First Illinois Speaks
hfma healthcare financial management association
HFMA's First Illinois Chapter Newsletter
July 2015

GO BEYOND

Highlights and Recap First Illinois Chapter Events begin on page 19

News, Events & Updates

In This Issue

Outpatient Prospective Payment System: 2015 Highlights and Four Steps to Implement Revisions

BY MEGAN N. BEASLEY, RHIA, DANIEL G. GAUTSCHI, AND CORY M. HERENDEEN

The Centers for Medicare & Medicaid Services (CMS) has issued its calendar year (CY) 2015 changes to the hospital outpatient prospective payment system (OPPS). Healthcare organizations should be ready to implement these changes.

Understanding the CY 2015 Changes

No healthcare organization can afford to lose precious reimbursement dollars. With an understanding of the most significant OPPS changes, hospitals and healthcare systems can better manage and capture revenue. CY 2015 highlights include:

2015 payment rates. The CY 2015 OPPS conversion factor (CF) for ambulatory payment classifications (APCs) is $74.144. This is a 2.2 percent increase from 2014. CMS also will impose a 2 percent reduction in the CF on any hospital that does not report the required quality measures. This reduced CF for 2015 will be $72.661.

Under this final rule with comment period, CMS estimates that total payments for CY 2015 to the approximately 4,000 facilities paid under the OPPS will be about

$56.1 billion. This is an increase of approximately $5.1 billion compared to CY 2014 payments.

Payment packaging. This year, CMS is moving toward more global reimbursement. In 2014, add-on codes assigned to device-dependent APCs were paid separately; in 2015, they are packaged.

The initial set of APCs that are conditionally packaged have a geometric mean cost of less than or equal to $100. If a packaged ancillary service has an increase in geometric mean cost above $100, the conditionally packaged status remains the same. Certain services—such as psychiatry and counseling-related services—are excluded from conditional packaging and will be paid separately. In CY 2015, prosthetic supplies are unconditionally packaged and not paid separately.

(continued on page 2)

Outpatient Prospective Payment System: 2015 Highlights and Four Steps to Implement Revisions

(continued from page 1)

Comprehensive APC changes. For CY 2015, CMS has introduced a new methodology called a comprehensive APC (C-APC). Similar to diagnosis-related groups in the inpatient setting, C-APCs are associated with a single payment based on the primary service delivered. CMS has designated certain high-cost, device- related outpatient services as "primary services."

Keep in mind that although the methodology is changing, reporting should not. Each service should be listed under the C-APC regardless of the fact that payment is not made on a line-item basis. Furthermore, rather than multiple copayments for various services, a single copayment will be associated with the C-APC designated as the primary service.

CMS has established 25 C-APCs and 248 current procedural terminology (CPT) codes, which are assigned to the newly created J1 status within 12 clinical families. Some of the adjunctive services that will be packaged and not paid separately include:

- Diagnostic procedures
- Laboratory tests and other diagnostic tests and treatments that assist in delivery of the primary procedure
- Visits and evaluations associated with primary procedures
- Uncoded services and supplies
- Hospital-administered drugs Some of the excluded services are:
- Self-administered drugs not considered supplies
- Recurring therapy services
- Diagnostic and screening mammography services
- Ambulance services
- Annual wellness visits with personalized prevention plan services
- Brachytherapy services
- Preventive services

Recurring services would not be included in C-APCs and should be filed on separate claims.

To determine C-APC payments, first identify the primary service. Understand which services are paid separately and which are packaged into the comprehensive service.

Next, rank the primary procedure only if the claim has multiple codes with a J1 status indicator. Finally, determine if complexity adjustments are applicable to determine the final C-APC.

Payment status indicator changes. As already described, the new status indicator for CY 2015 is J1, which applies to C-APCs. Status indicator X for ancillary services has been deleted.

Several codes have been revised for CY 2015. Payment will be made

(continued on page 3)

Outpatient Prospective Payment System: 2015 Highlights and Four Steps to Implement Revisions

(continued from page 2)

through the OPPS for status indicator Q1 when it is a packaged code with an S, T, or V indicator. Addendum B displays APC assignments when services are separately payable. They are considered a packaged APC payment if billed on the same date of service as a healthcare common procedure coding system (HCPCS) code assigned SI, S, T, or V. In other circumstances, reimbursement is given through a separate APC payment.

Executive-Level Project Checklist

To successfully integrate the annual CMS OPPS changes, healthcare organizations should have a specific process and dedicated resources. Here are suggested steps to help implement this year's revisions.

1. **Analyze the CDM.** Analyze the current charge description master (CDM) to understand the CPT/HCPCS coding, charge structure, and pricing revisions that need to be implemented.
2. **Update charge capture systems.** Inventory the specific charge capture subsystems that need to be updated as part of the process.
3. **Educate departments.** Make sure that required department staff members understand the implications of all applicable changes to the charge master and charge capture systems.
4. **Verify accuracy.** Once all changes to the CDM and charge capture systems are implemented, conduct an analysis to verify accuracy and completeness.

Contact Information

Megan Beasley is with Crowe Horwath LLP in the Oak Brook, Illinois, office. She can be reached at 630-575-4291 or megan.beasley@crowehorwath.com.

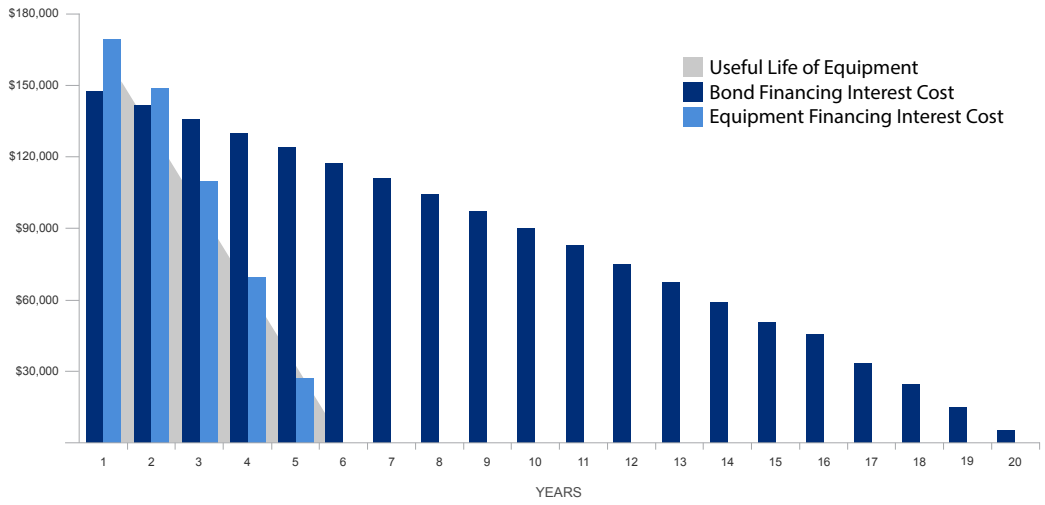
Daniel Gautschi is with Crowe in the Oak Brook office. He can be reached at 630-574-1847 or dan.gautschi@crowehorwath.com.

Cory Herendeen is a principal with Crowe in the Indianapolis, Indiana, office. He can be reached at 317-706-2781 or cory.herndeen@crowehorwath.com.

Equipment Financing and Bond Financing:
How Healthcare Organizations Are Making the Best Use of Each Financial Product

BY KIMBERLY MOORE, ASSISTANT VICE PRESIDENT, FIRST AMERICAN HEALTHCARE FINANCE

Interest Costs: Bond vs. Equipment Financing



Today's healthcare finance professionals have their work cut out for them. The combination of declining reimbursements, cost-cutting measures, and legislative uncertainty has created a complex maze for finance leaders. Most spend an increasing amount of time looking for new ways to bend the cost curve. By evaluating the different financial product options available for capital projects, you can determine the best fit for your needs and generate significant savings for your organization.

Bond Financing

Hospitals and other healthcare organizations across the country have looked to debt markets as an attractive source of long-term, fixed-rate financing. However, there are a several downsides to issuing bonds. First, they come with material issuance costs and can be administratively burdensome. Time is also a limitation, as it can take anywhere from three months to two years depending on the amount and structure.

Bond financing is generally not a good source for short- term projects or equipment that may have a useful life less than seven years. Putting short-term assets on long-term debt is akin to rolling your groceries into your mortgage. Issuing long-term debt to finance short-lived assets is a costly strategy, even at low rates.

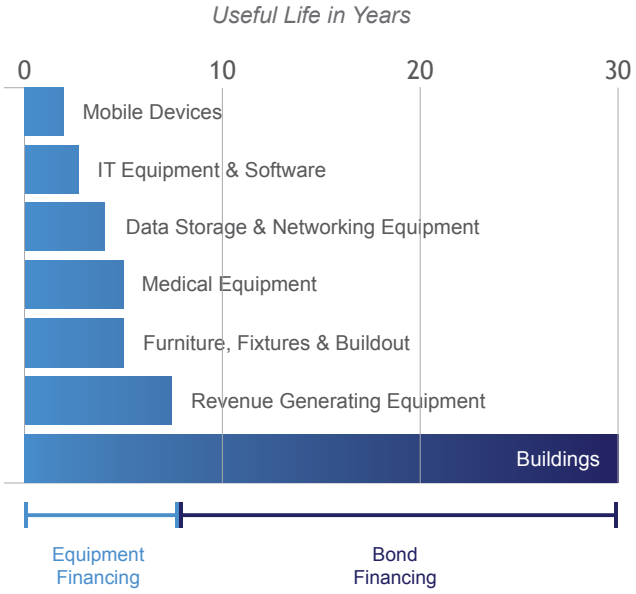
Consider the example in Figure 1, comparing a 20-year bond for $5 million with a fixed interest rate of 3% to a 5-year equipment financing agreement for the same amount with a rate of 4%. The interest costs on the 20-year bond total more than $1.6 million. Despite the equipment financing agreement's higher rate, its total interest cost is less than a third of the total interest cost for the bond.

Another significant, negative issue with debt is the restrictive covenants and blanket liens that limit future flexibility. The uncertainty surrounding healthcare reform in the Patient Protection and Affordable Care Act stands to be the biggest risk if an organization is not able to be nimble and adapt to changes.

Equipment Leasing and Financing

Like bond financing, the low-rate environment has fueled equipment leasing and finance products. Healthcare finance professionals have strategically used this source of capital to help prepare for the uncertainty that lies ahead.

Matching Useful Life with Financial Product



(continued on page 5)

(continued from page 4)

Lease financing products are intended for specific equipment or projects that have a useful life of seven years or less, as shown in Figure 2. Organizations are able to take advantage of the low, fixed rates without the issuance burdens or costs typical of bond debt. The lead-time is measured in days, not months or years.

The shorter terms allow organizations to strategically fund projects and equipment with a financial product that is closely aligned with the useful life and with the same low— if not lower—all-in rates as the bond market.

Since leases are collateralized by the equipment being financed, these products do not come with blanket liens or debt covenants that restrict an organization's flexibility. Each project can be evaluated independently for appropriate term and structure. These products also provide organizations with the option to use off-balance sheet financing. This can help increase efficiency metrics such as ROA, but more importantly, navigate around existing covenants the organization might have due to prior debt issuances.

For a more in-depth comparison between the features of equipment financing through First American and bonds, reference Table 1.

Utilizing lease financing as part of a hospital's capital structure can be a strategic, cost-effective and timely source of capital, especially for short-term assets like IT and medical equipment, furniture, office equipment and buildout costs. Healthcare organizations seeking flexibility and stability in the coming years should look to these products as a complement to their existing capital structures.

Equipment Financing vs. Bond Financing

	Leasing or Financing through First American	Bond Financing
Typical Term	2-7 years	10-30 years
Amount	$100,000 to $20,000,000	$5,000,000 to $200,000,000
Lease Rate	≤0%	Not applicable
Financing Rate	2%-5%	1%-4%
Fees and Issuance Costs	None	2%-5% of bond amount
Typical Assets Financed	Short useful life equipment like diagnostics, technology & office equipment and vehicles	Buildings, real estate, construction and expansions
Collateral	Only assets under lease	Letter of credit, insurance, real estate
Liens	Lien solely on leased assets	Blanket lien
Covenants	None	Common, including debt limitations
Required Documentation	**Minimal:** • 4-page Master Lease plus Equipment Schedule, Delivery Order, and Purchase Option	**Extensive:** • Offering documents such as official statement and bond purchase agreement • Legal documents such as loan agreement, mortgages or deeds, tax regulatory agreement, Form 8038 • Resolutions and certificates of the parties • Legal opinions • Other miscellaneous forms such as rating letters and appraisals
Timing for Approval and Funding	2-10 days	≥90+ days
Accounting Treatment	On- or off-balance sheet	On-balance sheet

Table 1

President's Message

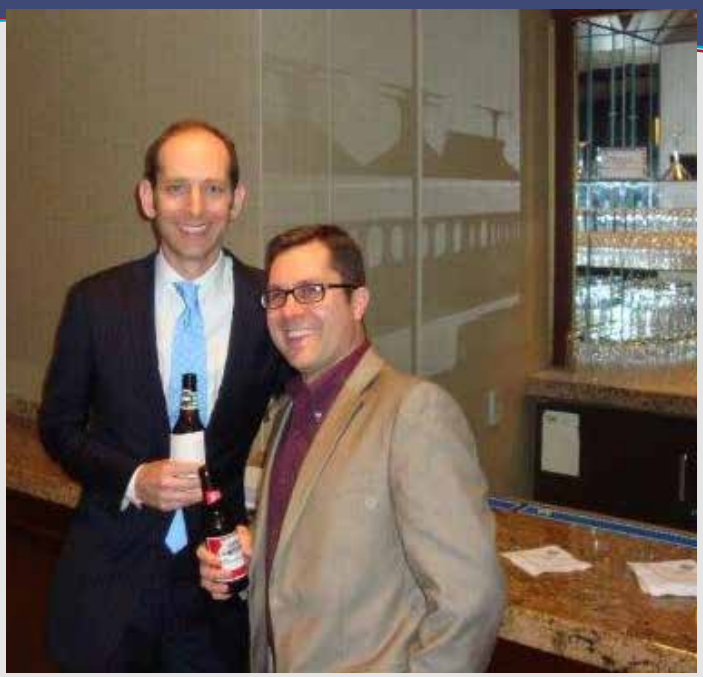
HFMA First Illinois is my "Cheers": My journey from the extra at the end of the bar to Norm!

Let me share with you a secret. There was no compelling reason why I joined HFMA several years ago. In fact, it was probably impulsive, and a little intimidating at first, but it has served me well. In looking back the primary driving factor was that it seemed like an interesting organization of individuals who shared my predisposition to health care finance. As a niche http://firstillinoishfma.org/membership/member-get-member/ group it definitely fell into my comfort zone.

Joining was the first step in October 2009. E-mails and invitations to attend an education or social event soon followed. Now I was confronted with the reality that I may appear out-of-place at a function—that I would be the proverbial extra at the other end of the bar from Norm and Cliff in "Cheers". Everyone knew Norm's and Cliff's names, but the extra was a perpetual outsider. So I attended on a few occasions and slowly built a network of acquaintances, which had a ripple effect. Soon I was seeing members at non-HFMA events. Now we had this shared experience: members of First Illinois HFMA. Friendly discussions with active volunteers translated into relationship building.

In improv comedy, and I'm by no means an expert, there are certain guiding principles. One of those principles is to always say, "Yes" when asked a question. The Improv premise being, opportunities for humor follow when an actor answers yes to a question. The same thing applies to life. So in one of those moments when the question was asked about building a webinar series, my answer was yes. Some would say that humor followed. Regardless, I enjoyed the opportunity to arrange regularly scheduled education events during the lunch hour. Moreover, while hosting a webinar on a wide variety of topics, I learned a great deal about other services, challenges and emerging issues that our members were facing. It became a very cost- and time-efficient way to expand my area of knowledge.

Admittedly, my fifth and final reason for joining was proximity. The events were near-by and thus not a huge time commitment if the event didn't appeal to me. Again no master plan, but more of a shot in the dark



"Norm and Cliff" hanging out at Cheers

that ultimately turned into a tremendous boon for both my personal and professional life.

Cathy Jacobson the CEO of Froedtert Health and a former national Chair said, "HFMA gives you more than you put in." I've found that to be absolutely true. So if you have a friend who may benefit, please suggest they join. If you have tried to volunteer in the past and a role wasn't a great fit, please try again. And finally if you attend an event and feel like that extra from Cheers, come up to me and say, "Norm!" I will help you meet three people that evening who may each help you meet three more. That is all you really need to turn HFMA from a professional organization to a place "where everyone knows your name."

Adam Lynch
2015 – 2016 First Illinois,
HFMA Chapter President

What A Tangled Web We Weave:
How to Make Value-Based Partnerships and Affiliations Successful

JEFF HOFFMAN, HEALTH CARE EXPERT, KURT SALMON

Developing integrated, value-based care delivery models requires unraveling existing systems and processes and weaving together new ones in new ways. It's an uncomfortable, disruptive effort with few guidelines, and most hospitals and health systems in the midst of it are finding it messy and complicated.

The reality is that many will fail. Mergers and acquisitions to build scale won't be enough to meet population health goals. Integrated care solutions call for larger, fiscally strong health organizations—not necessarily with shared balance sheets—to partner with one another and with other area providers to jointly develop systems of care that offer value-based solutions.

Difficulties typically arise when goals lack focus or there is a reluctance to challenge current clinical processes and physician-referral patterns, and success won't be dictated by who is involved or the structure and process they use. Ultimately, it will boil down to who can actually put these symbiotic relationships together—integrate cultures, technologies, geographies and financial circumstances—then deliver results and get paid for the value of these results.

Untangle the Value Conundrum

Two of the biggest issues a partnership must clarify relate to value: How will the network define value, and how do participants equitably distribute the value that is created among the participants?

The answers form the framework onto which all other relationships are woven. Getting agreement among partners about how to define value creates a framework for these new partnerships and prioritizes goals. Is the partnership about making care more efficient? Making care safer? Improving outcomes? Reducing costs and waste? Succeeding on a risk-based contract?

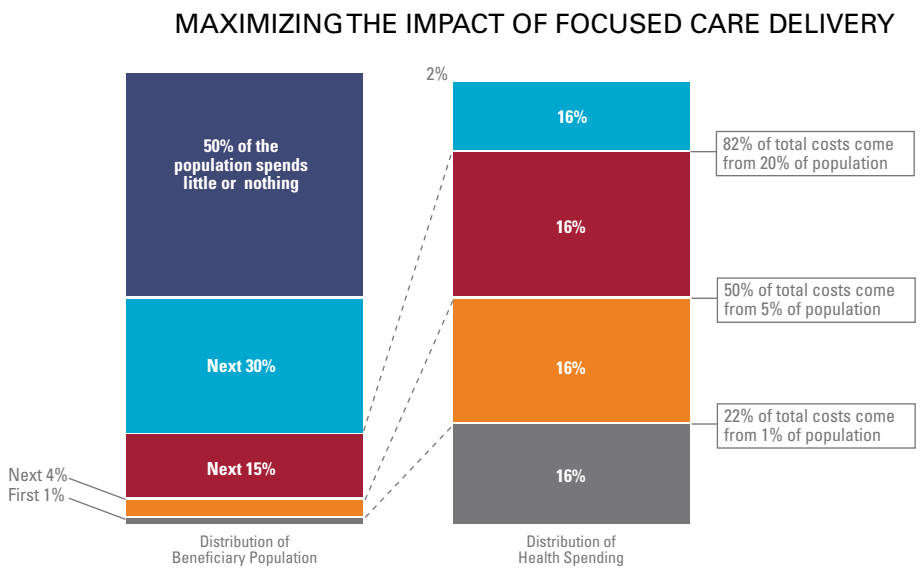
An even more challenging aspect, which few have answered, lies with the potential monetary return on the investment. How will financial returns be generated? Will they be distributed equally among hospital and physician partners? When, and in what magnitude?

One clinically integrated network approached this by unraveling its existing care system and refocusing on the 10% of patients generating a disproportionate share of the insurer's health care costs. They made behavioral health services a critical component in the care of these patients and estimated that more effective care management would reduce the high users' total spend from $9 million to $6 million. The $3 million savings generated will be split equally between the health system, the independent physician association partners and the insurer.

Besides defining how value will be distributed among partnership members, this network was also strategic in targeting a very specific population health goal. Narrowing the network's focus as much as possible in the beginning can help mitigate some of the early risks and help the entity achieve measurable value. (See Exhibit 1)

(continued on page 8)

EXHIBIT 1: Five percent of patients are responsible for 50% of health care spending.



 (continued from page 7)

Tighten the Weave

Partnerships by nature are looser arrangements than mergers or acquisitions, making them flexible, but also prone to fraying if they're not carefully constructed. Each partner must be well integrated into the overall design so the structure retains its integrity in the face of difficult decisions and inevitable challenges.

For organizations that want to start slower, staging the partnership can help ease everyone in. For example, the health systems and physicians in one new arrangement began by self-insuring their own employees. Initially, they share only "upside" savings (upside risk) as the physicians and the evolving clinical processes are tested and evaluated for success. All parties know that within two to three years they will move together toward accepting both "upside" and "downside" risk for caring for this specific population of employees and dependents.

Keep in mind, however, that partnerships aren't always equitable societies, so the ways in which individual partners come together may have to vary. Smaller providers and critical access hospitals, for example, won't necessarily have the same level of capital to invest in a partnership as a major health system, but may be essential components due to geographic location or strategic interest in changing care. There must be alternative options available for these organizations to have "skin in the game" without the same level of financial commitment or risk. In turn, it will be necessary for these differential partners to accept certain trade-offs, such as serving on a committee rather than holding a board seat. Outlining these criteria from the outset will not only set out participation expectations and help entities commit beyond the initial investment, but will also help all parties better understand how risk will be balanced across the network.

Ensure Expertise and Interest Govern the Group

A new entity formed by multiple parties is typically governed by a body representing all of those who invested, with local physicians also participating. But this typical approach will not work here. If these partnerships are established on the belief that dramatic change in the delivery and cost of care needs to happen, then governance expertise must trump or be equal to investment when it comes to governing.

This is a particularly sensitive spot for partners because it means giving up representative board seats, and that creates discomfort. But to succeed in unknown territory, in an area where the partners lack real expertise, partners must be willing to give up some of their governance control and be open to leadership guidance from experts from other parts of the health care field who have been down the road before.

To identify the right board mix, the partnership must be crystal clear in what it's trying to achieve, then seek out leaders with specific expertise. In some cases, this may require changing board bylaws to accommodate non-local or otherwise non-traditional board members.

In one PHMO, the founding and investing partners relinquished several board seats to add needed expertise, including a retired insurance executive who had served as CEO of a statewide insurer and the medical director of a large East Coast independent-physician association. Adding this level of expertise changed discussions and challenged the organization's goals, raising difficult but essential questions that aren't

(continued on page 9)

 (continued from page 8)

normally heard at health system board meetings.

Physicians too must play a significant role in the partnership's efforts to improve clinical care. In another uncomfortable truth, partners must recognize that traditionally hierarchical physician relationships must bow to the higher purpose of alignment and integration. Physician seniority must weigh less than interest in and engagement in the process. Some partnerships have successfully pulled in the right physicians by creating a job description that details the skill set and time dedication necessary, then interviewing physicians across the organization. As the job typically requires physicians to spend substantial time away from their practice, reasonable compensation is important. In some cases, compensation can run upward of $300 to $400 per hour.

Visualizing the Population Health Tapestry

We're at merely the beginning stages of changing the health care delivery system, so it will be some time before a clear image of fully integrated delivery systems emerges. These partnerships will be the flexible yet multidimensional bases of the future care paradigm and future physician and hospital revenue streams. Those that succeed will have unraveled a broken, fragmented system and created a new one, weaving in both old and new delivery platforms with both old and new leaders to truly disrupt the market, their own organizations and patient outcomes.

SIDEBAR: Common Constructs for Custom-Designed Partnerships

Partnerships take many forms to uniquely address local market dynamics. Among the most common partnerships forming across the country are:

- Health system integration. Hospitals or health systems partner or affiliate with other hospitals or health systems to create a virtual integrated delivery system to lower costs and improve care.
- Clinically integrated network (CIN). Hospitals or health systems create a network of care that they manage in conjunction with independent physicians or other providers to deliver or contract for care of specific populations.
- Population health management organization (PHMO). Independent hospitals and health systems invest jointly with physicians, and potentially insurers, to create a health care "utility" that provides the tools to better manage lives.

SIDEBAR: Focus Near-Term Efforts to Build Future Value

Population health is an immense goal. Narrowing a network's initial focus can provide early wins and also help the entity work through any kinks within a lower-risk, controlled environment. To do so:

1. At the outset, define "first opportunities" for care improvement, e.g., chronic and utilization-based care issues, unnecessary ED visits.
2. Start with the founding organization's own lives (employees and dependents) and direct them only to the participating physician partners in the network.
3. Concentrate on a specific subset of lives where there are opportunities to improve efficiencies in care delivery and focus the partnership's initial activities there.

4. Gather proof points on the impact the network had on waste and duplication, as well as on consumer satisfaction.
5. Showcase these results to build the network, gain new business and create confidence among the partners.

SIDEBAR: Weaving a Partnership That Won't Fray at the Edges

The significant change partnerships are designed to create will cause major disruption for the hospitals, physicians and others involved; backing out in the face of difficult decisions cannot be an option. There are a number of ways that partnerships can be structured to ensure all participants are firm in their long-term commitment, including:

- Risk-based contracting that shares the risk across the partnership
- Making larger joint investments that depend on the success of the original CIN or PHMO
- Joining each participant's clinical network together to share risk. Creating an organization with some level of control that is relinquished from the participating organizations, such as dedicating board seats to executives or physicians who are outside of the partnership and have specific expertise to support the new venture

PQRS: The Tip of the Iceberg in "Value-Based Reimbursement"

BY CHAD BESTE, PARTNER, PBC ADVISORS, LLC

Value-based programs are growing in importance and PQRS (Physician Quality Reporting System) is in many ways the cornerstone of CMS' various value programs. Unfortunately, PQRS is very complex and a number of practices have elected to simply accept the payment reductions (currently 2%) rather than attempt to comply. However, the total penalties for failure to successfully report PQRS are more significant than just the PQRS 2% negative adjustment.

There are three quality-based programs. With each of these programs, there are requirements related to successfully reporting on PQRS. These programs are:

- Physician Quality Reporting System (PQRS)
- Meaningful Use Program (significant changes are ahead that will simplify this program but PQRS is still part of this)
- Value Modifier Program (more on this below)

Most practices need to do PQRS in order to avoid additional penalties that will only increase over time. The one exception is that practices participating through an organization participating in a Medicare's Shared Savings Program ("Medicare ACO") may have reduced requirements (e.g., they can avoid the PQRS penalties by this participation). Practices need to understand that PQRS is the building block for achieving other value-based programs and the level of penalties are significantly greater than readily understood overall as the following chart illustrates:

Year	PQRS	EHR	VBPM I	Sequestration	Total
2015	-1.5%	-1.0%	-1.0%	-2.0%	-5.5%
2016	-2.0%	-2.0%	-2.0%	-2.0%	-8.0%
2017	-2.0%	-3.0%	-4.0%	-2.0%	-11.0%
2018	-2.0%	up to -1.0%	-4.0%	-2.0%	up to -13%

On top of this, the Health and Human Services department (HHS) developed the Health Care Payment Learning and Action Network – this is an attempt to develop more standardized approaches to determining value-based programs and to encourage other purchasers of care (insurers and employers) to adopt these approaches. In other words, while the penalties are currently tied to Medicare reimbursements, it is likely they will apply to other insurers payments as well in the not-too-distant future.

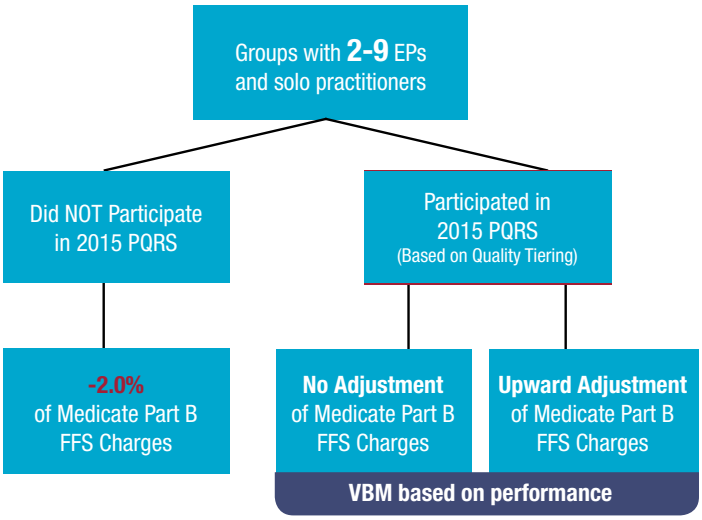
(continued on page 11)

PQRS: The Tip of the Iceberg in "Value-Based Reimbursement" (continued from page 10)

The Value Modifier program (VBPM) is a new program. It impacts practices with more than 100 providers in 2015 and will impact all practices in 2017. The VBPM provides for payment differential based on the quality and efficiency of care and is applied at the tax ID number level.

Through this VBPM program, CMS is producing a Quality and Resource Use Report (QRUR) for each practice. To access this, each practice must sign up with IACS to access their reports as the following: **http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/IACS/index.html**. In addition, to review a sample QRUR report, go to: **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2013-QRUR.html**.

To the right is an illustration of how PQRS impacts the Value Modifier program (this is for 2017 for groups of 1-9 providers; the negative adjustments are more significant for groups of 10 or more providers):



There are a number of ways to report PQRS but having an EMR for the practice is almost becoming a necessity. In addition, practices will need to rely increasingly on developing templates to insure compliance with these programs.

Finally, with the elimination of the hated SGR program, Congress has enacted that all of these programs be rolled into one program beginning in 2019—the Merit-Based Incentive Payment System (MIPS). Accordingly, we anticipate that over the next few years, these programs will begin to be integrated in advance of this 2019 date—this is positive for physician practices (due to the complexities of each of these individual programs).

In conclusion, despite the complexity, value base arrangements are here to stay. As we become more accustomed to these programs, practices will become more adept in administering these programs and higher performing practices will be rewarded economically.

A Message from Joe Fifer, HFMA National President:

Welcome to a New Chapter Year

BY JOE FIFER, HFMA NATIONAL PRESIDENT

Greetings HFMA Chapter Leaders,

I was happy to see so many HFMA chapter leaders in attendance at LTC! Thanks to all who took the time to join us in San Antonio! I hope that you found it a worthwhile experience and that you left invigorated to start work on activities in the new year! A number of requests from chapter leaders have come in asking for a summary of my presentation at the opening general session where I outlined several opportunities for all HFMA chapter leaders.

A full slide deck is available to download for your information, but here are some highlights from my session:

- Our industry is not shrinking. As consolidation and realignment continue, there will be fewer hospitals but health care overall is changing, not shrinking. Care is shifting from inpatient to outpatient and jobs are shifting from hospitals to other settings.
- American population demographics are changing.
  - By 2044, the Census Bureau predicts that no one racial group will have a majority share of the total population, and we will then officially become a majority-minority nation. The United States will officially become a plurality of racial and ethnic groups.
  - Another way the population is changing is that it's aging. While the overall population is aging, the work force is getting younger.
  - In 2014, Millennials ages 18 to 34 represented about 36 percent of the workforce. In five years, that number will be more than 45 percent. Millennials are already the single largest generation in the workforce.
  - Millennials are different from baby boomers. They change jobs more often. They have less tolerance for "paying your dues" and a long lead time to get ahead.

HFMA is changing in three key ways:

- We are ***diversifying our membership*** from many standpoints.
- We are ***transforming the membership experience*** to keep pace with a changing world, and to ensure that membership appeals to all of our members, including those we are starting to recruit.
- We are ***innovating to ensure that we stay relevant*** in a changing world.

I also issued a **Membership Challenge:**

- Five years from now, HFMA has to look different than it does today. It needs to be less hospital-centric and more representative of the changing healthcare industry and the changing demographics of our workforce and our population.
- Currently, we have more than 40,000 members, a number that has stayed fairly constant over the past few years. It's time for membership to grow. We should look to the other two circles—to physician groups and to health plans—for that growth.

On behalf of all of us at HFMA, thank you for your willingness to lead your chapters during a time of tremendous change, both in the industry and within the association. Your outreach efforts and your willingness to try something new are what will keep HFMA strong and ensure that we remain a vital and relevant organization throughout this time of transformation in our industry.

Of all the strategic partnerships going on in the industry today, none is more important than the partnership between the national and local levels of our association. That partnership is one of the things that makes our association special and sets us apart.

Coordinated Documentation Will Bolster Coordinated Care

BY J. STUART SHOWALTER, JD, MFS, CONTRIBUTING EDITOR, HFMA LEGAL & REGULATORY FORUM

As healthcare reform takes hold, coordination of care across the continuum is becoming more important than ever. That ideal underlies accountable care organizations (ACOs), the meaningful use standards for electronic health records, pay for performance (value-based purchasing), ICD-10, and other market-driven and regulatory phenomena. The intent, of course, is to eliminate medical errors, improve quality and efficiency, and reduce costs.

For a truly coordinated care system to exist, however, there must be coordinated documentation, according to Sharon Easterling, president/CEO of Recovery Analytics in Charlotte, N.C. Easterling dreams of the day when medical record documentation is consistent no matter the provider and no matter the payer type.

Holistic Documentation

Easterling says, "I call this concept 'holistic documentation.' It would be a system in which the patient's diagnosis reads the same in the physician's claim for an office visit and the hospital's claim for an inpatient stay."

Easterling cites the example of a patient with chronic systolic congestive heart failure (CHF). Currently it is not uncommon to see "chronic CHF" on the hospital's claim and "CHF, unspecified" on the Part B claim, she says. "Wouldn't it be nice if both the Part A and Part B claims read simply: "CHF, chronic, systolic"?

She gives another example. Without holistic documentation Mrs. Smith might have an inpatient claim with a diagnosis of "DM [diabetes mellitus] w/ peripheral neuropathy" and a physician office claim showing "DM unspecified; peripheral neuropathy, unspecified." These variations can trigger audits and claims denials.

Such discrepancies are not inevitable; they are an accident of history, resulting from different payment models for inpatient and outpatient services that evolved over the years. Easterling says, "The different payment methodologies and regulatory requirements for Part A versus Part B have led to 'silo thinking.' The hospital is concerned with its revenue cycle, the physician is concerned with office billing, and seldom do the two meet."

Times Are Changing

A few years ago, the dichotomy between fiscal intermediaries and carriers was eliminated in favor of Medicare Administrative Contractors (MACs). Easterling thinks this change augurs for more consistency between Part A and Part B billing. "Given that various market forces are changing the way we provide care, we should work to change the way we document that care," she says. "But even though Part A and Part B now share a MAC, there is currently no requirement for the documentation to be consistent between the two."

However, physician office documentation is often required to support an inpatient stay, and in addition, CMS is looking at denying Part B claims if the related Part A claims are denied. "Imagine if your documentation was more consistent across Part A and Part B. This could help you possibly avoid audits and denials because it would appear to the MAC that you are each treating the same condition because you are submitting the same codes for both," Easterling says.

Education Efforts Need to Expand

Good documentation is the key, and health information management professionals need to join forces to work toward the goal of holistic/collaborative documentation. We should be teaching the same requirements across our health systems and with our medical staffs (especially ACO members), according to Easterling, who shared a useful educational tool called "The 5 Ws for Documentation." **http://appealacademy.com/wp-content/uploads/2013/10/The-5-Ws-for-**

(continued on page 15)

Documentation-v1c.pdf

"If we extend our documentation improvement efforts to the Part B payment arena, this will provide us with better patient data and will assist with physician quality initiatives. It will help improve population health, especially in small towns and rural areas where physicians still round and see patients."

Improving documentation on the Part B side "can lead to improved documentation within Part A and allow our data to look cleaner as a health system and as a community," Easterling says. She points out that CMS has a new website on chronic conditions that focuses on data analytics more than ever and makes the data readily available. "This is an educational tool in its infancy and there is no end to where it can lead." **http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/index.html**

Easterling says clinical documentation improvement programs are present in many facilities but have not yet reached their full potential. She encourages hospitals and other providers to include improved documentation in their strategic plans. "Realistically, there will be some diagnoses that will never match, as signs and symptoms are all we have if a more definitive diagnosis has not been established. But chronicity and acuity of diagnoses do exist, and they should be fully reflected in the medical record."

Easterling firmly believes that improvements in documentation—especially working toward a holistic approach between Part A and Part B—can lead to fewer audits, fewer claims denials, and improved community health.

Nationally, Hospital Job Surge Continues into 2015

BY RICH DALY, SENIOR WRITER & EDITOR, HFMA WASHINGTON, D.C. OFFICE

A 2014 surge in hospital hiring continued this year with those organizations adding nearly 10,000 positions in January. Hospitals added 9,600 jobs in January, the Bureau of Labor Statistics (BLS) reported recently. The hospital jobs comprised a large part of the 38,000 positions added by the overall healthcare sector. Physicians' offices added 13,400 positions, nursing and residential care facilities added 7,000 jobs, and home health care services added 4,100. http://www.bls.gov/news.release/empsit.t17.htm. The healthcare sector averaged the creation of 26,000 jobs each month in 2014. January's hospital job increase followed a robust 2014, when those organizations added 47,300, according to BLS figures. The pickup from 2013 became even more pronounced with newly revised BLS job figures, which restated hospital jobs from flat to actually losing 18,000 positions that year.

A Trend?

"It looks like the trend's continuing," said Ani Turner, deputy director of the Center for Sustainable Health Spending at Altarum, who credited the increase to improving health insurance coverage for health reform and more employer-sponsored insurance as overall hiring picks up.

The Obama administration has credited the Affordable Care Act (ACA) with extending insurance coverage to 9.5 million through the public marketplaces and 10 million in Medicaid.

The jump in hospital employment could be making up for hospital cuts in 2013 but it also could serve as a harbinger of an increase in overall healthcare spending, which has undergone a historic slowdown since 2009, said Paul Hughes-Cromwick, a senior health economist at Altarum. Reports of surges in hospital utilization by for-profit hospitals throughout 2014 also could explain the need for more personnel and increased hiring, Turner said. That utilization increase has been especially sharp in states that had adopted the ACA's voluntary Medicaid expansion, Turner said.

M&A Impact Unclear

The latest jobs numbers came amid a growing number of reports that hospital merger and acquisition activity in 2014 slowed down from the previous year but was still robust. Irving Levin and Associates recently reported that there were 72 hospital transactions in 2014 through December 19, representing a 14 percent drop from 2013's 84 deals. That generally echoed a Kaufman, Hall & Associates report issued February 9 that concluded the 95 hospital transactions announced in 2014 were a slight decline from 2013. **http://www.hfma.org/Content.aspx?id=27259**

Hughes-Cromwick noted that hospital M&As are frequently touted as a way to create efficiencies and reduce the resources needed to provide care. "Any efficiencies that the M&A activities are creating are not showing up yet," Hughes-Cromwick said.

21st Annual Education Symposium, Executive Golf Outing

June 29, 2015

The CFO Committee of First Illinois Chapter HFMA hosted the 21st Annual Education Symposium and Executive Golf Outing on June 29, 2015, at Eagle Brook Country Club in Geneva, Illinois. The educational program theme was "Healthcare Transformation," featuring presentations and discussions with several industry leaders. "Once again this was such an incredible event for local healthcare executives and those who work with them," said Dan Yunker. "What we have learned over the years is that this event has value, and those executives who participate have had a good track record for coming back again in a following year."

The day began with opening comments from CFO Committee Co-Chairs Pat Moran and Dan Yunker, putting in context both the unprecedented pace of change in the U.S. healthcare industry and its inherent challenges, as well as underscoring the importance of events like these for industry leadership to engage in discussion with their peers, who will influence the way the industry responds and thrives through transformative times.

The speakers and program sessions supported and reinforced these themes. Doug McKinley, Psy.D., MCC Managing Partner at xcellero, presented on leadership. Doug engaged the group of senior leaders in a thought-provoking, interactive dialogue about how leaders must think and act driven by a set of core values with a focused approach at execution and balance. Doug's workshop provided an excellent foundation for dialogue among the group, and it was clear that the audience was engaged.

The energy continued with a panel discussion moderated by Dan Yunker featuring Dr. James Leonard, CEO of the Carle Clinic, Michael Eesley, CEO Centegra Health System, and Scott Stiener, CEO McNeal Hospital. Seldom is there an opportunity to hear CEOs talk about their strategies and challenges in the industry, but what made this panel even more impactful was the level of personal commentary provided by the panel members. Perhaps it was the result of the leadership session, or the anticipation of golf, but the panel members all seemed energized and relaxed, sharing personal experiences to demonstrate successful leaders understand that while it is critically important to be good at your job, it is more important to live by the principle that they are people first. Each speaker in one way or another acknowledged the responsibilities they have to their communities, and to their employees, and that sometimes "work" and "life" are not easily separated.

Before the audience broke for lunch, FI HFMA President Adam Lynch recognized Dan Yunker for being recipient of the 2015 Innovation Award from the Small Business Advocacy Council (SBAC). This award is given to an individual who has demonstrated a true commitment to the small business community through the development of programs and services. Dan received the award in April, which was presented by Chicago Cubs Chairman Tom Ricketts. Adam presented Dan with an official Cubs jersey, emblazoned with Yunker's name and the number 21. The jersey was signed by Ricketts with a personalized note to Dan. Dan acknowledged that such awards come from the opportunity to work with so many great people in his company and as a volunteer in organizations like First Illinois HFMA as he recognized so many leaders in the room. Kudos to Dan on winning such a prestigious award!

After lunch, it was time for golf. Early morning rains moved away, and although a few light sprinkles continued on and off throughout the day, they got the round in. A networking reception followed, and the general vibe was that it was a very special day all around. Also of note, for the second year in a row there was a hole in one. Chad Beste, partner at PBC Advisors, LLC, got a hole in one on Hole #3. Last year, Jennifer Powers of Powers & Powers shot a hole in one.

21st Annual Education Symposium, Executive Golf Outing (continued from page 18)

Our distinguished Panel discussing Leadership, Driving Transformation, and insights and experiences in today's marketplace

Adam Lynch presents Dan Yunker with Cubs jersey from Tom Ricketts/Cubs Chairman in recognition of Dan's 2015 Innovator Award from SBAC

Chad Beste celebrates his 2015 Hole In One with Adam Lynch and Jennifer Powers (Jen hit a Hole in One at the 2014 CFO Symposium); what are the odds of that happening 2 years in a row?!

Pat Moran, your host of hosts, making sure everyone is having fun and all is in order

Your FI HFMA 2015-2016 Officers & Board of Directors:

Officers:

President: Adam Lynch, Senior Director, MCHC

President Elect: Mary Treacy-Shiff, Vice President Finance, Advocate Good Samaritan Hospital

Treasurer: Richard Franco, Vice President & Chief Finance Officer, Northwestern Medical Group

Past President: Carl Pellettieri, Principal, Impact Healthcare Services

Board Members

David Tomlinson, CFO, Centegra Health System

Andy Scianimanico, Director of Revenue Cycle, Northwestern Memorial Healthcare

Kim McMahon, Senior Vice President, First Midwest Bank

Greg Kain, Regional Operations Manager, Integrated Project Management

Lana Dubinsky: Director, Sales & Business Development, American Medical Association

Louis Papoff, CFO, Chicago Health Systems/ Tenet Healthcare Corp

Congratulations to Carl and the entire 2014-2015 FI HFMA leadership team for an excellent year, and best wishes to Adam and the entire 2015-2016 FI HFMA leadership for the year that is to become!

2015-2016 FI HFMA Officers & Board of Directors

HFMA Event Summary

FI HFMA Annual Meeting & Transition Dinner

July 9, 2015 at Metro Club

Every summer FI HFMA leadership hosts a dinner for leaders and members at large to celebrate the Chapter Year that has concluded and the new Chapter Year that begins on June 1. Once again this year it was held at the Metro Club Chicago, and once again it was a memorable night to reflect on the past year's achievements and to set the vision for the coming year. Another highlight of the Annual Meeting is the presentation of the FI HFMA Scholarship Awards.

Adam Lynch was installed as the new FI HFMA President, as was the 2015-2016 FI HFMA Board of Directors. Carl Pellettieri, FI HFMA President 2014-2015 was celebrated and recognized along with the rest of the 2014-2015 Chapter Leadership for their achievements, including the presentation of the five (5) awards bestowed on FI HFMA at the annual National ANI in June (see above related ANI article).

Vince Pryor, Chair of the FI HFMA Scholarship Committee, presented the 2015 FI HFMA Scholarship Awards to this year's recipients:

Becky Breuer
Emory University, Atlanta
(Daughter of Gary and Kelly)

Alexandra Dye
Southern Adventist University, Chattanooga
(Daughter of Pamela and David)

Andrea Lillig
John Brown University
(Daughter of Jerry and Jori)

Maureen Sanderson
University of Illinois, Champaign/Urbana
(Daughter of Brian and Mary)

Saryu Sanghani
University of Wisconsin, Madison
(Daughter of Kailas and Dhiven)

Vince Pryor presents the 2015 FI HFMA Scholarship Awards

Carl Pellettieri celebrates one of the many 2014-2015 FI HFMA awards with Brian Washa and Gary Breuer

FI HFMA Wins Big at HFMA Annual National Institute (ANI)

Orlando June 22-25, 2015

Your First Illinois Chapter received several national awards at the annual Chapter President's Dinner held in June at the national HFMA Annual National Institute (ANI).

HFMA's Awards and Recognition Program is designed to provide incentives and recognition of chapter activities to achieve results as defined by the Davis Chapter Management System (DCMS) policy. It is intended to focus chapters on important activities that add value for members or the Association while simultaneously encouraging innovation and improvement. Six award groups are identified:

- The Robert M. Shelton Award for Sustained Chapter Excellence
- The Helen M. Yerger Special Recognition Award
- The C. Henry Hottum Award for Educational Performance Improvement
- Awards of Excellence for Education, including: •The Sister Mary Gerald Bronze Award of Excellence for Education
- The John M. Stag Silver Award of Excellence for Education
- The Charles F. Mehler Gold Award of Excellence for Education
- Award of Excellence for Improved Chapter Performance
- Awards of Excellence for Certification: Bronze, Silver and Gold Levels
- Awards of Excellence for Membership Growth and Retention: Bronze, Silver and Gold Levels

FI HFMA was recognized for the following awards and achievements, including three (3) Yerger Awards:

- Collaboration– Certification committee initiated joint education with Greater St Louis Chapter (Tim Stadelmann and Bart Richards co-chairs)
- Gold Award of Excellence – Membership growth and retention (2.7% growth) (Lana Dubinsky, chair)

FI HFMA was awarded Yerger Awards for the following:

1. Provider Executive forums- Innovation (Gary Breuer and Brian Washa)
2. Managed Care symposium – Collaboration (Cathy Peterson and Denise Cameron, co-chairs)
3. Membership recruitment and retention (Lana Dubinsky)

Congratulations to Carl Pellettieri for his tireless leadership as Chapter President this year, and the entire FI HFMA Board and Officers. A special thank you to all of you that volunteered your time and talent to make this happen! We wouldn't be who we are without all the chapter volunteers who commit to our success. Thank you! We had a truly outstanding year that was clearly recognized by HFMA National. We are continuing to find ways to improve our service to our members and to be recognized at the National Institute made us all proud.

HFMA Event Summary

FI HFMA Spring Summit Recap

April 21-22, 2015

FI HFMA hosted its 2015 Spring Summit on April 21-22, 2015, at Hilton Indian Lake in Bloomingdale. This year's theme was "Driving Transformation" and featured two days of educational sessions coupled with a full Exhibitor Hall and several Networking Events for Summit participants.

Day 1 of the program kicked off with "Market Transformation: The Anatomy of Revenue Cycle 2.0". Keynote speakers included: Charles J. Ditkoff, Vice Chairman and Head of Global Healthcare Corporate and Investment Banking, Bank of America Merrill Lynch, James A. Zadoorian, Ph.D., President, ARxChange, and Lou Porn, National Principal, Deloitte Consulting.

Day 2's opening presentation was "Managing Medicaid Expansion" and included Keynote Speakers Keith Kudla, President & CEO, Family Health Network, John Narenberg, Vice President, Physician Services, Advocate Healthcare, and Dan Yunker, President & CEO, MCHC.

Both days of the Spring Summit included educational tracks on Revenue Cycle, Treasury, Fundamentals of Health Care, and Driving Transformation. Networking events included a "Cubs v. Sox Fan Night" at Izzy & Moe's Sports Bar, where attendees were subject to that night's Cubs/Sox game; also the very popular "Beer & Wine Challenge".

Once again the Summit format provided FI HFMA members access to top notch educational sessions, networking and social opportunities, and a wide variety of industry vendor exhibits across a two-day period in a local setting.

Go Beyond: HFMA National Theme for 2015-2016 Chapter Year

GO BEYOND

This year's national HFMA theme is "Go Beyond". The theme was by National HFMA Chair Melinda S. Hancock, FHFMA, CPA, who explains its meaning below:

In the past, American health care was built on the fee-for-service payment system. Today, we know that system does not promote the high-value care that patients and other care purchasers demand and that providers want to deliver. We are going through a long transition to transformation—a transition that will require us to go beyond our current payment system which is increasingly being phased out. Finance leaders today must go beyond the ways of the past to succeed in the new era of health care.

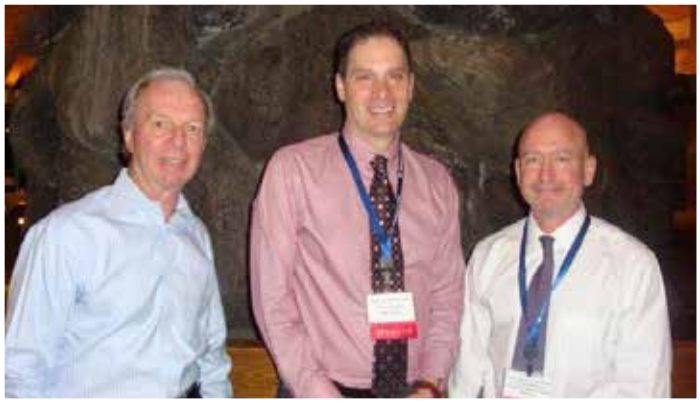
- In a time when key industry stakeholders are realigning at an unprecedented pace, finance leaders should go beyond old assumptions about traditional roles and responsibilities and collaborate with others to meet industry challenges together.
- In a time when pressures to resolve longstanding industry problems are mounting, finance leaders are challenged not only to meet but to go beyond expectations and deliver results that will set the bar ever higher for all of us.
- In a time when emerging care and payment models offer vast untapped potential, finance leaders should go beyond traditional mindsets to identify and seize the opportunities that abound during times of change.
- During this time, HFMA is also challenged to go beyond well established and proven methods of the past of learning, communications, membership composition and educational offerings.

When we commit to embracing change, our achievements—and the healthcare system that we are shaping—will go beyond our expectations.

We are all going through a long transition and transformation—a transition that will require all of us to go beyond. And through your service as a volunteer leader, I am confident that together we will accomplish great things for our industry and our communities. You already go beyond through your HFMA service and leadership in these dynamic times and you set a lasting example of what this theme means in actions, much more than words can express.

I want to remind you how much your efforts are appreciated. On behalf of the HFMA National Board of Directors, I want to express our gratitude, thank you for going beyond and I look forward to working with you throughout the coming year.

Spring Summit Attendees Enjoying Some Networking Time.



Day 1, Keynote Speakers, Charles J. Ditkoff, Vice Chairman and Head of Global Healthcare Corporate and Investment Banking, Bank of America Merrill Lynch, James A. Zadoorian, Ph.D., President, ARxChange, and Lou Porn, National Principal, Deloitte Consulting.

Day 2, FI HFMA President Carl Pellettieri working the crowd.

Day 2, Keynote Speakers, Keith Kudla, President & CEO, Family Health Network, John Narenberg, Vice President, Physician Services, Advocate Healthcare, and Dan Yunker, President & CEO, MCHC

Welcome New Members

Mary Kate Barraco
Senior Contract Administrator

Michael Blair
Van Ru Credit Corporation
Director of Vendor Management and TPO

Patti Carey
Centegra Health System
Revenue Cycle Project Manager

Bryan Foster
Centegra Health System
Decision Support Manager

Teresa Krafcisin
Centegra Health System
Manager-Accounting

Giovanna Losacco
Advanced Resources
Strategic Account Manager

Alice Smith
Centegra Health System
Supervisor of Financial Clearance Center

Tina Sviland
Northwestern Medicine
Manager Admitting and Registration

Kathleen Swire
Centegra Health System
Contract Administrator

Angela Teer
Centegra Health System
Patient Access Director

Stephanie Van Herzeele
Centegra Health System
Treasury Manager

Todd Weniger
Centegra Health System
Contract Manager

Matt Stone
Northwestern Memorial HealthCare Manager

Timothy Rivelli
Winston & Strawn, Partner

Kathryn Sanderlin
Novation, LLC
Portfolio Executive

Jeffery Calhoun
Northwestern Medicine
Manager, Patient Accounting

Shandra Lett
Northwestern Medical Group
Operations Coordinator, Patient Accounting

Jonathan Ortiz
Northwestern Medicine
Operations Coordinator

Marquita Rush
Northwestern Medicine
Manager, Patient Accounting

Diana Cano
Northwestern Medical Group
Operations Coordinator

Pat Gilmore
TransUnion Healthcare

Deborah Sharpe
The CCS Companies
Vice President National Business Development

Sabina Strzeminska
Northwestern Medicine
PB Manager

Stephanie Ortigara
VHC, Inc.
Operations Analyst

Erin O'Neill
JP Morgan

Jeff Leibach
Navigant Associate Director

James Anthony
OST, Principal

Cathy Marchlewski
Northwestern Memorial Healthcare
Manager SBO Patient Accounting Payment Recon, Refunds & Cash Applications

Nicole Parkinson
MedeAnalytics
Associate, Client Services

Tina Reagan
Northwestern Memorial Hospital, Manager, Admitting and Registration

Paul Searle
The Claro Group, LLC
Senior Consultant

Matt Evans
Monroe Capital
Managing Director

Bryan Beaudoin
The Claro Group, Manager

Andrew Campbell
Novack and Macey LLP

Megan Sorensen
Crowe Horwath
Healthcare Consultant

Crystal Agee
Northwestern Medicine
Managed Care Contract Specialist

Lori Brown
Patina Solutions
Managing Director

Andrew Conklin
Northwestern Memorial Hospital

Joe Lotysz
Invesco Municipal
Research Analyst

Brendan Stewart
First Trust Advisors
Municipal Analyst

Karen Szerszen
Allstate Investments
Senior Credit Research Analyst

Mark Whitaker
Northern Trust, Second VP, Municipal Research Analyst

Matthew Menning
American Medical Association

Kavya Chillapalli
Northwestern Medicine
Manager of Operations, Radiology

Kate Goodwin
Integrated Project Management
Business Development Executive

Mark Figura
Huron Consulting Group
Healthcare Consultant

Debra Ryan
Kaufman, Hall & Associates, Inc.
Vice President

Timothy Courtney
Mobile Aspects

Abhijeet Dumbre
Nitor Infotech Pvt. Ltd
Manager-Business Development

Analise Masciola
EnableComp
Business Development Executive

Patricia Jackson
Department of Health and Human Services
Administrative Officer

Cathryn Johnson
PBC Advisors, LLC
Senior Healthcare Consultant

James Blake
Kaufman, Hall & Associates, Inc.
Managing Director

Scott Schrader
Accretive Health Senior Vice President, Sales

Debbie Darrah
MBOS Inc., Director of Business Development

Ben Grover
Korn Ferry, Principal

Joseph Sidrys
Strategic Sourcing Results
Senior Consultant

David Melone
Bolder Healthcare

Declan Frye

Michael Farrell
Treasurer

Gary Wagner
Beacon Health Strategies
Network Manager

Janelle Haslett-Brousse
Nell Haslett-Brousse
Senior Consultant

Michael Walker
ZirMed

The First Illinois Chapter Sponsors

The First Illinois Chapter wishes to recognize and thank our sponsors for the 2015-2016 chapter year. Thank you for all your generous support of the chapter and its activities.

Platinum Sponsors

Harris & Harris
PNC Bank
Principle Valuation

Gold Sponsors

Array Services
Besler
Citi
Crowe Horwath
Enable Comp
Fifth Third Bank
GE
OST
PBC Advisors, LLC
Plante Moran
UCB
Vaughn Holland

Silver Sponsors

American Appraisal
Clear Balance
Capio Partners
Grant Thorton
McGladrey
MDS
Parallon
Passport
Triage
Wells Fargo

Bronze Sponsors

Amerinet
Mcare
Medical Business Bureau
Performance Services
American Express
Avadyne Health
Bank of America
Bottom Line Services
Cirius Group
Conifer
DGA Partners
Doxo
EY
HBCS
Healthcare Insights
HealthCare Payment Specialists
Impact Health Services
Lubaway Masten
Medical Business Associates
MiraMed
On Plan
Pavillion Group
ProAssurance
SS&G Healthcare Chicago, LLC
State Collection
Strategic Reimbursement
Tatum

First Illinois Speaks
HFMA's First Illinois Chapter Newsletter

Publication Information

Editor 2015-2016
Jim Watson ..... 630-928-5233 jim_watson@pbcgroup.com
Shane Ramsey ..... 312-515-7854 sramsey@healthgrades.com

Official Chapter Photographer
Randy Gelb ..... 847-227-4770 rgelb@mbb.net

Sponsorship
Chad Preston .....615-414-1025 cpreston@avectushealth.com

Design
DesignSpring Group, Kathy Bussert kbussert@designspringinc.com

HFMA Editorial Guidelines

First Illinois Speaks is the newsletter of the First Illinois Chapter of HFMA. *First Illinois Speaks* is published 4 times per year. Newsletter articles are written by professionals in the healthcare industry, typically chapter members, for professionals in the healthcare industry. We encourage members and other interested parties to submit materials for publication. The Editor reserves the right to edit material for content and length and also reserves the right to reject any contribution. Articles published elsewhere may on occasion be reprinted, with permission, in *First Illinois Speaks*. Requests for permission to reprint an article in another publication should be directed to the Editor. Please send all correspondence and material to the editor listed above.

The statements and opinions appearing in articles are those of the authors and not necessarily those of the First Illinois Chapter HFMA. The staff believes that the contents of *First Illinois Speaks* are interesting and thought-provoking but the staff has no authority to speak for the Officers or Board of Directors of the First Illinois Chapter HFMA. Readers are invited to comment on the opinions the authors express. Letters to the editor are invited, subject to condensation and editing. All rights reserved. *First Illinois Speaks* does not promote commercial services, products, or organizations in its editorial content. Materials submitted for consideration should not mention or promote specific commercial services, proprietary products or organizations.

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
October 2015	September 10, 2015
January 2016	December 10, 2016
April 2016	March 10, 2016
July 2016	June 10, 2016