i.e. number of months allowed for payment plan based on account balance). To qualify future accounts for the program, the provider uses vendor software and online tools to offer pre-approved financing options to new, self-pay patients at POS and/or once the self-pay balance is determined during the billing process. The vendor pays the balance up-front to the provider, minus collection fees. The vendor retains future collections obtained during normal billing and collections. In the event the account defaults, the vendor returns the patient account and remaining balance back to provider, ultimately to be written off as bad debt.

Once the program is established, providers often experience improved patient satisfaction and loyalty. Friendly and professional customer service from call center specialists, as well as improved regional marketing efforts and materials (e.g. TV and/or radio advertisements, brochures, kiosks) produced by the vendor, reduce patient confusion and stress. Vendor marketing information is often co-branded with the provider name and information, with the provider’s logo at the forefront. In addition, distribution of loan program information at POS (e.g. brochures, kiosks) and use of vendor financing tools improve transparency of billing process for the patient.
Current State Assessment:

Before initiating a conversation with loan program vendors, consider evaluating existing self-pay A/R, including relevant key performance indicators (KPI’s) and cost-to-collect. Assess the portfolio of current payment plans to understand volume and value of accounts potentially eligible for a loan program. A basic template has been provided below with sample account thresholds for analysis.

Summary of Payment Plans - Sample Template:

<table>
<thead>
<tr>
<th>Payment Plan Balance Threshold</th>
<th>Volume of Accounts</th>
<th>Balance of Accounts ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; $1,000</td>
<td>xx</td>
<td>xx</td>
</tr>
<tr>
<td>$1,001 - $5,000</td>
<td>xx</td>
<td>xx</td>
</tr>
<tr>
<td>≥ $5,000</td>
<td>xx</td>
<td>xx</td>
</tr>
<tr>
<td>Total</td>
<td>xx</td>
<td>xx</td>
</tr>
</tbody>
</table>

KPI’s to consider include net collection rates, average time to complete payment plan, default account percentage, new account volume added per month, existing vendor(s’) performance and cost, and internal expenses associated with collection opportunity. Clear internal consensus and understanding of overall performance is critical to comparing current state with vendor projections of future state, and facilitates contract negotiations once a vendor is selected.

Vendor Selection Process:

Establishing a vendor selection committee is an important early step. Consider carefully which individuals would be appropriate to facilitate the selection process and critically evaluate vendor responses, presentations, and data analysis. These individuals are often stakeholders in the self-pay account process, including a mix of patient access and back office billing leadership. They should understand the cultural implications of offering a loan program and are able to raise critical questions. As a final qualification, the collective group must have the authority to make a final vendor recommendation that will be supported by executive leadership.

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You know — more than anyone — the value of belonging to HFMA.

Spread the word. Invite your peers, your staff, and your colleagues to join you — and join HFMA.

HFMA.ORG/MGAM
Once selected, the committee’s first major responsibility is to develop a Request for Proposal (RFP). A sample RFP outline is as follows:

Sample RFP Outline:

1. Provider Overview & Background
2. Proposal Package & Submission Logistics
3. Vendor Overview
   a. Background
   b. Staffing
   c. Operations
4. Approach and Methodology
   a. Eligible patients
   b. Loan program terms
   c. Default/uncollectible accounts
   d. Customer experience
5. Patient Communication
   a. Customer service
   b. Marketing
   c. Payment support
   d. Complaint/issue resolution
6. Operations
   a. Facility support
   b. Post-implementation
   c. Tracking/reporting
   d. Patient financing compliance
   e. Internal processes
7. Information Technology Capabilities
8. References
9. Timing & Fees

Once the RFP is completed, next steps include development of a detailed submission and review timeline. A sample 12-week timeline is as follows:

- **Week 1:** RFP distributed to vendors
- **Week 2:** Clarifying questions from vendors due
- **Weeks 3-4:** Responses to vendor questions prepared and distributed
- **Weeks 5-6:** Waiting period for vendor responses - due at the end of Week 6
- **Weeks 7-9:** Selection committee reviews responses and decides which vendors to invite for onsite presentations
- **Weeks 10-11:** Vendor onsite presentations
- **Week 12:** Final committee discussion and selection of vendor

**New Hampshire/Vermont Chapter Sponsors**

Because of the generosity of the organizations listed below, we are able to offer quality services, such as this newsletter, to our members. To these organizations, we say “thank you”.

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Tyler, Simms & St. Sauveur, CPAs, P.C.
Conclusions and Next Steps:

Once the selection committee’s recommended vendor is approved by Leadership, next steps will include contract negotiations, program implementation, and tracking/monitoring of success. Close partnership with the vendor can ensure the best loan program offerings for the patient population are crafted. In turn, maximizing the organization’s goal of driving patient satisfaction, improving POS collections and reducing self-pay A/R.


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Health care is changing – and so is the Certified Healthcare Financial Professional (CHFP) designation.

The new CHFP from HFMA prepares finance professionals, clinical and nonclinical leaders, and payers to address the continually evolving healthcare business environment. Multidisciplinary courses focus on providing today’s essential skills: business acumen, strategy, collaboration, and leadership.

Course modules include:

**The Business of Healthcare**
Healthcare finance overview, risk mitigation, evolving payment models, healthcare accounting and cost analysis, strategic finance, and managing financial resources

**Operational Excellence**
Exercises and case studies on the application of business acumen in health care

Take the next step in your professional development – check out the new CHFP at [hfma.org/chfp](http://hfma.org/chfp).
Pass on the value of HFMA membership and be rewarded!

It's easy to get started.
After you establish a connection with a potential member, simply complete HFMA's Member-Get-A-Member Online Referral Form.

You’ll be rewarded.
For every new member you recruit who joins HFMA, you’ll receive points to redeem for great prizes any time using HFMA's new online Member-Get-A-Member Rewards Center. To access the Rewards Center site, a username and password will be forwarded to you after your sponsored new member has joined.

If you’re the top recruiter, you’ll receive The ANI 2018 Experience Package. This package includes:

- Complimentary conference registration
- Hotel accommodations during the conference
- A gift card for travel and incidentals

All recruiters also receive:

- Recognition on HFMA's Member-Get-A-Member leaderboard webpage (coming soon)
- An HFMA Member-Get-A-Member lapel pin

Additional Member-Get-A-Member Resources

- View the complete rules of HFMA's Member-Get-A-Member Program
- Access HFMA's Member-Get-A-Member Resource Center
- See the 2016-2017 Member-Get-A-Member Winner’s Circle

Questions?
Contact me directly at the number below, or contact HFMA's National Membership Manager at 800/252-4362, ext 339 (membership@hfma.org)!

Thank you,
Amy Vaughan
NH/VT HFMA 2017-2018 Membership Co-Chair
(802) 847-7809 or Amy.Vaughan@uvmhealth.org
MACRA is here – Are you ready?

Eric Wetherell, Healthcare Consulting Principal, Baker Newman Noyes

The deadline for accumulating the minimum data to ensure that your organization does not receive a negative adjustment to your Medicare Part B reimbursement under MACRA in 2019 is December 31, 2017. Starting in 2018, you will need to collect data for certain categories for the entire year to mitigate the risk of a negative payment adjustment in 2020. Are you prepared?

What is MACRA?
The Medicare Access and CHIP Reauthorization Act of 2015, or MACRA, is a bipartisan legislative act that was enacted on April 16, 2015. This law initiated drastic changes in the way physicians, and certain other providers are, and will be, paid. As part of a larger push to value-based payment methodologies, MACRA established two payment tracks, the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APMs). If you qualify under MACRA for one of these payment models, your Medicare Part B payments will be influenced in future payment years depending on data that you submit, or do not submit, in a quality reporting year to the Centers for Medicare & Medicaid Services (CMS).

Adjustments to Medicare Part B payments, both negative and positive, will begin in calendar year (CY) 2019 based on CY 2017 data. The percentage of payments subject to performance evaluation will gradually increase as the program continues, resulting in greater risk being shifted to the provider. Whether an eligible clinician (EC) realizes increased or decreased reimbursement will depend largely on how they have prepared themselves in the move from volume to value based payments.

What should you do?
There are several steps providers should take in evaluating the impact that MACRA will have on their organization. Determining whether you qualify for one of the two payment models under MACRA is the first step in being prepared. If you do qualify, the next step will be to evaluate which payment model your organization would fall under, MIPS or Advanced APM, and then to determine what reporting requirements are applicable to you.

Each clinician or organization will have different requirements depending on several factors, and understanding which ones apply to you will help to ensure that the necessary data is being accurately tracked and reported. After gaining an understanding of the reporting requirements, as well as your current reporting structure, you can then begin to measure compliance as well as financial impacts.

Evaluating and implementing MACRA effectively requires planning and collaboration. As risk continues to shift to the provider under MACRA, as well as other value-based initiatives, it will become increasingly important for providers to develop processes to monitor and improve performance.

Taking the first step
Preparing for MACRA can be a complicated process as there are many variables to consider. Here are a few things to keep in mind.

1. Do You Qualify Under MIPS?
Before you get started, you must assess whether your organization meets the qualifications under MIPS. Each performance period will impact Medicare Part B payments two years later. If you haven’t already done so, it is important to begin your preparation efforts for MACRA as soon as possible to avoid negative payment adjustments, and to potentially achieve positive adjustments to your Medicare Part B revenue in future payment years.

2. Should you do a MIPS Readiness Assessment and Initial Impact Assessment?
A MIPS readiness assessment will help align your organization’s current reporting processes and measures to those included in MIPS, as well as identify your strengths and weaknesses relative to MIPS. This process will allow you to focus efforts around the requirements to maximize your reimbursement.

An initial impact assessment will help determine the potential impact of MIPS to your Medicare Part B revenue as well as the efforts necessary to drive maximum Medicare Part B reimbursement for your organization.

3. You’ve implemented MACRA. What’s next?
Post-implementation, you will want to continuously monitor your MIPS performance category tracking and reporting efforts.

CONGRATULATIONS!

We want to acknowledge and congratulate

AMY VAUGHN, FHFMA

on receiving her Fellow of HFMA designation.

By receiving this designation, she has highlighted their commitment to the healthcare profession.

Way to go Amy!!!
Preparing for the New Lease Standard

Jerry Cahill, CPA

For the better part of the past decade, the Financial Accounting Standards Board (FASB) and International Accounting Standards Board (IASB) have been working to converge lease accounting rules. After much anticipation, the final version of Accounting Standards Update (ASU) 2016-02 has been issued and it will fundamentally change the rules that govern all leases. Under current lease guidance, if a lease does not meet at least one of the five capital lease criteria, it will be considered an operating lease. Operating leases do not get recorded to the balance sheet and are simply an operating expense. Capital leases are recorded to the balance sheet and the right of use asset is depreciated over the useful life and the present value of minimum lease payments is amortized over the lease term with the monthly payment being split between principal and interest. Under the new lease guidance, all leases will be treated similar to a capital lease and will either be referred to as a capital lease or operating lease. In order to be a capital lease, it will be considered an operating lease. Seems like the old guidance, right? So what’s different? Essentially the difference is two-fold. First, both types of leases will need to be recorded to the balance sheet and second, the way the types of leases affect the income statement will be different.

At lease inception, the present value of minimum lease payments will be calculated using the lease term, an annual borrowing rate, and the payment amount and then will be recorded as a liability. The right of use asset will equal the liability plus any direct costs and less any incentives. In the periods following inception under a finance lease, the asset will be depreciated straight-line over the lease term and the liability will amortize under a normal amortization. Under an operating lease, the initial recording of the liability and asset will be the same as a finance lease. In subsequent periods as the liability amortizes and asset depreciates, the interest plus the asset depreciation will equal the total lease payment. For example, a 36 month lease with a borrowing rate of 6.25% and a monthly payment of $1,000 would generate an interest amount in month one of $171. $1,000 - $171 = $829, which would be the monthly depreciation. In month two, the interest amount would be $166, therefore, the depreciation amount would be $834. Over the course of the lease in the interest expense will decrease and depreciation will increase, but in total, will always equal the lease payment.

While the previous summary is the bulk of the changes associated with the new ASU, there are a couple of other items to keep in mind:

1. Transfer of ownership
2. Option to purchase is reasonably certain
3. Lease term is a “major part” of the economic life
4. Present value of lease payments is “substantially all” of the fair value
5. Specialized nature (NEW)

When considering “specialized in nature”, think of leasehold improvements that only your organization or service line will be able to use. A subsequent organization would not be able to occupy the space without making additional modifications.

If the lease does not meet any of the previous criteria, it will be considered an operating lease. Given the substantial changes to the lease guidance, it will be important for organizations to begin taking stock of their leases now to determine the impact. It will also be important to keep the guidance in mind when entering into new leases.

The new ASU will be effective for public organizations (including conduit debt obligors) for annual periods beginning after December 15, 2018. For all other organizations the standard is effective for annual periods beginning after December 15, 2019. Early adoption is permitted for all organizations.

Please contact me if you have questions about Leases or any other accounting matters you may have.

Jerry Cahill, CPA, is a manager with Berry Dunn’s healthcare practice. He can be reached at jcahill@berrydunn.com or 603-518-2610.
Whether you work at a hospital, health system, physician practice, or payer, HFMA keeps you informed on fast-moving developments in healthcare finance. Member events, publications, seminars, and online tools identify best practices, and help you manage change.

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Joint Meeting MGMA

Our joint meeting with the NH Medical Group Management Association was held on November 8. Photo shows Peter Smith presenting on Managed Care Contracting.

Photo credit: Eric Walker

Revenue Cycle Institute

The Annual Revenue Cycle Institute was held on November 14. Photo shows Linda Davis and Hunter Ousterhout pointing us in the right direction during their discussion on Prioritizing Revenue: Modernizing Workflow Tools.

Photo credit: Greg Knight
Chapter Committee Chairs 2017–2018

Visit our Committee Opportunities webpage for more information about volunteering to be on one or more of our Committees.

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Meet your chapter officers for 2017-2018

**Eric F. Walker, CPA, FHFMA**

**Position:** President  
**Affiliation:** New Hampshire Healthy Families  
**Phone:** (603) 263-7116  
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**Email:** erwalker@centene.com

Eric is a Senior Manager of Finance with NH Healthy Families and CentiCare Health located in Bedford, NH. He received his Bachelors and Masters of Accounting degrees from the University of Maine. Eric holds both an active CPA license and Fellowship with HFMA. He has been a member of the Chapter since 2007 and has previously served as Newsletter Chair and on the Board of Directors.

**Greg Knight**

**Position:** Treasurer  
**Affiliation:** Baker Newman Noyes  
**Phone:** (207) 791-7147  
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Greg is a Senior Healthcare Consultant for Baker Newman Noyes. He specializes in Medicare and Medicaid cost reports and third-party reimbursements. Greg received his Bachelor's degree in Accounting from the University of Maine.

**Travis Boucher**

**Position:** President Elect  
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**Erica L. McNamara, CPA**

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**Diane L. Maheux, FHFMA**

**Position:** Immediate Past President  
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Diane is the Chief Financial Officer of Calais Regional Hospital located in Calais, ME. She has been an active member of NH-VT HFMA and has served in the past on the Certification, Membership, Newsletter, and Education Committees, as well as serving on the Chapter Board of Directors. Diane also served on the National Board of Examiners and has participated in HFMA's US-UK Exchange. She has earned Fellowship status in both HFMA and with the American College of Healthcare Executives (ACHE). She earned both her undergraduate and graduate degrees at Plymouth State College and is currently a Doctoral Candidate at Central Michigan University and working on her doctoral dissertation. In addition, Diane taught on both the undergraduate and graduate level at Plymouth State from 1995-2010. In her free time, she is an active hockey mom.

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