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first illinois chapter

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FIRST ILLINOIS SPEAKS

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Message From Our Chapter Presidents

BY BART RICHARDS, FHFMA, 2020-21 PRESIDENT &
RICH SCHEFKE , FHFMA, CPA, 2021-22 PRESIDENT

Farewell from outgoing FIHFMA president, Bart Richards

Dear Friends and Colleagues,

The First Illinois Chapter made significant progress in 2020-2021. I am so proud of what we have accomplished in challenging times. Executive Committee turnover, the transition to virtual events, the need to find new ways to connect with membership, uncertainty and risks posed by the pandemic, and the gradual stepping back into in-person events have all added to the complexity of moving the chapter forward. Nevertheless, as we always have, the chapter persevered.

Like for all of us, the events of 2020-2021 have had a profound impact on me. Black Lives Matter and the pandemic shed light on the inequities of our healthcare system. At the same time, COVID-19 reinforced the importance of our healthcare workers. The grace and professionalism with which front line healthcare workers conducted themselves during the pandemic has been inspiring. I witnessed it not only through my client experiences but also as a patient.

As I look forward to a promising year for the First Illinois Chapter under a new leadership team led by your new president, Rich Schefke, I leave you with a recap of some of the chapter highlights of the year.

Registration Figures at Key Events

As you might know, the First Illinois Chapter is part of Region 7, which includes First Illinois Chapter, McMahon-Illini Chapter, Southern Illinois Chapter, Indiana Pressler Memorial Chapter, and Wisconsin Chapter. Region 7 typically holds a region-wide conference once every two years. It was our turn to host the event!

As you can appreciate, volunteers across the chapter had spent a lot of time preparing for the Region 7 conference, typically held in the fall. The pandemic caused us to re-evaluate our plans, and the leadership of all the chapters across the region decided not to hold the conference. True to form, our chapter quickly pivoted and made plans to hold our Fall Summit in its place.

Our ability to turn on a dime and hold our Fall Summit virtually—with our own technology platform including live and recorded sessions, virtual booths for our annual partners and, most importantly, high-quality content for our members—was outstanding. That work led to just over 400 members registering for the Fall Summit.

Other registration totals included:

- Managed Care Symposium - 122
- Accounting and Reimbursement - 154
- Revenue Cycle - 107

Annual Partners

The support of our annual partners is key to our success. Their support of the chapter enables us to provide top-quality educational events throughout the year. Deliberate steps were taken to listen to their needs, pivot as much as we could in the virtual environment to deliver value to them, communicate our plans and deliver on our promises. Eileen Crow and Rich Franco, our Annual Partner Committee chairs, have done a great job with our annual partners.

Communication

I hope my president's video updates were helpful and a good change of pace. Of course, the chapter continued to use email as a major communication medium and relied heavily on our website (firstillinoishfma.org). We also had a strong focus on social media and specifically the chapter's LinkedIn page. Over the course of the year, our LinkedIn site membership grew from 170 to 345. What an accomplishment! Thank you to our Social Media chair, Morgan DeHaan.

Other

In December, the chapter worked with other healthcare associations in Chicagoland to support The Boulevard of Chicago. The First Illinois Chapter raised $3,000 for this great organization. If you add in what CHEF, HIMMS and others donated, we contributed over $4,500. Tim Stadelmann of Advocate did a great job organizing the event and emceeing the evening's activities. Meagan Edgren and Connor Loftus continued to do a great job with certification. Their efforts were recognized in the May issue of *hfm* magazine. Our 2013-14 Chapter President, Dan Yunker, is now a regional executive for Region 7. And finally, Sue Marr and Nicole Fountain led our Women in Leadership Committee to new heights. All of this was done while preserving the chapter's balance sheet.

Bart Richards, FHFMA
2020-20 FIHFMA President
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Greetings from new FIHFMA president, Rich Schefke

I am honored and humbled for this opportunity to help lead our chapter as we all transition out of the depths of the first (and hopefully only) pandemic of our lifetimes. Thank you to our current and prior leaders, volunteers, and partners for your stewardship, setting the strong foundation for the oldest chapter of HFMA. The chapter is in good hands for years to come. Brian Pavona, president-elect, and Katie White, secretary/treasurer, are excellent leaders with a wealth of chapter knowledge. Our Board of Directors is a dedicated group of involved members.

My special thanks to Bart Richards. The chapter is in a better place now, after a year of your leadership during the pandemic. It is great to work with you, and I look forward to your continued contributions in your role as past president.

Over the next 12 months, we will continue some of the excellent work and initiatives that have been a focus over the last few years:

- Providing members excellent educational and social networking opportunities
- Holding our key programming events including our Fall Summit, and Managed Care, Accounting and Reimbursement, and Revenue Cycle conferences
- Continuing the First Illinois Executive Forum meetings
- Holding our executive golf outing
- Supporting individual professional growth through certification
- Driving membership growth and membership engagement, especially individual membership
- Supporting our Women in Leadership efforts

In addition, we will be focused on new objectives, including:

- Holding more educational and social events in person
- Increasing our volunteer base
- Making it easier to support our scholarships
- For healthcare CPAs, becoming the healthcare CPA choice for CPE credits as this is a reporting year

By way of background, I am Director of Financial Planning, Analysis and Decision Support for Northwest Community Healthcare a part of NorthShore HealthSystem. I live in Aurora, Illinois and am married with two children. I like to socialize (in person finally!) with family and friends, go for walks, and follow my favorite Chicago sports teams. In terms of the First Illinois chapter, I began to volunteer with the chapter on the programming committee, was a board member and then part of the executive committee.

Stewardship is a core value of mine, as my goal is to always focus on developing those that follow me. There is no better way to be a steward than to make it easier to invest in the next generation. As many of you know, we are one of the few chapters that has a scholarship program for our members' college students. I am proud to announce that starting this chapter year, we have partnered with the national association and will be able to give a tax deduction for donations–100% of the donations will be used for the scholarships. Our goal is to raise at least $15,000 this year, and I ask that you please join me in helping be a steward of the next generation of members with a tax deductible donation.

There are well over 1,000 members and partners in our chapter, all with different backgrounds. A small portion of them are volunteers. My challenge to our chapter is to increase the volunteer base to bring in a greater number of backgrounds to help shape our chapter, so we all can do our part as stewards. Every new volunteer adds to our diversity of thought and background. Ten years ago, I was a silent member reading the national and local materials to learn more about the industry and kept going with my busy life of work and home. I know many of you reading this are in that category now, especially with all the additional challenges of the pandemic. If this describes you, I ask you to please give some time and invest in your chapter. I guarantee that no matter where you are in your career, you will get out of it more than you put in. We can find roles for any amount of time. I am certain future chapter presidents are reading this and will volunteer for the first time this chapter year. My hope is that is you!

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Pandemic Highlights Need for Better Use of Data Among Providers

Hospitals can use analytics to better manage capacity and talent

The coronavirus pandemic has presented a host of challenges for health care providers. But now that a vaccine has rolled out and providers prepare for a new normal after the pandemic, there are opportunities as well.

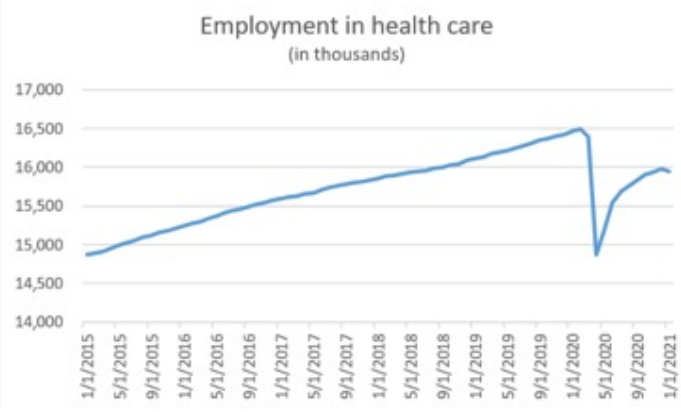
One way to capitalize on these opportunities is through enhanced use of data analytics, which hospitals can utilize to manage their capacity and talent more effectively.

As with other industries, health care providers have had to transform themselves technologically in a way that was hard to envision pre-pandemic. Whether it's dealing with a distributed workforce, serving patients remotely or managing their business more efficiently, health care providers are increasingly trying to do more with less—also known as *capacity management.*

Consider the widespread delays in non-emergency services. As the pandemic raged, hospitals—often under orders from state officials—put off many of these procedures in order to make room for COVID-19 patients.

But just because a pandemic raged did not mean that people stopped having bad knees or broken hips that needed replacing. If anything, the demand for these elective procedures has increased. Now, with pent-up demand for these services, how health care providers handle an influx of patients will likely dictate their success—or failure.

Another emerging health care issue is talent management. Because demand will be difficult to predict, it is critical to ensure that a health care provider's talent pipeline is prepared. As an industry, health care has yet to recover from the **employment losses brought on by the pandemic.** Thus, we expect a need for optimizing the talent in this industry, especially in regard to nurses and other frontline employees.



Preparing for these changes is where enhanced data management comes in. RSM has identified four areas where data analytics can be used to drive an organization forward:

- **Capacity management:** Many organizations have started to conduct exercises to better evaluate their own organization. For example, the average length of stay, known as throughput, is up 11% from this time last year. The need to better manage this measure of patient care will be critical as the vaccine rolls out and as providers look to be better stewards of their limited resources.
- **Scheduling talent:** We expect a return to historical patient volumes this year and into the next, though no one can predict exactly when. Data analytics can be a way to predict how much this demand will stretch a staff. Managing these resources effectively will be another crucial measure of success in the new normal.
- **Attracting the right talent:** Simply acquiring talent is hard enough, but that challenge is compounded by the need to get the right employee on board at the right time. That's where the use of data analytics can help providers monitor the effectiveness of strategies related to bringing staff members on board and training them.
- **Improving your culture:** Organizations have long used surveys to measure employee satisfaction, but with the right approach, analytics can help providers gain a more nuanced understanding of their workforce and drive further improvements.

The Takeaway

The coronavirus has forced significant changes upon health care providers. As the vaccine is distributed and providers prepare for life after the pandemic, how they manage this new normal via the use of analytics will be critical to their success.

About the Author

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What's the Cost of Price Transparency Non-Compliance? Consumer Trust

Hospitals' compliance with a federal price transparency rule that took effect on New Year's Day varies widely. But while the penalty for noncompliance is just $300 a day—"a flea on an elephant financially" for large systems, one expert says—consumer perception of noncompliance is another story.

Research shows that consumers crave transparency around healthcare costs. A recent AccessOne survey found that two-in-three individuals would shop around for care—and 38% already have. Forty-five percent say it's very important that providers publish price lists of common procedures, including half of Gen Xers—many of whom are coordinating care for themselves, their children and their parents.

Although some hospital leaders say the price transparency rule doesn't give people the information they need most—out-of-pocket costs of care—the perception of noncompliance will be one that is hard to shake. That's why hospitals must be seen as making financial information easier to access in an era when positive patient financial experiences are highly valued.

Making Meaningful Moves Toward Transparency

There are two aspects to the price transparency rule. The first requires hospitals to post charges for 300 shoppable services online in a searchable, consumer-friendly format, such as an online price estimation tool. The second demands that hospitals post a machine-readable file that includes the payer-negotiated rates for all services, by hospital, as well as the cash price offered to self-pay patients.

When it comes to price transparency, the best offense is a great defense. In 2021, as consumers delay non-essential care during the pandemic due to cost, there are three approaches to open financial communications that hospitals should consider.

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What's the Cost of Price Transparency Non-Compliance? Consumer Trust

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Initiate conversations about cost with patients. Nearly three-in-five consumers believe it's very important that providers share cost information before a procedure takes place, and about half want to discuss payment plans or financing, the survey shows. Yet 55% of respondents say they haven't had these conversations with their providers. As consumers become more willing to shop around for care before committing to a procedure, addressing financial concerns at the start of the patient encounter—whether at the point of registration or after a cost estimate is provided—provides peace of mind that the hospital will work with them around payment.

One best-practice approach: Connect with patients within 24 hours of providing an estimate. Then, walk patients through the range of payment plans available, from no-interest to low-interest plans, and offer to start the enrollment process.

Keep patients' financial literacy in mind. Consumer survey results show that two-in-five consumers only "somewhat" understand what expenses their health insurance will cover. This could be a barrier to care, given that nearly half of consumers would be somewhat or very concerned about their ability to pay for a medical bill less than $1,000. That's why it's important to find simplified ways to speak with individuals about their financial responsibility.

Financial education should not only be delivered before care is delivered, but also reinforced afterward. Make sure patients understand the difference between the total charge their out-of-pocket cost for care. Explain how the out-of-pocket cost was determined, being careful to define terms such as deductible, allowed amount, and out-of-pocket maximum. More and more, leading hospitals define these terms on billing statements as well.

Give consumers a single point of contact for financial communications. Americans are feeling the economic strain of the COVID-19 pandemic—and it's impacting both their medical and financial decisions. Pairing individuals with a single point of contact for financial communications ensures that when patients have questions regarding the amount they will be expected to pay out of pocket, a billing representative will be there to walk them through their options. It also supports financial continuity in care, which is vital to supporting a positive experience.

One-to-one patient financial care also gives revenue cycle staff greater confidence in conducting complex financial conversations. The more that staff become familiar with individuals' economic circumstances, the better able they are to direct patients toward personalized solutions—from charity care to community resources to no-interest and low-interest payment plans—that most effectively meet their needs.

A More Compassionate Approach to Financial Care

Closing the price transparency gap promotes higher levels of trust with consumers. It also enables access to care when individuals need it most. In 2021, hospitals should approach price transparency compliance as part of a holistic approach to patient financial care, making information easy to access, understand and act upon for consumers.

About the Author

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Three Key Issues for Hospital and Health System Fiduciaries to Consider in a Post-Covid World

In April, we spoke at the HFMA Greater Heartland Spring Conference webinar with CFOs and senior finance leaders from hospitals and health systems across the country. We shared insights on key market opportunities and challenges we see over the next 12-18 months, and we discussed critical decisions that healthcare fiduciaries may need to make regarding their operating, retirement and affiliated asset pools, and how those decisions could affect their financial situation.

With skyrocketing expenses and plunging revenues, hospitals and health systems have faced unprecedented challenges this past year and had to review and even restructure their financial plans to level-set the organization. One common theme that emerged from our conversation was that while much time has been spent on an organization's financial plan and operations, the same may not have been true for the investment program. What is clear is that the strong performance of the capital markets over the past 12 months has rewarded risk-taking. Now is a good time for healthcare fiduciaries to assess their investment portfolios and ensure they are aligned to support the organization's near- and long-term financial plans.

Forty percent of webinar participants stated that while they have not yet made changes to their investment program's strategic asset allocation in light of financial challenges related to the pandemic, they are considering making changes in the future. This also holds true for our own healthcare client base. In reality, most investors are still determining how best to proceed as we gradually shift from crisis mode into recovery mode. We think it is critical for senior finance leaders of hospitals and health systems to carefully consider the impact of their investments on the financial health of their organizations. Here are the key things we believe you and your team should be doing not only to stay afloat, but also to stay ahead of the curve, in a post-Covid world.

1. If the COVID-19 pandemic has materially impacted your system's financial plan, consider making appropriate changes to your investment strategy

Among our client base, some health systems, particularly those in metropolitan areas, have been more severely affected by the COVID-19 pandemic than others. If the pandemic has materially impacted your organization's finances, you should revisit your investment strategy and confirm whether it still aligns with your overall financial goals. If this proves to no longer be the case, you will need to make appropriate changes, preferably in concert with your investment provider. Take a step back and determine whether your investments match your risk tolerance, and whether the amount of risk in your investment strategy is aligned

with what you can afford in your financial plan—so that in case of another significant dip in the markets, your organization's key financial metrics don't take a big hit.

For example, one of our clients was restructuring their financial plan and balance sheet and needed to significantly reduce risk within their long-term portfolio. We worked with them to reduce exposure to risk assets within the portfolio and then set up a schedule to gradually re-risk the portfolio over time in line with improvements in key operational metrics. As operational metrics improved, the organization was able to re-risk so they could reset themselves going forward.

If you have a pension plan, you may want to look at how your funded status has changed, as discount rates have crept up due to rising equities. Additionally, if you do not have a liability-driven investment strategy, now is a good time to think about incorporating one.

2. Review capital market expectations for your investment strategy to ensure they still support your long-term goals

You should also check to see whether your asset allocation still delivers the rate of return you were expecting it to, and whether this takes the latest capital market expectations into account. For example, persistently low interest rates mean depressed bond yields and low borrowing costs, as well as lower long-term capital market forecasts. One area to reassess is fixed income, to which many hospitals and health systems have relatively higher allocations, typically around 30-50%. Certain types of fixed income, such as core fixed income, may have performed well in the past decade, but may not necessarily do as well going forward. Now is a

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Three Key Issues for Hospital and Health System Fiduciaries to Consider in a Post-Covid World

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good time to consider diversifying into other types of fixed income, such as absolute return or unconstrained fixed income.

Consider also looking beyond publicly traded bonds and diversifying your return sources to help improve your portfolios' risk-adjusted returns. Private debt is another area ripe with opportunities. Typically, hospitals and health systems don't have high allocations to illiquid assets, especially if there is concern regarding the impact this may have on the organization's credit rating. However, private debt can help achieve higher returns, with a shorter lockup of six to eight years and less illiquidity than private equity, which could have a lockup of 10-12 years.

3. Be aware of key drivers of risk in your current strategy

Lastly, you should be aware of key drivers of risk in your current investment strategy. These might include equity style factors such as growth versus value, country exposure (such as U.S. versus non-U.S. equities) or duration, credit, etc. Here are a few questions you might ask yourselves to check on your appetite for risk and whether you are comfortable with your risk exposures:

- Does your portfolio have a bias for growth equities, and have you considered the potential rotation in the markets toward favoring value equities?
- Many U.S. institutional investors have a home-country bias toward U.S. equities. How well has this been doing, and how comfortable are you that this trend will be here to stay? While U.S. equities may have outperformed non-U.S. equities in the last 10 years, will this continue?
- What is the duration of your fixed income, and the relative weights between Treasuries, government bonds and credit?

Overall, your investment decisions are vital to keeping both your patients and bottom lines healthy. Moreover, it's important to ensure your team is aligned on these decisions now, before the markets shift yet again.

Author

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Mars-landing' Capabilities Urgently Needed in Denial Management

Back in February, I watched in amazement as NASA's Perseverance Rover touched down softly on Mars. After traveling six and a half months and over 100 million miles, Perseverance aimed for the Jezero Crater, a 5-by-4-mile area featuring dangerous pits, cliffs and boulders. As I watched, I marveled at the precision of each calculated step that led to touchdown, and I celebrated (not always knowing why) whenever the NASA team cheered. NASA prepared for years and applied innovative, automated technology that mapped and analyzed rough terrain to find a precise spot for a flawless landing.

Being a technology geek as well as someone who spends his time thinking about how to streamline revenue cycle workflow and processes, naturally I started to think about denial management. OK, it's not the Mars landing, but it is a complex topic, made mission critical by the unprecedented strain on cash flow at healthcare entities across the nation.

The new technologies that allowed NASA to hit its target to perfection were not available for the early efforts at landing rovers or stationary devices, a few of which crash-landed. In healthcare revenue cycle today, our applications and processes are closer to NASA's older technology. We need to advance denial management into "Mars-landing denial science."

Hitting the wrong spot

Traditional denial management depends on data from remittance advice and other sources, and the denials are typically mapped to categories to identify trends. With this data, and in the spirit of "collaboration throughout the revenue cycle," denials are assigned to the department that caused them, such as health information management, utilization review, clinical service areas and registration. These departments are responsible for investigating the root cause of the denial and implementing improvements to ensure future claims won't meet the same fate.

What if Perseverance landed on Mars, but missed the Jezero Crater? NASA selected this spot following five years of research because Jezero offered the most promise for uncovering whether Mars held life billions of years ago. Missing it by a small margin would have ruined the mission. The problem with traditional denial management is that it frequently lands in the wrong spot—in areas that did not cause the denial and/or in the wrong follow-up work queue. The fault lies in problematic data.

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Mars-landing' Capabilities Urgently Needed in Denial Management

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The data problem

Denial data is inconsistent and potentially misleading. Under HIPAA, the government established national standards for electronic transactions, including codes that explain denials. However, between codes changing periodically and payers interpreting them differently, we've found that the categorization is not simple and cannot be static. In a 90-day period for one of our clients, a reason for denial based on "non-covered service" included eligibility (50%), coding or coverage (45%), and insurance and other issues (5%).

Based upon our client data, payer inconsistency could affect from 10% to 30% of denials that healthcare providers receive. NASA would not be satisfied with anything like that kind of failure rate. When data are faulty, denial management teams make inaccurate assignments and conclusions, including holding the wrong departments accountable.

Denial science

The industry is ready for denial scientists and next generation technology embedded in the business office.

Denial scientists apply scientific method to identify and correct data anomalies. Scientific method consists of making observations, formulating hypotheses, testing hypotheses, drawing conclusions and refining hypotheses. It implies that there is potential to continuously evolve as new hypotheses lead to new conclusions.

As a simple example, consider seeing a large volume of denials related to revenue codes. In health systems, there is typically a manager responsible for the charge description master (CDM) to map revenue codes to each service provided. In traditional denial management, the revenue code denials would be automatically routed to the CDM manager to fix issues. However, in this case the denial scientists identify that only one insurance is sending this denial. It is rare for revenue codes to be mapped differently for each payer, so the hypothesis is that this was not a CDM manager issue. Investigation reveals this was a false denial from the insurance company.

In a much broader context, an approach utilizing denial scientists to investigate denial abnormalities ensures accurate data and enables departments to review clearly defined problems, potentially saving their work on 10% to 30% of accounts. The time saved translates to more time to focus on improving processes or, more importantly, on patients.

Artificial intelligence will likely be the future of denial management. I have noted previously that right now AI is more of a dream than a reality in revenue cycle, however much the term is bandied about. In the meantime we need real-world solutions that:

- Enhance the accuracy of reporting denials and denial trends
- Accurately assign denials to responsible departments so they can identify and correct the root causes
- Simplify/optimize denial workflow and training

A focus on data integrity through denial science can ensure these goals are achieved and denial improvement objectives land precisely where they should, like Perseverance. In today's healthcare revenue reality, such an outcome, however far from the headlines, would be something to cheer.

About the Author

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Four Ways to Leverage the Power and Proven Performance of Contract Management: An Executive Checklist

Develop the best course of action to mitigate risk and understand trends.

1. Adopt an Integrated and Proactive Approach

A savvy contract management system can and should add efficiency to all revenue cycle processes at your hospital or health care organization that are dependent on net revenue while providing seamless integration among disparate data environments. It connects the dots by monitoring complex commercial payor contracts and capturing all rightfully earned revenue. The demand associated with multiple medical facilities, multiple contracts, and multiple data sources requires a unified, systemwide platform. Identifying systemic payor issues and underpayments to recover lost revenue will resolve recurring issues while also providing the foundation to protect long-term revenue.

2. Understand Contract Performance

It is imperative that health care leaders know how well their contracts are performing for both their hospital and ambulatory services. Is your Patient Access office effectively collecting every dollar that is being billed out? Consider the physician's side of the business, where the volume is tremendous, but the variances are slight. How do you collect massive amounts of data into an effective workflow? Or, have you examined other areas for improvement, such as month-end reserves? With a robust pricing engine, your contract management system should lend industry-leading flexibility, accuracy, and efficiency to the entire revenue cycle process.

3. Drive Contract Modeling Through Collaborative Investigation

Whether you lead one hospital or multiple hospitals, a successful contract management system provides significant in-house expertise so your teams can be free to focus on more critical tasks. Take a closer look at how your Managed Care team is negotiating contracts on behalf of the health system. How well is Patient Access collecting on incoming patients by generating patient estimations? Draft "what if" scenarios to prompt discussions across teams that identify and model projected financial impact, such as:

- What if I want to apply an across-the-board charge increase of 6% to my Charge Description Master (CDM) or model today's CDM to determine future financial impact?
- What if I want to change my stop loss?
- What if I want to add new service types or new lines of business to my proposals?

- What if I want to convert a simple contract to a series of complex contracts?
- What if I import cost? What's my profitability at the contract and account levels?

These scenarios will help facilitate negotiations by enabling team members to visualize complex situations that can arise. Examine these scenarios side-by-side to compare and contrast revenue impact across facilities and determine profitability at the contract and claim management levels. This activity will highlight areas where contract management's innovation can leverage historical data and simplify the reimbursement process. Begin with asking the question, "What does my data say compared to my contract?"

4. Garner a Competitive Edge Through Data

Data not only provides a picture of consumer behavior, but it can also be a tool to help adapt to upcoming changes. What steps do you currently have at your medical facilities to manage changes in payor policy and procedures that can impact collections? Through the correct application of health care data analytics, leaders can better understand underpayment trends to mitigate compliance risk. Audits and audit protections apply meaningful context to data variations and map the company's performance.

About the Author

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A Substantive Reimbursement Requirement for Medicare DSH Calculations

According to the Centers for Medicare & Medicaid Services' (CMS) 2016 Outpatient Prospective Payment System (OPPS) Final Rule, for hospitals to potentially qualify for Medicare reimbursement related to any given issue, they must first make a cost report claim for the reimbursement.

Alternatively, if the provider feels the reimbursement associated with a specific item doesn't adhere to current Medicare policy, they must file the cost report under protest. This regulation applies to cost reports starting on and after January 1, 2016.

Additionally, CMS has instructed its Medicare Administrative Contractors (MACs) to accept one amended cost report for the purpose of reporting disproportionate share hospital (DSH) days within 12 months of the initial cost report filing.

While the regulations aren't new, many organizations struggle to complete them correctly. Certain conditions apply, as discussed below, but hospitals have an avenue to help verify days that couldn't have been identified at initial cost report filing, which will be addressed at a later date.

Background

Introduced in the fiscal year (FY) 2015 Inpatient Prospective Payment System (IPPS) Proposed Rule, and then adopted in the 2016 OPPS Final Rule, CMS incorporated a concept into the regulations that was initially introduced by the Provider Reimbursement Review Board (PRRB) Rules in 2008.

The PRRB, from a jurisdiction perspective, had been requiring this same treatment for cost reports going back to those starting on and after December 1, 2008. Then, the 2016 OPPS rule provided a shift from board rules surrounding jurisdiction over an issue to regulations governing cost report payment to highlight the importance of this matter.

CMS cited several reasons surrounding this adoption, including advancing the "interests of administrative finality and efficiency," claiming that MACs would have "an opportunity to correct any misconceptions that the provider may have had" concerning items filed under protest. In addition, CMS asserted this adoption would "enhance CMS' ability to accurately estimate the program's potential liabilities."

Medicare DSH and Medicaid Eligible Days

One item of good news is CMS has clearly acknowledged one area where it may not be possible for providers to claim the appropriate cost at the time of the initial cost report filing.

Specifically, they noted that the documentation of all Medicaid eligible patients claimed in the Medicare Disproportionate Share Hospital (DSH) calculation may not be available due to various items outside of the provider's control. In these instances, CMS states providers will continue to have the opportunity to submit amended cost reports, and the MACs will be required to accept them.

Many hospitals have material changes when retrospectively reviewing Medicaid-eligible days. The additional Medicaid eligible days that can't be documented at the time of filing averages 6.6%.

Timeline to Amend

CMS has instructed MACs to accept "one amended cost report submitted within a 12-month period after the hospital's cost report due date, solely for the specific purpose of revising Medicaid eligible patient days in order to calculate DSH payments after a hospital receives updated Medicaid eligible patient days from the state." See page 266 of the 2016 OPPS rule for details.

Parameters for Amending

Echoing the Medicare DSH appeal requirements set forth in PRRB Alert 10, CMS has placed strict parameters around amending a cost report for additional Medicaid eligible days, and it's not as easy as it may sound. Specifically, the provider must do all of the following.

- Identify the number of additional Medicaid eligible days being sought in the amendment.
- Describe the process used to identify the days claimed in the initial filing.
- Explain why the additional Medicaid days couldn't be verified at the time of the initial filing.

Challenges Hospitals Face in Meeting the Parameters

These requirements pose significant challenges for providers; they require in-depth record keeping and processes to support a hospital's claim for additional Medicaid eligible days that couldn't have been claimed in the initial cost report filing. Many healthcare providers aren't prepared to provide that level of detail, the eligibility verification process descriptions, or an explanation of why Medicaid days couldn't be claimed at the time of the initial cost report filing.

For hospitals that didn't include a state match when preparing the initial Medicare DSH data—or those that use multiple processes, such as utilizing an internal process for the initial cost report filing and then a subsequent review by the hospital or an outside firm—proving the additional days found on a secondary run that couldn't have been claimed in the initial filing is challenging.

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A Substantive Reimbursement Requirement for Medicare DSH Calculations

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Additionally, the hospital will have to defend its process for completeness and thoroughness and prove it captured all the available days at initial cost report filing. This may prove difficult if there are different processes or different players involved in the two looks at DSH-eligible days.

Consequences

It's expected that MACs will strictly enforce these parameters, and it's clear that simply filing an amended cost report with additional Medicaid-eligible days without evidence of a robust Medicare DSH reimbursement process could be subject to rejection by the MAC.

Considerations for Hospitals

With this substantive reimbursement requirement firmly in place, hospitals must have a consistent process for claiming costs for Medicare DSH to fully address the filing of all allowable costs in the initial cost report and protest items. This process will also be necessary when filing timely cost report amendments.

As a result of the requirements, hospitals should:

- Evaluate if in-house or vendor's Medicare DSH processes meet these requirements
- Verify the reimbursement team has the necessary systems, resources, and protocols in place

It's also recommended hospitals put their best efforts forward when compiling initial cost report patient detail to help ensure it's complete and compliant.

Further, hospitals should verify their staff or vendor is monitoring the 12-month deadline. The 12-month window generally ends around the next filing of the cost report, therefore it's often a busy time, and this deadline could get missed.

The absence of a cohesive, consistent process is likely to result in hurdles and obstacles on the way to the successful settlement of amended cost report filings or, unfortunately, the denial of the amendment. If providers don't adhere to the timeline and requirements set forth in this regulation, initial payment determinations, an amended cost report, and any additional DSH reimbursement could fall to the wayside.

About the Author

Michael Newell *is a Partner at Moss Adams. You can reach Michael at michael.newell@mossadams.com.*

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SSR's deep industry knowledge and proven results expand BKD's service offerings related to supply chain, turnaround and margin improvement. Pete and his team join BKD's nearly 600 healthcare-focused professionals and will continue to work collaboratively with the First Illinois HFMA and Chicagoland healthcare organizations in bringing value-added insights and results.

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First Illinois Chapter 2021 Scholarship Program Recipients

Please join us in congratulating this year's First Illinois Chapter's scholarship recipients. The recipients will be formally recognized at the Annual Traditions Dinner on July 15. We hope to see you there!

- **Emma Bremer** received a $5,000 scholarship to McHenry County College
- **Cameron Marr** received a $4,000 scholarship to Texas Christian University
- **Benjamin Harper** received a $2,000 scholarship to Indiana University, Kelley Graduate School
- **Joshua Richards** received a $2,000 scholarship to the University of Notre Dame
- **Madison Yunker** received a $2,000 scholarship to the University of Iowa

Help Continue the Tradition - Make Your Tax-Deductible Donation Today

Over the years many of you have expressed tremendous support and pride in our chapter's ability to assist our future leaders pursue their educational dreams, so please take a moment to consider providing some level of financial support to continue this program.

All donations are 100% tax-deductiible and used only for the scholarship program. Gifts of any size are greatly appreciated. To make your 100% tax deductible donation, **CLICK HERE.**

Thank you for supporting our efforts to make a difference.

First Illinois Chapter Invitational Executive Golf and Scholarship Event 2021

Friday, August 20, 2021
1:00 pm Shotgun Start

Hilton Chicago Oak Brook Hills Resort and Conference Center
Oak Brook, IL 60523-2573

Join us for an afternoon of golfing, camaraderie and good food in support of the First Illinois Chapter's scholarship fund. Annually, the First Illinois Chapter awards $15,000 in scholarship monies to collegebound students of chapter members. The August golf event is the chapter's only golf event of the year and the largest source of funding for this worthy cause.

Located on the 150-acre estate of Hilton Chicago Oak Brook Hills Resort and Conference Center, Willow Crest Golf Club offers premiere course conditions combined with a spectacular natural setting for a memorable golf experience.

- 18-hole, 6,433-yard par 70 course designed by architect Dick Nugent
- Rated one of the "Top 40 Public Golf Courses" in Illinois by Chicagoland Golf
- Multi-tiered tees providing a quality and challenging golf experience for players of all experience levels
- Two putting greens and practice nets

New this year - All scholarship donations are 100% tax-deductiible and used only for the scholarship program. Gifts of any size are greatly appreciated . To make your 100% tax deductible donation, **CLICK HERE.**

For more information about golfing or event sponsorship opportunities, contact Golf Event and Partnership Coordinator at ecrow@firstillinoishfma.org.

First Illinois Chapter 2021-22 Officers and Board of Directors

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Katie White, FHFMA, CPA

Officer: 2021-22 Secretary/Treasurer

Katie is a director of client financial reporting at Innovista Health Solutions. She has been in healthcare finance for over 10 years with a focus in value and risk-based products for Independent Physician Associations (IPAs)/Accountable Care Organizations (ACOs), Medical Groups, and Physician Hospital Organizations (PHOs). She has been a member of the First Illinois Chapter HFMA for more than a decade, having served as the assistant treasurer and as a member of the chapter's Finance Committee. Katie has enjoyed the connections and friendships she has made working with other members of the chapter and finds that to be the most rewarding part as a member. She looks forward to serving the chapter as the secretary/treasurer in the upcoming year.

Connor Loftus, FHFMA, CRCR

Board of Directors: Term of Office 2021-23

Connor is a manager in the Performance Improvement Practice at Claro Healthcare, where he began his career in healthcare finance seven years ago. He works primarily with hospitals and healthcare systems across the country to improve operational and financial performance. Connor has been a member of the First Illinois Chapter HFMA for the past seven years, first as a volunteer on the Certification Committee and then co-chairing the committee for the last three years. He has enjoyed helping chapter members obtain their Certified Healthcare Finance Professional (CHFP) and other HFMA certifications, getting to know other healthcare finance professionals from the chapter and the region, and is looking forward to serving on the chapter's Board of Directors.

Stu Schaff, FHFMA, CVA

Board of Directors: Term of Office 2021-23

Stu has been a consultant to healthcare providers for 15 years with a focus on physician compensation, physician-hospital transactions, and medical group performance improvement. He has been a member of the First Illinois Chapter HFMA for more than a decade, has served as a member and co-chair of several chapter committees, and is a peer reviewer for the HFMA's *hfm* magazine. Stu has enjoyed meeting other local healthcare finance professionals through HFMA and is honored to serve the chapter's members on its Board of Directors.

2021 First Illinois HFMA Upcoming Educational Events

Education News

Visit the chapter website at firstillinoishfma.org for up-to-the minute chapter events and news.

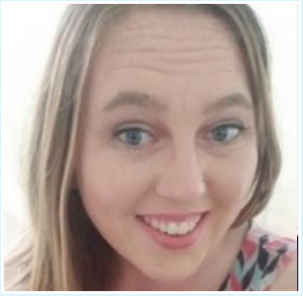
Fall Summit – October 2021

More details regarding dates and format will be available soon.

First Illinois Chapter's CHFP Practicum Goes Virtual and Regional

The First Illinois Chapter has offered an annual CHFP practicum for several years. Like many things, however, this year's event was different.

Planning and hosting a virtual event are quite a bit different than for an in-person event. Just ask Meagan Edgren, CHFP, a financial analyst in revenue accounting at Northwestern Medicine in Chicago, and Connor Loftus, CFA, a manager with Claro Healthcare in Chicago, the co-chairs of the First Illinois Chapter's certification committee. Their comments about pulling together the Chapter's first virtual CHFP practicum that took place Feb. 4-5 have been combined in this Q&A.



Megan Edgren said it was decided early to include other HFMA chapters in the virtual CHFP practicum.

Connor Loftus said networking is an important element of the practicum.

How was this year's event different?

Typically, it's a one-day, in-person event designed to help individuals complete their journey toward becoming a Certified Healthcare Financial Professional (CHFP). It also provides an opportunity to network with already certified chapter members. Due to the pandemic, however, we decided to try hosting the event virtually. We also decided pretty early in planning to include the other HFMA chapters in our region in hopes that their members also would benefit.

So together with our committee and the certification chairs from the other Region 7 chapters, we planned a two-day virtual course focused primarily on the second module of the CHFP exam: Operational Excellence.

Did you encounter any challenges along the way?

Our biggest challenge was navigating the new HFMA e-learning platform. The transition to the new site occurred at the same time as our event. Modifying the program to accommodate the virtual environment also required extra thought to ensure participants realized the benefits we've seen with the in-person sessions of the past.

What was the outcome?

Despite the challenges, six of the 34 individuals in the practicum cohort attempted the CHFP Operational Excellence exam, with a pass rate of nearly 70%. The others plan to take the exam in the near future. We will continue to follow up with those who did not attempt or pass the Operational Excellence exam to ensure they are well supported.

What was key to planning and hosting a successful event?

One of the biggest keys to our success was our instructor Christoph Stauder, FHFMA, CPA. He's a past president of the Oregon Chapter and has taught HFMA certification classes since 1988. Additionally, our certification committee put in extra outreach effort to find chapter members interested in pursuing the CHFP certification, help them sign up and support them through completion of the exams.

Any advice for other HFMA chapters interested in hosting a similar event?

Try to get individuals from all aspects of healthcare involved – not just providers but also payers and consultants as well as a range of positions and experience levels. This creates more unique discussion around the case studies as everyone brings their own perspective, background and experiences to the solution.

About the Author

Crystal Milazzo *is a writer and editor with HFMA, based in Beaverton, Oregon. Reprinted, with permission, from the May 2021 edition of hfm magazine.*

Welcome New Members

February 10–May 26, 2021

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Revenue Cycle Content Training
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Ellie Finnerty
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Welcome New Members (continued from page 20)

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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.

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 2021	September 1, 2021
February 2022	January 2, 2022
June 2022	May 1, 2022