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FIRST ILLINOIS SPEAKS

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First Illinois Chapter 2026-27 Officers and Board of Directors

Welcoming the 2026–2027 First Illinois Chapter Leadership Team

The First Illinois Chapter is pleased to introduce its 2026–2027 Board of Directors and Officers. These dedicated volunteers contribute their time, expertise, and leadership to support the chapter's mission of providing high-quality education, professional development, and networking opportunities for healthcare finance professionals throughout Illinois.

We are especially pleased to welcome **Brian Kirkendall** as Chapter President. Together with the Board, Brian will help guide the chapter through another year of learning, connection, and service to our members.

Please join us in thanking our volunteer leaders for their commitment to the chapter and in welcoming the 2026–2027 leadership team.

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Message From Our Incoming President

BRIAN KIRKENDALL, CHFP, CPA, 2026-27 PRESIDENT

Hello friends,

It is with tremendous gratitude and great excitement that I write to you as the President of the First Illinois HFMA Chapter (the FIRST chapter in HFMA's history) for the 2026-2027 chapter year.

For me, this year will be the culmination of a decade volunteering service to the chapter, and I couldn't be prouder of how the chapter has grown during that time. We have an incredible group of volunteer leaders, and I will do my very best to continue to support them and help them succeed, as I have observed from past presidents.

I see this year as a great honor and a great responsibility. The First Illinois Chapter has a tradition to uphold of producing meaningful educational content, opportunities for interaction for our members (especially important in an age when that is more difficult than ever), and perhaps most importantly, a place for the future health care leaders in the area to build their networks and take leadership positions of value and importance.

For me, with HFMA volunteer service, the journey is the reward. I promise to do my best as a servant-leader to the other volunteer leaders in the chapter and always look for ways to make our already-strong chapter even better.

I look forward to another wonderful year with the chapter and its equally wonderful members.

See you out there!

Brian Kirkendall
2026-27 President, First Illinois HFMA Chapter
Partner, RSM US LLP
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Upcoming Events

First Illinois Chapter

Check out our calendar now

Stay informed about exciting happenings!

Scan the QR code to view the full calendar & RSVP

The Cost of Ignoring Managed Care Contracts: How Contract Audits Protect Hospital Revenue

They sit in your computer's hard drive, or perhaps even in an old file cabinet in the corner. They can create a lot of unnecessary work, force you to devote valuable staff time just to meet their daily needs, and leech money from your revenue stream without you even being aware of it.

"They" are your Managed Care Contracts that sit, gathering dust, unreviewed year after year after they're executed.

Hospital executives are often relieved when contract negotiations – sometimes confrontational – are over. They turn their attention to countless other important priorities, while the executed contracts sit idle.

Unfortunately, untouched contracts do not sit "idle". They age, and often not very well. Terms and conditions that were acceptable five years ago are suddenly very concerning. Recently added services and new locations may not be considered part of the agreement, resulting in claim denials, lost revenue, and unhappy patients. And, of course, contractual rates have frequently failed to keep pace with costs and are no longer sufficient to fund hospital operations.

Managed Care Contract Best Practices

It is best practice for hospitals to have their managed care agreements audited regularly, particularly the top five commercial agreements and the top five Medicare agreements. Hospitals, or their contract auditors, should be looking at:

- Outdated / inadequate rates. Focus should be placed on fixed rates that do not have inflators attached, meaning that the reimbursement has failed to keep pace with inflation, the local market pricing, or with hospital benchmarks.
- Medicare Advantage reimbursement that represents a fraction of Traditional Medicare reimbursement.
- Missing contractual language addressing current market concerns, such as language protecting the hospital through payor performance guarantees.
- Missing products offered by a Payor that the hospital may need to be a part of.
- Contractual protection against cyber issues and privacy concerns.
- Contractual weaknesses pertaining to areas of specific concern to the hospital, such as:
  - Prior Authorization requirements and restrictions
  - Retroactive denials
  - Audit language
  - Imprecise Chargemaster language, including the actual chargemaster audit process, and the maximum allowed increase per year
  - Medicare Advantage settlements (Bad Debt, Cost)
  - Payor Proprietary fee schedules, which may be outdated
  - Amendment and Termination language provisions
  - One-sided language pertaining to performance guarantees
  - Lack of inflator language for fixed reimbursement rates
  - Contractual commitments that may put the hospital in a legal bind and potentially lead to breach
  - Ability to term individual payors (leased network contracts)
  - Downcoding

Regularly reviewing agreements, particularly the major ones, may save your hospital a lot of headaches, heartache, and money.

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DRIVING FINANCIAL & OPERATIONAL SUCCESS FOR HOSPITALS AND HEALTH SYSTEMS

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The psychology of patient payments:
How to improve collections and patient satisfaction

Imagine a physician asking a patient to decipher a complex medical diagnosis and develop their own treatment plan. It sounds absurd, doesn't it?

Yet patients are often expected to decode multi-page, jargon-filled bills – and somehow "pay upon receipt."

But what if unpacking the psychology behind patient payment obstacles could help organizations achieve better outcomes – for both satisfaction and collections?

Why patients don't pay: It's not just about cost

As patients accept more financial responsibility through higher premiums and deductibles, the burden grows.

Nearly two in three adults are worried about being able to afford healthcare.1 That makes step one for providers clear: You must offer realistic, accessible payment options. Financial assistance, payment plans, digital-first billing – no effort is too small when the majority of Americans are concerned about affording care.

While cost is a major factor, it's not the only one

The why behind what's owed – and how it's communicated – plays a powerful role.

Behavioral science helps us understand the emotional and cognitive drivers behind payment decisions. Our feelings, habits, and biases often outweigh logic, exacerbating psychological hurdles patients face, such as:

1. Fear of high costs
2. Lack of transparency
3. Decision fatigue

To untangle and overcome these complexities, let's further explore each obstacle.

3 reasons patients don't pay

1. Fear of high costs

Money is one of the most common stressors in daily life. In fact, 66% of people put financial stress at the top of the list.[2] Drill down on healthcare costs and you'll see an obvious trickle-down effect.

Research by KFF1 finds that roughly:

- Half of adults say they'd be unable to pay an unexpected medical bill of $500 without going into debt, and
- Two in five adults (41%) are already in debt due to medical or dental bills.

When patients receive a bill they didn't expect – especially one they can't pay in full – it's easier to avoid it altogether. Without self-service tools or flexible options, the bill simply gets set aside ... sometimes indefinitely.

2. Lack of transparency

Unclear bills break trust. Patients don't just get frustrated – they may avoid care or choose a different provider in the future.

One study[3] found that patients are twice as likely to switch providers after a negative front-desk or online experience than after a poor clinical

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The psychology of patient payments: How to improve collections and patient satisfaction

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one. But there's a silver lining for healthcare organizations: 84% of patients say they'll stay with a provider who offers easy payment processes.

Transparent billing and upfront cost estimates can go a long way toward retention – and timely payments.

3. Decision fatigue

The average adult makes **35,000 decisions** a day.[4] Add a confusing bill full of codes and line items? Patients may check out because they don't have the mental energy to deal with it at that moment.

But this is a solvable problem – and a missed opportunity from the provider perspective. The more decisions you can remove, the higher a patient's likelihood to pay.

3 simple steps to optimize your patient payment processes

Put this psychology to work in your organization:

1. **Audit your current payment communications and identify friction points.**

   Where do patients stop engaging? Start there.

2. **Implement behavioral strategies.**

   Personalize messaging, offer flexible payment options, and provide transparent cost estimates upfront.

3. **Continuously measure and refine.**

   Track key metrics and adjust your approach based on patient feedback.

About the Author

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Notes

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[2] The American Institute of Stress. What the Latest Reports Say About Stress in America. 2025.

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The Revenue Cycle Model is Being Rebuilt.
CFOs Are Leading the Way.

The revenue cycle has always been a reflection of broader healthcare pressures. When labor was more abundant and reimbursement rates were higher, a headcount-heavy model made sense. Today, neither of those conditions exist. What remains is a structural problem that more hiring and tighter workflows alone will not solve.

Median health system operating margins held near 1% throughout 2025,[1] and expenses are rising at roughly 6% annually while revenue grows at only 3%.[2] For CFOs trying to protect cash flow in that environment, the revenue cycle is no longer a back-office function to be managed. It is a strategic lever to be optimized.

That shift requires a fundamentally different operating model.

The Staffing Equation Has Changed

For most health systems, the default response to revenue cycle volume has been to add staff. More denials? Hire more follow-up billers. More complex claims? Expand the team. The problem is that this model was already strained before recent pressures accelerated the breaking point.

Labor shortages affect 83% of healthcare leaders across the revenue cycle,[3] and 90% report that those challenges further exacerbate operations. [4] Recruiting into these roles is harder and more expensive than it was five years ago, and the work itself has grown more complex as payer behavior has intensified. Payer audit volumes increased 30% year-over-year, with the average at-risk amount per audit rising 18%.[5] That is not a workload a new hiring plan can absorb.

The strategic response from leading health systems is to redesign where human judgment is actually required. The transactional, rules-based, high-volume work that has historically consumed the majority of revenue cycle staff hours is precisely where technology performs best and where the ROI case is clearest.

Automation Is Moving From Pilot to Infrastructure

The organizations seeing the best results are the ones treating automation as infrastructure by connecting it across the revenue cycle.

Healthcare has been talking about AI and automation in the revenue cycle for years. What has changed is the scope and seriousness of deployment. 72% of healthcare executives report that technology, including automation and AI, is their highest priority for revenue cycle investment over the next 12 months, and 86% of health systems already report leveraging AI in some capacity.[6]

The functions being targeted include eligibility verification, prior authorization, claims scrubbing, remittance posting, and denial routing. These are the pattern-matching tasks that humans perform consistently but slowly, and that machines can perform at scale with fewer errors.

What is more significant for CFOs is the shift happening further upstream. With claim denial rates at 11.8% of initial submissions in 2024,[7] and 65% of those denied claims never reworked,[8] the revenue that leaks at the back end is often gone for good. Machine learning models that flag at-risk claims before submission[6] address the problem at the source. Preventing a denial costs a fraction of what it takes to appeal one after the fact.

Strategic Outsourcing Belongs in the CFO's Playbook

There has historically been discomfort around outsourcing revenue cycle functions. It can feel like a concession that the internal team cannot handle the work. That framing is a strategic mistake, and the CFOs who have moved past it are building more resilient operating models.

A more productive way to frame the decision is around complexity: whether certain revenue cycle functions can be executed cost-effectively at scale by an internal team alone. Complex claims, underpayments, and high-dollar denials all require deep payer-specific expertise that is difficult and expensive to maintain in-house. Specialized external partners absorb that complexity as their core competency, at a scale that internal teams typically cannot match.

Healthcare revenue cycle outsourcing represents a $50–80 billion addressable market,[9] and the growth is being driven not by cost-cutting but by the recognition that certain work is better executed by entities built specifically for it. The CFO's role is to evaluate where that line sits for their organization and to ensure any partnership is governed by outcomes, not activity.

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The Metric That Makes This Work: Balancing Cost and Capture

None of these structural changes – fewer people on manual tasks, broader automation, more strategic outsourcing – are justifiable under a cost-to-collect framework alone.

Cost-to-collect answers how efficiently are we processing claims, but it leaves out how much revenue are we failing to capture. In today's environment, that gap is material. When two-thirds of denied claims go unworked and underpayments from commercial payers drain 1-3% of net revenue annually, the financial impact of missed revenue often exceeds the savings gained from incremental cost reductions. An organization can optimize cost-to-collect and still underperform financially if revenue leakage is not addressed.

A more complete view requires evaluating both sides of the equation: cost efficiency and revenue capture. ROI becomes the unifying metric – it quantifies what prevention and recovery programs return and provides a clear basis for evaluating technology investments as a margin protection strategy. In an environment where every unrealized dollar matters, ROI captures the full financial impact of revenue cycle performance and the full cost of inaction.

What the Next Model Looks Like

The revenue cycle organizations that will perform best over the next three to five years share some common traits. Internal teams are focused on high-complexity, judgment-intensive work where expertise and accountability matter. Automation handles the predictable, transactional volume that previously consumed staff bandwidth. Specialized partners absorb complex claims, underpayments, and escalated denials that require deep expertise to execute competitively.

Governance evolves alongside this model. Vendor relationships are measured on revenue recovered per dollar invested rather than cost containment or FTE productivity. Technology investments are evaluated against margin impact, not just efficiency gains.

Leading health systems are building this model today. And the CFOs driving it are doing it because the current model – built on scaled headcount, measured on cost-to-collect, and poorly equipped for the complexity ahead – will not sustain performance in the environment they are already operating in.

The structural evolution of the revenue cycle is not a trend to monitor. For CFOs who understand what is at stake, it is a mandate to act on.

About the Author

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Recovering What Payers Owe:
AI Contract Modeling and the Zero-Balance Opportunity

Most revenue cycle teams treat a zero-balance account as a closed case. A claim was submitted, a payment came in—or didn't—and the account moved off the worklist. What almost no one examines is whether the payment amount was actually correct.

That unexamined gap—between what payers remit and what contracts require—is where hundreds of millions in hospital revenue quietly disappear each year.

When Underpayments Look Like Resolutions

The fundamental challenge with underpayments is that they don't behave like denials. A denial creates a task. An underpayment often creates nothing—the shortfall settles into a zero-balance status, and the case closes without ever triggering a follow-up.

The scale of the problem is significant. In 2023, hospitals absorbed $130 billion in underpayments from Medicare and Medicaid, with Medicare reimbursing only 83 cents for every dollar of patient care delivered1. The Healthcare Financial Management Association estimates that commercial payer contract underpayments can reach as high as 11% of net patient revenue[2]. That's a substantial portion of earned revenue that was documented, delivered, and never fully paid.

Contract complexity makes the problem structurally difficult to address. A typical health system manages hundreds of payer agreements, each containing intricate fee schedules, carve-outs, episodic rates, and payment caps. Even well-staffed revenue cycle teams cannot manually reconcile every remittance against every applicable contract term. Underpayments caused by misapplied fee schedules, missed billing provisions, generic adjustment codes, and sub-minimum payments routinely close as zero-balance accounts—and stay there.

AI Contract Modeling: What It Does and How

Artificial intelligence is changing that dynamic in a concrete, operationally meaningful way.

AI-powered contract modeling uses large language models (LLMs) to ingest managed care contracts and addendums, extracting payment rules across hundreds of agreements simultaneously. These systems identify facilities, terms, fee schedules, and reference data, then layer in external sources—including payer policies and CMS guidelines—to build accurate pricing models reflecting what a hospital is genuinely owed.

The critical advantage over legacy contract management tools is currency. AI platforms maintain living databases updated in real time, rather than static repositories that require manual intervention every time a contract changes. For revenue cycle leaders managing dozens of active payer relationships, that's not an incremental improvement—it's a structural one.

The application to zero-balance accounts is particularly powerful. Instead of manually selecting a limited set of closed claims for review, AI contract modeling examines accounts at scale—comparing them against extracted contract terms to identify entire categories of claims that were underpaid due to payer system errors or contract misinterpretation.

Certain nationwide client data shows that 79% of underpayment recoveries exceed $1,000, with the most common recovery range falling between $1,001 and $2,5003. At volume, those figures represent significant aggregate revenue that manual review would never surface.

Building an Effective Recovery Program

1. **Complete Contract Ingestion:** Ensure the system processes the full complexity of payer agreements—addendums, amendments, and carve-outs—not just base contract language.

2. **Emphasize Volume:** The most recoverable revenue is typically spread across large numbers of mid-range claims, not concentrated in a small number of high-dollar accounts.

3. **Combine Contract and Clinical Intelligence:** Contract accuracy alone doesn't resolve every underpayment. The most effective programs pair contractual entitlement analysis with clinical documentation review—addressing both dimensions in each appeal.

4. **Treat Recovery as Prevention:** Understanding why underpayments happen—payer system errors, contract misinterpretation, billing gaps—creates intelligence that strengthens future negotiations and reduces recurrence.

5. **Work Small-Dollar Claims:** Hospitals that focus exclusively on high-value accounts leave meaningful aggregate recoveries unrealized. AI brings the speed and scale to make previously unworkable claims economically viable.

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Recovering What Payers Owe: Contract Modeling and the Zero-Balance Opportunity

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AI for Scale, Expertise for Resolution

The right framing for AI is amplification, not replacement. AI can identify discrepancies and surface opportunities at volume, tasks that would take human teams significant time to work through manually. Resolving those opportunities, especially where clinical or legal judgment is required, still depends on experienced professionals.

The most effective approach pairs AI's ability to process and
analyze large datasets quickly with the expertise of trained professionals who validate findings before any action is taken. Technology handles the volume and initial analysis; experienced humans handle the judgment calls.

That combination of AI for scale and humans for expertise is what separates programs that drive real results from those that simply generate opportunity lists no one has the capacity to act on.

Closed Accounts, Uncollected Revenue

Zero-balance doesn't mean settled. For revenue cycle executives operating on thin margins, that distinction carries real financial consequence—because the revenue sitting in those closed accounts was already earned, already documented, and in most cases already contractually guaranteed.

The question isn't whether that revenue exists. The question is whether the right technology and expertise are in place to recover it.

About the Author

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Notes

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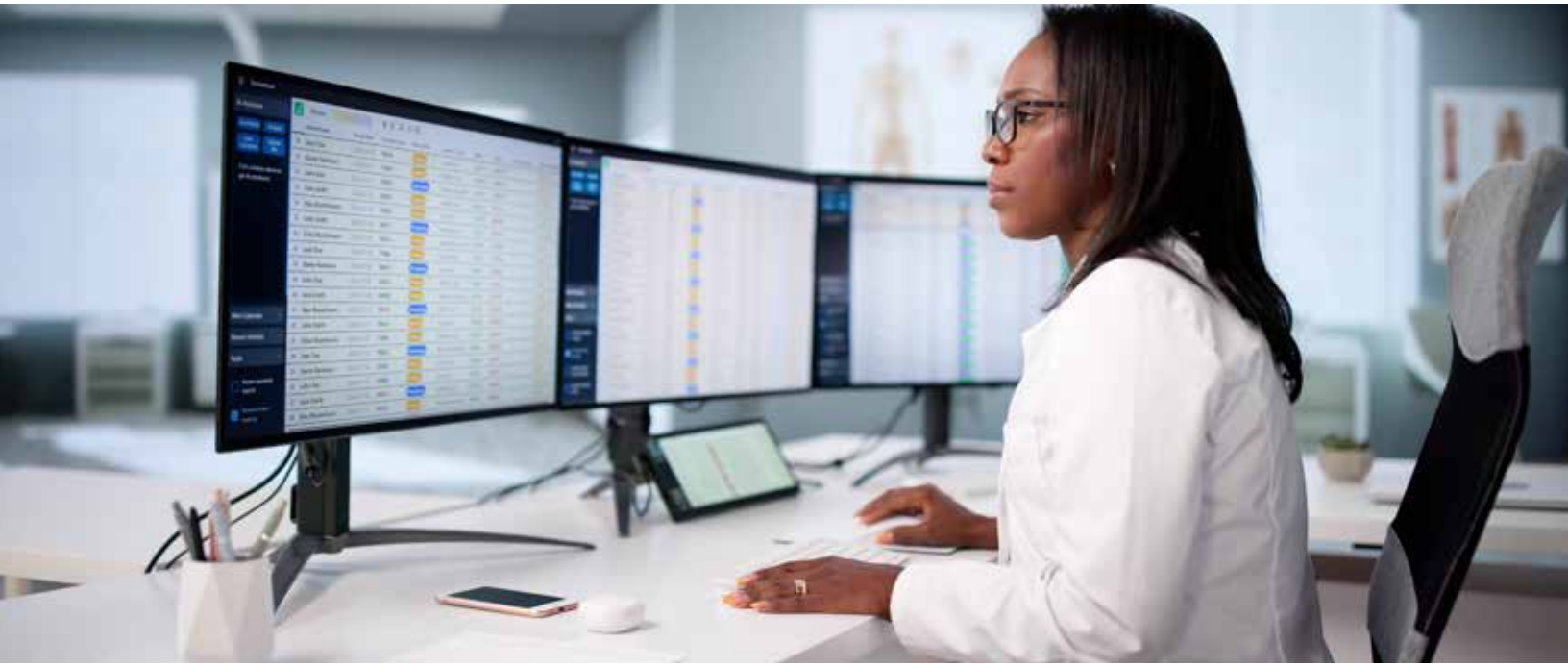
[3] "Faster, Smarter Clinical Denials Management with AI," Aspirion, October 2025



Prior Authorization in 2026:
What Illinois Health Finance Leaders Need to Know

If you've spent any time in healthcare administration over the past few years, you've probably heard the argument that prior authorization is on its way out. I've heard it too, at conferences, in trade press, in conversations with health system CFOs who are understandably exhausted by the administrative weight of it all. The reality, though, is quite the contrary, and I think the finance and revenue cycle leaders in this room are better served by an honest accounting of where things actually stand.

Prior authorization isn't going away. It's becoming more regulated, more visible, and in several meaningful respects, more consequential for the organizations that haven't built the infrastructure to manage it well.

The Federal Layer

Two federal rules are shaping how this plays out operationally. CMS-0057, finalized in early 2024, mandates FHIR-based API connectivity across Medicare Advantage, Medicaid managed care, CHIP, and Marketplace plans, with January 2026 requirements already in effect: 72-hour turnaround for urgent requests, seven calendar days for standard requests, and specific denial reasons that actually facilitate resubmission and appeals rather than leaving providers to guess. Public reporting of prior auth metrics began with data due March 31st of this year, which means approval rates, denial rates, and average decision times are becoming market-visible in a way they simply weren't before.

The second rule, CMS-4201, reins in how Medicare Advantage plans apply prior authorization, requiring alignment with Traditional Medicare coverage standards and mandating 90-day continuity of care when beneficiaries switch plans mid-treatment. CMS has been actively auditing MA plans throughout 2024 and 2025, and the data coming out of those audits is striking: on average, MA plans overturn 80% of denied claims when appealed, which tells you something important about the quality of initial determinations.

There's also the WISeR pilot to be aware of, even if Illinois isn't one of the six launch states. CMS selected six technology companies to manage AI-powered prior authorization for 17 high-risk service categories, and the program is actively running in Arizona, New Jersey, Ohio, Oklahoma, Texas, and Washington. The fact that CMS is comfortable outsourcing prior auth decisions to third-party AI vendors, with gold card exemptions for providers who sustain 90% approval rates, signals very clearly where federal policy is heading. Illinois health systems may benefit from paying attention to what's happening in those pilot states, because the program will almost certainly expand.

The Illinois Picture

Where things get specifically relevant for this audience is at the state level. Illinois has been one of the more active state legislatures on PA reform over the past two years, and one of the most significant

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Prior Authorization in 2026: What Illinois Health Finance Leaders Need to Know

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developments takes effect in 2026: the state has banned prior authorization for inpatient psychiatric admissions. For health systems with behavioral health lines, this is not a minor operational footnote. It removes a substantial documentation and approval burden for a patient population that already faces access barriers, but it also requires workflow reconfiguration and a clear internal accounting of which services are now exempt from the process.

Beyond the psychiatric admission ban, Illinois providers need to track an increasingly active state legislature on PA reform, one that has already moved on behavioral health access and is likely to revisit decision timelines, gold card thresholds, and clinical criteria transparency in coming sessions. What's in effect today may not reflect what's required by the end of the year.

What This Means for Finance Leaders

The operational and financial implications of this regulatory environment are worth thinking about carefully, particularly from a revenue cycle perspective. The compression of decision timelines creates real pressure on documentation quality upstream. Under a compressed seven-day timeline, an organization that submits an incomplete clinical bundle and receives a denial has very little runway to recover before the scheduling window closes or the patient seeks care elsewhere. The cost of that denial isn't just the administrative rework; it's the downstream revenue impact and, in some cases, the write-off that follows.

The public reporting requirement under CMS-0057 changes the competitive calculus in ways that I think are still underappreciated. When approval rates and average decision times are visible to health systems, payers, and eventually patients, organizations that have been managing prior auth reactively will find themselves at a measurable disadvantage. First-pass approval rates become a published credential, not just an internal KPI.

For organizations evaluating their current prior auth infrastructure, the questions worth asking are fairly direct: Can your current system handle the documentation preparation that compressed timelines require, and can it do so across the payer-specific policy variations that Illinois providers manage? Are your processes configurable enough to accommodate continual shifts in state legislature? Do you have the audit trail and reporting infrastructure that public metrics requirements are going to demand?

Where We Go From Here

The organizations that will be well-positioned as this regulatory environment continues to evolve are not the ones waiting for simplification that isn't coming. They're the ones that have made a deliberate decision to treat prior auth as a managed operational process rather than an administrative burden to be absorbed manually by both clinical and non-clinical staff. The regulatory complexity is real, and it's increasing, but it's also navigable for organizations that have built the right infrastructure to address it systematically.

Illinois health systems have specific obligations and specific opportunities right now. Understanding both is where compliance strategy has to start.

About the Author

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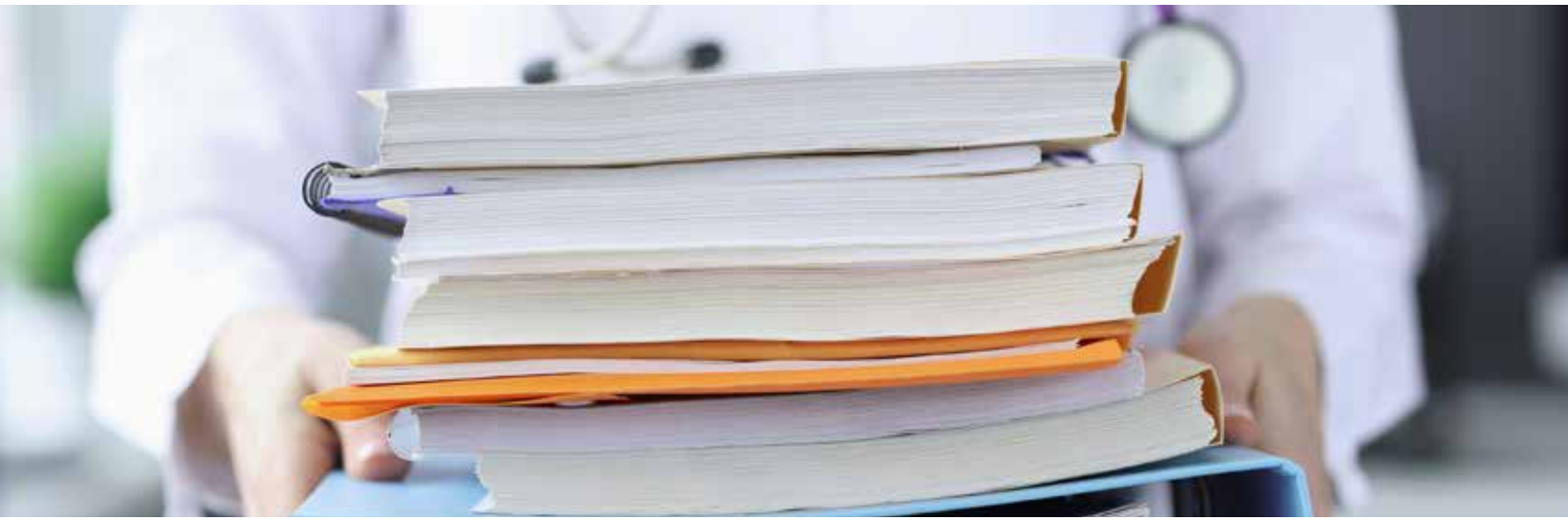
Why governance for health care organizations



Strengthening duty of care amid an evolving health care landscape

Governance for health care providers has never been more demanding. Boards of directors are navigating unprecedented operational, financial and regulatory complexity, often while serving in a fiduciary role that carries legal and reputational risk. As health care continues to evolve at a rapid pace, strong governance and an unwavering duty of care are no longer aspirational ideals; they are essential requirements for organizational resilience. Several core considerations consistently separate high-functioning boards from those struggling to keep pace.

Setting the tone

Health care operates at the intersection of complexity, urgency and vulnerability. Boards must contend with rising operating costs, persistent workforce shortages, declining reimbursement, cybersecurity threats, regulatory scrutiny and accelerating technological change. These pressures affect rural and urban health care providers alike, regardless of size or ownership structure.

In this environment, governance matters because boards set the "tone at the top." That tone cascades through executive leadership and ultimately shapes organizational culture, risk tolerance and decision making. Strong boards hold leadership accountable, remain informed about industry trends, invest in organizational capabilities and make diffcult decisions when required, even when those decisions are unpopular.

Good governance is often most visible when it is absent. Boards that fail to engage, defer accountability or avoid hard conversations create gaps that can quickly become operational, financial or compliance failures.

Understanding the board's fiduciary role

At its core, the board's duty of care is to act in good faith, remain informed and make decisions in the best interests of the organization and the communities it serves. Health care governance is not passive oversight. It requires active engagement with financial performance, regulatory obligations and strategic direction.

Key fiduciary responsibilities include reviewing financial statements and tax filings, overseeing executive compensation, monitoring conflicts of interest and ensuring appropriate policies and controls are in place. In many communities, particularly smaller or rural ones, conflicts of interest are inevitable. What matters is whether boards have transparent processes to identify, disclose and manage them.

Board members should also recognize that fiduciary risk is not theoretical. When health care organizations run into financial troubles, board members have been named in lawsuits alleging failures of oversight or breaches of duty. While insurance protections exist, they do not replace the need for diligence, education and engagement.

What good governance looks like

High-performing boards share several defining characteristics. They regularly assess their own performance, ensure they receive timely and accurate information, and maintain a diverse mix of skills and perspectives around the table. Elective boards understand that governance is not about managing day-to-day operations, but about partnering with executives to provide strategic oversight and informed guidance.

Clear role definitions are essential. When boards blur the line between governance and management, or when executives fail to provide

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Why governance for health care organizations (continued from page 16)

suffcient transparency, trust erodes and electiveness suffers. Meaningful board meetings focus on issues that materially alect organizational performance rather than individual concerns or operational minutiae.

Boards that function well also invest in relationships. Collaboration with executive leadership, candid dialogue and mutual respect enable better decision making, particularly during periods of stress or transition.

Improving board electiveness

Boards seeking to strengthen governance should focus on several core areas:

Prioritize continuous education and external engagement.

- Participate in industry associations, peer networks and governance forums.
- Stay current on best practices, emerging risks and sector-wide lessons learned.
- Broaden perspective beyond the experience of a single organization.

Leverage internal and external expertise.

- Ensure executives can clearly explain financial, clinical and operational metrics to support elective oversight.
- Engage external advisors—including legal, financial, insurance and audit professionals—to provide cross-organizational insights and independent perspective.

Strengthen recruitment and succession planning.

- Plan proactively for board turnover rather than reacting to vacancies.
- Recruit members with complementary skills and experience aligned to organizational needs.
- Avoid wholesale transitions that risk disrupting institutional knowledge.
- Use staggered terms and intentional skill mapping to balance continuity with fresh perspectives.

Staying ahead of health care trends

Elective governance also requires boards to remain informed about the forces reshaping health care delivery and economics:

Monitor workforce and demand pressures.

- Address ongoing workforce shortages, particularly for rural and underserved providers.
- Understand rising demand driven by demographic shifts and aging populations.

Oversee technology adoption and governance.

- Recognize the potential of technologies such as artificial intelligence to address labor and effciency challenges.
- Understand associated governance considerations, including data privacy, patient safety and return on investment.

Track structural and regulatory shifts.

- Follow the continued shift in site of care toward outpatient settings.
- Monitor challenges in value-based care adoption.
- Respond to growing consumer expectations for access and transparency.
- Stay alert to heightened regulatory oversight related to billing, fraud prevention and data security.

Understand reimbursement and margin pressures.

- Assess the impact of Medicare Advantage enrollment growth.
- Evaluate evolving site-neutral payment policies.
- Monitor declining margins from programs such as 340B drug pricing.
- Ensure clarity on how management is responding to these dynamics and which financial levers it is using.

Governance as a strategic advantage

Ultimately, strong governance is not about compliance alone; it is a strategic advantage. Boards that embrace their duty of care, invest in their own electiveness and remain attuned to industry change are better positioned to guide organizations through uncertainty. In a health care environment defined by complexity and constraint, thoughtful governance helps ensure that health care organizations can continue fulfilling their mission to serve patients and communities, today and well into the future.

About the Author

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FIHFMA Gives Back at Annual Northern Illinois Food Bank Drive

Over 30 of our First Illinois Chapter of the Healthcare Financial Management Association (FIHFMA) members and their families volunteered and packed food and meals for needy children in the Chicagoland community at the Northern Illinois Food Bank on the morning of January 31, 2026.

The food bank is a non-profit which brings together manufacturers, local and corporate grocers, area farmers, corporations, foundations, and individuals who donate food and funding, and each week volunteers help us evaluate, repack, and distribute food.

We appreciate the participation and enthusiastic work in this community event. We packed 13,566 pounds of food which provided 11,305 meals. Our FIHFMA volunteer team packed the following items into children's lunch bags for the food bank to distribute: peanut butter, granola bars, golden graham crackers, canned corn, canned beans, low fat milk, almond milk, and white chicken packets. In addition, we appreciate the support of our event sponsor Humata Health, represented by Lauren Beard, VP of Growth of Humata, who hosted lunch at a nearby restaurant for our volunteers. Thank you to everyone for making this year's food bank drive a great success.

Our half-day food bank drive initiative has become an annual event, and was chaired by Victoria Levitske of University of Chicago Physicians Group. We look forward to doing this event again in 2027 and encourage our members and family to participate again.

This event helped contribute to a worthwhile cause, and provided us the opportunity to better get to know each other and other members. If you would like to participate in this event in 2027 or would like to volunteer in other ways for FIHFMA, please contact Victoria Levitske, co-chair of the First Illinois Chatper Membership and Engagement Committee at education@firstillinoishfma.org.

Game Room Social:
Cocktails & Competition - March 26

Thanks to everyone who joined us for the Game Room Social: Cocktails & Competition event - an evening of great conversation, craft cocktails, award-winning food, and even a little friendly competition. An extra special thank you to our event sponsor, Collectly, for hosting at the historic Chicago Athletic Association Game Room. Reach out to Ryan at rdowns@realpartnersconsulting.com if you're interested in sponsoring a future FI HFMA social event.

Certification Spotlight

Teresa Gomez (Vargas), MHA CHFP
Manager, Life Sciences and Health Care
Deloitte & Touche LLP

1. What motivated you to pursue the CHFP certification?
I first got my certification early on in my career at Deloitte in 2019. During my first year, I saw firsthand how financial decisions impact the care a hospital can deliver to its community. I pursued CHFP because I wanted to be a more supportive and effective partner to healthcare leaders navigating complex regulatory and operational changes. For me, strengthening my financial foundation meant I could help provide clients with a better shot staying sustainable, financially healthy, and focused on what matters most.

2. What was the most valuable thing you learned during the process?
The most meaningful takeaway was learning to see how closely financial health is tied to operational excellence and, ultimately, patient care. This holistic perspective completely shaped how I approach mergers & acquisitions, compliance audits and value-based care designs. It taught me that financial discipline is not just about numbers; it is an act of stewardship that protects an organization's ability to serve its patients and support its clinical teams.

3. How do you think earning the CHFP will help you in your current role or future career?
It has given me confidence to walk alongside clients through their most high stake financial and operational challenges with empathy and experience. Whether helping secure millions in financial recovery reimbursements or review multiple compliance audit processes, this knowledge allows me to lift a heavy burden off clients' shoulders. My goal is to be a leader who translates complex finance into compassionate, practical solutions.

4. What specific part of the CHFP Bootcamp did you find most helpful, and who in your organization do you think would benefit the most from it?
I loved how the Bootcamp was in person (now virtual so much easier access). I am someone that learns best from an in-person session so learning healthcare finance this way and turning abstract concepts into practical ways to help. It created a clear bridge between everyday operations and the long-term well-being of the health system. I think anyone in consulting, strategy, or operations who cares about the future of healthcare would benefit deeply.

5. What does this achievement mean to you personally or professionally?
Professionally, it marks the moment I began intentionally blending analytical rigor with a deep care for the healthcare ecosystem. Personally, it is a reminder of my commitment to continuous learning so that I can better show up for clients every day.

To learn more about HFMA certification, please feel free to reach out to Connor Loftus (connor.loftus@kaufmanhall.com) or Sara Weisenberg (sweisenb@nm.org). You can reach Teresa at (tvargas@deloitte.com.)

You can also visit the HFMA website at https://www.hfma.org/education-events/certifications/

First Illinois Chapter Partners

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Volunteering for a First Illinois Chapter committee or event is a great way to get the most out of your chapter membership. Answer the call to be a chapter leader in four easy steps:

1. Visit https://www.hfma.org/chapters/region-7/first-illinois/volunteer-opportunities/
2. Check out the **Volunteer Opportunity Description**
3. Fill out the **volunteer form** and become more active today!

Or simply drop us an email at education@firstillinoishfma.org

FIRST ILLINOIS SPEAKS

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First Illinois Chapter HFMA Editorial Guidelines

First Illinois Speaks is the newsletter of the First Illinois Chapter of HFMA. *First Illinois Speaks* is published 3 times per year. Newsletter articles are written by professionals in the healthcare industry, typically chapter members, for professionals in the healthcare industry. We encourage members and other interested parties to submit materials for publication. The Editor reserves the right to edit material for content and length and also reserves the right to reject any contribution. Articles published elsewhere may on occasion be reprinted, with permission, in *First Illinois Speaks*. Requests for permission to reprint an article in another publication should be directed to the Editor. Please send all correspondence and material to the editor listed above.

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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
October 2026	September 1, 2026
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