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Redefining Bad Debt Expense and the Medicare Reimbursement Implications

BY STEVE PARDE, PARTNER, AND BRIAN PAVONA, MANAGING DIRECTOR, BKD CPAS AND ADVISORS

Understanding and calibrating the differences in reporting bad debts and other uncompensated costs among the cost report, IRS Form 990, financial statements and other filings, such as a community benefits report, has always been a significant endeavor for providers. And things may have just gotten more challenging!

On April 4, 2019, CMS caused a stir in the provider community by releasing a Medicare Learning Network (MLM) Connect® article to clarify its position related to the accounting treatment for Medicare-Medicaid crossover bad debts. To understand the challenges this creates, we must first consider how things used to be.

Historically, CMS has defined bad debt expense based on 42 CFR Section 413.89 and §302.1 of the Provider Reimbursement Manual (PRM), Part I, as "amounts to be uncollectible from accounts and notes receivable which are created or acquired in providing services" and "represent reductions in revenue." Based on 42 CFR §413.20, CMS requires providers to "maintain sufficient financial records … which are widely accepted in the hospital and related fields." Further, for cost report purposes, an unmet deductible or coinsurance amount related to Medicare beneficiaries who also are Medicaid eligible could be claimed by providers as a reimbursable Medicare bad debt if the bad debt was deemed uncollectible and there's no likelihood of recovery in accordance with 42 CFR §413.89.

With this historical guidance from CMS, there has long been a general consistency between the definition of bad debt for cost reports and the way bad debt expense is recognized under U.S. generally accepted accounting principles (GAAP) among health care providers. According to the April 4, 2019, CMS MLM Connect® article, however, providers must classify the unmet Medicare deductible and coinsurance amounts for Medicare-Medicaid crossover bad debts

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to an expense account for uncollectible accounts and can't write off the claim to a contractual allowance. This "clarification" is effective October 1, 2019.

While this recent clarification of CMS' policy related to Medicare-Medicaid crossover bad debts will most likely be challenged and litigated by providers, CMS and providers must address a bigger issue related to bad debt expense—the adoption of FASB's new standards on revenue recognition.

The implementation of FASB's Accounting Standards Update 2014-09, *Revenue from Contracts with Customers* (Topic 606), introduced the concept of "implicit price concessions" into the health industry's financial terminology. FASB Topic 606 was effective for public entities reporting under U.S. GAAP for annual and interim periods beginning after December 15, 2017, and for annual periods beginning after December 15, 2018, for nonpublic entities.

Under FASB Topic 606, health care providers must differentiate between an explicit price concession, an implicit price concession and a bad debt under U.S. GAAP. An **explicit price concession** occurs when a provider accepts a discount or concession to standard pricing that's explicitly stated, e.g., a contractually negotiated rate or self-pay policy discount. An **implicit price concession** occurs when the provider makes a determination that it will or is likely to accept a discount or concession to standard pricing for an individual patient or portfolio of patients before a credit risk assessment can be made, e.g., collection write-off. **Bad debts** under the new standard result when patients or payors who have been determined to have the financial capacity to pay for health care services (through a formal credit assessment prior to services being rendered) are later unwilling or unable to settle the claim.

Under this new guidance, most previous bad debts will be classified as implicit price concessions in a traditional health care environment. Here's a simplified example of what constitutes an implicit price concession under FASB Topic 606:

> In furthering its not-for-profit mission, the health care provider doesn't assess the patient's intent and ability to pay for their responsibility (deductible or coinsurance) **prior** to providing services.
>
> The standard charge for the services provided to the patient is $50,000. The provider receives $25,000 from Medicare as payment for the services, and the Medicare beneficiary's responsibility is $5,000. The contractual discount of $20,000 is an explicit price concession. Based on its historical experience of Medicare patients, the health care provider expects to collect only 80 percent ($4,000) of the Medicare beneficiary's responsibility.
>
> In this example, the $1,000 difference between the Medicare beneficiary's standard patient responsibility and the historical experience of what the provider expects to collect from the Medicare beneficiary is an implicit price concession.
>
> When presenting the financial statements under FASB Topic 606, patient service revenue is net of implicit price concessions and explicit price concessions. In this example, patient service revenue is $29,000. Prior to the adoption of FASB Topic 606, the provider would have presented patient service revenue of $30,000 and a provision for bad debts of $1,000.

Under FASB 606, a bad debt will only be recorded if the health care provider assesses the patient's or payor's intent and ability to pay their responsibility based on a credit assessment prior to services being performed and the provider is unable to collect the amount later. Therefore, in adopting FASB Topic 606, many health care providers will see a dramatic drop in the bad debt expense recorded in their financial statements and a new contra revenue account to capture implicit price concessions.

So why is this important from a Medicare reimbursement perspective?

First, as mentioned earlier, CMS issued a recent clarification that Medicare-Medicaid bad debts must be written off to an expense account and not a contractual discount account. Under FASB Topic 606, Medicare bad debts that were once written off to a bad debt expense account may now be written off to an implicit price concession contra revenue account (similar to how a contractual discount is recorded). Will CMS disallow all Medicare bad debt reimbursement—not just Medicare-Medicaid bad debts—if the unmet Medicare deductible and coinsurance amount is written off to an implicit price concession contra revenue account instead of to a bad debt expense account?

Second, Medicare disproportionate share hospitals (DSH) receive an additional Medicare inpatient payment for treating a disproportionate share of low-income patients. For federal fiscal year (FFY) 2020, the uncompensated care component of the Medicare DSH payment is determined, in part, based on the qualifying Medicare DSH hospital's charity care and bad debt expense from Worksheet S-10 of its Medicare cost report that began in FFY 2015. As mentioned earlier, providers adopting FASB Topic 606 will see a dramatic decrease in bad debt expense on their financial statements and an increase in implicit price concessions. Will CMS allow hospitals to include implicit price concession amounts on Worksheet S-10 and in determining a hospital's future Medicare DSH uncompensated care payments?

The Medicare bad debt and DSH reimbursement providers receive is significant. It's important for CMS to address the implications of FASB Topic 606 on the health care industry and update the Medicare cost report instructions and regulations to reflect current industry standards.

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It's time for CMS to update and address the antiquated PRM and CFR as they relate to the definition of total and Medicare bad debts to be in line with industry standards. In the meantime, it's important for providers to document their adoption of the new FASB Topic 606 requirements and how previous bad debts are recorded under the new standard as an implicit price concession. As always, continuing to educate key stakeholders on the differences in reporting bad debts and other uncompensated costs among the cost report, IRS Form 990, financial statements and other filings, such as a community benefits report, will continue to be an important role for the provider finance function.

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Four Ways to Use AI and Automation in Your Revenue Cycle

BY CHRIS REGAN, SALES DIRECTOR, EXPERIAN HEALTH

Artificial Intelligence (AI) and automation are the latest buzzwords in business innovation. But what exactly do they mean, and how can they help your healthcare organization?

Put simply (if that's possible!), AI is when a machine mimics human thinking. It can spot patterns, learn from experience and choose the best solution in a given situation, solving problems with little or no human involvement.

While AI is focused on achieving a particular goal, automation is process-oriented. You can set it to follow rules depending on certain data inputs. It's ideal for completing repetitive tasks efficiently, so the humans in your team can spend their time elsewhere.

In healthcare, there are endless opportunities for AI and automation to assist doctors in diagnosing and treating medical conditions, like Microsoft's "Hanover" machine, which helps oncologists predict the best combination of drugs for each patient. Harvard Business Review investigated 10 promising AI applications in healthcare, which could save the US healthcare system $150 billion per year by 2026. Examples include AI-assisted robotic surgery, faster and more accurate image diagnosis, and determining ideal drug dosages for individual patients.

The opportunities aren't all on the medical frontline either. AI and automation can be of significant value to a hospital's revenue cycle. But many providers have only scratched the surface when it comes to integrating new technologies within their revenue cycle operations.

There are plenty of repetitive processes within the revenue cycle that can be time-consuming, tedious and prone to human error. Thanks to automation, many rote tasks such as handling denied claims and missed authorizations can be taken off your team's to-do list, keeping productivity high and resource costs low.

Here are four ways AI and automation can help reduce claims denials specifically.

1. Staying on top of ever-changing payer policies

Constantly changing payer payment rules create serious challenges for many providers, causing delayed payments, denied claims, increased billing costs and lost revenue. Providers often have no central repository to share updates with the right people across their health system, meaning individual departments have to allocate staff time to digesting the same notifications and newsletters. It's extremely inefficient and can cost thousands in reworked claims.

With automated Payer Alerts you can avoid all of this. Payer Alerts give staff a convenient service that monitors more than 52,000 web pages by more than 725 payers, so you know you're

up to date with any changes. Handy daily email digests notify you of any specialty-specific updates, so you stay a step ahead.

John Neumeier from Arkansas Health Group says:

"Payer Alerts has been a very valuable tool. Before, our certified professional coders would go out and read all of the payer alerts and manuals from Medicare, Medicaid, Blue Cross and United Healthcare, and try to boil down and assimilate the things that were important to our organization. With Payer Alerts, we've got an email sitting there every morning with those things already done for us, so within just a couple of minutes we can scan through and identify what's important to us, and then very quickly communicate that out to all of our clinics and managers."

2. Better patient matching to reduce claims denials

A third of all denied claims are linked to inaccurate patient identification. This costs hospitals an average of $1.5 million per year. The go-to solution often involves an enterprise master patient index (EMPI) to match and identify patients electronically. However, EMPIs are limited by their reliance on a single data source – their patient rosters. And if an error sneaks into the patient roster, it'll be passed down when patient records are matched.

Instead, patient matching can be automated using a platform like the Universal Identity Manager. This draws on a variety of broader, more reliable data sources including Experian's demographic and credit data, then calculates the likelihood that two records refer to the same person. A Universal Patient Identifier is assigned to each patient, so their correctly matched data is always trackable.

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3. More efficient claims verification

Your claims team can probably guess the likelihood of a denial based on their experience and data, but actually turning those insights into a robust, efficient process is not easy.

Machine learning tools such as Claim Scrubber can look at which claims have been denied in the past and why, and use that data to predict future denials. It tags at-risk claims so you know to run additional checks before sending them off to the payer.

Kahlynn Lawrence, Coding Operations Manager from Northwell Health, told us:

"It was a way to automate and create a worklist so that the coder could then focus on true coding issues. By doing this we were able to see results… From 2013 to 2017 we've been able to reduce our denials by 50% through using the Experian Claims Scrubber tool."

4. Actionable insights to help optimize your revenue cycle

A high-performing revenue cycle relies on powerful data analytics. But monitoring and synthesizing all the data that flows through your organization can be challenging. Machine learning algorithms can help here, giving you deeper insights about the performance of your revenue process.

With a business intelligence tool like Analytics, you can leverage multiple datasets to find predictive solutions that boost productivity and maximize your ROI. This tool gathers several data sources into a single dashboard so you can monitor and compare your organization's performance against your most important KPIs. Industry comparisons and trends analysis will also help you find opportunities for more efficient billing, predictive reimbursement and improved payer performance.

Healthcare providers devote vast quantities of time and money to interactions with payers, often due to untracked payer policy changes, error-strewn patient records, or avoidable denied claims. More streamlined revenue cycle management can help you get those claims right the first time. You can stop wincing at the revenue and staff time lost to denials that could be invested elsewhere. So, if you're looking for ways to do more with less and stop the bleed of rising healthcare costs, perhaps cutting edge AI and automated solutions could hold some of the answers.

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Unleash Your Wellness Center for Maximum Return

BY DEBRA SIENA, PRESIDENT, MIDTOWN HEALTH

Operating a fitness and wellness center as an extension of your health system offers a unique set of advantages. It can create an invaluable connection with your patients, as they utilize the fitness center's programs and services to improve their health and well-being in a fun, supportive, caring environment. It can also motivate your employees, as well as serve as a tremendous recruitment and retention tool.

In addition, the center's reputation can lend additional credibility to your health system, as it brings comfort and encouragement to both groups as they strive to reach their personal goals and lead healthier, happier and more productive lives. By also being open to the general public, the center enhances your health system's ability to positively affect the health status of the entire community you serve.

Of course, there are costs associated with keeping up with the latest best practices in fitness and wellness center management so that you can provide the level of service and programming that will satisfy your members' needs and desires. To ensure that your facility is contributing the maximum value to your organization, it must be truly medically integrated with your health system and aligned with its mission. Also, it must yield attractive financial margins to be sustainable.

To achieve these goals, research has shown that, often, the best solution is to hire an expert management company to handle it "turnkey." Health systems and fitness centers are, in fact, very different businesses. The ideal candidate will have a medical integration team to develop and implement patient-based wellness programs to enhance outcomes. It will have the expertise to hire, educate and manage qualified and engaging staff to effectively deliver the latest fitness programs and services, which will attract and retain members. It will offer a complete array of support services. Finally, it will be able to grow revenue and right costs, while providing superior service, with the ultimate objective of making your fitness and wellness center a viable enterprise.

For this to occur, senior management must be convinced of the need for specialized expertise so that the management company you choose has the health system's full and unwavering commitment.

The Fitness Center and Your Mission

Right now, the health statistics for the U.S., and for most states and local communities, are bleak. Generating a wave of positive momentum by improving the health of your employees, your patients and your community goes to the core of your mission. Your mission is the foundation of your business, and certainly, your fitness center must be culturally aligned with its values as the filter for all center-operating decisions.

Every member and patient interaction—from the front desk check-in, to your patient wellness programs, to the membership sales process, to the group fitness classes—is a reflection of your health system and its integrity, as your fitness center is your premier consumer-facing asset. It's your opportunity to provide a remarkable and memorable experience for thousands of people in your community that will generate positive word-of-mouth. It should serve as a primary, two-way patient feeder—health system-to-fitness center, fitness center-to-health system—providing the opportunity for the continuum of care in the truest sense.

It's important to ask four fundamental questions: Has our fitness center been representing our health system in the best light? Has it been living up to its full potential? Is it helping the health system to enhance patient outcomes? Is it generating sufficient revenue to be financially sustainable?

The answer to all four should be a resounding yes; otherwise, it's time to take action. Without delay.

Fitness Centers vs. Health Systems

Living up to its potential means that your fitness center is consistently profitable or, at least, financially sustainable. If it's not generating attractive margins, it can't support your mission. Your center has little chance of being successful if it's managed the same as any other service line in your health system.

It's essential to concede that there are stark differences between fitness center management and health system management. Although synergies do exist, there are different fundamental business drivers that make a fitness center financially sustainable.

- **It's a retail business.** So, it must have a subscription membership dues model. The entire organization needs to embrace a culture of service and consumer-centered sales with attracting and retaining members as its top goal. Center staff must care enough to get to know each person individually to find out what their needs are and then suggest the appropriate programs and services to meet those needs. This is a retention-driven approach that keeps members engaged.

- **Joining is optional.** The majority of fitness center consumers have a leisure activity mindset. Because the member must make a discretionary spending decision every month to continue as a member of the facility, he or she must feel that the equipment, programs, services and support are worth the time and money. Therefore, the center's management and staff must be customer-focused and willing to prove themselves with every member interaction.

Unfortunately, the old premise of *build it and they will come* doesn't work for a retail business with immense competition. Your fitness center must always be promoting memberships and inviting your employee and patient community to join. Since today's marketplace offers so many options, people tend to be savvy and well educated

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about what they're buying. Just like a retail health club, your fitness center must differentiate—and distinguish itself—in your local market.

Much of the fitness center management company's value comes from the intellectual capital it possesses on cutting-edge health club industry trends and its execution of best practices with proven solutions. Having a resource that's on top of this knowledge is essential to appealing to a consumer with a retail mindset and focus.

Achieving Attractive Margins

As a retail business, expenses must be managed to ensure financial sustainability. The center needs to maintain operating margins in line with industry best practices. The ability to compare your center's metrics to industry benchmarks is very helpful in understanding where savings—that won't negatively affect the operation—can be found.

The International Health Racquet and Sportsclub Association (IHRSA), based in Boston, is a reliable resource for fitness industry continuing education, best practices and operating benchmarks. It tracks Key Performance Indicators that measure success, including membership growth, member retention, revenue growth and operating margins.

Best practices include:

1. **Revenue growth.** A firm with decades of experience owning successful retail health clubs can transfer its marketing and sales best practices to improve revenue of the fitness center. This revenue growth is paramount to the financial sustainability of the center.
2. **Well-chosen, well-educated, satisfied employees.** Enthusiastic, motivated staff members directly correlate to satisfied members. To attract and retain top talent, it's necessary to provide them with career paths, with access to industry expertise for professional development and growth, and with peer support. A qualified fitness center management company should involve employees with trade associations, such as IHRSA or the Medical Fitness Association, and professional round tables, certifying organizations, and other vehicles that will deepen and extend their knowledge, and keep them up to date. Your center's employees need training, support and resources to operate a first-rate facility with superior customer service.
3. **A strong bench.** Should any of the fitness center's current employees need replacement or a leave of absence, the management company can provide trained, competent personnel to keep the fitness center operating smoothly and efficiently.
4. **Superior back office support services.** You want to make sure the management company has the support team to deliver results. It should provide specialized support services in the following areas: accounting, human resources (including recruiting, ongoing education and employee training, employment law, and workman's compensation), risk management, purchasing, IT, software systems, design advisory, fitness equipment selection, capital replacement, medical integration, wellness programing, and marketing and sales. In addition, the management company can assume all workforce responsibilities and the risk/liability aspect of the fitness center.
5. **Savings on health benefits.** The management company may offer the center's employees full health benefits at a significant savings. As most benefits at health systems are 30% to 36% of total payroll, the difference can mean a significant savings to the health system, dropping 10-15% savings directly to the bottom line.
6. **Purchasing power.** If the management company runs a large number of fitness and wellness centers nationwide, it will have tremendous purchasing power that it can pass on to its clients. The health system may enjoy continued access to cost-effective, comprehensive workmen's compensation and liability insurance, fitness equipment discounts, and preferred pricing on all operating supplies.

Population Health Management for Continuum of Care

With the right firm in place, your fitness center can fully integrate with your medical service lines to extend the continuum of care for your patients. Patient-based fitness and wellness programs can also play an integral role in your Population Health Management strategy by improving patient outcomes at a low cost to maximize your return on bundled payments.

The fitness center management company should have a medical integration team that can collaborate with your health system's primary care physicians and service lines to constantly improve that integration. Effective, innovative medical integration programs can truly set your facility apart, drive down healthcare costs, and support your clinical network. Most important, these initiatives must be data-driven to ensure effective results.

The center's professional, qualified fitness staff should serve as part of the interdisciplinary care team to enhance patient outcomes and to provide them with the guidance, tools and resources to stay healthy for the long term. The team may include registered nurses, masters level exercise physiologists, certified medical fitness specialists, corrective exercise specialists and wellness coaches.

In tandem with the health system's physicians and clinicians, the fitness center staff can improve quality measures and promote long-term patient health maintenance.

For example, your health system may be looking for a resource to assist your primary care physicians with treating metabolic syndrome. Or, for an extension of its physical therapy practice. Or, for a pre-diabetic weight loss solution. Clearly, as a partner your fitness center can play a tremendous role in the continuum of care.

Exactly, how does this work?

- The physician diagnoses the patient's health issues, refers him or her to the center, and communicates all necessary information to the fitness center staff through their electronic

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health records (EHR).

- Clinicians at the fitness center choose the proper intervention.
- Patients take part in an instructor-led, 12-week program that meets twice per week, which combines movement, healthy eating and well-being tips.
- Participants can also attend weekly support groups.
- The center records and tracks weight, blood pressure, resting heart rate, BMI, six-minute walk test, physical activity vital signs (PAVS) and the person's "wellness score," as well as key biometrics such as A1C, cholesterol and triglycerides.
- The patient's participation and 12-week results are reported back to the referring physician to create a communication loop through their EHR.

The results can be dramatic. When that's the case, you've created a successful partnership with the fitness center management company that's built on a solid foundation of trust—and continuing success. That's the ideal, mutually beneficial scenario.

But it doesn't stop there. The medical integration committee continues to collaborate with the system's physicians to determine the needs of the medical community and research and develop best practices for the fitness center to make sure that they're tracked and transferred. The committee constantly develops, fine-tunes and enhances programs based on this ongoing research to better serve the patients' needs.

Lifestyle-Related Chronic Disease

The value of successful, medically based fitness and wellness centers has been well documented for decades. Given the current health status of Americans, the need for them is indisputable, even dire.

Right now, about half of all American adults—117 million people—have one or more chronic health conditions, according to the Centers for Disease Control and Prevention (CDC). Your fitness center can play a major role in the prevention and treatment of a number of these diseases—those that are related to lifestyle, in particular.

For example, the National Institutes of Health (NIH) estimates that 35% of the U.S. population has Metabolic Syndrome, a group of risk factors that raises the risk for heart disease and other health problems, such as diabetes and stroke.

The Health Status of Healthcare Professionals

It's quite a paradox; many healthcare professionals have become somewhat notorious for their unhealthy habits. Why? Could it be, as some experts project, that they're so focused on patient care that they neglect themselves? Or, that they hesitate to see the physicians

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on staff—with whom they have a professional relationship—for personal matters? Or, because they feel qualified to handle their own health issues? Whatever the reasons, their health often suffers.

One 2010 study from Truven Health Analytics (formerly the healthcare business of Thomson Reuters), looked at health risk and healthcare use among 740,000 hospital workers and their dependents, comparing them with 25 million general workforce employees and their dependents.

The results:

- Hospital workers were more likely to be diagnosed with chronic conditions such as asthma, obesity and depression, and were 5% more likely to be hospitalized.
- They were also less likely to undergo cholesterol testing and breast, cervical and colorectal cancer screening.
- As a result, these workers spent 9% more in healthcare costs than the general workforce.
- As for the physical demands of the job, surveys by the U.S. Department of Labor's Bureau of Labor Statistics (BLS) reveal that
    - o More than 35,000 back and other injuries occur among nursing employees every year, severe enough that they miss work.
    - o Nursing assistants are injured more than any other occupation, followed by warehouse workers, truckers, stock clerks and registered nurses.
    - o Nursing employees can sustain injuries from lifting and moving patients—things they must do on a regular basis.

At the same time, over the last 30 years, numerous studies in the workplace have shown that healthier, happier, fit employees will enjoy greater productivity, and will be sick, injured and absent less often.

A meta-analysis of 62 published studies of worksite health promotion programs published in the *American Journal of Health Promotion* in 2012, showed that companies that implemented effective wellness programs saw average reductions in sick leave, health plan costs, and workers' compensation and disability insurance costs of around 25%.

Clearly, with a successful fitness and wellness center, your employees will be capable of delivering a higher standard of patient care on a consistent basis—while your healthcare costs drop.

It's Time to Take the Action Required

If your fitness and wellness center could be performing better, if it could be more profitable, if it could serve a more vital role in improving patient outcomes, then it's time to move ahead. To create a strategic plan. To start generating that positive momentum. *Now.*

The members of your senior team share the responsibility for the performance of this asset. As the results improve, they'll share in that success. Why wait?

Several Medicare-For-All and Public Plan Proposals Introduced in Congress

BY KAISER FAMILY FOUNDATION (KFF)

Several bills have been introduced in the 116th Congress that would expand the role of public programs in health care. As more legislation is introduced, we will continue to update the side-by-side comparison tool. The bills range in scope from broad proposals to create a new national health insurance program for all residents to more incremental approaches that offer a public plan option in addition to current sources of coverage, private or public.

These bills are grouped into five general categories:

- Medicare-for-all, a single national health insurance program for all U.S. residents:
  - Medicare for All Act of 2019 by Rep. Jayapal, H.R. 1384
  - Medicare for All Act of 2019 by Sen. Sanders, S. 1129
- A new national health insurance program for all U.S. residents with an opt out for qualified coverage:
  - Medicare for America Act of 2019 by Rep. DeLauro and Rep. Schakowsky, H.R. 2452
- A new public plan option that would be offered to individuals through the ACA marketplace:
  - Keeping Health Insurance Affordable Act of 2019 by Sen. Cardin, S. 3
  - Choose Medicare Act by Sen. Merkley, S. 1261, and Rep. Richmond, H.R. 2463
  - Medicare-X Choice Act of 2019 by Sen. Bennet and Sen. Kaine, S. 981, and Rep. Delgado, H.R. 2000
  - The CHOICE Act by Rep. Schakowsky, H.R. 2085, and Sen. Whitehouse, S. 1033
- A Medicare buy-in option for older individuals not yet eligible for the current Medicare program:
  - Medicare at 50 Act by Sen. Stabenow, S. 470
  - Medicare Buy-In and Health Care Stabilization Act of 2019 by Rep. Higgins, H.R. 1346
- A Medicaid buy-in option that states can elect to offer to individuals through the ACA marketplace:
  - State Public Option Act by Sen. Schatz, S. 489, and Rep. Luján, H.R. 1277

Visit the KFF website for detailed plan comparisons:

https://www.kff.org/interactive/compare-medicare-for-all-public-plan-proposals

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Satisfied With the ROI on Your Employed Physician Platform?

BY KEVIN FITCH, VICE PRESIDENT, FINANCE, ADVOCATE MEDICAL GROUP

According to a February 2019 report from Physicians Advocacy Institute, 55% of physicians in the Midwest were employed by hospitals in 2018. The number of employed physicians was up 4.3% from 2016 and 60.7% from 2012.[1] As integrated delivery systems continue to acquire physician practices, finance leaders must be prepared to evaluate investment decisions and to measure performance after integrating the practices.

Finance leaders must understand the costs to acquire, set up and operate physician practices. Acquisition of an existing practice will require a significant up-front investment. Not-for-profit health systems purchase practices at the fair market value of fixed assets, including property and equipment, and intangible assets, such as medical records and assembled workforce. Additional investments also are required to integrate the practice into the system. Electronic medical record systems, office equipment, and upgrades to finishings and signage add to the expense.

In addition to the initial investment, an often misunderstood cost is the ongoing operating loss of a practice. A 2019 MGMA DataDive Cost and Revenue Survey revealed that the median operating loss for multispecialty practices employed by hospital systems in the Midwest was $199,458 per physician FTE in 2018.[2] Most physician-owned practices break even, but after joining health systems, medical groups typically operate in the red. The main drivers are decreased revenue due to lower productivity, movement of ancillary testing services (labs and imaging) to central departments, and increased salary and benefit expense for physicians and staff.

There are many reasons health systems acquire or build employed medical groups. When the natural order of the market fails to provide the physician workforce needed to meet the needs of the community, health systems justify investments based on community need and system-wide economics. Below are some strategic rationale for acquiring or employing physicians.

- Increase access to primary and specialty care in the community
- Maintain adequate coverage in the hospital setting for quality and throughput
- Grow innovative specialty services
- Expand the reach of the health network to new geographies

Because there are varying strategies and financial justifications for employing physicians, one needs to apply multiple approaches to measuring performance. Evaluating the performance of a practice on stand-alone operating income may cause tension within the organization and lead to bad decisions. The value of the employed practice needs to be assessed based on the performance of the health system's original rationale for the investment. Examples of financial benefit may include better access (shorter wait times) for appointments, improved length of stay and cost in the hospital, increased in-network care coordination, and reduced medical cost for capitated members.

While the total contribution to the health system is important, practice operations and financial performance should not be ignored. Below are tactics to improve the financial results for your employed practices.

Engage physician site leadership in practice and system performance. Local physician leaders can drive improved performance if system strategy and performance expectations are clear.

Improve clinical documentation and coding. Focused review of charge capture, documentation and evaluation, and management levels will assure compliance and potentially improve revenue.

Increase in-system care coordination. Management of specialty and ancillary orders within the system, where appropriate, will improve efficiency of care with better hand-offs and improved utilization of the system's capacity.

Standardize and centralize transactional tasks. Tasks such as coding, scheduling, the answering service and pharmacy refills can be centralized to shared service teams and work for many practices. This can lower the cost and free up clinical resources to treat more patient visits.

Consolidate small practices into larger multi-specialty sites. Site consolidation can lower occupancy and shared service expenses and optimize in-system care coordination and capacity utilization.

Align compensation models to system strategy. As business shifts from fee-for-service to value-based products, physician compensation models may shift from productivity (WRVU or collections) based approaches to salary, panel-size and contact capitation models.

Health systems should not assess medical groups as separate businesses but instead consider the entire contribution to the system's value proposition in the community. Applying these tactics will increase your satisfaction with the ROI on your system's employed medical group.

References:

[1] Physicians Advocacy Institute. "Updated Physician Practice Acquisition Study: National and Regional Changes in Physician Employment 2012-2018." February 2019. http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/021919-Avalere-PAI-Physician-Employment-Trends-Study-2018-Update.pdf?ver=2019-02-19-162735-117

[2] Medical Group Management Association. "MGMA DataDive Cost and Revenue Survey." 2019. https://data.mgma.com

Proposed CMS Medicare Rule Signals New Era of Orthopedics

BY CHAD BESTE, PARTNER, BDO CENTER FOR HEALTHCARE EXCELLENCE & INNOVATION

A recently proposed CMS rule signals that the healthcare industry should brace for another wave of orthopedic-related consolidations—especially those driven by private equity and health systems seeking to enter joint ventures with larger orthopedic practices.

In its 2020 Medicare payment rule, CMS proposed several orthopedic-related changes, including for:

- Ambulatory surgery center (ASC) facilities adding knee replacement and repair procedures as approved services
- Hospital outpatient facilities adding hip replacements as an approved service, shifting them away from their historical inpatient-only setting

At the same time, CMS has also updated its Bundled Payments for Care Improvement (BPCI) Advanced Model to include an outpatient component of knee replacements.

The move from inpatient to outpatient and ASCs began several years ago, but these collective changes from CMS represent a focused push to expedite that trend, which threatens a highly lucrative revenue stream for hospitals.

For example, the following changes are expected to negatively impact hospitals' revenue streams by the respective reimbursement amounts listed:

Approved Services Added	Estimated CMS Reimbursement
Inpatient diagnosis related group (DRG) payments	$12,750
Knee replacement procedures at ASCs	$8,600
Hip replacements at hospital outpatient facilities instead of in-patient settings	$11,000
Physician Fee Schedule	0.10%

If finalized, these changes to ASC knee replacement and outpatient hip replacements could have an adverse impact on hospitals as they open doors to new competitors, including ASC management companies and larger orthopedic practices. Such organizations could develop their own ASCs and capture this newly available patient population and value. For larger orthopedic practices in particular, this may increase their ability to add value and savings under the BPCI Program—providing even more impetus for change and opportunities for investors in the space.

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Proposed CMS Medicare Rule Signals New Era of Orthopedics

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This is triggering several responses across the health continuum:

1. Greater investment from private equity into orthopedics

BDO's Quick Take: Capitalizing on a highly fragmented market, PE firms have already been acquiring many larger physician practices with scale. As Becker's reported in May, orthopedists as well as other specialists like gastroenterologists—are among the newest targets in the PE rush into physician practices. "These firms are attracted to specialties that promise rich revenue from ambulatory surgery centers, lab, imaging and other ancillary services," the publication wrote.

This shift towards ASCs among lucrative joint replacement patients provides investors a growing opportunity for profitability, as orthopedic services provided in the outpatient setting have shown lower readmission rates and fewer complications. This is an attractive transition for PE firms to ride.

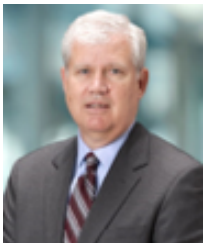
2. A new wave of branding and specialization efforts

BDO's Quick Take: The industry is moving to a value-based world, so organizations need to determine where they play in this world and promote that. Some health systems and hospitals may lose out on these lucrative volumes as patients go elsewhere for better value. Others may instead get ahead of the trend and create leading orthopedic centers of excellence to support higher reimbursement and profit margins.

Another option for health systems may be to create joint venture models with leading ASC management companies or orthopedic practices to promote volume protection and growth. For those who pursue this model, it will require both sides to conduct careful pre-venture due diligence around how to structure the agreement, what liabilities that structure opens them up to, and a careful review of clinical coding policies and procedures to ensure proper reimbursement and mitigate risk of clawbacks.

3. Increased emphasis on—and competition for—top orthopedic talent

BDO's Quick Take: In a value-based world, it's easier to identify the best surgeons based on patient volumes, complications and quality of outcomes. This information will become more readily available as industry efforts to boost transparency into the billing practices and quality ratings of healthcare organizations move forward. As greater emphasis is placed on outpatient facilities over the traditional hospital setting, organizations will need to ensure they have the infrastructure and leadership in place to attract—and retain—leading surgeons.



This article was written by Chad Beste, Partner, The BDO Center for Healthcare Excellence & Innovation, and published with permission.

Message From Our Chapter President

BY LANA DUBINSKY, PRESIDENT, FIHFMA

It's been quite a summer! Several of us attended the HFMA Annual Conference in Orlando in June, and you could feel that a new energy was in the air. There were inspirational and relevant keynote sessions followed by timely and pertinent tracks pulling healthcare finance further into innovation. The chapter is committed to taking this example and applying it to our local events and activities. We've already started!

Congratulations to the chapter leadership class of 2019 led by Rich Franco. The strategic plan Rich and the entire First Illinois leadership team set out to achieve in early 2018 was recognized and awarded during the annual conference banquet. Through Rich's leadership, vision, and commitment to create a sustainable and scalable infrastructure for the chapter, we can continue to deliver on your membership benefits for years to come.

July was a great month for us in kicking off our new vision and strategy of reinvigorating the First Illinois HFMA community. More than ever, we want to make sure you're receiving value from your membership, and you'll see us becoming even more member obsessed.

We know that your primary reason for membership is education and professional development. Did you participate in these summer offerings?

Our 25th Annual Senior Executive Invitational Golf Outing on July 8 brought over 50 of our community leaders out on the course. Chapter partners helped the event raise nearly $6,000 for our annual scholarship fund (a 35% increase over last year). A huge thank you goes to our golf co-chairs Dan Yunker and Pat Moran for another great event.

Over 80 members attended our annual Transition Dinner at Carlucci Restaurant in Rosemont on July 11. It was the first of many more opportunities for our community to come together. Multiple awards for certification, educational programming, membership, and the redesign of our website were given out. Congratulations to outgoing president Rich Franco and the outstanding volunteers this year who worked hard to bring necessary changes forward. *(See Transition Dinner Award Recipients)*

Our 5th Annual Women in Leadership Retreat was on August 19 at Eagle Brook Country Club in Geneva. Sixty-eight women leaders came out to connect with peers and themselves as they got loose with yoga, heard a reminder of the value of Taking Care of Yourself, and had a great day of golf. If you would like to join us for next year's women's event, please let us know what you'd like to see us do. Our feedback buttons are everywhere throughout our website now, so please tell us how we can meet your needs.

September chapter activities included the American Heart Association Walk at three locations: Chicago (September 20), Oak Brook (September 21) and Northfield (September 22). We hope to hear that many of our chapter members participated. Then, a social get-together was planned for just one week later, September 29, at the unique Penthouse 111 venue near Union Station. It was an opportunity to network and enjoy each other's company over the Bears vs. Vikings game, plus proceeds from the event were given to Ronald McDonald House Charities.

Now, our Fall Summit is right around the corner, on October 22-23, at the Drury Lane Conference Center in Oakbrook Terrace. It's our biggest educational event of the year. This year's program theme is ***Bold Change – Innovative Tools for Today & Tomorrow,*** and our exceptional curriculum will deliver actionable innovative best practices and insights attendees can take back to their organizations. I'm extremely proud of the team of volunteers challenging themselves to provide an exceptional curriculum for this major educational event. We're offering heavily discounted 5-person Provider Bundles to help your entire team(s) attend. Please don't miss out on this great opportunity. *(See Fall Summit 2019)*

Speaking of volunteers, each committee that makes these events happen has a need. Volunteer buttons throughout our revamped website can be used to learn where to get involved. Volunteering for a committee is a fantastic way to grow your network and help influence the value your HFMA chapter delivers. It's a hugely rewarding way to give back to our community and your fellow members. I'm excited to share we are on track to provide continuous networking and professional opportunities throughout the year; please consider volunteering.

This is the time of year when many review and re-evaluate their professional journey, and HFMA Certification may be part of your strategy for growth. Did you know First Illinois has an award winning program and committee to help you get certified? Our chapter has a higher pass rate than the national average given our commitment to preparing our members for the exam modules through special training, materials and availability of previously certified members. We'll be hosting an overview webinar on October 25, but please don't hesitate to reach out if you are ready to get started now.

Finally, I encourage you to continue to tell us the ways your chapter can improve. Please reach out to me or any of our chapter leaders. Use the feedback option on our website, or use the ***contact us link found here*** we want to hear from you.

Lana Dubinsky
2019-2020 FIHFMA President

FALL SUMMIT 2019

First Illinois HFMA

Drury Lane Conference Center
Oakbrook Terrace, IL

OCTOBER 22-23, 2019

Bold Change—Innovative Tools for Today & Tomorrow

Join us for what is always one of our biggest annual events: The FI HFMA Fall Summit. This year the Fall Summit will be held at Drury Lane Conference Center in Oak Brook on Tuesday and Wednesday, October 22-23, 2019. This year's summit promises to be a great one with several top-name featured speakers and two days of great content, including:

- Focused Educational Tracks
  - Revenue Cycle, Treasury/Finance, Compliance and Risk
  - Consumerism, Data Analytics, New Revenue Streams
- Interactive Leadership Panel Discussions
- Exhibitors
- Networking

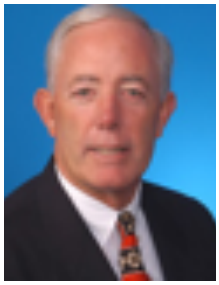
ATTEND THE FALL SUMMIT TO NETWORK WITH PEERS AND INDUSTRY LEADERS FROM Advocate Aurora Health, Lurie Children's Hospital, Northwest Community Health Care, Northwestern Memorial, Rochelle Community Hospital, Rush University Medical Center, and the University of Chicago.

HEAR PRESENTERS FROM Advocate Aurora Health, Banner Health, Baptist Health UAMS, Illinois Bone & Joint Institute, Lurie Children's Hospital, NorthShore University Health System, Northwestern Memorial, Rush University Medical Center, Shirley Ryan Ability Lab, Silver Cross Hospital, Sinai Health System, Thorek Memorial, and the University of Chicago Medical Center (UChicago Medicine).

Would your company like a presence at this year's Fall Summit? For information about exhibit space and event sponsorship opportunities that provide additional exposure for your company, contact fallsummit@firstillinoishfma.org.

REGISTER for the FI HFMA Fall Summit at http://firstillinoishfma.org.

This year's featured speakers include:



Kevin Brennan, CPA, FHFMA
A New Frontier-Healthcare Price Transparency in 2020 and Beyond

Richard L. Clarke, FHFMA
The Evolution of Health Care – Where We Are and Where We Are Going

Scott Steinberg
Leading With Innovation: How to Future-Proof Yourself, Fearlessly Innovate, and Succeed in the New Normal

First Illinois HFMA Hosts 2019 Transition Dinner

BY EILEEN CROW

The annual "Transition Dinner" is one of the most attended and popular events in the First Illinois Chapter. It's a celebration of the past chapter year and a preview of the coming chapter year, a thank-you to the officers, board members and volunteers, and a recognition event for our people and our accomplishments. This year's Transition Dinner was held on July 11, 2019, at Carlucci's Restaurant in Rosemont. Here's a summary of the evening's presentations.

2019 Chapter Achievement Awards

The Healthcare Financial Management Association (HFMA) Chapter Achievement Awards recognize chapters for outstanding performance achieved by excellent results in programs, services and administration. The First Illinois Chapter received the following awards:

Platinum Award of Excellence for Certification
Bronze Award of Excellence for Education Quality
Helen M. Yerger Special Recognition Award for
Improvement – Member Certification Program
Member Communication – Redesigned Chapter Website
Membership Retention – New Member Welcome Package
Improvement – Region 7 Conference (Multi-Chapter Award)

2019 Service Award Recipients

Founders Merit Award Program

HFMA recognizes that its strength lies in volunteers who contribute their time, ideas and energy to serve the healthcare industry, their profession, and one another.

Active participation in HFMA at the national, regional and/or chapter levels provides members with numerous opportunities for professional development, information, networking and advocacy. Established in 1960, the Founders Merit Award Program acknowledges the contributions made by HFMA members. These awards are part of a merit-rating plan in which specific activities are assigned a range of point values.

HFMA encourages continuous active participation at the local and national levels. Therefore, the point system and award levels have been established to promote continuous active participation in HFMA. The awards and this year's FI HFMA recipients are as follows.

The William G. Follmer Bronze Award is awarded after an individual has earned 25 member points. This award is named after William G. Follmer who is credited with the creation of the American Association of Hospital Accountants (AAHA), now HFMA.

Kevin F. Fitch, Jr., FHFMA, CPA
Lauren Gorski, CHFP
Greg Kain
Marilyn Niedzwiecki
Sue Marr
Denise N. Szalko
Peter Stille

The Robert H. Reeves Silver Award is awarded to an individual who has earned 50 total member points. Reeves, an organizing member of the AAHA, was elected president of AAHA in 1956 and was instrumental in creating the structure of AAHA.

Peter J. Leenhouts, FHFMA
Mathew J. Aumick

The Frederick T. Muncie Gold Award is presented to a member who has earned a total of 75 member points. This award honors Frederick T. Muncie, an organizing member of the AAHA and the first president of the association (1947-1949). Muncie also assisted in the organization of the first AAHA chapter (First Illinois).

Richard A. Franco, FHFMA

The Founders Medal of Honor was added in 1986 and is conferred by nomination of the Chapter Board of Directors. This prestigious award recognizes an individual who has been actively involved in HFMA for at least three years after earning the Muncie Gold Award, has provided significant service at the chapter, regional and/or national level in at least two of those years, and remains a member in good standing. A chapter may nominate members for this award at any time during the year.

Brian S. Katz, Manager, RSM US LLP
Carl A. Pellettieri, Principal, Impact Healthcare Solutions, LLC
John A. Orsini, CPA, SVP and CFO, Northwestern Medicine

2019 Scholarship Recipients

The First Illinois Chapter's annual scholarship program is for chapter members and their children seeking higher education. Scholarship recipients are chosen by the Scholarship Selection Committee made up of representatives from the chapter. In 2019, the chapter awarded five scholarships – one for $5,000, one for $4,000, and three for $2,000.

Riley Cooper
Joshua Harden
Brian Morton
Xihong (Jeff) Quan
Abigail Swiatek

Welcome New Members

Carlos Abadia
Senior Financial Analyst
Northwestern Medicine

Mike Adams
Director
RSM US

Jaeme Adams
CEO
SwervePay Health

Molly Addis
Manager, Financial Reporting
Northwestern Memorial HealthCare

Nick Aghakhan
Client Executive
Tract Manager

Priya Agrawal
Medical Case Manager - DRG
Mediclinic City Hospital

Maria Aguilar
Insurance Specialist III

Monsuru Alausa
Director, Business Performance
Dialysis Care Center LLC

Jean Alcantara
UX Designer
HFMA

Eric Alexander
Senior Associate
Berkeley Research Group

Anthony Armstrong
Director of Business Development
Howard Brown Health

Arshia Aslam
Finance Revenue Integrity Manager
Northwestern Memorial Hospital

Maxine Bacerdo
Program Manager, Internal Audit
Northwestern Memorial Hospital

Monica Barrett-Fischer
Director, Claims Operations
Boncura Health Solutions

Stylianos Bazigos, CSMC, CHFP, CSAF
Finance Manager - Revenue Accounting, Physican Groups
Northwestern Memorial

Ash Becks
VP, Mercy

Carrie Bill
VP Finance, Seasons Healthcare Management, Inc

Megan Bliss
Talent Acquisition Specialist YMCA of Metropolitan Chicago

Cara Boaz
AVP Client Services
Strata Decision Technology

Brandon Boone
Financial Analyst Planner
University of Illinois Hospital & Health Sciences System (UI Health)

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Welcome New Members (continued from page 19)

Aaron Brooks CRCR
Leader, Strategic Clients, Western US
Change Healthcare

Brandon Buck
Account Executive
TransUnion

Shelby Burghardt
Assurance Manager
RSM US

Kristine Burke
Health Care/Private Banker
Associated Bank

Claree Burks
Controller
Midwest Orthopaedics at Rush

Marla L Byrd
Grants Specialist
Rush University Medical Center

John Byrne
Contract Manager
ATI Physical Therapy

Nicola Byrne
Assoc VP of Finance
Swedish Covenant Hospital

Greg Caporale
Manager, Treasury
Rush University Medical Center

Armando Casas
Finance Manager
Department of Surgery
UChicago Medicine

Colleen Chenevey
Manager
Loyola Medicine

David Cook, CHFP
Administrative Fellow
Loyola University Medical Center

Donna Cooper, CRCR
COO
DuPage Medical Group

Merlinda Dalipi
Financial Analyst
Rush University Medical Center

Garrett Danelz
Administrative Fellow
Loyola University Medical Center

Hayley Dennison
Manager, KPMG

Andrew Digate
Director
Northern Illinois University

Kevin Domagala
Revenue Cycle Transformation Analyst
Nordic

Christopher Dons
CFO
Lawndale Christian Health Center

Tom Dreher
Healthcare Consultant
Baker Tilly

Matt Earle
Program Manager Finance
Northwestern Memorial HealthCare

Leticia Esparza, CHFP
Financial Analyst
Midwest Orthopaedics at Rush

Jennifer Evenhouse
AVP, Healthcare Marketing

Jon Geise
Regional Director, Strategy & Planning
Loyola Medicine

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Welcome New Members

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Anthony Gibbs
Director of Patient
Financial Services
UChicago Medicine

Brian Gilligan
Professor
Morton College

Dean Hackbarth
Account Executive I
TransUnion

Rubina Hafeez
Financial Analyst
Northwestern Medicine

Teya Harris
Revenue Cycle Supervisor
React Physical Therapy

Andrew Hughes
Data Analyst
Northwestern Medicine

Edward Ingraham
Senior Regional Sales Executive
TransUnion

Grace Jakubowski
Regional Sales Director
Experian

Karan Jariwala

Kristin Johnson
Quality Auditor
Northwestern Medicine

Garth Jordan
SVP Strategy
HFMA

Glenn Kaleta
Manager - Enterprise Capital Planning
Northwestern Memorial Healthcare

Gregory Kamp
Senior Internal Auditor
Northwestern Memorial
Hospital

Maxin Karikkattil Tomy
Accounting Associate
University of Illinois
Physicians Group
Medical Service Plan

Ted Karniewicz
Senior Director
Huron Consulting Group

Imran Kazmi
Senior Consultant
Navigant Consulting

Timothy Kelleher
Chief Financial Officer
Little Company of Mary
Hospital

Daniel Keller, CRCR
Consultant
BKD, LLP

Aryan Khan
Client Services Manager
TrueRCM Solutions Inc.

Robert Kleinhans, CHFP
Senior Solution Engineer
Oracle

Patricia Knepper
President/Owner
Great Lakes Medicaid, Inc.

Athanasia Kokkines
Senior Director Sales
Execution and Operations
HCL Technologies

Jospeh Kowalczyk
Chairman Internal
Medicine
Advocate Health

Ashok Kumar
Senior Director
GE Healthcare Partners

Natasha Lafayette Jones
Principal Consultant
Lafayette Jones
Consulting Services

Jenna Lambrecht
Associate Vice President
of Operations

Lindsey LaMotta
Event Marketing Specialist
TransUnion

Adam Leach
Sales Director
Flywire

John Loiacono
Project Manager
Xtend Healthcare

(continued on page 22)

Welcome New Members (continued from page 21)

Elizabeth Lopez
Controller
ENT&C Management LLC

Debbie Maguire
Consulting Operations
RSM US

Ben Maurer
Associate, RSM US

Stuart McDonald
Senior 340B Analyst
Maxor National Pharmacy Services Corp

Jim McGrath
Senior Vice President

Clare McIntyre
Audit Manager
KPMG, LLP

Walt Melcher
RVP, Transamerica

Julie Melvin
Executive
J Melvin & Associates

Peter Migely
Principal, CEM Medical

Grant Miller, CSPPM, CHFP, CSAF
Senior Tax Manager - Health Care, Wipfli LLP

Kate Moberg
Senior Managing Consultant
Berkeley Research Group

Richard Morrall
Region Director
Premier Healthcare Alliance

Patrick Murphy
Health Care Consulting Intern

Bilal Mushtaq
Chief Operating Officer
Paramount Health Solutions

Grace Myers, CRCR
Manager
Huron Consulting Group

Aaron Nieting
Senior Engagement Owner
Cerner Corporation

Janet Noncek
Revenue Cycle Performance Trainer
Northwestern Medicine

Jonathan O'Steen
Associate
TransUnion

Keith Olenik
Vice President, Revenue Cycle Services
Pivot Point Consulting

Hyoyun Park
Systems Analyst
Northwestern Medicine

Pooja Patel, CHFP
Analyst
Claro Healthcare

Abhi Patel
Senior Manager, Marketing
Strata Decision Technology

Natalie Perkins
Health Care Advisory Consulting, BKD, LLP

Isadorah Plaisimond
Healthcare Consultant
Navigant Consulting

Rakesh Reddy Ponagandla
Solution Designer
Cerner Healthcare Solutions

Allison Ramsden
Business Planning Analyst
University of Illinois Hospital & Health Sciences System (UI Health)

(continued on page 23)

Welcome New Members (continued from page 22)

Jillian Rodgers
Director, Patient Financial Services
UChicago Medicine

Miriam Romo
Financial Analyst Senior
Loyola University Medical Center

Mark Rosenhauer
Manager - Business Development
American Express

Diane Rudolph
Reimbursement Coordinator
Henry Ford Health System

Dhaval Shah
Division Administrator
Northwestern Memorial Hospital

Gary Silverstein
ENS Program Lead
HCSC

Harmeet Singh
Consultant
RSM US

Mike Sokol
Associate
RSM US

Nikki Stackhouse
AVP, NorthShore

Connor Sullivan
Financial Analyst

Blake Szostak
Managing Consultant
Navigant Consulting

Kyle Szumigalski
Manager
TransUnion

Ryan Tempel
Associate
TransUnion

Christopher Toups
Transaction Advisory Services
RSM US

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Rush University Medical Center

Minal Vahora
Financial Analyst Advocate
Illinois Masonic Medical Center

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Associate
Juniper Advisory

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OSF HealthCare

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Reimbursement Specialist III
Xtend Healthcare

Alison Weston
Director of Quality Improvement and Training
Rush University Medical Center

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Manager Patient Accounts - Dental Finance
Midwestern University

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Swedish Covenant Health

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Controller
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First Illinois Chapter Partners

The First Illinois Chapter wishes to recognize and thank our 2019 Partners for all your generous support of the chapter and its activities. ***Click here*** to learn more about the chapter's robust partnership program.

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VERALON

NAVIGANT

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First Illinois Chapter HFMA Editorial Guidelines

First Illinois Speaks is the newsletter of the First Illinois Chapter of HFMA. *First Illinois Speaks* is published 3 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.

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Style

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

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

Founders Points

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

Publication Scheduling

Publication Date	Articles Received By
February 2020	January 4, 2020
June 2020	May 1, 2020
September 2020	August 1, 2020