

First Illinois *Speaks*

HFMA's First Illinois Chapter Newsletter



April 2013



Highlights and Recap
First Illinois Chapter Events
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News, Events & Updates



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Will Course Be Altered by How You Purchase Insurance?

DANIEL T. YUNKER, SVP, MCHC / CEO LAND OF LINCOLN HEALTH AND FIRST ILLINOIS HFMA'S PRESIDENT-ELECT

In February, U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius and Illinois Governor Pat Quinn announced that the State of Illinois' health insurance marketplace platform had been approved by the federal government. The state's marketplace will be an online portal that individuals and small businesses in Illinois can access to compare and purchase health insurance plans.

Marketplaces have been described as a Travelocity® or Turbo Tax® for health insurance. A marketplace will leverage technology to make purchasing health insurance simpler and more comprehensible for consumers. As with both travel and (perhaps even more so) tax preparation, buying health insurance is often a daunting prospect for consumers, convoluted with jargon and confusing terms and conditions. An insurance marketplace will leverage technology to guide shoppers, ensuring that individuals can select an insurance product that meets their needs.

Each insurance marketplace (one is being set up for each state), will ask participating insurers to put together plans that run the gamut of coverage and meet certain standards. Consumers will be able to choose from bronze, silver, gold or platinum health insurance plans (referred to collectively as "the metals"). These different levels will allow consumers to easily compare and contrast similar plans from different insurance providers. As conceptualized, individuals will be able to enter their personal information, budget and insurance needs into a marketplace portal and receive an array of plan options to choose from. This shift to online marketplaces is a long-time coming for the health care industry. Many other industries have had major shifts in how their products and services are purchased, including the travel and tax preparation industries. Some think that with the advent of a marketplace, insurance brokerage firms, too, will have to invest in their own private insurance exchange platforms to sell to employers.

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www.FirstIllinoisHFMA.org ■ **First Illinois Speaks** ■ 1

Will Course be Altered By How You Purchase Insurance? (continued from page 1)

While the idea of a public marketplace is widely understood, there are still some unknowns regarding Illinois' health insurance marketplace. It has not yet been determined how many qualified health plans the state will allow to participate in the marketplace; too few could drastically limit consumer choice, while too many types of plan designs could cause unnecessary confusion if the marketplace is not well designed. Additionally, the criterion for each of the metal plans has also not been determined. It is assumed that bronze-level plans will provide catastrophic coverage while platinum plans will be very comprehensive. The specifics of each level of coverage will be determined by the actuarial value of these plans, but plan requirements are still being determined by the state.

With the Affordable Care Act's (ACA) individual mandate requiring nearly all Americans to have health insurance coverage by 2014, non-governmental organizations are also taking advantage of the large number of consumers who will be flooding the insurance market next year. Private health insurance marketplaces are also being developed in Illinois and appear to initially target small and large employers.

The ACA provides for subsidies to help those who may be struggling financially to ensure that they can purchase insurance as required. Federal subsidies are available for individuals who are not eligible for other forms of coverage and have an income that is less than 400 percent of poverty guidelines (\$43,560 for an individual and \$89,400 for

a family of four in 2011). People with coverage through their employer are eligible for a tax credit if their premium exceeds 9.5 percent of their household income or if their plan pays for less than 60 percent of the cost of covered benefits.

Insurance marketplaces will likely initiate a change in consumers' insurance buying behavior. In the next year, we will likely see more employers end their benefit plans in favor of providing employees with subsidies, vouchers or cost-sharing so that their employees can purchase their own coverage through a marketplace.

Companies have long been making the buying decisions for individuals' health insurance; providing coverage for people who have a wide range of needs and live in a geographically expansive area, resulting in the need for all-inclusive plans and broad networks. This one- (or two-) size-fits-all insurance model is uneconomical and unsustainable. By putting insurance choice in the hands of the individual, a person can determine what kind of coverage they need and how they can get the biggest bang for their buck. It might also actually engage the consumer in their health since they are part of the coverage purchasing decision. Today many consumers are apt to spend more hours researching the purchase of a flat-screen TV than filling out and understanding the insurance coverage selected for them by their employer. It is anticipated that once the choice is in their hands, many consumers will choose less costly insurance plans that are being developed as a result of narrower networks comprised of a smaller panel of providers in the plan. Others may opt for higher premiums in exchange for a broader network and/or smaller deductible. Eventually, as consumers build relationships with their providers, it is estimated that fewer consumers will find the need for expansive (and more expensive) networks, especially as health care moves toward the medical home and accountable care organization models.

To successfully facilitate nearly universal coverage for Illinois citizens, insurance marketplaces must capitalize on technological platforms that many individuals are already familiar with and replace traditional insurance jargon with more consumer-friendly language—making their products accessible and comprehensible to all. If launched correctly, public and private health insurance marketplaces are poised to be a go-to resource for the more than one million Illinoisans who will be required to obtain insurance by 2014 and for many others whose employers will no longer be making that purchasing decision for them. ☞

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Dan Yunker
SVP, MCHC / CEO Land of Lincoln
Health and First Illinois HFMA's
President-Elect

Legislation Connection

BY CHERYL A. WESOLOWSKI, CHAIR

State of Illinois Update from the II-MGMA Legislative Committee

On March 6, 2013, Governor Pat Quinn delivered his FY2014 budget address to the Illinois General Assembly. The theme of the Governor's budget address was "We Must Stop the Bleeding." Pension reform, was the obvious main focus of his budget address. He urged the State Legislators to take action on comprehensive pension reform. The Governor stated that within two years the State will spend more on public pensions than on education. He also addressed the backlog of bills that the State is attempting to pay down. Included in the Governor's plan would include suspending three corporate loopholes: the Foreign Dividend Corporate Loophole, the Federal Production Activities Loophole and the Non-Combination Rule. These three loopholes cost the State Treasury about \$445 million a year.

There have been a couple of healthcare related bills that our committee has been closely monitoring this year.

The Same in Springfield?

This particular bill was the source of a lot of controversy during the early part of this year. The State of Illinois Department of Financial and Professional Regulation (IDFPR) sent out a letter to all physicians in January. The letter stated that beginning on January 15, IDFPR was going to reduce the employees in the department from 26 to 8, that it would now take a year to 18 months to process license applications, and that the department needed an infusion of about \$9.6 million to keep the department up and running.

The state's medical licensing fees go to a dedicated fund. That fund is intended to underwrite the functions of the IDFPR. With the State of Illinois unable to pay its bills, it swept monies from the dedicated fund and used those monies for other purposes. When the funds were initially swept, there was the promise of repayment, which has never happened.

A bill was introduced to raise the physician licensing fees to \$750 per year. The Illinois State Medical Society (ISMS) issued several statements opposing the IDFPR backed bill to raise the physician licensing fees. ISMS was not opposed to an alternative proposal for an increase in funding to the IDFPR, but was opposed to legislation that included a payback provision, until all the swept money was returned to the fund.

The Illinois Hospital Association issued a statement that urged legislators to work a speedy resolution stating, "This situation is significantly affecting patients' access to care and impairing hospitals' and physicians' ability to care for Illinois residents." They were very concerned about the lengthy delay in getting new physicians licensed. And fearful that when Match Day came around, Illinois hospital




residency programs would lose medical students making their decision to leave Illinois.

The House and Senate were able to come up with a compromise bill. Raising the cost of licensure to \$700 from the current cost of \$300. It would remain at \$700 until July 1, 2018, when the cost reverts to \$500.

SB 622 has passed in both the House and the Senate. With the passage of this bill, the Illinois Department of Financial Professional Regulation's department was immediately able to re-hire the 18 employees that were laid off in January 2013.

SB 1630: Direct Anatomic Pathology Billing

The pathologists in Illinois have introduced a bill that would restrict clinical physicians from billing for certain pathology services. This bill mandates that only the entity personally rendering the service or supervising the service can directly bill the patient.

State of Illinois Legislation then went on Spring Break. The House of Representatives returned on April 8, and the Senate returned on April 10. 

Letter From the Editors

Last year at this time, we were not only enjoying 80 degree weather, but speculating about healthcare reform: What will it look like and, with the pending presidential election, would it “stick”? Well, for the most part, it stuck, and now we find ourselves trying to define—and implement—a “new” normal. Even with the upholding of the ACA and President Obama’s re-election, both sides are still split. Recently, the House and Senate worked up budget resolutions that still show a government divided—the Senate budget seeks to preserve the status quo; the House budget, on the other hand, seeks to repeal most of the ACA.

We, as a chapter, however, are united in our efforts to navigate the challenges we now face. We are 1,400 strong—and that makes us the largest HFMA chapter in the United States! Not to mention, with all of the recent mergers and affiliations, most of us are becoming “step brothers/sisters” or, at the very least, cousins. Finding strength in numbers and constantly increasing membership is crucial to creating a chapter environment that is conducive to the personal and professional growth of our members—members who are now living—and leading—the change.

With this newsletter, we begin to bring our 2012-2013 First Illinois HFMA Chapter year to an end (officially May 31st) and prepare for a change in leadership for 2013-2014. Kudos to our 2012-2013 chapter officers, especially Tracey Coyne, our president, board members, committee chairs/co-chairs and their teams for a very successful year. And, an enthusiastic welcome to Dan Yunker, incoming president, and the 2013-2014 leadership that will lead us through next year.

As always, Jim and I not only encourage you to take advantage of all the networking and resource opportunities that our chapter and HFMA National has to offer, but to contribute to the chapter’s newsletter as well—our strength IS in our numbers, literally and figuratively.

Happy Spring!

2012-2013 Newsletter Co-Chairs



Tim Manning



Jim Watson



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Return to Affordability: Seven Financial Management Strategies for a Decade of Payment Deflation

BY KEVIN F. FITCH, JR. CPA, MBA, CHE, CHFP

For most of our lives we've lived with moderating levels of inflation. This era, referred to as the Great Moderation, lasted nearly three decades. It was a period of economic growth and ever-declining interest rates. Assets inflated in value and consumer prices remained stable due to increases in productivity and supply. Much of this prosperity was funded by the expansion of credit (i.e., more debt and risk taking). Expansion of credit requires confidence that income will grow in order to repay debts and service interest. Beginning in 2007, confidence began to decline and credit contracted everywhere—everywhere but Washington DC.

Since 2007 we have witnessed limitless money printing and massive government deficits. Given all of the stimulus, one might expect roaring economic growth. But as recent as March 8, 2013, the Economic Cycle Research Institute (ECRI) issued a report stating that “U.S. Nominal GDP growth is recessionary and we are below a stall speed” (1). And the Congressional Budget Office lowered its real U.S. GDP growth expectation for 2013 to 1.4% (2). Private sector deleveraging is contributing to high unemployment, and low income and economic growth. Given the amount of debt and unfavorable demographic trends in developed economies, a deleveraging and deflationary cycle is likely to continue for several years.

What is deflation? *A change in the monetary conditions that results in a contraction of total money supply and credit; more commonly known by its symptom: a decrease in the price level of goods and services.* (3)

Can you imagine a U.S. healthcare system without inflation? Reimbursement rises by 2% to 3% in the good years, but stagnates or falls in the bad ones. Investment values are just as likely to fall as to rise, and the 10-year Treasury bond rate is below 2%. Deflation may have been unprecedented in our lifetimes, but not unprecedented. Prior to the creation of the Federal Reserve Bank in 1913, short periods of deflation were common place.

Is deflation bad? During times of deflation our money buys more goods and services. We all know cheaper computers, cell phones and appliances have made our lives better. Innovation and increased supply can reduce prices. Deflation also occurs when prices are above equilibrium with the money supply such that prices are unaffordable and must fall. The U.S. healthcare system is unaffordable and deflation is inevitable.

Payment deflation is a reality.

Cuts in Medicare reimbursement totaling more than \$450 billion from 2010 through 2019 are part of the Patient Protection and Affordable Care Act of 2010 (PPACA) and the fiscal cliff deal. These cuts include decreases in the market basket, disproportionate share, and payment reductions for hospital-acquired infections and readmissions (4). The cuts from Medicare also mean cuts from commercial payers, since

Medicare rates are an anchor upon which many commercial rates are based.

The outlook for Medicaid reimbursement is also negative. The State of Illinois was downgraded to A- with a negative outlook by S&P in 2013. The State has a cumulative general fund deficit of \$5 billion, and its largest pension plan is only 46% funded based on the market value of its assets (5)(6). Given Illinois' fiscal woes, the 2012 mid-year cut of 3.5% in Illinois Medicaid reimbursement is likely to be followed by further cuts.

In addition to lower payment rates, expect payer mix to deteriorate. As baby boomers age, a greater percent of payments will come from Medicare. Also, high unemployment is contributing to more uninsured patients. And increased coverage expected from the PPACA's health exchanges will likely pay at rates lower than existing commercial rates.

What actions can you take to prepare for and thrive under payment deflation?

- 1 Increase cash levels.** There are going to be unbelievable deals to be had. Liquidity provides flexibility to take advantage of opportunities and to weather periods of distress.
- 2 Avoid short-term debt.** Maturities of seven years or less should be avoided because deflation will make paying off or refinancing a loan more expensive.
- 3 Focus on becoming a more flexible and agile organization.** Shift or restructure costs that have traditionally been fixed to variable. Structure capital investments, programs and joint venture terms to be as variable as possible so the programs can scale up or down quickly with changing demands.
- 4 Be very selective on capital spending and acquisitions.** Consider alternatives such as linking up with another provider in the market, or adopting operational changes or alternative care models that reduce the need for capital.
- 5 Prepare for more “capitation-like” reimbursement models** such as shared savings programs, and fixed or bundled payment methods.
 - a. The HFMA Value Journey & Road Map is an excellent resource to help plans for value-based payment models. <http://www.hfma.org/valuejourney/>.
 - b. Build and expand your network of primary care providers and your use of hospitalists.
 - c. Concentrate efforts on population-based analytics and care coordination, especially for expensive, chronically ill patients.
- 6 Target high value cost management initiatives by integrating financial and clinical data.** Focus on expensive arenas such as

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Return to Affordability: Seven Financial Management Strategies for a Decade of Payment Deflation (continued from page 5)

ICUs, operating rooms, cath labs, emergency departments and oncology. Following are examples that reduce operational costs and the total cost of care.

- a. Enhance productivity with technology, process redesign and labor metrics.
- b. Reduce the number of physician preference items to lower supply costs.
- c. Reduce or eliminate elective inductions prior to 39 weeks of pregnancy.
- d. Reduce the number of blood transfusions.
- e. Reduce ventilator length of stay.
- f. Encourage appropriate use of the emergency department to avoid unnecessary visits.

7 Align compensation arrangements with physicians and leadership to the organization's goals including but not limited to financial measures. Greater use of salary incentives tied to profitability will promote greater flexibility to changes in reimbursement.

As financial managers, our organizations look to us to make decisions on investing in physician practices, bed towers, hybrid operating rooms, surgical robots, and so on. We build feasibility models to analyze expected return on investment and risk factors. The biggest risk we face over the next decade is little to no incremental revenue or payment inflation. Prioritize strategies that reduce cost and increase

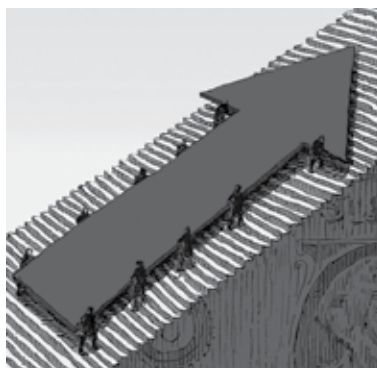
flexibility so your organization will be positioned to thrive in a decade of payment deflation. 

Footnotes:

- ¹ "The U.S. Business Cycle in the Context of the Yo-Yo Years," Lakshman Achuthan. March 8, 2013. http://ecri-prod.s3.amazonaws.com/downloads/ECRI_1303_US_Business_Cycle.pdf
- ² "The Budget and Economic Outlook: Fiscal Years 2013 to 2023." Congress Of The United States' Congressional Budget Office. February 2013. Page 4. <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43907-BudgetOutlook.pdf>
- ³ <http://www.deflation.com/what-is-deflation/>. March 2013.
- ⁴ "Estimated Financial Effects of the "Patient Protection and Affordable Care Act, as Amended." Richard S. Foster, Chief Actuary of CMS. April 22, 2010. Page 8. https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PPACA_2010-04-22.pdf
- ⁵ "State of Illinois General Obligation Bonds, February 2013 Preliminary Official Statement." January 2013.
- ⁶ "Teachers' Retirement System of the State Of Illinois June 30, 2011. Actuarial Valuation of Pension Benefits." Buck Consultants. December 2011. Page 1 http://trs.illinois.gov/subsections/general/Buck_2011_valuation_rept.pdf

Helping Hospitals Achieve Success in the "New Economy"

For all hospitals and health systems, the financial crisis and the potential impact of healthcare reform have prompted the need to proactively identify and evaluate strategic options. Major initiatives must be on-target strategically and affordable, given the changing healthcare delivery environment. Access to capital to fund the selected initiatives must be secured under the best-possible terms, and capital structure risk should be managed on both sides of the balance sheet. These are not "nice-to-have" actions, but management imperatives. *To learn more about how Kaufman Hall can help your organization to achieve success in the new economy, please call 847.441.8780 or visit kaufmanhall.com.*



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Kevin F. Fitch

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Denial Management Moves to Front End Denial Avoidance

BY STEVE CHRAPLA, CHFP, DIRECTOR 3RD PARTY SOLUTIONS, AVADYNE HEALTH

Denial Management has long been identified as the central process to improve cash flow, as well as reduce accounts receivable and write offs, through the management of rejected claims. While this process has been a valuable endeavor over the years, it has been built on the premise that denials are inevitable, and re-work is simply an integral part of the work flow.

Now is the time to establish a more effective approach—eliminate denials, or at least dramatically reduce them. The ultimate way to do this is at the beginning of the process: pre-access, and the front end of the revenue cycle.

To begin with, there must be recognition that the back end/patient accounting department is not accountable for denials. While employees in this area re-process the claims, file the appeals, and generate the resulting cash flow, true accountability for a denial resides with the source of the information represented on the claim. Only when these data sources are scrutinized and improved can a denial avoidance

program become truly effective. All claim information comes from other source-departments such as:

- Admitting physician
- Scheduling
- Registration
- Clinical documentation
- And many others

These departments, along with the systems that support their functions, are ultimately accountable for denials; therefore, an analysis of their role in creating denials must be the cornerstone of any effective denial avoidance program.

To put things in full perspective, you must identify the true magnitude of the denials. That means measuring not only how many denials occur, but also the reasons behind the denials: identify the root cause.

To measure the true volume of denials, we must account for all claims that are rejected or fail to pass billing system edits. It is critical to avoid measuring only those denials that result in a write off. Denied claims that are re-processed and eventually get paid still need to be accounted for because they required some type of re-work and consume valuable personnel resources. The objective to capturing the true denial rate or volume is to monitor every claim that did not pass an edit, either within the provider's billing system, or within the payer's system, or as an actual claim rejection by the payer.

This approach is called the "First Pass Denial" rate (FPD).

Measuring (for the most recent 90-day period) the number of claims that failed an edit or were rejected, then dividing that by the total number of billed claims during the 90-day-period, yields the most effective way to capture all claims that require additional handling to get the claim paid.

When you measure this monthly, it provides you with a true FPD rate that can be assessed without being influenced by case mix or dollar-amount of the claim.



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First Pass Denial Rate Calculation

of denied claims in a 90-day period / # billed claims in same 90-day period = FPD Rate

Calculate and track FPD Rate monthly based on rolling 90-day period

Understanding the reasons behind the denials, the claims failing to pass billing edits, or payer rejections is also crucial. To get to the root causes, you need to track the specific reasons the claims are delayed or not getting paid. This analysis includes reviewing claim submission reports to identify edit failures as well as payer denial reports and claim EOBs. In addition to EOBs that are zero-pays, you must also review underpayments, since they may represent a portion of a claim being denied.

Following the 80/20 rule, you now know where to focus your attention. The key is to design your solution to the root cause at the very beginning of the process and that is where your front end applications need to be integrated into the solutions. Identify claims failing edits or payer rejections for reasons such as:


- Patient identifier information incorrect
- Patient coverage not available
- Authorization or pre-certification not received
- Referrals required from primary care physician
- CPT, ICD-9 codes or modifiers not properly populating the claim
- Payer contract requirements not followed
- Non-covered services

Once root causes are identified, the next step is to bring the area responsible for the data elements into the resolution process on a realtime basis (or as close to real-time as possible). This information can then be used to design process improvements, procedures, and work flows that will prevent future denials. It is critical that the re-design processes are structured to be flexible—flexibility allows for ongoing evaluations and solution maximization to compensate for events such as regulatory changes and new payer contract requirements.

The design of a denial avoidance program must consider the following elements:

- An approach to address both current and retrospective denials from both front-end and back-end processes.
- Data and root cause identification and analysis of the denials.

- Dashboards and ongoing detailed reporting need to have at minimum:
 - Denial rates as well as dollars written off
 - Denials per avoidance/service area
 - Benchmarking of rates and dollars to goals
- Standardized identification of denials with feedback at every organizational level and clear identification of responsibilities for resolution to include all departments: Access /Coding/UR/ Contracting/Reimbursement /Clinical/etc.
- Pre and point of service process re-designed that is perpetually optimized to prevent future denials.
- Technology support and work flow management to drive processes and improvements to include:
 - Permanent back-to-front feedback
 - Work flows that automatically adapt to changes in reimbursement patterns
 - Automates entire work steps
 - Work flow with checklists to ensure work is performed optimally on both front-end and back-end
 - Pre-werice and point of service workflow with alerts based on rules and actual denial outcomes
 - Event-driven denial follow-up work flow based on historical denial behavior

This thorough and data-driven approach will move the management of the claim denials to the front-end and allow for the transformation from denial management to denial avoidance. 



Steve Chapla

For more information on how to transform your operation from managing denials to avoiding them by integrating the Pre-Access processes please contact Avadyne Health. www.avadynehealth.com

Steve Chapla is Director of 3rd Party Solutions for Avadyne Health and a member of the First Illinois HFMA Chapter. He can be reached at 847-395-7655.

Common Strategies for Achieving Value Report

BY HEALTHCARE FINANCE STRATEGIES

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

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

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

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

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

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

data over time, across all care settings, and integrated across clinical and financial domains.

Determine what process engineering methodologies to utilize.

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


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

Prepare for a second generation of value-based payment

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

Read the complete report from HFMA's Value Project, *The Value Journey: Organizational Road Maps for Value-Driven Health Care*. You'll find strategies that are common across all organizations as well as strategies specific to rural hospitals, academic medical centers, aligned integrated systems, multi-hospital systems, and integrated delivery systems.

More Insights on the Journey Toward Value

Through HFMA's Value Project, healthcare finance leaders are joining their clinical partners to shape this transformation. Launched in 2010, the Value Project is now in its second phase. Learn more about the Value Project and gain resources for improving value, including reports and a web tool. 

Not an HFMA member? Get exclusive access to practical strategies and thought leadership from HFMA and other industry experts. Join today. <http://www.hfma.org/membership/>

Would Your Inpatient Hospice Claims Pass the Test of Medical Necessity?

BY MARY DEVINE, SENIOR MANAGER, REVENUE CYCLE SERVICES

The Office of Inspector General (OIG) continues to scrutinize acute-care inpatient transfers to general inpatient (GIP) hospice care to assess the appropriateness of hospices' GIP claims.

Medicare is focusing on GIP hospice claims for medical necessity, are you ready?

The Medicare hospice benefit allows a beneficiary with a terminal illness to forgo curative treatment for the illness and instead receive palliative care, which is the relief of pain and other uncomfortable symptoms (Federal Register 42 CFR Part 418). The philosophy of care behind hospice takes into account all aspects of the patient and their family life providing supportive services and pain relief associated with life-threatening illnesses, issues congruent with end of life and relief from suffering. According to the Centers for Medicare and Medicaid Services (CMS), the revised Hospice Conditions of Participation (CoP's) are "patient-centered, outcome-oriented, and a transparent process that promotes quality patient care for every patient every time" (Federal Register 42 CFR Part 418).

The number of beneficiaries receiving hospice care has increased significantly in recent years. In fiscal year 2001, 580,000 Medicare beneficiaries received hospice care. In 2006, this number increased by 62 percent to 939,000 beneficiaries. Medicare spending on hospice care rose from \$3.6 billion in 2001 to \$9.2 billion in 2006. As the frequency and cost associated with this care continues to increase, Medicare and the OIG will continue to identify audits geared towards limiting waste or improving outcomes.

Hospice claims often do not meet even one of the Medicare coverage requirements. These requirements include:

- Election requirements
- Plan of care requirements
- Certification of terminal illness requirements

Concerns with Medical Necessity of General Inpatient (GIP) Hospice Care

Medicare has been focused on the medical necessity of all inpatient services and hospice GIP is not exempt from that same scrutiny. GIP hospice care is reimbursed at four times the rate of hospice home care or respite care. This patient transfer status also exempts the DRG payment from the Transfer DRG rules.


These patients electing hospice should only be placed in GIP hospice care if their care cannot be provided at home. This means their pain or acute condition cannot be managed appropriately at home, and the medical necessity must be clearly documented in the medical record.

Not only will CMS be reviewing this, but so will the Recovery Audit Contractors. They will be requesting the medical records for GIP hospice patients transferred from hospitals to ensure the medical necessity is supported by the documentation. CMS may also increase its scrutiny of the relationships between the hospital and the hospice.

Hospice programs should ensure the medical necessity is met based on the Hospice and Palliative Care Guidelines. These guidelines are specific to the criteria of these patients as it relates to pain, symptom management, psychosocial monitoring and imminent death. Focusing on the needs of the patient prior to accepting them into the GIP hospice care can eliminate the scrutiny Medicare plans to put hospice providers under.

Whether you have your own Hospice program or contract with a Hospice provider, you should:

- Evaluate written policies and procedures to ensure a mechanism for communication between the clinical and patient financial services staff, so that billing Medicare only occurs for eligible hospice patients. It is important to create an environment whereby policies and procedures are in compliance with federal regulations and state laws.
- Monitor general inpatient hospice days to ensure documentation is clear and benefits are justified based upon the requirements listed above.
- Develop a comprehensive compliance program to audit for potential risks and take a proactive approach to improving processes.
- Educate staff on the Hospice Conditions of Participation to ensure clinical and financial systems are functioning to capture required documentation.

As you assess your hospice compliance program, best practices include written action plans, monitoring, staff education and re-auditing to ensure sustained compliance. Should the OIG audit your hospice program, this proactive strategy may be utilized to mitigate any potential adverse findings. 

For more information please contact Mary Devine at 732-392-8241 or MDevine@besler.com.

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The Future of DSH and Uncompensated Care

BY DAVID VERBARO, TRICIA LIGATO

The Patient Protection and Affordable Care Act (PPACA) contains significant cuts to Medicare disproportionate share hospital (DSH) payments. Beginning in fiscal year 2014, hospitals will receive only 25% of their current Medicare DSH reimbursement. In addition, each hospital will receive a distribution from a pool based on its share of national uncompensated care. The formula for the uncompensated care pool is based on:

- The aggregate reduction in DSH payments to all hospitals attributable to the reduction in DSH payments (75% reduction value becomes the uncompensated care pool).
- The reduction in uninsured individuals (this pool is reduced by two factors, reduction in the uninsured percentage plus an artificial percentage decrease).
- Each hospital's share of uncompensated care provided by all hospitals.

On Tuesday, January 8, 2013, the Centers for Medicare and Medicaid Services (CMS) held a National Provider Call on the topic: *Implementation of Section 3133 of the Affordable Care Act: Improvement to Medicare Disproportionate Share Hospital Payments*. According to a CMS press release, the purpose of the call was to "present findings of their analyses identifying possible data sources and definitions for measuring the change in uninsured and uncompensated



care." During the call, CMS reviewed the basic reimbursement framework for DSH payments and the new uncompensated care pool. The call also gave participants an opportunity to voice their concerns and request certain considerations be made by CMS when ironing out the details. CMS did not, however, give providers what they need most—clear direction as to the methodology by which CMS will calculate and distribute the uncompensated care pool.

Specifically, providers are still struggling to understand how the uncompensated care pool will be determined and what the sources of data will be. The Medicare statute [42 U.S.C. §1395ww(r)(2)(C)(ii)] states that "appropriate data" will be the basis for a hospital's amount of uncompensated care. There is a lot of interpretive leeway for CMS in the term "appropriate data." CMS has not issued a directive specifying what specific data will be used and how providers will be reimbursed. CMS has stated it will use data on Worksheet S-10 to calculate the amount of a hospital's payment from the uncompensated care pool, although CMS has not specified what lines from Worksheet S-10 will be used, whether uniform standards for reporting data on the S-10 will be adopted, and whether the data will be audited.

Unfortunately, providers will not get a full-scale picture of how the new DSH/Uncompensated Care payment system will work until the FY 2014 IPPS Proposed Rule is released this spring. Nonetheless, hospitals should begin to shift their focus from the current DSH methodology to refining their methods of capturing uncompensated care data and getting a head start on their preparation for the imminent changes. It is important that providers accurately report the uncompensated care in which their facility provides on Worksheet S-10 of the FY 2012 Medicare Cost Reports to capture the full uncompensated care costs being borne by the provider. It is critical that providers also verify that they have the necessary supporting documentation required for compliance purposes.

BESLER will continue to publish information regarding the future of Medicare DSH and uncompensated care as it becomes available. In the meantime please contact Tricia Ligato at tligato@besler.com or Dave Verbaro at dverbaro@besler.com with any questions or concerns you may have. Both contacts can be reached by phone at 609-514-1400.



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Supply Chain Strategies: Dirty Data Drive Supply Chain Expenses

Dirty data within hospital supply chains is leading to increased labor costs and logistics expenses, inventory mismanagement, and inefficient contract management and accounts payable processes, according to a recent Novation white paper, *The Cost of Dirty Data*.

The root cause of dirty data is a lack of standardized product information, the report states. Through the use of data cleansing and advanced spend analytics, healthcare organizations can save 0.5 to 1.5 percent of their annual supply chain spend.

Dirty data results from such factors as the following:

- Product descriptions that lack a consistent and standardized format
- Products that are missing vendor or manufacturer information (e.g., name or catalog numbers)
- Products with incomplete packaging data (e.g., missing unit of measure and conversion factors)
- A high number of errors reported through electronic data interchange transactions



- Significant problems with invoice discrepancies
- Large numbers of manual purchase orders routinely submitted
- A significant amount of purchase-order discrepancies
- Poor contract pricing utilization with procurement processes

The white paper references an Accenture research study that estimates that healthcare organizations can save between 0.25 and 3.5 percent of their annual supply spend by employing processes

(continued on page 13)




On Call.

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Supply Chain Strategies: Dirty Data Drive Supply Chain Expenses (continued from page 12)

to enrich product information, which involves more effectively highlighting the functional difference between product attributes. Product enrichment drives stronger contract management and more favorable contract pricing, according to the white paper.

There are four ways hospitals can clean their supply chain data, according to the white paper.


Obtain enterprisewide buy-in/support for effective adoption and implementation of data management policies and processes. This involves identifying, involving, and educating key stakeholders (e.g., directors of contracting and clinical directors) throughout the supply chain.

Establish data management policies and processes. To help contain the negative impact of dirty data, include process performance measurements, such as the following:

- The number of duplicate records within the item master
- The number of routine, manual record orders that sidestep the item master
- The number of manual orders requested within a given month by department and requestor

The ability to report these data to stakeholders and establish attainable goals that are directly aligned with the organization's data cleansing strategy will facilitate faster supply chain savings.

Implement critical controls at each point where source data enters the supply chain. Adding, deleting, and changing product information in the item master is important for successful contracting, procurement, inventory, accounts payable, and payment processes.

Implement a proactive data-cleansing approach. To realize the most value from the supply chain, product information should be validated and enriched at the initiation of a request to add a record to the item master. 



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Technology Enhances Work Flow, Connectivity for Healthcare Finance Professionals

BY VICKIE AXFORD AUSTIN

It's hard to imagine our work lives before the advent of e-mail, SmartPhones and access to the Internet. Technology has impacted more than just the clinical side of healthcare. The way healthcare finance professionals work today is dependent on technology for access to information, work flow and staying in communication.

"Succeeding as a leader in today's healthcare landscape requires constant connectivity with work teams, customers, and partners," said Dan Yunker, senior vice president and chief financial officer of the Metropolitan Chicago Healthcare Council (MCHC) and president-elect of the First IL HFMA chapter. MCHC has invested in a strong wifi network at its downtown Chicago office and Dan carries an iPad and an iPhone that serve as his "internal and external offices."

Technology also has been a boon to efficiency at work, according to Stacey Ries, deputy general counsel and corporate integrity officer for Rush-Copley Medical Center. "All of our contracts are entered into an electronic system which allows for reminders to staff regarding renewals," Stacey reported. "We are also turning our paper contract approval process into an electronic format which will speed up the process significantly and allow for communication among the contract team members."

That same efficiency factor has streamlined work flow for consultants like Brian Katz, manager at RSM McGladrey, Inc. "If it wasn't for modern technological advances, my work would be much more tedious and difficult," Brian reported. "I work with cost report software, which has had significant advances in the past 10 to 15 years. The flow of cost and statistical allocations would take several weeks longer if it weren't for current technology, and today's software indicates errors and/or omissions from key data fields to unusual cost-to-charge ratios."

Brian added that his firm uses Excel and other software for database management engagements, such as disproportionate share hospital evaluations. "These software tools have been extremely helpful in evaluating data and cross-matching key data elements from different sources," Brian said.

For healthcare finance executives who travel, technology is a critical contribution. Tracy Coyne, senior manager at Grant Thornton, LLP, and this year's president of the First IL HFMA Chapter, reports that her greatest tool is her SmartPhone. "I can check in for flights with the [airline's] 'app' and save time when checking in with mobile boarding passes," Tracy said, adding that another favorite application is Kayak, which allows her to track airline arrivals and departures.



Is there a downside to this Brave New World of technology? Dan Yunker thinks not. "The more the better, as far as I'm concerned," he said. "Healthcare is technology-deep when it involves patient care [which] is great, but we need to evolve a delivery system that embraces the use of technology for business process improvement and knowledge sharing, consumer engagement and purchasing."

For Stacey Ries, a potential pitfall is the possibility of technology or social media outlets causing a break of patient privacy rules. "Certainly the staff have been educated about the issue, but as a compliance officer, [that's] my biggest concern," Stacey said. She also said that the use of technology has engendered the expectation of an immediate response, which isn't always possible. "Sometimes picking up the phone allows a great exchange of ideas and avoids several e-mail notes," she said.

The biggest challenge for Brian Katz is the technology itself. "Without a doubt, my biggest challenge is having the computer freeze and losing data files," he said. "It doesn't happen too often but when it does happen, it takes time to recover documents. At the firm, our internal audit support software files can become very large and often it takes significant amounts of time to download the data files, especially if we're working remotely."

And there's the "cost" of staying current with software and applications that seem to change exponentially. "Technology is changing so fast" that it's a challenge to keep ahead of the curve, said Tracy Coyne. "We have to force ourselves to continuously learn and use it... it's the right answer for the companies that we work for and for ourselves."

Access to technology also may mean that we feel pulled in too many directions, checking e-mail while we're in a meeting or texting when we're supposed to be engaged in conversation. Dan Yunker maintains that today's work requires the ability to multi-task. "Let's face it, the traditional meeting 'ramble' isn't all that productive so if you can

(continued on page 15)

Technology Enhances Work Flow, Connectivity for Healthcare Finance Professionals (continued from page 14)

check e-mail or text—of course, work-related—and listen in to the rambling at the same time, awesome!” If people aren’t engaged in a meeting, Dan says look to the agenda, not technology, as the culprit.

There are times, though, when face-to-face communication is the best answer. Whether it’s a knotty employee matter or a complex issue that takes more than a few e-mail volleys, connecting with each other in person may trump technology. According to Stacey Ries, “Sometimes you just need to pick up the phone... you cannot discount good old-fashioned communication.” ☎



Vickie Austin is a business and career coach and founder of CHOICES Worldwide. She helps individuals and organizations with strategic planning and she’s a frequent speaker at HFMA chapters around the country. You can connect with her at vaustin@choicesworldwide.com, 312-213-1795, or follow her on Twitter @Vickie_Austin and LinkedIn, www.linkedin.com/in/vickieaustin.

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HFMA Committee Updates

FI HFMA Annual Election of Officers and Board

BY TRACEY COYNE, PRESIDENT

Our Chapter vote is official, and we have a new officer and board group for our 2013-2014 chapter year.

Chapter Officers

President Dan Yunker, SVP, Metropolitan Chicago Healthcare Council
President-Elect Carl Pellettieri, Attorney, Law Office of Carl Pellettieri
Secretary Adam Lynch, Principle Valuation, LLC
Treasurer Mary Treacy Shiff, Vice-President Finance, Advocate Good Samaritan Hospital

2013-2014 Board of Directors

Gary Breuer VP Revenue Cycle, Alexian Brothers Health System
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Tim Manning Director of Practice Operations, Adventist Health Partners
John Orsini Executive VP CFO, Cadence Health
Brian Washa Senior VP Business Services, NorthShore University Health System

HFMA Event Summaries

Facilities Program

The second annual First Illinois Facilities Program was held at the University of Chicago's Gleacher Center on January 24. This year's conference was held in conjunction with the Building Owner's Management Association (BOMA) and the AHC (Affiliated Healthcare Consultants) and featured industry leading speakers from healthcare provider and service organizations. The program included networking opportunities, round table discussions, a panel of CFO experts and case studies from healthcare industry leaders, breakfast, lunch and a special cocktail reception following the program. This year, FI HFMA was also able to extend CEU credits from the AIA for its members.



Facilities Program: David Dastur, Mike Leopardo, Gina Weldy, Greg Gerber, and Paul Kopecki



Facilities Program: John Hattle, Rosalyn Ryan, Mike Czyrka, Julie Ford, and Gordon Soderlund

HFMA Event Summaries Continued

Managed Care Program

BY KATY ELDRIDGE

Managed Care is taking on an entirely new look as we move through healthcare reform. We will need to manage disease across patient populations while taking on more risk. If this isn't enough to motivate even the most seasoned health care administrator, we will also need to do this to shift focus from being patient centered to being consumer driven. Kenneth Weixel, CPA with the Deloitte Center for Health Solutions, divided healthcare reform into three phases. Phase I (2010-2013) added costs to the system and largely involved insurance reform. Phase II (2014-2016) will feature the "heavy lifting" which will impact providers as we must implement Meaningful Use and cope with ever decreasing reimbursement. Phase III (2017+) will be what Weixel called the "New Normal" with its foundation built on financing and delivery of health care services built on an IT platform. He described this new landscape as one with an empowered consumer at the top of the pyramid.

One area of interest and concern is the future of employer sponsored health care coverage. Weixel offered that while no major employer wants to be the first in a sector to abandon providing coverage to workers, there will be fast followers. Other scenarios to circumvent the requirements while avoiding the penalties for forgoing offering benefits may include reducing hours for workers to <30 hours per week and carving out coverage for costly treatments through direct employer to provider contracts.

In Weixel's view, there are currently four government issues. He believes the SGR will be fixed in the near future. A "grand bargain" will be struck which settles on a permanent rate which is 2% lower than the current payment for hospitals. Insurance exchanges are a significant unknown: What will they expect to pay providers? Will providers be willing to negotiate lower rates in exchange for the promise of a larger volume of patients? Will consumers be able to adequately understand what is available and the cost versus value? Lastly, there is the issue of Medicaid as the program expands to the states, many of which are not in a financial position to expand services. Who will pay and who will benefit? For an interesting look at what may lie ahead, Weixel recommends reading Chapter 224 of the Massachusetts health reform bill. <http://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224>

Linda McCracken, VP, Truven Health Analytics, discussed what she called the 5 Enduring Trends: (1) Building collaborative relationships which can reduce duplication of services and improve outcomes through communication. (2) Lack of care coordination which costs the system an estimated \$25-50 Billion per year. (3) Striving for perfection—we need to account for generational differences in patient groups to deliver the appropriate care and services on their terms and not on ours. We will find payments for services based on merit to compensate for the vast variances in a single market for similar services. (4) Transparency and accountability—McCracken pointed out that "cementing loyalty is easier than winning new customers." (5) Finally, improving health and wealth is a winning strategy for all

stakeholders. "Healthy employees make wealthier employers" not only in terms of reduced health care costs but in a reduction of lost time attributed to illness or injury.

Jeff Black, partner at Mercer, provided some structural details on what they see on the horizon. Of companies with fewer than 500 employees, studies indicate 22% will discontinue employer sponsored health care plans. For companies that continue to offer coverage, we will see larger deductibles and other cost sifting to employees, which may include the employee bearing all costs associated for buying up from the basic coverage. Incentives may shift to penalty for non compliance with chronic disease management. On the upside, we will see new innovations that deliver care through telemedicine, on site clinics for large employers, and access to care through web based products.

The message to all of us is to be looking beyond our usual horizons for solutions and service lines to fit into the "new normal" as health care reform's full effects are being felt by providers, payers and patients alike.



Katy Eldridge,
Practice Manager, DuPage Medical Group

March 7, 2013, at the University Club,
76 East Monroe Street, Chicago, IL, 60603



Managed Care Program: Dr. Opella Finley Ernest,
Dr. Nancy A. Diettrich, Dr. Peter McCauley, Dr. Haydee Muse
and Larry Boress

Revenue Cycle Program

The Three Rings of Revenue Cycle: Intersection of Clinical, Operations and Technology

BY KATY ELDRIDGE

Each of the speakers issued a call to action for all those who are engaged in the health care system today. The questions we must ask ourselves are, "What do we do and how do we do it?" It can be easy to get caught up in statistics and to allow benchmarking measures drive important change initiatives. The real measure of value, according to Dr. Sameer Badlani of U of C Medicine, is to measure efficiency in terms of "patient outcomes per dollar expended" instead of the number of RVUs performed by a physician on the ROI of a new EMR system. If the end result isn't demonstrable benefit for the patient, we have focused our efforts on the wrong goal.

Dr. Charles Darus, VP Medical Management from Advocate Good Samaritan Hospital, Lisa Dykstra, Executive Director of IT, U of C Medicine, and Vince Pryor, CFO Edward Hospital and Health Services, provided an interesting look at the complexities in navigating any change initiative involving EMR from their differing areas of expertise. They challenged us to have the courage to think outside the box and be open to seeking advice from those who might currently be considered unlikely collaborators. Collaboration is key and by moving away from silo behavior and thinking, we can identify common goals and measurement tools, recognize the interconnectivity between departments and other organizations, and engage all key stakeholders, including the end users, in the planning and implementation of process change and improvement. Dr. Darus stressed the importance of a "systematic, repeatable approach" including creating a formal, written plan for identifying and resolving problems.

Lisa Lenz and Marilyn Niedzwiecki, both with Lurie Children's Hospital, discussed the challenges they faced as they implemented EMR on both the hospital and physician sides to improve charge capture. Commitment to communication and collaboration enabled both sides to identify potential roadblocks and create a seamless pathway for charges as they move through both systems. Patrick McDermott, Sr. VP Revenue Services, Presence Health, provided anecdotes of learning experiences in early EMR implementation which have provided valuable knowledge for preparedness in subsequent rollouts. The takeaway here was, learn from your mistakes so you don't have to relive them!

The final presentation of the day provided an update for Illinois Medicaid Expansion and Reimbursement and the proposed transition in 2015 to Insurance Exchange. As we have been anticipating, reimbursement will be more closely tied to outcomes, reducing avoidable care, focus on potentially preventable readmissions and penalty for hospital-acquired conditions.

The theme of action targeted to improve patient experience and outcomes provides us with a beginning point as we prepare for the next phase of significant change. We cannot focus on only one of the three areas of the revenue cycle: clinical, operational or technological, but must strike a balance of how each of the three drive the need for change and improvement.

February 7, 2013 at the Hilton Garden Inn O'Hare, 2930 South River Road, DesPlaines, IL, 60018



Revenue Cycle Program: John Bomher, Joe Heller, Jack Ijams



Revenue Cycle Program: Vince Pryor, Lisa Dykstra, Patrick McDermott, and Dr. Charles Derus

HFMA Event Summaries Continued

Compliance Program

First Illinois HFMA presented its third annual Compliance Program on March 14 at Katten Muchin Rosenman LLP. This full day program was developed for Senior Financial Executives, Chief Compliance Officers, In-House Counsel, Chief Internal Audit Officers and members of Hospital Audit Committees responsible for Compliance within their healthcare organization. The program offered a practical source of information to educate attendees and their respective organizations. Expert speakers provided the latest developments on complex healthcare compliance issues and offered several helpful strategies to meet the current challenges. The program included a discussion of the new HIPAA Omnibus Rule and what it means for covered entities and business associates, recent trends in enforcement under the HITECH Act, including OCR HIPAA Audits and how best to prepare for an audit. Discussion also included tips and strategies in negotiating a CIA, the challenges in preparing for and implementing a CIA, tips and lessons learned when acquiring health care provider practices, and government enforcement actions under the recently modified False Claims Act.



Compliance Program: Lisa Rosenbaum and Blair Todt



Compliance Program: Stacey Ries and Douglas Swill

HFMA Career Center

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Develop your business and personal skills with tools created specifically for the healthcare finance professional. HFMA's new Career Center is organized into distinct career levels to help you as you enhance and further your career path into healthcare finance.

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- Starting My Career is for people who are seeking their professional path into healthcare financial management.
- Managing My Career focuses the drive to seek opportunity and take control of your career by acquiring and maintaining skill sets, networking, and self-branding.
- Advancing My Career teaches how to accelerate your career by improving your ability to anticipate future opportunities and by actively structuring and sequencing your work life.

Included in each career level are:

- Assessments that provide a plan to further develop your skills by determining your level of knowledge, skills, and behavioral competencies that are critical to current and future leadership needs in the industry.
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Learn more and further your career at hfma.org/careercenter.

HFMA Upcoming Events

The Value of Certification

Many healthcare organizations in today's challenging economy recognize their workforce as their most valuable asset. As such, these organizations tend to hold workforce development as a primary business strategy.

Investment in developing the talents, knowledge and skill sets of staffs are critical to the organization's success. HFMA's Healthcare Financial Pulse research identified this dynamic and noted that successful organizations today commit to the "bread and butter" of financial management, i.e., technically strong and comprehensive financial management.

Likewise, many individual financial managers today recognize the importance of assuming personal responsibility for their careers success. More than ever before, individuals understand the importance of acquiring and maintaining comprehensive skill sets to ensure their ability to provide the financial management demanded today. These individuals frequently seek out relevant professional development opportunities.

The larger business environment resulting from these forces is a heightened interest in workforce development initiatives including certifications and credentialing. Credentialing programs have exploded across the past couple of decades and include:

- Professional associations offering certifications
- Community colleges offering curriculum-based certificates
- Corporate sponsored in-house credentials for employees
- Technology companies providing proprietary credentials to customers

HFMA certification provides a fundamental business service to our industry, HFMA certification offers:

- Assessment of job-related competency
- The opportunity for an individual to demonstrate skills and knowledge
- Independent verification of the skills and knowledge
- Confirmation that an individual is current in the practice field

The value of HFMA certification can be seen in several reported value-adds:

- Increased departmental cooperation
- Heightened self-confidence among participants
- Increased performance against selected metrics
- Verification of staff knowledge and skills
- Assistance in structuring career paths

HFMA is committed to being the indispensable resource that defines, realizes and advances healthcare financial management practice. As such, HFMA provides professional certifications to achieve this purpose in today's business environment. This makes HFMA certification a smart workforce investment strategy.

For more information on HFMA certification, visit <http://www.hfma.org/certification/>.

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Maggie Fenstemaker
Officer, PNC Healthcare
PNC Bank

Stephane Letang
Accountant
Hartgrove Hospital

Pippa Laundry
Manager

Collin P Supple
Associate
Kaufman, Hall & Associates

Diane M Murray
Director, Continuum of Care
Cadence Health System

Margaret M Fitch
Business Development
Executive
Medical Recovery
Specialists, LLC

Kausar Karwa

Ken Maleske
Regional Manager,
Mid-America
SPi Healthcare

Meeta Dhillon
Pharmacy OneSource/
Wolters Kluwer Health

Dean Hobart
Appraisal Director
National Property Valuation
Advisors

Sarah Bader
Principal, Gensler

Michael Turek
Vice President of Finance
Fresenius Medical Services,
North Division

Jamie Sanchez
Director of Accounting
Metropolitan Chicago
Healthcare Council

Erin E Keene
Regional Director
Cardon Outreach

Anthony B Ferraro
Attorney-CPA
The Law Offices of Anthony
B. Ferraro, LLC

Kathleen Needham Howard
Clinical Quality
Improvement Specialist
Loyola University Health
System

Donald P Hammer, MMI
Health Solutions Director
Avanade, Inc.

Theresa June Hayes
Director of Accounting

Uriah Melchizedek
Consultant
Health Care Futures

Rogelio Tapnio
Executive Director, Revenue
Cycle Management
Northwest Community
Hospital

Rachel VonDielingen

Bradley Milovich
Director of Business
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Welcome New Members

(continued from page 22)

Donna Diblik

Business Unit Chief
Financial Officer
Presence Our Lady of the
Resurrection

Anthony Naccarato

Owner/General Partner
Doctor's Choice - Medical
Financial Medical Solutions,
LLC

Frank Morelli

National Sales
Representative
Vaughan Holland
Consulting, Inc.

Lauren L Craig

Reimbursement Specialist I,
Midwest Region

Maureen McCarthy

Katy Eldridge

Practice Manager
Dupage Medical Group

New Member Profile

Anthony Naccarato

Demographic Information:

Name: Anthony Naccarato

Organization: Doctor's Choice-Medical Financial
Solutions, LLC

Current Position: Owner/President

Education: B.S. in Accountancy,
M.B.A. in Finance

Years in healthcare: Almost 1 year

Questions:

Why did you decide to join First Illinois HFMA?

The HFMA is an excellent forum that provides the opportunity for any health care professional to learn from experienced individuals, and it is a reliable source of healthcare information.

What is your greatest achievement outside of work?

I take great pride in my annual charity drive for St. Jude Children Hospital/Research.

What is the best advice you ever received from a mentor?

"Never be afraid of doing and understanding the importance of manual labor. It is the heart and soul of any organization."

Finish this sentence:

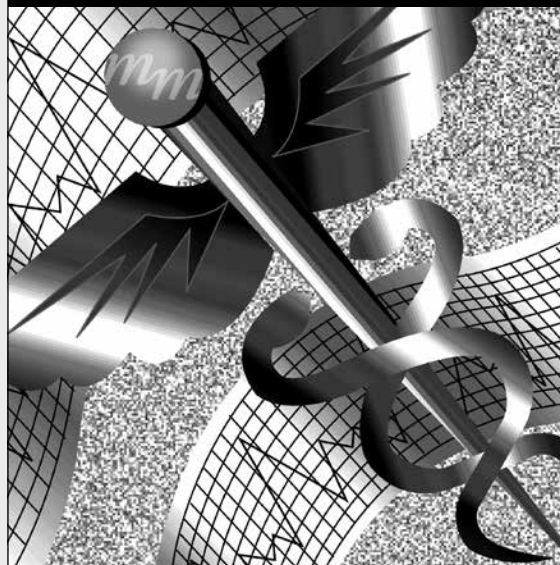
I think healthcare reform will...*eventually provide a sound business model that all (doctor's practices, hospitals and especially the patients) will benefit from. Like any new health care regulation, revisions will be necessary.*



Member Opportunity to Contribute

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

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First Illinois *Speaks*

HFMA's First Illinois Chapter Newsletter

Publication Information

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HFMA Editorial Guidelines

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

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

Style

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

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

Founders Points

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

Publication Scheduling

Publication Date

July 2013
October 2013
January 2014
April 2014

Articles Received By

June 10, 2013
September 10, 2013
December 10, 2014
March 10, 2014

First Illinois *Speaks* hfma healthcare financial management association

HFMA's First Illinois Chapter Newsletter

event-filhfmaorg@comcast.net

Chapter Educational and Events Calendar 2013

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

Tuesday, April 9, 2013

Webinar: "ICD-10 Transition Countdown: Ready, Set, Code - Your Complete Strategic Readiness Guide" - McGladrey

Thursday, April 18, 2013

IT Education Program

Friday, April 26, 2013

CFO Breakfast

Saturday - Monday, April 27-29, 2013

LTC

Monday - Friday, May 6-10, 2013

HCPRO Medicare Boot Camp - Hospital Version

Tuesday, May 14, 2013

Webinar: "Business Analytics - How to Maximize Your Information and Minimize Your Efforts" - Amerinet

Friday, May 17, 2013

May Board Meeting - National HFMA Westchester, Approval of Budget, Education Program and CBSC

Friday, June 21, 2013

CFO Webinar

Wednesday, July 17, 2013

HFMA Virtual Conference

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