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A Newsletter from HFMA's First Illinois Chapter

January 2011

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love your heart American Heart Association

STEP Up

INSIDE:
Highlights and Recap
First Illinois
Chapter Events
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The 2011 First Illinois Chapter HFMA Scholarship

Simulating the Impact of Reform on the Region

BY DAN YUNKER, VP & CFO, METROPOLITAN CHICAGO HEALTHCARE COUNCIL

Another year has gone by and what a year it has been! At the risk of being perceived as an extreme optimist, I feel that this is a great time to be in health care. I am aware that health reform is taking shape and the repercussions will unfold for many years to come and that the recession for some has dried up revenue streams,

decreased utilization, and battered investment portfolios. The reality is that like many things, sometimes the best change is a result of having our backs against the wall to do what we do differently. If we want to continue to carry out our missions we will have to transform how care is delivered and paid for. When the ink from President Obama's pen dried on March 23, 2010, the health care industry was given an unusual opportunity to gain perspective, rethink strategies and be more innovative in how we perform on a daily basis. To quantify some of the great deliverables our hospitals deliver each year, check out a new video located at www.supportourhospitals.com. I recently shared this video at a conference I was speaking at, and the room gave a standing ovation! I get chills every time I view it.

Over the past several months, I have been fortunate enough to meet with many executive teams and boards of MCHC member hospitals to talk about reform and its potential impact on the delivery of health care in the Chicago market.

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Frankly, I have heard some common themes in these meetings with many executive teams taking a very serious approach to addressing the quality, access and cost issues that have been plaguing the system long before the recession took hold in 2008. Planning appears to be focusing on making core changes that could actually disrupt the "same old way we do it." And it is this disruption that can lead to a real transformation of our industry.

Despite the efforts of those who oppose the law that led to the Virginia federal district judge who ruled that a provision of the Affordable Care Act is unconstitutional, it continues to be a very clear picture that governmental intervention will strain the industry in ways that are just beginning to emerge. With uninsured Americans gaining health coverage as a result of reform, how will Chicago area hospitals handle the influx of pent up demand for health care? Are we vulnerable from a capacity perspective? I have heard in the market that simply trying to scale up current care delivery processes to meet post-reform challenges will be a flawed strategy. Many executives are faced with utilization levels that have declined. We can't let this available capacity fool us into thinking that we can meet the demand. Despite lower utilization today, many of our hospitals "feel" full and many point out that this is a result of ineffective workflow processes.

Having access to and using information will be critical to planning for the future. To contribute to the market intelligence needed for this planning, MCHC completed a study of the region. The study examines key trends that may play out over the strategic planning horizon assisting executives to understand combinations of those trends, and to layer the implications of reform that create various scenarios of impact. Many industries use scenario-planning to provide a framework for driving action in a time of uncertainty, and it has never been more important for health care providers to plan and act now to gain a vision around the must-dos that will likely prevail in all scenarios.

Because of this regional study, Chicago area hospitals now have access to a regional model that is a sophisticated approach to simulating several of the impacts of reform. When taking on a major project like this, several layers must be considered to capture how populations differ in their attitudes and purchasing behavior.

- **Geographic Influences (county level):** Dividing the market to understand the geographic influences compared to the region and national trends is critical to local decision making.
- **Demographic Differences:** (e.g., age, income level, ethnicity, smoking status, legal resident status, and employer size) such perspectives are crucial along with decision making and health cost index simulations at the individual person level to account for the fact that health care costs vary dramatically from person to person. This can be simulated using a behavioral approach to individual decision making. This approach can simulate the multiple decision factors that individuals use when making health insurance choices.
- **Employer Sponsored Plans:** Dynamic simulation with feedback loops take into account the interactions between individuals, payors and employers. 'Virtual companies' were constructed to model employer reactions to reform and forecast the ramifications of decisions by those companies on coverage benefits. A good example of this is the risks and benefits associated with the Patient Protection and Affordable Care Act's coverage penalties. The model identifies two hurdle rates: 2 percent or 5 percent of savings. As you would expect, as savings potential increases so does the shift of employer sponsored coverage to the individual markets.
- **Consumer:** 'Virtual households' were constructed to model health insurance purchasing decisions and key aspects of reform based on household units.
- **Coverages:** The core output from the model is an objective forecast of insurance coverage shifts across categories (e.g., from commercial small group to individual exchange, from uninsured to Medicaid etc.).

There is a lot to learn and modeling is a way to take specific market or individual dynamics and model the levers that then influence the simulated view. Of course, as the legislation unfolds, the model needs to be ready for change itself and easily adapted. And after our first pass at this approach we learned the following.

Nationally, health care reform is expected to result in significant

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Simulating the Impact of Reform... (continued from page 2)

shifts in coverage; however, shifts will not be uniform across the country.

Coverage shifts in MCHC's nine-county region are projected to differ from national averages in several key areas.

- Larger growth in individual market (~175%), with total population of ~1.4M by 2016
- Smaller growth in Medicaid market (~25%), with total population of ~1.6M by 2016
- Larger decline in uninsured (~40%), with total population of ~830K by 2016

Similarly, coverage shifts will vary across individual counties within MCHC's region.

- Individual market will likely grow >180% in Cook County by 2016, but only ~160% in DeKalb County
- Medicaid market will likely grow >35% in McHenry County by 2016, but <20% in Kankakee County
- Uninsured population will likely decline by nearly 50% in McHenry County by 2016, but only ~40% in Will County

Assumptions made by hospital executives about employer decisions to offer coverage or not have significant impact on coverage shifts.

- Assuming scenario where higher number of employers cease offering coverage results in:

  ~25% increase in size of individual market in 2016 (5% savings threshold scenario vs. 2% scenario)

  ~10% decrease in size of commercial market in 2016

  ~10% increase in size of uninsured population in 2016

Personally, my schedule is already consumed with meetings with executives where we are presenting the full report and peeling back the onion of this model to define specific drill down projects that simulate the reform impact on specific Chicago hospitals. This demands a great deal of effort, but what great intelligence this is providing in a time that challenges all of us to find our role in contributing to the transformation of the industry. I am hoping that this is one step of many that helps Chicago area hospitals plan for the future and that in the end, hospitals continue to provide affordable and high quality access to care to all communities.

Letter from the President

Happy new year and welcome 2011! As I begin my column, I reflect on upcoming challenges of the New Year. I hope everyone has taken the time to complete the First Illinois membership survey. In an effort to meet our member needs, this is the first year opinions have been solicited from all members instead of a random selection of members.

Watch these pages in the near future for the results of our membership survey. My role as president of the chapter is to facilitate meeting our members' needs.

It is hard enough to stay on target when the target isn't moving. What you knew has to be supplemented with what's new if you expect to stay current. Using the resources that HFMA has available, both individually and collectively (such as webinars and seminars), you can stay on top of the newest strategies for dealing with change. With more organizations rearranging talent and staff taking on increased responsibilities, reviewing things you "used to know" can make things easier. Even the best of us need refresher training. The way to stay employable is to stay indispensable.

The goal of our chapter is to be responsive to our members' needs. We want your input. And this needs to be more frequent than an annual survey. Your specific challenges are common problems. Whatever issues you are dealing with, chances are someone else is struggling with the same issue or has figured out a way to address it. The best resource for talking through a work issue is a peer experiencing the same concerns. Who better to understand healthcare issues than peers within your industry? And, your spouse will appreciate you talking to someone else about it!

How can the chapter address your issues? We have two types of committees. Support committees, which include Membership, Communication and Website along with others, and Education committees, which include Treasury, Revenue Cycle and Compliance to name a few. All committees and their chairpersons can be found on the First Illinois website (www.firstillinoishfma.org).

What issues are you having at work? Could it be addressed with a webinar or at a live education event? Can First Illinois address the issue with an article in our newsletter? We need your input. Contact our program chairpersons to offer topic suggestions. If you have an idea, tell it. If you want to help, join the committee. Your future is what you make it.

Make 2011 the best yet!

Patricia K. Marlinghaus, CPA, MBA
2010 – 2011
Chapter President,
First Illinois, HFMA

Medicaid Advocacy Firm Successfully Challenges Illinois 'Sudden Onset' for Undocumented Immigrant

BY CHRISTOPHER THUNDER AND RYAN BREBNER, R&B SOLUTIONS, WAUKEGAN, IL

A Medicaid Advocacy company based out of Waukegan, Illinois, successfully challenged the state's "sudden onset" requirement on behalf of an undocumented immigrant whose Medicaid eligibility was denied based on existing symptoms that lacked "sudden onset." In *Elvira Arellano v. Illinois Department of Human Services,* the 2nd District Appellate Court ruled that the sudden onset language that the Department of Human Services added to the federal Medicaid regulation, which Illinois' regulation mirrors, impermissibly modifies the federal Medicaid statute that does not contain the sudden onset language and cannot be enforced.

Elvira Arellano, a low-income undocumented immigrant mother without health insurance, had a cough, which she attributed to a minor cold and treated as such. As her breathing difficulties went unresolved with normal home remedies, she sought medical attention at a free clinic that provided her some pharmaceuticals to treat it. When Arellano's condition worsened, her family took her to the local emergency room, and she was immediately admitted for a severe case of pneumonia. After an 18-day hospitalization, Arellano was faced with a medical bill she was unable to pay.

The hospital where Arellano received care contracts with an Illinois-based Medicaid Advocacy firm to assist individuals like Arellano with their Medicaid and other benefit program applications. Although she met the categorical and financial requirements for the Illinois Medicaid program, due to her citizenship status she could only qualify for alien emergency Medicaid benefits, which are a limited exception to the federal Medicaid ban on benefits for noncitizens. Arellano applied for emergency Medicaid and the Client Assessment Unit (CAU) evaluated her case three times. In its initial decision, CAU denied benefits on the basis that she had symptoms for approximately three weeks and her condition therefore was not of "sudden onset." In its second decision, CAU denied on the basis that her condition was not a "sudden acute life threatening condition" and could have been treated at a doctor's office. In its final decision, CAU again denied benefits on the basis of no sudden occurrence.

Dennis Brebner and Associates, legal counsel for the case, appealed the benefit denial and its final administrative decision, but the State of Illinois' Department of Human Services and Illinois Department of Healthcare & Family Services upheld the decision on the basis that Arellano had been experiencing a progression of symptoms before she sought treatment at the hospital. Therefore, her condition did not occur suddenly and unexpectedly. Even though the Circuit Court upheld the final administrative decision on appeal, the Second District Appellate Court reversed and remanded the decision on the basis that the "sudden onset" requirement contained in the federal emergency Medicaid regulation and the Illinois Administrative Code impermissibly alters the federal Medicaid statute, which does not require that emergency medical conditions be of "sudden onset," but was incorporated as Illinois law and regulation into the policy manual of the Illinois Department of Human Services. The State elected not to appeal the decision to the Supreme Court.

When the Medicaid statute passed in 1965, it was silent on whether it provided benefits to undocumented aliens. However, in response to a 1986 federal court ruling that stated denying benefits to undocumented aliens violated the federal Medicaid statute, Congress incorporated restrictions into the Medicaid statute via the Omnibus Budget Reconciliation Act of 1986. For many years, undocumented aliens have used local emergency rooms as their primary access point to healthcare because the Emergency Medical Treatment and Active Labor Act (EMTALA) (Section 1867 of the Social Security Act) requires hospitals to render at least stabilizing treatment, regardless of ability to pay. There are only two limited exceptions to that rule. One exception is known as the Alien Emergency Medical Assistance Program, which provides coverage only if such care and services are necessary for the treatment of an emergency medical condition of the alien, including emergency labor and delivery, manifesting itself by acute symptoms of sufficient severity that the absence of immedi-

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Medicaid Advocacy Firm Successfully Challenges Illinois "Sudden Onset"...

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ate medical attention could result in placing the patient's health in serious jeopardy, impairment, or dysfunction.

Brenda Manning, co-counsel on the Arellano case, said, "I would say the vast majority of our Alien Emergency (AE) cases in Illinois are denied because anyone who has symptoms for even a day or two before seeking treatment is denied due to lack of sudden onset, meaning the State is pretty much restricting AE to trauma type cases. It's our position that the State of Illinois uses the 'sudden onset' criteria as a means of restricting coverage to those who had symptoms for any appreciable amount of time beyond a few hours, despite that upon presentation the patient's condition clearly warranted emergency medical treatment."

The State of Illinois has consistently and routinely denied Alien Emergency cases like Arellano's for reimbursement, often times for vague misappropriations, such as a pre-existing or non-emergent condition. Although the Department of Human Services does have an obligation to tax payers to ensure that fraud and abuse do not rob a program of its funding, the department must make distinctions between non-emergent care that is not eligible for funding and emergent care that is. However, the guidelines the State was using for denials was expanding on the current law, not following it. Hospitals often found cases were commonly denied as not meeting a "sudden onset" requirement.

"[Illinois Attorney General] Lisa Madigan's office argued that the purpose of this was to discourage illegal immigration, which is absurd," Dennis Brebner said. "The hospitals can't control immigration. There are up to one million undocumented immigrants residing in Illinois. I agree that people who are not lawfully in this country should not receive any taxpayer-supported public benefits. However, our standard as a civilized society does not allow us to let people die because of failure to administer emergency medical treatment. We have had hundreds of these cases and usually the State loses, but the State never appeals and continues to ignore the law. The strange thing to me is that Illinois could have received matching federal funds and we would have a better idea as to how many undocumented people are accessing the health care system in this State. Instead, we have lost hundreds of millions of dollars in matching federal funds and stuck the hospitals with the bill when they have no choice but to provide care. All this has done is shift costs onto our overburdened health care system and the citizens that rely on it for care."

In 2002, the Center for Immigration Studies found the United States spent $4.7 billion to cover Medicaid and treatment for uninsured illegal immigrants, as determined by their study conducted in 2004. These unreimbursed medical care costs have caused 84 hospitals to close their doors in California alone, according to Dr. Madeleine Cosman in a 2005 article in the Journal of American Physicians and Surgeons.

Christopher Thunder is a policy analyst and writer for R&B Solutions, a Medicaid Advocacy company headquartered in Waukegan, Illinois.

Ryan Brebner is Manager of Business Development for R&B Solutions, and is responsible for leading the company's sales and marketing. Ryan is an active member of HFMA, AAHAM, and NAHAM. Ryan graduated from Saint Norbert College in DePere, Wisconsin with a Bachelor of Arts in Politics and Philosophy. For further information, Ryan Brebner can be reached at (847) 887-8514.

Letter from the Editors

Share Your Wealth of Information

Our goal as the 2010/2011 Newsletter Co-Chairs/Editors is to facilitate the development of a quarterly newsletter that provides timely, relevant and actionable information, and, thanks to the efforts of our growing membership, we have been able to do just that!

Thank you to all those who "stepped up" and contributed an article to the 2010 newsletters; we truly appreciate your collaboration, and we look forward to your contributions in the new year.

Below, please find the content deadlines and approximate publication dates for 2011:

Content Deadline	Publication Date (approximate)
March 10, 2011	April 15, 2011
June 10, 2011	July 15, 2011
September 10, 2011	October 15, 2011
December 10, 2011	January 15, 2012

We hope you enjoyed the holidays and your new year is off to a great start!

Tim Manning
Jim Watson
2010/2011 Newsletter Co-Chairs

Internal Control Pays Dividends

MARY CORBETT, FINANCE SUBJECT MATTER EXPERT, CHAN HEALTHCARE ADVISORS

Frustrated, the CFO reads through a laundry list of issues from another internal audit. The action plans suggested will be time consuming and costly. How can these items be added to the long to-do list of finance management, when the department is already under so much pressure? The CFO gears up to explain this position to the auditor, who is just as convinced that these actions are essential to the organization.

The CFO and the auditor have much to gain by working together. An auditor can help the CFO see vulnerabilities and threats due to missing control, while the CFO can provide operational context and bring a cost/benefit perspective. Too often a negative exchange related to an audit leads to lost opportunity and at times lost money. This article provides four practical examples from an internal audit perspective where formal attention to internal control resulted in improved financial performance. In these cases, the benefits of implementing controls far outweighed the cost.

Example 1: Premium Pay

An internal audit found that certain categories of premium pay were not being adequately monitored. Management responded with new processes and controls in the premium pay area. The organization saved over $800,000 annually. Premium pay is now actively managed to maintain these cost savings. There are three elements of premium pay that were addressed in audit findings and by management. Below are the details in these areas that led to the annual savings.

- Emergency Scheduling – The facility paid a premium if an individual was requested to fill an unscheduled shift with less than eight hours notice. The premium was payable at 1.5 times the normal pay rate. Review of this category of pay for a three-month period showed excessive use of the emergency scheduling category. Leadership began to actively manage the emergency scheduling category of pay through increased planning. Human Resources worked with departments to set goals and began to monitor emergency scheduling pay monthly. Additionally, a policy change was made so that employees were only eligible for this category of pay if called in less than 90 minutes prior to the shift, rather than eight hours.
- Exempt Excess Compensation – Analysis demonstrated that this category, used to pay additional stipends to exempt employees for extra efforts, had been utilized frequently without appropriate authorization from Human Resources and senior leadership. This particular category had been initially designed to be used infrequently, but ongoing controls were not established to monitor its use. To address the issues, Human Resources reviewed this category of special pay, eliminating certain routine payments as ineligible. Additionally, Human Resources began to receive a routine report to monitor pay in this category and established tighter approval process controls.
- On Call - Numerous departments were identified with significant on-call hours, but zero or very low call-in hours. Therefore, Human Resources began to work with departments utilizing on-call hours to identify other methods of staff coverage. Goals were set with individual departments, and ongoing monitoring of on-call vs. call-in hours was established.

Example 2: Implant Returns

Implant returns were not consistently processed promptly and entered into the materials management system in a timely manner. As a result, the organization was not receiving valid credits for these high dollar returned goods. By obtaining credits that were rightfully due to the facility, the organization saved approximately $450,000.

In analyzing this process, policies and procedures were developed concerning the processing of implant credits. Process changes necessitated an additional receiving clerk and an additional computer terminal within the receiving department. All return forms submitted were sent to the Accounts Payable department on a weekly basis for comparison to credit memos received from vendors. Additionally, the supervisor began spot checking the staff's work to confirm timely processing of returns.

Example 3: Biomedical Equipment Overcharges

The facility's contract with its biomedical equipment vendor was based upon service of a specific inventory of equipment. No ongoing controls had been established as part of the contract to confirm that the inventory records forming the basis for charges were monitored

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Internal Control Pays Dividends

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and updated. The organization saved over $350,000 in overbilling due to inventory that was no longer in use that continued to be included in the vendor's listing.

The contract was renegotiated to include provisions increasing the data provided to the facility by the vendor. The facility worked with the vendor to reconcile their inventory listing to the actual fixed asset records and identified a number of discrepancies.

Example 4: Employee Health Benefits – Dependent Audit

Due to the ongoing trend of increasing employee health insurance costs, the organization sought to evaluate controls over benefits administration. Implementation of additional procedures, while very time consuming, resulted in savings of over $11 million.

Historically, benefit eligibility testing for dependents was conducted by Human Resources by sampling a small percentage of dependents enrolled. Sampling showed a high rate of ineligibility among registered domestic partners and dependents over the age of 18.

Due to the results of Human Resources' sampling, the verification process was expanded to include all dependents. Additionally, the process for new enrollees was updated to require verification.

Action Steps

These specific areas of opportunity may or may not apply at your facility; however, some key principles can be drawn from these scenarios that should be considered by finance leadership.

First, it is important for staff throughout the hospital to understand how their daily activities impact the financial results of the organization. Individual departments do not necessarily understand this and certainly do not think of the procedures they perform on a daily basis as "internal controls." The departmental manager staffing her department through use of emergency scheduling is focused on getting employees into the facility to serve the patients, not on the cost of this expensive labor. The clerk responsible for tracking implant returns does not realize the organization is losing money because he has a significant backlog. Finance leadership can work to educate departmental leaders as to the financial impact of their everyday processes.

Second, investigate processes that have been done the same way for many years. Map out the risk points in the process, focusing on where areas of monetary loss may occur. Are control gaps present that are allowing dollars to slip through the cracks?

Finally, work with internal audit to identify those areas where the current processes and controls may need to be challenged. Internal audit can help to identify opportunities such as the items described above. Creating a partnership of trust between the CFO and the internal auditor can bring positive financial results.

Mary Corbett is the Finance Subject Matter Expert for CHAN Healthcare Auditors. She can be contacted at mcorbett@chanllc.com. CHAN Healthcare Auditors was the first and remains the only company in the nation focused exclusively on providing internal audit services to the healthcare industry.

Fireproof Your Career in 2011

BY VICKIE AXFORD AUSTIN

You've got a lot on your mind. Between the prospect of helping your organization adapt to healthcare reform and the day-to-day pressures of your job, there's very little time to think strategically about your own career. When it comes to planning, your focus is on the here and now.

Think again.

The biggest mistake we make is to abdicate responsibility for our careers to the organization, to human resources or to fate. *No one can manage your career better than you.* By taking the time to think about your career, you position yourself for success no matter what happens in the marketplace.

Here are some ideas to help you "fireproof" your career in 2011:

Treat your career as a business and manage it accordingly. The new year is an ideal time to take stock of where you are professionally. Write down some goals and objectives. Have you been meaning to work toward certification or become a fellow of HFMA? Think about the skills and connections you'll need to take your career to the next rung and put a written plan in place to get there, just like a business plan.

Take the time to look up from the daily operations and expand your vision. "People can get so bogged down on a day-to-day basis that they miss the big picture and the world passes them by," says Vincent Pryor, senior vice president and chief financial officer at Edward Hospital in Naperville. "Push yourself not to let that happen."

Add value to the organization—and don't be shy about it. Mike Nichols, managing director at RSM McGladrey, Inc., recommends staying flexible. "You may be expected to switch roles frequently and without notice," he said. "Understand your uniqueness to the organization and work hard to make sure others understand it as well."

Liz Simpkin, vice president of consulting services for Valence Health, says one way to add value is to take a positive view of healthcare reform. "That's going to set you apart from others who are resisting it," she said, an important competitive advantage. "We need to ask ourselves, 'How is this going to make our organization better at what we're really here to do—deliver safe, effective, high-quality healthcare?'"

Network as if your career depended on it… because it does. As a business and career coach, I frequently hear from people who say they "forgot to network." Absorbed in their jobs, they neglected their careers and now, caught in transition, they pay a steep price for that neglect.

"By building and maintaining a strong network, I've been fortunate to be involved in a variety of situations that have helped me advance in my career," said Mike Nichols, adding "HFMA has been a huge part of my networking strategy." Vince Pryor agrees. He says the value of a professional association transitions from technical education in the early years to expanding one's network farther along the career continuum. Being active in HFMA "has allowed me to create friendships but also to capture what's new in the market, what people are doing, what's different and how people are successful."

Listen and learn. Seek out people who have a point-of-view different from your own. Listen to your peers, your staff, the physicians, the nursing staff and other clinicians. "Many times [people within] the organization don't understand the financial impact of everything they do," Vince Pryor said. "Listen to what's important to them and translate what you discover into a win-win for both sides."

If you work in a hospital, listen to your vendors they bring valuable insights about current news and trends. And if your job is to sell services or products, listen to your clients. Sometimes we forget to ask clients what they need.

Stay visible. Work on teams that give you access and visibility. Volunteer to give a presentation. Join a local non-profit board that aligns with your mission and passion.

Your local HFMA chapter is an ideal platform for staying visible. Liz Simpkin acknowledges the First Illinois HFMA Chapter for giving her a chance to "join a committee, get an opportunity to speak or write an article for the local newsletter." She also worked for a managed care organization and through HFMA she met clients at chapter meetings. "I had personal

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All Eyes on Compliance with New Whistleblower Laws

BY REBECCA BUSCH, PRESIDENT & CEO, MEDICAL BUSINESS ASSOCIATES, INC.

With the new **rules and incentives** (http://www.bloomberg.com/news/2010-07-28/health-fraud-whistleblower-cases-may-surge-because-of-federal-law-overhaul.html) reported in the Patient Protection and Affordable Care Act, we are seeing more whistleblowers come forth alleging healthcare fraud. Currently, 90% of health care fraud cases are whistleblower cases – often in which the behavior of the "ethically challenged" directly posed risks to public health.

Regardless of whether the whistleblowers are concerned citizens, disgruntled employees or senior executives with a "lottery mentality," **hospitals and other healthcare companies must have strong compliance programs in place to stop fraudulent activity** – such as improperly billing Medicare and Medicaid and kickbacks to doctors. A list of healthcare companies that have signed corporate integrity agreements with the OIG of HHS can be found here (http://oig.hhs.gov/fraud/cia/cia_list.asp).

With the new incentives, hospitals and other health services companies are just as susceptible to whistleblowers. Now is the time to review your current compliance program and develop the necessary internal controls to protect your organization from committing fraud. Below are four simple but important considerations to keep in mind when evaluating compliance programs.

1. A comprehensive fraud risk assessment is conducted.
2. Standards of conduct for employees are written and distributed.
3. Educational and training programs are offered to all employees.
4. Audits are conducted to monitor compliance and identify problem areas.

The effectiveness of whistleblowers is also an integral part of the effort to combat healthcare fraud. **The first thing people need to do when encountering fraudulent activity in their workplace** is to make sure that they understand the reporting framework and seek appropriate legal counsel. As an expert witness, I have seen firsthand the enormous complexity of whistleblower suits.

Fireproof Your Career in 2011

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interactions with them which allowed me to build relationships in addition to those once-a-year contract negotiations," she said.

It's a new year and a new day. Yes, change is coming to healthcare but it isn't the first big change and it won't be the last. Remember, your career is a marathon, not a sprint. Plan accordingly. Have fun along the way and know that the work you do makes a big difference in your organization and with the people you serve.

Vickie Austin is a business and career coach and a professional speaker based in Wheaton, IL. She worked as a marketing communications professional in the healthcare industry for many years and was director of marketing for Modern Healthcare *and* Modern Physician *magazines. Vickie recently contributed to Adventures in Medicine, a career guide for resident physicians. You can reach her at 630-510-1900 or vaustin@choicesworldwide.com.*

Does the Revenue Cycle Impact the Total Patient Experience: Are Hospitals Missing the Financial Opportunity?

STEVE CHRAPLA, DIRECTOR THIRD PARTY SOLUTION AT REVENUE CYCLE PARTNERS

According to Jennifer Robinson, Senior Editor for the Gallup Management Journal, "For over 20 years or so, healthcare organizations have realized providing exemplary medical care isn't enough to engage hospital patients. That's because, from the patient's perspective, excellent medical attention is the least a healthcare organization can offer. Many hospitals recognize this and now focus on the patient experience."

So what is the "Patient Experience"?

The Beryl Institute collaborated with healthcare professionals and practitioners at hospitals around the county to develop a definition.

Patient Experience - The sum of all interactions, shaped by an organization's culture, that influence patient perception across a continuum of care.

This statement and effort is so powerful that 93% of healthcare leaders say patient experience is among their top 5 priorities. Additionally, HealthLeaders Media Patient Experience Leadership Survey indicated 45% of healthcare executives see this as a priority 5 years from now.

The landscape around experience in healthcare is shifting dramatically, in part due to the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS) and the pending value-based purchasing program that will link payments to clinical care. This will, in the future significantly impact the market basket index, that is used to annually adjust the Medicare Inpatient Payment Rates. The level of reimbursement hospitals receive from their largest payer will be directly tied to the HCAHPS survey. Healthcare economists are advising hospitals that with the advent of healthcare reform and future reimbursement levels, one of the financial objective hospitals will need to achieve is to generate positive returns under government reimbursement policies. This places increased significance on the outcomes of HCAHPS surveys, and hospitals will need to take a more proactive step in managing their operations as they are reflected within the survey.

The HCAHPS survey consists of 27 questions that cover everything from the cleanliness of the patient room, to nurse-patient communication, to pain management. However there are two questions, that by their nature transcend the entire spectrum of the healthcare delivery system.

- Rate the hospital on a scale from 0 to 10.
- Would you recommend the hospital?

The responses to these questions can definitely be impacted by the

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Does the Revenue Cycle Impact the Total Patient Experience...

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administrative processes within the revenue cycle. Remember, the revenue cycle representatives are usually the last contact with patients upon completion of their healthcare experience. While the time line for the HCAHPS survey requires the survey to be administered within six weeks of discharge, there is ability, with a deliberate focus on the patient interactions by the revenue cycle representatives stressing the organization's culture and responsiveness to assist with the administrative challenges patients deal with, to influence the patient's perception of the hospital. This is not only good business sense from an accounts receivable management position but also allows for a world class customer service environment that is proactively managing the patient's account portfolio. This is contrast to an approach that just puts out the fires and is limited to responding to questions and focused only on the immediate collection of a debt. Make no mistake collecting everything that is due is important but realize the collection of an out of pocket patient liability or even one entire patient account balance has far reaching effect on greater future reimbursements.

In fact, hospital revenue cycle representatives are the final personal touch points that usually occur between patients and the hospital.

You need to ask these questions:

- Are these touch points/encounters being used to positively support the hospital's mission statement?
- Is there active participation with patients during these encounters to shape the hospital's reputation and brand?

The answer to these questions all center around how to guide the patient's journey through the healthcare reimbursement maze to find the most appropriate solution for the patient's situation. This journey can be accomplished through the use of specific tools that focus on enhanced communications and a comprehensive resolution of the patient's account. By using people-driven, technology supported services, you can achieve a high level of patient satisfaction. Through this satisfaction, you can enhance both patient and physician loyalty to the hospital.

The loyalty of these patients can unlock huge future potential revenue sources. The patient lifetime revenue value is the amount of revenue a patient can expect to generate for a hospital over their lifetime if they choose to utilize the same hospital for all the medical needs. With the impact of consumerism in healthcare this lifetime revenue value is becoming an important part of hospital's reputation management process and strategic marketing initiatives.

What are things you need to do to maximize the revenue cycle impact on the patient experience as well as protect your future patient lifetime revenue potential?

- Educate all employees of the patient experience initiatives especially the revenue cycle representatives and their impact on the outcomes.
- Create an environment that fosters patient loyalty as a critical outcome.
- Design a patient centered revenue cycle process that is focused on customer service excellence while resolving all pa tient concerns.
- Integrate HCAHPS survey completion within the patient revenue cycle communication process.
- Utilize technology to support the customer service function with call center personnel trained and motivated to achieve established goals.
- Insure all third-party service providers are fully supporting your mission and your initiatives to enhance the patient experience.
- Explore social media sites to communicate your message and encourage patients to be positive spokespersons for your organization.

Remember, your reputation matters. What your patients are saying is crucial and these experiences are still be formed long after the patient leaves the hospital. That is why revenue cycle operations are critical to effective Total Patient Experience initiatives.

Revenue Cycle Partners provides customer service solutions for hospitals nationally that improve profitability while enhancing the Total Patient Experience. Call Steve Chrapla at (847) 395-7655 to learn more about Patient Experience and Reputation Management programs and how they can assist your organization.

HFMA Events

The 2011 First Illinois Chapter HFMA Scholorship

The First Illinois Chapter of HFMA ("the chapter") is proud to announce its fourth annual scholarship program for its members and their children seeking higher education. Scholarship recipients are chosen by the Scholarship Selection Committee made up of representatives from the chapter. The chapter is pleased to award up to three scholarships of $2,500; $1,500 and $1,000. The First Illinois HFMA application cycle is as follows.

- First Illinois HFMA applications can be downloaded from the First Illinois Chapter website – http://www.firstillinoishfma.org/.
- All applications must be postmarked by February 1, 2011.
- All applications should be mailed to:
  Vincent Pryor
  Edward Hospital
  801 South Washington
  Naperville, IL 60540
- All scholarships will be awarded no later than May 1, 2011.

The eligibility requirements for applicants for the 2011-2012 academic year are as follows:

- Applicants must attend or plan to attend an accredited college, university or proprietary/trade school.
- High school seniors and undergraduate students are eligible to apply.
- Only one scholarship per student will be awarded during their lifetime
- First Illinois Chapter HFMA members and their children are eligible for scholarships.
- Applicants must be U.S. citizens.

The application consists of six parts:

1. The application
2. Letter of recommendation from a faculty member
3. Two letters of reference
4. An essay/testimonial
5. Academic transcripts
6. Interview with the Selection Committee.

Please direct any questions to Vince Pryor at vpryor@edward.org or (630) 527-3035.

The Growing Charity Challenge: Form 990 and Health Reform

BY STEVE LEVIN, CEO, CONNANCE

Providers have made great progress in expanding and developing financial counseling processes over the past several years. Unfortunately, a large number of patients are continuing to fall through the cracks. Many patients meriting financial assistance fail to participate in financial counseling and are instead declared to be bad-debt and sent to collections.

This situation, while disappointing, is taking on new concern with Form 990 filing obligations, in which hospital executives are required to declare the amount of charity they believe they missed by current processes and which ended up as bad-debt. This admission of process breakdown is in addition to documenting the various types of financial assistance delivered and scale of community benefit spending.

It is likely that community groups and consumer advocates will closely study the new information disclosed on the Form 990. They will use this information to form opinions with respect to how well not-for-profit hospitals are delivering on their community responsibilities.

Recently passed health reform legislation is also picking up on this issue, setting expectations for comprehensive financial assistance effort prior to any extraordinary collection activity. How this component of the legislation ultimately is converted into guidelines and operating standards remains to be seen; however, it is hard to imagine that the results will lessen the current anxieties. Similarly, it remains unclear what limits or restrictions the new Consumer Financial Protection Agency will impose.

Size of the Opportunity

Based on research done by Connance and PARO, it is common to find that 20-30% of a provider's bad-debt is from guarantors that would qualify for charity, but slipped through the cracks in the process. This is a meaningful percentage and is sure to attract attention when reported on Form 990.

Of course, the amount of missed charity for any individual hospital varies based on the local market, their specific financial assistance policies, and the financial counseling process in place. Poverty is a local phenomenon.

Root Causes of Missed Charity

Simply working harder under today's standard patient access and financial counseling processes is unlikely to overcome the missed charity issue. Structural challenges stand between many poor people participating in counseling and properly documenting their eligibility.

Consumers living in poverty have less education and higher illiteracy than the average household. While statistics on illiteracy and poverty are limited, the U.S. Department of Education estimates that, on average, 1 in 5 Americans are functionally illiterate. With this national average, a sizable share of the poor are very likely unable to fill in a basic charity application or even read a charity sign in the emergency room.

People living in poverty often lack stable addresses, are immigrants, or are embarrassed by their situation and prefer to not participate in application processes and announce their plight.

The Federal Reserve estimated that as many as 25% of those living in poverty lack access to traditional "banking" resources such as a savings or checking account. This means they are unable to provide financial documentation and databases of such information will not have their information.

Poverty and Credit Scores

The relationship between poverty and credit scores is an interesting one.

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The Growing Charity Challenge: Form 990 and Health Reform

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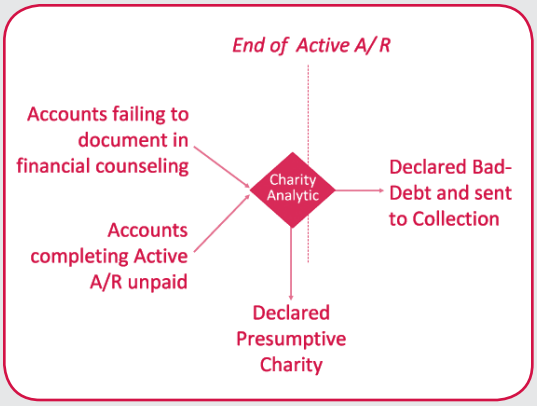
It stands to reason that if people living in poverty lack traditional banking relationships they will also lack a credit score. However, the corollary is not true – just because one lacks a credit score does not mean they are poor. There are many reasons other than income that will cause an individual to lack a credit score. Consider the situations of students who are just entering the workforce, someone who is newly widowed or divorced, or recent immigrants.

Next, consider that credit scores are really not an income measure but a delinquency measure. They answer the question "is this person likely to repay a new credit obligation?" Poverty is not a question of being overextended or spending more than you make. It is simply a question of income and household structure.

A common example of the difference between credit scores and poverty is an elderly patient living on a fixed income without any property. This patient will often have a bank account and a credit card, which they use sparingly or under tight control so as to never run up a bill they cannot afford. This patient will likely have a solid credit score, but also be eligible for poverty classification based on income. One can contrast this with a middle income consumer who has racked up large bills buying the latest electronics or being overextended on their mortgage. They probably have poor credit scores, but would not meet the charity test for low income.



Presumptive Charity Analytics Leading Solution

Presumptive charity analytics are the leading approach to addressing both day-to-day operational issues of missed charity and Form 990 disclosures. They are a type of predictive model built specifically for identifying accounts eligible for poverty classification. Presumptive charity analytics use publicly available information to predict whether or not that guarantor would have been approved for financial assistance had they participated in the process.

Providers are using predictive analytics to evaluate accounts that fail to document through standard financial counseling processes. Accounts are scored just prior to bad-debt assignment. Those qualifying for presumptive charity are reclassified as such and removed from the bad-debt placement file. Those failing to qualify are declared bad-debt and handled as such.

Using a presumptive charity analytic in this fashion complements the existing financial counseling and patient access processes by addressing recognized breakdowns and barriers. Every account, including those that were missed by or failed to participate in financial counseling, are reviewed using a proactive, consistent and repeatable process.

This approach also provides a clear pathway for Form 990 submissions. Hospitals are able to reclassify significant bad-debts as presumptive charity, demonstrating a truer view of their community benefit. The estimate of missed charity ending up in bad-debt is reduced to the error rate of the model applied against bad-debt placements. In total, the institution is communicating a comprehensive and proactive effort to identify and aid needy patients, even those unable to speak up. This is clearly on point with newly passed federal health reform legislation.

In order to implement this approach, charity policies need to ex-

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The Growing Charity Challenge...

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plicitly note that presumptive charity can be conferred based on a third-party analytic. Similarly, auditors should be apprised of the decision to implement a presumptive analytic. Their input should be incorporated into the process and policies.

Picking a Presumptive Charity Analytic

There are a range of presumptive charity analytics available to identify missed charity eligible accounts. In picking a model, consider the following elements:

- **Local calibration.** Poverty is heavily weighted to local economic circumstances and socio-economic attributes. Better predictive models will be calibrated during implementation to the hospital's specific community.
- **How the model handles households without bank accounts and credit files.** Credit based models may have challenges with this population. Socio-demographic models are often better able to handle households living in the cash economy.
- **Information required.** Some models require a current address and guarantor social security number for scoring. Understanding differences in data requirements is important as it can have significant impact on Patient Access activities.
- **Portion of accounts a model cannot evaluate.** Better models will have broader coverage, e.g., fewer accounts that are not able to be predicted or assessed. Some models cannot evaluate as many as 30% of self-pay accounts, while others will have issues with as few as 1-2%.
- **Sliding scale calibration.** Models differ in the extent to which they can be tuned to a hospital's sliding-scale discount, e.g., the discount offered at different income thresholds.
- **Acceptance by IRS, regulators and other organizations.** With many different vendors offering models, understand the extent to which the model in question has been used in previous filings or been recommended as an effective solution.

Few Simple Steps Solve Growing Issue

Analytics are commonly accessed through simple web-based applications and can be connected to a patient account system through secure file transfer. The system generates a file for scoring and sends it to the scoring website, much the same way patient accounting systems generate bad-debt placement files today. The web-based scoring system picks up the file, scores each account and sends back a response file. Your patient account system grabs the file and automatically reclassifies accounts based on the score.

Within just a few weeks of selecting a charity analytic an organization can be automatically reviewing accounts as they age out to bad-debt. In some instances it is also possible to review, at initiation, existing bad-debt inventory and execute a one-time financial adjustment for those identified as presumptive charity eligible.

Adopting a presumptive charity analytic is a straightforward, cost effective solution to a problem of significant public concern. It is additive to a great financial counseling and patient access program, closing the loop on patients missed in current routines, incapable of participating, or reluctant to make themselves visible. Your patients win and so does your organization.

Steve Levin is CEO and co-founder of Connance. Contact him at slevin@connance.com or visit www.connance.com.

This article relies on material published in "a Form 990 Schedule H conundrum" by Shari Bailey, David Franklin and Keith Hearle, hfm magazine, April 2010. Shari Bailey is VP, Verité Healthcare Consulting, LLC; David Franklin is Chief Development Officer, Connance, Inc.; and Keith Hearle is President, Verité Healthcare Consulting, LLC.

Life Cycle Cost Analysis: An Asset Management Strategy

BY STEPHEN BLAU, ILLINOIS TRANE

Many healthcare facilities still treat major heating, ventilation, and air conditioning (HVAC) system projects as if they were merely large maintenance expenses. However, the Consortium for Energy Efficiency reports that HVAC accounts for approximately 45 percent of a typical hospital's energy use. Also, it's clear that HVAC upgrades intended to last for decades are actually capital investments.

Thus, HVAC project planning and implementation are best treated as vital parts of a fixed asset management strategy.

Changing the Paradigm

The upfront cost of HVAC components often represents only 5% of their total cost of ownership over 20 or more years. Yet many organizations purchase HVAC upgrades on a first-cost basis, issuing requests for proposals (RFPs) that seek the lowest possible pricing for the initial equipment purchase.

Since a major HVAC project is a significant, long-term capital asset, well-managed healthcare facilities instead are maximizing efficiency and saving money by evaluating HVAC projects via their life cycle cost.

According to the NIST Handbook from the U.S. National Institute of Standards and Technology, life cycle cost (LCC) is "the total discounted dollar cost of owning, operating, maintaining, and disposing of a building or a building system" over a given period. A full life cycle cost analysis (LCCA) compares initial, maintenance, repair, and operating costs over the life of an HVAC system. The LCCA particularly examines such critical variables as equipment materials behavior, intended facility use, environmental conditions, and projected energy costs.

A comprehensive LCCA can pinpoint bad bargains such as supposedly "low-price" systems that turn out to feature unacceptably short lifespans or excessively large lifetime operational costs.

Initial Planning and Variables

Each RFP should include an LCCA, conducted as early as possible. The goal is to create a system that can operate at peak efficiency throughout its lifetime, making use of non-corrosive materials in harsh environments and eliminating system shutdowns.

The LCCA equation contains three vital variables: 1) the costs of ownership, 2) the period of time over which costs are incurred, and 3) the discount rate applied to future costs to equate them with present-day expenses.

Cost Variable — Initial Expenses

Costs incurred prior to system installation include capital costs for the system and its controls. Since flexible controls are the most important factor in maintaining a high-performance HVAC system at your hospital, emphasize issues such as centralized command and control; precise temperature and humidity control; ease of changing settings; control of core functions such as laundry, pharmacy, and security; and ease and efficiency of testing and balancing equipment.

Estimate initial construction costs by referencing historical data from similar facilities, and by consulting government and commercial cost estimating guides and databases.

Cost Variable — Future Expenses

Future costs are incurred after the system is in place. They include energy, water, and other utility costs, non-fuel operating costs, and maintenance and repair (OM&R) costs.

Energy and utility modeling software can help analyze a building's projected use, occupancy rates, schedules, and more. A thorough LCCA factors in an energy price

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Life Cycle Cost Analysis

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projection as well as rate type, rate structure, seasonal differentials, block rates, and demand charges.

Since operating schedules and standards of maintenance vary widely from building to building, so do OM&R costs. HVAC systems usually remain in place for several decades. If a low-cost system comes with exorbitant upgrade costs, your preparer should consider alternative options that may bear a higher initial price tag but are more cost-effective to upgrade over the system's lifetime.

Cost Variable — Non-Monetary Benefits

You may choose an HVAC system to optimize environmental advantages, including indoor air quality (IAQ), filtration, pressurization, airflow, and acoustics. (example: the non-monetary benefits derived from a particularly quiet system).

Time Variable

Typically, the LCCA study period for evaluating ownership and operations expense ranges from 20 to 40 years — generally less than the intended life of the facility. The NIST suggests dividing the study into planning/construction and service periods.

Discount Rate Variable

The discount rate is the rate applied to future costs to equate them to present-day expenses. It's the number that would make you indifferent whether you received a smaller payment now or a larger one later. Your preparer may consult the U.S. Department of Energy, whose discount rate is updated annually.

Constant-dollar analyses exclude the rate of general inflation; current-dollar analyses include the rate of general inflation in all dollar amounts, plus discount rates and price escalation rates. Both types of calculation result in identical present-value life cycle costs.

Conclusion

An LCC analysis is a valuable assessment to help hospitals build and maintain their facilities as assets, not commodities. Partnering with an innovative, knowledgeable HVAC provider is the first step toward optimal hospital performance and efficiency.

For more information, contact: Stephen Blau, Illinois TRANE, by phone: (630) 734-6083 or email: sblau@trane.com.

Welcome New Members

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MAP APP
Account Executive
HFMA

Trafton Elsea
Manager of Business Development
American Express

Timothy A. Marshall
Principal
The Claro Group

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Director of Patient Access Services
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Director, Network Relations
Access Community Health Network

Jordan Benson
Marketing Associate
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David Schlesinger
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Senior Internal Auditor
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Director, Program & Business Development
Delnor Hospital

Edward Chia
Sr. Accountant
Cancer Treatment Centers of America

Mathew Varghese
Administrator
ACHN of Cook County

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Publication Information

Editor 2010-2011
Jim Watson..... (630) 928-5233 jim_watson@pbcgroup.com
Tim Manning..... (630) 456-7155 tim.manning@dupagemd.com

Official Chapter Photographer
Al Staidl ..... (630) 724-1197

Sponsorship
Pat Moran .....(312) 218-6805 Patrick_Moran@dell.com

Design
DesignSpring Inc., Kathy Bussert kbussert@designspringinc.com

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Style

Articles for *First Illinois Speaks* should be written in a clear, concise style. Scholarly formats and styles should be avoided. Footnotes may be used when appropriate, but should be used sparingly. Preferred articles present strong examples, case studies, current facts and figures, and problem-solving or "how-to" approaches to issues in healthcare finance. The primary audience is First Illinois HFMA membership: chief financial officers, vice presidents of finance, controllers, patient financial services managers, business office managers, and other individuals responsible for all facets of the financial management of healthcare organizations in the Greater Chicago and Northern Illinois area.

A broad topical article may be 1000-1500 words in length. Shorter, "how-to" or single subject articles of 500-800 words are also welcome. Authors should suggest titles for their articles. Graphs, charts, and tables **(PDF or JPG only)** should be provided when appropriate. Footnotes should be placed at the end of the article. Authors should provide their full names, academic or professional titles, academic degrees, professional credentials, complete addresses, telephone and fax numbers, and e-mail addresses. Manuscripts should be submitted electronically, on computer disk or by e-mail as a Microsoft Word or ASCII document.

Founders Points

In recognition of your efforts, HFMA members who have articles published will receive 2 points toward earning the HFMA Founders Merit Award.

Publication Scheduling

Publication Date	Articles Received By
April 2011	March 10, 2011
July 2011	June 10, 2011
October 2011	September 10, 2011
January 2012	December 10, 2011

Healthcare Financial Management Association First Illinois Chapter

Chapter Educational and Events Calendar 2011

For a current listing of all upcoming First Illinois HFMA Chapter events, please visit: http://www.firstillinoishfma.org/calendar.htm

Friday, January 21, 2011
CFO Breakfast
Elmhurst Center for Health, Elmhurst, IL

Tuesday, January 25, 2011
Webinar
Online

Thursday, February 17, 2011
Physician Education Program
University Club, Chicago, IL

Friday, February 25, 2011
CFO Breakfast
Elmhurst Center for Health, Elmhurst, IL

Monday, February 28, 2011
Webinar
Online

Thursday, March 3, 2011
Compliance Education Program
Drinker, Biddle & Reath LLP, Chicago, IL

Monday, March 7, 2011
aIPAM
TBD

Thursday, March 17, 2011
Managed Care Education Program
University Club, Chicago, IL

Friday, March 25, 2011
CFO Breakfast
Elmhurst Center for Health, Elmhurst, IL

Tuesday, March 29, 2011
Webinar
Online

Wednesday, April 6, 2011
IT Education Program
Location TBD

Friday, April 22, 2011
CFO Breakfast
Elmhurst Center for Health, Elmhurst, IL

Tuesday, April 26, 2011
Webinar
Online

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The First Illinois Chapter wishes to recognize and thank our sponsors for the 2010-2011 chapter year. Thank you for all your generous support of the chapter and its activities.

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event-filhfmaorg@comcast.net