In this Issue:

Pg. 3 Regional Director Message

Education:
Pg. 4 Upcoming education

Articles:
Pg. 6 “Presidential Positions: Where the Candidates Stand on Health Care, Housing?”
Pg. 10 “Rating Agencies Update: Happy Days are Here Again ... But Will They Last?”

Sponsorships:
Pg. 20 Supporting sponsors
Great Lakes Chapter
Officers
President
Brent Smith

President Elect
Tom Matonican

Secretary
Michael Cwik

Treasurer
Kellie VanDeusen

Past President
Josh Wiggins

Board Members
Mark Kato
Tanya Hahn
Chad Gutzman
Sam Niemi

Directors
Northern Michigan
Gerald Artman

Upper Peninsula
Regina Bergh

Audit & Finance
Carolyn Obrecht

Certification
Chair:
Mark Thompson

Vice Chair:
Elizabeth Hooper-Linn

Members:

Link Chapter Representative:
Sam P Niemi

Membership
Chair:
Ben Smyth

Members:
Steve Panoff
Brent Smith
Tom Matonican

Mentoring
Chair:
Andrea Barnes

Members:
Carolyn Obrecht

Program

Co-Chairs:
Michelle Toups
Nicole Sulak

Members:
Gerald Artman
Amy Bilyea
Donald Dingman
Carolyn Obrecht

Sponsorship
Chair:
Patty Davis

Members:
Brent Smith

Networking
Chair:
Cinthia Brooks

Vice Chair:
Members:
Max Mendieta
Mike Cwik
Brent Smith
Tom Matonican

Membership Directory
Chair:
Elizabeth Hooper-Linn

Audit & Finance

Certification

Vice Chair:

Members:

Link Chapter Representative:

Membership

Chair:

Members:

Mentoring

Chair:

Members:

Program

Co-Chairs:

Members:

Sponsorship

Chair:

Members:

Networking

Chair:

Members:

Newsletter

Chair:

Members:

Web Site

Chair:

Members:
Regional Executive’s Message

This trimester I am taking a class in systematic theology…not an easy subject for this action-oriented, application-minded girl who struggles with theoretical models. One of the things we discussed was the image of God and how we are created in it. The perspective that most resonated with me was a relational view. As the name suggests, this viewpoint is one of relationships. It has social and moral components. To put it simply, we are exhibiting the image of God when we work in harmony, in community.

That’s how we are wired as humankind; we thrive when we work together. The implications for our work in healthcare is clear. We cannot be successful when we work in silos. The best ideas, the best care plans, the most successful teams, and the healthiest bottom lines are born out of collaboration and interdisciplinary work. The long-term viability of our organizations depends on relationships with our community, our patients, our employees, our boards—all the stakeholders. These relationships are shifting, and changes and information are coming at us fast and furiously. We spend our days performing a juggling act.

HFMA National is looking at these very issues in the strategic direction and planning for future relevancy. On a local level, our chapters continue to measure KPIs for the balanced scorecards while incorporating innovation and new kinds of collaboration to see what works for our members.

All of this can be exhausting, but it can also be invigorating if we focus on relationships—our common building block. Find and foster those relationships which renew and energize you. HFMA is certainly an avenue to achieve this goal. We will lighten our loads together and truly thrive in this chaotic world of healthcare finance.

Take care,

Dawn Balduf
Regional Executive, Region 6
UPCOMING DATES:

⇒ 501r: 60 Days Away and Counting, Webinar, Nov. 2015
⇒ Getting Started With Macros, Webinar, Nov. 2015
⇒ Medicare/Medicaid: Past, Present & Future, Webinar, Nov. 2015
⇒ Helping Hospitals Use Analytics, Webinar, Dec. 2015
⇒ Accounting & Auditing Update, Bay City, Jan. 2016
2016 Fall Reimbursement Update and Brewery Tour at the Bluewater Hall
September 23, 2016

Thank you to everyone who attended this year’s Traverse City reimbursement update conference and brewery tour. We had great participation allowing members and sponsors in the chapter to network and get updated with the latest information. Some of the topics covered included learning about 501r, managing the transition to value based payments, contractual allowance best practices and provider based clinic guidance.
Presidential Positions:
Where the Candidates Stand on Health Care, Housing

In seemingly every presidential election, we are told by pundits and politicos that this particular contest represents the starkest choice between two vastly opposed ideologies that we’ve seen in decades. The future, your kid’s future and your grandchildren’s future, depends on its outcome.

Some may argue that such hyperbole is an understatement this year, and, whether that’s true or not, one thing is clear—this election gives voters the choice between the known and the unknown. If Secretary Hillary Clinton wins, the nation will likely stay on its current path—a pursuit of incremental change shaded by Democratic ideologies. If Donald Trump wins, no one is quite sure what will happen, although a look at his proposals and the GOP’s 2016 platform provides some insight.

Health Care

Clinton has made it clear she believes in upholding and improving the Affordable Care Act (ACA). Her website lists several other health care policies including:

- Expanding Medicare by lowering eligibility age from 65 to 55
- Lower prescription drug costs by requiring drug companies to invest in research and development in order to receive taxpayer support
- Incentivize states to expand Medicaid (no specifics given)
- Allow families to buy insurance on the health exchanges regardless of immigration status
- Identify ways to make providers eligible for telehealth reimbursement under Medicare
- Expand federally qualified health centers and rural health clinics
- Double funding for primary-care community health centers

All this amounts to what would be a hefty expansion of the ACA and would likely face stiff resistance from the GOP-controlled Congress.

On Trump’s website, the candidate lists seven policy points regarding health care, with the first being repealing the ACA. The other positions consist of:

- Eliminating laws limiting the sale of insurance across state lines
- Make health insurance premium payments tax deductible for individuals
- Use health savings accounts (HSAs) as the primary program to replace the ACA
- Mandate price transparency from all providers so consumers can compare by price
- Block-grant Medicaid to the states
- Increase competition in the pharmaceutical industry by allowing consumers to purchase drugs from overseas. The last point is one of the few areas where the two candidates agree, as Clinton has also called for allowing foreign drug providers to sell to American consumers.
Probing the Plans

A recent analysis done by the RAND Corporation, a non-partisan policy think tank, highlights the differences between the two candidates’ health care plans. The study used RAND’s computer microsimulation to analyze the portions of each candidate’s plans with enough detail to model. The

<table>
<thead>
<tr>
<th>Candidate Positions Side-by-Side</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td><strong>ACA</strong></td>
</tr>
<tr>
<td>Maintain and build upon.</td>
</tr>
<tr>
<td><strong>Insurance premiums</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

| **Out-of-pocket costs**          |Hillary Clinton                  |Donald Trump                    |
|                                  | • Provide a new refundable tax   | • Allow people to enroll       |
|                                  | credit of up to $2,500 for an    | in tax-free HSAs to pay        |
|                                  | individual, $5,000 for a family, | for out-of-pocket costs,       |
|                                  | for costs in excess of 5% of     | usable for all family          |
|                                  | income for insured individuals   | members and inheritable       |
|                                  | not eligible for Medicare.       | without tax penalty.          |
|                                  | • Ensure consumers are required  | • Require price transparency   |
|                                  | to pay no more than in-network   | from all health care providers  |
|                                  | cost-sharing for care received   | to enable individuals to shop  |
|                                  | in a hospital in their network.  | for the best prices.          |
|                                  | • Enforce ACA transparency       |                                  |
|                                  | requirements.                    |                                  |

| **Medicaid**                     |Hillary Clinton                  |Donald Trump                    |
|                                  | • Maintain current Medicaid      | • Transform Medicaid into a    |
|                                  | funding structure.               | block-grant to states.         |

Source: Kaiser Family Foundation

analysis found that Clinton’s proposals would increase the amount of people with insurance by between 400,000 and 9.6 million in 2018, while Trump’s proposals would decrease the number of insured by between 15.6 million and 25.1 million.

Digging into each candidate’s specifics, the report found that Clinton’s tax credit proposals would cost approximately $94 billion. Her plan calls for offering refundable tax credits to individuals with private insurance whose premium out-of-pocket costs exceed 5% of income as well as lowering the maximum premium contribution on the marketplace to 8.5% of income. These would cost $90.4 billion and $3.5 billion respectively. Her call to fix the “family glitch,” offering marketplace premium tax credits to families with employer insurance if their contribution to a family plan would exceed 8.5% of income, would add another $10 billion to the deficit. Her proposal to add a public option, however, was projected to lower the deficit by $700 million.

Analyzing Trump’s plans, the study concluded that repealing the ACA would add $33.1 billion to the deficit. Further, implementing tax-deductible premiums would increase the deficit by $41
billion, allowing interstate insurance sales would add $33.7 billion and block-granting Medi- 
caid would add another $500 million.

As for out-of-pocket costs, the RAND study projected Trump’s plan to increase them for ACA 
enrollees anywhere from $300 to $2,500 per year while Clinton’s tax credits would decrease 
costs for low- and moderate-income individuals (those making $16,243 to $29,425 for an indi- 
vidual, $33,465 to $60,625 for a family of four) by an average of 33%. For example, under cur- 
rent law an individual with an income of $41,580 would be required to pay $4,017, whereas 
under Clinton’s plan that individual’s contribution would be reduced to $3,534. It should be 
noted that there were elements of Trump’s plans which could not be modeled due to lack of 
detail. The authors stated that if either candidate was to release further details that would alter 
the figures, they would run a new simulation and release new numbers.

The Future of Obamacare

Once again, the ACA is approaching a defining moment. After surviving a presidential election 
and two U.S. Supreme Court decisions, Obamacare is again in the political crosshairs. If 
Trump wins, some sort of dismantling will at the very least be attempted. Of course, taking in-
surance away from 20 million people, even if you have a plan to get it back to them in a differ-
ent form, won’t be easy. If Democrats take control of the Senate, it will be very difficult if not 
impossible for a President Trump to pass anything that harms Obama’s signature achievement.
If Trump wins and Republicans keep the Senate, Democrats will still have the power of the fili-
buster at their disposal.

Likewise, if Clinton wins, regardless of what party controls the Senate, Republicans will likely 
remain fiercely opposed to the ACA and could use the filibuster to prevent most of her major 
proposals, such as instituting a public option. What might be possible under a President Clin-
ton, according to reporting from Modern Healthcare, is an effort to increase exchange enrollment 
through system reforms and aggressive outreach, as well as increase subsidies for low- 
income patients. If Trump wins, most expect him to pass the issue to Speaker Paul Ryan, who 
would likely be unable to actually repeal the ACA but would try to chip away at it by attacking 
the individual and employer mandates, the Center for Medicaid and Medicare Services (CMS) 
Innovation Center, and the Medicare Independent Payment Advisory Board.

Of course, for the optimist, there is always a chance that the combination of a new president 
and national fatigue over fighting the ACA for seven years would inspire a compromise, re-
gardless of who wins. A possible bargain might consist of using Section 1332 of the ACA, 
which allows the federal government to grant waivers to states to leave the ACA exchanges 
and use their own methods to reach coverage and cost control goals. This would please con-
servatives as it takes power away from the federal government and gives it to states. In ex-
change, Democrats would likely ask for more cost-sharing subsidies for low-income enrollees.
Housing

Affordable multifamily housing issues rarely surface during general election campaigns and this year is no different. There is no mention of housing on Trump’s website. The Republican platform for 2016 stops short of calling for the abolition of Fannie Mae and Freddie Mac, but it does describe both as “corrupt business models” whose usefulness should be reconsidered. The platform calls for the end of government mandates that required Fannie, Freddie and federally-insured banks to satisfy lending quotas to specific groups, calling such practices discriminatory. It opposes the Obama Administration’s Affirmatively Further Fair Housing (AFFH) rule which it says undermines local zoning laws and gives too much control to the federal government. The goal of AFFH is to “address significant disparities in access to community assets, to overcome segregated living patterns and support and promote integrated communities” which it aims to do by requiring a new assessment of fair housing by HUD program participants.

Clinton has a housing section on her website that promotes increasing incentives for new development and strengthening programs that give low-income renters more options outside of high-poverty areas. Although she doesn’t mention the U.S. Supreme Court disparate impact decision last summer that makes it easier for developers to build low-income housing in high-income neighborhoods, it’s clear she supports it. Further, she recently penned an op-ed in the New York Times on poverty that advocates for the expansion of the low-income housing tax credit (LIHTC).

Clearly, the outcome of this contentious presidential election will have substantial ramifications on the health care and housing industries. The good news is, after almost two years of discussion and campaigning, the finish line is in sight.

Steve Kennedy is a senior managing director with Lancaster Pollard in Columbus. He may be reached at skennedy@lancasterpollard.com.
Rating Agencies Update: Happy Days are Here Again … But Will They Last?

The hospital sector saw one of its best years in recent memory during 2015. As a result of the Affordable Care Act (ACA), expanded insurance coverage was in full swing, along with a recovering economy, robust revenue growth and low interest rates. Readers may recall that 2014 showed improvement for the higher rating categories (“A-rated” and above), but the lower investment-grade and non-investment grade categories struggled. In 2015, the positive trend continued for the higher rated providers, but the improvement was more widely disbursed. The consensus theme of the three largest credit rating agencies (CRAs) is that all rating categories saw improvement. However, all CRAs cited economic and other factors that will challenge the industry in the near future, with smaller systems and stand-alone hospitals disproportionately affected.

Each of the CRAs issue an annual report that summarizes past performance and provides a forecast for the upcoming year. With approximately 95% of the world market share for credit ratings, Fitch Ratings (Fitch), Moody’s Investor Service (Moody’s) and Standard & Poor’s (S&P) reports provide a wealth of information which systems and stand-alone hospitals can use to make meaningful comparisons to financial benchmarks and emerging trends.

Operating Performance

One of the key observations noted by the CRAs was the improvement in operating margins for most providers, realized through a combination of good revenue growth and continued expense controls. All three agencies noted that 2015 was the first full year with any significant increase in insurance coverage attributable to the ACA, continuing a trend that began in 2014. Obviously, providers in “Medicaid expansion states” benefitted more, but there was improvement in most other states as well.

Moody’s reported a six-year high in annual revenue growth (7.5%), while expenses grew at a slower pace for the second consecutive year. All CRAs cited the Medicaid expansion and consolidation as the driving factors for the dramatic increase in revenue growth. While organic growth was prevalent across the board, Moody’s noted that revenue growth was greatest in the largest hospitals and systems because of consolidation. All three agencies expect that the effect of Medicaid expansion will moderate in 2016 and revenue growth will slow significantly.

While revenue increased, health care providers are effectively checking expense growth with increased operating efficiencies. Consolidation continues to provide benefits vis-a-vis economies of scale and operational synergies, in addition to better negotiating leverage with vendors and payors. S&P noted that many hospitals and systems are realizing the benefit of improved IT infrastructure that was put in place in recent years. Many systems have digested the expenses incurred with IT implementation and are seeing improvements in revenue cycle, inventory and supply management, and labor productivity. Fitch, however, did point out a few examples of downgrades resulting from poor implementation of IT systems.
As noted in the rating reports from last year, 2014 was the first year in which providers had assurance that ACA was here to stay. The resulting increase in Americans with health care coverage started to manifest in higher volumes in 2014, and the trend continued throughout 2015. The gains were largest in the Medicaid expansion states, but the CRAs noted that increased coverage is relatively widespread. However, Fitch and S&P pointed out potential challenges, as many of the newly qualified Medicaid-eligible patients often require a more complicated range of services than existing enrollees. In addition, emergency room volumes in some markets are booming, because the newly qualified patients do not have access to a primary care physician. While the increased volume may be positive, the rapid increase can stress an organization’s physical capacity and present staffing challenges.

Overall, the combined impact of increased revenue growth rates and greater cost controls yielded improved profitability. According to Fitch, the median operating margins for 2015 and 2014 were 3.5% and 3.0%, respectively. Operating earnings before interest, taxes, depreciation and amortization (EBITDA) margins demonstrated similar results. The increases follow similar improvements from 2013 to 2014, but all three agencies observed that the gains in productivity were more widespread this year. Fitch reported gains in all rating categories, while Moody’s and S&P observed similar results. None of the CRAs mentioned the improving economy as a major factor in revenue growth, but each agency noted that the economy will present a challenge to employment costs in the near term.

Non-Operating Income and Cash Flow

It is fortunate that operating performance improved in 2015, as poor investment returns were a drag on non-operating income. Overall EBITDA margins were good, because of the operating performance. Debt service coverage (DSC) also showed improvement, as focus on revenue cycle improvements and limited capital spending also contributed to cash flow. In addition, historically low interest rates and high demand for municipal bond debt helped keep interest expense very low for providers in nearly every rating category. Fitch discussed the extent to which hospitals are using technology and better management practices to improve the revenue cycle, despite challenges presented by changes in payor mix. As pointed out by Fitch, “while high deductible health plans have become more prevalent, management teams have become more adept at managing the seasonality of patient volumes. The investment in and focus on billing, coding and collections continue to reduce denials, improve collections and enhance overall cash flow.”

Liquidity and Capital Spending

The ubiquitous strength in profitability and increased focus on the revenue cycle have helped maintain liquidity, despite paltry investment returns in 2015. The CRAs observed that days’ cash on hand, cash to debt, and other liquidity measures were fairly stable in 2015. All three rating agencies observed a noticeable divergence in the level of capital spending between the largest (and typically higher rated) systems and the smaller (usually lower rated)
systems. Moody’s noted that, “capital spending remained below depreciation at 0.9 times for the smallest hospitals while the largest hospitals continue to spend above depreciation at 1.3 times.” Overall, capital spending did increase slightly in 2015 after hitting an eight-year low in 2014. However, average age of plant continued to decline. All three rating agencies noted that a large (and growing) percentage of capital spending is focused on IT projects. The construction projects that many providers are undertaking are aimed at modernizing existing facilities and building smaller structures to provide better access in furtherance of population health goals. None of the rating agencies noted a particular concern with the average age of plant, and the reduction in capital expenditures generally has a positive impact on liquidity.

**Trends and Expectations**

The following themes were common to all median reports:

- A moderation of the increase in revenue is expected in 2016, as baseline level of volume now includes the newly-qualified Medicaid recipients.

- Each agency pointed out the challenges presented by the improving economy. Tight labor markets will likely lead to higher salary and benefit costs, and “the movement toward population health management and a growing focus on chronic disease management have increased the competition for, and cost of, nurses in certain markets,” according to Fitch.

- Similar to last year’s reports, all three CRAs observed that risk or value based reimbursement programs have been slow to take hold, but the expectation is that these will accelerate at some point. The most efficient providers—who also tend to be the highest rated—stand to benefit most from this trend.

- Another trend carried over from last year is continued efficiency initiatives through increasing use of technology and further consolidation/affiliation, especially where larger systems acquire weaker providers that lack the scale to keep up with the pace of change.

While the trends above tend to support increased divergence between the highest rated (typically larger) providers and lowest rated (typically smaller) providers, 2015 was a good year across the rating spectrum. Unlike 2014, the lower rated categories enjoyed operating and EBITDA growth at a similar pace to the higher rated organizations. Also, most balance sheet measures remained flat from 2014 to 2015 in all rating categories. Improved operating margin was offset by weaker non-operating margins (mainly lower investment returns) leading to flat growth in cash balances.
S&P, Moody’s and Fitch all signaled that 2015 is likely to be as good as it gets for the hospital sector. With the full force of increased Medicaid enrollment, operating efficiencies from IT and management initiatives and greater economies of scale through consolidation and affiliation, most providers enjoyed excellent margins. Unfortunately, pressures from tighter labor markets and demands to push toward population health management will likely create strong headwinds in the latter half of 2016 and beyond. Further, the CRAs see relatively good performance of the lower rated organizations as a temporary phenomenon. It is likely that the long-term trend of greater consolidation and bifurcation of rating categories will continue in coming years.

Jason Dopoulos is a managing director with Lancaster Pollard in Columbus, Ohio. He may be reached at jdopoulous@lancasterpollard.com.

Ritchie Dickey is a vice president with Lancaster Pollard in Atlanta. He may be reached at rdickey@lancasterpollard.com.
## New Members

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Company</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polly</td>
<td>Keene</td>
<td>Sherloq Solutions</td>
</tr>
<tr>
<td>Wyatt</td>
<td>Short</td>
<td>The Ryber Group</td>
</tr>
<tr>
<td>Richard</td>
<td>Hall</td>
<td>MidMichigan Health</td>
</tr>
<tr>
<td>Brian</td>
<td>Drust</td>
<td>Affinia Health Network</td>
</tr>
<tr>
<td>Tara</td>
<td>Parkinson</td>
<td>Covenant HealthCare</td>
</tr>
<tr>
<td>Donna</td>
<td>Hulse</td>
<td>Morgan Consulting Resources, Inc.</td>
</tr>
<tr>
<td>Julia</td>
<td>Lowe</td>
<td>Affiliated Medical Billing, LLC</td>
</tr>
<tr>
<td>Joseph</td>
<td>King</td>
<td>MidMichigan Health</td>
</tr>
<tr>
<td>Kelly</td>
<td>Bruce</td>
<td>Sparrow Health System</td>
</tr>
<tr>
<td>Jennifer</td>
<td>Thorton</td>
<td>Sparrow Hospital</td>
</tr>
<tr>
<td>Raymone</td>
<td>Weaver</td>
<td>Credit-Check</td>
</tr>
<tr>
<td>Steve</td>
<td>Barnett</td>
<td>Mckenzie Health System</td>
</tr>
<tr>
<td>Heather</td>
<td>Flues-Harrington</td>
<td>Sterling Area Health Center</td>
</tr>
<tr>
<td>Amanda</td>
<td>Givens</td>
<td>MidMichigan Health</td>
</tr>
<tr>
<td>Melissa</td>
<td>Romanowski</td>
<td>Munson Healthcare</td>
</tr>
</tbody>
</table>
There’s more to McLaren.

At McLaren Flint, nothing brings us greater satisfaction and strengthens our commitment more than the trust placed in us by the people we serve. We’ll continue to offer the best value in health care and keep working to improve the well-being of families and communities through our expertise and services.

- Designated a Blue Distinction Center+ for Cardiac Care by Blue Cross Blue Shield of Michigan
- Designated a Blue Distinction Center+ for Hip and Knee Replacement by Blue Cross Blue Shield of Michigan
- Designated a Blue Distinction Center+ for Spine Surgery by Blue Cross Blue Shield of Michigan
- Certified as a Bariatric Surgery Center of Excellence by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program
- Certified as a Primary Stroke Center by the Joint Commission
- Three-year accreditation with commendation from the Commission on Cancer
- Site of the state’s first proton therapy center
- Specialized services, such as interventional neurology and minimally invasive surgery, including robotic-assisted surgery
- Affiliated with MSU College of Human Medicine for medical residency programs, including family practice, internal medicine, general surgery, orthopedic surgery, and radiology

For a physician referral, call [877] 625-2736 or visit mclaren.org/flint.
We see your patients as you do.

Treating people with dignity and respect is central to providing quality care. And part of taking good care of patients is to be sure that as a provider, you have the resources necessary to provide the quality of care they’ve come to expect.

capiopartners.com/respect

Get your revenue cycle back in gear.
Elevate your view.

Sometimes the best solutions are revealed when you change your perspective — and finding the right perspective is easier when you have a knowledgeable advisor. Our health system experts can help your organization gain a new perspective to rise above its challenges. Helping providers succeed in today’s ever-changing healthcare industry is a higher return on experience.

Oliver Jurkovic 616.643.4046
oliver.jurkovic@planteamoran.com
planteamoran.com

CBM
SERVICES, INC.

Specializing in Cash Back Management.

CBM Services has been recovering debt for medical, retail and commercial clients for over 95 years. CBM Services utilizes the most advanced tools in the industry to maximize results for our clients. Ultimately, this allows CBM Services to surpass our competitors! Let us help you improve your cash flow TODAY!

Call us today!
989-631-0104 or 800-968-2733
www.cbmservices.com

Experience • Innovation • Results!

Services:
• Customer Service
• Regular Collections
• Contract Management
• Early Out Collections
• Second Placement Collections
• Legal Referral & Follow Up
• Specialized Reports
• Consultation/Seminars
• Computerized File Transfer
I need the right answers at the right time.

Wipfli helps you get to the heart of the matter and address the issues that stand in the way of success. Our health care experts help you and your organization see the possibilities and inspire you, when necessary, to change course. For help in finding the answers to the difficult questions, contact Wipfli—the team who “gets it.”

Steve Thompson
920.662.2820
stompson@wipfli.com
www.wipfli.com/healthcare

WIPFLI LLP
CPAs and Consultants
HEALTH CARE PRACTICE

EXPERIENCE. EXPERTISE. EXCEEDING EXPECTATIONS.

From integrated healthcare systems, critical access and rural hospitals to long-term care facilities and physician practices, The Rybar Group understands the financial challenges the healthcare industry and will put that knowledge to work for you. Our services include:

- Provider Reimbursement Analytics
- Blue Cross Blue Shield Revenue Strategies
- Critical Access Hospital Resources and Strategies
- Data Integrity and Compliance
- Physician Services
- Regulatory Support for Legal Matter
- Revenue Cycle Management Services
- Volume Decrease Payment
- ICD-10 Services

Over the past 25 years, The Rybar Group has worked with providers nationwide across the spectrum of healthcare managed care and compliance issues, strategizing, implementing, appealing, negotiating and successfully resolving engagements. Learn more about our customized array of services by visiting our website theyrbargroup.com or calling 810.750.6822.
Improving Financial Performance and Patient Relations

UCB, Inc. services a national market offering extended business office solutions and receivable management services. UCB offers the following programs to its healthcare clients:

- Early Out Programs
- Pre-Collection Services
- Patient Access Solutions
- Charity and Financial Programs
- Scoring and Analytics Programs
- Revenue Cycle Consulting
- Bad Debt Collection Services
- Call Center Applications
- Insurance A/R Management
- Medical Eligibility Services
- Medical Billing A/R Follow Up

Intelligent Solutions

Please Contact Douglas Headnap, Vice President for additional information:
(913) 356-5294 / dheadnap@ucbinc.com

ARE YOU READY FOR THE NEW HEALTHCARE CONSUMER?

Financial engagement is key. CarePayment features unique patient financing solutions at 0.00% APR that help patients meet their financial obligations while optimizing your organization’s self-pay revenue cycle and improving your financial performance. To learn more visit www.carepayment.com


Allied Business Services

Professional Revenue Cycle Recovery Services Since 1953
(888) 381-9616
We are always looking for articles, job openings or local Great Lakes content for the newsletter. Please feel free to call or email your materials to myself, Cheryl or Alicia.

Wieslaw Herdzik  
989-839-3304  
Wieslaw.Herdzik@midmichigan.org

Cheryl Kotenko  
989-839-3184  
Cheryl.Kotenko@midmichigan.org

Alicia Kozak  
989-839-3732  
Alicia.Kozak@midmichigan.org