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first illinois chapter

October 2022

FIRST ILLINOIS SPEAKS

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HFMA Region 7

Midwest Conference

October 23-25, 2022

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

Where Will You Be on October 23-25?

Will we see you at the HFMA Region 7 Midwest Conference in Oak Brook, Illinois? The region's largest event is this October 23-25 at the Hilton Chicago/Oak Brook Hills Resort & Conference Center.

HFMA's Region 7 Chapters (First Illinois, McMahon-Illini, Southern Illinois, Indiana Pressler, and Wisconsin) are bringing together healthcare industry executives and experts for a two and a half-day premier event, with education sessions including keynote address from HFMA's 2022-23 chair Aaron Crane, an executive panel of the region's top leaders discussing their careers in healthcare, a panel discussion with presidents of each state's hospital association and much more!

More conference highlights include

- Connecting with healthcare financial professionals from organizations such as Advocate, Ascension, NorthShore University HealthSystems, OSF Healthcare Systems, Rush University Medical Center, University Chicago Medicine, University of Illinois Hospital & Health Services System who are already registered.

- Engaging in a variety of networking opportunities including a fun social event on Sunday night in the hotel's Tin Cup Bar and Grille and a festive Octoberfest dinner on Monday evening with great food, drinks, and music provided by a German band.

- Sharpening your toolbox by visiting the conference's extension list of onsite companies to learn about the many ways they can support you in your day-to-day business operations

- Earning up to 12 CPE Credits!

HFMA Safety Statement

HFMA recognizes that the safety of all of those on site at HFMA events is important. Our safety protocols continue to evolve based on state and federal guidance to ensure that all participants are as committed as we are to following safe and health protocols on site. ***Those who are vaccinated and can present proof of vaccination are welcome to attend.***

Message From Our Chapter President

Dear Friends and Colleagues,

In June, I wrote about three important topics the Chapter was focusing on, including:

Health Equities
Financial Acumen
and
Workforce Matters

I committed that the First Illinois HFMA Chapter would do its part to support healthcare organizations throughout Chicagoland in driving innovative ideas and tools, moderating tough conversations and hosting safe, **in-person** connections.

I'm pleased at how our healthcare financial volunteer leaders have stepped up and delivered in the first 100 days. A few of our collective achievements include:

- Completing our summer book club where members got together several times to discuss ***The Sum of Us:*** **What Racism Costs Everyone and How We Can Prosper Together** written by Heather McGhee. Revenue Cycle Leaders **Nichole Fountain** and **Ashley Teeters** from **University of Chicago Medicine** (Our Chapter's latest "Provider of the Year") lead discussions in July and August around important themes of the book that are relevant to all leaders and especially to healthcare leaders, including:
  - Public services, including healthcare, should not be considered luxuries
  - Racism is a common denominator of many of our most vexing public problems, including healthcare inequities
  - Fighting racism is NOT a zero-sum game and we are all better together when working to achieve equity
- Delivering **$15,000 in scholarships** to a diverse group of upcoming students attending college for the first time or pursuing advanced degrees. A special thank you to Vince Pryor as Scholarship Committee Chair for leading those efforts!
- Hosting webinars on several important topics including one of utmost importance in an environment of optimizing healthcare quality, patient satisfaction, and reimbursement…**Utilization Review and Observation Management.**
- **Gathering for important networking and relationship building** via the annual Transition Dinner and Scholarship Awards Ceremony, Executive Leadership Golf Outing and Back to School Happy Hour. A big thank you to Rich Franco, Kim Wedster, Eileen Crow, Brian Kirkendall and Meagan Edgren for your leadership in making these events happen!
- And behind the scenes, countless hours and effort have gone in to organizing and proving you the best in class when it comes to education. I'm proud to chair and collaborate with leaders from First Illinois HFMA, Wisconsin HFMA, McMahaon-Illini HFMA, Southern Illinois HFMA and Indiana Pressler Memorial HFMA on developing an awesome agenda for the Region 7 Midwest Conference to be held on October 23, 24, and 25. Join an awesome lineup of speakers (including the following) as well as the premier Oktoberfest on October 24!

2022 HFMA Region 7 Midwest Conference Speakers

Michael Allen, Chief Financial Officer, OSF Healthcare; Kim Alvis, CFO, Kirby Medical Center; Eric Borgerding, President & CEO, Wisconsin Hospital Association; Brandon Buchanan, Director, Health Equity, NorthShore University Health System; Lindsey Dunn, Vice President, American Hospital Association Center for Health Innovation; Brooke Dunn, CFO Health & Treasurer, Health & Hospital Corporation of Marion County; Mitch Evans, Chief Audit Officer, Rush; Carol Friesen, Chief Executive Officer Northern Region, OSF HealthCare; Cecilia Gonzalez, Director of Revenue Cycle, Community Care Network; Rachel Greenspan, Director, Revenue Cycle Operations, NorthShore University HealthSystem; Andrew Grimm, VP of Technology, The Bowen Center; Gregory Krupinski, Director, St. Vincent Health; Gregg Malott, Chief Financial Officer, PULASKI MEMORIAL HOSPITAL; Patricia O'Neil, SVP and CFO, Rush University Medical Center; Natalie Rudd, Regional Executive, American Hospital Association; Pat Schou, Executive Director, Illinois Critical Access Hospital Network; Brian Tabor, President, Indiana Hospital Association; Jennifer Ulrich, OSF Vice President Finance Eastern Region, OSF Healthcare System; Jennifer Venable, Chief Financial Officer, SSM Health; Seth Warren, President & CEO, Riverview Health; Doug Welday, CFO & Treasurer, NorthShore - Edward-Elmhurst Health; AJ Wilhelmi, President and CEO, Illinois Health and Hospital Association; Catherine Woerner, Reimbursement Manager, Community Healthcare System- IN

Landon Adkins, Director, Protiviti; Aaron Crane, Chairman, HFMA; Jonathan Dreasler, Manager, Risk Consulting, RSM US LLP; Alicia Faust, Director, Health Care Performance Services, FORVIS; Michelle Franklin, CEO, Sullivan County Community Hospital; Alina Henderson, Senior Director, Advisory Services, Strata Decision Technology; Garett Jackson, Chief Financial Officer, Intuitive Health; Barbara Johnson, Senior Revenue Cycle Consultant, ParaRev; Matt Kalina, VP Business Development, Olive; Cody McSellers-McCray, Vice President Health Equity, Centene; Becky Mills, Associate Vice President, Office of Marketing & Communications, University; Brian Pavona, Partner, FORVIS; Britney Ruegsegger, Regional Vice President, Caravan Health; Becky Sanders, Executive Director of Telehealth Services, OPYS Physician Services; Thom Serafin, Founder & CEO, Serafin & Associates; Frank Stevens, Chief Growth Officer, Strata Decision Technology; Arnold Torres, Executive Director, Healthcare Industry Specialist, J. P. Morgan Chase Bank, N. A.; Sandy, Wagner, Regional Nurse Liaison, OPYS Physician Services, Chris White, Practice Director, Robert Half; Lucy Zielinski, Managing Partner, Lumina Health Partners.

Brian Pavona, FHFMA, CPA
2022-23 FIHFMA President
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Healthcare Stability Outlook Report: 2022 and 2023

The same statement resurfaces whenever we face an economic downturn: healthcare is recession proof.

Unfortunately, that's more fiction than fact.

Just like other large organizations with workforce, supply chain and other fiscal concerns, healthcare organizations are impacted by economic conditions. However, it is true that the industry responds to economic downturns in unique ways. The downturn we are experiencing in 2022 is different in many ways than those that came before, especially because it's happening concurrently with an ongoing global pandemic that continues to destabilize the healthcare industry.

Healthcare leaders need to understand how the downturn could exacerbate issues brought forth by the pandemic and introduce new challenges.

In this article, we'll discuss both the challenges and opportunities that could lie ahead, categorized by healthcare providers' top fiscal priorities.

Patient Access and Experience

Challenges

- **Patients may start to defer care or continue to defer care** if they are already doing so. This may be due to high insurance deductibles, loss of health insurance due to unemployment, or less disposable income to pay for care. Deferred care could cause demand to drop, especially for elective services, and lead to worse long-term outcomes for patients with chronic conditions. Additionally, these worsened long-term outcomes may lead to negative performance for a provider's risk-based contracts, resulting in lower reimbursement and/or penalties for the care of those patients.
- **Quality of care may drop** as providers are pushed to do more with less and staffing issues persist at all levels, including nursing, allied health professionals, technologists and more.
- **Older patients may have fewer care options.** Many of these patients are dependent on pensions or fixed incomes and will struggle to afford assisted living and memory care. Over time, inability to fill these facilities could lead to cutbacks in services and ultimately permanent closures.

Opportunities

Prioritize patient-centric innovation.
You may need to reprioritize investments. Think about what innovation projects will bring the greatest benefits to your patients right now. Longer-term ROI projects may need to be deferred to preserve precious capital. This can help address potential access challenges.

Streamline your referral system.
It's important that you streamline the referral process to reduce hurdles and improve patient care coordination. Consider exploring how maximizing the value of your EHR system can facilitate a cleaner referral process.

Optimize your digital front door.
Your digital front door should make it easier for patients to schedule appointments, manage their health and understand the cost of their care.

Proactively monitor patient acuity and outcome measures.
Work with the applicable payers to negotiate potential modifications to reimbursement and penalties of risk-based contracts to address the negative trend.

Financial Health

Challenges

- **Demand decreases could lead to reduced revenue.** This is especially true for discretionary services. Providers may have to cut certain services due to both concerns with financial sustainability and staffing shortages.
- **Insurance coverage gaps** could lead to lower reimbursement rates for providers, particularly as more patients find insurance through the marketplace or Medicaid.
- **Bad debt will likely increase,** making it more difficult to collect payment for services rendered.
- **Days of cash on hand will likely decrease,** leaving less liquidity for healthcare providers to work with and potentially triggering debt covenants.
- **Bond ratings may go down** as debt covenant violations increase, resulting in higher interest rates.
- **Costs are likely to increase,** especially labor and supply costs. In addition, due to pandemic pressures, there will likely be fewer options to reduce expenses compared to previous recessions.
- **Providers may struggle to make contractual payments** such as lease payments. This is especially true for providers in the elder care space, such as skilled nursing facilities.
- **Private funding is likely to decrease.** In particular, we could see reductions in private grant awards in the coming months.

Opportunities

Assess your key financial metrics.
Make sure you aren't too heavily debt financed with variable rate debt.

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What's Next?
Business resilience is being tested daily.
It's time for an urgent script for healthcare. To survive in today's environment, healthcare leaders must identify ways to improve financial, clinical and digital performance. But it's not enough for your organization to just keep pace.
BDO stands with you to address your current situation, performance opportunities and future growth scenarios, helping you anticipate what's next and transform data into actionable insights.
Learn what's next for Healthcare CFOs in 2021
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Healthcare Stability Outlook Report: 2022 and 2023 (continued from page 4)

Prioritize investments and funding.
Ensure you're committing funding to critical projects related to business continuity. At the same time, look for projects that can be delayed. It's a good idea to re-engage with investment advisors to re-evaluate your investment allocations.

Re-examine your revenue cycle.
Consider optimizing or investing in Clinical Document Integrity (CDI), Coding, and Revenue Integrity programs. Managing denials, streamlining business office functions, and analyzing third party payer contract performance are important strategies to improve revenue performance.

Focus on strategic cost optimization rather than on cost cutting.
While there may be opportunities to identify and reduce certain high expenses, in the long-term you are likely to have more success with an optimization focused approach.

Consider whether consolidation could help you achieve long-term financial stability.
Explore options like M&A or consolidating real estate to see if there are opportunities to improve stability and performance.

Operations and Supply Chain

Challenges

- **Operating costs will likely increase** and options to reduce them will be limited.
- **Operating margins are likely to decline,** especially if we continue to see high compound annual growth rates (CAGR) for drugs and labor costs and vendor contracts tied to the Consumer Price Index (CPI), forcing providers to adopt more aggressive procurement policies.
- **Supply shortages are likely to continue** and become more severe, which could impact clinical outcomes. Operational technology shortages are expected to continue, making it difficult for providers—especially small- and mid-sized community hospitals—to access practical tech solutions.
- **Certain vendors may go out of business,** particularly niche vendors, further exacerbating supply difficulties across the industry.

Opportunities

Explore how EHR optimization can reduce operating costs.
You may be able to simplify workflows, reduce the amount of duplicative work that's required by both clinicians and support staff, and reduce the need for other software solutions, leading to an overall reduction in operating costs.

Consider working with a group purchasing organization (GPO).
Working with these organizations can support your supply chain management and help expand access to hard-to-find supplies.

Explore lower-cost supplies.
This may entail moving away from physician preferred supplies. Work with physicians to standardize supply, device and implant choices and optimize volume pricing.

Technology and Innovation

Challenges

- **New competitors may enter the healthcare space.** Privately funded, tech-enabled competitors may be able to offer lower costs to consumers.
- **Innovation priorities will likely change.** Certain innovation projects may be delayed or abandoned entirely.
- **Telehealth use could stall** depending on payers' willingness to reimburse for telehealth visits.

Opportunities

Calculate the ROI of your current innovation investments.
Which ones will drive the most value in the immediate future? Are there any that could be particularly helpful in supporting your organization through the downturn? Shift your dollars in that direction.

Consider service line and care model innovation.
For example, you could explore remote care monitoring and hospital-at-home solutions to expand patient access opportunities.

Focus on practical technology innovations rather than on what's shiny and new.
Adopt these solutions early so you aren't stymied by potential technology shortages in the coming months. Minor or small-scale automations can make a big difference in creating efficiencies and reducing costs.

Workforce and Talent

Challenges

- **Staffing struggles are likely to continue,** especially in nursing. Providers will likely need to continue working with travel nurses, and the associated fees may cause increased financial strain.
- **Burnout may increase** among both clinicians and support staff, which could lead to an exodus of healthcare workers from the industry.
- **The clinician pipeline may run dry** as fewer students choose to study medicine, prolonging and aggravating talent shortages in the industry.
- **Competition for talent** could become increasingly heated and smaller or independent providers may find themselves priced out of the talent pool.

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Healthcare Stability Outlook Report: 2022 and 2023 (continued from page 6)

Opportunities

Optimize tech solutions to reduce the burden on clinicians and support staff.
Optimizing your EHR system can help reduce the amount of documentation your staff needs to handle, potentially leading to lower levels of burnout.

Explore outsourcing options to compensate for staffing gaps.
For example, there could be opportunities to outsource for certain support roles if necessary.

Implement predictive staffing solutions.
This technology can help create a more efficient staffing system to further reduce burnout.

Invest in automation.
Automated solutions can help compensate for staffing shortages and the high cost of labor.

Regulation and Reporting

Challenges

- **Pricing scrutiny is likely to increase.** The public awareness and skepticism of both pricing policies and executive compensation levels will probably increase. Congress is also likely to continue focusing attention on enforcement of federal pricing mandates.
- **Government funding may dry up.** It's possible that the government will cease to provide funding, which some providers have come to rely on in the past several years.
- **Providers may face new reporting requirements.** Some requirements could be industry-wide, such as ESG reporting requirements. Additional requirements could also be created for specific institutions. Skilled nursing facilities, for example, are likely to face new reporting requirements in the coming years.
- **Medicare will be able to negotiate lower drug prices.** As part of the Inflation Reduction Act, Medicare will be able to negotiate drug prices for 10 high-cost (yet to be determined) drugs starting in 2026. Other provisions of the act include free vaccines for Medicare recipients and three-year extensions for subsidies from the Affordable Care Act (ACA).

Opportunities

Enhance your cost-estimate capabilities.
Explore tech solutions that can make your cost estimates more accurate and attainable. This will make it easier to comply with existing and potential future pricing mandates.

Look to Europe for reporting trends.
The U.S. often follows Europe in certain reporting trends, especially those around ESG. Stay up to date on what's happening across the ocean to better predict the future we might face in the states.

Your window of opportunity to prepare for these challenges is shrinking.

As a healthcare provider, you're likely to face substantial additional strain in the coming months. The impact of these challenges can reverberate for years if you're not properly prepared.

Fortunately, providers can protect themselves by capitalizing on the opportunities we've identified over the coming months.

About the Author

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Fall 2022 Financial Trends in the Health Care Industry:
From Inflation to a Tight Labor Market

Managing hospital operating and financial performance is perpetually challenging for health care leaders. This is especially true now, with record-breaking inflation, volatile investment conditions, a tight labor market, supply chain pressures, and continued COVID-19 disruption. The final Provider Relief Fund payments have been distributed, and a lack of additional federal stimulus funds will further exacerbate the impact of these disrupters. As such, many providers face continued significant operational and financial challenges.

Some good news: Hiring was strong in May, based on data from the U.S. Bureau of Labor Statistics, which reported that the health care sector added 28,300 jobs in May and 250,100 jobs over the past year. As health care employment continues to rise, the industry is tracking closer to its pre-pandemic levels—but overall, it is still down 223,000 positions, or 1.3%, from February 2020.

Health Care Employment

With labor representing about 60% of hospital costs, significant fluctuations in this operating budget line item inevitably affect operating margins and the quality of patient care.

According to the May Kaufman Hall report, which is based on data from more than 900 hospitals, April was another challenging month for hospitals and health systems, with a fourth straight month of negative margins, a reduction in volumes that led to poor revenue performance. Expenses dropped a bit compared to March but continue to rise compared to 2020 and are significantly above pre-pandemic levels as a result of labor shortages and supply chain issues. Other key takeaways from the report are as follows:

Hospital Financial Results*

From a balance sheet and liquidity perspective, Fitch Ratings expects hospital operating margins to weaken in 2022, acknowledges the strong balance sheets of many providers, and doesn't "anticipate any significant deterioration of rated health care providers' financial positions at this time. The agency is maintaining a sector outlook of neutral," according to a recent Healthcare Financial Management Association article.

	Budget variance	Month-over-month	Year-over-year	Year-over-year 2020
National margin				
Operating EBITDA margin less CARES Act funds	-47.8%	-29.7%	-56.1%	-103.9%
Operating margin less CARES Act funds	-71.2%	-38.8%	-77.9%	88.1%
National volume				
Discharges	-7.1%	-3.3%	-4.4%	-27.9%
National expense				
Total expense	3.9%	-4.3%	8.3%	26.2%
Total labor expense	5.5%	-4.2%	11.1%	26.2%
Total nonlabor expense	2.0%	-4.4%	4.5%	23.5%
Total expense per adjusted discharge	7.3%	-1.0%	10.1%	-21.9%
Labor expense per adjusted discharge	10.2%	-0.6%	13.0%	-23.2%
Non-labor expense per adjusted discharge	2.9%	-0.9%	5.5%	-25.3%
National revenue				
Gross operating revenue less CARES Act funds	-1.5%	-7.0%	1.4%	74.3%
Inpatient revenue	-7.3%	-7.1%	-1.3%	39.5%
Outpatient revenue	2.0%	-7.0%	3.5%	124.0%

Source: Kaufman Hall May 2022 National Hospital Flash Report *% change

Areas of Focus

As the effects of the pandemic continue to permeate the industry, there are mixed views on the financial outlook for U.S. health care systems for the remainder of 2022 due to the challenges surrounding ongoing labor shortages, changes in the delivery of care and reimbursement models, inflation, supply chain breakdowns, and cybersecurity risk. It will be critical for all members of leadership to tackle these areas in a thoughtful manner to identify and develop best practices and create sustainable, efficient, and effective operating models. Important concepts for hospital leadership include the following:

- Maintain effective scheduling and resource management tools to maximize resources and revenues
- Invest in technology and automate as many processes as possible to cut costs and maximize efficiency
- Review policies and procedures in procurement to ensure that efficient processes and a sufficient array of vendor relationships are both in place
- Stay abreast of regulatory and legislative changes to ensure organizational compliance
- Sharpen the focus on environmental, social and governance issues, which have drawn increased attention from consumers, regulators and investors.
- Ensure sufficient resources are in place to protect from cyberattacks, and review insurance coverages to mitigate the impact of financial losses
- Refresh and reevaluate the enterprise risk management framework to ensure it is adequate to mitigate risk

While all these focus areas are important, continuing to stay agile and resilient at all levels of the organization during these challenging times tops the list of priorities.

About the Author

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2022 Proposed Changes to the Medicare Cost Report and Instructions

The Centers for Medicare & Medicaid Services (CMS) issued a Federal Register notice in June pertaining to the CMS-2552-10 Hospital and Health Care Complex Cost Report and included proposed changes to Medicare Cost Reporting instructions.

This notice contains many of the same proposals from 2020 plus revisions to the Exhibit templates and, in some cases, instructions revised from the previous proposal.

Background

CMS previously issued a Federal Register notice on November 10, 2020, related to form CMS-2552-10 with a 60-day public comment period. In a supporting statement to the June notice, CMS said that due to the number of public comments plus some administrative issues, it was unable to process responses, and the form expired. The notice invited comments through July 22, 2022, on CMS' intention to collect information from the public.

Supporting Documents

A downloadable zip file containing the full set of documents associated with the most recent federal register notice is available on the CMS website under the PRA Listing Section.

The files include:

- **CMS-2552-10. Instructions** from Chapter 40 Hospital and Hospital Health Care Complex Cost Report Form CMS-2552-10 in the Medicare Provider Reimbursement Manual (PRM)
- **CMS-2552-10.___Crosswalk** summarizing the changes and information to be collected
- **CMS-2552-10.Cost Report Form_(P240f)** containing a draft of CMS Form 2552-10 which reflects the proposed changes
- **CMS-2552-10.Supporting_Statement_A_(30-day)** detailing CMS reasoning and justification for new information collection

There are also select sections of Electronic Code of Federal Regulations (eCFR):

- **eCFR_413.17**
- **eCFR_413.20**
- **eCFR_413.24**

Proposed Medicare Cost Report Changes

The Federal Register notice highlights changes to the PRM cost reporting instructions and changes to the cost reporting form. These changes include updates to current worksheets instructions and new worksheets.

The affected sections of the cost reporting form are summarized below.

Worksheet S-2, Part I

This worksheet features a new Exhibit 3A with a listing of Medicaid eligible days for Medicare Disproportionate Share Hospital (DSH) eligible hospitals.

Effective with cost reporting periods beginning on or after October 1, 2018, hospitals were required to submit a listing supporting Medicare DSH eligible days claimed in the cost report at the time of submission. Failure to do so would result in the rejection of the cost report. However, CMS offered no standardized format for submitting the required data. That will change.

In addition to revisions in reporting Medicare DSH eligible days' data on Worksheet S-2, Part I lines 24 and 25, columns 1-6, CMS now presents a standardized format to submit the patient-level detailed information. **This can be found in the new Exhibit 3A and is required for cost reporting periods beginning on or after October 1, 2022.**

Patient-level detail is required for each category of days reported on lines 24 and 25, columns 1 through 6.

The new exhibit, found on page 56 of the CMS PRM Chapter 40, has 18 data points including eligibility data.

Worksheet S-2, Part II

For cost reporting periods beginning on or after October 1, 2022, hospitals are now expected to submit Exhibit 2A, a listing of Medicare bad debts. If applicable, a separate Exhibit 2A should be submitted for each provider number in the health care complex and separated by inpatient and outpatient as well. Also, the exhibits should distinguish between dually eligible crossover accounts and non-dually eligible accounts.

The previous requirement was that providers supply a listing (Exhibit 2) of Medicare bad debts for cost reporting periods beginning on or after October 1, 2018. Failure to do so would result in the rejection of the cost report.

The new exhibit, found on page 70 of the CMS PRM Chapter 40, has 25 data points.

Worksheet S-3 Part I

An update adds Line 34 to report temporary expansion COVID-19 Public Health Emergency (PHE) acute care information.

Worksheet S-10: Proposed Instructions

CMS has revised the Worksheet S-10 instructions. The S-10 worksheet will have a Part I and Part II.

Part I will follow the current reporting instructions where the information reported for uncompensated and indigent care pertain to the entire hospital complex.

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2022 Proposed Changes to the Medicare Cost Report and Instructions (continued from page 10)

- **New Part II**
  This will report a subset of that information for only inpatient and outpatient services billed under the hospital CCN. This part focuses on data collection for uncompensated care; the instructions direct lines 2–19 shouldn't be completed for the new worksheet.

  These revised instructions would go into effect with cost reporting periods beginning on or after October 1, 2022.

- **Courtesy Discounts**
  CMS is clarifying the definition of courtesy discounts and what should be excluded from Worksheet S-10. It's also recognizing an inferred contractual relationship between an insurer and a provider when a provider accepts an amount from an insurer as payment, or partial payment, on behalf of an insured patient.

  This may impact where charity dollars are reported on Worksheet S-10 as uninsured or insured.

- **Uninsured Provider Relief Fund (PRF) Payments**
  As seen in current S-10 audits, CMS has updated the instructions to state that hospitals that receive HRSA-administered PRF payments for services provided to uninsured COVID-19 patients must not include the patient charges for those services on Worksheet S-10.

Worksheet S-10: Exhibit 3B

This worksheet has a new Exhibit 3B listing for charity care.

For cost reporting periods beginning on or after October 1, 2018, hospitals were required to submit a listing supporting charity care claimed in the cost report. Failure to do so would result in the rejection of the cost report. However, CMS offered no standardized format for submitting the required data.

For cost reporting periods beginning on or after October 1, 2022, Exhibit 3B represents the new standard format for reporting charity care amounts claimed in the cost report. The new exhibit, which is found on page 131 of the CMS PRM Chapter 40, has 21 data points with revised definitions included in the proposed PRM.

Worksheet S-10: Exhibit 3C

A total bad debt detail listing will now be required. This new form, Exhibit 3C, will be required for cost reporting periods beginning on or after October 1, 2022.

The new exhibit, which is found on page 135 of the CMS PRM Chapter 40, has 17 data points with definitions included in the proposed PRM.

Worksheets A, B, C, and D

In Worksheet A; Parts I, II, and B-1 of Worksheet B; Parts I and II of Worksheet C; and Parts II, IV and V, D-3, D-5 Part IV of Worksheet D, instructions were updated to clarify reporting for:

- Allogeneic hematopoietic stem cell
- Chimeric antigen receptor T-cell therapy
- Opioid Treatment Program acquisition costs

Worksheet D-1

Changes to the computation of inpatient operating costs include the addition of new lines to reflect temporary and permanent adjustments to TEFRA rates to properly calculate the TEFRA limit for inpatient costs.

Worksheet D-4

Instructions for computation of organ acquisition costs have been revised regarding the counting of organs including total usable organs, Medicare usable organs, organs for Medicare Advantage patients, and organs that have a primary and secondary payer.

Worksheet D-6

Worksheet D-6, *Computation of Acquisition Costs*, and instructions, was added to calculate the inpatient routine, ancillary, and other costs associated with the acquisition of allogeneic HSCT as required under Section 108 of the Further Consolidated Appropriations Act, 2020 (Pub. L. 116-94).

Worksheet E-3, Part V

Line 3.01 and instructions for cellular therapy acquisition cost were added.

Worksheet E-5

This worksheet, *Outlier Reconciliation at Tentative Settlement*, was added, with instructions, for contractor use, to report the outlier reconciliation amount during cost report tentative settlement.

Worksheet L-1, Part I

This worksheet was revised to add line 78 for CAR T-cell immunotherapy costs and to add line 102 for Opioid Treatment Program.

Potential Challenges and Considerations

It's anticipated that CMS will likely release a final notice. Additional reporting requirements could bring up challenges for providers depending on their current cost reporting practices.

Providers that rely on Medicaid payment as documentation for inclusion in the Medicare DSH calculation now face the issue of having to report detailed Medicaid eligibility information on worksheet S-2—including state eligibility codes—in the new exhibit 3A for all patients.

The addition of the required templates for charity and bad debt creates several new challenges and increased effort for the provider on worksheet S-10. Each account on both listings will need to be reconciled to ensure that all the activity from each patient account is recorded in the correct columns.

About the Authors

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The Nursing Shortage in the Pandemic:
Strategies to Promote a Resilient Workforce

Summary

The COVID-19 pandemic served as a catalyst unlike any other to create both a labor and skills shortage in registered nurses (RNs) across the United States. There is a decreased supply of graduating nurses due to schools' inability to accept all qualified candidates accompanied by an overall shift in RNs pursuing advanced nursing degrees. This decrease in supply is amplified by occurrences of early retirement for many nurses. Over half of the nursing population is over the age of 50. As these nurses leave the workforce, they also take the skill acquired over the course of their careers. Concerns whether these impacts will negatively affect the efficacy of patient care remain in the forefront of many healthcare workers' thoughts.

Introduction - Why Is There a Nursing Shortage?

The idea of a nursing shortage is not new as the United States has experienced periodic scarcities in nursing since the 1900s. However, the current state of nurse availability has been raising voices of concern. From 2015 to 2030, more than 1 million RNs will have retired from a workforce of currently 3.8 million RNs. By the end of 2022, 500,000 seasoned RNs anticipate retiring. In addition to supply constrictions, the demand for nursing will dramatically increase. The U.S. Census Bureau reported that by 2030, the number of U.S. residents aged 65 and older is projected to be 73 million; that number is currently 54 million.

As the older generation of nurses retire, they are no longer able to pass their knowledge to up and coming nurses, leading to concern over a skills shortage. This has the potential to impact the education of new nurses, which raises alarm for the effect on patients. More than 75% of RNs believe the nursing shortage presents a major problem for the quality of their work life, the quality of patient care, and the amount of time nurses can spend with patients. In recent studies, 98% of nurses see the shortage in the future as a catalyst for increasing stress on nurses, as well as lowering patient care quality (93%) and causing nurses to leave the profession (93%).

Decreased Supply in Graduating Nurses

Since the beginning of the pandemic, nursing schools have faced difficulty in obtaining hands-on experience for their students due to hospitals restricting access for anyone in order to limit the spread of germs. Hospitals began shutting down clinical rotations during COVID, unable to afford to spend valuable time and equipment on students, while simultaneously overworking veteran nurses. Some states like California decreased the number of required clinical hours after some nursing schools went fully remote.

Many schools are facing decreased aid from the government. The Centers for Medicare & Medicaid Services is reducing funding for nursing schools due to an internal error that occurred 10 years ago. The error caused for an estimated $1 billion for about 120 colleges.

Pursuance of Advanced Degrees

An additional reason for the lack of RNs is the rise in nurses pursuing advanced degrees. From 2010 to 2017, the increase in nurse practitioners reduced the size of the RN workforce by approximately 80,000 nurses. An estimated 175,000 RNs are needed per year and only about 155,000 graduate per year. Plus, 28,000 RNs are becoming NPs per year. Between 2008 and 2016, the percent of primary care providers in rural areas that were Nurse Practitioners jumped from 17.6% to 25.2%; urban areas grew from 15.9% to 23.0%. This gives the potential for surpluses of NPs.

Increased Occurrences of Early Retirement

The COVID-19 pandemic served as a mechanism for nurses bordering on retirement to decide to leave the workforce prematurely. The American Nurses Association predicts that 500,000 seasoned RNs anticipate retiring by 2022, and the U.S. Bureau of Labor Statistics projects more than 1 million new RNs are needed for expansion and replacement of experienced nurses. Many nurses have taken on the increased emotional burden of becoming sole support systems for patients in their dying hours, many of whom could not see their families. Among surveyed travel nurses, 67% responded that they felt the healthcare system did not prioritize nurses' health and mental well-being. In Mississippi, nurses are retiring early to avoid burnout: 2,000 fewer nurses than the beginning of 2021, not to mention the 6,000 vacancies they had prior. Two-thirds of nurses state their experiences during the COVID-19 crisis have caused them to consider leaving nursing. The supply of nurses is not meeting the demand, and the disparity is amplified by the fact that nursing schools cannot viably accept all qualified candidates.

Covid Impact on Nurses

As of 2021, approximately one in eight nurses had not gotten a Covid-19 vaccine nor did they plan to get one. A Texas hospital system had 153 people resign or were fired after refusing to get vaccinated. As the virus continued to spread, the American Association of Critical-Care Nurses conducted a survey showing two thirds of critical care nurses were considering quitting their jobs; as well, 67% of those surveyed were fearful of taking the virus home to their families. Nurses are reporting an overall decrease in career satisfaction in not only acute care facilities but long-term care and hospice settings.

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The Nursing Shortage in the Pandemic: Strategies to Promote a Resilient Workforce

(continued from page 13)

Nurses were forced to navigate through human and financial constraints, interpersonal conflict, and hostile work environments as the pandemic continued to move into its second year. This laid the foundation for nurses to leave the bedside, experience extreme burnout, mandatory overtime, and the inability to provide adequate patient care. Emotional and physical exhaustion in addition to lack of personal accomplishment are sources of burnout that can lead to secondary trauma. Experiencing trauma leads to lack of sleep, poor appetite, job dissatisfaction, and the inability to cope, putting nurses at risk for post-traumatic stress disorder. Traumatic experience has been associated with having to prioritize who gets care and the high number of deaths.

Professional quality of life can be affected by both positive and negative aspects. It is not uncommon for someone to feel burnout in many aspects of life, but understanding burnout related to working in healthcare during a pandemic is very distinct. Burnout comes from the work nurses do and can manifest in very distinct ways, which can have an impact on the people they are caring for. The current dynamics are 1) increased traumatic stress related to the pandemic, 2) cumulative grief with so much loss and death, 3) moral distress as nurses are having to practice differently, challenging their ethics and doing what does not feel right.

Nurse leaders are also experiencing a high level of stress as the job demands increase and organizational constraints continue to soar—constraints such as lack of beds, increased staffing ratios due to nurses leaving, and a large span of control. Leaders face not only patient and staff concerns but organizational constraints as well. Limited human and financial resources, interpersonal conflict, and a hostile work environment are also causes of nurse leader stress. Other concerns include the adoption of new staffing models to adapt to the shortage of nurses as well as how best to recognize nurses' contributions to the difficulties of today's work environment.

Strategies for Building a Resilient Nursing Workforce

Finding joy in work is rare in this current work environment, which has led to job dissatisfaction and a lack of employee engagement and sense of well-being. This is not a new problem for nursing but one that has been grossly exacerbated by the pandemic. Burnout is an occupational phenomenon and not necessarily an individual's problem; however, individuals must be healthy and resilient to the secondary trauma that occurs as part of the work. Therefore, strategies to create a resilient workforce require both support from organizations to create healthy work environments and from nurses to practice individual resilience building skills.

A healthy work environment includes adequate staffing, strong collaboration, communication, authentic leadership, recognition that is meaningful, and autonomy for the staff to make their own decisions. In order to achieve a healthy work environment, organizations must empower staff, which requires transformative leadership and shared governance. Many of these elements of healthy work environments are found in Magnet organizations or units that have been designated Beacon awards—highlighting these key elements of how to achieve well-being from an organizational perspective.

In addition to workplace health, individuals must practice increasing their own compassion through personal resilience building to counterbalance the risk of burnout. Of importance to note, practicing resilience should not be done to build barriers against a poor work environment. Instead, resilience—or the ability to grow and adapt from adversity—should be done to have strength against the potential hardships that are witnessed in caregiving, such as death, loss, suffering, and pain. Personal resilience-building skills can include practicing gratitude, mindfulness or meditation, journaling or debriefing through writing, and self-care, such as exercise. These activities are valuable moments to pause and reflect on the importance and significance of the work of nursing and the contribution caregivers bring to the quality of patients' lives. In practicing resilience building activities, nurses can potentially decrease burnout and secondary stress, which can lead to a longer, more fulfilling career in nursing.

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Current Healthcare Hiring and Compensation Trends

Administrative healthcare workers continue to be in strong demand, yet finding talent—especially those skilled in a variety of technology tools—is challenging for providers and payers alike. The growth of telehealth and remote working is amplifying the need for professionals with digital experience. Those proficient with electronic health records, medical coding, and electronic billing are needed everywhere.

In today's hiring environment, healthcare leaders need to keep up with the most current pay rates and salary trends. The recently published 2023 Salary Guide from one of the leading staffing firms features a comprehensive list of starting salary ranges for positions in the administrative healthcare field. The salaries are accompanied by recent insights gleaned from research that help explain what it is besides money that job seekers expect in this environment and what many companies are offering them in response. This article is based on the new guide.

A Scarcity of Talent

Job vacancies are hovering near a record high as employers struggle to find enough people to handle key growth opportunities. In a recent survey, 57% of healthcare managers said that adding administrative help is their most pressing need.

We've seen tight labor markets before, but some of the factors affecting hiring and retention today are unprecedented. Quitting a job and finding a new one is easier than ever now that remote work options are allowing candidates to locate opportunities in distant markets.

Even with uncertainties causing unease in the marketplace, starting salaries are still trending upward, and sharply so for some positions. In a recent poll, 82% of managers said they've given raises to employees who expressed salary concerns.

As companies offer hard-to-find talent higher starting salaries, a new kind of pay inequity is arising: 60% of U.S. employers have had workers raise concerns about pay discrepancies between new and longer-serving employees. Some firms are addressing the issue by benchmarking salaries, then giving raises to those underpaid.

Pay can also be affected by employee location. When determining compensation for remote workers, 40% of managers base starting salaries on the employee's location, while 29% use the company's location.

Many Employees Demand Off-site Work Options

Job candidates increasingly consider fully remote or hybrid (where teams alternate between home and office) work options to be as important as a higher salary—in some cases, even more important. While not every job in the administrative healthcare field can be performed

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remotely, workers in the positions that can, such as medical billing manager, medical coding manager, and medical data entry specialist, are adamant. Forty-six percent of U.S. senior healthcare managers responding to a poll said a strong candidate has turned down a job because it didn't include remote work options.

As a result of this trend, remote work, which began as a business necessity at the start of the COVID-19 pandemic, is evolving into a recruitment and retention strategy. Firms mandating that staff return to the office full time have the hardest time attracting and keeping talent.

Offering off-site work options not only addresses retention worries but also creates recruiting opportunities. Employers can access talent from anywhere. Seeking help locating candidates outside their company locations, many employers now partner with specialized recruiting firms that can tap into a global network of skilled professionals.

Workers also want other types of flexible work, such as nontraditional daily and weekly schedules. These include windowed work (the ability to break up the business day into two or three separate time slots, or windows) and a four-day workweek.

Flexible work helps boost diversity; 83% of professionals said their company's flexibility allows them to attract a more diverse and inclusive staff because hiring managers aren't limited to candidates who live within commute distance of the firm's offices.

Retention Just as Important as Recruitment

More than 4 million U.S. workers are resigning every month, putting companies in a bind as they try to replace them; 51% of senior managers said quits at their company have increased, while 78% are concerned even more employees will leave.

There are a number of ways employers are fighting back to keep people on board. One strategy is helping workers add skills to reach their career goals. Reskilling can help workers keep pace with how their jobs are evolving. Options include:

- Mentoring and reverse mentoring—Mentoring programs are a cost-effective way to upskill junior team members and make them feel valued. Reverse mentoring flips the script, giving senior staff the chance to learn from entry-level colleagues (particularly ones who are digital natives). The best mentoring matchups work in both directions.
- Job shadowing—This is a great way to reskill workers by letting them gain experience in a different area of the business.
- Subsidized online learning—Remote workers may feel cut off from the company's core operations. Offering to pay for a qualification or professional accreditation can help them re-engage with the business.

Another retention strategy focuses on accommodating the full scope of workers' needs. Some companies are offering more programs designed to address employee health and wellness, for example. Many firms are also boosting their environmental, social and governance efforts, which are very important to many professionals.

These efforts are paying off. According to recruiters, employers that are working to improve the employee experience and enhance the corporate culture are having more success with retention.

Firms Engaging More Contract Talent than in Prior Years

Hiring managers continue to depend on contract talent to access specialized expertise, fill skill gaps, support core teams and more. What's new is that the tough market for talent is prompting a greater use of contract professionals, including companies more often asking them to join the team on a permanent basis. Almost two-thirds of U.S. managers (64%) have converted more contract professionals to full-time hires this year than the year before.

Increasingly, companies are using customized consulting solutions when they face complex, often enterprise-level business challenges but lack the necessary expertise and skills internally to adequately address them. They find it's more efficient to access specialized talent and strategic advisory and consulting solutions from a single provider.

Research finds that 73% of U.S. companies use consulting solutions arrangements.

About the Author

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Price Transparency: A Cascade of Complexities

Price transparency regulations are like a geyser with underground pressures—in the form of the provider and payer transparency regulations, interoperability rules, proliferation of digital tools, consumer education efforts, and high deductible health plan adoption—that continue to build.

When these pressures break through, the "price transparency geyser" bursts. The resulting outflow of data, tools, awareness, and information create an opening for a cascade of complexities as the regulations that have formed the basis of the movement are enforced. The question is how much these complexities will impact and permanently change the landscape of the healthcare ecosystem that has evolved over previous decades.

Why 2022 Is Different: A Wave of New Penalties, Enforcement, and Data

There are three key drivers that have increased the temperature on payers and providers in 2022.

1. A 10-fold increase for penalties on providers signaled the Centers for Medicare & Medicaid Services (CMS) intent and broad support of politicians to continue the price transparency journey in perpetuity.
2. Increased activity and enforcement by CMS demonstrated that providers cannot ignore the regulations.
3. Payer regulations requiring them to post unprecedented amounts of rate data started July 1, 2022, also under the threat of massive penalties, strict standards, and clear data instructions.

Additionally, CMS has doubled down on its efforts in four distinct ways.

1. In January 2022, CMS increased the hospital compliance penalty from $300/day to up to $5,500/day, depending on the size of the hospital.
2. CMS recently submitted a request for proposal for a third party to aid in compliance of the payer rule.
3. Having learned from the inconsistency in methodology and format of hospital machine-readable files, CMS increased payer requirements by establishing strict and defined guidelines for how they must create and publish their machine-readable files.
4. Payers will be subject to hefty non-compliance penalties of $162/day per affected individual (which could cost billions of dollars, depending on membership enrollment volume).

As such, 2022 represents the largest standardized set of healthcare pricing information to ever be made available to the public.

Beyond the availability of data, there is additional legislation and mandated requirements that directly impact consumers. While the original intent of price transparency regulations was to increase competition and lower the overall cost of receiving healthcare in the U.S., the No Surprises Act (NSA) has the most direct impact on what costs the patient will ultimately pay at the time of service.

Market Expectations: A Cascade of Business Risks and Exposure

Exposed pricing will result in significant stakeholder scrutiny, from competitors to government regulators, consumers, third parties, and the media.

Payers and providers have been engaged in brinksmanship negotiations for years, creating significant pressure on the entire healthcare landscape. Although value-based care initiatives and payvider partnerships have attempted to relieve some of the pressure by fostering collaborative arrangements that put value over volume, the new *price-focused* regulations could create enough healthcare landscape pressure to reverse the progress. Finger pointing and more aggressive negotiations are expected.

In addition to payers and providers or their association/trade groups reverting to pointing fingers at each other being responsible for the high prices of healthcare, more aggressive negotiations are expected.

Government regulators may target large organizations on both the payer and provider side to audit (or continue auditing) compliance. They may use rate information to test compliance across the various mandates, which could result in additional regulations that payers and providers must continue to respond to. This information will be useful to understand pressures on rural and critical access hospitals.

The media will continue to scrutinize all three of the underlying healthcare landscape pressures. They will continue to point to variability in costs across common services, top health systems, and competitive markets. They will also scrutinize the patient experience, which will be significantly impacted by these regulations—including the individual stories that illustrate a frustrating journey through the healthcare system.

Employer groups (and the brokers who represent them) who have had to bear the brunt of rising healthcare expenses dictated by payer/provider negotiations will have access to data that can help them re-evaluate offerings for their employees, granting them leverage to renegotiate existing partnerships with healthcare providers and payers.

This could cause significant shifts in commercial membership among some of the largest payers in the country. The public will likely not access payer machine-readable files, given their incredibly large size. Employees may pressure their employers to switch carriers, switch carriers themselves, or delay care as they shop for the lowest cost services and/or react to media reports.

Consumers are more involved than ever in driving their own healthcare choices—but remain several steps removed from the meaningful, actionable data and technology that enables them to shop and make decisions in the way they do for other services. Patient choices will continue to be driven by physician referrals, integrated delivery

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Price Transparency: A Cascade of Complexities (continued from page 18)

systems, and ease of access. However, it is only a matter of time before the combination of eager startups and tech titans that are focusing investments in healthcare consumerism (Amazon, Apple, etc.) find ways to use this data to attract patients.

Third party vendors may saturate the market with solutions that aggregate pricing, benefit/product design, and claims editing data on behalf of the above stakeholders, fueling existing market responses, and continuing to put pressure on the entire healthcare ecosystem to manage the cost of healthcare services.

Technology investments will be required to develop interoperable solutions that deliver accurate, comparable, and consistent information between providers and co-providers, providers and payers, payers to members, and health systems to patients. Unfortunately, it will not be easy, as payers and providers each have proprietary information and methodologies of determining the pricing they charge and pay for services.

Opportunities: Taking Advantage of Price Transparency Rulings

Providing meaningful, valuable, and user-friendly solutions to enhance the consumer experience is a key differentiator for any healthcare player in today's market. Here are four ways to ensure your organization will meet expectations:

1. Use existing digital solutions for compliance, if possible.
2. Develop a communications strategy to respond to market inquiries.
3. Have resources in place to gather market insights from the broader transparency information that's available.
4. Understand your market's opportunities to support broader payer/provider partnerships.

Despite the geyser-like pressure that the entire healthcare industry is facing, the stakes regarding consumer trust and loyalty and an individual organization's market position are too high for leaders not to put their best foot forward. *Learn more*

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The Importance of Tracking KPIs and Metrics That Will Boost Your Profits

Healthcare organizations nationwide are continuously striving to be more efficient and ultimately more profitable operations. An important common factor that we've found among our clients, whether operating a physician practice, healthcare group, urgent and in-patient treatment center, or even a large-scale health system, is the constant necessity to monitor and work to improve revenue cycle management.

We believe a data-driven approach to revenue cycle management (RCM) empowers organizations with actionable intelligence that helps guide our clients to better financial outcomes. This includes implementing KPIs and metrics to better track the revenues they have earned. In this specific area, you might ask which ones you should track. Here are a few key baseline metrics we'd propose should be considered.

Days in Accounts Receivable (AR): This is the amount of time it takes to receive payment on a claim. It helps you to identify potential revenue cycle issues and measure the efficiency of your billing team. The industry standard benchmark to target is 35 days. Anything that goes over 60-90 days should trigger a red flag that it's time to intervene.

Percent in Accounts Receivable Greater than 120 Days: This helps measure whether your patients or payors are paying the operation promptly. Because it can be incredibly time and resource intensive, a lot of operations do not pursue AR cases that are greater than 60/90 days. A solid benchmark for ensuring an efficient patient payment process is to focus on keeping AR cases greater than 120 days to below 25% of total accounts receivable.

First Pass Clean Claim Rate: This helps to track any issues or problems in how the medical and billing team is submitting and processing claims. It measures the acceptance rate the first time that claim is submitted and successfully makes its way through validation and clearing house edits. Many operations struggle in this particular process, and it requires constant tweaks and monitoring to catch errors and input issues. The stronger the first pass clean claim rate, the lower AR days and quicker payments. The benchmark to aim for is 98% but always above 90% is where most provider operations need to be shooting to be.

Net Collection Rates: This helps to measure what you should realistically be collecting from both patients and their insurance companies. A high net collection rate indicates the claims are being billed in a timely manner, that those claims are being adjudicated, and that patient balances are collected. Focus on 90+% as a benchmark.

Denial Rates: This helps measure your overall revenue cycle management processes. A high denial rate means all other KPIs are impacted, and liquidity is impacted. A low denial rate means your medical and billing team is hitting its stride when it comes to coding, tracking information, determining eligibility, and ensuring authorizations. The benchmark to aim for is 5-10%.

The importance of simplifying data into actionable intelligence improving patient outcomes and overall practice performance has become increasing important. A healthcare organization must be founded and built with both a brain for business and a heart for patients, focusing on technology and operations that help their practices and organizations understand their profit/loss ratios, location population, allocation of resources, and patient and payer information by turning simplified data into actionable intelligence.

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Challenges Providers Face Complying with the No Surprises Act

The No Surprises Act (NSA), signed into law in December 2020, is meant to help protect patients from financial hardship due to surprise medical bills. Such bills are often the result of patients receiving emergency or nonemergency services from providers that don't participate in their health plan's network. Patients become aware of an issue only when they're hit with a hefty bill for those services, which their health plan won't cover. Meeting the NSA requirements is an arduous task for most healthcare providers and facilities.

The pressure is on for providers and facilities to stay on top of the evolving requirements, and ideally to get ahead of them. Providers and facilities should not underestimate how much time and effort will be needed to meet the demands under NSA, particularly when it comes to understanding how to navigate the dispute resolution process when the qualifying payment amount (QPA) is not agreed upon, when scenarios do permit balance billing, and in gathering information from co-providers and co-facilities to create good faith estimates (GFEs).

Understanding the NSA and its requirements is an important starting point for healthcare providers and facilities preparing to comply with the law. With that in mind, the following is a high-level overview of two key parts of the NSA—prohibitions on balance billing and GFEs.

Part I — Prohibitions on Balance Billing

Balance billing refers to billing a patient for an unexpected balance—aka "surprise billing." Under the NSA, hospital facilities, emergency departments (including freestanding ones), ambulatory surgery centers, urgent care centers (those licensed to provide emergency services), air ambulance services, and providers servicing the facilities mentioned are prohibited from billing patients more than the in-network cost-sharing amounts for surprise medical bills.The NSA also requires private health plans to cover out-of-network claims and apply in-network cost-sharing.

Here are three scenarios where an individual would be likely to receive a balance bill for care:

- Receiving emergency services from an out-of-network provider or out-of-network emergency facility
- Receiving covered nonemergency services from an out-of-network provider delivered as part of a visit to an in-network healthcare facility
- Receiving covered air ambulance services provided by an out-of-network provider of air ambulance services

To determine the applicability of the NSA and the ability to balance bill, the following information is required:

- **Service need:** Is the service emergent or not?
- **Type of facility**: Is the facility included in the NSA provisions?
- **Network status:** Is the facility/provider in or out-of-network?
- **Type of service:** Is the service provided "ancillary" (for example, the presence of an assistant surgeon during a procedure)?

In some limited situations, known as "notice-and-consent exceptions," the NSA allows for out-of-network providers and facilities to seek written consent to voluntarily waive their protections against balance billing when services include post-stabilization or nonancillary, nonemergency services.

When an exception doesn't apply, an emergency facility or provider can't bill an individual for an amount exceeding in-network limits or hold an individual liable for paying an amount exceeding in-network limits. In-network limits are determined by the payer through an all-payer agreement, equivalent state law, or the calculation of a QPA.

Table 1. NSA Part I: Scenarios for Emergent Services

Service	Network Status			Reimbursement			Notice-and-Consent Exception
	Facility	Provider	Ancillary	Facility	Provider	Ancillary	
Emergent	INN	INN	INN	C	C	C	N/A
	INN	INN	OON	C	C	QPA	
	INN	OON	INN	C	QPA	C	
	INN	OON	OON	C	QPA	QPA	
	OON	INN	INN	QPA	C	C	
	OON	INN	OON	QPA	C	QPA	
	OON	OON	INN	QPA	QPA	C	
	OON	OON	OON	QPA	QPA	QPA	

Key:
INN – In-network status
OON – Out-of-network status
C – Contractual Rate
QPA – Qualifying Payment Amount
N/A – Not Applicable

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Challenges Providers Face Complying with the No Surprises Act (continued from page 21)

Table 2. NSA Part II: Scenarios for Non-Emergent Services

Service	Network Status			Reimbursement			Notice-and-Consent Exception
	Facility	Provider	Ancillary	Facility	Provider	Ancillary	
Non-Emergent	INN	INN	INN	C	C	C	N/A
	INN	INN	OON	C	C	QPA	N/A
	INN	OON	INN	C	QPA/ N&C	C	Permitted for OON Provider
	INN	OON	OON	C	QPA/ N&C	QPA	Permitted for OON Provider
	OON	Non-emergent services provided at an OON facility are not protected under the No Surprises Act					

Key:
INN – In-network status
OON – Out-of-network status
C – Contractual Rate
QPA – Qualifying Payment Amount
N/A – Not Applicable

Part II – Good Faith Estimates (GFE) for the Uninsured

Under the NSA, providers and facilities must provide uninsured or self-pay patients with a GFE that includes expected charges for:

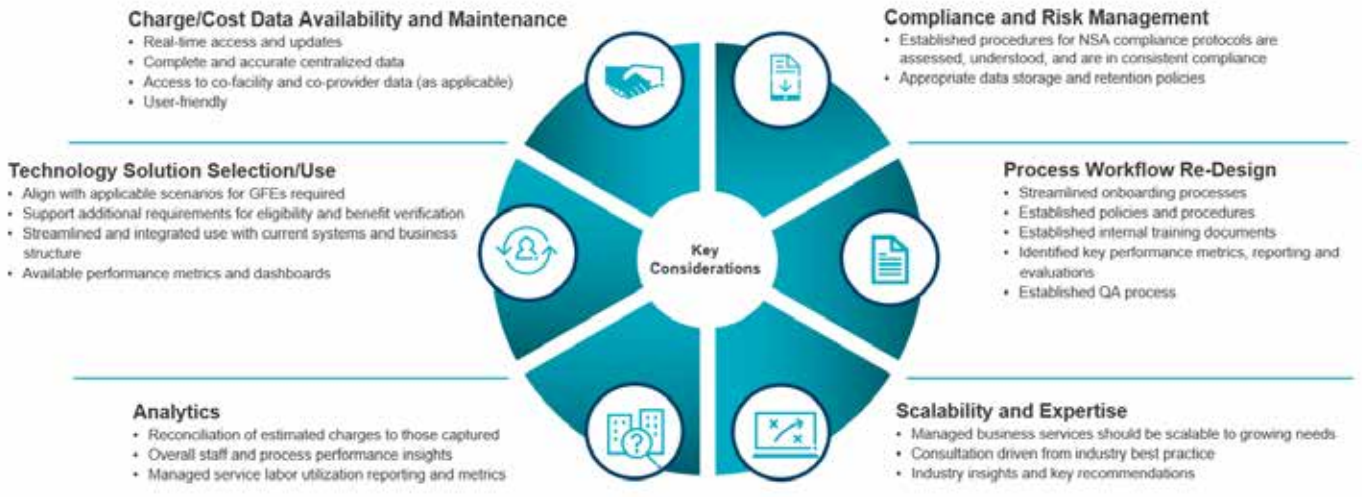
- Scheduled or requested items and services
- Items and services reasonably expected to be provided along with a primary item and/or service

Unlike the hospital price transparency rule, GFE requirements aren't limited to certain facility and provider types. They apply to all licensed healthcare facilities and providers. Currently, the requirement for GFEs is enforceable for the uninsured or self-pay patient population, with anticipated expansion to all patients (insured or not) slated for implementation and enforcement in future rulemaking.

There are also several additional requirements for GFEs, including the provision of a GFE in written form (paper or electronic) based on a patient's requested delivery method and within required time frames, and the use of clear and understandable language in the GFE.

Of the NSA's two key parts, GFE compliance requirements have shown to be the most challenging for healthcare providers and facilities—specifically, the requirement for collecting information from multiple, disparate sources, including co-providers and co-facilities outside of the care network. And while there are technology tools that can help to manage this process, no one solution can eliminate all the manual work and resources involved in gathering the information needed to create accurate and timely GFEs for patients.

Picture 1. Key Considerations for GFE Compliance



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Challenges Providers Face Complying with the No Surprises Act (continued from page 22)

NSA Compliance: Strategies for Success

To comply with the NSA, generally, and reduce the risk of bottom-line-eroding billing disputes, providers and facilities should consider effects on people, process and technology.

Table 3. Understanding Effects of the NSA Across NSA Parts I and II

Effect	Consideration	NSA Part I – Balance Billing	NSA Part II – Good Faith Estimate
People	Educate internal and external stakeholders to support simplified and standardized workflows	X	X
Process	Identify scenarios where balance billing is/is not appropriate, including in the provision of ancillary services and post-stabilization	X	
Process	Determine the minimum acceptable Qualifying Payment Amount (QPA) for items and services for out-of-network items and services	X	
Process	Outline processes for initiating open negotiations and dispute resolution processes with payers and patients	X	
Process	Identify out-of-network payers, co-providers and co-facilities, and understand their potential impact to the billing of services, as well as the preparation and monitoring of GFEs		X
Process	Identify data sources for compiling GFEs, reconciling the estimate to actual charges, and monitoring accuracy in estimates		X
Technology	Explore the use of technology to automate processes, create documentation, integrate disparate data sets, and set up effective communication workflows	X	X
Process & Technology	Monitor successes to identify repeatable best practices and areas for improvement	X	X

Providers and facilities will also need to develop a multidisciplinary group to manage NSA compliance. This team should consist primarily of revenue cycle leadership but may also include stakeholders from customer service, financial advocacy, patient access, and managed care. It's essential for providers and facilities to also consider the impact of dedicating staff to this work, as it will take them away from other priorities.

By taking a structured approach to NSA compliance, healthcare providers and facilities will be better positioned to manage the heavy lifting involved in meeting the law's requirements as delayed requirements become enforceable. And by being proactive, they can avoid being "surprised" themselves by a mountain of complex work while facing NSA compliance deadlines. As an immediate starting point, providers and facilities may want to consider working with a third party to help them identify potential obstacles to NSA compliance success, including data integration challenges, ineffective workflows, and potential data security and data privacy issues that may arise when handling sensitive patient data.

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Artificial Intelligence in Healthcare Revenue Cycle: Not Quite Ready for Prime Time?

Throughout my career as a health system CFO and a service provider to the industry, I have been fascinated by the interplay of technology and revenue cycle efficiency. In recent years, digital tools have changed the work lives of business office staff at many organizations, who now can use applications such as automated claim statusing to find out where a claim stands without picking up the phone or clicking through web pages.

Now we are on the cusp of an even bigger change, one with profound implications for every healthcare stakeholder—payers, providers, patients, and revenue cycle staff. We are talking about true artificial intelligence, machines learning how to do what only humans have done but doing it many times faster, more accurately, and at less expense.

There is a lot of marketing coming from software vendors suggesting that AI has already been integrated into hospital finance departments, including revenue cycle. Some of these early pronouncements have some weight, as the applications are more attuned to the current capabilities of the software. Many, however, are touting use cases that simply are not happening yet, or at least effectively.

One such sales approach being used by several vendors is the ability to go into the medical record, pull the needed clinical documentation from clinician notes and voice recordings, and use Natural Language Processing (NLP) to match the correct codes and even send out clean bills. Coding staff needed could be greatly diminished.

At a time when healthcare operating budgets are hosing red ink, this vision would be a dream come true. Denials and associated rework causing payment delays would be a thing of the past. And yet, having taken a close look, as I have in the past year, true machine learning in revenue cycle seems not fully realized, and when it is successfully implemented, it's for simpler processes.

With new vendors arriving on the scene seemingly almost weekly, offering infinite options and touting immediate AI solutions, I have been asking the same questions I always ask about new technologies. They are:

- Will this really work? So many technology solutions expend IT resources but are not embraced by staff and sometimes really don't deliver what was expected.
- Will today's investment underperform compared to emerging options?
- Is technology the solution for my immediate needs or is it staffing?
- Will the vendor be a partner I can grow with?

Having done the legwork, I can report a few main findings.

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Artificial Intelligence in Healthcare Revenue Cycle: Not Quite Ready for Prime Time?

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- AI is coming, but slowly. It will take three years or more to be fully realized across the revenue cycle operation.
- AI is on the road to fully automated coding, though not as far along as proponents say. AI companies are touting 97% or greater accuracy with automated claims, but they aren't telling you what those claims are and what they can't do yet. Not all medical cases are equivalent in terms of coding complexity. A cut treated with sutures at a local urgent care center is not the same as a complex case like orthopedic surgery, spanning months from the OR to final discharge from rehab care.
- AI is more advanced in the area of patient access. Pre-authorization, registration and scheduling are highly manual and time-consuming, not to mention a big patient dissatisfier as the patient usually must walk through the same information at the time of visit. This is a much simpler implementation.
- What many are selling as AI is actually robotic process automation. In addition to auto statusing, RPA can also be used to verify demographics and ensure a clean claim is submitted. RPA is supervised by humans, who control the variables with structured inputs and logic. True AI replaces human input and develops its own logic, asking questions about data that humans would not know to ask.
- It is true that the latest generation of NLP can model and understand the meaning of human language. Companies like Google, Amazon and Apple already employ it with increasing accuracy. In healthcare, AI machines could automatically read and summarize payer reimbursement policies, translate the diagnoses into ICD-10 codes, find answers to billing questions, and even answer patient questions about their bill. Yes, there are lots of mistakes in documentation, and notes aren't always clear. And yet, AI machines learn quickly from mistakes.

What galvanizes providers to rush out and spend on this technology is about more than clean claims and efficiency. They see themselves in an AI arms race with payers, which hospitals see as seeking to find more errors in claims in order to make instant denials. The winners will be those who invest in AI sooner and maintain their edge moving forward.

Why do I say it will take three years for revenue cycle to meaningfully adopt machine learning? Predictive modeling to identify all these patterns can take weeks or months in industries like finance. In healthcare, with the challenges of data integration and transformation, model building is likely to take much longer. Using conventional tools, machine learning projects may include thousands of separate tasks, many of which must be coded individually. Payers employ armies of data scientists to perform this work, but most provider organizations are already strapped for cash and staff. They cannot afford to lay off coders and wait years for AI to catch up.

When AI becomes fully integrated into the business office, it will be a Google-like transformation of the healthcare industry. For now, only the most deep-pocketed institutions get to play with these new tools. Others jumping in too early may only wind up with fool's gold.

About the Author

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5 Best-Practice Steps to Automate Prior Authorization

Preventing no-authorization denials and getting patients timely, quality care is no easy feat. As payers increase prior authorization requirements, providers struggle to hurdle escalating barriers to scheduling care, incurring millions of dollars in administrative costs and lost revenue..

Worse, patients are caught in the crossfire. While payers say the intent of prior authorization is to control healthcare costs, one-third of physicians surveyed said prior authorization requirements led to a serious adverse patient event.* And when no-auth denials come knockin', guess who foots the bill? The *surprise* bill, that is. You guessed it. Patients.

Why Providers Need Intelligent, Automated Prior Authorization

Despite the 278 transaction standard readily available for years, and the tremendous cost savings adopting electric transactions would bring, insurers continue to maintain arcane, convoluted prior authorization processes. Hospital groups are calling for government oversight to enforce the use of electronic transactions and to regulate payer response times, but in a time where hospitals are drowning in staffing shortages and managing constricted budgets, they can't afford to wait for a lifeline. *

Instead, providers have looked to technology companies to build automation tools using robotic process automation (RPA) and intelligent rules engines to navigate the ever-changing labyrinth of payer portals, rules and requirements. Many EHRs provide work queues for staff to manually complete prior authorization processes, which still rely heavily on human intervention—putting a strain on already short staff. Others solve for parts of the problem, one for determination, one for submission, another for retrieval. None deliver a comprehensive solution.

It doesn't have to be that way. Using intelligent automation, technology can solve for determination, submission and retrieval. Providers need real solutions, not more empty promises or misconstrued artificial intelligence.

5 Best-Practice Steps to Automate Prior Authorization

Step 1: Demographic Audit

It's critical to have automated quality assurance measures in place to audit patient data before prior authorization submissions. If not, you're susceptible to rework, denials and lost revenue.

An integrated first step of the prior authorization process, quality assurance:

- Automatically audits 100 percent of patient registrations to identify and prevent financial and administrative errors
- Alerts staff in work queues with errors and payment risks along with instructions for resolving issues
- Automatically re-audits registrations after any changes
- Uses pattern recognition analysis to continuously update automated rules engine to prevent recurring errors and related rework

Step 2: Eligibility Verification

Eligibility verification consists of two levels of automation: eligibility verification, plus benefit mapping. An intelligent rules engine analyzes remit data and isolates likely denial-causing payment risks before they occur.

Eligibility verification provides:

- Benefits verification on 100 percent of accounts
- General and targeted service verification
- Automated batch and manual real-time submission
- Self-pay verification
- Found coverage and coverage change detection
- Benefit threshold alerting
- Coordination of benefits alerting
- RTE, 270/271, HL7 transactions
- Benefit post-back to EMR

Step 3: Determination

Arguably the most critical and time-consuming step in prior authorization, hospitals dedicate a significant number of resources to determine when an account requires authorization. Automating determination reduces time spent on the phone, at the fax machine and searching payer websites to get patients authorized for the services they need—faster and with fewer denials.

Automated determination:

- Automatically determines if authorization is needed using rules that are payer- and employer-specific to ensure rules are as current as possible to predict and prevent denials
- Offers flexible options for grouping and sorting work to meet the unique needs of each customer (e.g., by payer, patient alphamix)
- Notifies staff within their work queues when authorization is needed
- Enables staff to easily look up when auth is needed by payer to reduce manual processes

Step 4: Submission

Automated submission:

- Standardizes manual and fax-based authorizations through a single web portal

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5 Best-Practice Steps to Automate Prior Authorization

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- Automates the generation and submission of web forms for easy staff upload
- Guides staff through payer rules and requirements, providing necessary forms and questionnaires, while pre-populating data as available
- Provides staff insight into the status of submissions within their work queues (i.e., appended/additional documentation needed)
- Customizes rules that alert to specific payer and employer plan needs
- Provides in-depth, real-time reporting on key authorization metrics, including payer turn-around time, coverage determinations and authorization requirements

Step 5: Retrieval

Automating retrieval eliminates the need to manually check status on payer portals. Intelligent automation can do the work for you, monitoring response status and retrieving the authorization or denial number, along with additional documentation requests.

Automated retrieval:

- Eliminates manually checking status on portals
- Delivers automated responses into staff work queues, including auth status, denial number or instruction if further documentation is required
- Enables clinical staff to proceed to service more quickly with less staff resources
- Eliminates time on hold, waiting for returned phone calls and manual updates to spreadsheets
- Allows staff to reallocate time to managing submissions to improve accuracy and likelihood of approval

Intelligent, End-to-End Automated Prior Authorization Is Here

Providers can't afford to wait for government intervention to regulate prior authorization. Using intelligent, end-to-end automation to automate the five best-practice steps of prior authorization reduces costs, alleviates staffing challenges and gets patients the care they need when they need it.

*Gellman, M. (2021): "Doctors say prior authorization led to life-threatening delays in care." Modern Healthcare

About the Author

Paul Shorrosh, *MBA, MSW, CHAM, is founder and CEO of AccuReg. You can reach Paul at paul@accuregsoftware.com. Click the following link to Read the eBook to learn how to automate determination, submission and retrieval for all payers and service lines.*

Improving Accounts Receivable Collections

Introduction

Maintaining ample cash flow is vital to the financial stability and success of any healthcare provider. It also allows them to grow and continue to provide critical services to the community. A key contributor to cash flow is the effective management of a provider's A/R inventory. However, many hospitals have limited resources to devote to it. A trusted revenue cycle management partner can not only alleviate the burden of stalled claims by handling follow-up, collecting payments, and recovering on overdue claims quickly and efficiently, but improve a provider's internal system for long term success. These days, it's increasingly difficult for a provider to effectively manage the revenue cycle using internal resources only. From my experience, combining technology, proven processes, and experienced people together is the winning combination to recovering payments.

Understanding Provider Pain Points

When Medicare moved away from cost-based reimbursement to a prospective payment system, I immediately saw the impact on hospitals as they were being paid less than the cost of their services. While this happened decades ago, many would agree that this move impacted hospital profitability significantly 1, and it's only one example of many that have made it increasingly difficult for providers to maintain a healthy profit margin. One of the biggest pain points for providers is many payers have reimbursement processes that don't pay health providers at the level of their cost, let alone their target profit margin.

Cash is the key driver of success for any provider or health system. It concerns me when providers announce they've lost hundreds of millions of dollars. According to a Kaufman Hall's most recent National Hospital Flash Report 2, released August 29, experts reported that 2022 is shaping up to be the worst year financially for U.S. hospitals and health systems since the beginning of the COVID-19 pandemic. The report said hospitals are experiencing some of the worst margins since the start of the pandemic, and they lack the federal funds to offset the damage. And the problem is worsening due to the tight labor market, increasing labor costs and unstable supply chain dynamics. Costs keep increasing. Cash reserves are critical to helping providers get through economic challenges.

Growth in Demand

Even though healthcare systems have announced big losses this year, there is a huge demand for A/R services, with a bubble of inventory growing because there aren't enough resources to handle the demand and work the accounts. What drives many providers to outsource to a vendor is the struggle to find the resources to cover their inventories. Smaller providers and stand-alone hospitals are most vulnerable.

Leveraging Technology

Leveraging systems through automation is a good idea as a tool to augment the expertise of an accounts receivable team. Team members should focus their time on exceptions and the automated system should handle most of the accounts. This approach translates to A/R inventory management as well. As a best practice, specialized technology with well-built processes can handle much of the inventory so that the expert A/R team can focus on the accounts that need a closer look.

Setting Clients Up for Long Term Success

Providers wanting to outsource to a revenue cycle vendor should look for a partner who has the people, process, and expertise to work alongside their hospital staff and system to re-bill payers, appeal denials, and communicate with payers. And as an added value, the best vendors will improve a client's revenue cycle claims process and share those insights with their client. Helping clients learn where their gaps are and providing the information they need to address those gaps is critical. Vendors should be setting their clients up for success and be committed to delivering unmatched service and an elevated client and patient experience. If providers of any size, including small to medium healthcare providers, community hospitals and large academic teaching facilities, hire the right vendor, they should expect to receive the resources they need to impact their cash flow. It makes a real difference in the lives of so many communities across the country.

About the Author

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Women in Leadership (WIL) Retreat Photo Recap

This year's Women in Leadership (WIL) Retreat took place at the Morton Arboretum and offered a full day of highly interactive learning sessions and great networking. Mark your calendar now for June 8, 2023! Details will be posted on First Illinois Chapter's webpage as they become available.

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Publication Date	Articles Received By
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June 2023	May 1, 2023
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