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first illinois chapter

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FIRST ILLINOIS SPEAKS

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Message From Our Chapter President

BY RICH SCHEFKE , FHFMA, CPA, 2021-22 PRESIDENT

Dear Friends and Colleagues,

We have now entered the fourth calendar year with COVID-19 being a part of our world, with new variants teaching us more of the Greek alphabet. It is safe to say we are all fatigued. It is also safe to say that our healthcare finance community has stepped up to the challenges by supporting our colleagues with the analysis and support they need to deliver high quality care while dealing with inflation plus labor and supply shortages.

At First Illinois HFMA, we continue to demonstrate how much we care about our community, and how we are serving our community and meeting our mission of providing healthcare finance education and professional development to our members.

Our chapter accomplished a lot in 2021 with the second half of the year highlighting great in-person events including the transitions dinner, golf, women in leadership, and culminating with the fall summit with our highest education survey results ever! Our chapter and region earned rare success awards for accomplishments during our last fiscal year for communication and certification. Less than 15% of chapters earned this, so kudos to Bart Richards, 2021-22 chapter president, for his leadership. It has also been great to engage our former presidents with two successful meetings of the advisory council. Lastly, our chapter was proud to finally offer a tax deduction for scholarship donations, and we are now over 2/3 to our fiscal year goal of $15,000. I encourage everyone to donate and help us achieve our goal. And for those members with college bound children, consider having them apply to the First Illinois HFMA Scholarship. *Click here to learn more!*

We continue to adapt to the ever-changing conditions and plan on providing our typical top-notch educational opportunities in 2022. We kicked off our monthly webinar series in January with a highly rated Medicare reimbursement event with representatives from National Government Services. In February, we pivoted the mid-winter get together for our Women in Leadership series to a webinar.

The First Illinois Chapter recognizes that social determinants of health and healthcare inequities is one of the most important healthcare financial issues of our day. In that spirit, we have aligned our virtual book club with Black History Month discussing Unequal Cities edited by Maureen R. Benjamins and Fernando G. De Maio, foreword by Julie Morita. The first discussion was impactful on February 1, and even if you have not read the book, I hope you will join the discussion led by those who have on March 1 from 12:00 to 1:00 pm CST for a deeper dialogue about the book overall and the important topic. *Click here to register.*

We also plan on having our award-winning complementary certification education event virtually on February 17 and 18. Earning the Certified Healthcare Financial Professional (CHFP) status is a significant achievement recognized by peers and employers alike. It is a designation that can empower you to advance to the next level in your career and ensure that your skills remain relevant and ahead of the latest industry trends. If you are a senior leader in your organization, I encourage you to consider having your team certified to amplify the importance of professional development and goal setting in your organization. Best of all, the certification fees and study materials are included with your membership dues, whether you earn one or all the designations available. Beyond CHFP this includes specialized certifications in revenue cycle, accounting and finance, business intelligence, managed care, and physician practice management. *Click here to register.*

Later in the spring, stay tuned for a super event that will combine our usually separate managed care, accounting/reimbursement, and revenue cycle events all in one place! In June, a full day in-person Women in Leadership education event is being planned with some of the best and brightest industry leaders. As we turn to summer, I hope to see you at one of our marquee networking events, the transition dinner. That's not all, we have our always popular golf outing on August 19. Finally, mark your calendars for what will be our premier education event on October 23-25 in Oak Brook, Illinois, as we supersize our regular fall summit by partnering and making it a regional conference. To make these events even greater, I have a call to action—please reach out and volunteer and bring a colleague or two. The more diversity and depth we have in our chapter operations the better our offerings and chapter become.

I want to encourage all members to give us feedback on how we are doing as a chapter. Feel free to contact me if you have thoughts on how we can improve and what is going well. HFMA is sending out our streamlined membership survey from "Bill Casey, HFMA" with the subject of "important chapter request." Each month, this survey is sent to one-twelfth of the member base to ensure widespread representation. This questionnaire assesses the ongoing value members place on the many features of HFMA membership, such as publications, chapter activities, education, and certifications. Please consider giving your chapter a "10 "if you receive the membership survey. Your feedback to our leaders, and the great survey scores we strive to earn, make a difference in helping in our goal of not only being the first chapter, but the best!

Thank you to all our annual partners for supporting the chapter. We recently went through our annual renewal process, and I'm very happy to report that the majority of our annual partners have renewed and we welcomed some new partners. Your support of the chapter allows us to continue to provide top-notch education to our members. Thank you so much for your commitment.

Finally, I want to thank all of our volunteers and our members. With you, healthcare finance in the Chicagoland area is in a world-class position. I wish everyone a healthy and happy year and I look forward to seeing you in 2022!

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5 Keys to Enterprise Risk Management in 2022

Investing in strategies to effectively anticipate, mitigate, and manage business risk is critical to future success.

As the healthcare industry moves from stability to volatility, enterprise risk management (ERM) strategies are evolving from check-the-box compliance exercises to key areas of focus for health system leaders.

The level of volatility in the healthcare industry is bigger than anyone anticipated. Distressed organizations are on the rise, half of health system leaders were unsure if they would meet budget in 2021, and more than 40 million patient records have been compromised due to cybersecurity incidents.

ERM is a leadership challenge. It is virtually impossible to predict all material variables accurately and to do so with precision at the pace required by a rapidly shifting market. In 2022, it is important that leaders make investments that help them more effectively anticipate, mitigate, and manage business risk. Five areas of focus should be top of mind.

1. Labor shortages.

Staff are "stressed, overworked, and in high demand"—and health systems are struggling to find creative solutions to lessen the load. Nurse turnover rates alone average 17.2%, while 43% of physicians are considering early retirement. Moreover, when new graduates enter the workforce, they are unprepared to provide the level of care required during the pandemic.

But there's another workforce shortage that is vexing hospitals: the shortage of nonclinical frontline staff and lower-wage clinical workers who can get paid more at Target, Walmart, or Whole Foods—and experience less grief—than at a hospital.

All of this is happening at an unexpectedly rapid pace—potentially putting patient safety and retention at risk. While some organizations have explored creative strategies to combat workforce shortages, ongoing surges of COVID-19 cases have ultimately made this impossible.

With fewer resources in place, leaders must create the means to reduce healthcare consumption. Here are six emerging prerequisites to implementing labor related ERM strategies that meet community health needs amid the presence of economic headwinds.

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5 Keys to Enterprise Risk Management in 2022

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1. Reshape the workforce to adapt to near-term demand.
2. Look for opportunities to reduce consumption of services—clinically and operationally—through improved efficiency, throughput, and capacity management.
3. Double down on strategies that navigate patients to the right care setting.
4. Get creative in recruiting talent.
5. Investigate the number of healthcare training slots in your community, the percentage of slots that are filled, and whether there are enough to fill routine needs.
6. Automate workflows to improve the employee and customer experience.

2. Capital planning.

Most capital plans were created in more stable times. Those funded by bonds include a risk section that reflected a stable operating environment.

Today, healthcare leaders must examine not just whether they have the right capital plan for an evolving environment, but also whether the financial covenants in their bond documents, combined with their operating performance, put their organizations at risk of default.

In instances where health systems are spending less on capital even with massive influxes in cash flow, there is also the business risk associated with lack of investment in innovation amid a period of disruption in healthcare.

Further, a hospital or health system's future financial position could be adversely affected by legislation, regulatory actions, economic conditions, increased competition from other providers, fluctuations in demand for healthcare services, and demographic changes. Any of these business risks could have a material adverse effect on the organization's financial health—which could affect the organization's ability to make payments under loan agreements.

ERM likely will impact your organization's capital finance agenda, especially if it's tax-exempt. The imperative for leaders: **Balance financial risk with your organization's mission imperative to invest in care delivery and resources.** This demands a more strategic, integrated approach to cost containment—one that prioritizes the goals that matter most, operationalizes improvement, and automates measurement.

3. Energy consumption and social determinants of health.

More and more, consumers view a health system's efforts to reduce energy consumption as a sign of its commitment to its mission to improve community health.

Today, air quality and water quality are considered social determinants of health, given their effects on gastrointestinal, neurological, respiratory, and even reproductive health. Among not-for-profit healthcare organizations, the call for community health needs assessments to reflect organizations' work around eliminating social determinants of health is gaining steam. It's not hard to imagine a time when an organization's work toward reducing its carbon emissions will become a focal point in CHNA review.

Developing a robust plan for energy efficiency and sustainability also makes good business sense, given that energy use comprises more than half of facility expenses. At Robert Wood Johnson University Hospital Somerset, a $5.7 million investment in energy efficiency improvements will save more than $600,000 annually.

However, as trailblazers in this area can attest, this work is not easy. **Success lies in taking stock of your organization's environmental activities, pressures, and impacts; developing a plan; securing organizational buy-in; and sustaining momentum.** It takes long-term investment and a shift in culture to reduce energy consumption.

4. Cyber risk.

Data is the new oil, but access to that data via more consumer-centric channels heightens cyber risk.

Healthcare organizations now have more IT assets per employee than any other industry in the world, with 10 to 20 devices per employee. This creates the largest attack surface with the least dollars spent per device on cybersecurity—and thus the easiest target to attack.

The currency of consumer data contained in patient health records—from social security numbers to financial and demographic data—also makes healthcare a prime target for cyberattack. In 2021 alone, 82% of health systems were the victims of cyberattacks.

It's time for healthcare leaders to develop a powerful cyber defense. Here are a few ways to start:

- **Remember that cybersecurity is not just a technology issue.** Security must be built into everything an organization does, not bolted on. As you roll out new processes, hire new personnel, and implement new technology, cybersecurity should be incorporated into each element of the organization's daily thinking.
- **Strengthen security of connected resources.** Interconnected resources increase efficiency, but they also expose your organization to higher levels of business risk. Before you plug in a new interconnected asset, it is vital to understand how the asset will help your organization meet its mission, the ways in which that asset can be secured, where it can be placed within the organization's security architecture, and the risks that the asset presents.
- **Conduct an annual assessment of your cyber posture.** Complete a third-party cyber maturity assessment on an annual basis. This provides a deeper view of an organization's cybersecurity gaps. It

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5 Keys to Enterprise Risk Management in 2022

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also generates a roadmap for measuring and improving cybersecurity maturity—vital to managing enterprise risk.

5. Increased pricing transparency.

When the price transparency regulations took effect, many in the industry thought they could just pay the fine and it would pass. As a result, by February 2021 30% of hospitals were not in full compliance with either aspect of the price transparency rule.

But the focus on price transparency has not dissipated. Instead, price transparency has expanded beyond a matter of compliance to an area of operational concern under the No Surprises Act. Organizations that lack controls to support compliance with these policies leave themselves vulnerable to enforcement action.

The stakes—consumer trust and loyalty and the organization's market position—are too high for leaders to miss an opportunity to put their organization's best foot forward. To achieve compliance, leaders should ask the following questions:

- **Scheduling:** How well does your organization validate in-network versus out-of-network coverage for non-employed providers? Are provider enrollment checks performed?
- **Billing:** How effective are your processes for adjusting or reviewing patient liabilities that fall outside the "good faith" threshold?
- **Insurance verification/eligibility:** Does your organization maintain strong processes around certification of benefits and eligibility? Are you comfortable with your price estimate process?
- **Case pricing:** Does your negotiating team have the appropriate support to navigate the independent dispute resolution process?
- **Contract negotiations:** Where does your organization stand relative to market median for your geography?

It will take strong ERM muscle to mitigate these threats in 2022 and executive support is crucial. Guidehouse works with clients across the country to help organizations anticipate and respond to volatility by integrating ERM into strategic decisions. Contact us to discuss what your enterprise risk playbook should look like in 2022 and beyond.

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2019 Supplemental Security Income Ratios Published

The Centers for Medicare and Medicaid Services (CMS) released the latest Supplemental Security Income (SSI) percentages for fiscal year (FY) 2019.

Find important information about the publication of percentages below.

Key Information

Applicable Health Care Entities

CMS published SSI data for the following health care entities:

- Inpatient Prospective Payment System (IPPS) hospitals
- Inpatient rehabilitation facilities (IRFs)
- Long-term care hospitals (LTCHs) that bill Medicare Administrative Contractors (MACs) for Medicare beneficiaries' services

Resources

You can access the FY 2019 SSI percentages electronically on the CMS website, and the following pages focus on each applicable health care entity:

- Ratios specific to IPPS hospitals
- Ratios specific to IRF hospitals
- Ratios specific to LTCHs

CMS also released a corresponding MLN Matters article–MM12516.

Timing

On November 16, 2021, CMS issued a Change Request (CR) providing technical direction to MACs.

The CR states that Medicare Part A "contractors shall update their IPPS, IRF, and LTCH provider specific files prospectively, within 30 days of the implementation date of this CR, using the latest year's SSI Ratio posted to the CMS website as of the implementation date of this CR, except when explicitly directed otherwise by CMS."

The guidance took effect December 17, 2021.

Data

The SSI data files contain:

- The provider number or CMS certification number
- Provider name
- SSI days
- Medicare days
- The ratio of days for patients entitled to Medicare Part A attributable to SSI recipients

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2019 Supplemental Security Income Ratios Published

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Methodology for Calculating FY 2019 SSI Ratios

Unlike past years, two separate SSI ratio data files exist for IPPS hospitals; one for hospitals under the Ninth Circuit's jurisdiction—Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon, and Washington—and one for all others.

According to the CR, SSI ratios for hospitals in the Ninth Circuit jurisdiction "include only 'covered days' in order to reflect the decision of the Ninth Circuit in Empire Health Foundation v. Azar (currently pending before the Supreme Court), in order to preliminarily settle cost reports.

For all other hospitals, the methodology for calculating FY 2019 SSI ratios uses total Medicare days, consistent with our existing regulations."

Considerations for Hospitals

Hospitals should keep a few factors in mind based on their classification.

IPPS Hospitals

FY 2019 SSI ratios will generally apply to Medicare cost reports beginning on or after October 1, 2018, and prior to October 1, 2019, for settlement purposes.

For IPPS hospitals, this updated data will be used to determine their Medicare Disproportionate Share (DSH) adjustment. For those hospitals that don't share the same fiscal year-end as the federal government—October 1 through September 30—we recommend a review to evaluate if the hospital would benefit from a recalculation.

Current CMS regulations allow a hospital to request a recalculation of its Medicare fraction or SSI ratio based on the hospital's cost-reporting period if it's different from the federal fiscal year. Learn more about how to recalculate an SSI percentage here - https://www.mossadams.com/articles/2020/09/ssi-redetermination.

IRF Hospitals

IRF hospitals will incorporate the updated percentages into their low-income patient adjustment.

LTCHs

LTCH discharges paid under the short-stay outlier payment adjustment will use updated SSI data.

Protecting SSI Fraction Appeal Rights

We recommend that hospitals not in the Ninth Circuit jurisdiction consult with counsel or their external partner to evaluate the necessity of a protest item for the SSI Fraction to protect the hospital's appeal rights pertaining to this issue.

When protesting items, it's important to:

- Remember to follow Medicare rules regarding the identification of an issue. Pursuant to Medicare rules, hospitals must claim an item if the MAC can pay it or protest it if in controversy.
- Provide a calculation detailing the amount in controversy including the accumulation of all applicable supporting documentation.
- Consult appeals counsel to ensure that you properly preserve your rights to reimbursement on this issue.

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Navigating Observation Level of Care and Appropriate Patient Status Determination

Placing a patient in the most appropriate level of care is important to ensure the patient is cared for with the right level of services and the hospital is reimbursed appropriately for services rendered. However, many hospitals are challenged by the status determination process and often over utilize the observation level of care. According to publicly available Medicare data, the national average observation rate (the ratio of bedded observation to inpatient cases) was 18% in 2019. The state average observation rate for Illinois facilities in the same period was 25%. This means that most short-term acute care facilities in Illinois had an observation rate that exceeded the national average (Figure 1). There are considerable financial implications to patient discharge status, which often results in missed revenue. Hospitals and health systems should consider implementing status determination process improvements to augment net patient revenue while prioritizing patient outcomes.

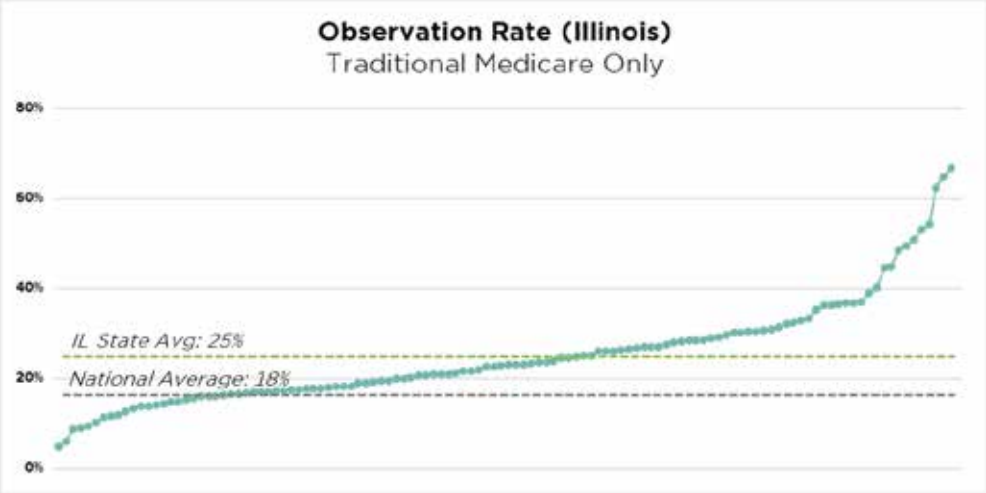

Figure 1: Traditional Medicare observation rates for Illinois short-term acute care facilities
Source: Publicly available Medicare data. Represents Traditional Medicare only.

Observation Status and Medical Necessity

Observation status is an outpatient designation that allows providers to place a patient in an acute care setting to monitor the need for an inpatient admission. Common signs and symptoms including chest pain, shortness of breath, nausea/vomiting/stomach pain and fever might result in placement in observation for further testing. Appropriate observation patients typically have much lower acuity and severity of illness compared to inpatient level of care and are commonly discharged from the facility in observation status within 24-36 hours.

A bedded observation patient can also be appropriately converted to inpatient status if there is evidence of medically necessary care. "Medical necessity," the principle defined by CMS and other payors, establishes the distinction and substantiating evidence between observation and inpatient levels of care. Medical necessity is documented within the medical record and should clearly and precisely illustrate the complexity of medical factors and the reasoning for the required inpatient admission (Figure 2). Inadequate documentation can result in payor denial for inpatient authorization and refusal of payment for services delivered. Physician documentation is the cornerstone for appropriate status determination, and there can be significant financial implications to the chosen level of care.

Observation Appropriate

- Patient complaint of shortness of breath
- Abnormal labs
- Vital signs stable
- Will need to monitor
- Consult nephrology and cardiology

Inpatient Appropriate

- Patient complaint of shortness of breath with imaging findings of new onset of congested heart failure
- Lasix 80mb IV given
- Oxygen saturation 87% once on 4L of 02
- Abnormal renal function consider, acute kidney injury
- Will need cardiology and nephrology consulted
- Patient appropriate for in patient level of care and anticipate 2 midnight stay

Figure 2: Traditional Medicare observation rates for Illinois short-term acute care facilities

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Navigating Observation Level of Care and Appropriate Patient Status Determination

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Financial Implications of Observation Management

Delivery of care and outcomes are the priority. But appropriate patient status and level of care determination can significantly affect net revenue. Payor reimbursement (for both government and private payors) typically differs considerably between observation and inpatient status. While the nuances of payor agreements may vary across payors and facilities, reimbursements for observation discharges are often lower than inpatient payments. While this reimbursement differential can vary, a typical Traditional Medicare case can provide an illustrative example. CMS IPPS and OPPS final rules stipulate that a standard inpatient case is reimbursed approximately $6,500, while a standard observation discharge is reimbursed approximately $2,000. In this example, there is approximately a $4,500 reimbursement variance for a case that might have received the exact same care but was discharged in an inappropriate status. This positive reimbursement variance is similarly prevalent with other government and private payors. Across most payors, documentation of medical necessity and deliberate processes for status determination can have a significant impact on net patient revenue.

Observation Management Best Practices

There are several ways that a facility can align care delivery and revenue cycle functions through level of care and status determination processes.

Care Team Collaboration

Collaboration and communication among the care team members (providers, utilization management, and nursing staff) is critical to a successful observation management program. This includes deliberate discussions regarding patient needs and plan of care between care teams. This also includes documentation within the medical record that clearly substantiates the medical necessity. A dedicated huddle to focus on observation patients also enables communication and collaboration. This observation huddle serves as a forum for Case Management, Utilization Management and Physician Advisors to review all observation patients at least once per day and is an effective method to highlight any barriers to discharge, necessary follow-up actions, and status conversion potential.

Status Determination at the Portal of Entry

Appropriate status determination from the emergency department reduces the need for conversion to an inpatient status later in the stay and helps place the patient in an appropriate care setting. Facilities with leading patient status processes dedicate Case Management/ Utilization Management staff in the emergency department to own the initial status determination process. These staff should be integrated into a collaborative process between ED providers and hospitalists that focuses on effective communication, accurate initial medical necessity reviews, and timely provider documentation of patient needs and acuity.

Utilization of Observation Units

When observation cases are bedded on inpatient units, care teams often have difficulty differentiating between patients placed in observation status or inpatient status. This results in longer lengths of stay for observation cases and increased resource utilization for observation care. A hospital can delineate patient status assignments by implementing a unit focused exclusively on observation patients. Sometimes these units are within or adjacent to emergency departments. This enables the care team to automatically differentiate observation patients from other bedded patients. It also allows for increased monitoring of observation patients (recommended rounding 3x per day vs 1x per day). Sometimes facilities will introduce diagnosis-specific algorithms to aid in this colocation process, including chief complaints such as chest pain, syncope and collapse, heart disease, cellulitis, and headaches. If a dedicated observation unit is not possible, providers and transfer centers should attempt to cohort observation patients as much as possible.

Physician Advisor Integration

A sophisticated Physician Advisor (PA) program utilizes the PA resource as an engaging liaison between Case Management, Utilization Management, providers, and administration. The PA can aid in the status determination process through secondary review of the observation cases and can assist the UM team and providers through the documentation process. The PA may also be involved in additional processes including payor appeals, denials management, education for providers, and other quality improvement efforts.

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Guide to the Provider Relief Fund Single Audit Requirement

As a provider of healthcare services and support operating during COVID-19, you may have received funding from the U.S. Department of Health and Human Services (HHS) as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act. If the funds are used appropriately, they do not need to be repaid, but they do come with unique compliance, reporting and audit requirements that recipients must adhere to.

Your facility's provider relief funds (PRF) are subject to a Single Audit if allowable expenditures or lost revenue amount to $750,000 or more during periods outlined in the HHS chart below. If this is the first time your organization is subject to the Single Audit, you are not alone. Over the next two years, many entities that have received federal funds and have incurred expenditures or lost revenue exceeding the $750,000 threshold may require a Single Audit for the first time.

	Payment received period (payments exceeding $10,000 in aggregate received)	Deadline to use funds	PRF portal reporting time period	Schedule of Expenditures for Federal Awards (SEFA) Reporting
PERIOD 1	From April 10, 2020, to June 30, 2020	June 30, 2021	July 1, 2021 to Sept 30, 2021	FYE's of June 30, 2021 through June 29, 2022
PERIOD 2	From July 1, 2020, to Dec 31, 2020	Dec 31, 2021	Jan 1, 2022 to March 31, 2022	FYE's of December 31, 2021 through FYE's June 29, 2022
PERIOD 3	From Jan 1, 2021, to June 30, 2021	June 30, 2022	July 1, 2022 to Sept 30, 2022	Guidance will be included in 2022 Compliance Supplement
PERIOD 4	From July 1, 2021, to Dec 31, 2021	Dec 31, 2022	Jan 1, 2023 to March 31, 2023	Guidance will be included in 2022 Compliance Supplement

According to the Office of Management and Budget (OMB), a Single Audit covers the entity's entire operations. It is intended to assure the federal government that a nonfederal entity is following the requirements of federal statutes, regulations, and terms and conditions of awards for its major federal programs, and it must be conducted by an independent auditor.

Though the Single Audit deadline is ordinarily nine months from the recipient's year end, OMB has made a six-month extension available to entities up to and including June 30, 2021, year-ends, for entities that have not yet filed their Single Audit as of March 19, 2021. The expenditures and lost revenue reported in the Single Audit should mirror the submission into the HHS reporting portal. Although the portal reporting for Period 1 ended on September 30, the HHS has extended a grace period lasting from October 1 through November 30 to complete portal submission. January 1 through March 31 is the filing timeline for entities who received funding in Period 2. Start preparing well ahead of your deadline. Now is the time to build your understanding of Single Audit requirements and prepare to file.

Tips for filing a Single Audit

There's a first time for everything, but in the case of meeting Single Audit filing requirements, you'll only have one chance to get it right. The path to accurate reporting is paved with the following best practices.

Mind your due dates

Shifting filing dates resulted in some confusion regarding deadlines, but this was not the OMB's intention. Deadlines were pushed back to give organizations time to deal with the ongoing pandemic, get records in order, and hire a qualified auditor. However, some entities feel they may need additional time. The OMB six-month extension, as mentioned above, is available to all entities who have not yet filed their

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Guide to the Provider Relief Fund Single Audit Requirement

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Single Audit as of March 19, 2021. Though organizations are not required to apply for this extension, recipients should maintain documentation of the reason for delayed filing.

First, assess internal controls

Filings must abide by the Schedule of Expenditures of Federal Awards (SEFA), which lists expenditures of all federal awards and should align with accounting and other records. The auditor uses the SEFA to assess risk, identify major programs to be audited, and determine whether the SEFA has been fairly stated in relation to the holistic financial statement. Prior to the Single Audit, it is helpful to conduct a gap assessment that compares the design and execution of internal controls to the requirements dictated by each major grant or funding source. Performing a gap assessment in advance of the auditor's review helps you identify problems—companies frequently find that although their internal design complies with SEFA, their execution does not—and prepare an explanation for why you may fall short of the requirements.

Hire an experienced independent auditor

Your Single Audit must be prepared by someone outside of your organization, but the unique nature of the Single Audit means you shouldn't trust just any outside party. The ideal independent auditor is typically a CPA who specializes in Single Audits and is up to date on continuing education courses required by Government Accounting Standards (GAS). Act quickly to secure the help of a specialist, as they'll likely be in high demand as filing deadlines creep closer.

Organize federal grant information and other financial records

The Single Audit encompasses expenses or lost revenue incurred in periods both before and after the award existed and spanning more than one fiscal year. An auditor can only assess what you provide, so it's important that you are transparent and methodical when presenting them with information. Organize all federal grant information, including grant award documentation and each award's Assistance Listing (AL) number so that the auditor can easily summarize it for filing. Supply the auditor with documents pertaining to expenditure justification as well as recent financial and performance reports.

Practice good data governance

Record organization comes easier to companies that prioritize data governance. Having processes and standards in place to manage and safeguard data can save you time, money and the potential reputational damage that could result from a breach. Healthcare data, such as patient medical records and payment information, is a prime target for a cyberattack. To protect patient data, more states are enacting and enforcing data privacy laws that come with hefty fines for non-compliance.

What should I do next?

Perhaps more than any other industry, healthcare has undergone major changes caused by COVID-19, but not all changes have to be overwhelming. Take it from a firm with experience: meeting the Single Audit filing requirements can be achieved with proper preparation and professional guidance.

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What's Next?
Business resilience is being tested daily.
It's time for an urgent script for healthcare. To survive in today's environment, healthcare leaders must identify ways to improve financial, clinical and digital performance. But it's not enough for your organization to just keep pace.
BDO stands with you to address your current situation, performance opportunities and future growth scenarios, helping you anticipate what's next and transform data into actionable insights.
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Emerging Transparency Laws:
Applying Lessons from the GameStop Saga to Healthcare

GameStop's publicly traded shares experienced unprecedented volatility, caught in a market battle between bulls and bears, longs and shorts, institutional and individual investors. It captured the imagination of the country, appearing to some as a distribution of wealth and others as wildly reckless behavior that must be regulated, while also capturing the attention of the government, resulting in hearings and new regulatory proposals.

What Happened with GameStop?

Individual investors gathered on Reddit, a website where internet communities organize within spaces called "subreddits." These subreddits are (mostly) autonomous message boards staffed by their own moderators, using their own rules and guidelines. One such subreddit, called WallStreetBets, has operated as a location where individual investors, whether highly sophisticated or poorly informed, gather to discuss potential investments.

Using metrics such as floating stock, short interest, and options activity, members of the subreddit began to believe that due to a particular set of circumstances, small investments in GameStop's shares could trigger a large movement in its price. As the price increased, and word got out about the strategy, more investors piled in, and the share price skyrocketed.

Lessons for Healthcare

Some healthcare industry segments have the same sensitive and complex data as do financial markets and have sought to emulate certain of their practices. In previous articles published in this newsletter, we have ourselves borrowed the concept of the financial portfolio in establishing the Personal Healthcare Portfolio for organizing health records. Translating the GameStop circumstances into healthcare, we have determined that there are three main points to take away.

1. Information transparency permitted individual investors to pull together increasingly sophisticated research.

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Emerging Transparency Laws: Applying Lessons from the GameStop Saga to Healthcare

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2. Technology facilitated both information gathering and sharing, and the organization of like-minded individuals.

3. Online communities played an important role for individual investors to more broadly share the available information and discuss how to interpret it.

Information Transparency

Information is crucial to identifying investment opportunities in the stock market, and technology has, over time, made access to it easier. Major exchanges, such as the Nasdaq and NYSE, are the major gatekeepers of this data, which can cost significant amounts of money to access.

Presently, certain metrics have become freely available thanks to the National Market System (NMS), which was established by the Securities and Exchange Commission (SEC). The SEC also enforced data transparency laws, which include certain financial and information disclosures (e.g., Form 10k) and which are all currently filed on the SEC website via the EDGAR database.

As noted with the events that led GameStop stock's meteoric rise, the availability and transparency of information to the general public played a key role in assisting the retail traders to evaluate the investment opportunity. Until recently, healthcare cost and price information has been anything but available and transparent. With the passing of the Affordable Care Act, there has been growing pressure to easily obtain price transparency for any healthcare services–before that particular service is provided. A new law, finalized in 2020, creates transparency around the cost of care that any insurance plan would provide through their programs. Patients could easily access pricing information associated with their insurance plan in order to review or price compare for the best deal.

A key feature of this new health transparency law is the partial disclosure of cost-sharing information–scheduled to be in effect in 2023 with plans to expand the amount of information that will be available after 2024. The specifics indicate that restrictions will limit available data to patients based on what providers are in their network, whether or not they are enrolled within that insurance plan, if the service they're seeking is medically required or not, and whether or not the treatment is considered preventative. Nevertheless, the law will certainly lead to patients and businesses that are enrolled in these plans accessing more detailed information than heretofore.

For hospitals, different regulations were enacted before this bill was finalized into law. In 2019, a CMS proposed price transparency rule came into effect that required all hospitals to publish their Chargemasters, which is a list of every possible hospital service and item with associated costs. While it is a step in the right direction, there are still many other factors that influence healthcare costs that are not readily available from simply viewing a list of prices online.

These tools only affect outpatient or planned visits and services and cannot account for any emergency or sudden medical care and would require further refining to prove effective.

Technology Assistance

In equities markets, the advent of the telegraph and the stock ticker were early technologies that widely expanded access to market data. From there, the telephone, television, and the internet revolutionized the way we trade and receive information about those trades. The internet in particular has removed many barriers to stock trading, as online brokerages provide detailed analysis, news, and the ability to place trades both on a computer and on a smart phone.

Further removing barriers to trade has been Robinhood, an online-only brokerage that has a sleek and simple interface and, most importantly, no fees for trading. Eliminating what has traditionally been a serious barrier to market participation, this further contributed to the GameStop saga as record levels of small investors entered the market.

It is still extraordinarily difficult for a patient to determine pricing using currently available information–but that is changing. Further advancements in handheld technology have streamlined how we access information and communicate with healthcare providers. Some healthcare systems began to use online portals to make providers and records more accessible to patients, and progress has been forcibly advanced due to COVID-19. Now nearly every healthcare provider has digitized how they reach out to patients or how patients can contact them.

Some organizations have taken this progression towards smartphones to the next level. United Healthcare has already rolled out what many believe is the next step in competitive healthcare pricing. Their app takes into account your area, available providers, and your current deductibles to compare providers and prices. Competitive pressures will likely lead to more insurance companies following suit, with increased price transparency and without the complications of governmental regulations.

Online Community Organization

The internet has facilitated information sharing and discussions worldwide, including on increasingly niche subjects. On the Reddit WallStreetBets forum, there are communities centered on particular company stocks, different asset classes, and alternative investment strategies.

WallStreetBets has its weaknesses, however, and is not an ideal model for how online forums can have a positive impact on patient choice in healthcare. Market research at WallStreetBets can range from careful considerations of trends, fundamentals, and news catalysts, to buying complex financial derivatives based on whether a gecko was hungry or not. Delving into the comments section of any given discussion thread

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may provide multiple sides of an argument; however, if there is too much runaway excitement about a stock, naysayers might be ganged up on and "down-voted to oblivion," using Reddit's voting system to effectively hide unpopular opinions. Despite its weaknesses, this environment developed organically and became the location where the information was shared that led to the rise of GameStop's stock price.

Although we were able to see the collective force of a global retail trading market come together to attempt to influence the stock market, the larger influence on the healthcare field will be limited. The limited issue of price transparency and how it affects patients is uniquely an issue within privatized healthcare.

Because of this fact, online communities will be limited in the information they can bring together and the influence they may have on healthcare pricing. Even with the advent of transparency laws, two barriers remain: the first is that the notion of proprietary rates held by payers is yet to be resolved. The second is that the list of hospital services and prices is itemized, and patients will not know how to combine them into the full charge for services they receive.

In comparison to the WallStreetBets forum, there is essentially no online presence of communities—outside of the professional industry—that are actively looking to find competing prices among healthcare providers, and little understanding of the process behind the prices themselves. This may change as new laws come into effect, of course. How these groups form, and under what circumstances, cannot be easily predicted.

Final Discussion

After seeing the close parallels between healthcare and financial markets in terms of data and communications trends, what can WallStreetBets and the GameStop saga tell us about the future of healthcare?

Most readily apparent is that healthcare still has a long road ahead towards a more transparent pricing market. From revenue cycle concepts to payor/provider negotiations, there is a lot that remains obfuscated and difficult to understand. The above trends should, over time, make the market more accessible. However, for the time being, healthcare remains significantly behind finance in terms of transparency.

In a more speculative light, is there a possibility that transparency in healthcare leads to an event similar to the activity around GameStop shares? Unlikely. While the trends towards data transparency and technology will lead to online community information sharing and discussion, the reasons why individuals pursue healthcare services creates no incentive to irrationally bid up their price, and little to avoid treatment until the price falls. If "meme" hospitals are not in our future, what may be?

In one scenario, providers could directly recruit patients into their own inclusive benefit plans, where the patient would pay directly to the provider for services, completely cutting the payor out of the transaction. Whether or not it would be more beneficial to the patient depends on a number of factors, but patients who become increasingly frustrated with the current payor system may opt into the benefit plan presented by the providers if it meant total and complete clarity regarding what they will pay for services received. This could disrupt the monetary relationships between the payor and the plan sponsor.

Or the consumer might directly reach out using a forum of exchange where pricing rates are negotiated directly with providers. This would also disrupt the monetary transactions within the current system. If online communities organized to promote these exchanges or alternative benefit plans, the effects would be even more pronounced.

Although commentators might argue whether the GameStop saga was an ethical exercise in the equities market, the trends leading to its occurrence—data transparency, technology, and community organization—has undeniably empowered more small investors to make their own data-driven decisions with their own money. We see information transparency, online information-sharing, and technology translating into cost savings for patients and greater autonomy for those empowered to learn.

About the Authors

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[I] E.g., https://www.nyse.com/market-data/pricing-policies-contracts-guidelines

[II] https://www.sec.gov/edgar/about

[III] Further information on what restrictions will be in place can be found within Bill S.4106.

[IV] Note: the movement of money from in between the patient, provider, payer, and plan sponsor

Continued Funding is Key to Health Care Recovery

The devastating effects of the pandemic have caused many to wonder if the world will ever be the same. For health care providers the impact has been extreme, multifaceted, and prolonged to the point that the end is not yet in sight.

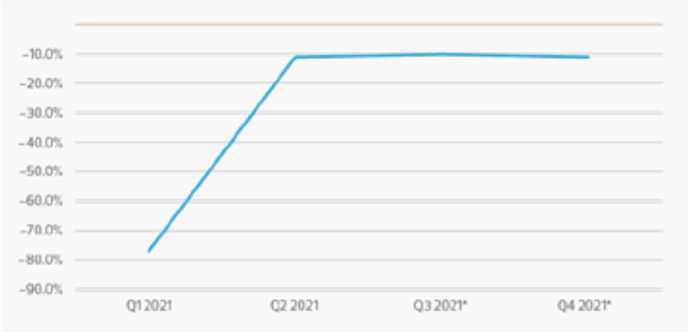
The financial impact of the pandemic has been fairly significant and dramatic for the health care industry for three primary reasons:

- Temporary government restrictions on non-emergent services
- People wary of coming into health care facilities due to fear of contracting COVID-19
- Rising costs of supplies and labor

The Coronavirus Aid, Relief, and Economic Security (CARES) Act, passed in late March 2020, provided health care providers financial relief as a result of the pandemic. Along with subsequent legislation, the CARES Act established the Provider Relief Fund with nearly $200 billion. The first distributions were paid in April 2020 and continued through 2021. The latest round of funding, referred to as Phase 4, was announced September 13. This phase will start distributing funds that were part of the American Rescue Plan.

This funding is much needed by the health care community. Kaufman Hall recently released an analysis suggesting hospital systems will lose an estimated $54 billion of net income even after taking into account the CARES Act funding. The data in the accompanying chart provides actual and projected margins for hospitals as compared to the pre-pandemic baseline.

Hosptials' net income margin change from pre-pandemic baseline



Source: Kaufman Hall; RSM US LLP *projection

Phase 4 funding will provide more relief for health Phase 4 funding will provide more relief for health care providers to help them get back to their baselines; however, the funding was established to provide assistance for lost revenues and expenses experienced only from July 1, 2020, through March 31, 2021.

We expect that health care providers will continue to lobby for further funding, particularly now that multiple variants have caused yet another influx of patients.

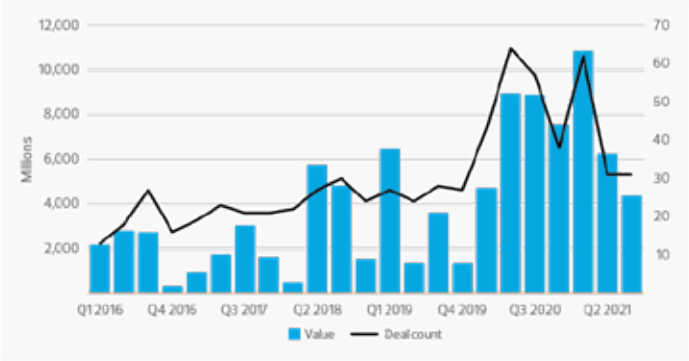
INVESTING

Capital market activity continues unabashed as the health care ecosystem responds to COVID-19

The pandemic has brought about significant disruption in health care. Patients received a taste of virtual and digital health solutions, and many do not want to fully return to pre-pandemic care delivery models. Administrative workforces have gone virtual or hybrid, and clinical workforces are clamoring for relief and reinforcements from travel nursing agencies and technology platforms. Financial investors are actively positioning themselves to capture the growth opportunity these changes represent, as seen in the public and private capital markets.

Initial public offerings, excluding biotech and pharmaceutical companies, have exploded since the onset of the pandemic. Investors poured $30 billion into 130 health care deals in 2020, and $21 billion across 130 deals through the third quarter of 2021. Prior to the pandemic, the ecosystem saw about 70 to 100 new listings per year that raised a cumulative $7 billion to $12 billion.

Health care product and service IPO value



Source: Bloomberg

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Continued Funding is Key to Health Care Recovery

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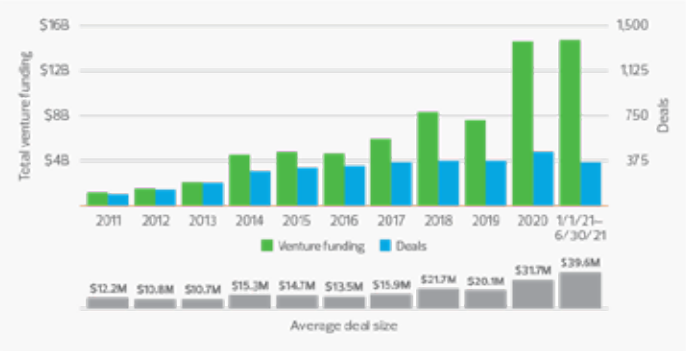
IPOs are an increasingly attractive exit for early-stage and private equity-backed companies. Some of the largest health care IPOs of the pandemic era include Bright Health (raised $924 million), Amwell ($853 million) and Clover ($828 million). In addition, billions of dollars sitting in special purpose acquisition companies may take private health care companies public via that process.

Investors in early-stage digital health companies are hopeful the favorable IPO market persists as they continue to invest record amounts in the space. According to Rock Health, such companies received $14.7 billion in venture capital during the first half of 2021, an increase over the $14.6 billion invested in the entire 2020 calendar year. Over that same period the average funding round increased to $39.6 from $31.7 million, underscoring the increased investor appetite for and competitive nature of early-stage digital health funding rounds.

Digital health funding, January 1, 2011 through June 30, 2021*



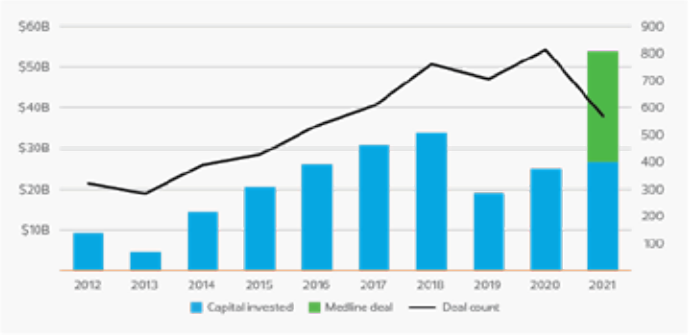
Source: Rock Health Funding Database

*Only includes U.S. deals >$2M

The year 2021 will no doubt go down as the busiest for private equity investments in health care, and it isn't over yet.

Meanwhile, private equity has doubled down on its activity within the health care ecosystem. The year 2021 will no doubt go down as the busiest for private equity investments in health care, and it isn't over yet. The behemoth $27 billion acquisition of Medline by a private equity syndicate—which included powerhouse firms Carlyle and Blackstone—reinforces the notion that private equity firms, and the limited partner investors they represent, remain intensely interested in health care.

Private equity has invested $237 billion in health care in the last 10 years



Source: PitchBook

Private equity investment shows no sign of slowing. Currently health care-focused funds in the United States have $148 billion in dry powder—i.e., undeployed capital. These same investment firms have also raised $35 billion in new health care dry powder, nearly halfway to their collective goal of raising $79 billion more, according to Bloomberg. For context, $148 billion could buy approximately 12 Ford-class aircraft carriers—and the U.S. Navy currently operates 11.

Health care expenditures continue to grow and market opportunities are expanding. Interest rates will also remain low for some time, further easing the deal-making climate.

Investment in health care will not slow in the near or immediate term. Health care expenditures continue to grow and market opportunities are expanding. Interest rates will also remain low for some time, further easing the deal-making climate. Leading health care organizations and investors are leveraging the capital markets for acquisitions, divestitures and additional funds to position themselves to capture future growth in the ever-changing health care ecosystem.

About the Authors

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ILLINOIS PROVIDERS BEWARE-
HFS' NEW MCO DISPUTE PORTAL LIMITS YOUR OPTIONS

We know with Department of Health and Family Services ("HFS") recent enactment and implementation of the new MCO Dispute Portal ("Portal") that many of your disputed claims with Managed Medicaid payors could be impacted. However, we wish to caution HFMA Members as the current structure of the Portal can set significant limitations on potential recovery, especially for contracted providers and claims dealing with clinical denials for lack of authorization. We understand that use of the Portal is subject to each of your individual contractual and business arrangements with the MCs and we continue to advocate for your best possible recovery options and strategies, whether they be through the Portal or through legal action.

General Layout

LEGAL FRAMEWORK FOR THE PORTAL: The Portal was established by 44 Ill. Reg. 4616 and became effective as of March 3, 2020. HFS now utilizes the Portal to encourage prompt resolution of disputed claims between Providers and MC payors. Under the new Illinois laws and regulations, Providers may submit disputed claims to the Portal through a uniform complaint system (limited to 100 complaints per submission) to resolve the claims. There are however many caveats to this noble arrangement.

Process:

First, Providers can only submit these disputed claims to the Portal after the internal dispute resolution process (es) of the subject MC payor has been completed. If Providers do not complete this internal dispute step, HFS and the Portal will reject the complaint.

Second, there is a limited time window within which to submit the complaint. Provider cannot submit the complaint until 30 days **after** submitting the claim to the MC through the internal dispute process, and **no later** than 30 days after the unsatisfactory resolution of the internal MCO process or 60 calendar days after submitting the dispute to the MCO internal process. Providers must follow this strict period for the claim to be eligible for use through the Portal.

Third, the Dispute Resolution itself does not objectively favor Providers. The system is set up in such a way that after the complaint is submitted through the Portal, HFS will submit the complaint to the MCO and the MCO will review the complaint and issue a proposal for resolution. Arguably, if the MCO has already denied the claim through its internal dispute process, it will not change its previous denial if nothing has changed. Further, if the proposal that the MC submits is unsatisfactory to the Provider's liking, the Provider can only appeal to HFS. The current Illinois rules and regulations are not specific enough nor clear enough to protect Providers from the erroneous MCO denials from being upheld. There are no specific requirements that HFS utilize skilled, unbiased reviewers. There are no requirements that clinicians review matters involving clinical denials. In fact, there is no requirement that HFS even utilize a process that ensures established guidelines or rules as to why HFS upheld or overturn a denial.

Fourth, the decision is FINAL. If HFS upholds the MCO's proposal/ denial - Providers have no further recourse. Providers lose all rights for recovery once the Portal process is complete.

Recommendation

We strongly encourage HFMA Members to consider the contractual protections they have agreed to in their established, well negotiated, MCO contracts and understand that such protections offer more effective advocacy. The Dispute Resolution provisions within MC agreements have clear, unique, specific guidelines that the Portal lacks.

In addition, for denials regarding clinical claims and claims for no authorization that require medical records and expert testimony, Providers should avoid using the Portal. The Portal system does not require expertise or specialization. HFS rules and requlations are not specific nor defined enough to establish the definition of medical necessity or convince an undetermined HFS reviewer that even if a claim lacks authorization, the claim should still be paid because the services were medically necessary and the Provider performed the medically necessary services. Providers are more likely to make successfully this foundational argument in dispute venues other than the Portal.

While we understand HFS intended to allow for expedient, effective MC claim dispute resolution, we must remind HFMA Members that HFS and the state are interested parties in these matters and the Portal does not protect Providers from that bias. The effective accountability of neutral third parties through either the Courts or Professional Dispute Resolution Systems like AAA offer additional protection that the Portal does not have. Should a judge rule improperly, or an arbitrator go way off the ranch - a Provider may be able to appeal. Under the Portal, Providers have no such recourse. Further, unlike the Portal, in a lawsuit or arbitration - it is possible to introduce precedence of prior rulings in similar matters that can effectively persuade a neutral third party. The Portal does not establish, nor require, nor efficiently implement the use of precedent and previous rulings when considering your complaint.

For those Providers handling MC claims in non- contracted situations, we encourage our clients to consider the cost -benefit analysis of a lawsuit against an MCO versus a submission through the Portal. The quick, relatively simply process of the Portal is quite attractive, but rife with potential restrictions and limitations.

About the Author

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First Illinois Chapter HFMA Scholarships

The First Illinois Chapter's 16th annual scholarship program for its members and their children seeking higher education will award five scholarships—one for $5,000, one for $4,000 and three for $2,000—for the 2022-2023 academic year. Scholarship recipients are chosen by the Scholarship Selection Committee made up of representatives from the chapter. The application consists of six parts: the application, a letter of recommendation from a faculty member, two letters of reference, an essay/testimonial, academic transcripts, and an interview with the Scholarship Selection Committee. Scholarship recipients and their parents will be recognized at the First Illinois Chapter's annual installation event and awards ceremony in Spring/Summer 2022.

All applications must be postmarked by March 4, 2022

Click here to download the 2022-2023 Scholarship Application

Eligibility requirements

- Applicants must attend or plan to attend an accredited college, university, or proprietary/trade school.
- High School Seniors and Undergraduate students are eligible to apply.
- Only one scholarship per student will be awarded during their lifetime.
- First Illinois Chapmembers and their children are eligible for scholarships.
- Applicants must be U.S. citizens/
- Mail applications to: Vincent Pryor, Silver Cross Hospital, 1900 Silver Cross Boulevard, New Lenox, IL 60451.
- All scholarships will be awarded no later than May 31, 2022.
- Please direct any questions to Vince Pryor at vpryor@silvercross.org or (815-300-7011.

The application consists of six parts: the application, a letter of recommendation from a faculty member, two letters of reference, an essay/testimonial, academic transcripts, and an interview with the Scholarship Selection Committee.

The Scholarship fund is supported by proceeds from the annual Executive Golf and Scholarship Event (August 19, 2022) and by your generous tax-deductible donations.

Click here to donate today.

First Illinois HFMA Upcoming Event Promotions

These in-person events are going to be special, and we can't wait to see everyone back together (safely).

Event Sponsorship Opportunities Available at all events!

First Illinois Chapter HFMA Spring Forward Event:
Managed Care, Revenue Cycle and Accounting & Reimbursement

May 19-20, 2022

Fairmont Chicago, Millennium Park
200 North Columbus Drive,
Chicago, IL 60601

You asked and we listened!

Join us for a day-and-a-half of education and networking in person event for the latest on Managed Care, Revenue Cycle and Accounting & Reimbursement...all at a beautiful downtown Chicago location

Women in Leadership Retreat

June 9, 2022

Morton Arboretum
4100 Illinois Route 53
Lisle, IL 60532

A not to be missed day of education in a bucolic setting including leadership panels and workshops

HFMA Region 7 Midwest Conference

October 23- 25, 2022

Hilton Chicago/Oak Brook Hills
Resort & Conference Center
3500 Midwest Road
Oak Brook, IL 60523

Join us at this year's dynamic two-and-a-half day educational and networking event that attracts healthcare leaders from the HFMA Region 7 chapters of Illinois, Indiana, and Wisconsin!

Welcome New Members

September 30, 2021 –February 5, 2022

Evelina Adamski
Business Analyst
Claro Healthcare

Shazad Ahmed
Director
Huron Consulting Group

Sophie Akin
Analyst, Advisory Services
Nordic Consulting Partners

Donisha Anderson
Financial Services
Advocate Aurora Health

Sarah Anderson
Performance Trainer
Northwestern Memorial Hospital

Olga Arango
Coder
Advocate Aurora Health

Carlos Aranibar
Senior Financial Analyst
Northwestern Medicine

Elizabeth Asare
Division Administrator
Northwestern Memorial Hospital

Hareem Baig
Healthcare Consultant
Guidehouse

Khushnaz Bamboat

Maggie Barlow
Senior Director
Huron Consulting Group

Jonathan Bender
COO
Doctors of Physical Therapy

Gregory Bergman
Corporate Controller
Allina Hospitals & Clinics

Stephanie Biegel
Senior Accountant
Advocate Aurora Health

Michael Borland
Integration Architect
Cerner Corporation

Connie Brown
Director
Huron Consulting Group

Lauren Bullaro
Senior Account Executive
Honeywell

Chad Calabria
Revenue Cycle Specialist - Patient Access
Advocate Aurora Health

Heather Callan
Director Revenue Cycle Education
Advocate Aurora Health

Sondra Cari
Managing Director
Huron Consulting Group

Connor Carmichael
Consultant
BKD, LLP

Idorenyin Carter
Financial Planning & Analysis Manager
University of Chicago Medicine

Anthony Cathey
Cancer Insurance Specialist
University of Chicago Medicine

Anthony Cathey
Cancer Insurance Specialist
University of Chicago Medicine

Ariel Chandler
Senior Consultant
Protiviti

Gina Cialoni
Practice Manager
Advocate Healthcare

Andy Clarke
Manager
Plante Moran PLLC

Vonica Coleman
Patient Access Coordinator
Advocate Trinity Hospital

Jacob Collins
Consultant
Guidehouse

Brandon Cosby
Director of Finance
Northwest Health La Porte

Kristina Costello
Consultant, Advisory Services
Nordic Consulting Partners

Stephen Crouch
Advocate Health Care

Tara D'Agostino
Tax Managing Director
KPMG LLP

Julie Dahlke
Physician Coding Lead
Advocate Aurora Health

April Damaska
Revenue Recovery Analyst
Ensemble - Ohio

Muntaz Darbar
Vice Dean Administration and Finance, VP Clinical Practice Finance
University of Chicago Medicine

Nyeema Davis
Patient Access
OSF Healthcare System

Susan Dominique
Claims Coding Specialist
University of Chicago Medicine

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Welcome New Members (continued from page 24)

Madeline Donner
Medical Coder 1
Mercy Health System- Janesville, WI

David Dopp
Administrator
Wheaton Eye Clinic

Kenneth Ducote
Manager
KPMG

Kris Dumisani, CRCR
Revenue Cycle Manager
Compass Health Center

Ken Dusold
Associate Attorney
Law Offices of Stephenson, Acquisto & Colman

Sydney Early
Senior Talent Acquisition Associate
RSM

Alcola Edwards
Health Unit Coordinator
Advocate Trinity Hospital

Kimberly Egizio
Coding specialist/ Unified revenue organization
Trinity Health

Alicia Ellingson
Senior Consultant
Chi-Matic Consulting

Nicole Ermilio
Inpatient Coder
Advocate Aurora Health

Jacquelyn Espinoza
BH Biller/Collector, IL
Special Programs
Advocate Aurora Health

Cristina Evans
Finance and Operations Lead
Chicago Vein Institute

Elissa First
Senior Director
Huron Consulting Group

Arlene Freeman
Financial Counselor
University of Chicago Medicine

Wilson Gabbard
VP, Clinical Risk Adjustment
Advocate Aurora Health

Yvonne George
Revenue Cycle Application Manager
Cancer Treatment Centers of America

Taylor Gibbons

Jennifer Gilbertson
Assistant Director, Therapy Services
University of Chicago Medicine

Lisa Godar-Fairless, RN
BSN, Coordinator Employee Health
Sherman Health

Giovanni Gomez
Director
AArete

Shana Gross
Patient Access
OSF Healthcare System

Edward Grossmayer
Senior Financial Analyst
Medical College of Wisconsin

Andrea Gruca

Bernadette Guyton
Clinical Risk Adjustment Coordinator
Advocate Medical Group

Raquel Guzman
Finance
Amita Health

Jennifer Hanes
Senior Reimbursement Specialist
Advocate Health Care

Khadijat Hawkins
Patient Account Supervisor
Conifer Health Solutions

Salvador Hazday
CEO
Harris & Harris

Bob Hedstrom
RVP, Channel Development, CPS
Change Healthcare

Bryant Honsa
Managing Consultant
Guidehouse

Kimberly Hughes
Patient Access
OSF Healthcare System

Brad Hunter
Manager
KPMG

Debra Jakstas
Advocate Good Samaritan Hospital

Mariko Kaonohi
Vice Dean, Administration and Finance
UChicago Medicine

Rajiv Kapadia
Senior Financial Analyst
Regent Surgical Health

Emma Kawasaki
Consultant
Guidehouse

Tate Kieffer

Marlene Kinkov
Managed Care Analyst
Advocate Healthcare

Renata Klein
Laboratory Billing Manager
University of Chicago Medicine

Kristy Kolar Smith
Segment Marketing Manager
Change Healthcare

Wendy Kreider

Nicole Lawrence
Manager
KPMG

Michelle Lebavitz
Clinical Appeals Nurse
Beaumont Health System

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Welcome New Members (continued from page 25)

Mary Ellen Lott
Associate
Huron Consulting Group

Tamara Luckey
Healthcare
Advocate Aurora Health

Shanta Mack
Financial Counselor
Advocate Illinois Masonic Hospital

Chrisoula Manokas
Financial Analyst
Advocate Aurora Health

Anna Marchiori
Executive Director, Cash Management and Refunds
Advocate Aurora Health

Griselle Martinez
Remote Inpatient Specialty Coder
Advocate Aurora Health

Eugenya Martinez
Manager of Revenue Cycle Quality and Systems
Advocate Aurora Health

Therese McMahon
Decision Support Analyst
Advocate Aurora Health

Andrew Meek
System Business Analyst
Northwestern Memorial Hospital

Andrea Miller
Director Women/Children Svs
Advocate Christ Medical Center

Logan Mitseff
Director
Healthrise

Annie Moran
Senior Director
Huron Consulting Group

Winifer Murphy
Financial Coordinator/Patient Financial
Services
University of Chicago Medicine

Cameron Myers
Talent Acquisition Specialist
Advocate Health Care

Laura Neitzel
Senior Accountant
Advocate Aurora Health

Alima Nickerson
Senior Director
Huron Consulting Group

Elli Onopa
Business Development Executive
Aston Carter

Dipak Pandya
Director
PwC, 1 North Wacker. Chicago 60606

Shinal Patel
Senior Consultant II
BKD, LLP

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Welcome New Members (continued from page 26)

Lisa Pease
Patient Access
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Accounting Manager
Advocate Aurora Health

Stephanie Perez
Medicaid Biller
Advocate Aurora Health

Shaelah Pfister
Patient Access
OSF Healthcare System

Dan Pintauro
Associate
Huron Consulting Group

Zeljko Popovic
Tax Manager
KPMG LLP

Matthew Primack
PT, DPT, MBA, President
Advocate Condell Medical Center

Margaret Pugh
Patient Access
OSF Healthcare System

Gloria Quenem
Patient Access
OSF Healthcare System

Faisal Rahman
Professor & Founding Dean
Saint Xavier University

Michael Randall
Chief Administrative Officer
Advocate Physician Partners

Clarissa Rangel
Patient Access
OSF Healthcare System

Kathy Rapata
PSR
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Have you considered sitting for one of HFMA's professional certifications?
Did you know that the registration fee is waied for HFMA members?

Like more information?
Contact the First Illinois Chapter's certifiation co-chairs Connor Loftus, CHFP at cloftus@clarohealthcare.com or Meagan Edgren, CHFP at meagan_edgren@rush.edu

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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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Publication Scheduling

Publication Date	Articles Received By
June 2022	May 1, 2022
October 2022	September 1, 2022
February 2023	January 2, 2023