hfma
first illinois chapter

February 2024

FIRST ILLINOIS SPEAKS

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First Illinois Event

You are invited to take a break from your day to learn from, and interact with, Revenue Cycle leaders from Rochelle Community Hospital, Northwestern Medicine at Central DuPage, University of Chicago, RUSH University Medical Center, Advocate Aurora, Northwestern Memorial and Silver Cross Hospital as they share how they are highlighting a patient-centric approach to revenue cycle and their areas of focus for 2024 and beyond.

In addition to robust panel discussions that open and close the program, other presentations include a range of topics focusing on pressing Revenue Cycle issues. For example, Thomas Moran, MD, Vice President and Chief Medical Officer at Northwestern Medicine at Central DuPage Hospital and Dan Burke, Vice President, Claro Healthcare will provide an overview of patient status determination and medical necessity denial processes during their presentation on *Observation Management and the Impact of Managed Medicare Payors*. Cheri Lockhart, PFS Coordinator at Rochelle Community Hospital and Nick McLaughlin, CEO of Breez Health will provide an overview of the Protect Illinoisans from Unfair Medical Debt Law going into effect July 2024 and outline a new vision for FAP screening during their session on *Effective Practices for Meeting New Billing Act FAP Screening Requirements.* Have we caught your attention to learn more about the conference?

Mark your calendar for **March 14**, and join your colleagues at the University of Chicago Medical Center - Burr Ridge Revenue Cycle Office, Burr Ridge, IL.

CLICK HERE to register today!

Message From Our Chapter President

Dear Friends and Colleagues,

As we round the corner into our last few months of our 75th year as a chapter, I can't help but reflect on the amazing events our team has put on this winter. Though a mild winter here in Chicago, it was anything but that when it came to our chapter events, get-togethers, and collaborations. I truly mean it when I say we have some of the best people in the healthcare industry who are the most dedicated to our healthcare community. It's an honor to be a small part of it.

Our annual Fall Summit in October, a staple for our chapter over the past 10+ years, was awesome. So many new faces. Lead by Greg Burdett and supported by an outstanding committee, the agenda for the event was relevant, insightful, and engaging. All aspects of healthcare finance were touched on. Some of my favorites included AI and VBC contract management, hospital reimbursement, keynote speaker Ann Jordan, HFMA's new president, and closing panel of experienced CFOs. A special shout out to Shelby Burghardt, co-chair of our programing committee for her experience and support of this event!

In November our DEI committee held its first joint event with N.A.H.S.E Chicago/Midwest, UChicago Medicine, and Cook County Health to discuss the cost of healthcare and homelessness. For me, this important discussion highlighted and added fuel to the energy in the room on how important it is that we keep innovating in financing and supporting our communities in achieving standards of care and life for all. Appreciation to Ashley Teeters and Nicole Fountain for bringing this amazing panel together.

December was a month to celebrate and break bread with our volunteers who give so much of their time and energy to our chapter and members. At our annual holiday dinner, it was great to see everyone, catch up on personal and professional happenings and celebrate the new year. In the spirit of community support, we were also able to host a coat and food drive for The Boulevard of Chicago. Thank you to all who contributed!

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First Illinois HFMA President's Message Continued

The DEI committee was at it again in January collaborating with NALHE and Sini Chicago for a special Q&A with Dr. Ngozi Ezike. I have had the privilege of hearing Dr. Ezike speak in the past. The passion and energy she brings to serving a safety net community is contagious. Our progress in healthcare equality is exemplified by those she encounters. Thank you, Dr. Ezike, for your time and speaking with our members and members of NALHE.

To kick of February, we held one of my favorite events, the newly renamed Payer and Provider Summit (formally known as the Managed Care Program). The work this committee does to put on a sold-out event year--over-year and quality content with updates from payer speakers is why I love this event so much. Cathy Peterson and Jim Watson who led this committee, are not only the best, but have become good friends. Thank you both for all that you do with this program and shout out to the rest of the committee on brining this event to life.

We have accomplished so much already this year, but we are only getting started. We have a great line up of events this spring held at provider locations for a more intimate setting. Don't miss our Revenue Cycle Event, March 14 at UChicago, Burr Ridge, and Accounting and Reimbursement Event May 16 at Advocate, Oak Lawn. Excited to be on site at these locations and seeing you all soon!

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Health care industry eyes challenges and opportunities in the coming months

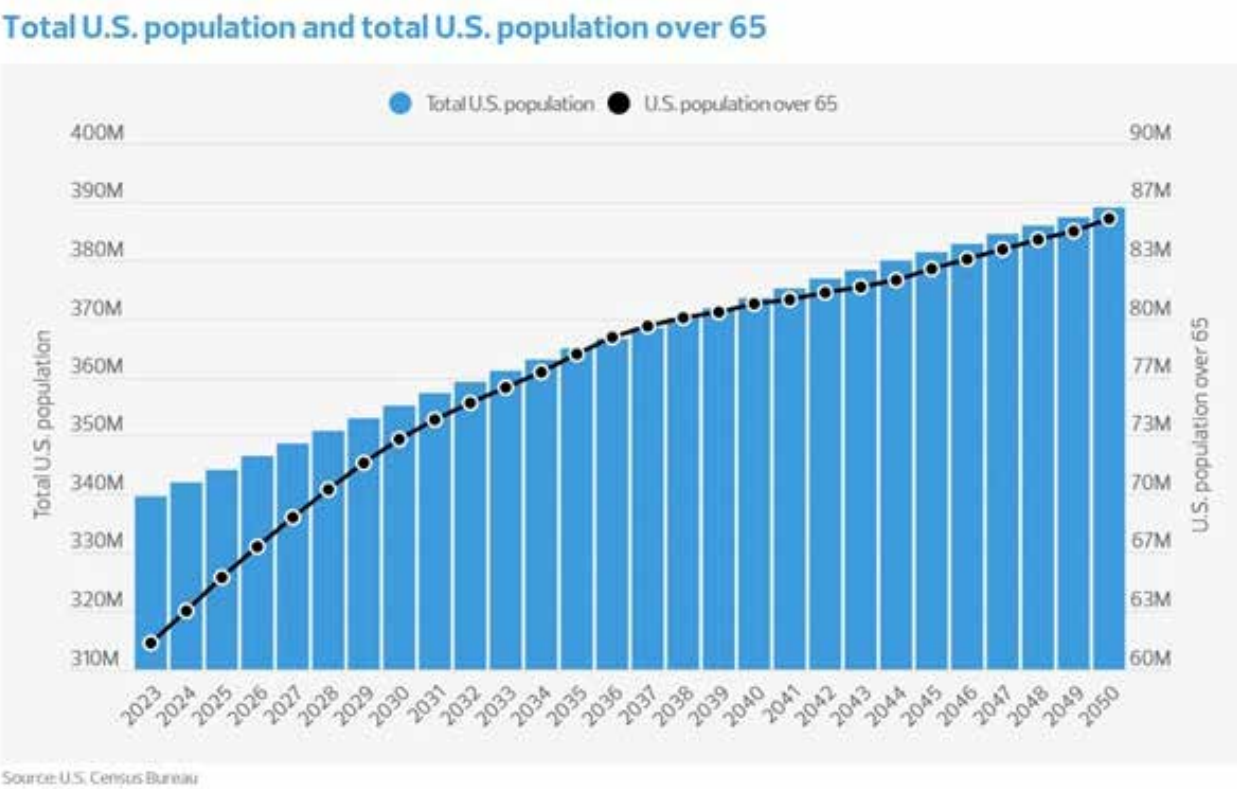
From labor challenges to the booming demand for senior and home health care, what's in store for 2024 in the health care industry?

Labor challenges continue, but AI could provide answers

Health care organizations will continue to experience economic headwinds in 2024. Prevalent labor challenges will add to uncertainty.

Recent data from the American Association of Colleges of Nursing shows registered nursing and bachelor of science in nursing enrollment figures for the 2022–23 school period dropped by 16.9% compared to the prior enrollment period. The number of physicians is expected to decrease as well; the Association of American Medical Colleges projects a shortage of 37,800 to 124,000 doctors by 2034. Contributing to this decline, four out of 10 physicians will retire by 2034, according to the AAMC.

Meanwhile, the U.S. population is expected to grow 7% by 2034, with the number of people over 65 increasing by 25%, according to the U.S. Census Bureau. The need for physician services and overall health care will likely continue to increase as Americans age.



Source: U.S. Census Bureau

Is generative AI the answer to the labor challenge?

Health care providers and the systems that support them are at a crossroads. How can they meet future demand amid a decreasing workforce? Some are looking to emerging technology solutions, such as generative artificial intelligence, to address pervasive challenges.

To that end, organizations should identify specific processes and care solutions for which technologies could be safely implemented. Streamlining the prior-authorization process by automating the collection and review of patient data to enable timely care for individuals, providing remote patient monitoring by reducing or predicting adverse events like a fall in a hospital setting, and enhancing the patient messaging experience by assisting a physician with generating a tailored response are a few examples. However, careful evaluation and organizational AI literacy are key to adoption, risk mitigation and effectiveness.

In addition, a comprehensive governance framework at the enterprise level is essential. The following diagram outlines the key considerations health care organizations should address when implementing an AI governance strategy.

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Health care industry eyes challenges and opportunities in the coming months (continued from page 5)

Technology giants with generative AI capabilities continue to announce partnerships with major electronic health record software companies to implement generative AI solutions for various hospitals across the nation. However, before adopting these new offerings, strategic health care organizations should promote awareness and enhance AI literacy among their workforce. Strategies could include implementing an educational program focused on the benefits, risks and ethical implications of using generative AI in health care; providing access to AI-powered clinical decision support systems for hands-on learning experiences; and ensuring the latest developments in generative AI technology are communicated to the workforce.

The takeaway

While executives on the midyear earnings calls of technology-focused health care providers acknowledged that emerging technologies will be a tailwind to help meet the growing demand for service, ensuring awareness and acceptance among the organizational workforce is key to the future success of these solutions, including generative AI.

Health care deal activity to remain steady amid elevated interest rates

While deal volume in 2023 remained lower in comparison to 2022 and 2021, mergers and acquisitions in the health care sector remain a popular option for investors as they continue to seek value in an environment of onerous capital costs underscored by high interest rates and tightening credit requirements.

Cross-market opportunities

Cross-market consolidation among hospitals and health care systems will continue as organizations look to manage costs and gain operational efficiencies.

Organizations exploring M&A are focusing on potential staffing improvements, expansion of services and optimization of patient throughput. Hospitals and health care systems have recently focused on cross-market consolidation, whether in state or out of state. Below is a list of recent cross-market announcements where combined operating revenues exceed $1 billion.

Cross-market merger announcements*

Year announced	Larger system by state location	Operating revenues ($B)	Smaller system by state location	Operating revenues ($B)	Combined revenues ($B)
2021	Utah	$7.70	Colorado	$2.90	$10.60
2021	Michigan	$8.30	Michigan	$4.60	$12.90
2022	Michigan	$5.60	Michigan	$1.50	$7.10
2022	Wisconsin	$2.80	Minnesota	$2.60	$5.40
2022	South Dakota	$7.10	Minnesota	$6.40	$13.50
2022	Illinois	$14.10	North Carolina	$9.00	$23.10
2023	Missouri	$6.30	Missouri	$2.40	$8.70
2023	California	$95.40	Pennsylvania	$6.90	$102.30
2023	New Mexico	$5.50	Iowa	$4.30	$9.80

Source: Kaiser Family Foundation

*Operating revenues come from audited financial statements covering the fiscal year prior to the merger announcement

One tailwind helping cross-market mergers is the increase in digital enhancements throughout the health care industry. Investment in robust electronic medical record platforms and virtual tools such as telehealth and back-office platforms has reduced geographical barriers. Investment in digital technologies, coupled with higher inflation and interest rate costs, will continue to encourage hospitals and health systems to look for complementary capabilities with organizations beyond their current geographical borders.

Private equity continues to adore health care

Private equity continues to find value in health care as well. According to Levin Associates, private equity transactions through June 30 have accounted for 36% of health care M&A activity in 2023, a figure that hovered around 40% in 2022 and 2021.

Private equity's focus on improving operational efficiencies and overhauling back-office functions like scheduling, clinical coding, billing and financial planning makes health care an attractive market for private equity funds as well as strategic acquirers. Independent physicians' offices today are overburdened by administrative back-office tasks that diminish the time available for patient care. Private equity sponsors can alleviate that stress and

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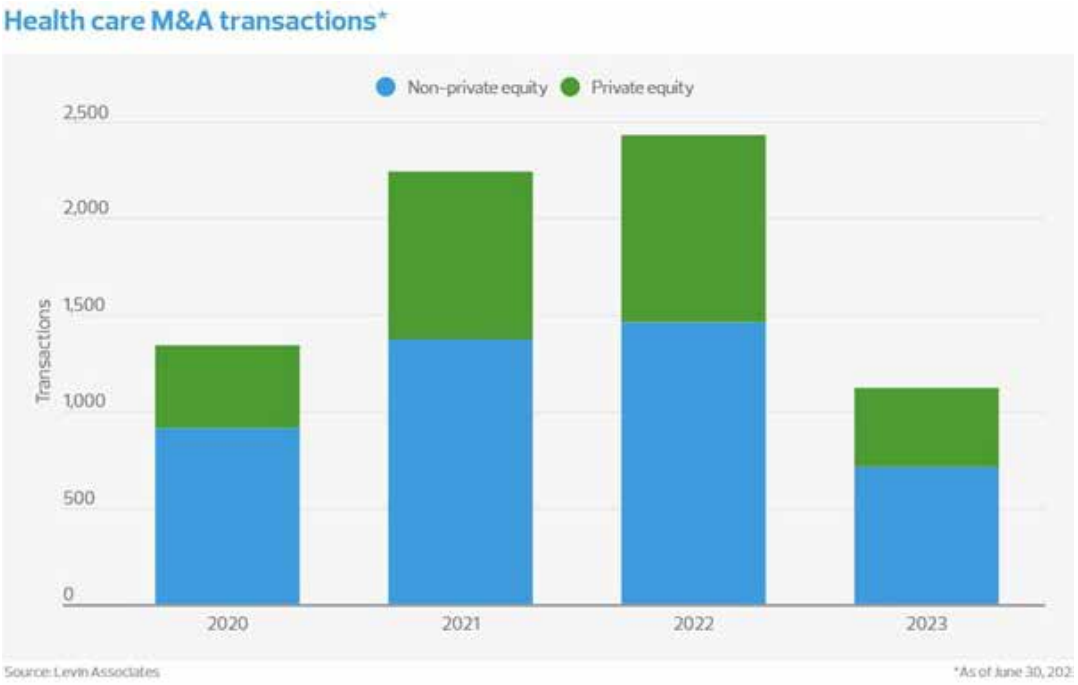
Health care industry eyes challenges and opportunities in the coming months (continued from page 6)



find their strategic role in the health care ecosystem by acquiring these practices, adjusting procedures to scale and managing the administrative functions.

However, while health care can be an attractive endeavor for private equity, regulatory risks and barriers continue to emerge as well. Recently, the Federal Trade Commission filed suit against a private equity firm, scrutinizing how it "rolls up" or consolidates practices, a common strategy for many private equity groups investing in health care organizations. Health care will likely continue to see heightened scrutiny around private equity strategies.

The takeaway

M&A activity in the health care industry remains stable. The desire to increase market share or achieve economies of scale will continue to drive deals. As elevated interest rates and higher capital costs continue, hospital and health system leaders should consider how cross-market mergers and private equity investors can help them meet their goals for cost-efficiency and higher quality.

Senior care looks to technology to address labor woes and patient engagement

The senior care labor force has yet to recover to pre-pandemic levels. The latest U.S. Census Bureau data indicates that approximately 76.4 million baby boomers, or those born from 1946 to 1964, will be fully eligible for Medicare by 2030. Though both senior care and home health have added thousands of jobs so far in 2023, the aging population and growing demand for services continue to outpace labor numbers.

The steady surge in the senior population has created booming demand for home health care—from health monitoring and hospice care to occupational therapy and skilled nursing care. Home health care is positioned to answer growing demand for senior services by offering flexibility and convenience to consumers, wherever they are along the continuum of care. However, the sector will continue to seek out additional solutions to minimize caregiver burnout.

Bridging patient needs and workforce demands

Today, sophisticated technology is essential for the delivery of home health care and senior care. It provides critical solutions to bridge workforce constraints and patient needs, and can help to fuel overall growth. For instance, generative artificial intelligence and remote patient monitoring continue to grow in effectiveness and accessibility. These emerging technologies represent new ways to reach patients and provide them with personalized care.

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Health care industry eyes challenges and opportunities in the coming months (continued from page 7)

In addition, the sector should expect to see greater adoption of voice and video in senior and post-acute care services next year, driven in part by an increase in digital health companies focused on aging. Voice- and video-based technologies allow older adults to maintain their independence by accessing information on demand and connecting with others remotely.

Senior care organizations can provide customizable experiences for their clients through these technologies to drive resident engagement. Staffing issues aren't going away, but automation can give clinical and nonclinical staff more time in their day to focus on patients and residents. Automation of repetitive tasks such as filling out forms related to employee onboarding or patient data can boost efficiency in clinician and operational workflows.

In addition to implementing automation for documentation, many senior care organizations are turning to robots for help. One example is the use of dining robots, which are replacing people for repetitive tasks such as running meals and dirty dishes to and from the kitchen. This gives dining staff more time to talk with residents during meals.

The next wave of adults eligible for senior living could be just what the industry needs to boost occupancy and operating margins as labor and development challenges linger. From getting creative on supplementing labor to implementing technology to support operations, senior living providers must innovate to survive while high interest rates and other market forces dampen new growth.

Senior living operators face elevated expenses and tightening margins; even as the client census improves, uncertainty on the capital side will continue to slow down growth. With the runway for distressed properties shorter than ever before, senior care organizations are having hard conversations with lenders. However, long-term positive market conditions will ultimately mean that the winners will pick up more management contracts and capital providers could be the losers.

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This article was originally published as RSM's 2024 health care industry outlook.

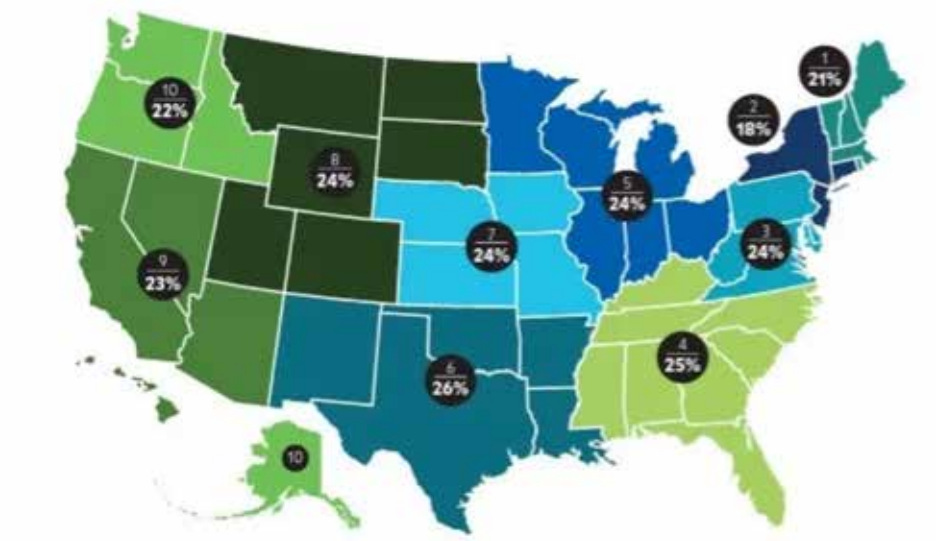
How to determine appropriate patient status and navigate observation-level care

Reprinted From hfm

The Financial implications of ensuring appropriate patient status throughout a hospital stay are substantial, so it is in organizations' interest to enhance the process.

Challenged by the status determination process, many hospitals often inappropriately admit patients into observation or inpatient status. The nature of the challenge is illustrated in the exhibit below, which shows that observation rates among different CMS regions vary by as many as 8 percentage points.

Fee-for-service Medicare observation rates by CMS



Source: Analysis of publicly available Medicare fee-for-service data

Choosing the most appropriate designation is vital to ensure high-quality patient care is delivered and that financial reimbursement is appropriate for services rendered. To augment net patient revenue while prioritizing patient outcomes, hospitals and health systems should consider whether they need to improve their processes for determining patient status.

Financial implications of status determinations

Appropriate care delivery and optimal patient outcomes are the primary priorities, which can be achieved irrespective of status. Nevertheless, the ability to determine appropriate patient status and level of care has significant implications for payment.

Payer reimbursement typically differs between observation and inpatient status. While the nuances of agreements may vary across payers and facilities, reimbursement for observation discharges often is lower than for inpatient care.

Consider a standard inpatient case that may be reimbursed at about $6,500, based on CMS regulations, compared with $2,000 for a standard observation discharge. In this example, there is a $4,500 variance for a case that might have received the exact same care but was discharged with an inappropriate status. This variance is similarly prevalent with other payers, meaning documentation of medical necessity and deliberate processes for status determination can have a significant impact on net patient revenue.

On the other hand, while inpatient status potentially generates more revenue, the payer might deny that revenue and revert payment to observation status if the patient does not meet criteria for inpatient status.

Appropriate status determination and discharge status can also have significant Financial consequences for the patient. A discharge from observation status may result in a higher out-of-pocket expense compared with an inpatient discharge if not performed in the most fiscally appropriate and timedependent manner. Since observation status is an outpatient service, a Medicare patient pays 20% of billed charges as coinsurance.

However, a well-run and fiscally responsible observation stay can result in out-of-pocket expenses not unlike a daily deductible for an inpatient stay. Such an outcome depends on determining appropriate status, minimizing unnecessary testing and treatment, and expediting discharge or, if necessary, transition to inpatient status.

Best practices for observation management

Implementing the following approaches can help hospitals and health systems align care delivery and revenue cycle functions, ensuring patients are in the right status and receiving the appropriate level of care throughout their hospital stay.

Care team collaboration. Collaboration and communication among the care team members (physicians, utilization management staff and nursing staff) are critical to a successful observation management program. Keys include deliberate discussions between care teams regarding patient needs and plans of care, as well as documentation within the medical record that clearly substantiates medical necessity (see the sidebar "Observation status hinges on medical necessity" below).

A dedicated huddle to focus on observation patients also enables communication and collaboration. This huddle serves as a forum for case management, utilization management

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How to determine appropriate patient status and navigate observation-level care

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and physician advisers to review all observation patients at least once a day. It also provides an effective means for highlighting barriers to discharge, necessary follow-up actions and status conversion potential.

Status determination at the portal of entry. Determining status appropriately in the emergency department (ED) reduces the potential need for a conversion to inpatient status later in the stay and helps place the patient in the proper care setting.

In facilities with leading patient-status processes, case management or utilization management staff in the ED assume ownership of the initial status determination process. These staff are integrated into a collaborative process between ED clinicians and hospitalists that focuses on effective communication, accurate initial medical necessity reviews and timely provider documentation of patient needs and acuity.

Integration of physician advisers. A sophisticated program utilizes physician advisers as engagement liaisons between case management, utilization management, clinicians and administration. Advisers can aid in status determinations through secondary reviews of observation cases and can assist the utilization management team and physicians throughout the process. Advisers may also be involved in additional processes, including payer appeals, denials management, and education for clinicians and other quality improvement efforts.

Utilization of observation units. Dedicating provider staffing models to observation medicine ensures appropriate status designation and improves outcomes for this patient population. Much has been published on ways to implement observation-status designation, but all data point to the superiority of dedicating physician, nursing and ancillary staff to the process of observation medicine and the creation of dedicated units.

Devoting space and staffing to observation status allows the focus to remain on one type of patient and one type of medicine. Though the patients and their conditions can vary, the types of patients and conditions do not.

This uniformity allows for creation of protocols for conditions that historically tend to meet observation criteria, fitting nicely into a standardized approach. It limits variation in the general pathways for workup and treatment of these conditions, creating efficiency and, in turn, cost containment. That's especially key for observation stays because reimbursement tends to be significantly less per patient encounter compared with inpatient status.

Dedicated observation units repeatedly have shown far superior metrics regarding length of stay and cost to the facility compared with patients in observation status who are not in a dedicated unit. Working to ensure most if not all appropriate observation patients fall under the purview of staff on dedicated units becomes a matter of not only clinical but also Financial importance.

Patient outcomes are improved through the use of protocols for specific diagnoses that are tailored to short-stay observation medicine. Such protocols can eliminate unnecessary testing and potentially unwarranted treatments that could prolong the patient's hospital stay at least and result in patient harm at worst.

Dedicated staff who consistently adhere to the same process better understand the expectations and can deliver a higher quality of care, resulting in higher patient satisfaction scores, improved clinical outcomes and, invariably, cost savings.

These savings can be seen in two distinct forms:

- On a per patient basis from the efficient workup and expedited treatment of a patient in a dedicated observation unit, specifically through less testing, consultation and patient time spent in the facility
- In reduced bed hours in the facility, thus opening beds for higher-revenuegenerating patients

An urgent priority

Appropriate status determination is a nuanced process that has significant implications for patient care and reimbursement. Fortunately, the steps needed to improve this process are well within reach for hospitals.

Observation status hinges on medical necessity

Observation status is an outpatient designation that allows providers to place a patient in an acute care setting to monitor the need for an inpatient admission and diagnose and treat disease pathologies that may respond or improve quickly. Common signs and symptoms including chest pain, shortness of breath, nausea/vomiting/stomach pain and fever might result in patients being placed in observation for further testing.

Patients who have been appropriately assigned to observation status typically have much lower acuity and severity of illness compared with patients receiving inpatient care and are commonly discharged from the facility within 24 to 36 hours.

A bedded observation patient can be appropriately converted to inpatient status if needed. Medical necessity, the principle defined by CMS and other payers, establishes the distinction between observation and inpatient levels of care.

Medical necessity is documented within the medical record and should clearly and precisely illustrate the complexity of medical factors and the reasoning for the required inpatient admission. Inadequate documentation can result in payer denial of inpatient authorization and refusal of payment for services delivered.

Examples of how medical necessity can support an inpatient admission

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How to determine appropriate patient status and navigate observation-level care

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Appropriate for observation status

- Patient complaint of shortness of breath
- Abnormal labs
- Vital signs stable
- Will need to monitor
- Consult with nephrology and cardiology

Appropriate for inpatient status

- Patient complaint of shortness of breath with imaging findings of new onset of congestive heart failure
- Lasix 80 mg IV given
- Oxygen saturation 87% on room air, improved to 100% once on 4L of O_2
- Abnormal renal function, consider acute kidney injury
- Will need cardiology and nephrology consulted
- Patient appropriate for inpatient level of care, anticipate 2-midnight stay

Importance of physician documentation for patient stays

Appropriate documentation in the medical record has been a mainstay of coding and billing, and more recently the basis for determining patient status as well.

Both physicians and utilization management staff can make the best upfront determinations regarding whether a patient would be best suited for observation or inpatient status. Each patient should be viewed in totality as opposed to simply on the basis of one problem at a time. It is hence vital that as much appropriate and useful information as possible be entered into the medical record up front.

All staff – including providers and utilization management, coding and billing – must understand the various components to documentation:

Appropriate chief complaint

- Supporting diagnoses
- Acknowledgment of physical examination
- Historical and workup findings (e.g., lab, imaging)
- Assessments of patients
- Plans for treatment and/or further workup

Documentation should support medical necessity. All who review the medical record must fully understand the primary and secondary diagnoses, the recommended treatment and additional workup, the overall level of concern for the patient, risk factors that make the patient more complex, and the patient's anticipated trajectory during the hospitalization.

The need for comprehensive, precise documentation

The clinician must offer as many potential diagnoses as possible to support better understanding of the presented chief complaint. This list should contain all acute pathologies, including new acute conditions and chronic conditions.

Additionally, any significant comorbid disease that could factor into the level of complexity or affect the patient's hospital stay should be mentioned in the medical record to support documentation indicating the trajectory could be longer or more complex than the presenting acute condition suggests.

Equally important is highlighting abnormal lab, imaging and vital-sign findings. If a patient has vital-sign abnormalities such as transient hypoxia, tachycardia or tachypnea, but no such acknowledgment is in the record, anyone reviewing the chart (including other clinicians) would be unable to make a fair determination about the patient's stability or potential hospital course. Such information can be the difference between inpatient and observation status. More important, a lack of information can prevent other clinicians from efficiently ascertaining a patient's acuity.

Why the impetus is on clinicians

It can be difficult for non-clinicians to recognize whether patients have the potential to get sicker more quickly and thus require a higher degree of services and more time in the hospital. Therefore, it is important for trained clinicians to make this distinction. This step can have important consequences for status determination.

Consider young, otherwise healthy patients with no comorbid disease who present with pneumonia. Clinicians know that in most cases, those patients very well might not need hospitalization. However, any such patients who have significant comorbid disease are at considerable risk for both failed outpatient treatment and longer hospital stays. Properly relaying the potential for higher-level needs can be the difference between observation versus inpatient status.

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Here's Where Healthcare is Headed in 2024

Healthcare CFOs are facing a challenging year ahead, one where high interest rates, ongoing economic uncertainty, and elevated costs will continue to impact financial stability across the industry. However, the outlook isn't all bad: According to a recently published 2024 Healthcare CFO Outlook Survey from one of the leaders in strategic technology and business advisory services, that polled healthcare CFOs on their outlook for the year ahead, healthcare leaders are expecting a return to growth this year, with 79% anticipating revenue increases.

Following are some insights taken from the survey:

To realize this growth, healthcare CFOs will have to navigate ongoing challenges and move quickly to take advantage of new opportunities. Read on to learn the top three industry trends that healthcare CFOs need to know to succeed in 2024.

1 Bond and Loan Covenant Violations Are a Major Risk

While most CFOs are optimistic about growth in 2024, 41% admit they are concerned they may violate their bond or loan covenants in the next 12 months. Additionally, while actual violations are trending downward year-over-year, 52% report they violated their covenants in 2023.

At the same time, cash on hand remains an issue: Only 35% of healthcare organizations reported having more than 60 days of cash on hand. It comes as no surprise that 39% are planning to adjust their revenue cycle management to improve liquidity this year, making it their top-cited financial improvement strategy.

Healthcare CFOs need to not only revisit their revenue cycle management, but also develop a sustainable revenue strategy that combines cost optimization with strategic investments, with an eye towards long-term financial stability.

2 Healthcare Is Using Generative AI for Clinical Decision Support

Historically, healthcare has been slow to adopt new technologies. But that seems to be changing: BDO's survey found that 98% of healthcare organizations are already piloting generative AI programs in 2024, with 46% building their own proprietary platforms (likely on top of an existing solution).

Furthermore, AI use isn't restricted to administrative functions: 39% of healthcare CFOs are using generative AI to create treatment plans. Clinical decision support is a key opportunity for healthcare providers to leverage AI, but it comes with serious risk: roughly one in four healthcare CFOs say their top generative AI risk is its potential to generate or act on incorrect information. Healthcare leaders exploring generative AI need to keep a clinician in the loop to ensure the AI output is accurate and appropriate to the patient's needs.

3 Shifting Investment Plans Could Impact Care Access

Specialty services like cardiology, oncology, and dermatology will see more capital in 2024, with 52% of CFOs reporting they plan to increase investment in these areas, likely because these services can generate significant revenue for healthcare organizations. At the same time, primary care – a major access point for many patients – is seeing decreased investment, with 42% of healthcare CFOs planning to divest this year.

Primary care has become a target for divestment largely due to significant cash flow pressures and a shift in site of service towards the retail market. However, less investment for primary care could reduce access to care for many patient populations, making it more difficult to receive preventive care. The result could be higher volumes of more acute patients, putting an even greater strain on the healthcare system in the long term.

Healthcare CFOs need to first consider the needs of their patient population before making any divestment decisions. While some services, like OBGYN services, may be expensive to maintain, they are crucial to the patient population the healthcare organization is serving, and as such, the top priority must be maintaining access to these critical care offerings.

Closing Thoughts

The road ahead for healthcare isn't an easy one – healthcare organizations will need to navigate continuing challenges that have no simple answers. However, by understanding the financial, clinical, digital, and operational landscape, healthcare CFOs can make their organizations more sustainable and stable, even as they remain surrounded by instability.

About the Author

Jim Watson *is a principal at BDO USA, LLP. You can reach Jim at jwatson@bdo.com. Click on the following link to read BDO's 2024 Healthcare CFO Outlook Survey on what the healthcare landscape will look like in 2024 and how you can successfully navigate it.*

How Illinois Hospitals Can Comply with and Overcome Operational Challenges of the New Screening Act

A new law that took effect in Illinois on January 1, 2024, called the Fair Patient Billing-Screening Act [1], requires hospitals in the state to screen all consenting uninsured patients for eligibility in state and federal health insurance programs as well as financial assistance programs when they are admitted. Hospitals must apply the screening requirements of the act to all services provided by the hospital on or after July 1 of this year and are not allowed to pursue collection actions against patients if they have not completed these requirements.

The number of people without medical insurance is increasing and many are unaware they may qualify for government assistance programs such as Medicaid. A 2021 study by the Illinois Department of Healthcare and Family Services found that more than 900,000 Illinois residents are living without health insurance – and about a third of them qualify for Medicaid but are not enrolled.[2]

Enrolling in these programs can be confusing for patients and often involves the time-consuming task of filling out a lot of paperwork. Additionally, the process of screening patients for eligibility for federal, state, and local programs and helping with enrollment requires a high level of expertise and time to devote to the follow-up process.

Under the new law, an uninsured person is considered any person receiving services from the hospital and any individual who is the guarantor of the payment of services who is not insured by a health care plan and who is not a beneficiary under a government-funded program, workers' compensation, or accident liability insurance. If an uninsured patient agrees to be screened, the hospital must screen the patient during registration unless doing so would delay the patient's care. In such instances, the hospital would need to screen the patient at the "earliest reasonable moment." If an uninsured patient declines or fails to respond to a hospital's screening then the hospital would need to document within the patient's record the patient's decision, the date of such decision, and the method by which the patient declined or failed to respond.

Hospitals must also track all uninsured patient declinations and failures to respond to all such offers in the uninsured patients' medical records. Hospitals must also post on their public website the total number of uninsured patients who decline or fail to respond to such offers, along with the five most frequent reasons cited for doing so.

While these new requirements will reduce the financial medical burden of many patients receiving care, they present operational challenges for hospitals that must comply. As costs rise and workforce shortages continue, providers have the option to outsource eligibility and enrollment services to alleviate obstacles for themselves and their patients. A trusted eligibility partner can help with the additional screening volume, alleviating the burden for hospitals so they don't have to hire more patient access staff. Additionally, hospitals will want a partner that has the tools and resources to track reason codes to report the necessary requirements. With the right revenue cycle management partner, hospitals can maximize reimbursement, increase patient satisfaction, and make sure they act in accordance with this new law, meeting all its obligations.

About the Author

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Resources

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Hospital OPPS: Remedy for 340B Payment Policy for CY 2018-2022

There has rarely been a dull moment in the world of the 340B Drug Pricing Program. The program, which allows eligible healthcare entities to stretch their scarce federal resources further and provide additional benefits and services through discounted drug prices, is continually seeing challenges, clarifications, and other changes.

One welcome relief to eligible providers regarding the 340B Program occurred in June 2022 with a Supreme Court decision. In the case of American Hospital Association v. Becerra, the court unanimously ruled that the differential payment rates for 340B-acquired drugs, which were lowered by CMS for CY 2018-2022, were unlawful because prior to implementing the rates, HHS failed to conduct a survey of hospitals' acquisition costs under the relevant statute.

Shortly after the court ruling, eligible providers began receiving the higher rates on a "go-forward" basis, but questions remained throughout 2022 and the first half of 2023 as to how eligible providers were going to receive the lost reimbursement retroactive back to CY 2018.

Some clarity was provided on July 7, 2023, when CMS issued a proposed rule outlining the proposed remedy for CY 2018-2022. There were two central components in the proposed rule. First, CMS proposed to repay 340B hospitals that were unlawfully underpaid from 2018 to 2022 in a single lump-sum payment and provided an estimate for each of the approximately 1,600 affected 340B-covered entity hospitals. Second, CMS proposed a policy to recoup funds from those hospitals that received increased rates for non-drug services from 2018 to 2022. Specifically, CMS proposed to recoup these funds by adjusting the Outpatient Prospective Payment System (OPPS) conversion factor for all hospitals affected by the OPPS by minus 0.5% starting in CY 2025.

On November 2, CMS issued a final rule, that was mostly consistent with the proposed rule with one key difference. The proposed offset of future non-drug items and services through adjusting the OPPS conversion factor was changed in the final rule to begin in FY 2026, providing an extra year before cuts will go into effect. CMS estimates it could take up to 16 years.

Lump-sum provider payment amounts are located on CMS-1793-F. The final rule has indicated it would provide instructions to the MACs to make payments and that such payments should be made within 60 days of delivery of said instructions. However, it should be noted that the estimates and payments from CMS only cover traditional Medicare, and organizations may need to consider the impact of the Supreme Court ruling on reimbursement from other payors, such as Medicare Advantage payors.

Accounting and financial reporting questions have arisen not only due to the timing of certain announcements and decisions but also due to the uncertainty that remained until a final rule was issued. Provider care organizations are required to consider the conditions that exist at the balance sheet date, and which might develop subsequently in thinking through such accounting and financial reporting considerations.

The industry was generally in agreement that neither the Supreme Court ruling in June 2022 nor the proposed CMS rule in July 2023 provided enough probability that recording amounts are appropriate. Consideration of past items requiring CMS approval has led the industry to consider this as a Type 2 subsequent event (disclosed but not recorded) for year-ends prior to the issuance of the final rule (November 2, 2023, i.e., October 31, 2023 FYEs and earlier). The main factor leading to the conclusion of a Type 2 subsequent event is that until CMS approves a final rule, it technically can significantly change the nature, timing, and extent of reimbursement. Further, proposed rules have typically not met the designation of additional transaction price such that an event or condition at the balance sheet date does not yet exist until a final rule was issued.

Accordingly, most agree that in considering the additional reimbursement, applying ASC 606, i.e., revenue recognition, is most appropriate. The Supreme Court decision on June 15, 2022 in favor of the American Hospital Association created a situation in which hospitals were entitled to additional reimbursement, i.e., variable consideration. At the same time, most agree that the court decision alone did not provide enough information for hospitals to conclude it should record additional revenue as the risk of significant revenue reversal was more than remote, i.e., not enough information to estimate and conclude probable. Accordingly, most did not record additional revenue, i.e., applied the variable constraint, upon notification of the Supreme Court Ruling or through July 7, 2023, when CMS issued its proposed rule.

Most also agreed that the proposed rule issued on July 7, 2023 was new information that should be considered but most also agreed it was not enough information to conclude the variable constraint was no longer present, i.e., not yet ready to recognize.

Finally, most agree that the final rule issued in late 2023 is the point at which revenue recognition was met.

There also appears to be consensus that the budget neutrality aspect of the CMS proposed rule does not currently trigger accounting implications from a potential payback. The OPPS reimbursement reduction is commonly viewed separate and distinct from the 340B back pay to hospitals and considered as a future reduction in reimbursement accounted on a go-forward basis. This is similar to sequestration; when future rate cuts were announced, organizations accounted for them prospectively.

GASB considerations: There also appeared to be a consensus that although the terminology is different (gain contingency under revenue recognition), the accounting for revenue recognition would substantially be the same as FASB.

In this environment of continual change, organizations are encouraged to:

- Stay up to date on the CMS proposed and ultimate final rule and document consideration and conclusions relative to revenue recognition.
- Continue to update executives and boards about the uncertainties in the 340B program, including how the discounted drug price benefits are currently being used by the organization and what might need to happen if the benefits decrease.
- Ensure timely 340B Mock HRSA audits and benefit assessments are performed by qualified third parties to help minimize risk and consider opportunities under current program structures.

About the Author

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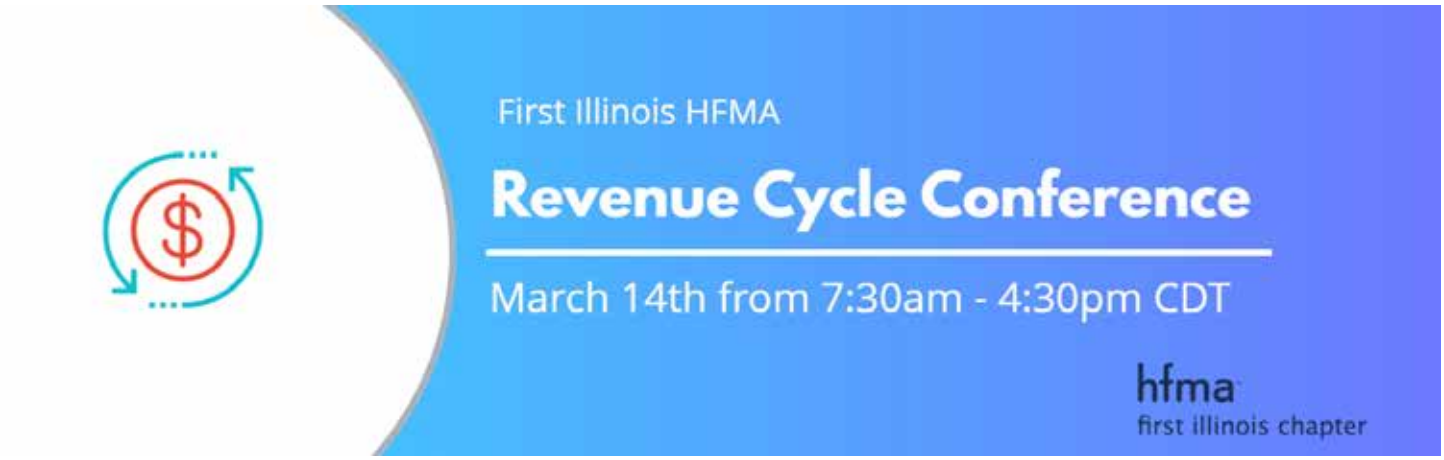
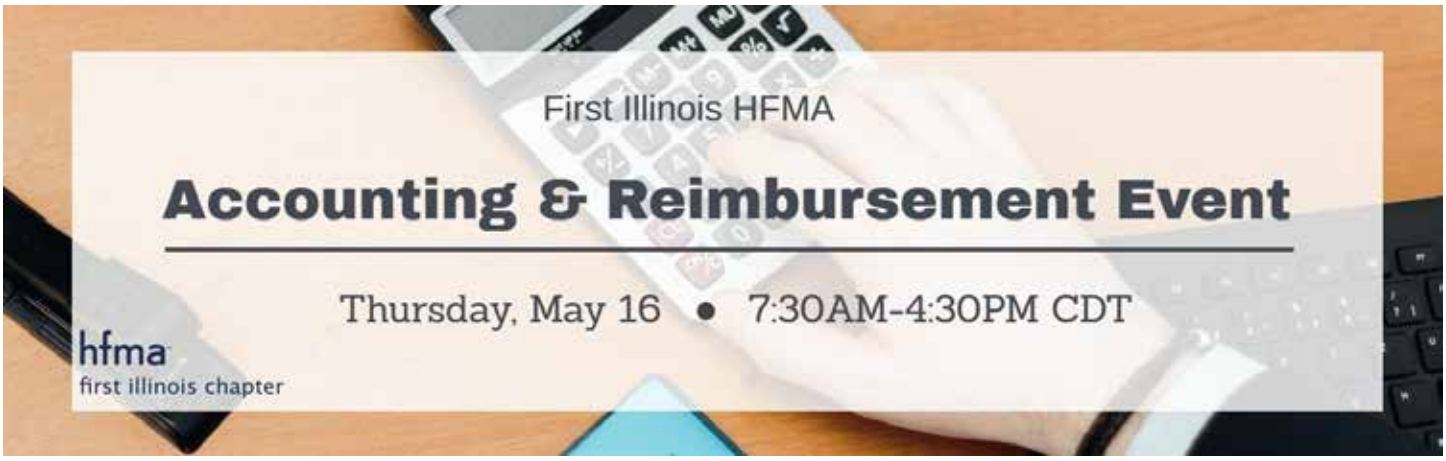
First Illinois Chapter HFMA News & Events



Join local revenue cycle leaders on March 14 at University of Chicago Medical Center Offices in Burr Ridge, IL for this one-day event as they share how they are highlighting a patient-centric approach to revenue cycle and their areas of focus for 2024 and beyond. The University of Chicago Medical Center Offices in Burr Ridge, IL, offers free parking and easy access to major highways. CLICK HERE to learn more and register.



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Mark your calendars for June 13 and plan to join us for a day of learning, networking, and celebration as we mark the 10th anniversary of the Women in Leadership Retreat. ***Leading with Diamond Precision: Empowering Women to Shine.*** This year's day-long event will be at Le Jardin Room on the beautiful Cantigny Park campus located at 1 S, 151 Winfield Rd, Wheaton, IL 60189 CLICK HERE to learn more and register.

75th Anniversary

As has been our history, the other chapters are watching us and following our lead. A few months back, I collaborated on this article published in the *hfm* magazine to get the word out. As we approach the halfway mark of the 75th anniversary celebration, I encourage you to join us at one of our events in 2024 and continue the tradition of premier healthcare finance education and networking. Better yet, strengthen our next 75 years by volunteering to maintain and grow our great content so we can continue as the first and the best chapter!

Rich Schefke
2021-22 First Illinois Chapter President
Chair, 75th anniversary celebration

First Illinois Chapter kicks of 75th anniversary celebration

Reprinted From hfm

HFMA's first chapter – fittingly named First Illinois – recently turned 75 and is marking the major milestone with a year-long celebration. How did they kick things off? With a party, of course.

The event took place July 20 at the Carlucci restaurant in Rosemont, Illinois. Seventy-two attended the celebration, which was part of the Chapter's annual transition dinner. In addition to speeches by the outgoing and incoming Chapter presidents, award presentations and announcement of college scholarship winners, Rich Schefke, FHFMA, CPA, MAS, a past First Illinois president and the 75th anniversary chair, gave a presentation highlighting the Chapter's early history and its accomplishments through the years. The evening also featured a recognition of the longest-standing past presidents in attendance.

Schefke, director of financial planning, analysis and decision support for NorthShore – Edward-Elmhurst Health in Arlington Heights, Illinois, said one of the most popular aspects of the evening was a special keepsake book that included chapter highlights as well as reflections from past presidents. During appetizers and networking, one attendee treated it like a yearbook and started collecting signatures. It wasn't long before others did as well.

"Seeing everyone going around and getting notes and signatures from other attendees was one of my favorite aspects of the event," said Schefke.

Schefke credited the 75th anniversary committee, a subset of the Chapter's past presidents committee, with the event's success. He also noted it was just the start as they've planned something for every major Chapter event this year, including a special video montage they're creating for an event next spring that will feature current and former leaders at all levels sharing what First Illinois means to them.

According to Schefke, the biggest challenge in planning the year-long celebration was finding all the past presidents for the past 25 years, but they did it. He also said getting those who were interested to help drive ideas and plan was key. To that end, he encourages other chapters planning such events to get as many former leaders involved as possible.

"They helped your chapter get to this point, and the passion flame that drove them is still there," said Schefke. "Just ask!" Current First Illinois Chapter.

About the Author

Crystal Milazzo *Crystal Milazzo is a senior editor with HFMA, based in Beaverton, Oregon.*

Current First Illinois Chapter President Katie White, FHFMA,CPA, shows the keepsake book given to attendees at the Chapter's 75th anniversary dinner. Thirteen former presidents also attended: Joe Parrillo (1983/84), Steve Berger (2000/01), Martin D'Cruz (2004/05), Vince Pryor (2006/07), Jim Watson (2007/08), Mike Nichols (2009/10), Tracey Coyne (2012/13), Dan Yunker (2013/14), Brian Katz (2017/18), Rich Franco (2018/19), Bart Richards (2020/21), Rich Schefke (2021/22) and Brian Pavona (2022/23).

First Illinois HFMA Diversity, Equity and Inclusion Committee Co-Sponsors Event on The Cost of Healthcare + Homelessness

Pictured above: Joel Jackson, Donnica Austin-Cathey, Nicole Fountain, Tim Jostrand, Carolyn Ross, Tiara Muse, James Williams, Ashley Teeters, Sherry Pace

It has been proven that homelessness and healthcare are inextricably linked.

At a federal level, there have been two major updates with CMS with regard to how homelessness is being addressed. In August, CMS issued a final payment rule and will increase payments to hospitals for treating homeless patients and implementing equitable quality measures aimed at reducing preventable harm. In October, CMS implemented a new place of service code 27 for "Outreach Site/Street," described as a non-permanent location on the street or found environment, not described by any other POS code, where health professionals provide preventive, screening, diagnostic, and/or treatment services to unsheltered homeless individuals.

Research has shown that homeless children are more likely to develop physical or mental health-related issues. Likewise, homeless adults are more likely to have chronic health conditions that go unmanaged.

At our November 15 event, we were able to use the first portion of our time together to network and meet attendees from our four organizations: First Illinois HFMA, N.A.H.S.E. Chicago/Midwest, University of Chicago Medical Center (UChicago) and Cook County Health.

Donica Austin-Cathey, Chief Hospital Executive at John H. Stroger, Jr. Hospital helped kick off our event, representing Cook County as the host location for our event. Ashley Teeters, First Illinois HFMA, introduced our panel speakers and James Williams, Vice President of DEI at UChicago, introduced our moderator.

Sherry Pace
CEO
Chicago Family Health Center

Timothy Jostrand
Board President
Chicago Street Medicine

Carolyn Ross
President & CEO
All Chicago

Joel Jackson, Director of Inclusion and Equity at UChicago then

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First Illinois HFMA Diversity, Equity and Inclusion Committee Co-Sponsors Event on The Cost of Healthcare + Homelessness (continued from page 20)

moderated our incredible panel of speakers. The panel shared varying perspectives while exploring how healthcare and homelessness contribute to healthcare inequities, how they are shaping change and solutions and what the future looks like if we do not act on much needed improvements to address this crisis.

Attendees walked away with an understanding of how data is informing policy and programs. We learned how medical centers are connecting individuals experiencing homelessness with resources and avenues for providing direct care to those experiencing homelessness while managing chronic health conditions on the street. The panel explored the urgency surrounding the financial burden of emergency care versus preventative care for vulnerable populations.

We discussed that there is often a negative stigma associated with homelessness. One great solution offered is to meet the individual where they are and approach the care of that individual with less judgment of their situation. We often think of homeless individuals as someone on the street with addiction issues and may be forgetting veterans, families with children or individuals with behavioral health related issues. A person or family who is homeless might be living in a variety of other homes while they try to secure housing of their own.

One of the largest barriers to care for homeless individuals pertains to social determinants of health, which often means access to adequate, affordable housing. Our panelists discussed ways to tackle these barriers and the incredible work that each of their organizations are doing to make a difference.

We are proud that such a diverse group of organizations and individuals were able to come together to network, learn and identify ways we can continue to make a difference at reducing homelessness.

If you are interested in learning more about homelessness or are interested in getting involved further in our DEI efforts, please reach out to Ashley Teeters at Ashley.Teeters@uchicagomedicine.org. We welcome you to join our efforts and be part of the conversation.

First Illinois HFMA Diversity, Equity and Inclusion Committee Co-Sponsors a Q&A with Dr. Ngozi Ezike

Pictured above: Dimas Ortega, Dr. Ngozi Ezike, Christina Martinez and Ashley Teeters

NALHE Chicagoland, HFMA First Illinois Chapter and Sinai Chicago, presents Q&A with Dr. Ngozi Ezike, President and CEO of Sinai Chicago. Dr. Ezike will be sharing with us the importance of having minority representation in the leadership and c-suite of your organization.

Dr. Ezike is the immediate past Director of the Illinois Department of Public Health (IDPH), where she valiantly navigated the state through the most difficult waves of the COVID-19 pandemic. Dr. Ezike is an advocate for the Hispanic Population and the first black woman to lead Sinai Chicago in the system's 103-year history.

At our January 25 event, we were able to use the first portion of our time together to network and meet attendees from our three organizations: First Illinois HFMA, N.A.L.H.E. Chicagoland and Sinai Chicago.

Christina Martinez, NALHE President, helped kick off our event, with an introduction and overview of the NALHE organization. Ashley Teeters then gave an overview of First Illinois HFMA. Dimas Ortega then introduced our speaker, Dr. Ngozi Ezike, with a Q & A moderated by Dimas Ortega and Christna Martinez.

Many of us from the Chicagoland area will remember Dr. Ngozi Ezike as she served as Illinois's health director at the Illinois Department of Public Health during the pandemic. Since then, she has been serving as the President and CEO of Sinai Chicago.

Dr. Ezike joined us for a Q & A session to discuss how we can lift up and recognize minorities within our organizations. She spoke about being a child of immigrants and her incredible career journey. Dr. Ezike has spent years directly involved in healthcare, seeing firsthand the impacts of our underserved minority and immigrant communities.

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First Illinois HFMA Diversity, Equity and Inclusion Committee Co-Sponsors a Q&A with Dr. Ngozi Ezike (continued from page 22)

Black and brown communities are often fearful of the medical community or treatment plans. We also see a lack of diverse representation in healthcare leadership or medical professionals. The audience was able to participate in a conversation about ways to uplift minority communities to improve healthcare outcomes. We learned about efforts to meet the community where they are, mentally or geographically. Dr. Ezike talked about how to improve minority representation and grow leadership diversity. She shared with us advice she has received along the way, tips on finding trusted mentors and pathways to bring diverse perspectives into leadership roles.

If you are interested in learning more about minority efforts or are interested in getting involved further in our DEI Committee, please reach out to Ashley Teeters at Ashley.Teeters@uchicagomedicine.org. We welcome you to join our efforts and be part of the conversation.

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Publication Scheduling

Publication Date	Articles Received By
June 2024	May 1, 2024
October 2024	September 1, 2024
February 2025	January 2, 2025