hfma
first illinois chapter

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FIRST ILLINOIS SPEAKS

IN THIS ISSUE

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To Meet Our 2024-25 Officers & Board of Directors CLICK HERE

October 21, 2024 – October 23, 2024

Hilton Chicago/Oak Brook Hills Resort & Conference Center (Chicagoland)
3500 Midwest Road
Oak Brook, 60523

HFMA's Region 7 Chapters (Greater Illinois, First Illinois, Wisconsin and Indiana Pressler) are bringing together healthcare industry executives and experts for a two and a half-day premier event at the Hilton Chicago/Oak Brook Hills Resort & Conference Center, Oak Brook, IL. The education/networking event offers education sessions, an executive panel of the region's top leaders discussing their careers in healthcare, a panel discussion with presidents of each state's hospital association and much more!

Attend to hear speakers from American Hospital Association, Ann & Robert H. Lurie Children's Hospital of Chicago, Froedtert ThedaCare Health Inc, Humbolt Park Health, Illinois Health and Hospital Association, Indiana Hospital Association, Katherine Shaw Bethea Hospital, OSF HealthCare, Indiana Rural Health Association, Mayo Clinic Health System, Northwestern Memorial Healthcare, Rush University Medical Center, Silver Cross Hospital, and University of Chicago.

Over 300 healthcare financial professionals are expected to attend. There will be valuable networking opportunities including a social event on Monday & Tuesday evening with great food, drinks, and music. Plus, you will earn up to 13 CPE credits.

CLICK HERE to register today!

Message From Our Outgoing President

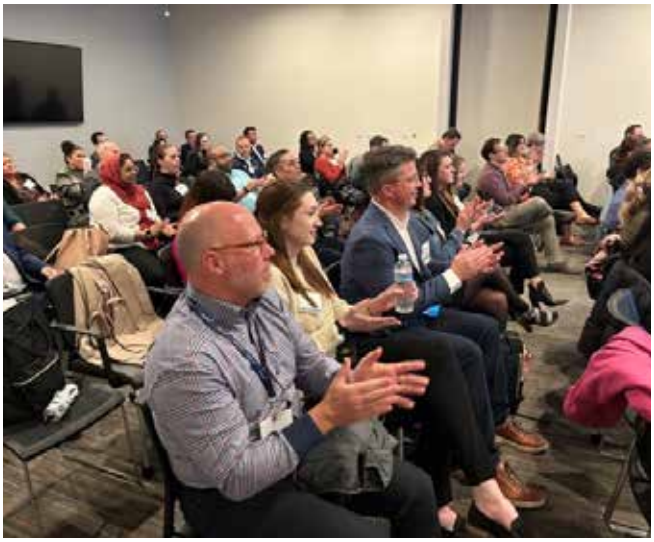
BY KATIE WHITE , FHFMA, CPA, 2023-24 PRESIDENT

Dear Friends & Colleagues,

Our 75th year as a chapter is in the books and what a year it has been! We rounded out the year with two very strong educational events. On March 14, the Revenue Cycle Conference was hosted by UChicago Medicine in Burr Ridge with an excellent agenda put together by the Revenue Cycle Committee, chaired by Mary Ann Zarkin and Ryan Bell. The May 16 Accounting & Reimbursement Conference, hosted by Advocate Christ Medical Center in Oak Lawn, closed out our education for the chapter year with a robust agenda put together by the Accounting and Reimbursement Committee led by Shelby Burghardt and Brian Kirkendall.

Looking back on the year I can't help but feel so lucky to be a part of this chapter and organization. We have accomplished so much and expanded our reach tremendously in the last 12 months. We have the best volunteers, stewards, leaders, and professionals that make this organization what it is. I truly could not be more humbled to work beside them. The entire team of leaders took our goals for this year and executed them beyond expectations. I have learned so much over the years what a dedicated team can accomplish, and this year only added to that.

This year we approved a budget that required us to make some changes to how, specifically where, we provide education to our membership. Our number one goal is to provide affordable quality education to our membership and that required making changes on the expense side. We had to find venues that would be cost-effective and sustainable for years to come. We made a change to our Fall Summit location for this reason and moved our Spring events back to provider-hosted sites, allowing us to control costs, and not only meet budget goals, but deliver quality education at an affordable cost. Thank you to the entire programing committee volunteers and a special thank you to Shelby Burghardt for making this vision become a reality.



HFMA headquarters holds a volunteer meeting at the beginning of every chapter year that lays out the focuses for the year with which they then challenge all the chapters. This past year the challenge was about being more inclusive, and not necessarily in the typical ways you might think of like gender, race, age, ethnicity, etc. but in the education we provide, the type of events we hold, and the organizations with whom we partner. Are we meeting the needs of all the members and communities we support? Our chapter took this challenge and made it a special focus for the year. Our Diversity, Equity and Inclusion (DEI) committee grew from one to fourteen members, increased our book clubs from two book clubs a year to three, and delivered two collaboration events: partnering with the National Association of Health Services Executives (NASHE) for *The Cost of Healthcare and Homelessness* and partnering with National Association of Latino Healthcare Executives (NALHE) for a discussion with Dr. Ngozi Ezike on *Solving for Healthcare Equality in our Underserved Chicago Communities*. I am proud of the work that this committee has done—so much within a year with much more on the horizon for next year. A special thank you to that committee and its co-chairs, Ashley Teeters and Nicole Fountain.

Lastly, I want to say thank you to our membership for electing me and allowing me to lead the First Illinois Chapter this past year. The experience has been rewarding in so many ways, and special to my family and me. It gave more to me, then I to it, and I am very thankful for that. Thank you to our volunteers, our board of directors, and our executive team, you made this role easy with all your support and leadership. Congratulations to Matt Aumick, your next President. The chapter is in great hands for the year to come and I look forward to all the exciting and new events we have coming up!

Katie White, FHFMA, CPA
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Message From Our Incoming President

MATT AUMICK , CHFP, CPA, 2024-25 PRESIDENT

Dear FIHFMA Chapter Members,

It is an honor and privilege to serve as the 2024-2025 First Illinois Chapter President! First, I would like to extend my gratitude to our outgoing president, Katie White, as well as our board members who have finished their terms this past year. Thank you for guiding us through a successful 75th year with your hard work and commitment to the chapter. As the incoming president, I am thrilled to be working with such talented and dedicated volunteers that our chapter is so lucky to have.

Our industry continues to face an uphill battle to increase operating margins with the current economic environment, high labor costs, and continued reimbursement challenges. Working for three different healthcare providers throughout my career, I am constantly reminded that our industry can overcome these challenges. These organizations have always put the patient first, and even every non-clinical meeting starts with a "mission moment" highlighting an incredible patient success story. At HFMA's Leadership Training Conference this year, we were reminded to "own the crisis and champion the cure." When we reflect on these patient success stories, it is a great reminder that as healthcare professionals we can help champion the cure for the industry, just as our colleagues do every day on the front lines.

HFMA and the First Illinois Chapter are no different. Our business partners and healthcare provider members are here to collaborate with one another to solve the complex issues we face as finance professionals. Our chapter is fortunate to have so many incredible healthcare organizations in the area, and leaders from those organizations who are always willing to share their experiences and expertise with our members.

As we look ahead to this year, our primary goal is to help develop the next generation of healthcare professionals. As the workforce continues to age, it is critical for us to develop future generations in our industry. We plan to work with universities in the Chicagoland area to identify students interested in healthcare finance. We are excited to introduce educational content, new and refreshed social events, as well as volunteer opportunities for these students and emerging leaders within our chapter. If you are new to the chapter or considering becoming more involved, please check out our committees and volunteer opportunities!

Thank you again to our board members, committee chairs, volunteers, and chapter sponsors. Each one of you is critical to making our chapter what it is today. I look forward to working with our volunteers and creating excellent and meaningful educational content, as well as networking events for our members this coming year.

Matt Aumick, CHFP, CPA
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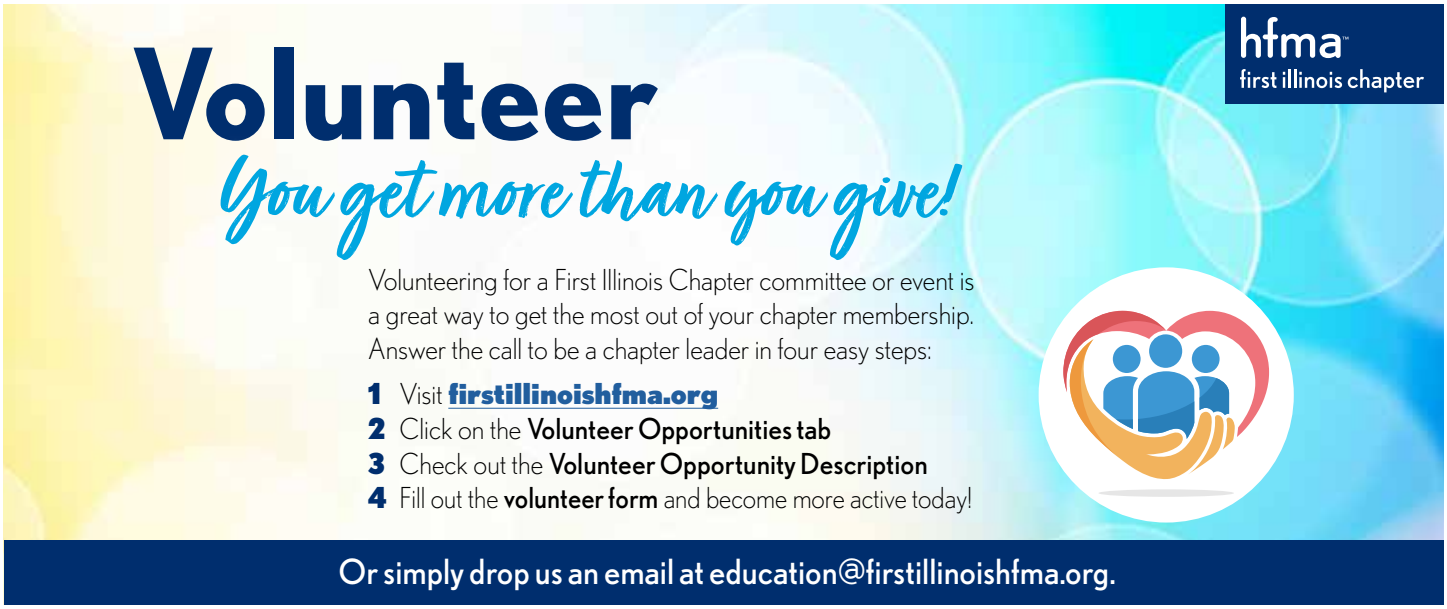

Tax Considerations in Health Care Deals

Tax structuring and tax due diligence are critical aspects of any deal. However, health care deals present distinct challenges, as the industry is subject to specific federal and state regulations. Thorough examination of all tax-related considerations before finalizing a health care transaction is critical to mitigate risk and obtain anticipated deal value.

This article explores six notable tax considerations in health care deals.

1 Tax structuring: "Friendly doctor" and other considerations

The basic premise of tax structuring applies to health care deals. Buyers tend to prefer asset or deemed asset transactions, which provide a stepped-up tax basis in the acquired assets equal to the fair market value, producing a tax shield. Sellers, on the other hand, tend to prefer selling equity with no tax step-up, to limit future liability, increase administrative ease and secure capital gains tax treatment.

That said, health care structures need to also consider state regulations and the types of entities a state will allow (e.g., corporation, partnership, etc.); who is allowed to be an owner in a regulated health care company (e.g., licensed individuals, a certain percentage of licensed individuals, etc.); and what economic arrangements are permitted.

For example, in a "friendly doctor" structure, many states have laws against the corporate practice of medicine and require a licensed physician to own the practice entity. As a result, a nonlicensed buyer may need to set up a separate entity—namely, a management services organization (MSO)—to purchase the nonclinical assets of the practice and enter into a management services agreement with the practice entity.

The agreements between practice entities and the MSO affect how the IRS views the structure and the tax reporting implications going forward. Regardless of the type of health care transaction, effective tax structuring is critical for tax efficiency and shaping the overall economics of the deal.

2 Transfer pricing: Reviewing and structuring for compliance and tax efficiencies

Transfer pricing considerations assume particular significance in health care deals, as organizations often engage in transactions with related parties, such as the transfer of intellectual property, services or products. The complexity of the health care industry, with its diverse revenue streams and specialized services, necessitates careful consideration of transfer pricing implications in transactions.

Ensuring that transactions between related parties are conducted at arm's length is crucial for compliance with tax regulations. Addressing the transfer of services, goods, intangible assets and internally developed software as well as service arrangements, cost-sharing agreements, cross-border transactions and advance pricing agreements (APAs) is vital for preventing tax liabilities and aligning with regulatory expectations.

Reviewing and structuring for transfer pricing during a transaction not only facilitates regulatory compliance but also helps in optimizing tax efficiencies and avoiding potential disputes with tax authorities post-close.

3 Accounting methods: Revenue recognition and more

Accounting methods are another key area to assess in health care deals. The impact of tax accounting methods on a transaction may be significant, influencing both the valuation and the ongoing tax liabilities of the target.

The cash method of accounting and revenue recognition are common tax issues in health care deals; understanding differences among financial and tax methods is key. Many sellers on the cash method need to convert to accrual, while buyers typically want to be shielded from any additional taxes on the switch from cash to accrual.

Additionally, revenue and expense recognition can be complex and affect the perceived value of the target. Moreover, disparities in tax accounting methods may lead to differing taxable income calculations pre- and post-transaction.

A buyer must assess the compatibility of the target's tax accounting methods with its own, considering any necessary adjustments to maximize overall tax efficiency. A thorough review of the tax accounting methods is important for identifying and addressing potential discrepancies, minimizing surprises and optimizing the financial outcome of the transaction.

4 Sales tax: Exemption certificates and understanding nexus

Sales tax issues can be difficult to address in health care deals because variations in sales tax regulations and rates across jurisdictions complicate the analysis.

Sales tax considerations extend beyond the traditional sale of goods, encompassing a diverse range of services, both in-person and telehealth; the transfer of tangible personal property; the sale or lease of durable medical equipment; and the use of medical supplies. Successfully managing the taxability of services, tangible personal property and

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Tax Considerations in Health Care Deals

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contractual obligations—including intercompany service arrangements—requires a meticulous approach.

Equally important are the proper handling of exemption certificates, understanding nexus and ensuring accurate sales tax reporting. Reviewing sales tax filings and processes is essential for identifying potential liabilities related to past sales tax filings and ensuring compliance with local tax laws. Addressing these issues proactively can mitigate risks, contribute to a successful transaction outcome and streamline the integration process.

5 Unclaimed property: Beyond the conventional scope

Unclaimed property considerations in health care deals extend beyond the conventional scope, encompassing a broad range of financial transactions. The three most common property types are:

- Uncashed payroll checks
- Uncashed accounts payable/vendor checks
- Accounts receivable credit balances, including those that historically have been written off

Health care providers also commonly have issues with patient refunds, deposits, insurance payments and reimbursements, trust fund accounts, and medical equipment deposits.

Patient credit balances may arise due to duplicate payments and overpayments resulting from complicated payment application processes, particularly when multiple payors are involved, and a lack of accurate adherence to contractual agreements with insurers.

The complexities of health care payments present account reconciliation issues that examiners often target because the burden of proof that funds are not due is on the holder of the funds. In some cases, even the rightful owner is unclear as to whether the funds belong to the patient or an insurer.

Other considerations are contractual estimates versus true credits, state and federal insurance recoupment laws, and business-to-business exemptions. Failing to address these issues adequately can result in penalties and financial repercussions. Proper due diligence in uncovering and resolving unclaimed property matters contributes to regulatory compliance and risk mitigation.

6 Payroll tax: Identifying and remediating discrepancies

The complex nature of health care organizations, with diverse employee classifications and compensation structures, necessitates a thorough examination of the payroll tax compliance filings and processes. This includes properly classifying health care professionals and administrative staff as employees or independent contractors to ensure accurate tax withholdings and proper treatment under applicable regulations.

Reviewing compliance with federal and state payroll tax regulations is critical to identifying and remediating discrepancies. Unemployment taxes, fringe benefits, employee expense reimbursement, and owner personal expenses should also be reviewed. By conducting a thorough examination of payroll tax matters during a transaction, potential exposures can be identified and addressed pre-close, in the purchase agreement, or post-close.

The takeaway

Tax structuring and tax due diligence play a vital role in the success of a health care deal. The health care industry has an intricate regulatory landscape, with tax issues specific to health care transactions. To help ensure a successful transaction, buyers and sellers should seek support from advisors familiar with the industry and its complexities.

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Graduate Medical Education Strategies to Consider with Affiliation Agreements Deadline

Health systems have until June 30 to establish hospital affiliation agreements.

To meet the future unmet demand for physicians, several hospitals have elected "rural status" to increase their IME full-time equivalent (FTE) cap by 30% and obtain access to additional FTE slots for new residency programs. Even with the advantages provided by "rural status," many teaching hospitals remain over their IME FTE cap.

Medicare Affiliation Agreements

The upcoming deadline for establishing affiliation agreements is June 30, 2024. As hospitals continue to consolidate into larger health systems, teaching hospitals should consider Medicare GME affiliation agreements between their system hospitals. 42 CFR Section 413.75 and 42 CFR Section 413.79 provide guidance on Medicare graduate medical education (GME) affiliated groups that allow health systems to aggregate IME and DGME resident FTE caps for hospitals that share rotations.

To enter into a Medicare GME affiliation agreement, the hospitals must meet one of the following criteria:

- Two or more hospitals that are located in the same urban or rural area or in a contiguous area and meet the rotation requirements in §413.79(f)(2).
- Two or more hospitals that are not located in the same or in a contiguous urban or rural area, but meet the rotation requirement in §413.79(f)(2), and are jointly listed as:
  - The sponsor, primary clinical site, or major participating institution for one or more programs as these terms are used in the most current publication of the Graduate Medical Education Directory; or
  - The sponsor is listed under "affiliations and outside rotations" for one or more programs in operation in Opportunities, Directory of Osteopathic Postdoctoral Education Programs.
- Two or more hospitals that are under common ownership and, effective for all Medicare GME affiliation agreements beginning July 1, 2003, meet the rotation requirement in §413.79(f)(2).

Entering into a Medicare GME affiliation agreement allows teaching hospitals to fully utilize available FTE cap amounts and the differences that might exist in IME and DGME reimbursement between hospitals. For example: if a teaching hospital has a higher per resident amount (PRA) and a higher Medicare utilization, then a Medicare GME affiliation agreement may be utilized to improve overall reimbursement for the health system, by transferring FTE cap from a hospital with a lower PRA and lower Medicare utilization.

This can be an effective strategy for health systems to improve overall systemwide reimbursement and give the system more opportunities to train new residents and establish new programs. Even if hospitals are not under common ownership, Medicare GME affiliation agreements are an added strategy that should still be considered for hospitals located in the same area when those hospitals share rotations.

GME reimbursement strategies are complex and require increased collaboration between hospitals; and, if executed properly, these strategies can yield significant financial benefits for your health system.

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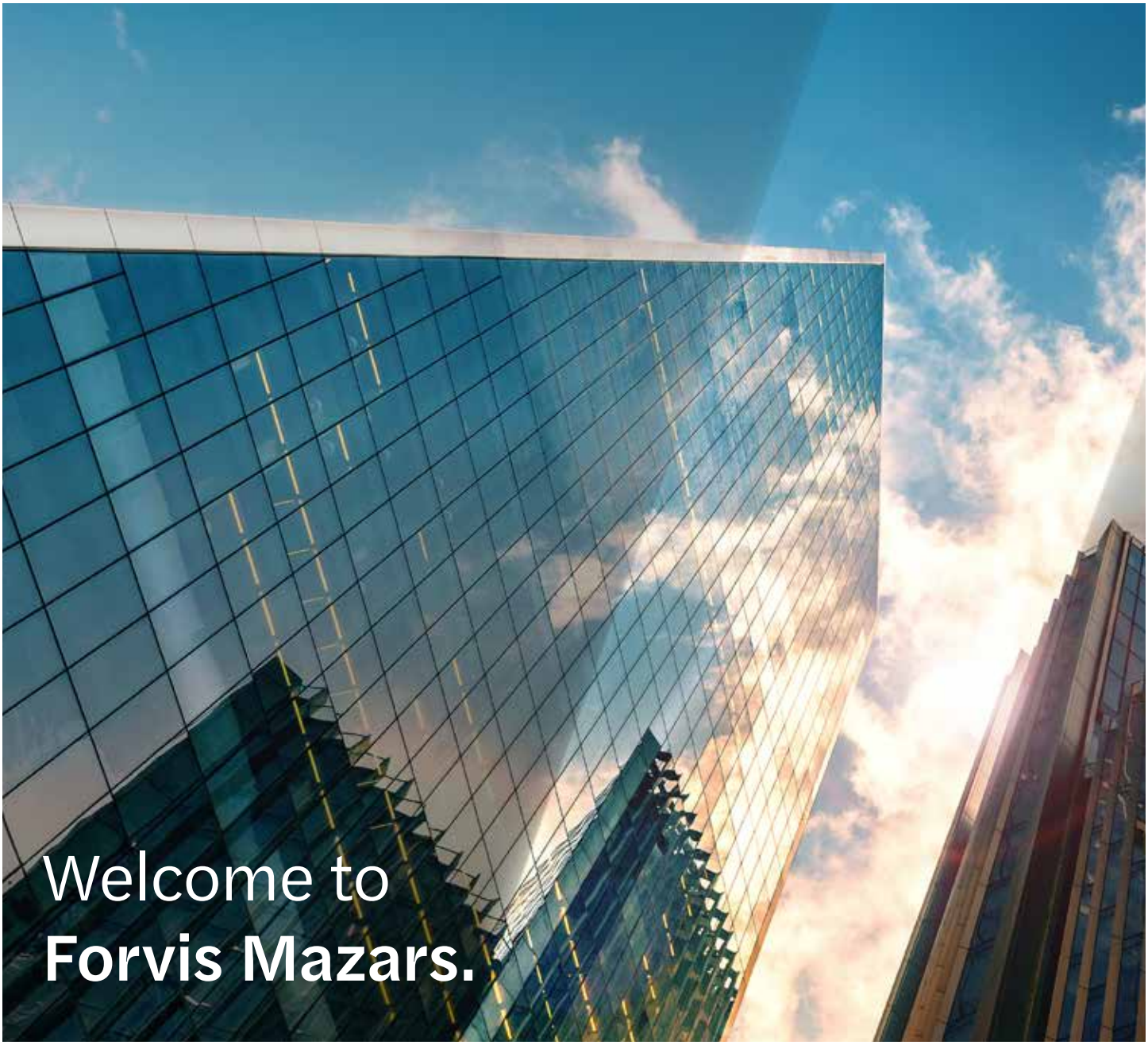

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Optimizing 340B Participation Compliantly While "Waiting and Watching" New Developments

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Hospitals and health systems that participate in the federal 340B Drug Pricing Program are currently facing challenges on multiple fronts, including manufacturer restrictions and program audits, legal challenges, and constantly-evolving federal and state requirements for participation.

Since 1992, the 340B program has required drug manufacturers to provide drugs used for the outpatients of eligible health care organizations and other covered entities at significantly reduced prices, with the intent of helping safety net organizations improve their financial stability. In turn, hospitals are expected to demonstrate that the savings they receive from the program benefit their patients.

Presently, many hospitals are "waiting and watching" regulatory and legal developments that may impact their future 340B participation. In the interim, however, there are steps organizations can take to optimize their 340B programs compliantly, with the intent of improving financial outcomes, increasing revenue, and benefitting patients, employees, and the communities they serve.

Consider creating an internal pharmacy

Many 340B hospitals are moving in the direction of opening their own in-house retail or specialty pharmacies as part of their strategy to address restrictions from drug manufacturers. These pharmacies can serve patients, employees, or the general public, depending on how they are structured.

Key benefits of creating an internal pharmacy include:

- Increased revenue
- Potential alignment with managing patient care, including greater insight over patient prescription adherence and the overall cost of care
- Opportunities to provide easier access to prescriptions for patients
- Opportunities to align employee benefits programs with 340B to achieve additional cost savings
- Positive community perception by partnering with locally owned pharmacy businesses

Strategically utilize contract pharmacy networks

Covered entities can also contract with retail pharmacies (whether they are owned, community-based, or specialty pharmacies) and extend their 340B discounts for their patients who fill scripts at these locations. These "contract pharmacies" must be registered on the Health Resources & Services Administration (HRSA) website once a contract is established.

Contract pharmacy networks can play a particularly important role with regards to specialty drugs, which, according to our analyses, comprise more than half of all hospital spending on drugs despite comprising only 2% of volume. Even organizations that have an in-house pharmacy may not be best positioned to distribute oncology drugs, given their limited distribution.

These high-cost medications treat rare, complex, chronic health conditions. Key therapies for specialty drugs include oncology, multiple sclerosis, HIV/AIDS, Crohn's Disease, blood/ bleeding disorders, and inflammatory diseases, among others.

Closing thoughts

As hospitals await further legal, regulatory, and manufacturer-related shifts in the administration of 340B, the steps outlined in this article offer an interim path forward. Given the promise of the 340B program to help stabilize hospital finances, optimizing the program's benefits while remaining compliant with its rules and regulations should be top of mind for any participating organization.

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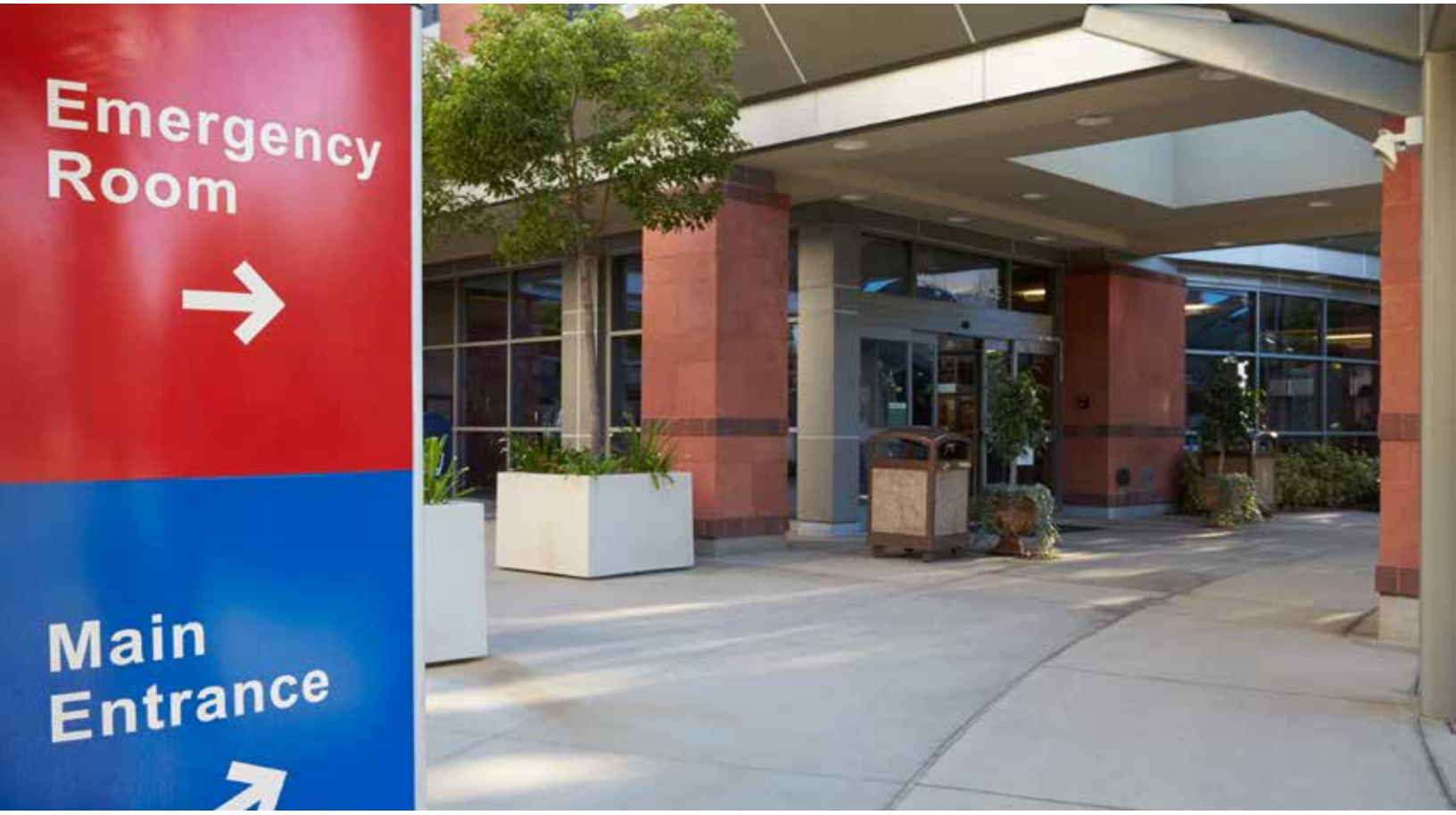
Three Strategies to Reduce Denials and Downgrades in the Emergency Room



As payer criteria change and observation volumes rise, hospitals are experiencing costly denials and downgrades. Collaboration between your emergency department and utilization review teams can ensure a proper patient classification – before writing the admission order.

Hospital emergency departments (EDs) are challenged to keep pace with ever-changing payer admission criteria. But since your facility's bottom line takes a hit with each downgrade or denial, it's imperative to take a proactive stance.

If your business office is trying to recapture lost dollars from denials and downgrades on the back end, it's consuming an extraordinary amount of staffing resources. Instead, focus on the front-end: engaging your utilization review (UR) team before ED providers write an admission order.

Hospital EDs tend to have more resources focused on the case management side of the equation – helping patients get discharged safely with arrangements made for home care, follow-up appointments, and social services as needs dictate. Yet we often see EDs overlook the equally important interaction with UR. This is a missed opportunity since UR has a superpower your ED should be leveraging: understanding payer criteria and knowing how to appropriately classify patient status, whether for admission, observation, or discharge.

Consider these three strategies to help your hospital reduce payer downgrades and denials stemming from incorrect patient classifications made in the ED.

1. Strengthen communications between your ED and UR

To reduce ED downgrades and denials, your ED must work with UR to determine whether a patient meets the criteria for inpatient admission. This should be a collaborative practice completed when ED provider decides to place an admission order. If the patient meets criteria, UR can confirm that admitting them to an inpatient bed is appropriate and can assign the correct patient classification and working diagnosis-related group (DRG).

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Three Strategies to Reduce Denials and Downgrades in the Emergency Room

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If UR determines the patient doesn't meet inpatient criteria, the ED can assign the patient to observation status and move them out of the ED. Not only does this prevent a subsequent downgrade or denial; it also frees up an ED bed and helps the care team better manage patient flow.

The relationship between ED providers and your UR team should be consultative in nature, with the UR and ED teams in continuous communication. UR can support ED providers by letting them know specifically why a patient does or doesn't meet criteria for a particular patient classification and what the provider can do to ensure criteria are met. Skipping a consultation with UR raises the risk of getting it wrong.

Your ED providers should engage UR early to determine a patient's classification, and UR must be available to provide real-time input to guide the decision. Consider supportive tools such as a text messaging system between ED providers and UR or "sticky note"-type features in your electronic medical record (EMR) system. When it comes to reducing downgrades and denials, real-time communication isn't a luxury – it's essential.

2. Standardize ED provider documentation

A close working relationship between the ED and UR needs to be supported by clear and detailed medical record documentation by the ED provider. Standardizing key portions of provider documentation ensures UR has the information it needs to:

- Conduct an initial review of the patient's insurance.
- Determine criteria for inpatient or observation status.
- Provide an accurate patient classification at the time of admission.

Your UR team can only assess and determine an appropriate patient classification status when they have adequate ED provider documentation in front of them. An ED provider might know a patient needs an inpatient bed, but if payer-specified tests haven't been ordered and documented in the medical record, the patient may not meet criteria for admission. When UR is in close communication with the ED, it can provide guidance to ED providers on additional criteria to be met, further documentation and diagnostics needed on a case-by-case basis. Your UR team is much better equipped to call the correct patient classification when it has the right medical documentation from your ED providers, and this reduces denials and downgrades.

Remember that observation status isn't a diagnosis – it's a payer classification. Put another way, your ED clinicians are experts in diagnosing their patients and, through comprehensive, standardized documentation in the patient's EMR, your UR team is expert in using that information to assign the proper classification.

3. Leverage the EMR system

Use the EMR to drive the worklist for the UR team to review during the ED's busiest hours, typically 5 p.m. to 11 p.m. By creating a running worklist of ED cases for review, the UR team can readily perform an initial review quickly – before a provider assigns a classification.

Designate an ED-specific UR resource – be it an individual or a group – and ensure that resource is available to cover the ED during peak times. This allows UR to review criteria for admission in real-time, rather than making retrospective changes to a patient's classification after an order has been placed.

If scheduling UR staff during peak ED hours is a challenge, consider using a remote UR team that can review documentation and run criteria during high-volume periods.

In conclusion

Observation volumes are rising for hospitals due to changes in payer criteria, increasing the likelihood of costly denials and downgrades. Focusing on the front-end helps protect your bottom line, but it takes a real partnership between your ED and UR teams. The efforts will pay off if you can identify the classification right – the first time.

About the Author

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Finding the Perfect Balance:
Integrating State-of-the-Art AI with Human Expertise

In today's fast-paced business world, particularly in the field of Revenue Cycle Management (RCM), the integration of technology and human insight is not just advantageous—it's imperative. As organizations strive to optimize their revenue cycle processes and improve financial outcomes, the role of state-of-the-art artificial intelligence (AI) becomes increasingly central. However, the true power lies in harmonizing these advanced technologies with innovative workflows and unique staffing solutions, creating a synergy that drives unprecedented efficiency and accuracy in RCM.

The Role of AI in Revenue Cycle Management

AI technology in RCM is transformative, offering capabilities that range from automating data entry to sophisticated analytics that predict payment trends and patient billing complexities. These AI systems can process vast amounts of data with precision and speed, far beyond human capabilities, which facilitates faster billing cycles and reduced errors. For instance, AI-driven tools can automatically update patient records and process claims, ensuring that they are accurate and complete for quicker reimbursements.

However, the introduction of AI does not eliminate the need for human expertise; rather, it reshapes it. AI excels in handling routine tasks and analyzing large datasets, but human professionals are essential for managing more complex decisions that require emotional intelligence, ethical considerations, and strategic thinking.

Enhancing Workflow through Strategic Technology Integration

The effectiveness of AI technologies in RCM hinges on the underlying workflows that govern their use. Optimizing these workflows involves designing processes that allow human workers and AI tools to complement each other. For example, while AI can automate the initial stages of claims processing, staff can focus on handling exceptions, customer service, and complex case reviews. This division of labor maximizes the strengths of both humans and technology, leading to improved operational efficiency and job satisfaction.

Moreover, innovative workflow designs often incorporate feedback loops where human insights help in refining AI algorithms. By analyzing decisions made by human experts, AI systems can learn and adapt, thereby becoming more effective over time. This iterative process ensures that the technology remains aligned with the organization's changing needs and continues to support its strategic objectives.

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Finding the Perfect Balance:
Integrating State-of-the-Art AI with Human Expertise (continued from page 12)

Unique Staffing Solutions: The Human Element

Integrating AI into Revenue Cycle Management (RCM) not only transforms technology use but also underscores the critical role of experienced RCM professionals. As AI handles routine data tasks, the real value lies in deploying seasoned experts in key areas—like complex problem-solving and enhancing customer interactions—where they make the most impact. To further empower these professionals, organizations are focusing on:

- Up-Skilling Staff: Initiatives like targeted training programs, workshops, and online courses are being introduced to enhance skills in analytical decision-making and complex problem-solving. This not only prepares staff for more advanced roles but also aligns with the evolving needs of the healthcare industry.

- Recasting OKRs: With AI taking over routine tasks, OKRs are recalibrated to emphasize strategic outcomes and quality over volume. This shift in metrics fosters a culture that values precision and strategic impact, encouraging staff to focus on areas where they can make the most significant difference.

- Democratizing Access to Data: Providing staff at all levels with access to real-time analytics and insights allows for better decision-making and operational efficiency. This empowerment leads to proactive management of cases and more streamlined processes, enhancing the overall effectiveness of the RCM department.

These strategic uses of experienced staff not only maximize their expertise but also boost job satisfaction by freeing them from monotonous tasks. Moreover, by leveraging experienced staff in roles that require a human touch, organizations can significantly improve the customer or patient experience. Personal interactions in billing and customer service can dramatically affect patient satisfaction and loyalty. When patients receive thoughtful, knowledgeable interactions, they perceive their care as more holistic and attentive, which is crucial in healthcare settings.

Conclusion: A Synergistic Approach to RCM

The journey towards integrating AI in Revenue Cycle Management is not about choosing technology over people but rather creating an environment where both can thrive. The perfect balance involves leveraging the speed, accuracy, and scalability of AI while also fostering an innovative organizational culture that values and develops human expertise. Organizations that successfully integrate state-of-the-art AI with effective workflows and innovative staffing solutions are setting a new standard in the industry. They not only achieve greater efficiency and accuracy in their processes but also empower their employees and enhance customer satisfaction. Ultimately, the goal is to harness the full potential of both technology and people to drive success in the increasingly complex landscape of Revenue Cycle Management.

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Are You Losing Money on Your Hospital Managed Care Contracts?

Two patients are waiting in the emergency room at Harmony General Hospital, both with seemingly broken arms. Joseph fell off a ladder at work, landing on his arm when he fell. Across from him in the waiting room is Brian, who fell and hurt his arm while playing street hockey with his children.

Which patient will be more expensive to treat? Joseph and Brian have similar injuries, but Joseph will be using his workers' compensation insurance, while Brian will be using his private employer-sponsored insurance. In many cases, such as this one, it is more expensive to treat the work-related injury than it is a regular injury.

If you have seen cases similar to this in your hospital, you may be wondering: Are we losing money on our hospital managed care contracts? To put it simply ... yes. The disparities in the cost of treating these two patients reflect the complexities of healthcare pricing and revenue cycle operations – and underscore the challenges that hospitals face when seeking reimbursement on workers' compensation claims.

The Benefits – and Costs – of Managed Care Contracts in RCM

When treating work-related injuries, hospitals must refer to the workers' compensation fee schedule, which is a predetermined list of maximum allowable charges for medical services provided to injured workers. For example, a workers' compensation fee schedule might state that the maximum reimbursement for treating Joseph's broken arm is $1,000. This means that, regardless of the actual cost of the treatment, the workers' compensation insurance company will reimburse the hospital only up to $1,000 for the entire treatment – including the examination, X-rays, casting, and any follow-up appointments.

However, in addition to adhering to workers' compensation fee schedules, many hospitals find themselves locked into contracts with managed care organizations (MCOs). MCOs manage and coordinate healthcare services for injured workers and negotiate rates for these services with healthcare providers.

As a revenue cycle leader or managed care leader, you may chuckle at "negotiate." Negotiating fair rates in workers' compensation managed care contracts can be a challenge, and hospitals are often put in a position where they lack the bargaining power to secure favorable terms. As a revenue cycle leader or managed care leader, you have likely dealt with challenges such as:

- Discrepancies in price. Often, these negotiated rates don't align with workers' compensation fee schedules, leading to discrepancies in price and hospitals giving managed care discounts on top of the predetermined fee schedule cost, which is already discounted. The interplay of fee schedules and managed care contracts can put hospitals in a precarious financial position when it comes time to seek reimbursement for workers' compensation claims.
- Negotiating multiple contracts. Very rarely do hospitals deal with only one payer or MCO. Negotiating these contracts and securing fair rates with each payer or MCO can be a tedious and time-consuming process.
- Complex regulatory requirements. Workers' compensation is not federally regulated. Every state manages workers' compensation claims differently, meaning hospitals – especially those that treat patients from multiple states – must stay informed about changes in regulations and compliance requirements. Even hospitals that operate in just one state must deal with the ever-changing regulations and changes to workers' compensation fee schedules. Revenue cycle teams must stay up to date on these changes and adjust negotiations accordingly.

Get Paid for the Work You Do

Hospitals want to provide care and help all people who need it – but unfair reimbursement rates can affect their ability and/or willingness to do so. Hospitals lose more money on workers' compensation claims because of unfair managed care contracts and discrepancies in price than for any other reason. Tack on the administrative burden of paperwork, coordination with payers and contract negotiations, and this group of tedious claims can drain your team's resources. Workers' compensation claims may represent only 5% or less of your hospital's annual revenue – but that can amount to millions of dollars.

Outsourcing workers' compensation claims to an outside partner can bring specialized expertise to the table. You want a vendor that:

- Understands the intricacies of managed care contracts
- Aggressively pursues underpayments and denials
- Continuously monitors and analyzes your claims
- Has technology capabilities to streamline processes and enhance efficiency
- Prioritizes data security and compliance with healthcare regulations
- Understands the legal and regulatory requirements unique to workers' compensation
- Pushes for fair reimbursement rates and ensures maximum ROI for your organization

When you're ready to outsource, look for a partner with decades of specialty RCM expertise and a powerful technology platform designed to streamline the process and help you get the most from your workers' compensation claims.

About the Author

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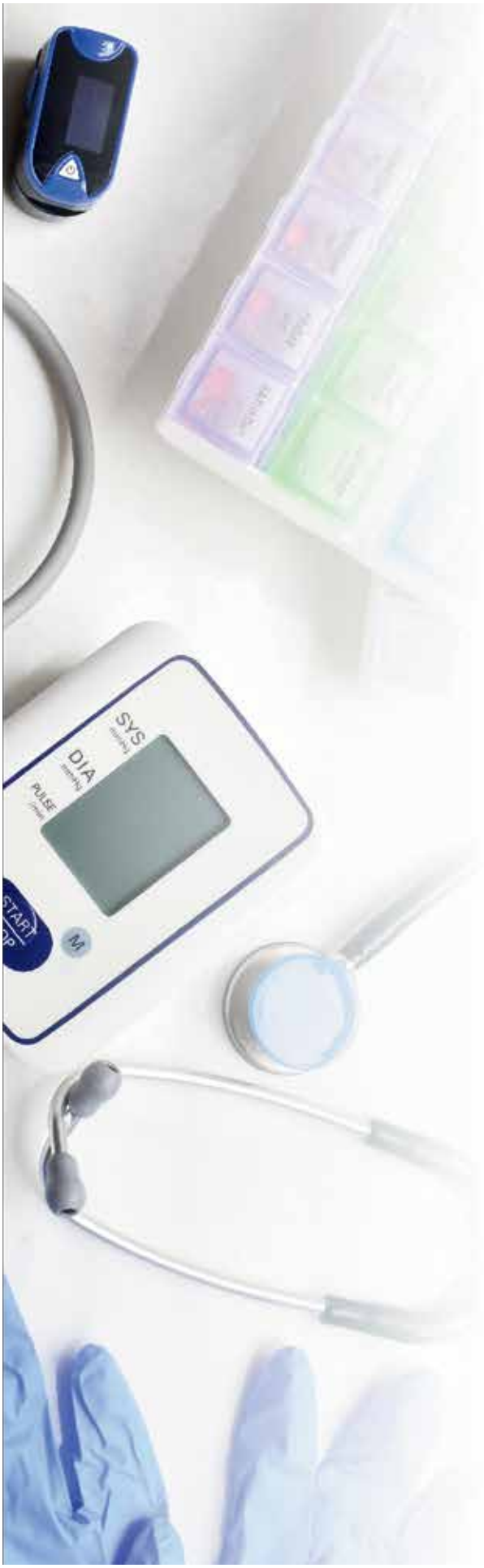

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4. Fill out the **volunteer form** and become more active today!

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

Upcoming Chapter Events

Date	Event	Location
July 25	Transition Dinner Celebration	Carlucci Restaurant, Rosemont, IL
August 4	Baseball Outing–Kane County Cougars vs Sioux City Explorers	Northwestern Medicine Field Geneva, IL
August 23	Topgolf Outing & Topgolf Outing & Scholarship Event	Topgolf Naperville, IL
October 21-23	HFMA Region 7 Midwest Conference	Hilton Chicago/Oak Brook Hills Resort & Conference Center Oak Brook, IL

Scan the QR code for event details

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