First Illinois Speaks
HFMA's First Illinois Chapter Newsletter
March 2019

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Future of Hospital Cardiac Programs in Flux - $700,000,000 at Stake

BY RONALD HIRSCH, MD, FACP, CHCQM, VICE PRESIDENT, REGULATIONS AND EDUCATION, R1 RCM INC., PHYSICIAN ADVISORY DIVISION

Much of the talk in the last few months has been about the changes proposed by the Centers for Medicare & Medicaid Services (CMS) to the physician evaluation and management code selection and payment regulations in the 2019 Proposed Physician Fee Schedule Rule. And there was a collective national sigh of relief when CMS elected to defer any drastic changes until 2021.

With the continuing confusion over the removal of total knee arthroplasty from the inpatient only list, there was more relief when CMS declined to remove total hip arthroplasty from the inpatient only list and chose not to add either total hip or knee arthroplasty to the list of surgeries allowed in ambulatory surgery centers (ASCs).

CMS Proposes Allowing Cardiac Catheterizations at ASCs

But hospitals might not want to take too long to celebrate that temporary reprieve since CMS did adopt a change which may have significant financial implications for hospitals. In the Outpatient Prospective Payment System Final Rule, CMS is adding 17 cardiac procedures to the list of ASC-approved procedures. These 17 procedures, represented by CPT codes 93451-93462 and 93566-93568, 93571, and 93572, include left and right heart catheterization and cardiac angiography. In 2016, there were over 523,000 cardiac catheterizations with those CPT codes performed on outpatient Medicare beneficiaries in hospitals, resulting in an estimated $682,000,000 in payments for those procedures.

Most are aware of the use of emergent coronary angiography and percutaneous cardiac intervention with stenting as a common life-saving treatment for heart attacks. Additionally, every day in thousands of hospitals around the country patients undergo elective coronary angiography for chest pain or other symptoms that are not deemed to be emergent and

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therefore are being electively scheduled and performed. Often, these are accompanied by an intervention such as stent placement. (There is an ongoing debate in the medical literature on the effectiveness of cardiac stenting for patients who are not having a heart attack, and interested readers should do an internet search for articles on the ORBITA trial.)

Under current Medicare regulations, that testing must be performed in a hospital, usually as an outpatient with a hospital stay lasting several hours to overnight. But if cardiac catheterization and angiography are allowed in ASCs, that might change. The financial implications both to providers and the Medicare Trust Fund are fascinating to analyze.

Cardiovascular Use of ASCs Currently Limited

The only cardiovascular procedures allowed at ASCs as of 2018 are peripheral vascular interventions, such as lower extremity angioplasty and placement of pacemakers and defibrillators. There currently are few ASCs that perform these cardiovascular procedures. In 2016, there were only 31 ASCs nationwide that billed Medicare for performing peripheral angiography and angioplasty or placement of pacemakers or defibrillators, likely due to the requirement for specialized equipment and not enough potential volume to cover those fixed costs.

Furthermore, since a large percentage of cardiologists' patients are of Medicare age and much of the invasive cardiac testing Medicare patients require is not permitted at ASCs, there is little reason for cardiologists to be privileged to work in ASCs, much less have an ownership interest as is seen with general surgeons, orthopedic surgeons, ophthalmologists, and other surgical specialists.

The ability to perform cardiac catherization and angiography may provide enough volume for more ASCs to consider offering cardiac procedures. Thus, more cardiologists may consider applying for privileges and even investing in ASCs.

Large cardiology groups may see a benefit in having one or more physicians at the ASC on specific days of the week doing all elective procedures. This allows them to be performed with no interruptions for emergent procedures as is common in the catheterization lab at the hospital. This also is often more convenient and at a significantly lower coinsurance for the patient. Although the payment to the facility for the procedure varies depending on the site of service, the physician fee does not. The physician is paid the same professional fee for an angiogram done at the hospital or an ASC.

If a patient has coronary angiography and it is determined that an intervention such as a stent is indicated, the patient will require that procedure at a later date. This leads to a second professional fee payment to the physician. It is critical at this point to note that the fees associated with a procedure should never be a consideration in choosing the site of service or determining if the procedure will or will not be done. Rather, they are discussed here simply to provide a full financial and logistical analysis of the proposed change.

From the standpoint of the Medicare Trust Fund, the finances also are complex. It should be noted that the positive or negative financial effect of adding a procedure to the ASC list is not one of the factors that is considered by CMS. And in this case, the financial effect on a case-by-case basis could be either positive or negative. Consider these examples.

Elective angiogram with no intervention

If a patient has an elective coronary angiogram at a hospital as outpatient and no intervention is performed, the facility fee payment to the hospital is approximately $2,800 (C-APC 5191) with adjustments made for wage index and other (nearly impossible to understand) factors.

If the same procedure is performed at an ASC, the facility fee payment to the ASC is approximately $1,400. This results in a Trust Fund savings of $1,400 for every angiogram performed at an ASC as opposed to a hospital.

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Elective angiogram with intervention

If a patient has an angiogram at a hospital and it is determined that stenting is indicated, and it is done at the same time with a drug-eluting stent, the hospital facility fee payment is approximately $10,500 (C-APC 5193) using 2018 payment rates.

If that patient has their angiogram at an ASC and stenting is needed, the patient will need to be scheduled at the hospital for that procedure at a later date. In that case, the ASC gets a facility fee of $1,400 and the hospital gets $10,500 (C-APC 5193). The total expenditure of $11,900 results in a Trust Fund loss of $1,400.

An even more complex scenario is also possible. There is an increased ability to risk stratify patients presenting to the hospital with chest pain to determine those who require hospital care and urgent testing. For patients who are not considered high risk, some of the tests could potentially be scheduled semi-electively. This provides safe care for patients while also not filling beds with patients who could be treated in a lesser setting.

Patient in ED with chest pain

Such a patient would present in the emergency department. Testing there would determine that the patient was not having a myocardial infarction but requires a period of monitoring. The patient would be placed outpatient with observation services to perform testing to determine if the patient has unstable angina and does indeed require urgent intervention. At the end of a period of observation, if testing is normal a stress test is performed. In some cases that stress test is mildly abnormal, not requiring immediate angiography. The patient is discharged home on medications and scheduled for an angiogram at an ASC. That angiogram done soon thereafter is abnormal and a stent is indicated. The patient is then scheduled at the hospital for their intervention and it is successful.

In this complex scenario, the following facility fees would be paid: observation stay with stress test, $2,350 to hospital (C-APC 8011); cardiac angiography at ASC, $1,400; coronary intervention with stenting at hospital, $10,500 (C-APC 5193). The total cost would be $14,250.

If this same patient was placed outpatient with observation services at the hospital, kept hospitalized and underwent cardiac angiography with stenting at the hospital, and was discharged prior to the second midnight, the hospital payment would be $10,500 (C-APC 5193). Dividing this patient's evaluation into three parts, with the observation stay at the hospital, the performance of the angiogram at the ASC, then the stenting at the hospital, would result in the Trust Fund paying $3,750 more.

But then again, if the patient had the angiogram and stenting at the same time and the medically necessary stay passed the second midnight, the facility would be paid by DRG, most likely 247, with a facility base payment (without any inpatient fee adjustments for wage index, teaching status, DSH payments, etc.) of $13,000. This would save the Trust Fund $1,250.

On the other hand, if the patient didn't require intervention, the Trust Fund would have spent $2,800 if the patient was placed outpatient with observation services and had an angiogram at the hospital (C-APC 5191) but $3,750 if the patient had an outpatient with observation stay at the hospital (C-APC 8011-$2,350) and then an angiogram at an ASC ($1,400) resulting in a Trust Fund expenditure of an additional $950.

Comprehensive APC Rules Often Fiscally Painful

The careful observer of the numbers noted above may have realized that the patient with chest pain who has simply a period of observation results in a hospital payment of $2,350. If that same patient has an angiogram without stenting, the payment goes up to $2,800. That suggests that the hospital is being paid only $450 additional for the angiogram.

Several years ago, CMS developed the comprehensive APC payment classification for procedures where CMS felt paying for each service as a line item did not encourage thoughtful use of medical services by providers. When they introduced the concept, they described the patient who was coming to the hospital "to have a pacemaker placed." CMS felt that since the patient was coming for one procedure, there should be one single payment made for the stay regardless of what was done in addition to the actual placement of the pacemaker.

Although it appeared that CMS' intent was to apply this to the many elective outpatient procedures, the billing rules also make this payment applicable to patients who present emergently and then need a procedure. For example, the patient who presents to the emergency department with syncope and is found to have heart block and has a pacemaker placed the same day will result in a hospital payment that is the same as the electively scheduled pacemaker placement, despite the emergency patient's use of significant resources in the emergency department.

The same applies to the observation patient who subsequently has a procedure to which the comprehensive APC rules apply. In that case, the patient will incur not only use of emergency department resources but also room and board and nursing care during their period of observation prior to surgery for which there is no additional revenue.

Conclusions

Now that CMS has decided to allow these cardiac procedures at ASCs, whether more ASCs equip themselves to perform these cardiac procedures and recruit cardiologists to join their medical staffs remains uncertain. If they do, cardiologists may not only shift Medicare patients to the ASCs but also most of their commercially-insured patients. Hospitals will need to look closely at the financial implications of this loss of volume from their facilities and act accordingly.

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2019 Medicare Updates

BY CHAD BESTE, PARTNER, BDO HEALTHCARE ADVISORY SERVICES

Each year in early November, CMS (Medicare) announces final program policy changes and updates to its various fee schedules. This has become a much-anticipated time as the pace of change is increasing and offers important implications to providers of all types. Below is a summary of recent fee schedule change announcements from CMS:

2019 Medicare Payment System Updates (per Medicare)	% Change	Projected $ Increase
Hospital Inpatient Prospective Payment System (IPPS)	1.80%	4.8 Billion
Uncompensated Care Payments to hospitals	18.10%	1.5 Billion
Skilled Nursing Facilities	2.40%	820 Million
Home Health Agencies	2.20%	420 Million
Long Term Acute Care Hospital Prospective Payment System	0.90%	39 Million
Ambulatory Surgery Centers	2.10%	Not Stated
Hospital Outpatient Prospective Payment System (OPPS)	1.35%	Not Stated
Physician Fee Schedule	0.10%	Not Stated

The Federal Government has truly become the most innovative "payor" in its efforts to transform healthcare from a fee-for-service system to a value-based system. It is utilizing its inherent clout as it controls roughly 50% of all U.S. healthcare spending (Medicare and Medicaid programs).

There are some common themes in each of these provider type updates:

- **Transparency and performance updates** – CMS will require hospitals to publish for patients a list of its standard charges. CMS has also updated the Nursing Home Compare program available to patients. CMS has significantly increased data and information available to patients as well as cost and utilization information available to the public.
- **Meaningful measures/patients over paperwork** – CMS has announced a number of measures across provider types it believes will reduce costs associated with the administrative burdens its programs have adopted over the years. This is new and much needed.
- **Modernizing Medicare** – CMS is recognizing how technology is transforming healthcare by compensating for technology-enabled "virtual check-ups" and expanding coverage for telehealth services.
- **Framing of CMS messaging** – CMS is cleverly documenting how the program changes are designed to benefit beneficiaries of the program.

In 2019, there are significant updates that will have a lasting impact on the national dialogue related to health care costs including:

- **Site neutrality.** This is controversial. CMS is looking to neutralize payments across provider types. This is targeted directly at hospitals, which for a variety of historical reasons have been paid more for providing the same services as other providers.

  For physician services, CMS will phase out the additional reimbursement for off-campus provider-based departments (designated hospital outpatient centers) over three years, from 70% to 40% to 0% in 2019-2021. In this manner, CMS will reimburse for these services the same as within the physician fee schedule.

  CMS is beginning to try and reduce the cost differentials between reimbursement for ambulatory surgery centers and hospital outpatient surgery departments.

  This emphasis on payment differentials between sites-of-service will open the door more broadly to other commercial payors. It will be increasingly challenging for hospitals to maintain these historic pricing advantages for outpatient services across their payor mixes.

- **Streamlining documentation and payment changes for evaluation and management physician visits.** These are "office visits," and historically CMS has had five different reimbursement levels depending on the complexity of the visit. CMS had originally proposed both to simplify the rules and to reduce the number of reimbursement levels to two. In the end, the vocal outcry was too high related to the reduction in reimbursement levels, so CMS will be phasing this change in over three years.

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2019 Medicare Updates (continued from page 5)

- Overall, this is a positive step for physicians. Coding accuracy for office visits is exceedingly complex in the current environment, and physician organizations spend an inordinate amount of time complying with the existing rules. Physicians will have some additional time for either more direct face interaction with patients and/or spending less time late at night completing the coding for patient encounters from the previous day.

- Time will tell whether the payment change to two reimbursement levels will lead to issues. Like all change, there tend to be winners and losers. There is some concern that physicians treating the most complex patients will lose incentives to spend the proper amount of time with these patients. However, with the presence of modifiers, CMS is trying to counter-balance this impact.

- Finally, these changes should have a positive reduction in the amount of annual expense organizations dedicate to regulatory compliance specific to coding of these services.

- **Care at home.** While everyone is aware of the trend away from inpatient care, care at home is going to explode. CMS is recognizing there are new ways for patients to receive care without ever leaving their home, whether it is providers coming to them (e.g., home health care), telehealth services, or now through technology-enabled tools that monitor patients wherever they happen to be. This is just a start.

- **Uncompensated care payments for hospitals.** In FY 2019, CMS will be distributing about $1.5 billion more for uncompensated care payments. To that end, CMS will continue to incorporate uncompensated care cost data from Worksheet S-10 of the Medicare cost report from FY 2014 and FY 2015. Hospitals are strongly advised to pay particular attention to completing their cost data as accurately as possible.

In summary, CMS is a driving force in the transformation of our healthcare system and is facilitating the disruption we see both today and into the future.

Companies need to rapidly break down silos to drive value across their ecosystem. To accomplish this, most need to reach beyond their four walls to share data and other resources that can lead to more effective population health management strategies and better consumer outcomes. In general, this involves five business imperatives: a) capitalize on data, b) maximize profitability, c) manage risk, d) transform to compete, and e) innovate patient care.

A CFO's Guide to AI Strategy

BY NEIL SHAH, UTSAV SHAH AND DEVANSHU YADAV, MBA

Artificial intelligence (AI) investments can provide significant ROI for healthcare organizations

Ever-rising costs, declining payment, razor-thin operating margins, and an uncertain regulatory environment are major issues that confound the healthcare industry and keep hospital CFOs up at night. Sustaining margins becomes increasingly difficult as the industry moves toward value-based payment and its focus on improving efficiency and reducing cost without adversely affecting the quality of care. AI offers opportunities for healthcare executives to achieve their goals by leveraging innovative technology.

Hailed in several quarters as the fourth industrial revolution, AI is no longer just a futuristic technology in health care. It is here, and it is skyrocketing in popularity. An Accenture study notes, "Growth in the AI health market is expected to reach $6.6 billion by 2021—that's a compound annual growth rate of 40 percent." The key for CFOs is to execute a strategy that realizes AI's potential to maximize their organizations' value.

AI Defined

Since the invention of computers in the mid-20th century, people have pursued a decades-old quest for computers to think and perform tasks like humans. We are still far away from reaching that pinnacle. However, the past decade has been particularly promising for AI development. There has been a phenomenal rise in software's capability to process data and automate processes. AI also is discussed with terms like machine learning, big data, and natural language processing (NLP).

Machine learning is the most promising subfield of AI and an engine on which AI runs today. The term refers to the ability of a computer, or machine, to smartly process larger sets of data to find patterns without being told explicitly what to find. The more data the machine sees, the more refined and accurate it becomes in finding patterns in a process of constant learning.

Big data is a phenomenon that drives machine learning. It is the proliferation of data due to modern technology that allows large sets of data to be injected into software for machine learning.

NLP is the function that enables computers to understand and process human languages.

Despite AI's vast capabilities, health care has been slow to adapt the technology for various reasons including the following:

- Limited interoperability, which creates challenges in integrating the new technology into existing workflows
- Information overload affecting the many hospitals that are not equipped to process the large sets of data
- Real concerns about data security, particularly regarding the privacy of patient data

- Little proof of concept, which has made it difficult to identify a business case and ROI opportunities

The industry already is using AI in unprecedented ways to capitalize on the tremendous volume of electronic data, increased speed of computing, and the rise of cloud computing—all of which make it affordable and scalable for health systems and technology companies to create and deploy AI-enabled applications.

The Impact of AI

Historically, health systems looked to the CFO to ensure the accuracy of hospital financials. Today, with the increase of electronic data, CFOs are looked upon to advise other leaders as they map out the strategic future of the organization. To meet modern expectations, health systems must operate more efficiently and analyze data from across the revenue cycle.

Four characteristics of AI enable it to accomplish both objectives:

1. It is highly efficient and effective. As AI automates manual repetitive tasks, it frees up valuable time for leaders and staff to concentrate on strategic initiatives. As AI develops, healthcare CFOs and their teams can shift from routine transaction processing to performing critical analyses that help their organizations improve outcomes and sustain growth.
2. It offers data-driven insights. AI can crunch large data sets and identify statistically correlated patterns and trends at a level that is not possible for humans, helping healthcare leaders tap into previously unavailable degrees of insight.
3. It enables CFOs to make informed decisions. AI does the data analysis, but the CFO turns those insights into value for the organization.
4. It helps healthcare leaders monitor performance. When AI is fed data in real time, it is able to find trends and patterns continuously, making it a highly valuable and powerful tool for performance monitoring.

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Top 10 AI Strategies for Healthcare Leaders

Healthcare leaders who are developing their AI strategies should consider the following steps.

1. **Test the waters.** Organizations that are just starting with AI should start small. They should avoid the trap of blindly trusting any AI tool without due diligence and not be beguiled by the promise of phenomenal benefits at the risk of wasting massive investments. Small pilots of various AI tools with small-scale, quantifiable payoffs as the goal can offer key lessons to inform a larger implementation. One good starting point might be less-developed areas of the health system that have large sets of data but inadequate access to analytics. Speaking with industry peers who have AI experience also can be helpful.

2. **Upgrade the organization's data sources.** AI is only as effective as the data that feeds it. The best way to prepare for AI is to continuously improve the organization's data infrastructure, focusing on three key pillars: quality of data, quantity of data, and real-time data.

3. **Create a robust data management strategy.** The effectiveness of AI will be compromised without a good data strategy. Data must be collected in a way that provides for integration and interoperability with other systems. Health system leaders should follow a connected-platform approach. An ad hoc approach with a variety of systems will interrupt the data flow, negatively affecting AI's pattern- and trends-identifying ability. By leveraging a platform perspective, health systems will have a strong and scalable foundation for innovation that delivers a far superior hospital performance and patient experience.

4. **Select an AI tool with data-driven decision-making capability.** It is important to strategically select AI technologies and tools that offer real time tracking of the AI project's objectives. These tools should have dashboards and analytics to help the organization visualize things, such as the impact on key performance indicators, root cause analysis, as well as reasons and insights behind the data the system is generating and rules that led to particular recommendations. These capabilities will provide a crucial competitive edge to not only survive but thrive in an ever-changing environment of the healthcare industry.

5. **Collaborate wisely.** When using an external vendor or expert, a health system leader's strategy and focus should be on knowledge transference. CFOs must plan for the knowledge transfer from the vendor to internal staff to ensure that staff develop skills required to handle the data.

6. **Tackle budget issues.** One of the biggest hindrances for AI adoption is the budget. AI will be the driver of innovation and competitive advantage in the modern healthcare industry. In many cases, the insights derived from this robust technology can mean the difference between a health system surviving or being acquired or shut down. Not investing in AI is incredibly risky if a healthcare organization's focus is on cost reduction and a value-based future. However, if the budget is still a sticking point for the health system, making small investments in AI automation tools and machine learning for manual and repetitive tasks is a smart initial strategy. These types of investments tend to show results quickly and can make the case for bigger investments in AI.

7. **Obtain internal buy-in.** It's easy to convince people of the benefits of AI. The difficult part is the human element. It is only natural for staff to feel unsure and threatened by AI because it can do part of the work they do. The healthcare leader's strategy should be to educate team members and frame AI to them as an augmentation of their capabilities rather than a replacement, allowing them to pursue more productive work that requires human intellect. It is crucial for C-suite executives to be in unison on AI strategy, especially the CFO and CIO. The good working relationship will go a long way in successfully implementing AI in your health system.

8. **Institutionalize the AI readiness.** AI should not be seen just as a tool but also as a revolutionary phenomenon that could transform a health system. To realize greater benefits and value from AI, a shift in mindset is required. Deep change in behaviors and ways of thinking is needed. This can lead to cultural anxiety among employees. Hence, AI expertise must be incorporated into a health system's process, structure, culture, and governance. Such expertise is obtained by developing an AI-smart workforce that will use AI to improve efficiency, quality of treatment, and patient outcomes. Leaders can pursue strategic goals such as building trust, proactively managing related challenges, getting staff excited for the AI change, training new skills like critical thinking, helping staff interpret trends and patterns generated by machine learning, and providing education on the use of AI tools.

9. **Prioritize talent acquisition.** Talent acquisition could well be the biggest barrier in the adoption of AI. CFOs and CIOs need to chart out a short-term as well as a long-term strategy for acquiring AI skills. The short-term strategy can include providing ongoing training to existing staff on data science tools and educating the team regarding results of the AI pilots conducted at its respective hospitals as well as at peer hospitals. Long-term strategies can revolve around continuously leveraging academic communities, AI research papers, and open-source technologies.

10. **Invest in cloud-based AI technology over traditional on-premises AI systems.** Cloud technology provides the best way to cost-effectively build, store, and analyze data for AI-based insights. Cloud-based AI technology is modern and built for big data. Hence, it beats on-premise AI technology in storage, scalability, accessibility, flexibility, and cost. AI technologies embedded in cloud applications are at the forefront of delivering benefit through end-to-end to single-platform solutions.

AI ROI

The previously mentioned Accenture study notes, "By 2026, AI can create $150 billion in annual savings for the U.S. healthcare economy." Another study published in MIT Technology Review states that "more than half of early stage and mature-stage users of AI say their efforts

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have resulted in demonstrable ROI." After decades of promise and disappointments, AI has finally started to deliver. But AI in health care can mean multiple technologies and tools, which could cause confusion for leaders waiting to dip their toes in the water.

AI in health care can be broadly classified in two buckets: clinical and operational. Clinical AI (e.g., AI robots, clinical decision support) is much more elaborate and tends to generate greater interest than operational AI (e.g., revenue cycle automation, coding workflow optimization). Clinical AI has huge potential, but it is still in a nascent stage, and a clear recipe for success hasn't emerged. Because of the current uncertainties regarding ROI for clinical AI—both in measuring it and being able to realize it quickly—CFOs should be cautious about investing in it.

On the other hand, there are many success stories with demonstrable ROI associated with operational AI. These tools basically automate manual tasks, eliminate error-prone processes, and remove administrative burden in a revenue cycle. These capabilities represent clearly defined opportunities to quantify value and ROI from improved operational efficiency, payment, and cash flow of the health system. However, the likelihood of success largely depends on the organization's agility in adapting to AI tools and the degree to which the organization's AI vendor partner can provide essential support.

Healthcare leaders should take an adaptive approach with ROI, be clear and vocal about the expected costs, set expectations accordingly, and be prepared for those expectations to be revised significantly as the AI solution scope is further refined. Leaders also should be prepared to shut down experimental AI projects that aren't producing benefits.

The primary aim of an AI strategy will be to integrate this technology in a way that maximizes the capabilities of human expertise with AI tools. Healthcare CFOs need not be software geniuses to make sense of AI. Neither should they have to call for massive investments to apply AI toward transforming their organizations. Now is the time for CFOs to explore this technology and identify ways it might best be initially implemented. CFOs who adopt AI today will be industry leaders tomorrow.

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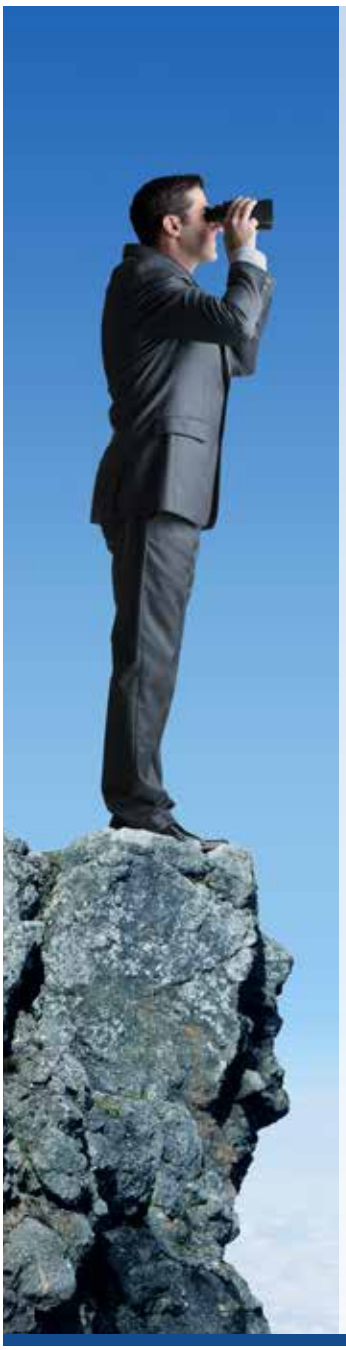
Footnotes

a. Collier, M., Fu, R. Yin, L., and Christiansen, P., Artificial Intelligence (AI): Healthcare's New Nervous System, Accenture, 2017.

b. MIT Technology Review Insights, "Machine Learning: The New Proving Ground for Competitive Advantage," MIT Technology Review, March 16, 2017.



FALL SUMMIT 2019

First Illinois HFMA

OCTOBER 22-23, 2019

Drury Lane Conference Center
Oakbrook Terrace, IL

Call for Presentations
Open through April 30, 2019
https://www.surveymonkey.com/r/3NFB3NJ

Format
Case Studies, Panels, Presentations by or with a Provider

Topic Areas
Healthcare topics, including key areas members want to hear from like Business Intelligence and data analytics, Managing and measuring the total cost of care, and Accounting and financial reporting issues related to emerging payment models.

Committee Participation
Interested in being part of the chapter's premier educational event committee? **We want to hear from YOU!**
Email us at fallsummit@firstillinoishfma.org

Tips for a Successful Fall Summit Presentation

- Healthcare financial management needs topics that focus on
  - measurable outcomes, process improvements, unique information, tools/takeaways, and attendee involvement in the session.
- Sessions are 50-minutes long and should include some time for Q & A. Case studies and Panel discussions formats are highly desirable.
- Attendee feedback reflects
  - Having a provider as part of the presentation provides greater value to the session.
  - Participants feel a closer connection to the presentation/topic when a provider "partner" is in the room.
- All non-providers must present with a provider. Do you have a health-care client you have worked with in the Chicago area that you could invite to present with you? The provider only has to be present for this session - Perhaps share some feedback along the lines of what they were looking for when they engaged with your company- what need was met/how working with your company has been a win-win scenario, as well as be available for questions immediately following the session.
- Presenter(s)'s registration is complimentary.

Questions? Email fallsummit@firstillinoishfma.org

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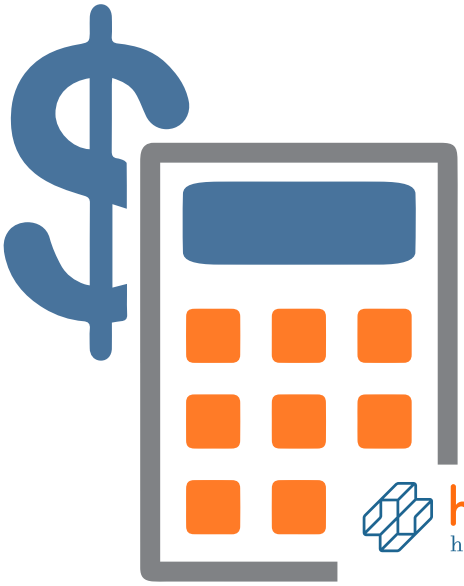
First Illinois HFMA Chapter is proud to present the following two events:



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SPRING SYMPOSIUM 2019

Monday, March 25

Track 1
PHYSICIAN STRATEGY

Track 2
ELECTRONIC HEALTH RECORDS

Tuesday, March 26

Track 3
REVENUE CYCLE 101

Track 4
DATA ANALYTICS

Register for individual tracks or as a package for huge discounts!

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HFMA Educational Events

Concurrent Educational Programming Events - March 25-26, 2019 - Chicago Illinois

Join your colleagues on March 25 and/or 26 for two outstanding educational opportunities in one convenient downtown location, Prentice Women's Hospital, Chicago IL.

UP TO 14 CPE CREDITS AWARDED!

Accounting and Reimbursement - All day program

March 25, 2019

Prentice Women's Hospital

Click here for details and registration

Spring Symposium - Four half-day tracks

March 25-26

Prentice Women's Hospital

Click here for details and registration

The newly developed Spring Symposium was developed in response to member feedback and features four half-day tracks. Day One features Physician Group Management in the morning and EHR Innovations in the afternoon. Day Two features Revenue Cycle in morning and Data Analytics Innovation in the afternoon.

Networking Event

March 25. 4:30-5:30pm

A networking event will be held together on site for both events to provide increased networking opportunities. Please join us for cocktails, appetizers, and great networking opportunities.

Annual FIHFMA Managed Care Symposium Held

First Illinois HFMA's 2019 Managed Care Symposium was held on February 7 at the University Club in Chicago. Over 140 people attended. The conference focused on a variety of topics including:

- State of healthcare in Chicago
- Value-based care transformation to value-based care
- Social determinants of healthcare
- Innovators disrupting the healthcare industry

Highlights included:

- Frank Williams, the CEO of Evolent Health, discussed some of the forces that are shaping the future of healthcare reimbursement as the focus has moved from the expansion of coverage to how to reduce the cost of care and how providers can position themselves to lead these efforts.
- Art Jones, MD and CMO of Medical Home Network, discussed the impact key demographic and social risk factors such as education, homelessness, behavioral health, poverty, substance abuse, and diminished parental functioning have on life expectancy, and how organizations are using data to identify where interventions are needed. Luke Hansen, MD MHS, Chief Medical Officer for Population Health at Amita, discussed how his organization is managing healthcare outside of the four walls of the hospital to improve outcomes and reduce costs.
- David Smith, CEO of Third Horizon Strategies, provided an overview of the Healthcare Council of Chicago's annual report on the state of healthcare in the city and the impact of the recent election and challenges with Medicaid.
- Donna Levigne, DSVP Health Care Delivery at BlueCross BlueShield of Illinois, highlighted how they are engaged with providers, employers, and patients to make healthcare more affordable.

There was also a C-Suite Panel that included executives from Chicago-area healthcare organizations who discussed the challenges their organizations were facing and the strategies they were implementing to overcome them. Jim Watson facilitated the panel discussion with these Chicago-area healthcare leaders:

- Angela Breton, Vice President of Sales & Client Services, Boncura Health Solutions
- Brad Buxton, Vice President, Strategy & Business Development, Northwest Community Hospital
- James Kiamos, Chief Executive Officer, CountyCare Health Plan
- Jason Whetsel, Executive Director, Benefits and Employee Health Management, University of Chicago Medical Center

The event closed with a social hour, and by all accounts the program was excellent. Special kudos to our committee chairs, Cathy Peterson and Lee Kuhn, for putting together another great FIHFMA Managed Care Symposium.

Annual Scholarship Application Deadline March 8, 2019

Every year, First Illinois Chapter HFMA awards scholarships to eligible HFMA members and their dependents. This year will be the 13th annual scholarship provided by our chapter.

Over the previous 12 years, we have recognized 53 students and have awarded over $125,000 in scholarships to deserving students. This year, we will be awarding five scholarships for a total of $15,000 to members and their children seeking higher education.

We are extending the original due date for applications to March 8, 2019. You can find the application on the FIHFMA Chapter website www.firstillinoishfma.org.

As we have done in the past, we plan to recognize our scholarship recipients and their parents at the annual installation event and awards ceremony in July 2019.

Welcome New Members

Christa Jordan-Mitchem

Jeffrey Logan

Meaghan Tobin
Tobin
Human Resources Manager

Patrick Bandy
Intellis
Director of Client Development

Ella Burbank
Cook County Hospital
Oak Forest
Pre-Registration Specialist

Elizabeth Bachelder
S&P Global
Associate Director

Stefanie Lamm
Gartner
Strategic Account Executive

Jason P. Siegel
LaSalle Network
Director of Healthcare Partnerships

Jerad Clifford
LaSalle Network
Sr. Unit Manager Healthcare Revenue Cycle

Denisha Mason
Saint Bernard Hospital
Staff Accountant

Chris Cable
Berkeley Research Group
Managing Consultant

Tina Cress
Molina Healthcare
Sr. Business Analyst

Su Chen Yang
University of Illinois Hospital & Health Sciences System
Budget Analyst II

Barbara Loeb
Trinity - Loyola Medicine
Chief Medical Officer

Marcus Morrow
Law Offices of Stephenson Acquisto & Colman Inc.
Attorney

Michelle Smith
PRNRX Pharmacy Associates
Pharmacy Executive

Erin DeVries
Advocate Health Care
Manager, Learning and Development

Margaret Dougherty
Little Company of Mary

Hannah Levine
UChicago Medicine
Executive Director, Finance Program Management

Robert Cundiff
Loyola University Medical Center
Director, Managed Care Contracting

David Smith
Third Horizon Strategies
Founder

Melissa Ford
Northwestern Memorial Healthcare
Quality Assurance

Ryan Brogan
Press Ganey Associates
Associate Regional Director

Jeffrey Terry
Director

Daniel Addison
Prism Healthcare Partners
Senior Analytics Consultant

Peter Letarte
Huron Consulting Group
Consultant

Daniel Verdon
Verdon
Chief Content Officer

Christina Claussner
BDO
Director, Healthcare Advisory

Seham Ataullah
Cook County Hospital System
Financial Analyst

Harisha Kodali
HFMA
Business Systems Analyst

Elaena Zalewski
Crowe LLP

Alison Cerny
Crowe LLP
Healthcare Advisory Consultant

Robert Doolittle
The Thresholds
Director, Payer Contracting - RCM

Timothy Gajdorus
B2K Integrated Medical Solutions
President

Ron Nagel
Huntington Technology Finance
National Account Manager

Rasa Razgas
University of Chicago - Physicians Group
Director of Revenue Cycle

Joe O'Malley
Protiviti
Manager

Ruchi Gupta
HGS EBOS, LLC.
Director Client Services Healthcare

Laife Fulk
Northwestern Medicine

Sabrina Prodhan
ZirMed
Client Success Manager

Essra Moussawi
Northwestern Medicine
Financial Analyst, Managed Care

Bryan Paull
Bank of America
VP, Senior Relationship Manager

Lauren Bjur
RSM
Consulting Supervisor

Jeremy Banks
Northwestern Memorial Healthcare
Operations Coordinator, Patient Accounting Revenue Cycle

Towanda Walls
Thresholds
Asst. Director, Revenue Cycle Mgmt

Betsy Matthews
American Center for Spine & Neurosurgery
CFO

Rachel E. McDonnell
Palos Community Hospital
CDM Analyst, Revenue Integrity

Sara Sims
Bank of America Merrill Lynch
Healthcare Treasury Solutions

Ryan Calverley
ColorJar
Copywriter

Joe Blatz
Novo Nordisk
Health Systems Account Manager

David Winkin

Keith Gagen
Amita Health
Senior Accountant

Welcome New Members (continued from page 15)

Michael Kritsmar, CPA

Indrit Cela
Healthcare Financial Resources (HFRI)
M&A Associate

Jaimin Patel
RSM US
Senior Associate

Emily Mason
Claro Healthcare
Analyst

Sharon D'Souza

Jason Ranville
PwC
Sr Manager - Payer and Providers

Doug Falso
Bankers Healthcare Group
VP Patient Lending

Shane Fitzgerald
Huron
Manager

Lawrence Underwood
Aetna
Senior Business Consultant

Morgan DeHaan

Timothy Marron
Claro Healthcare
Analyst

Nick Siderys
Claro Healthcare
Analyst

Amanda Vest
Claro Healthcare
Analyst

Ahmed Salim

Robert Cramer
Cramer
Regional Director

Noreen Sarhene
Deloitte & Touche LLC
Healthcare Consultant

Julia Blum

Ryan McGee
Cerner Corporation
Technical Project Manager

Ellen Gottlieb
Claro Healthcare
Analyst

T.L. Barrett
Mt. Zion Baptist Church
Pastor

Dana Sharo
Claro Healthcare
Analyst

Lauren Schingel
Claro Healthcare
Analyst

Meghna Sharma

Mark Mosk
SBSC, Inc.
VP Client Strategy

Allison Ritchie
Protiviti
Senior Consultant

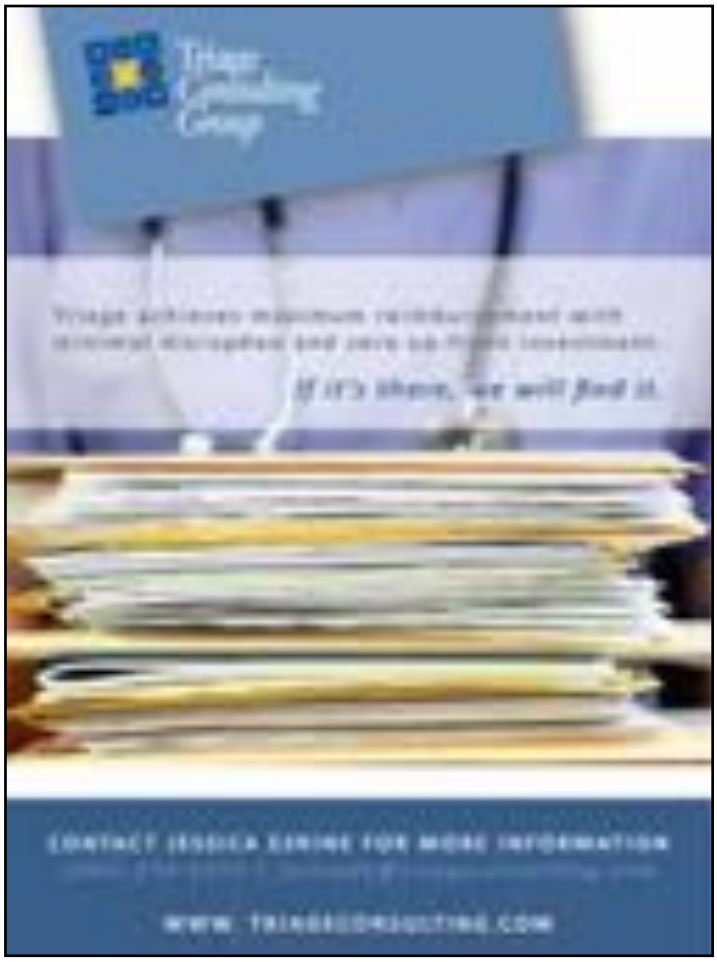
Laura Mishlove
Wintrust Bank
Senior Vice President

Tom Smolic
Cerner Healthcare
Senior Engagement Owner

Ally Weaver
Milliman
Associate Actuary

Tanesha Daniels
Loretto Hospital
Chief Experience Officer

Jonathan Webster
ColorJar
Accounts Director



Catherine Jefcoat
Jefcoat
Senior Consultant

Jonathan Giuliani
HFRI
Vice President of Operations

Gail Wilkening
BDO
Director, Healthcare Advisory

Zach Zoccola
Claro Healthcare

Theresa Hush
Roji Health Intelligence
CEO and Co-Founder

Nancy Hermann
Preferred Med Network
Director

AnMarie Mackey
Loyola Medicine
Executive Director, Population Health Operations

Lauren Waggoner
Loyola Medicine
Administrative Fellow

George Stamelos
Nordic Consulting Partners, Inc.
Consultant

Nicole Powell
Loyola Medicine
Manager

First Illinois Chapter Partners

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

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Triage Consulting Group

First Illinois Speaks
HFMA's First Illinois Chapter Newsletter

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HFMA Editorial Guidelines

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Style

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

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

Founders Points

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

Publication Scheduling

Publication Date	Articles Received By
May 2019	April 30, 2019
September 2019	August 31, 2019
February 2020	January 31, 2020