HFMA Redesigns the CHFP Certification Program

by Jane Piotrowski, CHFP

At the beginning of this Chapter year, HFMA adopted a new integrated approach to their certification in healthcare finance. This approach extended beyond demonstrating competence in finance and accounting to focusing on skills that address the needs of the changing healthcare industry. The changes to the new CHFP certification are designed to prepare leaders for the new era in health care. The goal was to build a broad understanding of healthcare finance together with leadership skills, business acumen, practical knowledge and collaboration.

The new configuration of the CHFP certification consists of two modules (both must be successfully completed to receive the CHFP designation; HFMA membership is needed to complete Module II):

- **Module I** – The Business of Healthcare - a big picture overview of healthcare finance; and

- **Module II** – Operational Excellence - a case study approach to understanding the business of healthcare.

Once again, the NH/VT Chapter has joined forces with the Arizona, Connecticut and Wisconsin chapters to provide a joint educational program that will assist our members in preparing for this new CHFP exam.

This newly designed joint educational program will use modern technology to teach the certification material. Through the use of **You Tube**, we will provide:

- Six (free) pre-recorded coaching sessions from subject matter experts for the Module I topics. These sessions will be available through the Chapter’s website beginning in March 2016. Stay tuned for the flyer that will be coming out announcing the program.

In addition, the Chapter is reviewing options to help Members prepare for Module II this Spring 2016.

Finally, for those members who successfully complete this program, the Chapter will provide an **incentive payment of $250** to help defray the cost of the certification.

Certification via HFMA's CHFP designation is a valuable component of the healthcare financial professional's skillset. It is recognized by employers and peers alike, and as the healthcare landscape becomes more competitive, it is important for the financial professional to gain every advantage.
Thank you for everyone who responded to the Member Satisfaction Survey that National sent out this past October. Recently the results were published and I am thrilled to report how well our Chapter did. The overall satisfaction score for members who are “very satisfied” or “extremely satisfied” was 77% this year. Also what is important to note that any officer or board member is excluded from the survey process to make sure the data is not skewed. Our Chapter is volunteer based and without this critical information we would not know where to focus our efforts, so thank you for your participation.

What we did well! The following is a list of the top 3 areas where members felt “very” or “extremely” satisfied.

► Speakers at Chapter programs
► The Chapter Newsletter
► NH/VT Chapter Overall

Our Newsletter has consistently been rated highly by our members. Chapters from around the country have looked at our newsletter for inspiration. I am also happy to see “speakers at the chapter programs” being highly rated. Often finding quality speakers is one of the more challenging areas when putting together.

The following are top 3 areas members would like to see improved.

► Location of the Chapter programs
► The Educational Topics addressed at Chapter programs
► Chapter Networking opportunities.

These three areas of improvement were exactly the same last year. Specifically the location of chapter programs is terribly difficult for a chapter like ours given the geography of the region. NH/VT is a small chapter of approximately 400 members. Often we have education events in Lebanon, NH as that tends to be the most central location for both states. We are, however, having our Annual meeting in Meredith, NH on March 17th and 18th at the same facility it was at a few years ago, the Inn at Mills Falls. And for the first time we are having a Women in Leadership conference at the Manchester Country Club in April. At the annual meeting we will be having our 2016/2017 Education pre-planning session. If you have ideas about topics and/or venue locations please join us or send me your feedback and I will make sure your voice is heard.

Networking is something we have been challenged with. Historically when we have had some sessions, there have not been many members showing up. If you have ideas please reach out to our social committee.

Thank you again to each of you who took the time to share your thoughts. Our board of directors and officers review these results carefully to make sure we are achieving the mission of HFMA. Please reach out to me directly any time should you have suggestions or comments or would like to get involved with our Chapter. I can be reached at 603-740-6562 or Robert. Gilbert@wdhospital.com

Thank you,
Robert Gilbert
FHFMA, NH/VT HFMA President 15-16
On the Rise: How Three Hospitals Improved Their Fiscal Outlooks

The last several years have been challenging for hospitals, as uncertainty regarding the Affordable Care Act (ACA) and a narrowing in operating profitability became the norm. In 2015, however, the three major credit rating agencies (CRAs) presented refreshingly optimistic reports, particularly for the larger providers, citing strong revenue growth, continued cost containment, greater clarity with respect to the ACA and industry trends (e.g., consolidation and technology) as reasons for the positive momentum.

In this more encouraging environment, there are a variety of financing structures a hospital can pursue to improve its fiscal outlook and better serve its patients. Below, we present three examples of hospitals that took advantage of the positive momentum and completed transactions that benefited both the hospitals and their communities. In the first, a health care district refunded three expensive bond issues with a general obligation (GO) bond that will save the district’s taxpayers approximately $2.8 million. In the second, a health care system used a direct bank placement to fund a new construction project that resulted in an expanded campus and enhanced specialty services. Finally, we detail how a hospital used one tax-exempt bond transaction to fund an expansion, renovation and a refinance all at once, resulting in a thorough and comprehensive fiscal upgrade.

Saving Taxpayers’ Money

Formed in 1962, Sierra Kings Health Care District is a subdivision of the State of California encompassing over 230,000 acres in southeastern Fresno County. The District previously owned and operated a 49-bed acute care hospital known as Sierra Kings Hospital. In 2009, the District filed for bankruptcy and subsequently transferred the operations of the hospital to Reedley Community Hospital, an affiliate of Adventist Health System/West. The District maintained its ownership of the hospital.

To help guide them through the bankruptcy process and improve the hospital’s overall financial situation, the District hired HFS Consultants. Of chief concern, HFS sought to refund three prior bond issues that each carried a high cost of capital. The bond issues were not payable from, nor secured by, the revenues or assets of the hospital, meaning that the District’s taxpayers were paying the high debt service costs.

HFS worked with the District’s investment bank to refund the three bond issues using a $27 million general obligation (GO) bond with a 25-year term. The investment bank used a current refunder structure to refund the first two series of bonds from 2002 and 2007. For the third series of bonds from 2009, it structured an advanced refunder and established an escrow-based pay structure. In addition, HFS and the investment bank navigated issues regarding the remedial disclosure on the prior bonds and worked with bond counsel to maximize debt service savings for the District.

“This refunding resulted in a significant benefit to district taxpayers by reducing the amount of interest that would otherwise be paid under the refunding bonds,” said Sandy Haskins, managing director of HFS Consultants. “The savings, adjusted for the time value of money, approximates $2.8 million or about 11% of the bond principal. This is a very high rate compared to industry standards.”

Expanding Services

Kennedy Health is an integrated health care delivery system that provides a full continuum of care, ranging from acute-care hospitals to a broad spectrum of outpatient and wellness programs. It owns and operates a 607-bed multi-campus system which includes three acute care hospitals in New Jersey: Cherry Hill, Stratford and Washington Township. Kennedy Health sought funding for a new construction project that would expand and improve its campus in Cherry Hill. The goal was to provide more room for state-of-the-art specialty services and allow for more open green space and improved parking options, resulting in a family-centric facility that would enhance health care access in its community.

Kennedy’s investment banker conducted a competitive bidding process with over 12 prominent funding sources. The firm ultimately put together a two-bank syndicate to finance $71 million, a strategic decision that enabled Kennedy Health to maintain multiple bank relationships. The debt is secured by Kennedy Health’s obligated group under a master trust indenture put in place when its investment banker underwrote its last bond issue in 2012. The financing carries a 10-year term, variable rate, and no prepayment penalties, allowing Kennedy Health to retain financial flexibility as it pursues an aggressive repayment plan. Furthermore, the competitive bid process resulted in a reduction of 40 basis points in the cost of capital compared to the initial bids received.

Continued, next page
The $71 million transaction will allow Kennedy Health to build a new medical office building, a parking garage and a lobby addition to its campus in Cherry Hill. Once complete, the Cherry Hill campus will provide enhanced specialty services, including radiology, orthopedics and cardiology. Further, the financing allows Kennedy Health to retain cash on its balance sheet which will be used to support the future development of all three of its campuses.

“The new construction project at our Cherry Hill campus is an important part of Kennedy’s continued efforts to improve our integrated health care delivery system and expand services to Cherry Hill residents and the surrounding community,” said Gary Terrinoni, executive vice president of administration and chief financial officer of Kennedy Health System.

**One Financing, Three Objectives Achieved**

Graham Hospital is a nonprofit hospital that provides inpatient, outpatient, home care and long-term care services in Canton, Illinois. It currently operates 25 private medicine/surgery beds, 13 progressive care unit (PCU) beds, five intensive care unit (ICU) beds, six obstetric care (OB) beds, 20 skilled nursing and 18 long-term care beds. Graham Hospital sought funding for multiple capital expenditures, including the renovation of its skilled nursing facility totaling $2.1 million, expansion to its physician clinic totaling $8.5 million, and a small addition and total remodeling of its five inpatient/outpatient surgery suites of $11.4 million. The hospital’s outstanding debt of $26 million was in the form of tax-exempt, variable-rate demand bonds (VRDBs) enhanced by a direct pay letter-of-credit from a regional bank. The debt was hedged by two floating-to-fixed rate swaps with two separate swap counterparties.

Graham’s investment banker conducted a competitive process that resulted in financing proposals from eight funding sources, ranging from local, regional and national banks to non-bank funds. Hospital leadership elected to proceed with the funding option that offered a blend of the lowest cost of capital and favorable terms.

The $48 million funding structure converted Graham Hospital’s letter-of-credit backed bond structure to a private placement structure, thereby eliminating letter-of-credit renewal risk and extending the term of the financing by nearly a decade. The structure also permitted the hospital to retain its existing interest rate swaps, thereby preserving the hospital’s interest rate hedge and preventing the hospital from realizing a swap termination mark-to-market payment. Finally, the structure provides funds for capital expenditures using a cost effective draw structure, minimizing interest expense to the hospital as it further upgrades its hospital facilities.

“This transaction allows Graham Hospital to continue to grow and add providers and new services,” said Robert Senneff, president and CEO of Graham Hospital. “The oncology suite will be relocated from Graham Hospital to our state-of-the-art medical office building, which will allow all of our patients who are undergoing chemotherapy treatment the advent of natural light throughout the suite. We will also complete a major remodeling of our entire 20-bed skilled unit, an addition to our inpatient/outpatient surgery floor, and a total infrastructure remodel/modernization. These projects would not have been possible without the ability to access funds at very attractive rates and terms.”

As demonstrated above, low-cost capital is available for strong hospitals looking to improve their fiscal outlook and better serve their populations. The key to success is in identifying the right funding structure for a hospitals’ specific objectives.

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Your life has value way beyond any job you will ever have, so start living your life for the things that really matter… faith, family, friends and certification, because that value will be forever treasured. If you have not been encouraged lately, consider making it a goal for CHFP, CRCR or any of the Technical Certificates.

Google it or go to YouTube. Search for: “Module 1 CHFP Coaching Program”. This is a Work in Process and you will find Lessons #1 thru #3 published individually or a playlist for Lessons #1-#3. Lessons #4-#6 will be published within the next month.

Watch for the coaching lessons for Module I, related quizzes for Module I Lessons to be posted on our website, as well as, suggestions on how to study for the Module II exam.

A friendly reminder and an Announcement:

To retain certified status with HFMA, certified members are required to remain an active member annually as well as to maintain the designation every three years through participation in relevant professional development activities (60 hours). These activities are continuing education, submitting professional papers for publication, and other established National criteria. Hint: several members are delinquent for those that must report by May 31, 2016.

Congratulations are in store for our members that have taken the new CHFP exam or met the requirements for the Fellowship status. These members are:

Janet Carroll, CHFP
The University of Vermont Medical Center
Assistant Director of Nursing

Dana Wehe, CHFP
Central Vermont Medical Center
Decision Support / Data Analyst

Jane Piotrowski, FHFMA
Geisel School of Medicine – Dept. of Psychiatry
Financial Manager

We encourage you to seek out the Certification Committee for answers about the new CHFP exams. The passing rate is promising… and we want to help with the material that is available for you. Also, the Chapter is prepared to offer a $250 subsidy to our members for successful completion of both exams!

All the best,
NH/VT Certification Co-Chairs:
Diane Blaha, FHFMA    Diane.Blaha@gmail.com
Peter Smith, FHFMA    peter.smith@wdhospital.com
501(r)...Just What is a Plain Language Summary?

by Janet Hodgdon, Director, BAKER NEWMAN NOYES

First released in final form on December 29, 2014 (published in the Federal Register on December 31, 2014), the final 501(r) Treasury regulations are effective for taxable years beginning on/after December 29, 2015. Compliance is mandatory for all 501(c)(3) hospital facilities. Penalties for noncompliance are varied but could include substantial fines and revocation of nonprofit status.

Although an IRS regulation, these rules are truly operational in nature and may directly affect your financial assistance policies. One of the requirements is to have a plain language summary of your financial assistance policies made available. But just what is plain language? Simply put, it is writing for your audience. If your intended reader is a “rocket scientist”, then language used may be far different than that used when addressing the average reading level of any given community. In this case, a much simpler language approach is required and is generally considered to be that of an 8th grade level.

President Obama signed Public Law 111-274, The Plain Writing Act of 2010, on October 13, 2010, requiring all federal agencies to comply with the plain language guidelines. As a follow up to that legislation, Federal Plain Language Guidelines were first published in March, 2011. The Federal Government definition is:

Plain language is communication your audience can understand the first time they read or hear it. Language that is plain to one set of readers may not be plain to others. Written material is in plain language if your audience can:
► Find what they need;
► Understand what they find; and
► Use what they find to meet their needs.

On the surface, this appears fairly straightforward, but it actually can be a complex process. So much so that the guidelines referenced above are 112 pages in length. Written in plain language and extremely straightforward, this guide provides advice on clear communication and it may be a helpful tool as you start to prepare your own plain language summaries. As examples from that document:

Don’t say “involuntarily undomiciled” when you can say “homeless”.

Use “How do I apply?” as opposed to “Submission of applications”.

The most important thing to do is know who your audience is, what they might know about the subject (in this case, your financial assistance policies) and what they need to know. Ultimately, the writer should focus on the intended audience and, by doing so, help ensure clear writing that allows readers to gain the knowledge they need.

At a minimum, plain language summaries of your financial assistance policies as required under 501(r) must include:
► Summary of the policy itself
► Website address and physical location where copies of policy and application can be obtained
► Information on how and when to apply for financial assistance
► Details on how to get help completing the documents

Summarizing complex and sometimes lengthy policies into a plain language summary that an average 8th grader can understand may prove to be a daunting process for nonprofit hospitals as they work toward compliance with the 501(r) regulations. The IRS expects clear communication with members of your community and this plain language summary is only one part of the overall regulations. Hospitals should pay close attention to these in order to retain their 501(c)(3) status as a nonprofit organization.

Important Reminder: May 31st is the Deadline for reporting CEU hours

Every 3 years, HFMA Certified Healthcare Financial Professionals must complete 60 contact hours of eligible continuing education and must report it by May 31st. Reporting is done online and can include HFMA sponsored educational programs or other qualifying programs. If you fail to complete the necessary credits and timely report, you will lose your CHFP status. For more information about when and how to report, go to “Maintaining my Certification” at: www.hfma.org/maintain
ICD-10 Today: The Journey Isn’t Over

Emily Anne Nolte, PwC, Sr. Associate and Cheri Kane, PwC, Managing Director

As it was billed and touted, ICD-10-CM/PCS gives medical personnel vastly expanded powers of specificity when diagnosing diseases and other health issues. Yet that greatly enhanced specificity comes with a price tag; namely, a transition period that some observers believed could be messy and disruptive. As physicians and other healthcare workers learned to adapt to the system, healthcare professionals feared productivity, and revenue, would plummet sharply. Some even went so far as to call ICD-10 the “Y2K” of medical coding.

Now that we are more than three months into the transition, are these fears more hype than reality? By gathering field reports and provisional data, we’ve come to the following early conclusions about the transition:

► Not everyone was ready. This was due, in part, to previous delays in ICD-10 implementation. For some organizations, the belief that another delay was likely reduced the urgency to prepare. While the transition was relatively smooth from an information technology perspective, productivity impacts ranging from 30 to 50 percent have been realized for organizations that did not adequately prepare. Many HIM departments have offset productivity impacts by incurring overtime or employing contract staff. Highly qualified coders, trainers, and “DRG validators” remain difficult to find for both contract and full-time positions even after the transition.

► Ingrained behavior of physicians still must be changed. Hospital personnel are still adapting to the pressure to provide more documentation, a sometimes tall order in a hectic hospital environment. Physician complaints regarding the increased need for documentation and the amount of time spent on computers instead examining patients are common. Many health systems are addressing these concerns through the use of scribes trained in ICD-10 and anatomy and physiology to shadow the physicians and assist with documentation although patients often find an additional stranger in the exam room off-putting. Computers in the exam room are here to stay, as are additional documentation requirements. However, physicians must see some benefit from these changes if we expect them to adapt.

► The learning curve is significant. PwC’s proprietary SMART analytics shows that more than a quarter of assigned ICD-10-CM diagnosis codes include the term “unspecified.” Often physicians select “unspecified” codes assuming coders will review and update the selection to a more detailed code prior to the claim being billed. Some physicians select these codes as they simply have yet to be convinced of any benefit to ICD-10. On-going education and examples of early “wins” due to information now available with ICD-10 should be shared to help build momentum. Continued reliance on “unspecified” codes may result in an uptick in medical necessity denials. With a few months data available for analysis, consider reviewing who your top “unspecified” code users are and work with them to understand why they are selecting these codes and what can be done to change this behavior. Oftentimes physicians are not aware of the financial implications of selecting one code over another and a little knowledge can go a long way towards behavior changes.

► ICD-10 isn’t being used to its fullest capabilities — yet. According to preliminary data gathered from PwC’s SMART analytics, fewer than 10 percent of the 140,000 classification codes are being used. Additionally, most hospitals are not prepared to leverage the data opportunity provided to them by ICD-10 codes. Whether looking globally at international disease and symptom tracking or locally with community-focused population health and bundled payment efforts, ICD-10 offers a new, untapped opportunity for data scientists and health systems to improve the lives of the patients we treat.

Continued, next page
► **Denials have increased – but it is still early.** Our experience shows there are some reimbursement issues, however most are relatively minor. Overall, some health care systems reported productivity declines, but it’s too early to tell if productivity will ever rebound to pre-ICD-10 levels. Denials will increase once the ICD-10 “grace period”, particularly the CMS flexibility regarding code selection within the same “family”, ends and approvals must meet more stringent standards.

► **Other IT issues have fallen by the wayside.** Many hospitals and health systems devoted considerable IT hands available to ICD-10 testing and transition. Other priorities such as meaningful use, data security, and regular system upgrades and maintenance may have slipped on the priority list or lost resources and funding. Now is the time to evaluate your IT project portfolio and identify any gaps.

**ICD-10 Transition**

Some caution that ICD-10 interpretation issues may still loom as 12,000 hospitals and other providers adapt to the system simultaneously. Industry specialists believe payers, CMS among them, will begin implementing stricter diagnosis requirements for treatment.

The last major hurdle to a successful transition will involve changing long-standing behavior and work habits as physicians are asked to provide more thorough documentation. Organizations are evaluating the need to reinforce clinical documentation improvement initiatives, and strengthen quality assurance and revenue integrity functions to improve coding accuracy. This will enable organizations to adapt to changes that may come from payers later down the road. Once coders and healthcare professionals get fully up to speed, the specificity gains offered by ICD-10 will have come at a relatively minor cost in terms of patient care and successful reimbursement procedures.

Hopefully over the next few years we will see the benefit of this major industry-wide work effort. Large scale data analysis of previous treatment plans for ultra-specific diagnosis may highlight an improved care pathway for future patients. International data-sharing may lead to better and faster global disease tracking and symptom diagnosis. Locally, we can better understand our patient population and their conditions better as we transition from fee for service to value based care.
Jane Piotrowski Earns Fellowship Designation from the Healthcare Financial Management Association

The NH/VT Chapter of HFMA has announced that Jane Piotrowski, FHFMA, recently became a Fellow of the Healthcare Financial Management Association (FHFMA).

To be awarded the FHFMA distinction, applicants must be credentialed as a Certified Healthcare Financial Professional (CHFP); be an HFMA member for at least five years; complete a bachelor’s degree or 120 semester hours from an accredited college or university; and volunteer in HFMA or the healthcare industry. More than 1,700 HFMA members nationwide have achieved this accomplishment in the organization’s 68-year history.

In addition to FHFMA, HFMA offers a variety of other certification programs: Certified Healthcare Financial Professional® (CHFP®), Certified Specialist Business Intelligence (CSBI), Certified Specialist Physician Practice Management (CSPPM), Certified Specialist Managed Care (CSMC), and Certified Specialist Accounting & Finance (CSAF). Learn more at hfma.org/certification.

your TURN

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We continue to be impressed with the volume of accounting updates that will have implications for healthcare organizations. We like to use this space as an opportunity to discuss recent Financial Accounting Standards Boards (FASB) activity, as it helps organizations be more cognizant of accounting changes that may affect their financial reporting in the near future. As we write this article, FASB is considering what items will be addressed within the next few years. FASB’s Emerging Issues Task Force (EITF) also recently issued No. 2016-EITF-15F, “Statement of Cash Flows (Topic 230)” an exposure draft that is intended to reduce some diversity in practice on how some specific cash receipts and payments are presented. This month’s column will give you an idea on what may lay ahead for the financial reporting of your organization.

Classification of Certain Cash Receipts and Cash Payments

FASB indicated this EITF exposure draft is in response to claims from stakeholders that there is significant diversity in practice in reporting on the statement of cash flows. Stakeholders are considered to represent all of us — preparers and practitioners (the independent CPAs), the organizations whose reports are being presented, and the users of the financial statements; most notably financing organizations and the legal community, but also those in the general public that may read and rely upon the financial statements. Outside of the normal items that are common to most statements of cash flows (think changes in accounts payable, purchases of fixed assets, repayment of debt, etc.), there are less frequently used items that current generally accepted accounting principles (GAAP) are neither clear about nor do they provide specific guidance on classification as an operating, investing or financing activity. This exposure draft addresses eight specific cash flow issues. Items that you are more likely to come across include the following four matters:

► Debt prepayment or debt extinguishment costs – currently, there is no specific guidance on how costs incurred with the extinguishment of debt should be handled. It is proposed to be included in the financing activity section of the statement of cash flows.

► Proceeds from the settlement of insurance claims – existing guidance is unclear on the classification of these proceeds. It is proposed to be classified on the basis of the related coverage (whether the nature of the loss related to an operating, financing, or investing cost)

► Contingent consideration payments made after a business combination – currently, there is no specific guidance on the classification of cash payments made by an acquirer for contingent liabilities in existence at the time of acquisition. It is proposed to be included in financing activities for the amount up to the recognized liability, with the remainder classified in the operating activity section of the statement of cash flows.

► Separately identifiable cash flows and application of the predominance principle – existing guidance is unclear about when cash activity should be classified into more than one class of cash flows and when it should be based on the predominant cash flow. Proposed guidance will clarify when it should be separated and when reasonable judgment is required to estimate and allocate cash flows.

The above are just a few of the items being discussed. As you may have noticed, these items are not necessarily seen on an annual basis by an organization, especially smaller ones. This is one of the reasons why they have not been already been addressed in current GAAP. The proposed amendment is considered to be an improvement to current GAAP, as there would now be specific guidance on the issues addressed.

Application

The proposed amendment will apply to all entities and would be applied retrospectively to all prior periods presented. The effective date and the ability to early adopt will be determined after stakeholder feedback is reviewed. The exposure draft is open for comments, with a deadline of March 29, 2016. The exposure draft may be
revised based upon the responses received before being finalized.

FASB Research Agenda
In early February, FASB announced it was going to perform further research on six topics for consideration of possible future accounting standard setting. Specifically, four issues will be added to its research agenda and included in an agenda discussion paper that is expected to be issued in the first half of 2016. The four issues are:

► Financial performance reporting
► Pensions and other post-retirement employee benefit plans
► Intangible assets
► Distinguishing liabilities from equity

In a recent post on the FASB website, the chairman noted that he considers setting FASB’s future agenda its greatest challenge and greatest opportunity. The above noted items came about as a result of a recent survey that was taken of stakeholders to find out what issues should be tackled in 2016 and beyond. As discussed earlier, these groups are those that future updates will matter most to. The survey sought opinions on what the most needed financial improvements were, whether any problems (or lack of feasible alternatives) cause them, and how soon a solution would be needed. This process is similar to one that occurred three years ago, which helped determine what areas FASB is currently working on. Our more recent columns discuss changes to financial disclosures, simplified accounting concepts, and improvements to GAAP overall – all items that are directly related to this. It is our opinion that we will be reading about these and other items included in the soon to be released agenda paper in future years, thus ensuring no shortage of relevant content for the HFMA membership.

Contact us with questions about these or any other accounting matters you may have.

W. Karl Baker, CPA, is a principal in the New England health care practice at CliftonLarsonAllen LLP. He can be reached at karl.baker@CLAconnect.com or 617-984-8162.

Joseph Lopatosky, CPA, is a manager in the New England health care practice at CliftonLarsonAllen LLP. He can be reached at Joe.Lopatosky@CLAconnect.com or 617-984-8138.

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First Annual HFMA Region 1 Provider Poster Celebration
HFMA Region 1 Conference - Mohegan Sun, CT - May 25, 2016

Ever wanted to present one of your achievements in front of your colleagues but were afraid to take the plunge?

Concerned that writing a long presentation would be too much pressure?

Stressed by the idea of presenting in front of a large group?

Consider presenting your idea at the first annual HFMA Poster Celebration!!!

The Region 1 meeting is the perfect opportunity to exhibit your idea, practice your skills in a safe environment with other members of HFMA.

Read our Poster Celebration Details article in this newsletter for more information!!!

For more details, check out www.hfmaregion1.org
Join your peers at ANI 2016 and think out of the box to drive success where it matters most:

► Meet the challenges of consumerism—from first contact to final payment
► Manage costs while delivering quality
► Capture more revenue, whatever the payment or delivery model
► Leverage analytics to make smarter decisions in an uncertain environment

Plus, reach out to physicians, payers, and providers—the partners/collaborators you’ll need to succeed.

ANI 2016 keynote presentations include:

► **Julie Williamson, PhD**, Coauthor of Matter: Move Beyond the Competition, Create More Value, and Become the Obvious Choice
Finding Your Edge of Disruption: Learn how innovative, “generative organizations” are able to continuously create more impact on their customers, employees, and communities.

► **Eric Topol, MD**, Cardiologist and author of The Patient Will See You Now: The Future of Medicine Is in Your Hands
The Future of Medicine Is in Your Hands: Hear insights on the future of medicine—as well as innovations that will be required to drive health solutions aimed at improving outcomes.

► **Healthcare Innovation Panel** — A discussion around the possibilities of using hospitals and clinics as learning laboratories to commercialize innovation. Moderated by Joe Fifer, President and CEO, HFMA.

You’ll also hear from ANI featured speakers—leading innovators at the forefront of collaboration and change including:

► **Mark Chassin, MD**, Joint Commission Center for Transforming Healthcare — Getting to High Reliability Healthcare While Generating Positive ROI

► **David Johnson, CEO & Founder, 4Sight Health** — Competition, Consumerism, and Choice: Building a Better Healthcare Market

► **Vivian Lee, PhD, MD, MBA, Sr. VP for Health Sciences, University of Utah** — Finding a Better Way Toward Patient-Centered Medicine

► **Thomas Lee, MD, CMO, Press Ganey** — What Drives Patient Loyalty? Analyses from Inpatient, Outpatient, and Emergency Department Patients

► **Paul Keckley, PhD, Navigant** — Provider-Sponsored Health Plan Analysis of Competitive Landscape

► **Sachin Jain, MD, CareMore** — Enabling Physicians to Deliver Value-Based Care

► **Martin Arrick, Managing Director, Standard & Poor’s** — Industry Trends and Credit Issues

At ANI, you’ll have the opportunity to lay out your action plan—find out “how to” with Innovation Lab specifics. Try out new tools and takeaways. Check out 400+ products & services. Earn up to 25.5 CPEs. And, with ANI to Go, access ANI sessions until October 7, 2016.

Register now and get what you need to STAND OUT.
ANI 2016. June 26-29. Las Vegas, NV. To register and for full session details, go to hfma.org/ani.
Whatever your role in delivering value, if it’s essential to innovation in health care, you’ll find it at ANI.

General Session Spotlight
Eric Topol, MD
Hear his insights on the future of medicine including the innovations that will be required to drive more personalized and cost-effective health solutions.

REGISTER NOW. hfma.org/ani
BerryDunn’s team of seasoned professionals puts its audit, tax, and consulting know-how to work for you in a way that fits your operational style. Our hospital and health care system professionals stay on the leading edge of health care financial issues and strategies, combining our industry knowledge with an understanding of your organization’s strategic goals to help you make better-informed decisions. We help you capitalize on opportunities that drive value—all with more control!

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Connecting industry expertise with customized solutions is how healthcare systems and patients grow stronger.

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The power of global connections™
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).
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The New Hampshire/Vermont Chapter of the Healthcare Financial Management Association (HFMA) is a professional membership organization for individuals in financial management of healthcare institutions and related patient organizations.