First Illinois Speaks

hfma healthcare financial management association

HFMA's First Illinois Chapter Newsletter

October 2012

LEADERSHIP MATTERS

Highlights and Recap First Illinois Chapter Events begin on page 17

Captured News, Events & Updates

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President's Message

Dear First Illinois Chapter Members:

On behalf of the officers and Board of Directors of your chapter, I'd like to welcome you to what we believe will be a rich, fulfilling and valuable chapter year.

The November election will potentially affect the future of the Affordable Care Act as well as other outstanding healthcare issues. To navigate this uncertainty, providers need to focus on building the core capabilities to develop agile organizations and to improve value. Our chapter year is structured to provide you with new information and insights to help you be agile during these changing times.

Value by Attending our Educational Seminars and Webinars

The education committee kicked off the chapter year in June with a working dinner meeting for committee chairs involved with several of our upcoming programs. Thank you to Brian Katz, Tom Faure and Colleen Murphy for organizing this event and furthering the development of our Program Planning Guidebook.

In August, the chapter hosted its annual "HFMA 101" event. We had 40 new members attend as the current leadership team communicated to our new members the "Value of HFMA." Thank you to Vince Pryor and Pat Moran for their guest appearances as past presidents and sharing with our new members their personal journeys with HFMA.

We have also continued to be enriched through monthly webinars covering regulatory and financial reporting updates, cost-saving ideas and other relevant topics. These webinars are only possible by the hard work of Adam Lynch and the Webinar Committee. Thank you to Adam and the First Illinois HFMA Webinar Committee.

As of the publication of this newsletter, we are preparing to launch our fall educational seminars: Hospital Operational Improvement Opportunities, Revenomics 101, and our annual Accounting and Reimbursement Program. We hope all of you will mark your calendars to attend.

Value by Networking

Beyond all the education the chapter provides, one of our greatest strengths is through the networking

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opportunities created by attending chapter events. Our annual rewards and recognition / installation of officers was held in July at Petterino's in Chicago. Eighty-five members and guests were treated to a fine meal and exquisite camaraderie. Thank you to Pat Moran for his leadership last year and for organizing this successful networking event.

In August, the chapter hosted its annual baseball game event at Cellular Field. It was a beautiful night for baseball, and the White Sox halted its losing skid despite Derek Jeter's hot hitting, defeating the Yankees by a score of 9 to 6. Thank you to Tim Heinrich for his work in organizing the club seating and ensuring the event went off without a hitch.

In September, the Golf Committee held their annual golf outing at Glen Eagles in Lemont, which provided a great golf experience, especially for the casual golfer. Thank you to Sandi Costler, Colleen Murphy and the Golf Committee for their hard work in organizing a successful outing.

I hope that you enjoy this issue of your newsletter and that you are making the most of your membership in the First Illinois HFMA chapter. We have many great events planned, and I look forward to meeting you.

My goal is to ensure you are "Getting **Value** from your First Illinois HFMA Membership." If there is anything you need, please don't hesitate to reach out to me.

Tracey Coyne
2012 – 2013 First Illinois, HFMA Chapter President

Legislation Connection

BY ANDREW DIGATE, MBA, HEALTHCARE CONSULTANT, PBC INC.

End of the Year Legislative Drama in Springfield and DC: Lots of Cans in the Road

As we mentioned in our last column, the specter of change will be upon us in Springfield as we will see an unprecedented number of new legislators heading down to the state capital. Legislative boundaries were redrawn ("remap") so this election will present itself with many contested elections. Additionally, we will see a number of elected officials leaving Springfield altogether.

In August, the Governor called both houses into a special session to consider pension reform. While there were many proposals put forth, the pension reform effort failed on that day. It was no coincidence then that S&P followed suit and lowered the state credit rating from A+ to A. Senate President John Cullerton told the Chicago Tribune editorial board in mid September that pension reform won't happen until January 1 at the earliest. He cites the lack of votes to do it before then. House Speaker Mike Madigian has also indicated that January might be a more likely time to change pensions. The elections in November can quickly change this discourse, especially since Governor Quinn wants this issue addressed sooner than later. The Governor threatened to use his bully pulpit to push this issue, even relying on the Web to promote his message via www.saveourstate.illinois.gov.

The pension issue will not be solved overnight and there will be significant give and take or "horse trading," to use the political vernacular, to get this issue solved. Absent of an influx of new taxes as a result of business growth, at the end of the day, budget shortfalls are solved by program cuts and/or tax increases. Healthcare professionals will need to keep a keen eye on Springfield as this pension issue will have direct impact on their bottom line and in providing care to their patients.

While the state continues to work through pressing issues and an upcoming election, federal legislators are operating in a near parallel universe, including the specter of a lame duck session before national legislators are sworn into office in 2013. They, too, are back home attempting to work every corner of their district in anticipation of the election in November. Key issues, though, are simmering back in DC that impact everyone, including healthcare professionals.

To get a national "in the trenches" perspective on these issues, we took the opportunity to speak with two people clearly in the know: Jeb Shepard, Government Affairs Representative from the MGMA's Governmental Affairs office in DC, and Chad Mulvany, a technical director for HFMA and also based out of that association's Washington, D.C., office. Chad is responsible for creating content covering reimbursement issues and healthcare reform. He also is a regular contributor to *hfm magazine* and speaks frequently to local chapters. Jeb and Chad and their respective colleagues are well versed on Beltway issues and are sought out from legislative leaders and their staff for input on healthcare matters.

Both agree that while healthcare legislation will take a back seat to economic issues, getting the federal fiscal house in order before the end of the year will be a priority issue. Related to that are the Bush Tax Cuts, which are set to expire at the end of the year. Both concurred that a short-term extension could be agreed upon as part of a larger compromise, but at this point in time, there is nothing definitive at all. "The results of the election in the fall could give a better glimpse on how the Bush Tax Cuts will be addressed," said Chad.

Back in 2011 when national policymakers were at the proverbial financial cliff, they passed the Budget Control Act of 2011, which, among others things, addressed the huge debt crisis facing this country. One of the stipulations within the bill was "sequestration" or a carrot and stick in the form of automatic increases to the debt and a decrease to Medicare in 2013 if Congress failed to produce a deficit reduction bill worth $1.2 trillion in cuts. Since Congress failed to get the needed cuts, all eyes, including the healthcare industry, are on the nation's capital as to the potential of a 2% Medicare cut. "There will probably be an agreed upon short term solution whereby leaders decide to hold off the cuts until later into 2013," said Chad.

SGR is set to expire at the end of the year as the "temporary" fix put in place on December 31, 2011, will expire again on December 31, 2012. "It is highly unlikely that Congress will provide a permanent repeal of the SGR in 2012, however a temporary fix is likely to take place this year so that Congress can tackle the issue in 2013," said Jeb.

As we look toward the election and the remainder of the year right now, healthcare professionals should not expect a solution to these many issues. Regardless though, as belt tightening continues in DC and Springfield and lame duck sessions are clearly in order, we in the healthcare industry still need to be well aware of the potential decisions and their impact.

Andrew Digate
Healthcare Consultant, PBC Inc.

Article provided in collaboration with:

IL MGMA
Illinois Medical Group Management Association

Introduction: Region 7 Regional Executive

HFMA greetings to Region 7

My name is Ron Snyder and I am honored to introduce myself as your Region 7 regional executive for the June 2012 through May 2013 chapter year. I am a member of the McMahon-Illini Chapter as well as your representative on the HFMA Regional Executive Council.

The purposes of HFMA's regional executive program are:

- To serve as the primary volunteer and policy link between the chapters and HFMA National;
- To assist chapter leaders in serving members;
- To foster a dialogue and effective communications between the national and chapter levels of HFMA;
- To represent the needs and interests of chapter leaders to the HFMA board and management, and
- To encourage chapters to collaborate and help other chapters.

I would like to extend a sincere thank you to my predecessor, Connie Bishop, for her service as our regional executive this past year and for being a wonderful leader, organizer, and mentor. She represented our region extremely well and has set the stage for continued success. In addition, please welcome Mike Nichols from the First Illinois Chapter as your regional executive-elect.

HFMA's Region 7 is made up of five very strong chapters. They are: First Illinois, Indiana, McMahon-Illini, Southern Illinois and Wisconsin. Congratulations to each and every one of them for completing a successful year with outstanding achievements honored at this year's Annual National Institute in Las Vegas in June. All five chapters in Region 7 earned awards. What a testament to the dedication and commitment of our chapter leaders to providing exceptional service to their members.

This year's chairman's theme is "Leadership Matters." I have had the privilege of working with each of your chapter presidents over the past year, and more recently each president-elect at HFMA's 2012 Leadership Training Conference. I know your chapter leaders have you, the members, in mind when they develop their chapter goals. However, every member in HFMA has the opportunity to be a leader on a daily basis, even when you perform in routine, everyday situations to facilitate organizational change during these uneasy times in healthcare. As regional executive, I commit to being engaged in the success of each chapter during the coming year by making myself available as consultant, collaborator, and biggest supporter!

Ron Snyder

Thank you for the opportunity to serve Region 7, the best region in HFMA! I look forward to working alongside your chapter leaders and meeting many of you as I travel around the region. My telephone number is 800-973-9890 and my email address is rsnyder@avadynehealth.com. I welcome your questions and comments, any time.

The Impact of Reform on I.T. Investments

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

Recently, I had the opportunity to spend valuable time with a team of leaders from CDW Healthcare team to discuss the environmental and economic impact of healthcare reform on the industry. Several interesting perspectives on key trends that are shaping I.T. investments were contemplated.

As hospital executives look to navigate the U.S. healthcare delivery system into the next year, there's a tremendous transformation taking hold. Never has there been a time of greater change, marked first by the U.S. Supreme Court's decision to uphold the Affordable Care Act and more recently by the release of the CMS' final requirements for Stage 2 meaningful use. Stage 2, which will begin as early as 2014, requires that providers have the necessary health information technology infrastructure in place to improve healthcare quality, efficiency and patient safety.

The use of certified EHR technology in a meaningful way is one piece of a broader solution, but today's I.T. leaders must look at the bigger environmental and economic issues that will challenge their ability to navigate a healthcare delivery system that is not sustainable. For a typical hospital, at least 50 percent of its net patient revenues come from Medicare and Medicaid reimbursement, another 40 percent from commercial payers (i.e., employer group health coverage), and the balance from charity contributions.

While the grip of healthcare reform tightens its hold, we're seeing increased trending toward downward reimbursement. We're essentially saddled with value-based fee-for-service models for the next five years, as the system grapples with ways to reduce unnecessary test and procedures, and patient readmissions. Many health systems and physician practices will experience distress. During such times of transformation, we'll see growing demands on capital as health systems struggle to improve quality while decreasing costs across the continuum of care.

Healthcare organizations that ultimately emerge as winners will be the ones that adopt new technology and embrace innovation. Consider the following ways that the regulatory climate will shape 2013 healthcare I.T. investments – and how providers can stay ahead of the curve:

- **Diagnosis right the first time.** The buzz around ICD-10 is fueled by the frenzy to provide an accurate patient diagnosis upfront – whether through an x-ray, MRI, PET or lab work – to prevent the need for duplicative testing, which Medicare, Medicaid and commercial providers will no longer cover. Because the sheer complexity of ICD-10 coding is so stymying, we'll start to see a trend toward automated coding systems. Technologies that can facilitate throughput of patients, physician documentation and recording of events will be in high demand and of high value.

- **Electronic information exchange.** I.T. infrastructure must support healthcare connectivity so that providers can openly and securely promote health information exchange in compliance with Stage 2 criteria. Many healthcare organizations already are, or soon will be, involved in a regional or state HIE in order to support ACOs and coordinated care initiatives. For example, the MetroChicago HIE currently has 80 percent of Chicago-area hospitals under a letter of intent to participate in a five-year implementation to connect the Chicago healthcare market. Once they get their operational policies in place, several will start exchanging data as early as November 1, 2012. While HIEs may not reap a short-term ROI, they help further a long-range strategy for clinical integration that ultimately will be a key component to help reducing redundant tests, costly readmissions and will be the backbone to managing at risk patient populations.

- **Tighter alignment between I.T. and financial leaders.** We'll be seeing CIO and CFOs partnering more closely than ever in the spirit of ensuring that the I.T. investments made today bear a greater return tomorrow. The focus is appropriately shifting from immediate ROI and more toward building a long-term strategy based on healthcare connectivity that creates value for the healthcare organization and for the patients it serves. Our current healthcare industry is undergoing the same transformation parallel to what banking and financial institutions experienced years ago. A transformation that forever changed the consumer's expectations of banking. With a greater emphasis on healthcare connectivity and customer service, healthcare I.T. and financial executives together will need to evaluate technology that not only reduces costs, but promotes quality of care and communication with other providers and with patients themselves.

- **Greater patient accountability.** The growing digitization of personal health information is leading to greater accountability on patients to self-manage their wellness. Under Stage 2, patients will be able to view and download their electronic health records and communicate with their providers online through secure electronic messaging. As insurance co-pays increase and consumers become more active participants in selecting their healthcare plans, the onus for ensuring that a redundant test doesn't occur will fall more to the patient. Consumers will select healthcare organizations that have the technology in

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The Impact of Reform on I.T. Investments

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place to facilitate this exchange and enable them to directly engage with providers to cut costs, bolster care delivery and boost service and satisfaction levels.

As we move into 2013, healthcare executives will need to think and work their way through a whole new world that's driven not only by healthcare reform, but by the consumer. CEOs, CIOs and CFOs must set the vision now to steer their healthcare organizations through the next decade. They must be equipped to understand the strategic value of their I.T. investment and how they will operate in a connected healthcare community. This will necessitate a stronger partnership with a technology vendor who offers an integrated package of solutions and services to not only help healthcare leaders achieve their goals, but also stay within budget, accelerate timelines and ensure successful execution. Healthcare I.T. innovation that reduces cost, yet enhances revenue, is among the essential survival strategies needed to thrive in a dramatically changing healthcare delivery system.

Dan Yunker

VP & CFO, Metropolitan
Chicago Healthcare Council

Self Pay Receivables: What You Don't See

BY JERRY SWARZMAN AND DAVID JUPP, MCARE SOLUTIONS, INC.

Many of us remember years ago when Self Pay accounts were only an incidental aspect of the hospital's entire accounts receivable. Consequently, the focus, effort and resources of the patient accounting department were directed at the third party receivable, and if the third party receivable was properly managed and maintained, the operations of the business office would be considered a success. In the "old days," the difficulties and frequent failures in collecting the Self Pay receivables were easily absorbed by third party receivable management success. But that was when patient accounting life was less complicated.

And that was before the advent of compliance, economic hardships and rising unemployment, excessive use of emergency rooms for primary medical care, and the more complicated insurance coverage guidelines became prevalent factors contributing to a growing Self Pay population …and Self Pay accounts receivable. The Self Pay receivable, previously "swept under the rug," has become the kind of lump that people now trip over.

To respond to the escalating Self Pay problem, a new era of tools and strategies has arrived to combat the Self Pay collection problem: credit card processing at point of service, timely outsourcing of Self Pay accounts, new pricing methods for patient charging, and increasing financial counselor and Medicaid eligibility work-up resources to attempt to resolve the problem. Yet in spite of this wave of fixes, we continue to experience rising unpaid Self Pay accounts, charity care, and the inevitable bad debt. So the challenge continues. What are we still missing?

Hidden Third Party Coverage

In spite of the most contemporary eligibility systems being used by hospitals, third party coverage is not captured by the hospital on anywhere from 3% to 8% of the active Self Pay receivables. That means that hospitals are dunning patients and their guarantors when they should be billing and collecting from a third party payer who is legally obligated to pay for the care provided. There are several major factors that cause this dilemma:

- Emergency Room registration is limited by the ER setting and the type of patient encounter. EMTALA laws restrict the financial conversation with the patient, who arrives for care oftentimes unprepared for the financial interview, and departs without a proper financial discharge.
- Eligibility systems are structured to perform a "one record to one payer data base" ANSI 270 inquiry to confirm active third party coverage. If that inquiry is misdirected, the research process ends instead of being redirected to a more relevant third party data base.
- The patient's demographic information must be precise to confirm third party coverage in an automated eligibility verification protocol. So often a patient's demographics change due to changing patient circumstances or status, yet the patient's identification and/or insurance cards do not reflect those changes. In other circumstances, human error in the registration process leads to erroneously recorded or deficient information that compromises the eligibility search.
- And when all else fails, hospital systems and processes, including Self Pay outsourcing alternatives, cannot compensate for the circumstances that must be addressed to "correct and re-route" the eligibility confirmation process and to successfully seek out third party coverage, should it exist.

Therefore, the contemporary patient accounting operation is adding a new weapon to improving the collectability of Self Pay receivables: Payer Verification. The incentive is based on the fact that it's easier to collect from a third party payer than a delinquent patient creditor, and it's compliant too.

This change in the Self Pay account process is simple and straight forward, and the cost of this change is absorbed through the positive results that it generates. Here's how the modified Self Pay account process would work boiled down to a few fundamental steps.

1. **The First Statement – The Customer Service Cycle:** Regardless of whether the hospital insources or outsources its Self Pay statement and collection cycle, a first statement is sent to the patient for the outstanding debt. Of course the hope is that the patient will pay the amount due, but oftentimes what surfaces are issues and questions from patients/guarantors challenging the statement and/or its content. Missed patient insurance is common among other types of complaints or questions, and patients will call with third party coverage information that was not captured during registration. The Customer Service area receives this information, and will update the patient's account and redirect the billing process.

   But then there is the issue of returned mail, which quickly becomes overwhelming or expensive and time-consuming to research and correct. Hospitals with active emergency rooms and outpatient volumes can experience up to a 20% return statement rate. Even with the best intentions, it is not feasible for a patient accounting department to dedicate enough resources to this problem. The result is an inactive receivable ("stop statements"), an inflated Self Pay receivable, and runaway processing costs. This situation segues logically into the next step in the process.

2. **Data Scrubbing, Payer Verification and Receivable "Scoring"** – The end of the initial Customer Service cycle (approximately 28 days) isolates those Self Pay accounts that will pose a collection problem. These accounts have reached the end of the expected initial payment cycle and remain unpaid, and timely action is needed to avoid an impending bad debt. There are three tactics to be employed at this critical juncture:

   - Ensure that the patient demographic data related to the unpaid receivable is as "clean" as possible, thereby maximizing the possibil-

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ity of success for the subsequent two actions.

- Search for third party coverage that may have been missed during registration and Customer Service, as collecting from a third party is the preferred option to an unresponsive or "lost" patient.

- Determine the patient's payment history in order to pursue the patient without insurance through more intensive, professional collection processes.

Therefore, providers increasingly are referring unpaid Self Pay receivables that have aged into the 30 to 60 day aging bucket to payer verification firms specializing in both data scrubbing and third party searches.

Patient Demographic Data Scrubbing – The First Phase: The unpaid Self Pay receivable review begins with data cleansing, as data improvements augment both the third party search and, if unsuccessful, the subsequent patient collection process. The payer verification vendor will receive the hospital's Self Pay receivables, and reformat that data to interact with publically available data bases to find the correct demographic and, in some cases, employment information. Data cleansing will produce corrected names, addresses, phone numbers and social security numbers, and confirms the validity of any newly found information to avoid incorrect patient identification.

Third Party Search and Scoring – The Second Phase: With corrected information, the payer verification vendor will create the ANSI 270 and begin a strategically organized series of queries to the third party payer groups, which typically include Medicare, Medicaid, Commercial Insurance, and Workers Compensation and No Fault insurance (the latter group searches for "E" diagnosis code encounters). This is an interactive process at certain levels when, for example, various iterations of the social security number with prefix or suffix are used to query the Medicare Common Working File. The third party search process cascades downward through the payer hierarchy until coverage is found or the process ends.

For the more ambitious patient accounting operation, the payer verification vendor will assign a credit score to those individual patient accounts where insurance was not found. This score, determined by the patient/guarantor's credit and payment history dealing with healthcare bills, allows the provider to properly manage the true Self Pay aging receivable, where the cost/benefit ratio of the collection strategy can be optimized for the categories of scored receivables.

3. **Uploading Corrected, Scored and Third Party Information –** The Third Phase: Data cleansing and third party searches normally require ten working days or less to complete, and the hospital should expect to act on the results of that effort in a timely manner. Results are normally available via the payer verification vendor's user-friendly website, or can be uploaded from the vendor's system in an automated arrangement if volumes warrant. The key, or course, is updating the host patient accounting system before the collection effort resumes or is escalated.

4. **The Billing and/or Collection Process Begins – The Final Phase:** Timely host system updating avoids compliance violations when patient/guarantor dunning activity is strictly prohibited by the payer.

Updating the host system initiates third party billing within payer timelines, and creates timely third party statistics that may be used for cost reporting and other third party filing. The updating of the host system also allows the patient accounting process to proceed with the following strategic advantages:

- If third party coverage is found, the correct third party billing improves the patient relationship, the third party relationship, the collectability of the impacted receivable and the quality of the statistics that billing generates.

- Following the Self Pay account processing sequence presented above allows the business office to maintain a simpler and more manageable Self Pay account operation, while improving the operation's overall effectiveness and results.

- Regardless of whether the hospital insources or outsources the subsequent collection effort, the collection process immediately improves. Bad addresses and phones numbers have been dramatically reduced, thereby augmenting the intent and effectiveness of the next mail and telephone collection contact. Scoring ranking is considered in the subsequent collection strategy.

- Payer verification vendors charge a percentage of what the hospital is able to bill and collect from the newly found insurance coverage, thereby covering the cost of this process improvement through recovered third party reimbursement.

- Finally, the analysis of receivable performance, performed by patient accounting management and intended to isolate weaknesses in the accounts receivable process, will generate more meaningful and accurate results. The opportunity for operational improvements, using the input of payer verification vendor reporting, allows management to implement changes to reduce future registration errors and oversights.

Unfortunately, the era of the Self Pay receivable is here to stay, bringing with it a tougher agenda to manage this difficult collection challenge. But patient accounting management is not without options, and as heads turn to focus on bringing this receivable under control, more tools will be made available to carry the day. The patient accounting manager must keep the vision contemporary and be ready to change as the industry moves forward.

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Financing Technology: It's Like Marriage Counseling

BY SHEA HUSTON, WINTHROP RESOURCES

How would you rate your organization in terms of its ability to adapt quickly to the fast paced changes and uncertainty in healthcare? How are these changes impacting your business strategies? And thus, your technology strategies? What is your organization's strategy for mitigating these risks?

Most CIOs would agree that it is their primary responsibility to ensure the organization's technology strategies stay aligned with the business strategies. However, business strategies are changing so quickly (for reasons beyond their control) that the underlying technology that supports those business strategies are impacted. How does he or she keep up, plan for the inevitable - obsolescence - and account for this risk?

Most CFOs would agree that it is their primary responsibility to ensure the fiscal resources of the organization are used wisely and in such a way to support the business needs and future growth of the organization. In today's world, that means (among other things) planning for the ever-increasing line item(s) in their capital budget called technology. As technology spending goes up, and as its critical role in the organization increases, so does the financial risk of technology obsolescence to the organization. When asked almost every CFO will tell you their organization has "an insatiable appetite for capital." Every dollar spent on technology is a dollar not available for other capital needs.

What we have here are the makings of a classic marriage counseling session: the CIO needs to spend and the CFO needs to conserve. Who is right? And how do we maintain strong alignment amidst these competing interests?

Enter technology leasing.

One of the best financial tools that has gained broad acceptance within healthcare organizations is technology leasing. Leasing technology, as opposed to using capital, affords today's healthcare organizations many benefits:

* Re-deploy capital for strategic and growth oriented initiatives
* Lower the financial and operational risks of technology obsolescence
* Improve ROI of technology projects by matching the costs with the benefits
* Maintain alignment between the business strategies of the organization and the underlying technology needed to support it
* Maximize the value of every dollar spent on technology
* Address the strategic needs of the organization that often give way to the urgent: do more with less

As many healthcare organizations move to the "cloud," leasing provides a similar benefit by allowing organizations to treat their technology as a utility. How many CFOs do you know that pay their phone bills or electric bills three years in advance?

There are many other reasons healthcare organizations elect to lease technology, among them:

Strategic complement to banking relationships.

Growing healthcare organizations need multiple sources of capital to meet increasing capital demands.

Reduce costs

Utilizing technology beyond its useful life can lead to inefficiencies as well as increased support and maintenance costs.

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Financial Diversification

Many organizations prefer to have technology assets off their balance sheets as that may help with debt covenants, reimbursements or bond ratings and is more consistent with how the equipment behaves.

Liquidity

Unlike bonds or other cumbersome long-term debt instruments, leases can often be changed overnight while avoiding the additional time and cost of attorneys and oversight committees. This offers CFOs more liquidity in their overall capital structure as well as more control over cash flows.

The "Financial Cloud"

The "Financial Cloud" allows end-users to pay for the use of technology without giving up control or flexibility in customizing how and where the technology services are delivered.

Former General Electric CEO Jack Welch said, "Smart companies will use any opportunity to take change and make it into a competitive advantage. A company's fundamental strength is its ability to adapt to change, rather than predict it. Don't hide from it, grab it and do something with it!"

As most would agree, change and uncertainty is the "new normal" in today's healthcare marketplace. To the extent that you believe this will impact your organization's business strategies, and thus your technology strategies, it might be time to seek some marriage counseling. Leasing is a great option to consider.

Contact Shea Huston, Winthrop Resources today at 952-656-7563 or shuston@winthropresources.com to learn more about how financing technology can boost the bottom line of your organization.

Shea Huston

Innovator Shaping the Future of Healthcare

INTERVIEW OF BADRI NARASIMHAN, PRESIDENT & CEO, CHARGE MD, LLC

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

Dan: All of us have experienced mobile technology change in our daily lives – everything from buying movie tickets to depositing checks in a bank by taking a picture. How has it impacted the physician?

Badri: *The impact on the routine tasks of a physician is yet to come. Most of the applications that are available for a physician today are reference applications. Instead of carrying a book or a "cheat sheet," a physician may access apps to evaluate the scores for various risk assessments or look up codes for billing. Some use mobile apps to access their office network and then turn around and launch a full-fledged desktop software via a mobile device or a tablet. All of these are in the infancy of mobile apps to come.*

There are products with the ability to take a picture of the barcode on the bracelet of a patient and from that gather the necessary demographics of the patient (through an interface with the hospital) and digitally send the facesheet to the practice, register the patient and enter professional fees in seconds. Whereas this sounds futuristic, when done well, it is the simplicity of the process that drives adoption. Instead of taking a picture of the check to deposit, the physician takes a picture of the barcode and enters charges – it can literally be that simple.

Dan: Why would a hospital want to provide an interface to enable this kind of billing?

Badri: *There are several reasons. For one, an easy billing process for physicians makes it incredibly easy to do business at the hospital. If I as a physician practice at a few different hospitals, I am going to gravitate my patients towards the one where it is the easiest to do business. Technology is certainly not the make or break factor in such a decision, but a lot of little things add up to a decision and such technology becomes yet another factor in making a good hospital great.*

Dan: We have seen many hospitals focus on their physician relationships. How inclined are hospitals to implement technology to increase ease of doing business?

Badri: *Great question. Products that only improve the lives of physicians are likely to meet with resistance. If a product can both cater to the physician group and be beneficial to the hospital, there is a good opportunity to provide value to all. For example, a highly efficient process for the hospital to make the ICD9/ICD10 diagnosis codes in the employed and independent physician's professional fee process consistent with the hospital's DRG-based billing process may be delivered by a technology that also makes it easy to do business at the hospital. This is a win-win. Today, the hospital employs several documentation specialist nurses who either round with the physician or round separately to identify opportunities for improving documentation, identify DRG changes, review it with the physician and complete the review. This process is ripe for innovation. As we move from fee for service to fee for value, documentation becomes king and any inconsistency between physician offices and hospitals becomes the enemy.*

Dan: Now that you mentioned ICD-10, what, if any, are ramifications of ICD10 on software at the hands of physicians today?

Badri: *The changes are dependent on how the software vendor chooses to tackle ICD10. The physician should be spared the effort of training in billing. Physicians should search for codes in plain English (e.g., hip pain) and the complexities of which code it maps to behind the scenes are dealt with by our product. For example, pain in the left and right hip are one and the same in ICD9 but the physician should not need to know or care about it. The same should hold in ICD10. When there are additional questions or clarifications, technology should walk the physician through them in English and keep the complexity away from them.*

Dan: When will mobile technology start impacting other staff members around the hospital such as nurses, pharmacists, etc.?

Badri: *Pioneering work is being done by many players there as well. Nursing labor is one of the top three expense items for a hospital P & L and yet the budgeting for that follows a crude algorithm of counting the number of patients in the bed at midnight on a day. The activity during the day when there were 50 admissions and 50 discharges compared to one where there were five and five are not even comparable…but based on today's industry metrics, the expectation would be that the costs for both days be the same! This metric (nursing labor per patient day) is ripe for innovation as well.*

Some day in the future, each nurse may carry an app that will be like a weather forecast. Instead of showing how likely it is to rain in the next four days, it will show how likely it is that this particular nurse will be called in over the next few shifts.

Dan: Any closing comments?

Badri: *We are in the new age of shared hospital and physician interests. What is good for the hospital is now good for the physician and vice versa. There are several technology solutions that cater to extracting maximum value from this reality. Hospital administrators should seek to find the best solution for their needs. The time is now for leaders. The followers may lose market share and may be forced to adapt trends instead of gaining competitive advantage by moving early.*

Payer Accountability: A Critial Element in Your Denial Management Process

BY STACY SMITH, ESQ. AND GLORIANN SORDO, ESQ. TRILOGI, INC.

Denial management has been all the buzz in healthcare finance for over a decade now. An entire industry of IT services and solutions has been built for the purpose of tracking claim denial reasons, identifying the source of the denials, and quantifying the financial impact of the denials. Hospitals around the country have formed denial management teams or committees to review and analyze the information gathered by these IT solutions and to implement processes to prevent future denials from occurring. Yet the denials and lost revenue opportunities keep occurring. Why? A lack of accountability.

Enough has been said about the need to hold the various department heads within a hospital organization accountable for their department's role in the hospital's revenue cycle. However, there is not enough attention placed on the payer as an important stakeholder in your hospital's revenue cycle and the need to hold the payer accountable for its actions. Claims denied in error, delays in reviewing appeals, and untimely release of payment on overturned denials all contribute negatively to your bottom line. To make your denial management efforts even more effective, we suggest the following:

1. Understand the payers' commitments.

In order to do business, a payer commits to transact business according to various guidelines. It is important that your staff members understand that these guidelines exist and that they govern how claims are to be processed. These guidelines are set out in:

- The state insurance rules and regulations
- The summary plan description
- The members' policy documents
- The contract with the hospital

2. You can't manage what you don't measure.

Payer report cards can be a very powerful tool. Develop key metrics to measure your payers' performance and share the results with the payers, as well as your internal stakeholders, on a monthly basis. Metrics to be measured, quantified based on volume and dollars, include:

- Number of denials received
  - Drilldown to the denial specifics:

 (continued from page 10)

  - Type of denial: clinical versus technical
  - Type of service/admission: ER, inpatient, outpatient
- Number of denials appealed
- Number of denials overturned/upheld
- Number of accounts and dollars with appeals and payments outstanding more than a specified period of time
- Average time between denial overturn date and payment issue date

Everyone wants to be top of the class. Compare payers in the key metric measurements and share the results with each of the payers.

3. Holding others accountable is 90% communication, 10% consequences.

Consistent communication with your payers is vital to decrease denials and increase revenue capture.

- Provide the report cards to your payers on a monthly basis.
- Establish a set schedule of meetings with your payers to review the results of the report cards; the frequency of the meetings should be dictated by the results of the report cards, not the convenience of the payer.
- Prepare the agenda for the meetings and lead the discussion; requires additional work on the hospital's part but there are tremendous payoffs.
- Meetings by conference call can be effective but consider holding face- to-face meetings on a quarterly basis.

4. Establish a collaborative relationship with your payers.

While it would appear that in a denial management process a provider and a payer would have differing objectives, there is common ground in that both parties want to avoid or reduce the administrative expenses associated with the claims appeal process. Leverage that common ground to develop mutual understandings of factors resulting in denied claims, such as differing interpretations of contract terms, and to streamline processes.

Allowing the payers to dictate the denial resolution process will result in continued unjust denials and aging accounts receivable. Implementing a system of consistent payer accountability is another means of taking control of your denials and will allow consistent communication to ensure your payers are effectively and fairly administering clinical and reimbursement policies. The end result will be a decrease in claim denials, thereby a decrease in write-offs of uncollectible dollars, and an increase in cash collections.

Gloriann Sordo, Esq., Assistant Vice President of Quality and Legal
Gloriann joined Trilogi in April 2008 as Managing Attorney. In this role, she was responsible for overseeing teams of attorneys and claims representative working and managing inventories across various product lines. She was promoted to Assistant Vice President of Quality and Legal where she closely works with the various departments ensuring Trilogi standards, procedures, and results exceed client expectations. She promotes continuous improvement to make sure Trilogi methods are cutting edge at expediting resolution for assigned inventory. Prior to joining Trilogi, Gloriann was the Managing Attorney for the Southeast Operations of AHC, Inc., a national healthcare receivables management company. Gloriann received her Bachelors in Business Administration with a minor in Information Technology from Stetson University, DeLand, Florida, and her Juris Doctorate from Nova Southeastern University Shepard Broad LawCenter, Ft. Lauderdale, Florida and is licensed to practice in Florida.

Stacy Smith, Esq., co-founder of Trilogi
Stacy was responsible for the overall performance of Trilogi's client engagements. Prior to founding Trilogi, Inc., in May 2007, Stacy was Vice President of Operations at AHC, Inc., a national healthcare receivables management company. During her 11 years with AHC, Stacy held various positions including senior attorney in the Problem Claims and Legal Departments, research attorney, and Vice President of Client Management and Program Implementation. She published several articles on healthcare topics and was a frequent speaker at tradeshows and hospitals on patient access and insurance legal reimbursement issues. Stacy received her Juris Doctorate from Loyola University School of Law, New Orleans, Louisiana, and is licensed to practice in Virginia and New Hampshire.

The Power of Choice: When Less is More

BY VICKIE AXFORD AUSTIN

When I was a child, I celebrated my birthday with a free ice cream cone offered by Baskin-Robbins, also known as "31 Flavors." My birthday ritual included going to Baskin-Robbins with my family and choosing from a vast and ever-changing array of flavors. After long and careful deliberation, I would choose mint chocolate chip. Many years have gone by and guess what? I still choose mint chocolate chip.

The abundance of choices and our freedom to choose may be overrated, according to Sheena Iyengar, a prominent social psychologist at Columbia Business School and the author of *The Art of Choosing* (Twelve, 2010). Dr. Iyengar and her colleagues have done research on the cultural implications of choice, why people make the decisions they make and what drives us to choose. Whether we're choosing among ice cream flavors or making more sobering choices related to health care or our careers, we may overstate the role of choice in our lives.

In an interview from "Knowledge@Wharton," (http://knowledge.wharton.upenn.edu), Dr. Iyengar shares why a multitude of choices don't always bring us what we want. "It turns out that we don't always recognize our preferences even though our choices are supposed to be in line with them," she says, citing research she's done with graduating seniors from the University of Pennsylvania. When asking the seniors what they wanted in a job at three different intervals, the students changed their answers along the way. In the end, the correlation between what they said they wanted at the beginning of the experiment and what they got when they graduated in May was "utterly non-significant." And the people who remembered what they originally said they wanted were less satisfied with the job offers they had accepted. "Maybe there is some truth to [what our grandmothers told us, that] happiness doesn't come from getting what you want, but wanting what you got," Dr. Iyengar says.

The pursuit of the American dream is based on some assumptions—that our choices are limitless, more is better and choices affirm our individuality and freedom. But the work shared by Dr. Iyengar challenges these assumptions. She did an experiment at a grocery store called Drager's, a "little Wonderland" of food options that carried more than 500 kinds of fruits and vegetables, 75 brands of olive oil and 348 different kinds of jams. To test the impact of choice on consumers, she set up a tasting booth in which they offered, first, six different flavors of jam. Later, they offered 24 different flavors of jam. While people tended to stop and visit at the booth with the 24 varieties, only 3% actually purchased jam from that booth. Of those who visited the booth with only six kinds of jam, 30% made a purchase.

"We always knew that our eyes were too big for our stomachs," Dr. Iyengar said. "Is it possible that our eyes are actually too big for our minds, too?" She goes on to cite instances of where, given too many options among financial products, employee participation in a 401(K) plan dropped 15%. Overwhelmed by options and exhausted by the volume of choices we make in our lives, we become disengaged. And this can have a powerful impact on us, not just as consumers baffled by 24 varieties of jam but also in our role as business leaders.

Past research has shown that employees report greater job satisfaction when given a high degree of choice. A recent article, "Tiptoeing Toward Freedom" in Columbia Business School's Ideas at Work blog (https://www.gsb.columbia.edu), reports that Dr. Iyengar and graduate student Roy Chua conducted experiments to test how giving employees autonomy and decision-making latitude can impact the perception of managers as leaders. Those leaders who offered their employees limited choices—"some options, but not too many"—were seen as more effective. Too many choices, however, gave employees the perception that their leaders were not as competent or conscientious.

"Employees think of those managers [who gave limited choices] as effective leaders because they feel that they have spent time thinking about their goals and have been more strategic…" Iyengar says. "In that situation, they think of the choices their managers have given them as empowering."

Whether you're a healthcare provider, offering choices to physicians and patients, or a supplier who supports those providers with a vari-

(continued on page 16)

The Power of Choice... (continued from page 15)

ety of products and services, *The Art of Choosing* raises provocative questions that could impact your business. Challenging assumptions around the "more is better" mentality might offer you new insights into the way you deliver those products or services. Consider this: in spite of offering 31 Flavors, historically 50% of Baskin-Robbins' sales are accounted for in just three flavors—vanilla, chocolate and strawberry ice cream. And perhaps another 1% in mint chocolate chip.

Vickie Austin, founder of CHOICES Worldwide, is a business and career coach and a professional speaker based in Wheaton, Illinois. She is honored to be a contributing writer for First Illinois Speaks, HFMA's First Illinois Chapter's newsletter. You can contact her at 630-510-1900 or vaustin@choicesworldwide.com.

Vicki Austin

HFMA Scholarship Winners

BY SLYLVIA SORGEL, SORGEL CONSULTING, LLC

For those of you who were unable to attend the wonderful Annual Recognition Dinner at Petterino's in July, we thought it would be worthwhile for you to know a bit about the 2012 winners.

This year, thanks to the generosity of our officers and board, we have FIVE awardees! Every year when I have the pleasure of participating in the Scholarship Committee meetings, my faith in the excellence of the young people coming up is strengthened. This year the choices were extremely difficult to make, but what a joy to read about and meet such exemplary students! Our 2012 winners were:

$1,500.00 winner - Kate McCole – Kate is attending the University of VA, Charlottesville where she will graduate with a Bachelor of Science Degree. Besides being an athletic medal award winner in H.S., Katie's community involvement has been extensive, including co-director for the children's Clinic Circle 80, which provides medical and dental care to impoverished children. She was also president of the Lutheran Youth Organization at her church. Her plan is to become a pediatrician. One of the reference letters sent on Katie's behalf said "With her work ethic, her intelligence and her shining personal qualities make her about the best investment a scholarship committee could make."

$1,500.00 winner – Hunter Standen – Hunter has not yet chosen a college but intends to pursue a career with the State Department or another government agency involved with international relations. One statement in his application letter really stood out as an indicator of his intellect and curiosity: "when I come across CNN on the computer screen I find it difficult to pull myself away as I am intrigued by the multitude of stories taking place around the world. When reading these stories I wonder what is left out of the article on purpose to preserve some government secret or confidential information." Hunter was awarded the exceptional history student award in his FRESHMAN year! One reference letter from a history teacher said, "I was thrilled at the opportunity to teach a potentially outstanding student, and my expectations were not only met but Hunter exceeded them tremendously."

Jsmes Moran

$2,000 winner – James Moran – James will be attending Boston University and is planning to major in psychology. Besides being an outstanding student and athlete, his community involvement speaks volumes about who James is, with over 100 hours of community service for organization. such as Temple Shalom Soup Kitchen, Chicago Food Depository and Juvenile Diabetes Research Foundation. A psychologist who James interviewed because of his interest in the field said that "James exhibits an intellect, reflectiveness and sensitivity well beyond his peers" and those characteristics came shining through in our scholarship interview.

Sarah Pryor

$2,500 winner – Sarah Pryor – Sarah will be attending her Dad's alma mater, Notre Dame. I couldn't possibly list all Sarah's extracurricular activities but just to cite a few, she participated all four years of H.S. as a Fall Festival volunteer for special needs community members and has served as a team member for the Bully Prevention Group for elementary students. She is a National Honor Society and was captain of her softball team (chosen by teammates and coaches). Her involvement in her parish includes too many activities to even list but one of particular note was a youth mission trip with Young Neighbors in Action in Detroit, Michigan in 2011. The campus minister at Marist H.S. says "almost every graduating class has one, the student you will actually miss. Sarah is that girl – the perfect blend of academics, leadership, communication skills and faith."

Amanda Zeisel

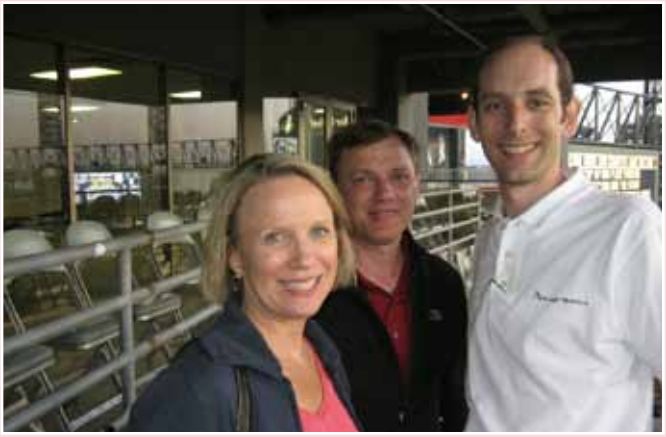
$4,000 winner - Amanda Zeisel – Amanda has not decided on a college yet but has already been accepted by top universities such as Ohio State, University of Wisconsin, the University of Georgia, Alabama, Minnesota, and , MN, and OSU. Her career plans include a major in microbiology and a joint PhD/MD graduate program to further study immunology and microbiology. Her future plans are to split her time between seeing patients and conducting medical research. Special recognitions/awards include but are not limited to AP Scholar with Honor, Indian Prairie Scholar and Prairie State Achievement Award in Science, Reading and Math. Amanda is deeply involved in her church and as part of that commitment, volunteers with EDGE, Feed My Starving Children and has served as a retreat leader for high school Catholics that were studying for confirmation. As part of her passion for medicine, she observed a cancer research lab at the Children's Research Institute in the Medical College of Wisconsin and learned about lab procedures and immunology. A reference letter from her English teacher stated, "She is a young woman with a bright and promising future and I can only wait to hear of all the amazing things she will go on to accomplish."

Annual Transition Recognition Dinner: July 19, 2012

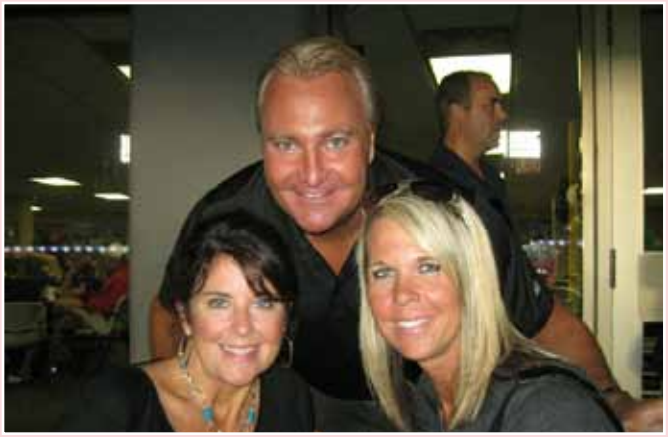
HFMA 2012 Installation Dinner, Education Chairs

HFMA 2012 Installation Dinner, New Officers and Directors

White Sox Game: August 21, 2012



HFMA 2012 White Sox Game



HFMA 2012 White Sox Game

Golf Invitational and Dinner: September 12, 2012

HFMA 2012 Golf Outine, Winning Team, J. Ostrow, P. Kopecki, S. Helfrich, and T. McKenna

Golf Outing, 5th Graders, TJ Cosler and Max Farley

HFMA Events

Save the Dates and Updates

Supply Chain Seminar Date Change

The Supply Chain Seminar has been rescheduled to November 30, 2012.

ANI 2012 Update

The 2012 ANI: The HFMA National Institute has come to a close. This year's conference was a success and we hope all attendees enjoyed a rewarding and insighful experinece. We encourage you to visit www.hfmaconference.org to find recaps of keynote speakers, special sessions, award presenations, photos and videos.

ANI 2013 Save the Date

Mark your calendars for next year's ANI event, which will be held June 16-19, 2013 in Orlando, Florida.

Worksheet S-10 Reimbursable Impacts

BY DAVID VERBARO

All hospitals have now had their first encounter with the new 2552-10 Medicare cost report forms. Although the cost reports have been submitted, the impact these changes to the cost report forms will have on a hospital's reimbursement remains to be seen. No worksheet has seen more alterations than Worksheet S-10. Hospital CFOs and reimbursement directors should understand how the changes to this worksheet will influence the amount of reimbursement they currently receive. So what is the potential impact the new S-10 will have on hospitals?

Until recently, the S-10 form had no reimbursement impact and, in fact, the Centers for Medicare and Medicaid Services (CMS) did not even require that hospitals complete the form. Starting in 2010, CMS has instructed all acute care and critical access hospitals to complete the form to calculate hospitals' cost of providing care for which they are not compensated. Going forward, Worksheet S-10 will play a vital role in the distribution of a hospital's Electronic Health Record (EHR) incentive payments and may be used in the calculation of future Disproportionate Share (DSH) payments.

To determine a hospital's uncompensated care costs on Worksheet S-10, a hospital records charges and payments, and calculates costs using the cost-to-charge ratio (CCR) from Worksheet C for the following:

- services to Medicaid patients
- services to SCHIP patients
- services to patients covered by a state or local government indigent care program
- services to patients who are given a discount under a hospital's charity care policy

In addition, Worksheet S-10 includes costs (again, using the CCR from Worksheet C) for:

- non-Medicare and non-reimbursable Medicare bad debt

Worksheet S-10 Impact on EHR Payments

A hospital's EHR payment is driven by the amount of charity care it provides. Higher documented charity care will result in a more substantial EHR payment. The hospital's uncompensated care amount consists of charity care and bad debt, both non-Medicare and non-reimbursable. This amount of uncompensated care is now calculated on line 20 of the 2552-10 Worksheet S-10. A hospital's individual charity care policy will determine what services are eligible for line 20. A less stringent charity care policy will most likely result in a higher amount of reported charity care. Accordingly, hospitals should continue to review their charity care policies, which are usually governed in part by state regulations. If a hospital fails to submit any information on the S-10, it may put EHR payments at risk. This omission could jeopardize millions of dollars in payments. Calculating EHR payments may not be the sole purpose of the Worksheet S-10.

Worksheet S-10's Possible Impact on Future DSH Payments

Beginning in federal fiscal year (FY) 2014 (October 2013) hospitals will receive only 25% of their current DSH payments. The remaining 75% (or most of it) will be included in an uncompensated care pool. A hospital will receive funding from this pool based upon its ratio of uncompensated care provided compared to the ratio of uncompensated care provided by all hospitals. The Medicare statute [42 U.S.C. §1395ww(r)(2)(C)(i)] states that "appropriate data" will be the basis for a hospital's amount of uncompensated care. CMS has not issued a rule specifying the specific data it will use. It seems very likely, however, that CMS will use data on Worksheet S-10 to calculate the amount of a hospital's payment from the uncompensated care pool. Regardless of the specific source of data, hospitals should begin to shift their focus from the current DSH methodology to refining their methods of capturing uncompensated care payments.

Hospitals will soon have to contend with an increased amount of hospitals eligible for these payments. Now is the time for hospitals to evaluate their charity care policies to determine they are in accordance with CMS regulations. Hospitals should ensure they have included all of the proper documentation to support their amounts, while also trying to maximize their share of the uncompensated care pool.

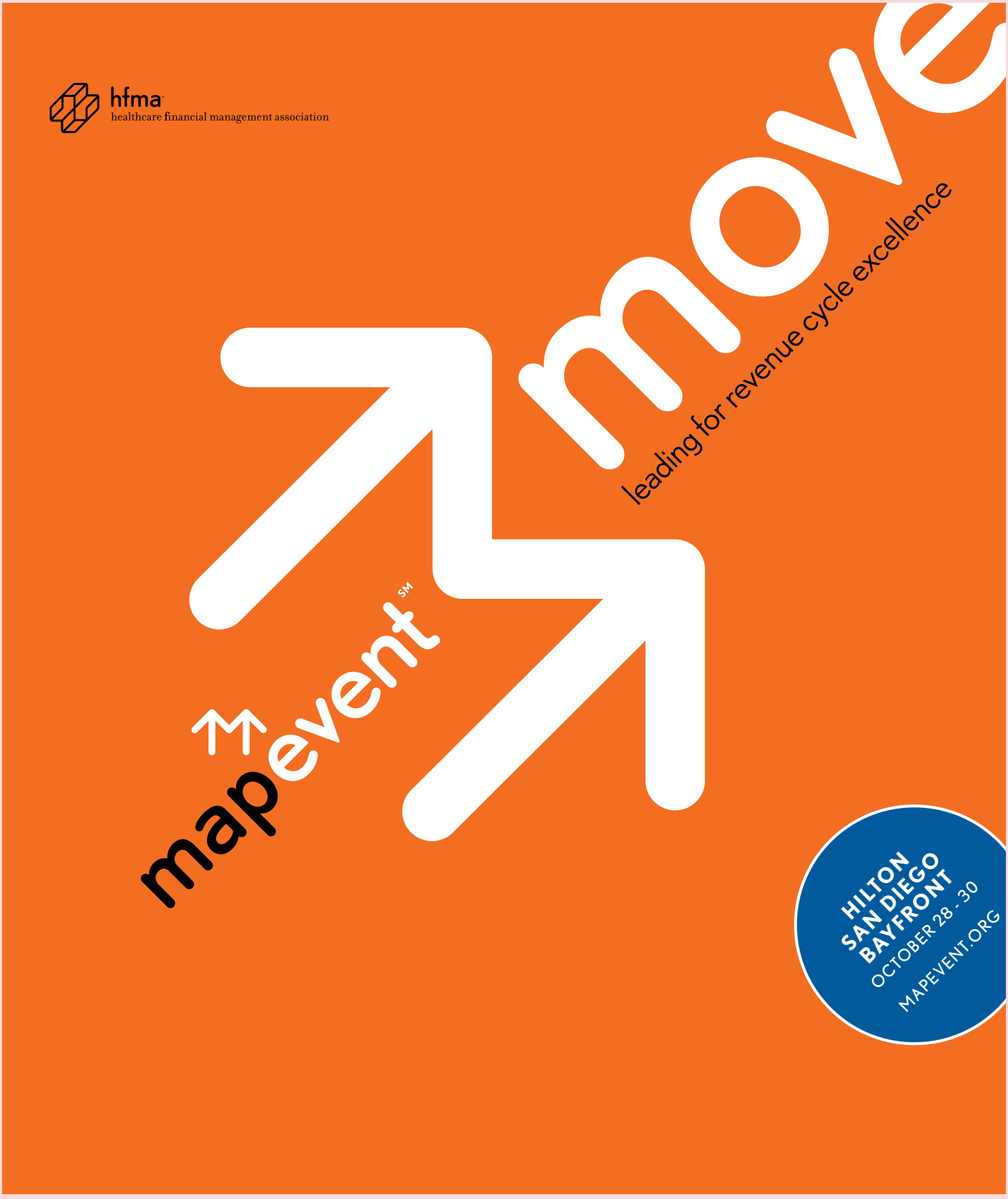
Conclusion

Hospitals have a significant number of issues to consider when completing their Worksheet S-10. These considerations include data collection, classification of uncompensated care, and various reporting requirements. With regards to data collection, hospitals will now have to determine who is responsible for obtaining the necessary information to support their amounts. Each line of the Worksheet S-10 may have its own interpretation. For example, hospitals will need to determine how they will record partial payments from charity care patients. Data collection will be a key factor in completing this form. Understanding the impact that this data will have on your reimbursement will be critical to maintain your current level of payment. Hospitals may have an additional opportunity to review their submission, but it is not certain, so careful preparation and review is essential.

For more information about the changes to the Worksheet S-10 and the impact on reimbursement, please contact David Verbaro at dverbaro@besler.com or (732) 392-8242

David A. Verbaro, Consultant, after working two years as an intern while attending college, Dave joined BESLER as a full time consultant in August of 2011. Dave has assisted each product line with a myriad of data analysis, claims analysis, compliance and financial reviews. Dave's main focus has been assisting hospitals in the preparation and review of their annual Medicare cost reports. In addition, he has assisted with Wage Index analysis and various reclassification projects. Dave is a member of the New Jersey Chapter of the HFMA and an active participant in both the Education and Reimbursement committees. Dave graduated from James Madison University with a Bachelor of Science degree in Accounting and is currently pursuing his MBA at Rutgers University-Camden.

MAP Event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Terri J Clever
Practice Manager
Aurora Eye Clinic, Ltd.

Chris Fielding
Vice President, Healthcare
PNC Equipment Finance

(continued on page 23)

Member Opportunity to Contribute

Are you new to First Illinois HFMA? A student member? Are you looking for an opportunity to contribute to the chapter and learn? We are looking for members to attend our seminars **– free of charge –** in exchange for providing "recaps" of the events for our newsletter. If you are interested, please contact Tim Manning via email at Newsletter@hfma.com.

Welcome New Members

(continued from page 22)

Violet Szczebak
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Melody Altman
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Anthony McAndrews
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Cancer Treatment Centers
of America

First Illinois *Speaks*
HFMA's First Illinois Chapter Newsletter

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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 2012	September 10, 2012
January 2013	December 10, 2012
April 2013	March 10, 2013
July 2013	June 10, 2013

First Illinois Speaks
HFMA's First Illinois Chapter Newsletter

event-filhfmaorg@comcast.net

Chapter Educational and Events Calendar 2012

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

Thursday, October 4, 2012
Revenue Cycle 101

Tuesday, October 9, 2012
Webinar: "Direct Bank Purchase of Section 501c3 Bonds" - JPMorgan Chase Bank, N. A. and Ungaretti & Harris

Thursday, October 18, 2012
Accounting/Reimbursement Program

Tuesday, October 23, 2012
Webinar: "Closing the Loop - Orders, schedulstration to clinical results" - Passport Health Communications

Friday, October 26, 2012
CFO Breakfast

Tuesday, November 13, 2012
Webinar: "Accessing Low Hanging Fruit Opportunities in Your Hospital to Achieve Dramatic Bottom Line Improvements" - Healthcare Insights

Thursday, November 29, 2012
Webinar: TBD

Friday, November 30, 2012
CFO Breakfast

Friday, November 30, 2012
OI Supply Chain

Tuesday, December 4, 2012
Webinar: Recent Mergers & Acquisitions Business and Legal Trends" - Ziegler and McDermott Will & Emery

Wednesday, December 6, 2012
Treasury Education Program

Tuesday & Wednesday, December 11-12, 2012
National HFMA Virtual Conference

Friday, December 14, 2012
CFO Breakfast

Tuesday, January 8, 2013
Webinar: "Electronic Medical Record Implementation: Lessons Learned and Leading Practices" - Chan Healthcare

Tuesday, January 22, 2013
Webinar: "Model for Commercial Value Based Purchasing with Quantifiable Results and Optimal Gain Sharing Potential" - Accountable Care Solutions Group

Friday, January 25, 2013
CFO Breakfast

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