First Illinois Speaks
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LEADING the CHANGE

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**News, Events & Updates**

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# Developing an Investment Strategy that Considers Enterprise Risk

BY CRAIG STANDEN, DIRECTOR OF HEALTHCARE ADVISORY SERVICES, SEI

Healthcare executives are facing an increasingly complex operating environment, where growing pressure on margins is resulting in greater reliance on investment performance of various asset pools to maintain a stable financial profile. Healthcare providers must take risks to grow and add value. At the same time, since the 2008 financial crisis, many organizations are focusing more time and attention on developing strategies to better withstand the impact of macro, systemic shocks, and respond appropriately should similar events occur in the future.

Risk is inherent in the pursuit of business objectives, and effective risk management is a key success factor in today's volatile market environment. The traditional asset-only approach to portfolio decision-making does not take into account the correlation among and impact of risks present across the organization. As such, the financial dynamics of healthcare systems and hospitals necessitate comprehensive, proactive and ongoing review of broader enterprise risks and more specifically the impact that asset allocation decisions and investment returns have on financial and operational performance.

As operating uncertainty has grown in the healthcare sector, management and boards are recognizing the benefits of closely linking strategy development with a better understanding of the associated risks. An Enterprise Risk Management (ERM) framework provides a useful construct to identify, measure, monitor and respond to risks present across an organization. For healthcare providers, there are four main components of enterprise risk:

- **Unrestricted liquidity** provides operating and working capital, has long-term growth expectations, and supports strategic objectives, including capital spending requirements. The unrestricted liquidity pools also carry risks associated with the allocation strategy.
- **Capital structures** of many providers are composed of various forms of debt, each of which

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## Developing an Investment Strategy that Considers Enterprise Risk

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has it's own risk profiles and interest rate sensitivity. In addition, financial covenants require providers to consistently meet defined financial performance thresholds or risk a potential default. And rating agency views on capital structure risks will factor into the credit rating and impact a provider's cost of or access to capital.

- **Operations/capital budgeting** risks encompass competitive positioning activities and execution of strategic initiatives, including spending needs and Affordable Care Act implementation, which drive financial performance and attainment of a desired rating level.
- **Defined benefit plans** have an additional set of risks for those that have them. Contribution requirements impact cash flow, and plan funded status will directly impact the balance sheet. In addition, the discount rate used to determined benefit obligations, as well as earnings on plan assets, are subject to interest rate sensitivity.

ERM is a systematic and strategic process that closely links organizational strategy, operations, finance and treasury. It is designed to identify potential events/risks that may impact the organization and helps prioritize and appropriately manage identified risks within the organization's defined risk 'appetite.'

Organizational risk 'appetite' is a key consideration in setting objectives and developing strategy, including asset allocation decisions. There are several factors that can help providers determine their own unique risk appetite.

- **Current risk profile** is an inventory of the level and range of organizational risks across various categories; some examples include financial, operational, market, and/or reputational risks.
- **Capacity for risk** is the maximum amount of risk that an organization can sustain and remain in business.
- **Tolerance for risk** is the acceptable amount of variation around the desired outcome.
- **Desired level of risk** represents the 'desired' risk/return profile.

There is no standard or 'correct' risk appetite, just one that is deemed appropriate for a particular organization after evaluating the trade-offs associated with having a "high", "medium" or "low" risk appetite. Once a risk appetite has been determined, it is important to align strategy objective and expected outcomes appropriately. A highly risk averse hospital would probably not feel comfortable with an 80 percent equity allocation; conversely, a health system with a tolerance for higher risk and volatility would probably not invest the lion's share of it's investment assets in Treasury bills and money market funds.

With clear or better understanding of the type of risks present across their organization, how these risks are correlated, and the tolerance or 'appetite' for risk, providers will be in a better position to make more informed decisions about strategic asset allocation.

Stochastic modeling is an important tool SEI uses to evaluate more broadly the impact of asset allocation decisions on financial performance and key financial metrics—including bond covenants—and more closely aligns asset allocation decisions to organizational goals and objectives. Using multi-year financial projections (ideally) and other data that covers each of the enterprise risk components noted above, stochastic modeling uses statistical analysis to generate probability distributions of expected outcomes under a range of economic environments, which helps highlight the risk/return profiles of potential asset allocation strategies.

Risk is inherent in the pursuit of business objectives, and effective risk management is a key success factor for any organization. ERM principles provide a model for identifying, measuring and monitoring enterprise risks to better enable you to achieve your organizational goals and objectives. Finally, a siloed, asset-only approach to allocation decision making will give you one answer, but not necessarily the right answer without taking into account the risks present across your organization and linking those decisions to broader organizational goals and objectives.

Craig Standen

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# Legislation Connection

BY CHERYL A. WESOLOWSKI, CHAIR

## State of Illinois Update from the IL-MGMA Legislative Committee

The 98th General Assembly finished in a flurry of vetoes and last minute bill signings by Governor Quinn. The gubernatorial election has been the focus of all things legislative in Springfield this session.

The IL-MGMA legislative committee has been watching the following bills in the State of Illinois Legislature:

### SB 1630: ANATOMIC PATHOLOGY BILLING

This amends the Medical Practice Act of 1987 and the Illinois Clinical Laboratory and Blood Bank Act: Prohibition on the mark up of anatomic pathology services. This mandates that a physician not performing the service, can only bill the patient a charge for specimen collection and transportation.

Current status: Governor Amendatory Veto. The bill had successfully passed both houses and was sent to Governor Quinn to sign. On August 5, Governor Quinn recommended the following changes in language to the bill. He would like the Department of Financial and Professional Regulation to have the authority to revoke, suspend, or deny renewal of a physician's license that is caught wrongfully marking up a patient's bill for indirect anatomic pathology services.

The bill was returned to the General Assembly. The General Assembly can take one of three actions:

1). Do nothing and the bill dies.

2). Vote to approve the Governor's changes in both the House and Senate.

3). Vote to override the veto, this requires 60 percent vote in both the House and Senate.

As of the writing of this article this bill is not yet scheduled for a hearing in either the House or the Senate.

### SB3409: DENTIST ADMINISTER VACCINES

On June 23, 2014, this bill was signed into law by Governor Quinn, amending the Illinois Dental Practice Act to add a provision that allows dentists with the appropriate training to administer vaccinations to patients 18 years of age and older pursuant to a valid prescription or standing order of a physician. The bill provides that vaccinations may only be administered for influenza, hepatitis B, HPV, and shingles. The dentist is required to document in the patient's dental record, provide notification to the primary physician, and enter it in the immunization data registry maintained by the Department of Public Health.

After the November election, we hope to see some meaningful healthcare legislation in the State.

The IL-MGMA Legislative Committee continually monitors all healthcare bills that are active in the Illinois State Legislature.

# President's Message

Hard to believe it, but 2014 is in the home stretch! The weather is turning colder, baseball season has turned to football season, and the transformation underway in our healthcare system is accelerating. I can't recall a more busy and exciting time in healthcare in the 30-plus years I've been in the industry. We continue to see rapid consolidation in our marketplace, including and especially in Chicago, and notably the proposed merger between Advocate HealthCare and NorthShore University HealthSystem announced in early September and the approval of the merger of Cadence Health and Northwestern Medicine. Health insurance options for uninsured, Medicaid and Medicare enrollees continues to rapidly evolve, placing significant new demands on provider revenue cycle management, throughput and "value-based purchasing" capabilities. Other reimbursement and cost pressures are mounting due to legislatively-driven changes to provider reimbursement in Medicare and Medicaid. And yet, costs continue to increase and employers and individuals are expressing shock at the premium increases they are being quoted for 2015. Strap in folks; the next couple years are going to be a wild ride!

First Illinois Chapter HFMA continues to strive to be a source of good information, education, and collaboration. Our Fall Summit 2014 held October 30-31, 2014 is a great example of that, as is our collaboration with HFMA National and other healthcare associations. In July we celebrated the conclusion of one successful chapter year and the beginning of another. I'd like to congratulate Dan Yunker, who handed the FI HFMA president baton to me in July, on a very successful year as chapter president. I'd also like to thank Dan for the excellent foundation he has built for me to expand upon, and for the guidance and support of our Board of Directors. FI HFMA continues to be one of the largest and most successful HFMA chapters in the country, thanks to the commitment of our leadership, and to our engaged membership. I am committed to keeping up that tradition of excellence as we move forward with this chapter year.

Now more than ever, HFMA represents an excellent resource for healthcare professionals to stay on top of their game, strengthen their careers, and expand their networking relationships. In the environment of "hyper change" we are in today, having access to best practices and content experts can help you help your organizations effectively and efficiently. So I encourage you to be engaged, be involved, and utilize the resources that FI HFMA and HFMA National provide via your HFMA membership.

In closing, I'd like to reiterate something that is obvious but important: In these times of hyper change, heightened demands, and busy schedules in an unbelievably complex marketplace, the importance of staying focused to end-customer needs should remain Job #1. By remembering that we do this for patients and patient care, taking care of people who need to be taken care of, we are able to rise above the daily stresses of our "jobs" and find reward and high levels of satisfaction in what we've chosen as a profession.

Carl Pelletieri
2014 – 2015 First Illinois,
HFMA Chapter President

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# Financial Leadership: Needed to Improve Quality, Reduce Costs

BY ATUL GAWANDE, M.D., HFMA ANI 2014

Data and leadership by healthcare finance experts will have the biggest effects on improving quality and cost control in the U.S. healthcare system, according to a leading healthcare researcher and quality improvement expert.

Atul Gawande, MD, a surgeon at Brigham and Women's Hospital in Boston and researcher on cost and barriers to quality improvement, told attendees at the HFMA National Institute that improving the care of and reducing costs for the most expensive patients show the way to improving the overall system.

"It's still all about the sickest; what we do and whether our systems can care for the sickest in our society," Gawande said about the 5 percent of patients who account for 50 percent of healthcare spending. "That's how we fix health care."

To improve clinical and financial outcomes for the sickest parts of the population, providers and payers have to change how the healthcare system interacts with those patients.

Initiatives, such as one focused on 100 of the highest healthcare users in Camden, N.J., found that teams of providers were needed instead of just one clinician. That initiative found problems were not identified by the many separate providers seeing a patient, such as the asthmatic patient who required repeated hospitalizations because no one ever taught him how to use his inhaler correctly. The same patient also benefited from nontraditional healthcare interventions, such as buying him a vacuum to help clean the air in his home.

"For these highest-cost patients we need entirely new systems and require entirely new investments," Gawande said.

That is why new clinical teams focusing on the sickest will need the involvement, and sometimes the leadership, of healthcare finance leaders. Such professionals are in a position to push for financial incentives that reward providers for avoiding unnecessary care and pay for nontraditional interventions that are clinically effective.

Without motivation by hospital finance officials to change the incentives under which providers are paid so that they financially benefit when patients become healthier—and not from retreatment of patients whose care was poorly coordinated—"that discussion doesn't even get started," Gawande said.

## Perverse Financial Incentives

That commitment by finance leaders may be complicated by factors that were identified in Gawande's own research published last year. His study showed a hospital's surgical profits increased 330 percent when there was a surgical complication because insurers pay hospitals to fix their own mistakes.

"It allowed them to go back to their insurers and say, 'We need to make a different deal because we don't want to be in this position; we want to profit when we make it go right, so we have to find a solution to be able to do that,'" Gawande said. Without the results of the study, "that discussion doesn't even get started."

The hospital in the study, Texas Health Resources, developed a deal with insurers according to which their payments would remain unchanged if they achieved a 10 percent reduction in errors. They ended up with a reduction of 15 percent.

"We'll try to find out if we have made a system or an approach that has worked to solve this," Gawande said, referring to final financial figures expected later this summer from the hospital's new insurer arrangements.

Gawande emphasized that a crucial component in "flipping around" the financial incentives to reward high-quality care is a growth in such transparency.

Transparency in quality and cost outcomes can help drive the healthcare system toward improvement, with research having shown that often the best care is delivered at the lowest cost.

"When it turns out that the best care is possible by making it more like a system, more organized, avoiding complications, making more sense along the way, and that it ends up being among the lowest-costing, that is a tremendous opportunity," Gawande said.

# The Missing Link on LinkedIn

BY VICKIE AUSTIN

Social media has made networking a breeze and one of the most powerful social media tools is LinkedIn. Designed to help us make connections with people we know and the people *they* know, LinkedIn helps us build existing relationships as well as expand our networks to include people and companies we specifically want to target.

Why, then, is LinkedIn so often misused or underutilized by so many? What's the missing link?

## Harnessing the power of LinkedIn

Just like networking in person, LinkedIn is most effective when you **honor the person who is right in front of you**—either the person you're inviting or the person who has invited you to connect. That means personalizing your invitations and responding to those you've accepted.

The generic default LinkedIn invitation says "I'd like to add you to my professional network on LinkedIn." Why? Are you adding numbers to your collection? Or are you really intending to build a relationship with that person for mutual gain? When you're sending an invitation to someone, take just a minute or two to write a note. With LinkedIn, context is everything.

Let's say you came back from an HFMA chapter meeting with some business cards and among those cards is one from someone you'd like to get to know better. Perhaps you see the potential for working on a project together. Maybe the person works for a company you'd like to know more about. Whatever your motive, go to his or her LinkedIn profile and review it. Then click "Connect." You'll receive options for how you know that person.

LinkedIn gives categories like "Colleague," "Classmate," "We've done business together…" and "Friend." If you haven't shared some common experience, you're prompted to include an e-mail address—you can use the address on the business card. Then, there's a box that says "Include a personal note" which could be as simple as this:

> "Dear Mike:
>
> So good to meet you at the First IL HFMA Chapter annual dinner. I'd be delighted if you would accept my invitation to connect on LinkedIn.
>
> –Joe"

Joe could throw in a sentence referring to his conversation with Mike ("Really enjoyed hearing about your trip to Hawaii") or include a sentence that expresses the intent of getting to know Mike better ("Hope to see you at the upcoming chapter Fall Summit"). Now Joe has told Mike how he knows him, extended an invitation to stay connected via LinkedIn and maybe even thrown in an invitation to connect in person. That's what LinkedIn is designed to do—build professional relationships and take them to the next level.

## The importance of groups

At this writing there are more than 36,000 members in the HFMA LinkedIn group with nearly 200 people in the First IL HFMA chapter group. Are you a member of both? Groups are designed to help you connect with folks in your industry and profession and LinkedIn has made it easy for you to do that both locally and nationally.

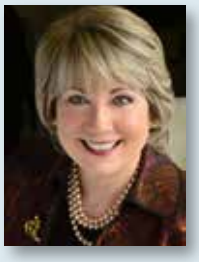
Once you're in a group you can reach out to any member of that group to connect. "Groups" is one of the options to choose when you're personalizing your invitation and the drop-down menu will automatically populate with the group or groups you share. Also, you can follow discussions within the group and see what's trending. You can start a discussion and position yourself as a thought leader. If you have a question about best practices, you can pose it to the group and get responses from group members.

## The face of LinkedIn

All of these suggestions are based on the assumption that you've completely filled out your LinkedIn profile. Here are some tips to ensure your LinkedIn profile is complete:

- You must have a photo. Unless you're in the witness protection program, not having a photo on LinkedIn is tantamount to bad manners. Use a professional head shot, too—LinkedIn is designed for business and has a very different look and feel than Facebook.
- Complete your summary and work experience. Don't just dump your resume into the profile: summarize your experience so people get the essence of what you've accomplished.
- Include "texture" within your summary. Honors, hobbies and interests, how to reach you—all of these give people a hint of who you are and why they should want to connect with you.
- Don't get too "group happy." Be selective. Otherwise, following and managing your participation in those groups may become overwhelming.

Just as in real life, fostering and maintaining relationships via LinkedIn takes an investment. Be strategic about using LinkedIn as a tool. Be generous but circumspect about how you build your LinkedIn network to support you and your ambitious career goals and you'll get a handsome return on your investment.



Vickie Austin

*Vickie Austin is big fan of LinkedIn and welcomes your invitations to connect at www.linkedin.com/in/vickieaustin. She's a business and career coach and founder of CHOICES Worldwide, helping individuals and organizations with strategic career and business planning. Vickie speaks at HFMA chapters around the country. You can also connect with her at vaustin@choicesworldwide.com, 312-213-1795, and follow her on Twitter @vickie_austin.*

# Healthcare Business Models Face Disruption

BY KENNETH KAUFMAN, CEO, KAUFMAN HALL, HFMA ANI 2014

"We're hitting a time in healthcare where we may see our story as Blockbuster to Netflix," warned Kenneth Kaufman, CEO, Kaufman Hall, during his presentation, "Leveraging the Business Model to Improve Value," at ANI: The HFMA National Institute this past June.

Citing a variety of industry-disrupting forces, such as the need to curb national healthcare expenditures as a percentage of gross domestic product and new uses of pharmaceuticals that replace some surgical services, he urged those attending to prepare for rapid changes in how their organizations operate.

Specifically, hospitals need to reexamine their underlying business models to engage with patients in increasingly outpatient-focused, navigation-oriented ways; lower their cost structures; aggressively reposition for fee-for-value payment; and prepare for new landscapes of competitive threat, he said.

Kaufman envisions a move from traditional fee-for-service/Medicare-based business models to new types of arrangements, in which a "healthcare company" serves as the primary means for helping employers, patients, and Medicare and Medicaid enrollees access hospital, physician, outpatient, and continuum-of-care services. Just as a cable TV company helps consumers access HBO or ESPN without actually creating the content, a healthcare company will focus primarily on organizing services according to specifications and then segmenting the market based on particular consumer demands, he said.

Hospitals, or any other current player in the industry, may not necessarily fill this "healthcare company" role, he added.

## Hospitals Must Operate Differently

Kaufman also challenged attendees to think of themselves as not needing to be better so much as needing to be different in how they operate. Hospitals will need to move from models largely founded on aggregated services and healthcare delivered in the hospital setting to new models based around disaggregated services delivered in the community, he said.

"When you say 'hospital,' most envision a patient in a bed," Kaufman said. "In the new model, we need to envision a patient walking around, and you are helping him or her identify the right service at the right place at the right time. Can we as an industry make that attitude change?"

Financial strategies also need to change. Strong bond ratings are becoming less important than a willingness to invest in the resources needed to accommodate these shifts in business, Kaufman said. Even healthcare providers operating at comfortable margins under fee for service need to be entering into some value-based contracts and assuming risk to gain the competencies needed to succeed when the time comes to participate on a broader level.

"If you think you're going to have time to change [to being a value-focused provider], you're wrong," he said. "You can't time this change."

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## New Revenue Strategies Required

The entry of new, well-funded, and highly capable competitors will change how hospitals view current business strengths and risk.

Kaufman pointed to the success Walgreens has had in diagnosing and monitoring chronic-care patients through its clinics. Market disruption is occurring, with many retail providers able to compete on convenience, accessibility, low-cost structure, lack of physician involvement/complexity, and low price.

He then shared with attendees a list of pricing for an emergency department (ED) compared with an urgent care center for more than a dozen common conditions, such as treatment for urinary tract infection ($665 in an ED versus $110 in an urgent care center) and strep throat ($531 versus $110). Retail providers presumably can offer even lower prices.

"Pricing competition has arrived, and it's probably one of the scariest challenges hospitals have faced in the past 25 to 30 years," he said.

What's more, retail competitors can bank on the fact that hospitals won't compete with them in the traditional way—hospitals cannot reduce their revenue base without significant consideration as to how worthwhile it is for them to do so, Kaufman said. "If you [as a hospital provider] lower your prices to compete, then what percentage of patients will you draw back on that price sensitivity? Is it better for your revenue base to simply let them go? For how long?" Such considerations bring complexities the industry never imagined, he said.

## Technology Spawns Competition

Kaufman also noted that transforming technologies pose a new type of threat to hospitals. The Theranos business line of Walgreens offers more than 200 of the most commonly ordered blood diagnostic tests in a painless fashion from a drop of blood—all without the need for a syringe. "With 90 percent of the population living within 2 miles of a Walgreens, this is a serious threat," he said, noting that many other disruptive technologies are on their way in radiology, surgical services, and other areas.

Other forces that will take legacy providers out of their comfort zone in this new world of health care include competition based on brand strength, customer satisfaction, IT connectivity, and service level, Kaufman said. He also alerted attendees to transformations occurring within the employee insurance market. High-deductible plans are changing how patients view healthcare needs and the importance of pricing. In addition, some employers are beginning to put their employees on private health-plan exchanges. When employees are offered such options, Kaufman said, research shows they will typically buy down, choosing aggregate benefits that are lower than what the employer was previously purchasing.

With this change, managing cost structures to a break-even point on Medicare payments will be vital for providers, who no longer will have the same opportunities to subsidize Medicare losses elsewhere, Kaufman said.

Healthcare consulting firm Accenture predicts annual enrollment of 40 million in private exchanges in 2018. "The ACA is going to look like child's play compared to that impact," Kaufman said.

# Common Strategies for Achieving Value:
## An Update on the HFMA Value Project

BY KENNETH KAUFMAN, CEO, KAUFMAN HALL, HFMA ANI 2014

Virtually all hospitals and health systems are negotiating the transition to value-based business models—and there are common strategies and initiatives that each should consider, regardless of the size of their organizations, their location, or the populations they serve, according to the new HFMA Value Project Report The Value Journey. The report is based on research involving 35 hospitals and health systems to better understand their road maps to value.

HFMA's research has identified a number of common approaches that will help all types of providers close the value gap, wherein rising costs outpace improvements in quality of care. Strategies that hospitals and health systems should consider include the following.

***Reassess ways to achieve economies of scale.*** Standalone and rural hospitals will face particular challenges in pursuing a value strategy without some form of linkage with other organizations, whether through mergers, alliances, or other forms of partnership. For academic medical centers, such linkages are a way of tying the referral base closer. Meanwhile, for multihospital systems, doing so provides a unique opportunity to add still more scale.

***Evaluate the types of staffing and skills that will be necessary in the future.*** Develop transition plans that take these assessments into account. Many organizations, such as Franklin Memorial Hospital, a rural hospital in Farmington, Maine, and Billings Clinic, an aligned integrated system in Billings, Mont., have developed plans related to staff attrition, using retirements as opportunities to redeploy available positions in more strategic ways. Providers across the country also are planning to add staff strategically, with an emphasis on analysts, care coordinators, and physician extenders.

***Review strategies for cross-subsidizing services, business units, and other components of the organization.*** Take a careful look at strategies for cross-subsidizing services for key population segments, evaluating the needs and values of each segment relative to the organization's ability to deliver on them. For example, what is the organization's strategy for chronic care patients, for those whose visits to the emergency department could be curtailed if they were given lower-cost options for care, or even for those who are well much of the time? Refining strategic and tactical plans specific to each population segment the organization serves can accomplish longer-term, segment-specific financial performance.

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## Common Strategies for Achieving Value: An Update on the HFMA Value Project

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***Consider organizational goals related to episode-of-care management, chronic disease care, population health management, and research when investing in IT.*** Organizations that are dealing with more than one electronic health record system or costing system are actively moving toward common (or, in some cases, integrated) information systems and data definitions. The goal is for care teams and finance teams to have access to patient-specific data over time, across all care settings, and integrated across clinical and financial domains.

***Determine what process engineering methodologies to utilize. Methodologies such as Lean and Plan-Do-Check-Act can be used in optimizing care delivery, reducing variation, achieving administrative simplification, improving the patient experience, and allocating resources appropriately.*** Hospitals and health systems should establish a cross-functional forum to identify and select which process improvement initiatives will be undertaken. Dean Health, an aligned integrated system based in Madison, Wis., and Bon Secours Health System, a multihospital system based in Richmond, Va., have developed proven approaches that involve clinical, financial, and administrative leadership.

***Develop multiyear cost-containment plans.*** Dean Health is in the process of establishing a rolling calendar of initiatives that are built into budget planning processes. New York-Presbyterian Hospital, an academic medical center, has established a similar approach. Partners HealthCare in Boston also is planning value-based initiatives over multiple years.

***Prepare for a second generation of value-based payment approaches.*** As noted in the HFMA Value Project report, Defining and Delivering Value, the emerging payment environment has been described by stakeholders as a period of experimentation and learning. Providers should expect industry learning to further shape new payment experiments in the future.

# CMS Report on ACOs: How Are We Doing?

BY JIM WATSON, PARTNER, PBC ADVISORS, LLC

In September, CMS released a report on the performance of Accountable Care Organizations (ACOs) and Medicare Shared Savings Programs (MSSPs). At the same time, a flurry of opinions and reports came out stating that the CMS report did not highlight some of the more unfavorable aspects of the performance of these programs. Depending on what you read and who you believe, the CMS ACOs are either meeting their objectives or failing miserably.

**A Brief History on ACOs:** ACOs were originally conceived 20 years ago in the The Dartmouth Atlas Project, which underscored broad geographic variations in cost and quality across healthcare markets. The Medicare Payment Advisory Commission (MedPAC) formalized the concept and featured it in its June 2009 report to Congress during the development of healthcare reform. CMS finalized rules for participation in the Medicare ACO program on 10/20/11 (also referred to as "Medicare Shared Savings Program" or MSSP). In Chicago and other markets, PHOs/IPAs serve as a logical starting point for building an ACO (care management, risk sharing, claims analysis, patient engagement, etc).

**The ACO Model:** ACOs encompass a broad array of providers: Physicians and clinicians (primary care focused but specialists play an important role as do mid-level providers, (hospitals, pharmacies, SNFs/LTCs, etc). The ACO incentivizes and rewards reductions in costs and improvement in patient outcomes using various metrics to measure success in a number of "Quality Domains" (see table below). ACOs may choose to participate in one of two tracks: *Track 1:* "One sided" (upside risk/shared savings only), or *Track 2:* "Two sided" (upside and downside risk, shared savings and losses). An ACO's agreement period with CMS is three years; all ACOs that continue after the first three-year agreement must move to the two-sided model.

## Summarizing ACO/MSSP Performance to Date:

Last year, the ACOs had higher quality and better patient experience than published benchmarks. This year, the ACOs improved significantly for almost all of the quality and patient experience measures demonstrating that these organizations improve care. ACOs in the Pioneer ACO Model and Medicare Shared Shavings Program also generated over $372 million in total program savings for Medicare ACOs. At the same time, ACOs qualified for shared savings payments of $445 million. The encouraging news comes from preliminary quality and financial results from the second year of performance for 23 Pioneer ACOs and the first year of performance for 220 Shared Savings Program ACOs. Other highlights from the CMS Fact Sheet on ACO Performance:

- 53 Shared Savings Program ACOs held spending $652 million below their targets and earned performance payments of more than $300 million as their share of program savings. One ACO in Track 2 overspent its target by $10 million and owed shared losses of $4 million. The Medicare Trust Funds will save about $345 million, including repayment of losses for one Track 2 ACO.
- An additional 52 ACOs reduced health costs compared to their benchmark, but did not qualify for shared savings, as they did not meet the minimum savings threshold.
- Shared Savings Program ACOs improved on 30 of 33 quality measures. Quality improvement was shown in such measures as patients' ratings of clinicians' communication, beneficiaries' rating of their doctor, health promotion and education, screening for tobacco use and cessation, and screening for high blood pressure.
- Shared Savings Program ACOs achieved higher average performance rates on 17 of the 22 Group Practice Reporting Option Web Interface measures reported by other Medicare FFS providers reporting through this system.
- In 2013 alone, over 125,000 eligible professionals who were ACO providers or suppliers qualified for their incentive payments for reporting their quality of care through the Physician Quality Reporting System (PQRS). These providers will also avoid the PQRS payment adjustment in 2015 because they demonstrated the ability to report quality measures through their ACO.

**Pioneer ACO Performance:** Pioneer ACOs showed improvements in three key areas:

### Financial:

- During the second performance year, Pioneer ACOs generated estimated total model savings of over $96 million and at the same time qualified for shared savings payments of $68 million. They

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| Quality Domain | | Number of Measures | Data Source |
|---|---|---|---|
| Patient/Caregiver Experience | | 7 total measures | Patient Survey |
| Care Coordination/Patient Safety | | 7 total measures | Claims |
| Preventive Health | | 7 total measures | GPRO Web Interface |
| At-Risk Populations | | 7 total measures | GPRO Web Interface |
| | Diabetes | 7 total measures | GPRO Web Interface |
| | Heart Failure | 7 total measures | GPRO Web Interface |
| | Coronary Artery Disease | 7 total measures | GPRO Web Interface |
| | Hypertension | 7 total measures | GPRO Web Interface |
| | Ischemic Vascular Disease | 7 total measures | GPRO Web Interface |

## CMS Report on ACOs: How Are We Doing?

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saved the Medicare Trust Fund approximately $41 million. The total model savings and other financial results are subject to revision.

- Pioneer ACOs achieved lower per capita growth in spending for the Medicare program at 1.4 percent, which is about 0.45 percent lower than Medicare fee-for-service.
- Eleven Pioneer ACOs earned shared savings, three generated shared losses, and three elected to defer reconciliation until after the completion of performance year three.

### Quality of Care and Patient Experience:

- The mean quality score among Pioneer ACOs increased by 19 percent, from 71.8 percent in 2012 to 85.2 percent in 2013.
- The organizations showed improvements in 28 of the 33 quality measures and experienced average improvements of 14.8 percent across all quality measures. These measures included screening for future fall risk, screening for tobacco use and cessation, patient experience in health promotion and education, and controlling high blood pressure.
- The Pioneer ACOs improved the average performance score for patient and caregiver experience in six out of seven measures. These results suggest that Medicare beneficiaries who obtain care from a provider participating in Pioneer ACOs report a positive patient and caregiver experience.

### Some Argue the Picture Isn't as Rosy:

The National Association of ACOs (NAACOS) reports that only 53 of the 220 ACO/MSSPs will receive payment and recoup some of their investment. NAACOS estimates that $1B has been spent on ACO development, with only $373M in returns so far. Across all CMS ACOs, 167 ACOs will receive no return on their investment.

Some argue that the the Pioneer ACO program isn't working: 10 have exited since the program began. The providers in the Pioneer program, chosen because of their relative maturity and presumed ability to handle risk, have not benefited from the program in the way they'd hoped.

An example of this is Sharp HealthCare in San Diego, which recently dropped out of the Pioneer program. In its third-quarter financial report Sharp leaders noted that they were at risk for making a big payment to Medicare, despite the fact that they had cut readmission rates. Sharp execs said the deal wasn't working out because CMS was setting standards on a national level rather than adapting to the markets in which it operated. The Sharp HealthCare experience underscores a big problem with the core intent of ACOs. If even a high performer like Sharp risks having to pay millions back to Medicare, there's something seriously wrong here.

Other initial problems cited in ACO performance include start up costs and operational challenges: The average cost to start an ACO is $2M. Because of the slow build on return/lag on reconciliations, the average ACO will have to assume three years of operational costs ($3.5M average) before it will see any cash flow from shared savings. Operational challenges include:

- Accessing CMS data/learning to use it
- Difficulty in meeting ACO implementation schedules
- Slow/costly IT implementation
- Lack of skill sets among staff/leaders
- Translating data into actionable information for caregivers
- Enrollee attribution and compliance challenges

### Important Changes on the Way to Help Increase Success Probability of ACOs:

CMS seems to be cognizant of the challenges and has proposed new rules to help create better success stories and address the critics/challenges. These proposed changes include:

#### Additional Quality Improvement Reward:

- Revising quality scoring strategy to recognize and reward ACOs that make year-to-year improvements in quality performance scores on individual measures by adding a quality improvement measure that adds bonus points to each of the four quality measure domains based on improvement.

#### Revisions to Quality Measure Benchmarks:

- In response to feedback regarding "topped out" measures, modifying benchmarking methodology to use flat percentages to establish the benchmark for a measure when the national FFS data results in the 90th percentile being greater than or equal to 95 percent.

#### Modifications to the Quality Measures that Make Up the Quality Reporting Standard:

- Revisions to reflect up-to-date clinical guidelines and practice, reduce duplicative measures, increase focus on claims-based outcome measures, and reduce ACO reporting burden.
- The proposed changes increase the number of measures calculated through claims and decrease the number of measures reported by the ACO through the GPRO Web Interface.
- The total number of quality measures for quality reporting would increase from 33 to 37 measures under this proposal.
- Specifically, new measures would be added to focus on avoidable admissions for patients with multiple chronic conditions, heart failure and diabetes; depression remission; all cause readmissions to a skilled nursing facility; and stewardship of patient resources. The existing composite measures for diabetes and coronary artery disease would also be updated.

Additionally, CMS is seeking public comment on future quality measures for consideration that address the following areas:

- Gaps in measures and additional specific measures
- Measures for retirement (e.g., "topped out" measures)

*(continued on page 13)*

## The CMS Report on ACOs: How Are We Doing?

(continued from page 12)

- Caregiver experience of care
  - Alignment with the Value-Based Payment Modified ( VBM)
  - Assess care in the frail elderly population
  - Utilization
  - Health outcomes
  - Public health

NAACOS proposes further suggested program changes, based on their survey of ACOs currently in operation:

- Change the way patients are attributed to the ACO and bring stability to the population the ACO is serving
- Strengthen the relationship of the Medicare Beneficiary with their ACO physician
- Improve the formula for risk-adjusting and setting the savings targets
- Account for the fact that in some communities the costs of care are well below the national average, and for them, it is even more difficult to achieve savings
- Improve the clinical and claims data ACOs receive to improve care
- Recognize that quality of care varies from community to community and allow regional differences and allow ACOs to receive savings/rewards if their overall quality of care is improved year over year

**Moving forward with a commitment to healthcare reform and the ACO concept:**

Organizations across the country have spent significant time and money on ACOs, and other "Accountable Care" models. Increasingly, these organizations are asking themselves: Are we connecting the dots on cost, return, and value? Are all these things aligning (the infrastructure, the requirements to manage/comply, the quality and performance metrics, the payor incentive/rewards)?

The latest reports on ACOs and other "Accountable Care" models offer two conclusions:

- Depending on what you read and who you believe, ACO performance has been a mixed-bag.
- CMS and the provider community seem to still support the concept, recognizing that changes need to be made to improve ACO performance and long-term success probability.

One central question remains: Can we rely on the federal government to continue its support across party lines over the next several years to sustain commitment to ACO programs, which regardless of what you read by who, are programs that can improve the cost and quality of care over time. If not, what then?

***Sources:***

- CMS ACO Fact Sheet 9/16/14
- The National Association of ACOs (NAACOS)

## HFMA Event Summary

# First Illinois HFMA Annual Dinner Recap

Every year First Illinois HFMA hosts an event to celebrate the past chapter year and to begin the new chapter year. This year's annual dinner was held on July 17, 2014, at the Metropolitan Club of Chicago located in the Willis Tower. The annual dinner is a great event that celebrates the success that the chapter had over the past year and highlights the future. The location on the 67th floor looking over the Chicago skyline was enjoyable and some would say even symbolic of the Chapters new heights of achievement during the 2013-2014 chapter year.

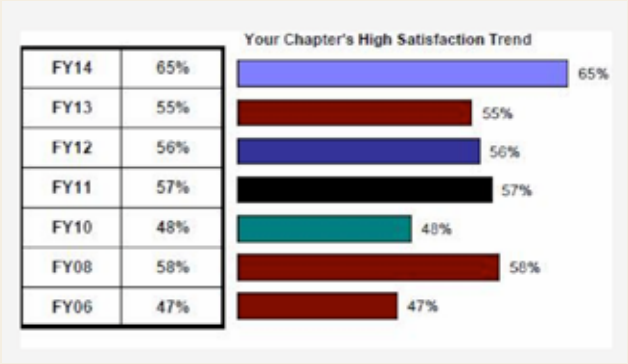
Dan Yunker, outgoing president (now past president) kicked off the evening by welcoming everyone and setting the agenda for the evening. He shared with us the board's goals of advancing the chapter in a direction that makes it a value to members, volunteers, and sponsors, along with the chapter's strategic framework. The audience was reminded of the key principles that were embraced to set the year's agenda which included:

- Those volunteer leaders before us have led us to this point and we enjoy a vibrant chapter.
- Recognition that the industry is changing and the chapter needs to evolve with it to stay sustainable.
- Several strategic planning sessions coupled with member feedback from surveys set the stage to take action during that chapter year.
- An organization should never rest on its position at the top and should always be looking to improve.

What was also impressive was to hear the From – To (current to desired states) that came out of several strategic planning sessions and to recognize how much progress has been made by a volunteer board. (See chart below). It is exciting that the volunteer leadership of the First Illinois HFMA board is so structured and committed to advance the chapter.

| Metric | Goal | Achievement |
|---|---|---|
| Education Hours | 14,535.7 | 23,831.9 |
| Hours Per Member | 9.9 | 16.4 |
| Satisfaction | 60% | 65% (up 10%) |
| Certified Members | 5.5% | 5.6% |
| Days Cash | 150-600 | 385.2 |
| DCMS Reporting | 4 | 4 |
| Provider BOD | 40% | 55% |
| Membership | 1451 | 1441 (April 30)<br>1469 (May 31) |

HFMA National recognized the chapter's success by presenting Dan Yunker as president seven achievement awards: Yerger awards for innovation, member service, improvement, and member communications. Performance awards for excellence in education and certification with a special improvement award for the chapter's educational accomplishments. With all the changes designed to advance the chapter, membership satisfaction hit a five year high:




Adam Lynch, FI HFMA secretary, provided some comments on Carl's behalf regarding the goals and objectives of the 2014-2015 FI HFMA chapter year.

Our number one goal is to continue to be the indispensible resource for healthcare finance leaders. Providing solid education at our fall and spring summits is paramount. In response to the chapter survey

*(continued on page 15)*

we solicited input from providers and others for topics. We also are focused on certification (CHFP) in order to meet our required number of certified members. The chapter is offering free certification training and testing for chapter members. The first practicum is on October 30 at the Fall Summit. Our third major goal this year is to grow our membership. Adam expressed that we are asking everyone to share their HFMA experiences with their friends and colleagues. There is no other healthcare organization that brings together education, networking, career growth and fun the way we do. It takes a large group of dedicated volunteers to deliver on our goals. Adam thanked one and all for their ongoing efforts to make HFMA what it is today.

Brian Sinclair, FI HFMA Chapter Awards chairperson, presented the 2013-2014 First Illinois HFMA Awards. The first award presented was the 2014 Medal of Honor winners.

This award is given by the First Illinois Chapter Board of Directors to members who have met the HFMA criteria for significant service to the chapter in the years following their receipt of all the Founders Merit Awards. To date there have only been 13 prior recipients of this award. This year there were two additional members receiving the honor. They were James Watson and Michael Nichols. The presentation was made by Dan Yunker, who cited all of their contributions and service and thanked them on behalf of the chapter.

The other special award was the Alice V. Runyan Achievement Award. The recipient was Alan Staidl. He was out of town and unable to be at the dinner but Dan Yunker was able to make an electronic connection with Alan and the award was presented long distance. Alan is only the 12th person to receive this honor since the chapter originated it back in 1980. Also of note, his father received the same award in 1982. We all thank Alan for his long and significant service to the chapter.

Since the dinner the recipients of the 2014 Founders Merit Award program have also been determined and announced. Award plaques have been ordered and will be presented at upcoming programs. This years recipients are:

*(continued on page 16)*

Partial Group 2014-2015 Board Members - Kim McMahon, David Tomlinson, Daniel Yunker, Mary Treacy Shiff, Adam Lynch, Andy Scianimanico and Richard Franco

Adam Lynch, Dan Yunker and Brian Washa

Dan Yunker, Adam Lynch and Kevin Weinstein

Dan Yunker, Mary Treacy Shiff and Adam Lynch

## First Illinois HFMA Annual Dinner Recap (continued from page 15)

**GOLD AWARD:** Tracey Coyne, Brian Katz, Sylvia Sorgel, Gary Gasbarra

**SILVER AWARD:** Tim Manning, Brian Washa

**BRONZE AWARD:** Adam Lynch

Our chapter is very fortunate to have all these active members that have contributed to the success of the organization. Feel free to reach out to Brian with any questions about the First Illinois HFMA Awards Program at 630 -207-7308 or bsinclair9 @aol.com.

Vince Pryor, FI HFMA past president, and scholarship chair, was introduced to announce the 2014 FI HFMA Scholarship Award recipients:

- Timothy Hubner
- Connor Perlin
- Carly Washa
- Katherine Knowles
- Brianna Lear

Medal of Honor Winners - Jim Watson, Dan Yunker and Mike Nichols

Vince shared with the audience that, like in years past, the quality of the applicants continues to increase, making the job of the Scholarship Committee a challenging but rewarding process.

# Health Information Exchange: Get on Board

BY DAN YUNKER, PAST PRESIDENT, FI HFMA, SVP, METROPOLITAN CHICAGO HEALTHCARE COUNCIL, CEO, LAND OF LINCOLN HEALTH

As someone who believes in a connected health care community delivering high-quality, value-based care, the implementation of health information exchanges (HIE) is just one of many topics near and dear to me. But it is one in which I most strongly believe. HIEs have the incredible power to help health care organizations meet the triple aim of health care reform—reducing costs, enhancing quality and increasing access to care. For those whose organizations are not yet connected, it's time to get on board.

By participating in an HIE, hospitals are making a significant investment to deliver the best care experience to their communities. This investment represents a commitment not only to saving their patients time and money, but to enhancing outcomes and making sure patients' receive top-notch treatment at these connected facilities. Sharing this quantity of data empowers providers to build meaningful relationships with their patients. And the availability of more accurate, up-to-date patient records allows these connected providers to deliver the highest quality of care by, for example, avoiding duplicate or unnecessary tests and procedures.

Beyond community investment, HIEs have been shown in a number of markets to be an effective tool at improving care coordination among hospitals and doctors. This curbs readmission rates, which in turn decreases Medicare reimbursement penalties and enhances hospitals' revenue. Illinois has one of the highest rates of readmission in the country. Not only is that bad for patients, it leads to penalties—and revenue loss—for Illinois providers. Following recent launches of HIEs in Illinois, including the MetroChicago HIE, we expect that readmission rates will soon be lowered in our markets.

As a closing thought, I like to think of an HIE as a tool to make sure your health information is where you need it, when you need it. A colleague and I were recently discussing the topic, and it was likened to an ATM—even if your primary bank isn't nearby, you can go to an ATM and know that you have total access to your own money. HIE will one day soon be the equivalent of a health care ATM. When you're away from your primary caregiver, you will know that you still have access to your personal health care information if and when you need it.

As more providers connect to HIEs, more consumers will expect that their information has the ability to follow them—like an ATM—and will seek out doctors and hospitals that can provide that service. HIE is the way of the future. Like I said earlier, it's time to get on board.

# Attention Providers:
## Regulatory Calendar of Due Dates and Deadlines Forthcoming

This year under the strategic direction of our chapter president we have initiated a Provider Value Committee. The first asset the Provider Value Committee has created is a Regulatory Calendar of Due Dates and Deadlines (FIHFMA Regulatory Calendar). The calendar of due dates is segregated into the three segments of our membership: hospitals, practitioners and health plans. Thank you to RelayHealth and McGladrey for sponsoring and authoring. This regulatory calendar will also be posted on our First Illinois HFMA website, atfirstillinoishfma.org/resources/regulatory calendar, and refreshed on a quarterly basis. For more information or if you have questions, please contact: Tracey Coyne, committee chair, at tracey.coyne@us.gt.com.

# Member Satisfaction Survey

At the end of October you will receive a Member Satisfaction Survey from National HFMA. It is important for you to complete the survey. In response to last year's survey we created a Social Committee to increase networking opportunities. We created a Provider Value Committee to identify timely educational topics and to encourage more provider/sponsor interaction. We also improved our educational summit by changing the location and bringing forth exciting and relevant education. We have made many improvements for you and expect to receive high marks from you.

Keep a look out for the survey and fill it out. We value your opinion and want to hear from you. If you have any concerns that are not being addressed, please contact our chapter president, Carl Pellettieri, at cpellettieri@impacths.net. Thank you!

## HFMA Upcoming Events

### The Fall Summit Is Scheduled for October 30 & 31!

The theme for the fall event is the Healthcare Reform Landscape. Our national president Joe Fifer will talk about HFMA's task force on price transparency and other national issues. Kevin Brennan, CFO from Geisinger Health System in Pennsylvania, will be joining Joe Fifer as a speaker at the Fall Summit. Geisinger Health System is one of a handful of healthcare delivery systems that President Obama highlights regarding the way to improve outcomes and lower costs going forward. Visit the FI HFMA website for more information or to register (www.firstillinoishfma.org).

## Save the Date:

## The "Invitation Only" 21st Annual Educational Symposium & Executive Golf Outing

### Monday, May 11, 2015

Eagle Brook Country Club is a private country club in Geneva, Illinois with nearly 300 members and containing a golf course designed by Roger Packard and Andy North, swimming and tennis facilities and a wonderful clubhouse. As one of the best finishing holes in the Chicago area, hole 18 presents players with a challenging tee shot. It must be straight enough to avoid the water on the left and long enough to let your approach shot carry to an island green. The golf fee includes 18 holes of golf with a cart, driving range, putting green, bag service, tee favors, locker room facilities, Pro-Shop services, and other valuables.

## First Illinois HFMA's & Chicago Health Executive Forum's Managed Care Meeting 2014

### January 29, 2015, at University Club - 8am to 5:30pm

A full invitation including program details and information on how to register was sent by October 1. If you have any questions, please feel free to contact the Committee Co-Chairs: Cathy A. Peterson at 773-580-6800 or Denise Cameron at 312-942-0738.


HFMA has partnered with McGladrey LLP to offer a three-part webinar series covering key revenue cycle strategies. With the rise of incorrect or unpaid insurance claims, increasing patient debt, mounting operational costs and the burden of ever-changing compliance demands, health care organizations are feeling the squeeze to successfully manage a complex revenue cycle landscape. From pricing to payment challenges, there's much to be concerned about.

Part 3 of the webinar series "Revenue Cycle Leakage" will be on **Wednesday, Nov. 19, 2014 from 12pm to 1:30 pm CT.** *Questions?* Please contact kauser.karwa@mcgladrey.com or visit the FI HFMA website at www.firstillinoishfma.org

# Welcome New Members

**Bradley Cutter**
Accretive Health

**Dan Seals**
Vice President of
Business Development
Technology Inc.
MPA, Inc.

**Omar Salim**
RDMS, CHAM
Manager, Financial
Counseling

**Matthew S. Tolf**
Development/Provider
Relations, CorVel Healthcare

**Robert Kairis**
Associate
Huron Consulting Group

**Meg Connolly**
Mortenson

**Sasidhar Aradyula**
Healthcare Advisory
Consultant, Crowe Horwath

**Robin Czajka**
Vice President
Kaufman Hall & Associates

**Alma L. Boyles**
Manager, Outpatient
Registration
Northwestern Medicine

**Jorrie L. Cerullo**
Senior Contract
Administrator
Northwestern Memorial
HealthCare

**Scott Holway**

**Vincente Lopez**
Manager, Budget and
Decision Support
Edward Hospital & Health
Services

**Sandra C. Lood**
Cash Application Manager
Cadence Health

**Steven J. Schouten**
Manager, Revenue Cycle
Cadence Health

**Paula Kudlinski**
VP Business Development
Diamond Healthcare
Communications

**Lynn Zimmerman**
Sr. Director Marketing
Adreima

**Lauren Humes**
Consultant

**Justin Beeker**
Analyst
Huron Consulting Group

**Fifi Hunt**
Balancing Matters, LLC

**Shazad Ahmed**
Manager, Admitting and
Registration
Northwestern Medicine

**Barbara K. Herring**
Program Manager
Northwestern Memorial
Hospital

**Jacquelin E. Kelly**
Enrollment Coordinator
Experian Health

**Kimberly Nelson**
Program Manager
Northwestern Medicine

**Alexandra Paans**
Contract Modeling Analyst
Accretive Health

**Stacia Hahn**
Controller
Centegra Health System

**Jamie Bennett**
Marketing Analyst

**Melissa Meyers**
Director of Client Relations
Harris & Harris LTD

**Larry E. Volkmar**
Managing Director
The Claro Group

**Nicole Voges**
Marketing
CHAN Healthcare

**Nizamuddin Hussain**
Accretive Health

**Shantanu Kamra**
Senior Health Care
Consultant, Wipfli Llp

**Eric Meizlish**
COO
Procured Health

**Badri Narasimhan**
Chief Executive Officer
AlertMD

**JJ Rorie**
Health Forum

**Ryan Rushing**
Senior Director
Business Development
Walgreens

**Dan Seargeant**
Vice President
Kaufman Hall & Associates

**Sachin Sharma**
Manager
Prism Healthcare Partners

**Lauren Bernardini**
Senior Associate
Berkeley Research Group

**Robert F. Long**
Director Sales
Canon Business
Process Services

**Leslie Ann Konnerth**
Director, Patient Accounts
Dupage Medical Group

**Matthew Barber**
Associate
Flexpoint Ford

**Jonathan Becker**
The Claro Group

**Richard A. Fisher**
President, Hospital &
Government Affairs
AlertMD

**Rob Fromberg**
Vice President,
Thought Leadership
Kaufman Hall & Associates

**Karen Garrow**
Talent Coordinator &
Business Manager, Tatum

**Thomasina Wilkins**
Health Care Management
The CLARO Group

**Daniel W. Pratscher**
Supervisor, McGladrey

**Elizabeth Sams**
COO, Procured Health

**Nicole Cantu**
Provider Services
Consultant, Rush Health

**Jason S. Lazar**
Revenue Cycle Consultant
FTI Consulting

**Randy Tieman**
Director of Real Estate
Development, Mortenson
Development, Inc.

**Thomas J. McGrath**
Sales Director, Shay Health
Care Services, Inc.

**Karla Alvarez**
Internal Auditor
Advocate Health Care

**Frances Elaine McDermott**
Sr. Internal Auditor
Advocate Health Care

**James E. Myers**
Associate Vice President
Rush University Medical
Center

**Maheki Shah**
Internal Auditor II
Advocate Health Care

**Eric Speicher**
Sr. Internal Auditor
Advocate Health Care

**Gail S. Wilkening**
Sr Healthcare Consultant
PBC Advisors, LLC

**Gabriela Zdun**

**Jason Brehm**
PwC

**Foram Soni**
Consultant

# New Member Profile

## Mike Richardson

Vice President of Sales, Northern Region,

Hollis Cobb Associates

### Brief history of Hollis Cobb Associates:

Hollis Cobb Associates began operations in April 1977 with two full-time employees and a singular focus on healthcare collections. Our very first hospital client was Northside Hospital, and they remain a valued client today. We have expanded our business to over 200 employees in multiple locations, including a collection office in Des Plaines, IL.

### Brief history of Mike Richardson:

I am fairly new to the healthcare industry, but I have 23 years previous banking experience and spent the last 14 years in sales and sales management. I live in Muncie, Indiana, and graduated from Ball State University. I also officiated high school and college football in the Mid-West for over 20 years.

### Goals for membership in First Illinois HFMA:

Hollis Cobb has had a presence in the healthcare receivables and collection arena for 37 years, mostly in the southeast. We are looking to expand our services to hospitals and medical practices in the northern parts of the United States. I feel that by joining HFMA I will be able to not only make new contacts, but be able to give back some of our expertise to those providers in the Healthcare Financial Management Association. The Chicagoland area has a very diverse healthcare history, both in size of facilities and uniqueness of the services they offer. I am looking forward to getting acquainted with all of you in the coming months.

"Far and away the best prize that life offers is the chance to work hard at work worth doing."

~Theodore Roosevelt

## The First Illinois Chapter Sponsors

The First Illinois Chapter wishes to recognize and thank our sponsors for the 2014-2015 chapter year. Thank you for all your generous support of the chapter and its activities.

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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.  *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 |
|---|---|
| January 2015 | December 10, 2015 |
| April 2015 | March 10, 2015 |
| July 2015 | June 10, 2015 |
| October 2015 | September 10, 2015 |