hfma
first illinois chapter

October 2024

# FIRST ILLINOIS SPEAKS


## IN THIS ISSUE



**To View the Midwest Conference 2024 - Oct. 21-23 In-Person Event**

**To Register for the Midwest Conference CLICK HERE**

**To View Message from Our Chapter President CLICK HERE**


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

**This year's Region 7 Midwest Conference on October 21-23 at the Hilton Chicago/Oakbrook Resort & Conference Center Oak Brook. IL has it all - Great speakers, topics plus two fun networking events.**

### Monday, October 21, 5:00-7:00 pm
### Football Tailgate Event

Tin Cup Bar & Grille. (at the Hilton Chicago/Oak Brook Hills Resort). Wear your favorite team's gear as we spend our first night back together as a region enjoying food, drinks, cash giveaways, and Monday Night Football!

- Tailgate-style heavy appetizers and open bar
- Gift Card Giveaways every half hour (must be present to win)
- Bags/cornhole (weather-permitting)

**How to Make the Most of the Event:**

- Come early to qualify for extra gift card drawings!
- Wear your favorite team's gear to earn extra raffle tickets!
- Bring a friend!
- Post-Event Monday Night Football viewing available in B. Restaurant & Lounge (Lobby Bar)
  - Baltimore Ravens @ Tampa Bay Buccaneers | 7:15 PM
  - Los Angeles Chargers @ Arizona Cardinals | 8:00 PM

**CLICK HERE to register today!**

### Tuesday, October 22, 5:00-7:00 pm
### Happy Hour Trivia

Beautiful heated/air conditioned Marquis Tent sponsored by Forvis Mazars. Compete for the grand prize (and bragging rights!) at this year's 2024 Region 7 Trivia!

**What to Expect**

- Buffet-style food with drink tickets
- Live Trivia with HFMA, Current Event, & "Pioneer" Themed Questions
- A chance to take home the Trivia Grand Prize
- Announcement of main raffle winners (must be present to win)
- Professional photographer with fun-themed photo props

**How to Make the Most of the Event:**

- Form your trivia dream team of 5-8 people (or reach out to any committee member to be added to a team)
- Pick a fun team name (extra points will be awarded for best name!)
- Download the Slido App for Trivia.

Fun committee members will be looking for throughout the conference to hand out raffle tickets, for example:

- Arrive early (first 50 people to check-in on Mon & Tues)
- Sign-up to be a chapter volunteer (available at the Registration Desk)
- Visit Sponsor Booths
- Participate in Tuesday Night Trivia
- Show your Region 7 spirit:
  - Wear your favorite team gear for the Monday event
  - Show your "pioneer" look at Tuesday's Event

# Message From Our Chapter President

## Dear Friends and Colleagues,

I hope everyone has enjoyed their summer, somehow time flew by and fall is here! The First Illinois Chapter had a busy and exciting summer schedule.

We kicked things off with the 10th Annual Women in Leadership Retreat in June. The DEI /Women in Leadership committee continues to knock this event out of the park with record breaking attendance and an action-packed agenda. The location moved to a larger venue this year to allow for even more attendees. I look forward to seeing this event grow each year and cannot wait to see what the committee has planned for 2025.


Next up was our annual Transition Dinner where we celebrate the accomplishments of the past year, thank our outing board members and officers, as well as welcome incoming board members and officers. We also highlighted some of our remarkable volunteers and organizations: Endeavor Health was recognized and awarded as Provider of the Year, Shelby Burghardt was recognized and awarded as Volunteer of the Year, and Ryan Downs was recognized and awarded as Emerging Volunteer of the Year. Congratulations again to our award recipients—we can't thank you enough for your dedication to the chapter! We also continued our annual tradition of the Scholarship Committee awarding future college students with a total of $15,000 in scholarship awards. It is always a pleasure to gather each year to kick off another chapter year!

August was another busy month with two social events. First the Kane County Cougars baseball outing, where families were invited to enjoy a minor baseball league game as well as participate in the team's family fun area. It was great to meet some of our members' families for the first time. We hope to have a similar event in the late spring or early summer of 2025.

While we continued to have our annual Golf Outing and Scholarship Event, this was the first time hosting the event at Topgolf rather than at traditional 18-hole golf course. What an incredible turnout from both our provider organizations as well as business partners! We had 11 provider organizations competing for the top score, with KSB Hospital taking the title and our first winner of the annual golf outing trophy! Most importantly this event is the main fundraiser for the chapter's student scholarship fund. I am happy to report that we raised just over $15,000! On behalf of the chapter, I would like to thank all the participants and business partners for their generosity this year! I would also like to thank the Golf Committee for putting on such a successful event and meeting our scholarship goal for the year!

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# First Illinois HFMA President's Message Continued

What an incredible summer for our chapter! As we head into the fall, we begin our goal of identifying 25 college students to join our chapter for the upcoming year as part of HFMA National's student scholarship program. We intend to have these students volunteer on committees, attend in-person education events, and even attend a chapter board meeting to get hands-on experience in the finance and healthcare industry. We are off to a great start and hope to meet the goal once students have returned for the upcoming fall semester. If you know of a college student in the Chicago area who may be interested in joining our chapter, please let me know.

We have three upcoming events we are looking forward to over the next several months. On September 28, we will participate in our second annual landscaping volunteer event at The Boulevard, an organization which provides medical respite care, holistic support, and housing services to help ill and injured homeless adults. We will follow this up with lunch afterwards; space is limited so be sure to register soon. From October 21-23, we have our biennial Region 7 Midwest Conference at the Hilton Chicago/Oak Brook Hills Resort and Conference Center in Oak Brook, IL. We have two fun networking events in the evenings planned along with an amazing lineup of speakers. Lastly, on November 14, we will head to The Puttery in the West Loop for the second Happy Hour of the chapter year sponsored by Blue & Company. Space is limited so be on the lookout for registration to RSVP and reserve your spot!

I'd like to thank once again all those who took part in events so far this chapter year. We would not be able to put on the educational content and networking opportunities without each one of you.


Please be sure to visit our chapter website for more information on all our upcoming events and hope to see you there!

**Scan the QR code for upcoming event details**

**Matt Aumick, CHFP, CPA**
**2024-25 President, First Illinois HFMA Chapter**
Controller, US Acute Care Solutions
aumickm@usacs.com

# Volunteer

*You get more than you give!*

hfma first illinois chapter

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

1. Visit **firstillinoishfma.org**
2. Click on the **Volunteer Opportunities tab**
3. Check out the **Volunteer Opportunity Description**
4. Fill out the **volunteer form** and become more active today!

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

# Transforming Episode Accountability Model (TEAM):
## A New Era in Healthcare Financial Management

The Centers for Medicare and Medicaid Services (CMS) has finalized a 5-year mandatory bundle payment model called Transforming Episode Accountability Model (TEAM), set to begin in January 2026 and conclude in December 2030.

## Program Overview

**Timeline and Scope:**

- **Duration:** January 2026- December 2030
- **Coverage:** 188 Core Based Statistical Areas (CBSAs) out of over 900, representing approximately 25% of CBSAs. Hospitals withing these selected CBSAs are mandated to participate.

**Rationale:**

Lis Fowler, CMS Deputy Administrator and Director of the CMS Innovation Center, emphasizes that the TEAM model addresses the fragmented care often experienced by Medicare beneficiaries before and after surgery. This fragmentation can lead to complications, prolonged recovery, unnecessary care, and readmissions. By bundling costs for a 30-day episode, the model incentivizes care coordination, enhances patient care transitions, and reduces the risk of avoidable readmissions. CMS projects that TEAM will save the Medicare program $705 million over the five performance years.

## Bundles and Costs

Participating hospitals will receive a regional target price, expected to come around June of 2025, to cover all costs associated with the 30-day episode of care for the following bundles:

| Bundle Name | Average National Cost | Number of National Episodes | MS-DRGs and/or HCPCS codes* |
|---|---|---|---|
| Coronary Artery Bypass Graft Surgery (CABG) | $48,905 | 28,088 | MS-DRG 231, 232, 233, 234, 235, 236 |
| Lower Extremity Joint Replacement (LEJR) | $21,063 | 215,957 | MS-DRG 469, 470, 521, 522 HCPCS 27447, 27130, 27702 |
| Surgical Hip and Femur Fracture Treatment (SHFFT) | $35,501 | 75,254 | MS-DRG 480, 481, 482 |
| Spinal Fusion (non-Cervical) | $46,326 | 65,968 | MS-DRG 402, 426-430, 447, 448, 450, 451, 471-473 HCPCS 22551, 2554, 22612, 22630, 2263 |
| Major Bowel Procedure | $29,184 | 59,983 | MS-DRG 329, 330, 331 |

** Note: Ambulatory Surgery Centers (ASCs) will not initiate an episode.*

## Accountability and Performance

Hospitals will be accountable for ensuring Medicare beneficiaries receive coordinated, high-quality care during the procedure and for 30 days post-discharge. Providers will continue to bill Medicare as the do today, with an annual reconciliation of actual costs against the established target price. Hospitals will earn a bonus payment from CMS, subject to a quality adjustment, if their actual spending is below the target price. Conversely, hospitals may owe CMS a payment if their spending exceeds the target price.

Hospitals will receive monthly claims files from Medicare to assess their bundle performance, necessitating the ability to turn data into actionable insights, including applying risk adjustment.

## Participation Tracks

The program offers graduated risk through different participation tracks to accommodate varying levels of risk and reward.

**Track 1**

**No downside risk and lower levels of reward** for the first year, or up to 3 years for safety net hospitals.

**Track 2**

**Lower levels of risk and reward** for years 2-5, or for safety net hospitals and rural hospitals.

**Track 3**

**Higher levels or risk and reward** for years 1-5.

## Additional Program Elements

- **Incentive Sharing:** TEAM participants can share incentives with physicians, downstream providers, and suppliers, based on the premise that aligned incentives improve care coordination and health outcomes.

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# Transforming Episode Accountability Model (TEAM):
## A New Era in Healthcare Financial Management (continued from page 5)

- **Quarterly Deliverables:** Hospitals must provide quarterly deliverables and program updates to Medicare.
- **Primary Care Referrals:** Hospitals will be required to refer patients to primary care services to support optimal, long-term health outcomes.
- **Health Equity and Environmental Reporting:** TEAM Hospitals are encouraged to voluntarily submit health equity plans to CMS and report metrics related to greenhouse gas emissions. CMS will provide individualized feedback and public recognition for participation.

## Case Study and Preparation

Expected in June 2025, hospitals will receive their historical spend information alongside target prices. For example, a hospital's aggregated historical spending by site-of-services for the Lower Extremity Joint Replacement 30-day bundle may reveal significant insights.

| Facility Type | Cost/ Episode Hospital | % of Total Cost- Hospital | Cost/ Episode Regional | % of Total Cost- Regional |
|---|---|---|---|---|
| All | $23,409 | 100% | $17,504 | 100% |
| Anchor Inpatient | $13,641 | 58% | $13,643 | 78% |
| Non-Anchor Inpatient | $1,099 | 5% | $1,084 | 6% |
| Skilled Nursing Facility | $8,206 | 35% | $1,896 | 11% |
| Home Health Agency | $382 | 2% | $674 | 4% |
| Outpatient | $81 | .4% | $207 | 1% |

In this example, the hospital's Skilled Nursing Facility ("SNF") cost greatly exceeds the regional cost. The hospital should further delve into the site-of-service detail to understand:

- Which SNFs are they utilizing?
- Which what % of their patients are going to SNFs?
- How many days are the patients staying at the respective SNFs?
- Can the hospital consider increasing Home Health utilization (a lower cost setting) to offset the higher SNF costs?
- Should the hospital partner with certain high performing SNF and Home Health agencies to improve the total cost of care?

To prepare for TEAM, hospitals should:

1. Confirm whether they or competing hospitals are within the designated mandatory CBSA's.
2. Understand historical spending and utilization for the episodes, using Medicare or regional databases for a preview of 30-day bundle cost information.
3. Assess clinical expertise and establish a leadership team for the initiative, building physician and clinician buy-in.
4. Identify and refine post-acute handoffs and define a high quality post-acute network.
5. Leverage existing case management team resources to focus on outlier patients.
6. Engage patients and caregivers for optimal outcomes.

## Future Implications

Excelling at bundles now will position hospitals for future success if Medicare mandates this program for all hospitals, adds additional bundles, or if hospitals pursue commercial and/ or Medicaid bundle programs. Ultimately, the goal is to manage the total cost of care while maintaining optimal quality and outcomes.

***About the Author***

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# Deal Flow to Increase With Clarity on Fed Policy and Valuation Convergence

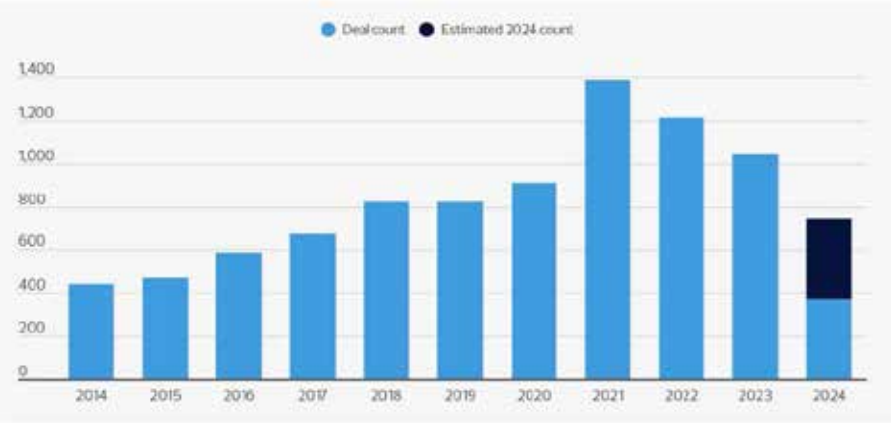
## Key takeaways

- Private investors are eager to invest in health care.
- Health care deal volume has nearly returned to prepandemic averages.
- Fundraising and deal-making challenges remain, but headwinds will ease with interest rate cuts.

Private markets are primed for health care. The expected start of the interest rate cut cycle will spur meaningful deal activity, despite longer due diligence cycles and a general market complaint about a lack of quality assets. The health care sector remains too large and too fragmented to avoid investment.

We expect 700 to 800 deals in private equity-backed health care services deal volume for 2024, in line with industry transactions from 2017 to 2019. While this number is significantly below the nearly 1,400 deals in 2021, it isn't quite the dearth many market participants are proclaiming.

### Health care private equity deal count




Source: PitchBook; RSM US LLP

Investors want exposure to the health care sector, and this will continue to drive volume. Health care dry powder—capital that has been contributed to private equity funds but not yet invested—remains high, signifying investor optimism for the sector.

According to data from Bloomberg, private equity and debt funds have accumulated $238 billion as well as $14 billion of dry powder, respectively. Bloomberg further estimates that $125 billion of health care buyout funds are currently raising money and expects at least $45 billion of new funds to begin fundraising in 2025. However, firms will continue to face a challenging fundraising environment, as limited partners—the investors in private funds—are scrutinizing sponsor performance and raising expectations for returns.

Much of this capital is being held on the sidelines as sponsors, sellers and other market participants wait for the Federal Reserve to begin a much-anticipated cycle of rate cuts. This will make capital less expensive, and more deals will be attractive to more buyers and sellers. Additionally, sellers who have been waiting for more favorable conditions and valuations will be motivated to sell, boosting supply.

Despite the Fed's policy of holding rates steady, we have seen some reductions in the rates of leveraged loan yields. These loans are a primary way private equity sponsors finance their investments. Leveraged loan spreads have fallen compared to the second half of 2023, when 81% of loans were issued at 600 or more basis points above the secured overnight financing rate; only 17% of loans were issued at that level in the first half of 2024. Over the same period, the proportion of loans issued at premiums of 500 to 549 basis points increased to 48% of volume, from 10%. Reduced financing rates will continue to drive deal volume.

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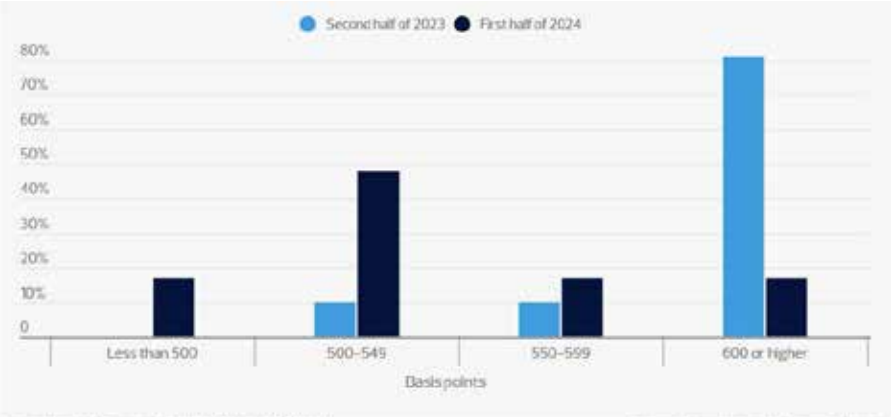
# Deal Flow to Increase With Clarity on Fed Policy and Valuation Convergence (continued from page 8)

## Leveraged loan spreads*

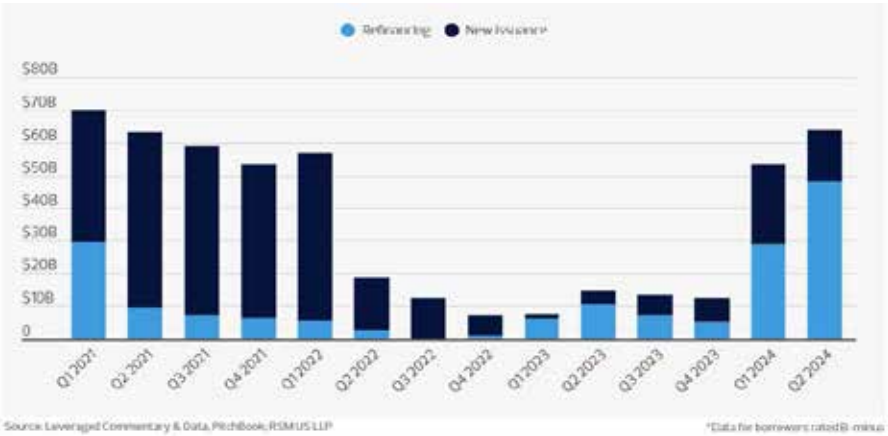



Source: Leveraged Commentary & Data, PitchBook, RSM US LLP

*Spreads on senior secured loans and unitranches

One caveat is that much of the debt financing activity in the first half of 2024 was related to refinancing and not new issuances. However, when excluding refinancings, the first half of 2024 saw $40 billion of total leveraged loan issuance compared to $13.4 billion in the second half of 2023. As financing becomes less expensive—and the timing of future rate cuts becomes clearer—debt will become more available and drive more financing.

## Total loan issuance recovering ahead of Fed rate cuts*




Source: Leveraged Commentary & Data, PitchBook, RSM US LLP

*Data for borrowers rated B- minus

## The takeaway

Private investors are eager to invest in health care. Despite declines in deal volume, the sky is not falling, and volume has nearly returned to prepandemic averages. The fundraising and deal-making environments have challenges, but the mechanisms are working and we expect headwinds to ease, particularly once the Fed embarks on its anticipated rate cut campaign. This will drive deal-making throughout the next macro cycle.

***About the Author***

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# 10 Key Takeaways From the FY 2025 IPPS Final Rule

On August 1, 2024, CMS released its fiscal year 2025 Inpatient Prospective Payment System (IPPS) final rule. CMS estimates hospital inpatient payments will increase by $2.9 billion nationally in FY 2025 due to the changes. CMS also takes a step toward achieving its goal of having all Medicare fee-for-service (FFS) beneficiaries covered under a value-based payment arrangement by 2030 by implementing a new, mandatory bundled payment model in 25% of core-based statistical areas (CBSAs).

**Below are 10 takeaways from the final rule.**

### 1. Payment Update Less Than Recent Input Price Inflation

CMS finalized a net IPPS market basket update (MBU) of 2.9% and capital update of 3.1%. The resulting base operating and capital rates are available here (pg. 2822).

The MBUs in 2021 through 2023 were underestimated by a cumulative 4.3 percentage points compared to the actual data collected after the fact. Despite concerns from hospitals and MedPAC, CMS has indicated it will not adjust the MBU to reflect inflation. This puts pressure on hospitals to accelerate aggressive cost management efforts and look for opportunities to increase allowable Medicare reimbursement.

### 2. Mandatory Bundles in Select Markets

Beginning on January 1, 2026, CMS will require hospitals in selected CBSAs to participate in the Transforming Episode Accountability Model (TEAM). Current participants in other CMMI episodic payment models may elect to participate in TEAM.

TEAM is a 30-day risk-bearing bundle that includes almost all Part A and B spending from the date of the triggering procedure to 30 days post-procedure for five surgical episodes. Target prices are based on regional data adjusted for certain hospital- and patient-specific factors and include a discount—which varies based on episode—to promote CMS savings.

These five episodes account for 15% of allowable inpatient charges nationally. Hospitals have at least 16 months before the model begins, but preparation will take time. Important steps include analyzing claims data from the benchmark period to understand improvement opportunities, aligning with physicians to redesign care pathways, and developing the high-value post-acute care networks essential to success. Additional details on TEAM are available here.

### 3. Uncompensated Care Disproportionate Share Hospital Payment Shrinks Again

The dollars available for distribution to disproportionate share hospitals (DSH) for uncompensated care (UC) decreased by $200 million compared to the FY 2024 IPPS final rule. Despite ongoing Medicaid redeterminations, CMS projects the uninsured rate will decrease relative to 2024, which drives the reduction in payment.

Since 2020, CMS has decreased UC by approximately 32% ($2.6 billion). The shrinking UC DSH pool increases the importance of accurately capturing all eligible UC costs on worksheet S-10 and the related exhibits that became effective for cost reports filed on or after October 1, 2022. A comprehensive understanding of the exhibit requirements is imperative for hospitals to receive their share of these shrinking funds.

### 4. Wage Index

CMS finalized a labor-related share of 67.6%, a three-year extension of its low-wage index policy, and implemented changes to certain CBSAs. CMS estimates 771 hospitals will receive their state's rural floor wage index value in FY 2025.

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# 10 Key Takeaways From the FY 2025 IPPS Final Rule (continued from page 11)

CMS may not be able to sustain the low wage index policy for its intended three-year extension. On July 23 the U.S. Court of Appeals for the D.C. Circuit not only upheld a lower court ruling that found the policy impermissible, but vacated the regulations. The 9th Circuit Court is hearing a similar legal challenge. CMS has 90 days from the date of the decision to seek a review by the Supreme Court, or it may seek an en banc review by all the judges of the D.C. Circuit Court.

The final rule notes approximately 33 hospitals considered part of an urban CBSA will be considered located in a rural area for FY 2025 under the revised CBSA delineations. An additional 24 hospitals in rural areas will be located in urban areas under the revised CBSAs.

In general, affected hospitals should review any add-on payments and/or special payment statuses they currently receive to understand the payment impact of the change in CBSA and review the CMS regulations to identify steps they can take.

Moving from rural to urban status cancels Critical Access Hospital, Sole Community Hospital, or Medicare Dependent Hospital status and impacts resident caps. Depending on the circumstance, hospitals may need to reclassify to mitigate the impact or take advantage of a transition period. Urban hospitals that become rural could experience a cap on DSH payments. CMS provides a three-year transition period in these instances.

### 5. Medicare Dependent Hospital (MDH) Status

Unless Congress intervenes, the final rule reminds hospitals that by statute MDH status expires for discharges occurring on or after January 1, 2025. If an MDH qualifies, it may apply for Sole Community Hospital (SCH) status. To receive SCH status effective January 1, 2025, an MDH must apply by December 2, 2024. CMS estimates that of the 173 MDHs, 117 would be paid based on the blended rate.

### 6. Outlier Threshold

CMS finalized an acute outlier threshold of $46,152 for FY 2025. This is lower than the proposed threshold of $49,237 but higher than the FY 2024 final rule threshold of $42,750. The increase in the threshold will result in a reduction in outlier payments relative to FY 2024.

### 7. Graduate Medical Education (GME)

CMS finalized distribution criteria for the 200 new residency slots, effective July 1, 2026, created by the Consolidated Appropriations Act (CAA) of 2023. The criteria are largely similar to the criteria CMS is using to allocate the 1,000 new slots included in the CAA of 2021. The one exception is that by statute, half of the slots created by the CAA of 2023 must be allocated to psychiatry or psychiatry subspecialty residency training programs.

Applications for the additional slots created by the CAAs of 2021 and 2023 are due by March 31, 2025, and must be submitted via the Medicare Electronic Application Request Information System (MEARIS). To assist hospitals in preparing for their applications, Health Professional Shortage Area (HPSA) information will be posted when the online application system becomes available on the CMS website. It is anticipated the application and related information will become available in early 2025.

### 8. Small, Independent Hospitals Eligible for Separate Payment for Stockpiling Essential Medicines

Independent hospitals with 100 or fewer beds are eligible for payment for the "IPPS share" of the additional resource costs necessary to establish and maintain a six-month buffer stock of one or more of 86 essential medicines. The payment is effective for cost reporting periods beginning on or after October 1, 2024.

### 9. Inpatient Quality Reporting/Value-Based Purchasing Program Updates

CMS finalized seven new measures for the Hospital Inpatient Quality Reporting (IQR) Program—five measure removals and two measure modifications—including changes to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measure. CMS made related changes to the scoring methodology of the Hospital Value-Based Purchasing (VBP) Program to account for the HCAHPS modifications. The rule also includes modifications to the Electronic Clinical Quality Measures (eCQM) data reporting and submission requirements, including a progressive increase in the number of eCQMs hospitals are required to report.

### 10. Conditions of Participation Requirements for Hospitals and Critical Access Hospitals (CAHs) to Report Acute Respiratory Illnesses

CMS replaced the COVID-19 and Seasonal Influenza reporting standards for hospitals and CAHs with a new standard addressing acute respiratory illnesses. Beginning on November 1, 2024, hospitals and CAHs must electronically report information about COVID-19, influenza, and respiratory syncytial virus (RSV). CMS also finalized that outside of a public health emergency, hospitals and CAHs would have to report these data on a weekly basis.

***About the Author***

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# What's Top of Mind for Revenue Cycle Leaders?

Revenue cycle leaders are tasked with far more in today's environment than just managing the revenue cycle itself. The role has evolved to require a technology, regulatory, cybersecurity and talent development lens. Each of these brings its own challenges and opportunities to healthcare systems. The Bank of America healthcare team recently attended a HealthLeaders' Revenue Cycle Exchange where select healthcare leaders met to share best practices.

## Staying up to date and choosing the right partner are essential

**Q: How are providers leveraging Big Data?**


Abtalion: Big Data is a term that one encounters frequently these days. Revenue Cycle Exchange providers shared that they have an abundance of raw datasets related to every facet of the care delivery process and that there is ample opportunity to leverage this data in an endless number of transformative ways. However, the amount and complexity of the data make it very challenging to drive insights. Machine learning (ML) removes that limitation and can position organizations to unlock the raw potential of their data. By harnessing the power of ML, organizations are beginning to successfully analyze historical data, patient patterns and bed utilization. This, in turn, allows providers to make decisions around streamlining operations, reducing wait times and ultimately driving an improved patient experience while driving down care delivery cost. Examples provided by revenue cycle leaders who are leveraging big data and ML included improving patient interactions, determining propensity to pay, identifying patients who would benefit from financial assistance and addressing payer behaviors.

**Q: How are providers introducing and maintaining patient-centric solutions?**

Abtalion: Being patient-focused, or patient-centric, is not new. The concept is an ongoing effort that's been gaining more traction and importance every year since the passing of the Affordable Care Act (ACA) in 2010. This has resulted in the shift of the onus of the financial burden from payor to patient, which has led to patient collections being projected as the fastest growing source of payments within health systems this year. Given this ever-growing segment, revenue cycle leaders continue to deploy an omnichannel communications and collections strategy aimed at meeting their patients through their preferred method of engagement. Additionally, there was ample discussion around billing simplification and the tight relationship required between revenue cycle and patient financial assistance teams. Organizations are pushing for easier-to-digest bills that align with retail experiences, while also ensuring empathy and compassion throughout the collections process.

> "Revenue Cycle Exchange providers shared that they have an abundance of raw datasets related to every facet of the care delivery process and that there is ample opportunity to leverage this data in an endless number of transformative ways."

**Q: Are providers seeing success leveraging new technology for automation?**

Crispin: Yes, providers are seeing success; however, unsurprisingly, the adoption and success have been inconsistent, and further deployment of AI continues to be top of mind. Generative AI, and machine learning more broadly, is still in its early stages in the revenue cycle space. Some providers have had success leveraging this category of AI to automate processes, including drafting letters to payers and assembling

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## What's Top of Mind for Revenue Cycle Leaders? (continued from page 14)

appeal packages. The outputs from machine learning processes still typically require human review, so these are productivity enhancers versus fully end-to-end automated processes. Robotic process automation (RPA) is more widely deployed at this point. Providers are having varying degrees of success automating internal processes and interfaces with third parties, typically payers. We will continue to see additional applications for AI, machine learning and RPA as competitive pressures drive the adoption of efficiency and cost-conscious measures.

**Q: How are providers thinking about their vendor relationships?**

Crispin: Building trust is a crucial aspect of third-party relationships, especially when technology solutions are involved. Providers are looking for a positive track record and strong evidence that a solution is real, that it's scalable and that it can deliver in their environment. Healthcare systems typically gravitate toward large vendors that can meet their stability and resiliency requirements. Of course, there are still plenty of systems that prefer to partner with smaller, nimbler firms. Recent cybersecurity events are causing health systems to reconsider all relationships, as risk mitigation and business resiliency become even more critical. Vendor affordability is always a factor, but finding a collaborative partner relationship is rising to the top as a priority.

## Key takeaways

- Keeping on top of the latest thinking and finding the right partner could allow revenue cycle leaders to focus on delivering care and furthering their mission.
- A desire to become more patient-centric is driving omnichannel communications and collections strategies, as well as billing simplification.
- New technologies like machine learning can help organizations unlock the raw



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# 2025 Healthcare Hiring Outlook:
## Finance Roles Take Center Stage

With healthcare financial systems becoming more complex, the demand for skilled professionals in healthcare administration and finance has been steadily growing.

Whether you're a job seeker or an employer, it can be helpful to know about the latest trends shaping this crucial segment of the healthcare job market.

### The talent crunch continues

According to recent research, 80% of healthcare managers are experiencing challenges finding highly skilled workers, with demand projected to grow another 13% over the current decade – much faster than the average estimated for all occupations. This increase, coupled with an aging workforce and burnout-induced turnover, has created a highly competitive job and hiring environment.

According to The 2025 Salary Guide from one of the leading talent solutions firms, here are the financial roles likely to be among the hottest:

- **Revenue Cycle Management (RCM) Specialists** ensure healthcare providers receive accurate and prompt reimbursement for their services. Their work improves cash flow for providers and helps prevent and manage claim denials through careful oversight of the billing process.

- **Healthcare Financial Analysts** help providers and other healthcare organizations make data-driven decisions to optimize operations and improve financial performance.

- **Medical Billing Managers** help healthcare facilities adapt to new payment systems. They are becoming highly valuable as reimbursement models evolve.

### Flexible work no longer just a perk

Remote work has evolved from an added incentive to a standard expectation for finance professionals in many industries. While clinical roles often require on-site presence, many healthcare finance positions

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# 2025 Healthcare Hiring Outlook: Finance Roles Take Center Stage (continued from page 16)

are embracing remote and hybrid models. This shift toward flexibility not only attracts top talent but also improves retention rates.

Increasingly, healthcare hiring managers are offering higher pay for in-office work. For jobs that can be done remotely, 69% of healthcare managers are willing to increase starting salaries for new hires to work in the office full or part time. Of those, 58% are offering up to 20% more pay to come in 4 to 5 days per week. Our research shows professionals in this field prefer an average of 3 days per week on-site.

## Certifications matter

Healthcare finance professionals can significantly enhance their career prospects by obtaining the right certifications. These credentials not only demonstrate expertise but also set individuals apart in the competitive healthcare job market.

Depending on the role, these accreditations may be appropriate:

- **Healthcare Financial Management Association (HFMA) Certifications:** These include various certifications that cover a wide range of financial management skills tailored to the healthcare industry
- **Certified Professional Biller (CPB):** This certification is essential for those involved in medical billing, ensuring a deep understanding of billing processes and compliance.
- **Certified Professional Coder (CPC):** Ideal for professionals focused on medical coding, this certification highlights proficiency in coding guidelines and regulations.
- **Registered Health Information Administrator (RHIA):** This credential is crucial for those managing patient health information and medical records, emphasizing leadership in health information management.
- **Certified Healthcare Financial Professional (CHFP):** Designed for mid-level healthcare professionals, this certification demonstrates a commitment to maintaining up-to-date skills and knowledge in healthcare finance.
- **Revenue Cycle Management Certificate:** Focused on the financial processes associated with patient care, this certification is valuable for those looking to streamline healthcare operations and improve financial outcomes

## Contracting for a win-win-solution

To address talent shortages and manage workloads, almost half (48%) of healthcare managers plan to increase their use of contract professionals, according to Robert Half research. This trend is particularly prominent in finance-related areas like medical administration, billing and collections, payment processing and revenue cycle management.

Here are some job and hiring market tips based on research for The 2025 Salary Guide:

***About the Author***

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# 9 Data Mistakes That Amplify Risk in Value-based Care

**Is your data program setting you up for success in a value-based care model? Avoid these 9 mistakes to make sure your data and analytics are supporting your goals.**

After years of anticipation, value-based care (VBC) and alternative payment models (APMs) are here – along with new risks for hospitals and health systems to navigate. When hospitals adopt VBC, they assume downside risk, which involves financial penalties if performance targets aren't met. Transparency challenges can arise due to unclear value-based formulas and metrics, along with other risks like misalignment between providers and executives. Hospitals and health systems need accurate and timely data and data analytics to support behavioral changes and continuously improve their care delivery to ensure they receive compensation.

While existing dashboards in electronic health records (EHRs) help, ensuring seamless integration of data from various sources is crucial for real-time population monitoring. To have confidence when taking on the risks that come with VBC and APMs, hospitals and health systems are investing to build a modern data platform that allows for better data-sharing, care coordination, and innovation. If you're among this group of forward-thinking industry leaders, take note of these 9 data gaps that could make the business of risk in VBC even riskier.

### 1. Lacking usable dashboards to continuously monitor your population and outcomes

Dashboards are supposed to simplify complexity, but they often can create information overload. When taking on risk, dashboards must strike the right balance – simplifying data while still providing enough information to monitor population trends and care outcomes. When done correctly, they play a critical role in reducing risk.

For example, one health system built dashboards in Tableau and analytics processed through Alteryx to identify an increase in high emergency department utilizers presenting with nonemergent diagnoses. Because many of these patients lacked insurance, the health system assumed the risk of caring for them, consistent with its mission as a public, safety-net health system. The dashboards helped tell the story of this specific patient population, including their complex behavioral and mental health needs along with a set of social determinants of health (SDOH) that increased their vulnerability. The health system used these dashboards to launch a population health initiative to continuously monitor this population and prioritize case management interventions to engage the patient in primary care, address their SDOH needs, and monitor their outcomes. As they track this population over time, they'll be much better prepared to spot trends, understand their level of risk, and ensure their actions are leading to improvement.

### 2. Failing to monitor clearly defined KPI trends in a payer scorecard

A key indicator of readiness for managing payer relationships in a VBC model is the successful management of payer performance within a fee-for-service model. As providers face increased margin pressure and explore efforts to increase collections and revenue integrity with analytics, payers are also investing in analytics to make sure reimbursement is consistent with their contracts and policies.

The result is a zero-sum mindset that causes friction between payers and providers, rather than promoting a partnership with a shared vision (patient health) and mutual benefits (achieving their mission). Strained payer-provider relationships can be improved through transparently reviewing agreed-upon KPI trends together during recurring meetings with the payer.

Payer scorecards aren't new – in fact, many EHRs include dashboards and reports with the standard metrics in a payer scorecard, such as percentage of first payments denied, average days to denial resolution, and percentage of accounts receivable greater than 90 days. But the standard dashboards often either aren't used in payer meetings or aren't effective.

To be effective, the dashboard should roll up the multiple insurance plans you have into one view, which may require integrating data using a platform like Informatica or Snowflake as well as a third-party dashboarding application like Tableau, Sigma, Qlik, or Power BI. Second, the KPIs in the dashboard must be standardized, meaning the payer also agrees with the KPI definition. The dashboard also should be benchmarked so you can show each payer their comparative performance. This will help to make sure the KPIs have targets that you, the provider, and the payer agree upon. Finally, the scorecard should show trended, historical data demonstrating how performance and the payer-provider partnership is improving.

### 3. Relying on data siloes for reporting instead of a modern data platform

Most hospitals and health systems have more than a hundred individual data sources with clinical information to help manage their population – in other words, data siloes. When clinicians and care coordinators rely on data siloes, they can't see the complete profile of a patient's clinical and SDOH needs. However, integrating these siloes with on-premise solutions can be expensive, with high hardware and software costs as well the expense for staff time dedicated to managing complex data integrations.

To prepare for value-based care, we advise hospitals and health systems to first deploy a scalable modern data platform like AMN

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# 9 Data Mistakes That Amplify Risk In Value-Based Care (continued from page 18)

Healthcare did with Snowflake to eliminate data siloes, which can dramatically reduce costs and help make meaningful improvements to patient care.

### 4. Caring for patients without continuous, real-time feedback loops to clinicians

The founder of the quality movement, W. Edwards Deming, said that "Quality is everyone's responsibility." This is perhaps most true in a healthcare setting, where the actions of every provider and healthcare worker can impact quality measures. And as the shift from fee-for-service to VBC continues, it will be even more important for hospitals and health systems to manage the quality measures through continuous quality improvement initiatives. In fact, your reimbursement may depend on it.

One method to master your VBC measures for maximum reimbursement is leveraging your data to provide real-time feedback to clinicians on patient outcomes and quality measures. Feedback loops are critical to reinforcing behavior. When a driver presses the gas pedal on a car, they see, hear, and feel that it achieves the outcome they expect. In the same way, it's vital to help clinicians to see and confidently know the actions they're taking are making improvements.

With the hundreds of data sources in a typical hospital or health system, this can be difficult. Tools like Informatica can help to integrate data quickly, as New York Health + Hospitals experienced by empowering 50,000 healthcare professionals with trusted data and analytics.

### 5. Lacking the ability to ingest shared data from partners and monitor attributed lives

When you take on a downside risk arrangement to manage a population, you can't do it alone. While you may be attributed to the patient life, you'll be relying on data from other providers, clinics, hospitals, pharmacies, insurers, laboratories, and community partners to manage your population.

Without the tools to ingest data from partners and see a complete clinical profile of your population, you potentially assume unknown risks you're not aware of without the information you need to manage the risk. This requires a very thoughtful data strategy and a robust data governance program. Even though the inability to access data from your partners is a risk, ingesting data without a clear plan to manage the security risk – and potentially introducing data that may not be consistent with your organization's data standards – is also risky. Participating in a healthy information exchange can help promote these standards, and we advise clients to prepare by building a modern data platform such as a combination of Informatica and Snowflake that can ingest and manage data and scale with your needs.

### 6. Modeling complex APM payment performance and cashflow scenarios in the wrong tool

Modeling fee-for-service contracts is complex enough with the need to account for different base weights and rates by facility, bundled services, and complex outlier provisions. Your health system has likely invested in robust contract modeling solutions to both estimate potential reimbursement scenarios and validate that payers are reimbursing claims consistent with contract terms. And even through all of this effort, you still may uncover special cases that require refining your contract models – that's why it's important to find a platform that's nimble enough for your team to modify as needed.

When transitioning from the well-understood fee-for-service model to a less-understood VBC model, which has more variables and downside risk, hospitals and health systems shouldn't rely on overly rigid modeling tools. The payers you're negotiating with have teams of actuaries and years of actuarial experience modeling risk through their underwriting process. When entering into risk-based contracts with them, hospitals and health systems CFOs should work with their CIO or chief data officer (CDO) colleagues to level the playing field with a modern data platform and technologies to model risk-based contracts.

### 7. Relying on "pull" reports instead of "push" alerts for data-driven decisions

As we saw during the COVID-19 pandemic, timely data is correlated with timely decision-making. In response to the pandemic, many health systems launched new dashboards with real-time (or near real-time) data to quickly respond to the rapidly changing operational situation. In each department, teams of clinicians and leaders would ask for the most current reports to find the handful of key data points to inform their decision-making. This system won't be efficient enough going forward.

You shouldn't need to pull data reports from your tools; your tools should automatically send you the information you need to make decisions when you need it. To be prepared for a risk-based world, hospitals and health systems will need push alerts to provide care for patients, manage attributed lives, and mitigate risk. In a VBC environment, operations will make you or break you and will require you to proactively manage patient care, based on data, as highlighted in these four tips to manage the switch.

### 8. Lacking interoperability tools to share real-time data and seamlessly coordinate care

When taking on risk for attributed lives, you need to be able to support all other providers and community partners who deliver care and services for your population. And one of the best ways you can support them is through securely providing the clinical patient data they need, when and where they need it.

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# 9 Data Mistakes That Amplify Risk In Value-Based Care (continued from page 19)

In the wake of the widely publicized Change Healthcare ransomware attacks, many hospitals and health systems are reevaluating their data security and data-sharing policies, which is appropriate given that protecting sensitive patient data requires a collaborative, organizationwide strategy.

But as the shift to VBC continues, simply avoiding data-sharing isn't a viable long-term option. It'll be necessary for hospitals and health systems to have the interoperability tools to share data and provide timely access. For example, a modern data platform such as Snowflake provides a flexible and secure method to confidently and quickly share data with partner organizations as demonstrated by the Colorado Community Managed Care Network. As interoperability standards like Fast Healthcare Interoperability Resources become more widely adopted, and as your partners gain the ability to receive data, the expectation (and opportunity) to share real-time data that helps to seamlessly coordinate care will grow.

### 9. Having data governance gaps that cause poor or inconsistent data quality

You can fix every other data mistake on this list, but it would all be for nought if your data was incomplete or inaccurate. The transition to VBC will illuminate the divide between two types of healthcare organizations – those that invest in and protect their data as a strategic asset and those that disregard it as just another technology cost.

When 30% of the world's data volume is being generated by the healthcare industry, but only 57% of a healthcare organization's data is used in key decision-making, it seems there must be a problem. Perhaps it's because just 20% of healthcare organization executives fully trust their data.

## Getting started

There's an imperative on the horizon for all hospitals and health systems to formalize a robust data governance program. The program should be designed to educate your people, enhance your data management processes, and deploy data governance technologies to improve data quality and advance your readiness for taking on risk.

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# Price Transparency Requirements for CY2024 Bring About Standardization For Machine-Readable Files

The hospital price transparency rule was implemented on January 1, 2021 and codified in the Code of Federal Regulations (Title 45, Subtitle A, Subchapter E, Part 180). While the rule was met with great debate within the industry, the Centers for Medicare and Medicaid Services (CMS) has continued its initiatives for greater transparency in healthcare. In response to the industry's request for standardization in reporting, CMS responded with the development of a CMS template and encoding requirements of data elements.

The CY2024 Outpatient Prospective Payment System (OPPS) published November 22, 2023 , provides guidance and related implementation (compliance) dates specific to the accessibility, format and structure, and content of the machine-readable file (MRF). Compliance dates vary across adoption of the requirements beginning in January of 2024 through to January of 2025.

### Accessibility

As of January 1, 2024, hospitals must ensure that their MRF(s) are easily accessible to the public as well as to improve automated access by CMS for purposes of auditing for compliance. The requirements include the addition of a .txt file and website footer. A hospital's good faith effort in providing access to their MRF is demonstrated through meeting this requirement together with publishing of the MRF itself.

### Format and Content

As of July 1, 2024, hospital MRFs must conform to a CMS template layout. CMS has published the template layout in three formats: CSV "Tall", CVS "Wide" and JSON. Hospitals may choose the format for publishing their charges. Within each format, CMS has adopted established standards and industry norms. This includes valid types by data element; including string, date, Enum, numeric and Boolean. Values encoded incorrectly will generate a deficiency.

The content for the CMS template resembles much of what has been in place since 2021 as it relates to providing item and service descriptions, billing identifiers and standard charges; including, gross, discounted cash price, and de-identified minimum and maximum charges. Under the CY2024 Final Rule, additional data elements are included with the objective to improve the public's understanding of hospital provider and payer charge methodologies.

The data elements provide for information or groups of information that contextualize the standard charges of the hospital.

| Category | New Data Element as of July 1, 2024<br>Those asterisked have a compliance date of January 1, 2025 | Definition/Considerations |
|---|---|---|
| **MRF Information (Header)** | MRF Date | The calendar date of the last file update. |
| | CMS Template Version | The CMS Template version. |
| | Affirmation Statement | A pre-populated statement written and re-quired by CMS, with a value encoded of "True" or "False". |
| **Hospital Information (Header)** | Hospital Name | The legal name of the hospital. |
| | Hospital Location(s) | The unique name of the hospital location(s), absent acronyms. |
| | Hospital Address(es) | The geographic address of the corresponding locations. |
| | Hospital Licensure Information | The hospital license and state/territory acronym. |
| **Standard Charges** | Standard Charge Method | The method used to establish the payer-specific negotiated charge (e.g., case rate, fee schedule). |
| | Payer-Specific Negotiated Charge – Dollar Amount | The negotiated charge that a hospital has negotiated with a third-party payer for the corresponding item or service. This is ex-pressed as a dollar amount without $, 1000 separator and without .00 values (e.g., 1000, 1000.01). |
| | Payer-Specific Negotiated Charge – Percentage | Indicated only when the payer-specific negotiated charge has been established as a percentage and no dollar amount can be calculated. |
| | Payer-Specific Negotiated Charge – Algorithm | Expressed algorithm that the hospital has negotiated. |
| | Estimated Allowed Amount* | The average dollar amount that the hospital has historically received from a third-party payer for an item or service. |
| | Additional Generic Notes | A free text data element used to explain any of the data including charity care policies, or other contextual information that aids in the understanding of the standard charges. |

# Price Transparency Requirements for CY2024 bring about standardization for machine-readable files (continued from page 21)

| Category | New Data Element as of July 1, 2024<br>Those asterisked have a compliance date of January 1, 2025 | Definition/Considerations |
|---|---|---|
| | Additional Payer-Specific Notes | A free text data element used to help explain data in the file that is related to a payer-specific negotiated charge. |
| **Item & Service Information** | Setting | Indicates the setting of the item or service (e.g., Inpatient). |
| | Drug Unit of Measure* | Indicates the unit value that corresponds to the established standard charge.<br>For example, an 81mg aspirin unit of measure would be indicated as "1". |
| | Drug Type of Measurement* | The measurement type that corresponds to the established standard charge for drugs as defined by either the National Drug Code or the National Council for Prescription Drug Programs.<br>The measurement aligns to volume measurement and may not correspond with HCPCS (e.g., J-Code) billable units.<br>For example, an 81mg aspirin type of measurement would be indicated as "UN".<br>Valid values include:<br>• GR Grams<br>• ME Milligrams<br>• ML Milliliters<br>• UN Unit<br>• F2 International Unit<br>• EA Each<br>• GM Gram |
| **Coding Information** | Billing/Accounting Code | The code(s) used by the hospital for purposes of billing or accounting for the item or service. |
| | Code Type | Corresponds to the Billing/Accounting Code to indicate the type of code displayed (e.g., CPT, HCPCS, RC) |
| | Modifiers* | Provides for any modifier(s) that may change the standard charge that corresponds to hos-pital items or services (e.g., payment modifiers) |

## In Conclusion

Hospitals at the highest risk of non-compliance include those that do not meet accessibility requirements or publish a machine-readable file in the required CMS template format. As hospitals and health systems continue to work toward achieving (and maintaining) price transparency compliance, they should perform proactive audits of their MRF and take steps to correct issues in-house where possible. If they don't have the capabilities within the organization, they should reach out to a trusted, objective business partner for assistance. By correcting any issues and achieving compliance, hospitals can reduce the risk of monetary fines, public scrutiny and reputation damage while potentially uncovering potential charge capture opportunities and increasing quality and efficiency of their revenue cycle processes.

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