First Illinois Speaks
hfma healthcare financial management association
HFMA's First Illinois Chapter Newsletter
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WHATEVER IT TAKES

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News, Events & Updates

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Provider Sponsored Health Plans

BY JAMES R. SMITH, FACHE, MBA; GREGORY SHUFELT, MBA; WILLIAM RINGWOOD, & DANIEL T. YUNKER, MBA

Under healthcare reform, payers are seeking to increase the quality of care delivery while simultaneously shifting incentives and more of the risk associated with managing healthcare costs to providers, physicians, and to the consumer. As these new policies are broadly implemented by governmental and private payers, healthcare providers are being asked to take greater responsibility for population health and total cost of care. As a result, many integrated delivery systems across the country find themselves asking the question: Is now the right time to create a health plan or to partner with other provider sponsored health plans?

The influence of the consumer on healthcare is emerging, and when insurance coverage is purchased at the consumer level through both public and private health insurance marketplaces (exchanges), choice of a provider brand that they know can be a powerful attractor to the individual and very strategic for a provider. When consumers select provider sponsored plans they are in essence making a decision to engage with that provider as their preferred or primary place of care. This upfront selection of a network by the consumer enables them to know and commit to a partnership with the physicians, hospitals and plan, and offers providers a new paradigm for patient and community engagement and market share strategies.

In the Midwest, several provider organizations have answered this question with a yes, and have made plans to, or have already implemented, a provider sponsored health plan. Numerous large integrated delivery systems in the Midwest have decided to either start up, join, or affiliate with a provider sponsored health plan. Several of these systems are highlighted in Exhibit 1. Two Midwest provider sponsored health plans, Health Alliance Plan and Priority Health, rank among the top ten provider sponsored health plans in the country (by medical enrollment), according to AIS' Directory of Health Plans.

While all of these organizations have unique characteristics, they also all have a common structural component in their provider profile that allows them

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Provider Sponsored Health Plans and Your Future

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to successfully participate in a provider sponsored health plan—their ability to manage population health across the full continuum of care. When evaluating organizational readiness for pursuing the development of a provider sponsored health plan, hospitals, physician groups, and integrated delivery systems should consider the following attributes of a prepared organization and evaluate how their organization measures up:

Profile (Internal)

- You are a highly evolved network of healthcare providers with experience and success in managing financial risks of populations (i.e., risk-based quality payment programs, capitation, and percentage of premium, as well as payers and products such as Medicare MSSP or Medicare Advantage, commercial accountable care organization or health maintenance organization ["HMO"], and private and public exchange-based plans, self-funded, Medicaid, and dual eligible).
- Your capacity and volume is large enough to enable scale investment and risk assessment.
- You have engaged physicians and strong physician leadership in key positions and governance roles throughout the organization management.

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Provider Sponsored Health Plans and Your Future

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- You have created care management and transitions of care programs with workflow redesign, clinical, and information technology, supporting the care providers and assisting them in quickly moving patients to the right care at the right time and place.
- Your organization has installed and has proven analytics and reporting capabilities to monitor clinical quality, cost, outcome, and satisfaction measures used to create better outcomes and healthier populations.
- You have a strong managed care department that has mastered contracting and understands the requirements needed for successful collaborative agreements.
- You have relationships with stop loss carriers and understand your risk exposure and how to mitigate and position your products and your delivery network.
- You have a deep balance sheet, and either have or can access cash reserves to meet requirements for growth and risk-based capital requirements.

Market (External)

- You own the "top of mind" brand in the market and are one of the "must have" networks.
- The market is fragmented with multiple payers, dominated by small to mid-size employers, regional, private and public exchange plans, and multiple governmental players: Medicaid, Medicare Advantage, dual eligible plans, etc.
- You have or can establish relationships with providers other than your own to provide an attractive and well-coordinated network of care.
- Payers are not actively seeking partner networks that create value through data, informatics, and continuous care redesign and those investing in people, shared clinical data, processes, and management of each patient population.
- You recognize that to be successful, you need to attract new share and long-term commitment by creating value for the consumer payers with new products and innovative design; not through doing "more and more" through large networks, leveraged contracts, and rich benefit plans.

For the internal profile, how does your organization measure up against these attributes? Externally, do these market conditions exist in your primary service area? If the answer is yes to either of these questions then it may be the right time to assess your organizational and market readiness, and develop the appropriate strategy for developing and operating a health plan.

An early key strategic decision point is determining whether your organization should build its own or buy an existing health plan. Starting a health plan is a long, arduous, and expensive journey, so proper due diligence is critical before embarking down this path. An alternative strategy is to partner with an existing health plan. Within this strategy exist three sub- strategies: partner with a national commercial insurer (e.g., UnitedHealthcare, Cigna, Blue Cross and Blue Shield, etc.), partner with an existing local or regional provider sponsored health plan, or partner with a consumer operated and oriented plan ("CO-OP"). The sole CO-OP in Illinois, Land of Lincoln Health, is sponsored by the Metropolitan Chicago Healthcare Council, an organization that consists of 150 local healthcare organizations throughout the greater Chicago area. Any of these organizational models may be right for your organization; the key will be to assess existing capabilities, organizational, and community needs, and external market characteristics. The graphic [on the next page] summarizes the core strategic and operational criteria, and key considerations that should be assessed and evaluated when developing a provider owned health plan.

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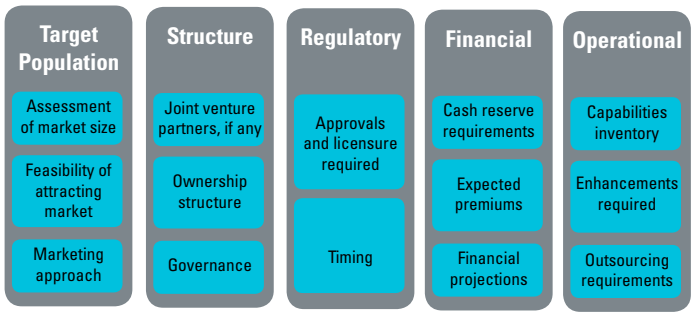
Provider Sponsored Health Plans and Your Future (continued from page 3)

Key Planning and Decision Points in Developing a Strategy for a Health Plan



This pathway to a provider sponsored health plan requires most organizations 18 to 36 months from readiness assessment and strategy development, through tactical and operational planning, and implementation.

A key advantage to operating a health plan or building products with a health plan is that it allows for greater control in attracting new members and deciding what and when to invest and develop, be it new products or expanded delivery networks. It allows organizations to build the skills and expertise necessary to succeed in effectively managing population health and total costs of care, while leveraging expensive organizational infrastructure and creating operational efficiencies through scale. However, it is not for the faint of heart or those without the financial wherewithal to get through the learning curve phase, so consider your opportunities and potential partners in such an endeavor carefully.

To learn more about whether your organization should operate a health plan, please contact Mr. Jim Smith at 585-512-3900 or e-mail him at jsmith@thecamdengroup.com, or Mr. Greg Shufelt at 312-775-1700 or e-mail him at gshufelt@thecamdengroup.com. To explore partnership opportunities with Land of Lincoln Health, contact Mr. Dan Yunker at 312-906-6003 or email him at dyunker@landoflincolnhealth.com.

Exhibit 1

Midwest	Location	Provider Description	Provider Sponsored Health Plan	Health Plan Description
Avera Health	Sioux Falls, South Dakota	Offers a range of acute care, specialty care, and wellness services at more than 300 locations	Avera Health Plans	Health plan coverage for 70,000 plus members
Detroit Medical Center	Detroit, Michigan	Academically integrated system in metropolitan Detroit; largest healthcare provider in southeast Michigan	ProCare Health Plan Inc.	Detroit-based HMO that covers Medicaid beneficiaries in Wayne County
Fairview	Minneapolis, Minnesota	Includes over 22,000 employees, 3,346 credentialed physicians, seven hospitals and medical centers, and over 40 primary care clinics	PreferredOne	Founded in 1984 and is owned by Fairview Health Services, North Memorial Health Care, and PreferredOne Physician Associates
Gundersen Health System	La Crosse, Wisconsin	System consists of three hospitals, four nursing homes, 24 medical clinics, and a variety of other health clinics	Gundersen Health Plan	Products offered include: HMO, point of service, self-funded, Medicare Advantage, Medicare Supplement, BadgerCare Plus
Henry Ford Health System	Detroit, Michigan	System includes hospitals, medical centers, and the Henry Ford Medical Group, which includes more than 1,200 physicians practicing in over 40 specialties	Health Alliance Plan	A health plan that provides coverage to individuals through robust disease management and wellness programs
Indiana University Health	Bloomington, Indiana	With 3,541 staffed beds this Academic Medical Center is comprised of hospitals, physicians, and allied services including hospital-based physician practices, and outpatient centers	MDwise	Works with the state of Indiana and Centers for Medicare and Medicaid Services to offer the Hoosier Healthwise, Healthy Indiana Plan, Indiana Care Select, and MDwise Marketplace health insurance programs
McLaren Health Care	Flint, Michigan	Includes 10 hospitals as well as ambulatory surgery centers, a regional network of cancer centers, assisted living facilities, and McLaren Medical Group	McLaren Health Plan	HMO offering products for employee sponsored groups (Commercial) and government sponsored plan (Medicaid)
Sanford Health	Sioux Falls, South Dakota and Fargo, North Dakota	Largest rural non-profit health system in the country	Sanford Health Plan	Non-profit offering commercial, Medicaid, and Medicare plans
Spectrum Health	Grand Rapids, Michigan	Includes nine hospitals,130 ambulatory sites, two physician groups totalling more than 750 providers	PriorityHealth	600,000 plus members covered by more than 27,000 doctors and other providers and more than 110 acute care hospitals
Trinity Health	Livonia, Michigan	Includes 47 acute care hospitals, 432 outpatient facilities, 33 long-term care facilities, multiple home health offices and hospice programs, and 3,400 employed and residents	Mount Carmel Health Plan	A provider owned Health Insuring Corporation that operates MediGold; a Medicare Advantage program in greater central Ohio

Women in the C-Suite:
Healthcare Financial Management Professionals "Lean In"

BY VICKIE AUSTIN

Inspired by the best-selling book, *Lean In: Women, Work and the Will to Lead* by Sheryl Sandberg, the women on the board of HFMA hosted the first-ever panel discussion for women HFMA members on June 18, 2013, at ANI in Orlando, Florida. Leading the charge at the program "Women as Leaders" was Kim Griffin-Hunter, CPA, MBA, National Leader/AERS Provider Healthcare Practice and Partner, Deloitte & Touche, LLP, in Miami, Florida, who acted as moderator. Panel members included Kari Cornicelli, FHFMA, CPA, VP/CFO for Sharp Grossmont Hospital in La Mesa, California; Melinda Hancock, FHFMA, CPA, CFO and Senior VP at Bon Secours Health System in Richmond, Virginia; Carol Friesen, FHFMA, Vice President of Health System Services for Bryan Health in Lincoln, Nebraska; and Rebecca Speight, FHMFA, CPA, CFO at Lake Pointe Health Network in Rowlett, Texas.

The energy and enthusiasm in the room was palpable and it was a standing-room only crowd with extra tables and chairs pulled in to accommodate the audience. Ms. Griffin-Hunter began the discussion by assuring the audience that the evening would be straight talk as well as "women talk." Each panel member introduced herself and shared about her background, including her commitment to serve as an HFMA leader. Ms. Friesen mentioned her brother's triumph over challenges as a success story. Ms. Speight shared generously about adopting a daughter from China. Ms. Hancock talked about the opportunity to combine her faith with her work. Ms. Cornicelli mentioned the privilege of working with strong female mentors.

The book, *Lean In,* precipitated this forum, an opportunity for women in healthcare financial management to share the struggles and triumphs of being women in a predominately male field. Sheryl Sandberg's book rattled the cages of women—and men—throughout the business world, calling for women to take more risks and embrace authority. Armed with loads of data, Ms. Sandberg, chief operating officer of Facebook and ranked by *Fortune* magazine as one of the Top 50 Most Powerful Women in Business, challenges readers to step into leadership as their authentic selves. And this HFMA women leaders' forum did just that.

As Ms. Griffin-Hunter lobbed her questions to the panel, there was laughter and even at one point a box of Kleenex was circulated for those who were moved to tears. The camaraderie of the panel and the warmth of the audience reflected the supportive way in which these women have helped each other with their careers. Someone quoted the famous line by Madeleine Albright, former U.S. Secretary of State: "There's a special place in hell for women who don't help other women." And there were kudos for the many men who have supported each of them along the way, including husbands, co-workers, bosses and mentors.

Ms. Griffin-Hunter asked each panel member to share their collective wisdom and experience, which included:

- **Know thyself.** Women are good at their jobs and need to leverage their strengths with confidence. Good leaders find people who are great at what they don't do in order to build a team.

Speakers at the "Women as Leaders" panel at ANI 2013 included HFMA Board Members (L to R) Becky Speight, Kari Cornicelli, Carol Friesen, Melinda Hancock and Kim Griffin-Hunter.

- **Have a year's salary in the bank.** That way, you'll have choices and won't have to stay in a miserable job situation.
- **Stop trying to be two different people.** Integrate work life with family life and stop apologizing for being a mom.
- **Manage the art of scheduling.** The key is to communicate with staff and associates so you can attend that Mother's Day tea, dance recital or soccer game.
- **Aim for completion, not perfection.** "Done is done," said one panel member. "It doesn't have to be perfect."

"What would you have done differently?" Ms. Griffin-Hunter asked the panel members. "I would have adopted sooner," said Ms. Speight. She spoke about the delights of parenting her daughter Emma and working in a job where she can blend motherhood with her ambitions. Ms. Cornicelli confessed that she's a recovering multi-tasker and she strives to be more present. Ms. Friesen said she has no regrets about her career choices but that as someone who is relentless she needs to learn to "stop and smell the roses" and relish her success. Ms. Hancock advised the women in the audience to take the time to get to know themselves better so they can bring something to the table more fully when they are leaders.

Other themes we heard throughout the evening included finding a mentor or mentors who can guide you along your career path, being discerning about career choices and being willing to turn down opportunities that won't lead you to your goal, collaborating ("in spades!") with others to accomplish your mission, and using the art of compassion as a career advantage. That's advice that any HFMA leader, both men and women, can use.

Vickie Austin

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Cashing in on Revenue Cycle Improvements

BY RITCHIE DICKEY

There is nothing more important to potential creditors than a borrower's liquidity position. With all of the uncertainty in the health care industry—and the economy today for that matter—there is no substitute for the margin of safety and flexibility that cash provides.

Most health care providers recognize the importance of liquidity and treat the cash on their balance sheet as sacred. But defending the balance sheet is only part of the battle. Surprisingly, many managers fail to take the necessary steps to increase their liquidity position.

Of course, there are myriad factors that can undermine a hospital's efforts to generate cash flow from operations: payor reimbursement, economic conditions, competitive landscape, cost and supply of labor, demographics of the market, etc. While it is true that hospital management has little to no control over these factors, there are other areas where it could have an equal—if not greater—impact on the credit profile.

In particular, managing the payment cycle can help cash flow, but it also serves as a signal to potential creditors. Having a consistent focus on improving these measures demonstrates to creditors that management is competent and attentive to issues that it can affect. Conversely, large fluctuations in bad debt expense and/or days in accounts receivable or a large percentage of "old" receivables causes a financial analyst to question the competency of management and the integrity of the historical income statements.

Challenges to Increasing Liquidity

The Affordable Care Act introduces additional uncertainty into an already murky revenue picture for health care providers throughout the country. Who is covered by insurance and how much will the insured be required to self-fund will likely remain uncertain for some time. Although state budgets have improved somewhat, uncertainty remains in state Medicaid reimbursement programs. The integration of technology, such as electronic health records, holds great long-term promise, but short-run costs, shifting requirements and implementation challenges make planning difficult. Most creditors will expect a competent management team to have a plan, which is robust enough to provide flexibility with each of the above factors; however, banks and other creditors also recognize that these issues are challenges and any plan to address them will be fraught with uncertainty.

Given the uncertainty of supply/demand, pricing and expenses, it is imperative that providers improve cash flow through factors that are within their control. Indeed, it is more important than ever that management develop a "fortress balance sheet," to borrow a term often used in the banking industry.

One clear indication of the importance of liquidity is the view of the rating agencies. The measures: cash to debt and days cash on hand have the clearest correlation to hospital ratings of all the metrics shown in the Standard and Poor's industry medians. Obviously, increasing revenue and cutting expenses are two ways of increasing cash, but options for affecting the profit and loss statement are usually limited. One can do nothing about the supply/demand balance and there is little to be done about reimbursement rates. Cutting expenses is always good, but by far the largest expense—personnel costs—is the hardest and most painful to cut. Other sources of revenue—investment income, contributions, government allocations, etc.—are usually dependent on external factors, which defy management intervention.

Uncovering Cash Trapped in Working Capital

Given the lack of options for intervention on the revenue side and the challenges for affecting change on the expense side, one might feel as though balance sheet improvement is not possible. This view fails to recognize that there might be significant cash tied up in working capital and this is an area where management can exert influence. In fact, just five days in the payment cycle can have huge impact on a company's balance sheet.

The example [below] may appear trivial, but five days of accounts receivable (AR) represents more than $4 million in this case. Many health care providers can achieve changes of this magnitude in 6 months to one year, with proper attention and a focus on gradual improvements. Representatives of Community Hospital Corporation, a company that provides consulting and management services to rural and community hospitals, noted that even more extreme examples exist. In one case, a hospital was showing more than 30

Effect of Reducing AR by Five Days

	Before	After
Cash	$ 91,529	$ 95,542
AR	$ 40,137	$ 36,123
Other Current Assets	$ 10,000	$ 10,000
Total Current Assets	$141,666	$141,666
Total Current Liabilities	$ 95,000	$ 95,000
Debt	$110,276	$110,276
Patient Revenue	$293,000	$293,000
Total Operating Revenue	$305,000	$305,000
Operating Expenses	$298,900	$298,900
Depreciation	$ 33,550	$ 33,550
Current Ratio	149.0%	149.0%
Days Cash on Hand	125.9	131.4
Days AR	50.0	45.0
Cash/Debt	83.0%	86.6%

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Cashing in on Revenue Cycle Improvements

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days of "unbilled" accounts, resulting in serious cash flow shortfalls. The example in the table also points out the increased margin of safety from turning over accounts receivable. If an emergency occurred, this organization would not have excess cash to cover its obligations; likely, it would have to sell assets, factor receivables or execute some other compromise. This demonstrates the danger of looking at working capital as a measure of short-term liquidity strength. Reducing its days in accounts receivable by 10% effectively creates an emergency fund of more than $4 million. Furthermore, an increase in accounts receivable balances often signals to an analyst a number of problems: revenue may have been overstated, bad debt may have been understated, management is unable or unwilling to effectively deal with its payers, processes and procedures are not adequate to process claims, and a host of other deficiencies that relate to management effectiveness.

The process of filing and collecting claims is lengthy even in the best of circumstances, but oftentimes hospitals focus solely on the tail end of the process, (i.e., collections). Clearly, collecting for services rendered is vital, but there are a number of steps prior to collections, which provide an opportunity to eliminate

waste. This is an area where hospitals can learn from process improvement techniques used in other industries.

Process Improvement

Using Toyota Production System's or other lean manufacturing methodology, providers can focus on eliminating waste and making the process more efficient. As with any process, there is an opportunity to eliminate waste at every stage and there are many different kinds of waste: transportation, inventory, motion, waiting, overprocessing, overproduction, defects, resources and talent. All of which can contribute to time in the process.

One key point that the most effective providers emphasize is precertification on the front end. Obtaining authorization before a patient even arrives is a key to eliminating waste later in the process. The idea is that taking extra time and devoting resources before the patient arrives eliminates the need to hassle patients or negotiate with insurers later in the process. More importantly, upfront authorization greatly reduces bad debt due to misunderstanding over coverage or inability to pay. Precertifcation also provides an opportunity to improve patient satisfaction. By clearly articulating the patient's financial responsibility before a procedure, indeed before the patient arrives, the hospital avoids promoting sticker shock and limits difficult conversations when a patient does not have the capacity to pay. Failure to precertify procedures tends to create waste of overproduction and overprocessing.

Another key aspect of efficiency within the revenue cycle is the education and training of persons responsible for tasks throughout the billing cycle. With the rapid changes in the health care industry, it is difficult to stay up to date on requirements. In

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Cashing in on Revenue Cycle Improvements (continued from page 7)

addition, constantly evolving technology and system infrastructure can create a stressful environment for those responsible for managing the system. Keeping the workforce confident that they are performing the job accurately is important, and training is vital in this regard. Perhaps equally important is ensuring that the staff is accountable for and empowered in performing the tasks from scheduling through billing and collections. Generally, billing errors are the result of poor training or a failure of institutional focus on the importance of quality. Errors of this type are known as "defects" in lean manufacturing terminology and this is perhaps the most expensive form of waste as defects often lead to performing the same task two or more times.

Ideally, work teams can be cross-trained to ensure a full understanding of the process, and the organizational structure is arranged to minimize hand-offs between departments. Movement of activities between departments tends to create waste by "inventory" build-up, and "waiting" times, and increases the risk of "defects."

Many providers despair of the inability to make significant reductions in bad debt or days in accounts receivable, but as with any task, advancement is a gradual evolution of marginal improvements. Considering the demands on time of management and staff, it may seem difficult to justify devoting resources to process improvement, but the benefit of increased liquidity and demonstration of management effectiveness can greatly enhance a provider's credit profile.

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The Transition to Emerging Revenue Models

BY JOHN M. HARRIS & RASHI HEMNANI

AT A GLANCE

A financial assessment aimed at gauging the true impact of the healthcare industry's new value-based payment models for a health system should begin with separate analyses of the following:

> The direct contract results
> The impact of volume changes on net income
> The impact of operational improvements
> Net income at risk from competitor actions

The results of these four analyses then should be evaluated in combination to identify the ultimate impact of the new revenue models on the health system's bottom line.

Planning a successful transition from fee-for-service to new revenue models may be the greatest impending challenge for finance executives of hospitals and health systems.

Hospital and health system finance leaders are presented with the challenge of deciding whether to embrace the healthcare industry's apparently inexorable trend away from fee-for-service payment and adopt a variety of emerging new value-based revenue models. These models include accountable care organizations (ACOs), bundled payment arrangements, quality performance incentives, gainsharing with physicians, narrow network arrangements, and shared-risk or full-risk contracts.

Making the transition to these new revenue models has been described as crossing a chasm. Yet finance leaders are charged with creating smooth financial paths forward, not making daring leaps across chasms.

To ensure a smooth transition, finance leaders need analytic models that allow them to plan thoughtfully and recognize all of the effects of these new revenue models. They also must decide how quickly to pursue these initiatives, how much revenue to shift, and how their organizations will succeed in this new environment. Choosing among potential contracts and setting the right pace may determine future success more than any other organizational strategy.

The Rationale for Pursuing the New Payment Models

The often repeated rationale for transitioning to new value-based revenue models is well known: Payers are demanding new value-based payment arrangements, believing they can yield both quality improvement and cost savings. Medicare has thrown its significant market scale into the endeavor. And perhaps most important, some leading providers in some markets are demonstrating results.

Nonetheless, many hospital finance leaders may be tempted to reject the common wisdom and view value-based payment as a fad, focusing on methodological flaws, complexity, and the perception that the new model may be promising more than it can deliver. Indeed, finance leaders *should* be appropriately skeptical of new fads, especially when they may undercut revenue.

So it is tempting for them in the case of value-based payment just to wait for the inevitable contracting failures and the rebound back to traditional fee-for-service. It's tempting—but not wise.

Carl von Clausewitz, the 19th Century military strategist, famously wrote, "War is the continuation of politics by other means." Similarly, it could be said that "new revenue models are the continuation of *competition* by other means." Competition for market share and physician loyalty. Competition for operational success.

The reasons to transition to these new models are only partly about whether they will yield savings or additional revenue. The essential features of new revenue models are determined by how they will change the competitive marketplace. Based on this perspective, it is important to measure new revenue models in four key ways:

- Contract results
- Market share
- Improved operational results
- Success in outmaneuvering competitors

Given the complex set of goals and benefits associated with new revenue models, a more involved analytic structure is required to assess their true impact.

How to Gauge the True Impact of New Revenue Models

The financial analysis for new revenue models is different from how hospital senior finance executives evaluate traditional fee-for-service contracts. Traditionally, a finance executive could focus on the direct contract results and in doing so would know the impact of a contract on the health system bottom line. The new revenue models require several more layers of analysis to calculate their true impact on the health system. In addition to the direct result of the contract, the greatest impact of these new revenue models may be in how they position a health system to secure market share, enhance operations, align with physicians, improve operational results, hedge against a competitor grabbing market share, and achieve other strategic benefits.

A health system's analysis should support consideration of all of these points.

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A Sample Analysis

To illustrate the range of factors that should be addressed in an analysis of the potential impact of new revenue models, we offer the following sample financial analysis based on estimated results for four different hypothetical contracts:

- Medicare ACO with 10,000 lives
- Commercial ACO with 20,000 lives
- Medicare bundled payments with 275 expected cases
- Commercial narrow network with 10,000 lives

To effectively guide a health system to financial health, an analysis of new revenue models should take into account five factors:

- Direct contract results for the health system
- Impact of volume changes on net income
- Impact of operational improvements
- Revenue at risk from competitor actions
- Other strategic benefits

In such an analysis, each factor should be boiled down to its estimated impact on net income, so that the final analysis assesses the bottom line results of new revenue models on the organization.

Direct Contract Results

Estimating the results of a contract involving a new revenue model is much more difficult than analyzing results of traditional fee-for-services contracts. Payments under the new revenue models are contingent on meeting quality targets, achieving population health savings, or meeting other performance measures. Despite these complications, estimating direct contract results is the first step in understanding the impact of such a contract on the health system's bottom line. Although ACO, bundled payment, and other new models all use different strategies to align interests, they can be analyzed side by side as demonstrated.

First, the approach to examine all of these new models should consider the payer spend that is being addressed, which will be different for the various models. For example, ACOs focus on total population health cost, while bundled payments target the payments for a particular clinical episode.

From this starting point, one can estimate the incentive the payer is offering to ensure its spend is well managed, the contract administration costs, and the discounts (e.g., bundled payment discount to the Centers for Medicare and Medicaid Services [CMS]). In addition, incentives may be shared with physicians.

After all of these factors are considered, the direct financial result of the contract can be estimated for each type of contract. For example, in our sample analysis shown in the exhibit below, the estimated direct contract results are positive for some contracts and negative for others. In total, the four contracts would reduce net income by $740,000 on almost $200 million of payer spend. (Note that the $200 million of payer spend does not represent $200 million of health system revenue, as payers are spending some of these funds on other types of providers.)

In many cases, the direct result of the contract may be neutral or negative. As will be seen later, that does not mean the overall impact of the contract will be negative, particularly when competitor actions are considered.

Impact of Volume Changes on Net Income

New payment models will likely drive down utilization as patients will benefit from improvements in care coordination and other population health management efforts. However, successful health systems may achieve increases in market share as these new contracts support either preferred tiers in health plans, a better patient experience, or increased ability to recruit physicians who prefer a better coordinated model of care. It is important to consider these volume changes and their likely impact on net income.

In calculating the impact on utilization rates, health system leaders should remember that some reductions will be in the health system's own volume, and some may affect volume at other facilities delivering

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ESTIMATED DIRECT CONTRACT RESULTS

	Medicare ACO	Commercial ACO	Medicare Bundled Payments	Commercial Narrow Network	Total
Units	Lives	Lives	Episodes	Lives	
Annual Volume	10,000 Lives	20,000 Lives	275 Episodes	10,000 Lives	
Average Payer Spend per Unit	$9,000/ Member	$3,200/ Member	$40,000/ Episode	$3,200/ Member	
Annual Payer Spend	$90,000,000	$64,000,000	$11,000,000	$32,000,000	$197,000,000
Estimated Incentive (as a % of payer spend)	2%	1%	2%	0%	
Estimated Incentive from Payer	$1,800,000	$640,000	$220,000	$0	$2,660,000
Contract Administration Costs	– $1,500,000	–$400,000	– $100,000	– $50,000	– $2,050,000
Impact of Discounts	$0	$0	– $220,000	– $800,000	– $1,020,000
Incentives Payments to Others (e.g., physicians)	– $150,000	– $120,000	– $60,000	$0	–$330,000
Direct Contract Results for Health System	**$150,000**	**$120,000**	**– $160,000**	**– $850,000**	**– $740,000**

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Financial Model Notes

For simplicity, the illustrative example provided in this article assumes a single year of results for contracting options that might be available for a medium-size hospital. The central concept of the methodology is to start with the payer's spend, as the demonstration of value must yield savings for the population or episode. However, achieving that value has significant downstream effects on hospital net income. The model seeks to capture and quantify each of those impacts.

The sample analysis is for baseline estimates of results. With a model built, it will be possible to perform sensitivity analyses to assess the risks and benefits associated with each contract.

In addition, it will help to estimate results for multiple years, as the ability to achieve positive results will vary by year. It could become easier to succeed as infrastructure develops and experience grows. Or it could become more difficult if past success leads to higher targets for future performance.

care to the same population the health system is managing. For example, an ACO may expect to reduce admissions (and hospital revenue) by 10 percent, but a third of the readmissions may have historically occurred at a competing facility. There is no loss to a facility from reducing a competitor's volume.

Market share growth may be more difficult to predict, but it should be considered nonetheless. The starting point for estimating market share growth should be the hospital's current fee-for-service revenue for the relevant payer (and clinical service, in the case of bundled payments). For example, ACOs and bundled payments can yield additional market share either by attracting more patients or physicians to its better coordinated set of services, or by helping to ensure that current patients select the hospital for follow on services they may have previously sought at competing hospitals. Under a narrow network contract, the market share gain is the main benefit. Restrictions on the use of other hospitals or lower patient copayments may induce or persuade more patients to select the hospital.

When considering the impact of market share, it also is important to consider whether the organization will be in a preferred position relative to competitors, or whether competitors are pursuing the same strategy, thereby offsetting some of the desired market share gains.

After translating utilization changes and market share to volume and revenue, variable cost savings (or increases) associated with the estimated change in volume should be considered to estimate the impact on net income. In the sample analysis below, the combined impact of market share and utilization across the four sample contracts yields a roughly $600,000 negative impact on net income.

Impact of Operational Improvements

Operational improvements gained through these efforts also will affect a health system's bottom line, in part by adding value through efficiencies in length of stay, supply chain, and other areas. ACO and bundled payment initiatives also could help address readmissions and other value-based performance measures. Such results can improve hospital revenue in the Medicare Hospital Value-Based Purchasing (VBP) Program and the Hospital Readmissions Reduction Program—which currently can combine to change inpatient reimbursement by as much as 3 percent, although this figure will increase in future years. Because these two Medicare programs are mandatory, we have not included them in our sample analysis as potential contracts to assess. However, because they do reward performance, they do magnify the benefits of the overlapping improvement initiatives in the other contracts.

It can be difficult to estimate this impact, as hospital performance is ranked against the performance of other hospitals to determine the incentive. In the sample analysis in the exhibit below, the VBP and Readmission Reduction Program have a relatively small impact (calculated as less than a half percent of the hospital's Medicare inpatient revenue). The larger component of the $1 million positive impact from operational improvement comes from savings in operational costs, including reduced length of stay and supply chain, that can be achieved with closer alignment with physicians.

(continued on page 12)

MARKET SHARE AND UTILIZATION IMPACT

	Medicare ACO	Commercial ACO	Medicare Bundled Payments	Commercial Narrow Network	Total
Change in Revenue from Utilization	– $2,700,000	– $2,369,000	– $198,000	$0	– 5,267,000
Change in Revenue from Market Share	$1,800,000	$1,280,000	$220,000	$960,000	$4,260,000
Impact of Volume Changes on Revenue	**– $900,000**	**– $1,089,000**	**$22,000**	**$960,000**	**– $1,007,000**
Variable Cost Savings	$360,000	$436,000	– $9,000	– $384,000	$403,000
Impact of Volume Changes on Net Income	**– $540,000**	**–$653,000**	**$13,000**	**– $604,000**	**– $604,000**

The Transition to Emerging Revenue Models (continued from page 11)

One might argue that these figures are speculative and should not be included. But failure to estimate this impact may significantly underestimate the value of some of the new revenue models to impact care delivery and payments. In addition, savings on hospital operating costs may carry over to patients not in the particular contracting arrangement, magnifying the positive results from these efforts.

Net Income at Risk from Competitor Actions

Just as new revenue models offer a health system opportunities to increase market share, competitors may use them for the same purpose. So the point of comparison should not be historical results, because maintaining historical volumes may not be achievable. Instead, expected results should be compared with potential future effects of inaction in the face of competitor action.

If, by piloting new arrangements, building partnerships with physicians, and pursuing new opportunities, a health system's competitors are able to steer patients away from the system, they could win market share at the health system's expense. Physician entities also could disrupt the health system's market by competing to take a central role in managing population health, driving down hospital utilization and/or comparison shopping among hospitals.

To calculate net income at risk from competitor actions, the health system should estimate possible market share losses and utilization reductions from competitor strategies. In particular, this analysis also should consider the degree to which the health system's pursuit of particular contracts helps to offset its competitors' ability to enter the breach and undermine its position. In the sample analysis shown in the exhibit [on page 13], the value and impact of this risk have been estimated to be significant, totaling $2 million. Given the high fixed-cost nature of health systems, any reduction from utilization management or shifted market share can have a significant impact on profits.

Combined Net Impact on a Health System's Bottom Line

The exhibit on [page 14] summarizes the results from each of the four prior analyses.

The direct contract results, impact from volume changes, and impact from operational improvements (described earlier) will sum to indicate the combined impact on the health system from any new revenue models that are implemented. In our example, the result of these new models is a loss of $300,000. If all of the contracts are pursued, the system must find those savings somewhere to offset that loss.

If a loss is expected (overall or on a specific contract), why does it make sense to pursue the strategy? The response to this question should consider another question: "Compared with what other strategy?" When a health system's history, or status quo, is used as the basis for comparison, pursuing the new revenue models does not seem preferable. But the future is likely to upset the status quo, and it is important to factor into the analysis the very real likelihood of competitor activity threatening market share losses and utilization reductions—as well as the potential for a $2 million positive impact from countering this activity. Taking into account such considerations, the overall net impact becomes significantly positive, suggesting that it is best to pursue the contracting strategy.

Other Strategic Benefits

Despite our best efforts to quantify all of the impacts of new revenue models, some are more difficult to quantify, but still should be considered.

Strengthening physicians' economic opportunity. Some incentives in new revenue models accrue to physicians. Improvements to physician income can help ensure an adequate supply of physicians in a community. Incentive payments also can offset losses for physicians employed by a health system. In addition, if a health system fails to provide these economic opportunities, physicians may work directly with health plans to secure them.

Driving quality improvement and maintaining reputation. Virtually all new revenue models include a significant quality measurement component. As the quality of outcomes become increasingly transparent, failure to address quality deficiencies could harm a health system's attractiveness to patients, physicians, and health plans.

For better or worse, payers and physicians often view these new revenue models as representing advancement and as an indicator that a health system is "cutting edge," particularly when the quality improvements are notable. And the public sometimes shares this perception.

Aligning with physicians is one of the main benefits of pursuing new revenue models. Most models include some form of waiver to allow for relationships that regulations would otherwise prohibit.

IMPACT OF OPERATIONAL IMPROVEMENTS

	Medicare ACO	Commercial ACO	Medicare Bundled Payments	Commercial Narrow Network	Total
Operational Cost Savings	$480,000	$200,000	$180,000	$0	$860,000
Impact on Medicare Value-Based Purchasing	$80,000	$20,000	$28,000	$0	$128,000
Impact on Medicare Readmissions Penalties	$40,000	$10,000	$6,000	$0	$56,000
Total Impact of Operational Improvements	**$600,000**	**$230,000**	**$214,000**	**$0**	**$1,044,000**

(continued on page 13)

 (continued from page 12)

REVENUE AT RISK FROM COMPETITOR ACTIONS

	Medicare ACO	Commercial ACO	Medicare Bundled Payments	Commercial Narrow Network	Total
From Competitor Utilization Reduction Strategies	$540,000	$384,000	$72,000	$0	$996,000
From Competitor Market Share Strategies	$900,000	$640,000	$110,000	$688,000	$2,338,000
Total Revenue at Risk	**$1,440,000**	**$1,024,000**	**$182,000**	**$688,000**	**$3,334,000**
Variable Cost Savings	– $576,000	– $410,000	– $73,000	– $275,000	– $1,334,000
Net Income at Risk from Competitor Actions	**$864,000**	**$614,000**	**$109,000**	**$413,000**	**$2,000,000**

Factors Determining the Pace of the Transition

Armed with the analytic framework described above, a health system can begin to decide at what pace it should move forward with new revenue models. The health system should consider a number of important factors that will determine the speed of transition and the particular arrangements that the organization undertakes, including the competitive landscape, payer readiness, physician interest, and organizational capabilities (taking into account, in particular, required lead time and short-term impact).

Competitor actions. A health system may be forced to take quicker action or lose market share if competing health systems are entering the new revenue models. Health systems also face the threat of physician entities disrupting the marketplace as they are pursuing care and cost management efforts. Physician-only ACOs, as well as patient-centered medical home (PCMH) contracts, are broadening the appeal for physicians to use their central role in care delivery to manage population health and steer patients to cooperative hospitals.

Payer interest. The capabilities and interests of payers in each local market will determine the availability of new revenue model opportunities. The major payers, including most Blues plans, are experimenting with some kind of new approach. Some are generous, and others are less so. Some focus on health systems, while others focus on physicians.

It is helpful to start with what payers want to pursue, as they have usually developed the IT and related capabilities to manage these initiatives. It can be risky to enter agreements that the payers are not capable of adequately administering. Payers also often want to demonstrate that providers have accepted their initiative. They therefore may be more likely to put additional funds on the table to avoid the embarrassment and waste of launching an initiative that providers reject.

It is usually easier to start many of these initiatives with HMO populations because of a clearer identification of the patient population being addressed. Over time, these initiatives can be expanded to include PPO populations for which responsibility for the member would be attributed based on historical utilization.

Physician interest. Aligning with physicians is one of the main benefits of pursuing new revenue models. Most models include some form of waiver to allow for relationships that regulations would otherwise prohibit. However, physicians are often skeptical of new revenue models and distrustful of hospitals. At the same time, they usually lack the time to investigate these options on their own. Hospitals must pursue a careful balance of engaging, educating, and crafting opportunities together with their physicians to build trust and interest.

It is easiest to work first with physicians employed by the hospital. However, the greatest benefits come from engaging independent physicians and aligning interests with them. Care should be taken to avoid alienating independent physicians by assuming they are not interested, or by pushing them too hard to participate if they are not ready.

Lead time. Developing familiarity and expertise in new revenue models does not occur overnight. New decision support tools will be needed to feed key data into the type of net impact analysis included above and to track results. Such tools ideally will allow a health system to compare contract results and evaluate future contract options. Even if the finance suite has such experience, physicians and key hospital departments will require time to gain expertise and skill, particularly in light of the actuarial skills and physician leadership that will be needed.

Short-term impact. Organizations should balance the short-term revenue impact with the benefits of a strong vision and drive that acknowledges the strategic and intrinsic value of these efforts. Finance leaders should consider how ready and willing their organizations are to handle potential short-term negative variances in revenue and volume, and what proportion of revenue should be shifted to the new payment models initially. In addition to addressing these difficult questions, these leaders should identify and consider the factors influencing how much revenue will be affected and be ready to manage the impact.

(continued on page 14)

SUMMARY: COMBINED IMPACT

	Medicare ACO	Commercial ACO	Medicare Bundled Payments	Commercial Narrow Network	Total
Direct Contract Results for Health System	$150,000	$120,000	– $160,000	– $850,000	– $740,000
Impact of Volume Changes on Net Income	– $540,000	– $653,000	$13,000	$576,000	– $604,000
Total Impact of Operational Improvements	$600,000	$230,000	$214,000	$0	$1,044,000
Combined Net Impact on Health System Bottom Line	**$210,000 –**	**$303,000**	**$67,000**	**– $274,000**	**– $300,000**
Net Income at Risk from Competitor Actions	$864,000	$614,000	$109,000	$413,000	$2,000,000
Net Impact Compared with Risk from Competitor Actions	**$1,074,000**	**$311,000**	**$176,000**	**$139,000**	**$1,700,000**

A Winning Strategy

As they make the transition to new payment models,organizations also should continue to assess their capabilities and develop competencies to manage care and cost. High costs (both unit costs and population health costs) will lead to vulnerabilities in market share and position. Engaging physicians in addressing and managing operating costs will help to decrease hospital unit costs. Other physician alignment efforts will provide opportunities to better manage population health.

Finance leaders should understand that the short-term impact of these new revenue models will most likely be negative, and they may prove difficult to defend as all payments are being squeezed and financial results are likely to be less positive in the coming years. However, the tendency to compare current circumstances with historical figures, while natural, is flawed when market share and competitive position are at stake.

Finance leaders should assess what opportunities are appropriate for the organization, budgeting conservatively while innovating boldly, recognizing that future market success may depend on new revenue models. Organizations that thoughtfully engage in and prepare for the transition from volume-based to value-based payments will be well positioned for the future and the challenges of the changing healthcare market.

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Preparing for the Taper:
How Changes to Fed Stimulus May Impact Nonprofit Portfolios

BY WILLIAM M. COURSON

After more than five years, the Federal Reserve Board (the Fed) announced on Dec. 18, 2013, that the quantitative easing program currently in place, the monthly open-market purchase of $85 billion of mortgage-backed securities and treasury securities, would begin to slow. The announcement described a $10 billion reduction of monthly securities purchases beginning in January.

While stock markets soared—the S&P 500 rose 1.66%—treasury yields responded more gently as bond market participants had anticipated this move for many months. The announcement came six months after Fed Chairman Ben Bernanke first referenced the "tapering" of bond purchases.

On June 19, 2013, Bernanke, who also is chairman of the Federal Open Market Committee (FOMC), addressed the media at the conclusion of the committee's two-day meeting. In this press conference, he stated that the Federal Reserve could begin to taper the amount of monthly asset purchases later in 2013. This announcement preceded a sharp sell-off in the bond and equity markets and led many investors and economists to believe a decrease in the rate of asset purchases would be announced at the conclusion of the FOMC's September meeting.

Contrary to popular consensus, the committee voted 9-1 to continue the pace of asset purchases at its September meeting. Bernanke cited a slow recovery in the labor market and the fiscal uncertainty in Washington as the primary drivers behind the decision to delay tapering. The bond markets rallied at the announcement, with the 10-year yield falling to 2.7% from 2.85% the previous day. As the December meeting approached, bond markets anticipated a tapering announcement as the yield on the 10-year treasury note rose to 2.92%.

The Fed also chose to alleviate concerns of a complete reversal of its easy money policy by communicating its intentions in a post-meeting press conference to keep interest rates low "well past the time" that the unemployment rate falls below 6.5%. While Chairman Bernanke stated that Fed actions will remain "accommodative," he noted that the labor markets had witnessed "substantial improvement."

How We Got Here

The Federal Reserve Reform Act of 1977 established the Federal Reserve's monetary policy objectives to be to "promote…maximum employment, stable prices and moderate long-term interest rates."[1] The Fed has been given several tools to achieve these objectives, including setting the discount rate, setting reserve requirements for banks and conducting open market operations. While its board of governors is responsible for setting the discount rate and reserve requirements, the FOMC, comprised of the seven members of the board and five of the Federal Reserve Bank presidents, is responsible for conducting open market operations, including purchasing assets in the open market as a tool for manipulating interest rates. By manipulating interest rates, the Fed is able to provide cheap financing to companies in periods of economic downturn as well as to raise borrowing rates when the economy begins to overheat, a situation where production is unable to keep pace with growing demand often resulting in high inflation.

In response to the financial crisis of 2008, the FOMC implemented unprecedented open market activities, in the form of asset purchases, to prevent large institutions from failing while also aiding in broad economic recovery. The committee began purchasing short-term securities in the open market at an accelerated pace in September 2008, pushing short-term interest rates to extremely low levels and providing easier access to liquidity for struggling financial institutions. Two months later, it initiated an $800 billion asset purchase program or "quantitative easing," later referred to as QE1, that significantly lowered long-term interest rates, allowing corporations and consumers to secure long-term capital at historically low rates. Since then, additional quantitative easing actions have been taken with the goals of increasing economic expansion and lowering unemployment by increasing consumer spending via reducing borrowing costs. As a result of over five years of quantitative easing, the assets on the balance sheet of the Fed have increased by nearly $3 trillion.

Easing Off the Accelerator

At the conclusion of the June 2013 FOMC meeting, Bernanke discussed potential tapering of the current $85 billion in monthly asset purchases, firmly stating that the Fed would not abruptly end the easy monetary policy. He likened a tapering to "easing off the accelerator" as opposed to "slamming on the brake." Despite his cautious words, markets reacted sharply, with the S&P falling 3.4% within three days of the announcement, while the yield on 10-year U.S. Treasuries rose from 2.18% on the day before the announcement to 2.48% by the end of the following week. The market reaction was a clear indication that a reduction in stimulus would not be well received by the markets.

The FOMC has repeatedly stated that tapering will not begin until economic conditions have improved and growth can continue naturally. A tapering of asset purchases, therefore, should be interpreted as a positive by the markets, as strong economic growth and low unemployment are catalysts for asset prices. Despite this logic, markets typically have reacted poorly to the mention of tapering or stricter monetary policy and this has led some to believe that quantitative easing from the Fed may be artificially inflating asset prices.

What to Expect

On Jan. 31, 2014, Chairman Bernanke will be replaced by current Fed Vice Chair Janet Yellen, who has expressed the opinion that the current direction of Fed policy will remain in place. While the Fed will continue to maintain an easy monetary policy, further reductions to the current stimulus are inevitable as economic conditions continue to improve, however. In Yellen's nomination hearing in November 2013, the soon-to-be chairwoman dismissed the thought that the FOMC would consider

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Preparing for the Taper: How Changes to Fed Stimulus May Impact Nonprofit Portfolios (continued from page 15)

the impact of tapering on asset prices by stating, "I don't think that the Fed ever can be, or should be, a prisoner of the markets."

Impact on Nonprofit Portfolios

As observed at the end of every Fed meeting over the past six months, news of tapering results in short-term volatility. The long-term impact is likely to be less meaningful, however. After all, tapering is a sign that economic conditions are improving and a strong economy leads to strong performance across the markets. However, there are a few steps investors can take to strengthen their portfolios against a reduction in stimulus that will likely lead to higher interest rates.

As the Fed begins to decrease asset purchases, long-term interest rates are expected to rise. Fixed-income securities typically perform poorly in rising interest rate environments, so the prices of bonds will fall as interest rates rise. When interest rates are rising, it is prudent to maintain a shorter duration in the fixed-income portfolio to mitigate expected price declines. Shorter duration can be attained in a number of ways, including allocating to short-term bonds, fixed-income securities with higher coupons and/or assets that have variable interest payments.

In addition to allocating assets within the fixed-income portfolio, there are opportunities to allocate among asset classes. Some assets have historically performed well in periods of rising interest rates. For example, over the 20-year period prior to the beginning of quantitative easing in 2008, commodities produced an average annual return of 21.04% in years in which the 10-year yield rose compared to a return of only 7.89% in years when the 10-year yield was falling.[2] This compares to a return for investment-grade fixed income of 3.54% when the 10-year yield is rising and 9.53% when the yield is falling.[3]

In addition to commodities, several other equity asset classes as well as asset classes with equity-like characteristics have traditionally performed well in periods of rising rates. These include emerging markets equities (27.3% in years the 10-year yield rose versus 16.31% in years the yield fell) and developed markets equities (15.55% versus 4.67%).[4] While these broad observations are encouraging, many other factors outside of historical performance should be considered before making allocation decisions, such as current valuations, portfolio risk tolerance, economic outlook, etc.

Given improving economic conditions and statements by the FOMC, tapering will begin in January 2014. A decrease in demand by the FOMC is expected to drive interest rates higher, both increasing borrowing costs and leading to falling prices for fixed-income investments. Investors can combat rising interest rates by both shortening the duration of the fixed-income allocation and considering asset classes that have performed well in periods of rising rates.

1 "The Federal Reserve's Dual Mandate." Federal Reserve Bank of Chicago. Last updated Nov. 13, 2013.

2 As measured by the S&P GSCI.

3 As measured by the Barclays Intermediate Government/Credit Index.

4 As measured by the MSCI Emerging Markets Index and MSCI EAFE Index respectively.

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HFMA Event Summary

2013 Fall Summit

Since its founding as the first HFMA chapter in the country, the First Illinois HFMA Chapter has sought to build an association that offers both provider and non-provider members the opportunity to collaborate and share ideas. Delivering high-value, timely, impactful, in-person educational programs has been, and remains, foundational to this goal.

This year, the chapter transitioned from multiple single-day events, that each cover a single topic, to more comprehensive two-day Summits, one in the fall and another in the spring. I feel the Fall and Spring Summits will be a key component to ensure members have the necessary resources to grow their knowledge and skills. Furthermore, I hope these Summits will become the cornerstone events for Chicago-based healthcare finance professionals.

This year's inaugural Fall Summit was held November 4-5 at Arlington Race Track, and it featured a wide range of topics and provided exceptional locally-delivered education. The Summit aggregated more than 300 healthcare leaders from the Chicago market and delivered a lineup of more than 20 thought-provoking sessions grouped into five tracks:

- Finance & Treasury
- Revenue Cycle
- Managed Care
- Information Technology
- Leadership

In addition to receiving up to five CPE credits, attendees had numerous networking opportunities. And, given the rapid rate of change in health care, these networking opportunities were an invaluable way to learn from peers.

The Summit wasn't all work, however, as we had a fun-filled evening reception and dinner on November 4 with a variety of themed contests that culminated with awarding more than 15 prizes ranging in value from $25 to $250.

It is my sincerest hope that you found the Fall Summit as much of a success as I did, and I hope you will find as much—or more—value in the upcoming Spring Summit.

Regards,
Dan Yunker

Gregg Ferlin, Christine Erdmann and Brian Pavona

Marcus Padgett, Cathy Peterson, Mandy Long and Brent Estes

Adam Lynch, Mary Treacy Shiff, Thomas Fahey and John Stroger, Jr.

David Fix, Chuck Weiss, Karen Davis and John Callahan

David Kanzler, Jeff Piejak, Tom Sayer and Fletcher Boyle

Karl West, David Sontag, Laurie Wyatt and Ashif Jiwani

John Norenberg, Dan Yunker, John Bartley, Chuck Cox, Peter Ingram and Julio Silva

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"I turn to HFMA to keep up with the rapid change in the profession, enhance my career, and strengthen our chapter. HFMA delivers the essential information that healthcare financial management professionals require to stay on top of their game and ahead of the curve."

Mark A. Hartman, FHFMA, CPA, Arkansas Chapter

Save the Date for the Spring Summit

The Spring Summit is scheduled to occur from April 10 - April 11, 2014 at the Eaglewood Resort and Spa. We will again offer multiple education tracks on topics ranging from revenue cycle, to ICD_10 and Treasury and more. Altogether, we're proud to offer more than 30 hours of educational content and the chance to network with peers and industry experts. Registration details will soon be available on the Chapter Website at http://firstillinoishfma.org/

Save the Date for ANI 2014

Mark your calendar—ANI 2014 will take place June 22-25 in Las Vegas, Nevada. Visit http://www.hfma.org/Content.aspx?id=501 for updates, deadlines, and registration savings.

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HFMA Editorial Guidelines

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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.

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July 2014	June 10, 2014
October 2014	September 10, 2014
January 2015	December 10, 2015

First Illinois Speaks
HFMA's First Illinois Chapter Newsletter
event-filhfmaorg@comcast.net

Chapter Educational and Events Calendar 2014

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

Thursday, February 6, 2014
Supply Chain Management for Financial Executives: Opportunities and Strategies

Tuesday, February 11, 2014
Health Care Provider and Payer Markets in Wisconsin: Key Trends and Issues

Tuesday, February 18, 2014
Securing Guaranteed Returns in the Face of Growing Patient Financial Responsibility

Thursday & Friday, April 10-11, 2014
Spring Summit
Eaglewood Resort and Spa

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