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FIRST ILLINOIS SPEAKS

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From Defense to Offense:
How AI Turns the Tables on Payer Denials

Ever feel like you're trapped in a never-ending cycle of denied claims? You're not alone. But the denials crisis hitting your revenue cycle isn't just a feeling—it's a measurable reality affecting healthcare providers coast to coast. Teams everywhere are struggling with the same crushing workload of denied claims that drain resources, delay critical payments, and exhaust already stretched staff. What if there were a way to remove the administrative burden from your staff, allowing them to use their time in a more productive way?

The Crisis by the Numbers

The statistics paint a grim picture. The landscape of claims processing has dramatically shifted, with claim denials climbing over 15% in four years, from 10.2% in 2020 to 11.8% in 2024—and it's accelerating fast.[1] Chances are you're part of the 77% of providers dealing with rising denials—that's nearly double the 42% who reported this problem back in 2022[2].

Here's what that looks like in dollars: the average hospital loses $5 million annually to claim denials, which translates to about 5% of net patient revenue.[3] Scale that across the industry, and payers are rejecting $260 billion worth of hospital claims every single year.

The AI Arms Race

Here's the part that should really get your attention: payers aren't just denying more claims—they're using cutting-edge AI to do it at lightning speed. A total of 85% of health payers are now using AI in their operations, and they're not holding back.[4] Cigna's algorithm processed 300,000 denials in just two months, with reviewers spending an average of 1.2 seconds per case![5] They've essentially automated "no" while some providers are still processing accounts the old-fashioned way. It's time to level the playing field.

The Response

So, what's our countermove? It's time to bring our own tech firepower to the table. Imagine if your revenue cycle could harness the same AI capabilities to:

- Flag likely denials before submission
- Auto-generate compelling appeals based on previous successes
- Instantly extract key evidence from medical documentation without manual review
- Continuously learn and adapt to changing payer tactics

Empowering Excellence, Not Replacing It

Let's be crystal clear: AI doesn't replace experience—it amplifies it. It's about letting us shine at what we as humans do best. Our experienced team members are still our secret weapon, but now they can focus on what they do best. What if they could slash a significant amount of the time they spend digging through pages and pages of endless medical records and assembling appeal narratives, freeing them up to focus instead on strategic appeals that require human judgment?

The magic happens when sophisticated technology meets seasoned expertise. AI handles the data crunching, pattern recognition, and repetitive tasks, while your team applies their experience, negotiation skills, and clinical knowledge to the complex cases that truly need human intervention.

Proven Results from Healthcare Leaders

The encouraging news? Forward-thinking revenue cycle leaders aren't just talking about AI—they're already winning with it. Through Aspirion's pilot program, several prominent health systems—Banner Health, Houston Methodist, and Legacy Health—have demonstrated the transformative potential of AI technology in combating payer denials.

The numbers don't lie. Banner Health doubled down on DRG downgrades and saw their success rate jump to 32%—a 50% improvement over traditional methods—while boosting their daily appeal volume by 20%. Legacy Health is winning 55% of their appeals and collecting on 89% of AI-enhanced cases. Houston Methodist broke new ground, using AI to tackle previously impossible denial types and scaling their appeal operations without proportional headcount growth.[6]

These measurable results demonstrate that AI delivers both enhanced effectiveness and operational scalability, providing clear ROI while addressing critical capacity constraints across health systems.

The AI Success Framework: Four Must-Have Components

Effective AI implementation for denials management hinges on four fundamental pillars:

1. **Strategic targeting:** Resist the urge to tackle everything at once—zero in on specific denial categories where AI can create immediate, visible results.
2. **Solid data infrastructure:** Quality input equals quality output—your historical claims data must be accurate, complete, and easily accessible for AI processing.
3. **Seamless technology integration:** Select a solution that meshes with your existing workflows while delivering sophisticated analytical power.

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4. **AI-ready team:** Equip your staff with the skills to partner effectively with AI—they need to understand how to interpret outputs and translate them into winning strategies.

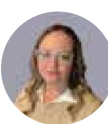
Picture it this way: AI provides the horsepower, data supplies the energy, your strategy sets the course, and your people navigate the journey. All four elements must work in harmony.

Your Path Forward

AI technology is evolving at lightning speed, making your implementation strategy more critical than ever. You've got three paths: buy off-the-shelf solutions for quick deployment that might have limited customization and ongoing costs, build your own technology which offers maximum control but can be resource intensive, or partner with an experienced vendor that has the advanced tech and the ability to scale fast, as the technology develops at a rapid pace.

Your team is already fighting an uphill battle to overcome a complex, shifting payer landscape. They deserve tools that work just as fast—and just as smart—as the ones being used against them.

Your patients—and your bottom line—are counting on it.



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Strategic Resilience: A Survival Guide For Healthcare and Senior Living Providers

Healthcare and senior living organizations are confronting existential challenges in the face of regulatory changes, funding shortfalls, and demographic shifts. Learn how performance improvement and strategic transformation can help your organization navigate the uncertain times ahead.

As healthcare and senior living organizations grapple with rising costs, declining margins, an uncertain regulatory environment, and federal initiatives targeting efficiency in healthcare spending, many are heeding it as a warning call to evolve beyond traditional ways of doing business.

For decades, the healthcare and senior living sectors have been in a state of gradual transition, adapting to external forces that change the economics of their industry. Recent policy discussions signal a continuation of this trajectory. It's clear that "doing nothing" isn't an option, and a disciplined, forward-thinking approach is necessary to survive the financial and operational challenges ahead.

The importance of strategic agility

Many of today's healthcare and senior living challenges are beyond the stage of trying to solve with yesterday's solutions, such as mergers and acquisitions, organizationwide staff reductions, or other traditional strategies. Deeper action is critical. To survive the coming change, hospitals, health systems, and senior care providers must focus on strategic frameworks aimed at optimizing performance and transforming longer-term business models, adopting principles that will ensure effective financial and operational management isn't just a practice, but a complete pathway to success. This journey involves two paths: optimizing near-term performance and transforming the organization to meet the future market.

Optimize your performance: Execution as a strategy

Maximizing your revenue cycle is the place to start in order to provide your organization every financial advantage possible when adapting to longer-term changes. Consider the following questions in your analysis.

- Are the payer sources you rely on effectively meeting their financial obligations? Over-dependence on nonviable payers could strain your resources without proportional benefits.
- Is there a breakdown in information flow within your organization that's inhibiting optimal collections?
- Have you developed a plan of action to clean up the current accounts receivable aging to further identify revenue cycle opportunities?

Maximizing your revenue cycle is the place to start in order to provide your organization every financial advantage possible when adapting to longer-term changes.

Achieving execution excellence requires returning to basics and attending to the core values of the marketplace. Here are some actionable strategies to help fine-tune your operations.

- **Performance optimization::** Investigate hidden opportunities for cost-savings without sacrificing quality. Market and productivity studies, aided by data analytics and benchmarks, can shed light on efficiency gaps. Enhance your technology to help improve productivity and inform better organizational choices. Analyze your contracts and consider eliminating payer sources that aren't economically viable.

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- **Financial resilience:** Emphasize healthy financial ratios that can withstand disturbances. Regularly monitor your key metrics, adopt flexible forecasting, and lean on your external advisors to help develop a well-rounded financial plan for your organization.
- **Accountability:** Develop a culture of responsibility and flexibility. Set defined performance targets, engage in regular performance audits, and cultivate cross-functional collaboration to maintain adaptability.

Attention to detail in these strategies will help you optimize your revenue cycles, stabilize financials, and provide the foundation for your organization's long-term survival.

Strategic transformation: Future-proofing your organization

Immediate performance upgrades, while vital, address just one component of the challenge. Most organizations face a larger, longer-term issue: transforming the business to meet the future market. This requires fundamental shifts and a comprehensive redesign of strategies that take into consideration external realities such as community needs and reimbursement trends.

Transformation demands not just restructuring but reenvisioning your organizational identity in response to industry and economic changes. Your organization may need to let go of emotional ties to existing facilities and service lines and embrace new governance structures. This shift in mindset and strategy is critical to achieving organizational strength during times of adversity.

Proactive contingency planning

Contingency planning – aimed at mitigating unexpected scenarios – is an essential first step in your journey of transformation. Your plan should include:

- Strategies to manage low-performing portfolio elements, including loss-inducing contracts and building usage.
- Scenario-based financial models tailored to various economic conditions.
- Emergency cost-saving tactics and alternative revenue avenues.
- A crisis management framework to enable swift decision-making in unpredictable scenarios.

Establishing a baseline strategy

With the contingency plan in place, the next step is to develop your strategic vision. Determine which service lines will maintain relevance and critical mass in your community. Analyze local market conditions to develop an understanding of the future landscape of healthcare and senior living in your area.

Consider how an evolving care model will influence personnel, resources, and infrastructure. Your strategy may necessitate realigning service priorities across geographic locations and sites to maximize sustainable outcomes.

Governance: Adopting a new leadership horizon

- Strengthening board collaboration with active engagement in the strategic decision-making process.
- Enhancing transparency through regular financial and operational updates.
- Searching for nontraditional perspectives in leadership by recruiting executives that have demonstrated transformational success in other industries.

As service models evolve, a forward-looking governance structure is a necessary ingredient in your transformation.

As these elements converge, your organization will be better prepared to meet the demands of the future industry landscape.

Finding your path forward

In the face of rapid policy, demographic, and industry evolution, healthcare and senior care organizations face momentous change not only to survive, but to create thriving organizations for the benefit of their communities. Let innovation, accountability, and transformation serve as your guide. Taking proactive steps during uncertain times can transform potential adversity into competitive advantage, making resilience a hallmark of your organization's future success.

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Modernizing Utilization Management:
A Case For System-level Change

For many health systems, utilization management (UM) has long been a functional necessity, but rarely a strategic priority. Originally designed to ensure clinical appropriateness and support payer requirements, UM often grew up within hospital walls, shaped by local workflows and embedded within broader care management structures. As a result, traditional UM functions today are frequently fragmented, inconsistent and outpaced by competing financial, operational and regulatory demands.

Today's healthcare environment calls for elevated utilization management performance. Capacity constraints, complex payer expectations and heightened scrutiny on patient status determinations have elevated UM's importance within the context of organizational strategy. What was once seen as a component of care management is now its own critical piece of systemwide performance. This means that health systems face a pivotal moment. The question is no longer whether to modernize UM, but how.

Limitations of traditional UM models

Legacy UM functions typically evolved at the hospital level, often with autonomy or at least variability in how, and by whom, utilization reviews were conducted. This allowed flexibility, but it also led to fragmentation. Processes varied across facilities within the same system. Decision criteria were inconsistently applied. In some systems, UM was housed under nursing; in others, it reported to finance or revenue cycle. Centralized governance was lacking, and with it, accountability.

Another challenge has been role dilution. In many hospitals, case managers or care coordinators were tasked with handling UM reviews in addition to discharge Modernizing utilization management: A case for system-level change planning and patient progression. These competing responsibilities often forced staff to triage their time– focusing on immediate discharge barriers while deferring UM reviews. That delay undermined timely care decisions and exposed systems to payer denials, which jeopardized reimbursement.

Even in systems that attempted to centralize UM, true standardization was rare. Policy differences persisted across hospitals. Staff training was inconsistent. And technological support was often lacking, with manual processes prevailing over integrated digital workflows. The result: a patchwork of practices with no unified approach.

The case for centralization

In contrast, a truly centralized UM function offers a strategic, scalable alternative. A centralized approach separates UM from other care management functions by establishing dedicated teams focused exclusively on utilization review. Staff are trained in clinical criteria and payer-specific requirements. Workflows are standardized across the enterprise. Technology enables real-time status reviews, communication with payers and audit trails.

Centralized UM brings several advantages. First, it **reduces variation.** With shared protocols and unified oversight to ensure medical necessity documentation is captured, health systems can count on consistent decisions, regardless of site, shift or reviewer. This helps reduce denials, improve documentation accuracy and support compliance with payer rules.

Second, centralization **supports financial accountability.** By aligning UM under the revenue cycle or in partnership with finance, organizations reinforce the connection between clinical decisions and reimbursement integrity. Escalation pathways for complex cases, pre-claim appeals and physician advisor reviews become embedded processes, not ad hoc reactions. This establishes a proactive, not reactionary, approach to securing authorization or payment.

Third, centralized UM **strengthens payer engagement.** Health plans increasingly demand timely, well-documented reviews supported by standardized clinical evidence. A cohesive UM structure gives systems the data, scale and clout to negotiate and advocate effectively.

Governance, leadership and culture

Successfully building a centralized UM function requires more than reassigning staff. It demands system-level governance and strong, visionary leadership. UM must be anchored in executive priorities and supported across revenue cycle, operations, clinical leadership and information technology. In high-performing systems, sponsorship often comes through the chief financial officer (CFO) or revenue cycle, while nursing and hospital operations ensure day-to-day integration.

But structure alone is not enough. Culture matters. A shift to centralized UM must be framed not as a loss of local control but as a strategic evolution. Clear communication, aligned incentives and transparency about roles and expectations are essential to build buy-in and sustain momentum.

The role of physician engagement

Equally critical is physician partnership. UM functions thrive with the active involvement of physician advisors (typically reporting to the chief

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Successful elements of a centralized utilization management function

1. Strong support from C-suite leadership
2. Strong partnerships with onsite clinicians and care management
3. Comprehensive staff training
4. Clear definitions of roles
5. Technological support

medical officer) who guide clinical decision-making, support appeals and bridge conversations with frontline providers. This clinical voice is vital in maintaining credibility and trust.

Today's healthcare environment calls for elevated utilization management performance. The question is no longer whether to modernize UM, but how.

Yet true engagement extends beyond leadership roles. Successful UM programs cultivate collaboration between reviewers and admitting and attending physicians. This fosters shared ownership of status decisions and streamlines workflows to minimize administrative burden on clinicians. The clinician retains responsibility for the status decision, but UM provides a critical support and assist role. Under this model, UM is not merely a financial function. It's a clinical partnership.

Successful elements of a centralized utilization management function

In 2020, Geisinger Health System was confronting a capacity crisis. Across the Danville, PA-based system's 9 hospitals, inpatient units were regularly at or above full occupancy, stalling patient throughput and creating operational strain. Upon closer analysis, Geisinger identified a critical bottleneck: its UM function, then embedded within case management and discharge planning, was delaying status determinations and contributing to financial risk.

Nurses tasked with UM reviews were also responsible for discharge planning and patient progression. Pulled toward urgent clinical needs, they often didn't initiate UM reviews until days into a patient's stay—far too late to meet payer notification requirements or support timely reimbursement.

To address this, Geisinger centralized and restructured its UM function. The new model created a dedicated UM team, separate from discharge planning, with clear role definitions and focused accountability.

Several elements enabled the shift. Leadership buy-in was foundational—particularly from the CFO, revenue cycle and clinical operations. Staff were trained to apply evidence-based clinical criteria, despite the variability in payer standards.

Technology enhancements linked admission orders to automated work queues within the electronic health record, enabling timely review. Physician engagement was also key; the UM team committed to minimizing unnecessary communication and maintaining clinical alignment.

The results were swift and significant. Observation rates dropped from over 26 percent to between 7 and 10 percent depending on the campus, and the system realized $54 million in revenue improvements in the first year. The division of labor also proved vital during the Covid-19 pandemic, helping discharge planners stay focused amid unprecedented demand.

Geisinger continues to refine the model. In 2023, it launched a strengthened appeals and denials management initiative, escalating payer disputes to physician advisors and initiating pre-claim appeals. Early signs point to stronger compliance and financial performance, reinforcing the value of centralized UM as both a strategic and operational asset.

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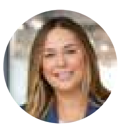

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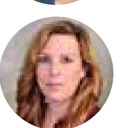

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The Power of Patterns: Turning AR Trends into Tactical Wins

In today's hospital revenue cycle, patterns in accounts receivable (AR) are more than just numbers on a report - they're signals. They reveal early warning signs, highlight opportunities to strengthen payer relationships, and provide a roadmap for sustainable cash flow. Leaders who learn to spot and act on these patterns can shift from reactive firefighting to proactive, strategic management.

Spotting Early Warning Signs

Every AR leader knows the anxiety of a sudden slowdown in cash. But revenue disruptions rarely appear overnight - they build quietly, accumulating until they become full-blown crises. The organizations that thrive are those that detect the signals early and intervene before problems spiral.

Consider the following red flags:

- A sudden spike in AR aging beyond 90 days for a specific payer or service line
- A 20%+ increase in denials for medical necessity or authorization
- Payment turnaround times stretch well beyond contract terms
- A drop in first-pass resolution rates below 85%
- A spike in small balance write-offs that erode net revenue

Each of these metrics represents an early warning. When caught quickly, they can be managed with minimal disruption. Left unchecked, they threaten both short-term liquidity and long-term financial stability.

Key takeaway: Early detection equals better control of cash flow.

Improving Payer Relationships Through Data

Patterns are not just for internal monitoring - they can also transform payer conversations. Too often, providers approach payers with generalized frustrations: "We're seeing too many denials." While true, such statements rarely prompt meaningful action.

Now imagine reframing the discussion with concrete data:

"In the past 60 days, 23% of cardiology claims have been denied for medical necessity, totaling $1.2 million. What steps can we take together to address this trend?"

Data-driven conversations move from complaint to collaboration. They:

- Ground the dialogue in facts, not anecdotes.
- Create accountability by quantifying the financial impact.
- Position providers as proactive partners rather than adversaries.

Reflection point: How is your organization currently presenting denial data to payers - reactively, after the damage is done, or proactively, as an opportunity to prevent future issues?

Turning Insights Into Action

Spotting a trend is only the first step. The true value of patterns lies in the actions they inspire. For example:

Consider the following red flags:

- Re-prioritize staff worklists to target the highest-dollar denial categories.
- Adjust front-end workflows, such as registration or authorization, to reduce repeat issues.
- Reallocate resources temporarily to payer-specific backlogs until trends stabilize.
- Deploy automation strategically to give staff more bandwidth for prevention.

Imagine your denial rate for "No Authorization" jumps 20% overnight. The first three changes you make to your workflow will determine whether that spike is a short-term blip or the start of a dangerous pattern.

Key takeaway: Proactive leaders don't just watch the numbers - they pivot quickly, using data as their compass.

Driving Targeted Action Through Data

Not every issue deserves equal attention. The challenge for AR leaders is separating the signal from the noise. Dashboards, heat maps, and prioritized lists help identify which trends warrant immediate intervention.

A practical framework is to focus on the "big rocks" - the problems with both the highest dollar impact and greatest frequency. Fixing small but high-dollar issues generates faster wins and builds momentum across the team.

Consider these questions:

- If you could only address one denial category this quarter, which would it be?
- How much revenue could you reclaim by tackling that category first?
- How would solving it impact downstream workflows?

Targeting action where it matters most keeps teams focused and results visible.

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The Power of Patterns: Turning AR Trends into Tactical Wins (continued from page 11)

Empowering Teams for Long-Term Wins

Data loses its power if it only lives on leadership dashboards. Frontline staff must see the same patterns, understand their significance, and feel empowered to act.

Weekly huddles that review denial categories, assigning "category owners" to specific trends, and sharing transparent scorecards can drive ownership. When teams know what matters most - and when their contributions are celebrated - they develop a sense of agency and accountability.

For example, reducing no-auth denials by 10% should be recognized as a win, not just another data point. Recognition builds morale and reinforces the value of data-driven problem-solving.

Ask yourself: Do your frontline staff know which trends matter most, or are they working queues without context?

Empowered teams don't just resolve today's denials - they prevent tomorrow's.

Case-in-Point Scenarios

To make this more tangible, here are a few common "data detective" moments AR leaders face:

Scenario 1: Authorization Denials Spike.

- Authorization denials have increased 58% this month. The payer is the same, but the procedure mix has shifted. The best first step? Review authorization submission processes, as workflow gaps are often the culprit.

Scenario 2: Aging Balances Build.

- Your top three payers each have more than 40% of balances in the 181-365-day bucket. Immediate escalation with payers is essential; these accounts are at risk of timely filing write-offs.

Scenario 3: Dashboard Red Flags.

- Denials are up 15%, cash collections are down 10%, but productivity is steady. The logical place to start? Audit denial trending, as rising denials are directly cutting into cash flow.

Each of these examples demonstrates that trends are not static - they are calls to action.

Conclusion

Organizations can no longer afford to treat denials and AR delays as isolated frustrations. Patterns tell a story. When leaders spot them early, use them to guide payer dialogue, align staff around targeted interventions, and empower teams, they transform patterns into tactical wins.

In the end, trends are the compass - but action is the map that gets you to results.

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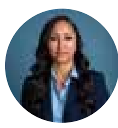

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Improving Medicare Advantage Provider Performance: An Integrated Approach

Over the past 15 years, Medicare Advantage (MA) plans have taken on an increasing role in our healthcare system. Enrollment in MA plans has grown from 11 million (25% of Medicare beneficiaries) in 2010 to a projected 35 million (56% of Medicare beneficiaries) in 2025, and that growth is expected to continue.[1] At the same time, health systems are facing numerous challenges when it comes to realizing MA negotiated rates for services rendered, including denials and delayed payments.

As a result, many health systems are reconsidering their relationships with MA plans. Within the last year, at least 41 health systems dropped out of 62 MA plans serving 25 states.[2] A recent survey conducted by HFMA suggests that number could grow, as 16% of hospital and health system CFOs surveyed plan to drop one or more MA plans in the next 24 months, with another 45% considering doing so.[3]

However, the decision to leave or stay in an MA plan is not one that should be taken lightly, given the wide-ranging impact on not only the organization and its employed physicians but also aligned community physicians. Any decision related to MA contract participation requires careful consideration of the options, estimation of the impact across the organization and its aligned physicians, and alignment with overall strategic goals. With this in mind, we recommend providers take an integrated approach when reviewing their portfolio of MA contracts to identify a path forward that helps improve performance for both the organization and its physician partners.

Addressing the Root Causes of MA Challenges

For many provider organizations, MA challenges present as a combination of inadequate rates and lower-than-anticipated yields from negotiated rates. In response, providers may undertake projects to improve revenue cycle performance, use insights from performance improvement efforts to address issues with MA plans in real time, and secure changes in contracting language in future negotiations—all of which are vital to improving short-term performance. However, if organizations stop here, they are likely only addressing the symptoms of financial underperformance related to MA plans.

To get to the root of their challenges, provider organizations must step back and evaluate whether they are working with the MA health plans that align with them from a quality and financial perspective. As organizations refresh their strategic plans, they should inventory their existing MA contracts to understand the strategy behind participating in each, how participation in a given MA contract supports (or doesn't support) the organization's physician alignment strategy (both employed and community), and whether the contract's financial performance supports or detracts from the organization's mission and strategic goals.

Successfully executing this process requires an experienced managed care contracting team supported by a strong analytics function and an interdisciplinary team that includes representatives from each of the following areas:

- **Strategy**: Supports alignment with overarching organizational goals
- **Finance**: Provides budgeting and modeling support
- **Physician enterprise/clinically integrated network:** Helps ground contracts in clinical workflow realities
- **Utilization management/revenue cycle:** Reviews contract terms for reasonability and how they fit into administrative workflows

Including stakeholders from across the organization promotes consideration of the myriad operational and strategic implications of partnering (or opting not to partner) with an MA plan. In addition, providers should consider how their approach to MA contracts aligns with the five core capabilities for achieving health outlined in our Healthcare Market Point of View: aligned growth, financial discipline, regulatory excellence, strategic agility, and talent optimization. Below, we explore key considerations within each core capability that providers should think through as they evaluate their portfolio of MA relationships.

Aligned Growth: Building Strategic Relationships With MA Plans

Building strategic partnerships with MA plans can help providers achieve growth objectives, expand access, and drive value for the communities they serve. When providers evaluate their portfolio of MA contracts with aligned growth in mind, they should consider three factors:

- **Strategic Alignment:** One important consideration is whether MA

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contracts align with the organization's strategic goals. For example, if the organization is a safety net system focused on population health, do the contracts have a strong value-based component and provide resources to address social determinants of health? Strategic alignment also includes consideration of volume, rate, effective yield, and margin leakage. While leakage can be related to revenue cycle issues, it can also occur when a provider network is insufficient to capture anticipated physician referrals and/or realize value-based incentive payments.

In addition, providers should consider the quality of the relationship with the plan. To support strategic alignment, plans should be willing to work toward mutually beneficial solutions to inevitable challenges, rather than treating every interaction as a zero-sum transaction.

- **Market Alignment:** Providers should consider the current and anticipated penetration of MA in the markets they serve, as well as whether the plans in their market meet network adequacy requirements. There may be opportunities to partner more closely with plans in ways that are mutually beneficial.
- **Change Pathway:** Providers should identify the value proposition for narrowing (or expanding) their portfolio of MA plans. If there isn't clear value in dropping one or more MA plans, the organization may instead be able to improve administrative workflows, clinical pathways, data analytics, and reporting capabilities to strengthen performance under existing contracts.

Financial Discipline: Addressing the Margin Impact of MA Contracts

To thrive financially and maintain market relevance, providers must pay close attention to the impact of MA contracts on their operating margins. This starts with understanding that it is rare for MA contracts to yield the full negotiated amount. Some amount of performance degradation should be built into financial models to determine whether the negotiated rates will help the organization achieve financial discipline and support access to care for the community.

In addition, providers need to pay close attention to contract language. For example, it is common for a plan and provider to agree to "Medicare rates," but without contract language that specifically includes add-on payments such as uncompensated care for Medicare disproportionate share hospitals (DSH), which leads to the provider losing this revenue. When negotiating contracts for other product lines, plans often try to include language that would require providers to participate in a new MA plan. Providers need to review such language carefully to be sure that any new partnerships would be margin accretive.

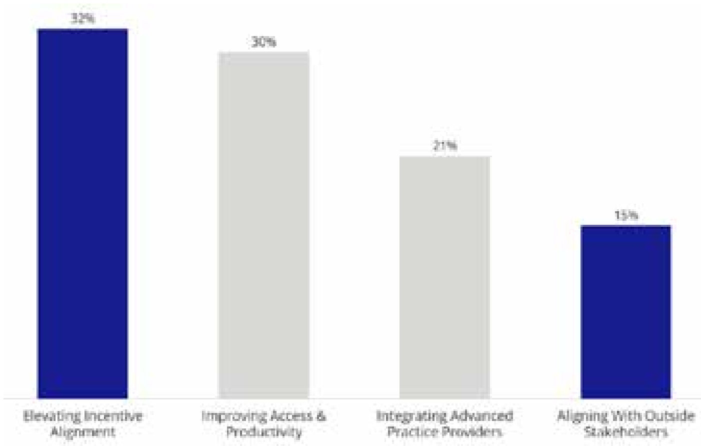
Between contract reviews, providers should focus on improving performance to succeed under existing contracts and collecting data to support future negotiations. First, organizations should analyze medical necessity and other denials data to correct documentation issues and improve processes for utilization review (UR) and physician advisors. Second, revenue cycle and UR teams should provide data and context to the contracting team regarding issues that are decreasing yield. This will help the team resolve issues during monthly meetings and ultimately support the argument for changes in administratively burdensome terms during contract renegotiations. Finally, it is important to secure language in MA contracts that clearly defines turnaround times on prior authorization decisions to help prevent delays in admissions and discharges that pose risks to patient outcomes.

Regulatory Excellence: Making the Most of Performance-Based Incentives

Many MA contracts include meaningful performance-based incentives related to quality and cost metrics. However, most provider organizations struggle to realize these opportunities, which deprives them of not only revenue, but also a powerful mechanism for creating alignment with community-based physicians participating in the same contracts. Failure to secure incentives can be attributed to factors such as insufficient analytics capabilities, attempts to achieve too many metrics across too many contracts, and lack of clear communication to align goals and incentives with participating physicians.

Nearly 40% of executives say lack of incentive alignment is the biggest challenge to enhancing their physician workforce 39%.[4]

Addressing each of these challenges is crucial to making the most of performance-based incentives. First, providers need a strong analytics function—either internal or sourced from strategic advisors—that can create and regularly update user-friendly performance dashboards for physicians and performance improvement teams. Second, they need to work with their physicians and clinicians to identify and define a realistic, focused set of quality metrics that aligns with the organization's goals for improving health outcomes. Using this input, the managed care contracting team should pursue metric standardization across all MA contracts. Finally, they should communicate their value-based goals and incentive opportunities



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with physicians in a clear, understandable way that facilitates systematic clinical process improvement, helping the organization improve both patient and financial outcomes.

Key focus areas for the physician enterprise include elevating incentive alignment to organizational success factors and aligning with health plans and other outside stakeholders.[5]

Strategic Agility: Fostering Physician Alignment With Strategic Goals

Agile organizations must understand how changes in strategic direction will affect all facets of the enterprise. As providers contemplate changes to their MA contract portfolio, they need to carefully consider the second-order impacts on both employed and aligned physicians. Terminating one or more MA contracts will likely impact panel size and productivity. If, for example, a health system terminates a contract with a plan that includes 20% of its panel, the organization will need a carefully orchestrated backfill strategy and subsidy plan (within the constraints of fair market value requirements) to allow for the backfill to ramp up.

In addition to productivity and backfill, provider organizations need to account for the yield that employed and aligned physicians are realizing from their contracts. This is particularly true for organizations with a strong value-based performance platform in which physicians receive significant bonus payments. Assuming incentives are aligned, and physicians are salaried, it is often possible to move employed physicians from a terminated contract to other contracts. For aligned physicians, it is important to focus the broader contracting strategy on creating win-win relationships with other plans to reduce revenue disruption.

Talent Optimization: Creating a Value Proposition for Physicians

How providers contract with MA plans will impact how they build exceptional teams and equip them to succeed in mission-aligned objectives. Organizations will need to make decisions around compensation models, network design, and MA contracting terms.

- **Compensation Models:** Instead of putting employed physicians directly at risk, employment contracts should move them toward value-based care. When an organization adjusts its MA portfolio, it may be necessary to revisit the compensation model for some or all members of the physician enterprise. Similarly, for aligned physicians, the contract should create shared savings opportunities that align with the network's overall goal.
- **Network Design:** Organizations need to carefully consider their current provider complement and the network size and makeup necessary to reduce leakage and capture increased steerage that may result from new or renegotiated MA contracts. If organizations have employed physicians (particularly specialists) to help an MA plan meet network adequacy standards, they may need to account for the cost of helping plans meet this requirement.
- **Physician Burnout:** Compensation is just one component when developing a compelling value proposition for both employed and aligned physicians. Organizations should also use MA contract negotiations to help reduce the number of services subject to prior authorization requirements, implement "gold card" programs to streamline the physician advisor process, and secure other provisions that reduce unnecessary clinical denials, which create artificial barriers to patient care and contribute to physician burnout.

While the challenges of an aging population and growing MA enrollment may be daunting for providers, they also present opportunities for strategic alignment with MA plans, which need high-quality provider networks to promote access and meet network adequacy requirements.

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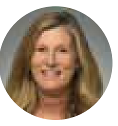

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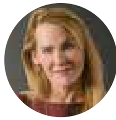

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From Chaos to Cash Flow:
Mastering Denial Management with Clean Claims

Every denied claim tells a story of a missing detail, a mistimed submission, or a misstep somewhere in the revenue cycle. And every story costs money.

In today's healthcare landscape, denial management isn't just about fixing errors after the fact it's about building a front-to-back strategy that prevents them altogether. At the center of that strategy is one powerful metric: the clean claim rate. A high clean claim rate means faster payments, fewer write-offs, and less wasted effort. A low one? It means revenue left on the table.

Let's explore why clean claims are the backbone of effective denial management and how improving them can transform your bottom line.

Understanding Denial Management

Denial management refers to the systematic process of identifying, analyzing, preventing, and resolving denied or rejected claims. While some denials are unavoidable due to patient eligibility issues or payer policies, a significant portion stem from preventable errors. In fact, up to 90% of claim denials are preventable, according to the American Medical Association (AMA).

These preventable denials delay payment, increase rework costs, and place undue stress on billing teams. What's more alarming is that 35% of denied claims are never reworked, resulting in permanent revenue loss.

Why Clean Claims Matter

A **clean claim** is one that is submitted accurately the first time - with all required data elements properly populated and no errors that would result in a denial or delay. Clean claims are essential because:

- **They reduce denial rates:** Healthcare Financial Management Association (HFMA) data shows that providers who maintain a clean claim rate of 95% or higher experience (75% or higher for safety net hospitals with high Medicaid volume) 20-30% fewer denials.
- **They expedite reimbursement:** Clean claims are typically paid in half the time of denied claims that require resubmission or appeal.

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- **They minimize operational inefficiency:** Each denied claim can cost $25 to $118 to rework, depending on complexity. Clean claims eliminate this expense.
- **They support payer relationships:** Frequent denials due to errors can flag a provider for audits or delay resolution of other claims.

Clean Claim Rate as a Quality Indicator

Clean claim rate is more than just a billing metric - it's a direct reflection of the quality of data flowing from all upstream departments. Every claim depends on accurate inputs from multiple touchpoints, including:

- **Patient Access and Registration:** Accurate demographics, insurance information, and coverage verification
- **Clinical Documentation:** Timely and complete charting that supports coded procedures
- **Coding and Charge Capture:** Proper CPT/HCPCS coding aligned with payer requirements
- **Authorization and Order Management:** Pre-approvals for services that require payer consent

When breakdowns occur in any of these areas, the claim may fail payer edits and result in denials, delays, or write-offs. High-performing organizations recognize that clean claims start upstream and invest in front-end training, process audits, and system integrations that ensure data accuracy before the claim is ever billed.

Common Causes of Preventable Denials

To prevent denials, it's critical to understand their root causes. Industry reports indicate that the top five reasons for denials include:

- **Missing or invalid claim data** – 26.6%
- **Patient eligibility issues** – 18.2%
- **Authorization/precertification missing** – 12.4%
- **Service not covered** – 10.6%
- **Medical necessity denial** – 8.6%

Building a Clean Claim Culture

To reduce denial rates, healthcare organizations must invest in building a "clean claim culture." This involves proactive strategies across the RCM spectrum:

1. **Front-End Accuracy:** Up to 24% of claim denials originate from front-end issues. Ensuring correct patient demographics, insurance information, and authorizations helps avoid downstream errors.
2. **Coder and Clinician Alignment:** Regular audits and training can reduce coding errors, which account for 10-15% of claim rejections.
3. **Payer-Specific Edits and Rules:** Organizations using automated claims scrubbing tools report up to a 30% reduction in initial denials.
4. **Training and Auditing:** Facilities that incorporate denial trend reviews into staff training see significant reductions in repeat errors.
5. **Technology Integration:** Automated eligibility and prior auth verification can prevent up to 70% of eligibility-related denials.

The ROI of Clean Claims

Organizations that prioritize clean claims report substantial improvements in revenue cycle performance, including:

- **First-pass resolution rates exceeding 90%,** compared to the industry average of 85%
- **Reduced days in A/R by 5–10 days**
- **Decreased denial write-offs by 20–40%**
- **Lower cost to collect,** with fewer staff hours spent on appeals and follow-up
- **Increased patient satisfaction** due to fewer billing errors or surprise statements

Final Thoughts

Denial management begins long before a claim is ever denied. The most effective way to combat denials is to stop them from happening in the first place by sending out clean, accurate claims every time. Clean claims aren't just a billing best practice; they're a reflection of end-to-end operational quality. By embedding accuracy at the front end and fostering accountability across all departments involved in the revenue cycle, healthcare organizations can drive measurable financial gains and long-term sustainability.

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Unlocking the Value of Medicare Cost Report Financial Schedules: A Guide for Budgeting, Operations, and Financial Analysis

As we all know, every hospital in the United States that participates in Medicare is required to file an annual Medicare Cost Report (MCR). For many finance teams, the report is viewed as a compliance exercise—an unavoidable task that satisfies federal requirements. However, the financial information embedded in the cost report represent a treasure trove of data that can be leveraged well beyond compliance. When properly analyzed, these schedules can support budgeting, operations management, and financial performance analysis, providing hospital leaders with actionable insights.

This article explores how to use the financial statement schedules of the Medicare Cost Report for three purposes: (1) budgeting, (2) operational management, and (3) financial analysis, including key ratios.

Understanding the Financial Statement Schedules

Within the Medicare Cost Report, several schedules present hospital financial statements in a standardized format. Among the most relevant:

- **Worksheet G:** Balance Sheet and Statement of Revenues and Expenses.
- **Worksheet G-1:** Statement of Changes in Fund Balances
- **Worksheet G-2:** Statement of Revenues and Operating Expenses
- **Worksheet G-3:** Statements of Revenues and Expenses
- **Worksheet A Series:** Trial Balance of Expenses, Detailed listing of expenses by cost center, including general service, inpatient, outpatient, and ancillary.
- **Worksheet B Series:** Cost Allocation Step-down allocation of overhead costs via hospital operating statistics such as square feet, pound of laundry, and meals served.
- **Worksheet C Series:** Calculation of IP and OP cost to charge ratios. Which can be compared to the corresponding charge master items.

Taken together, these schedules mirror audited financial statements but add layers of detail specific to healthcare reimbursement and cost allocation.

Budgeting Applications

Budgeting is the process of translating strategy into financial targets. The Medicare Cost Report schedules offer several points of reference:

1. Uniform Historical Baseline

The cost report provides audited-level historical financial data, often more reliable than internal reports that may exclude reclassifications. Finance teams can use prior-year worksheets as a baseline for constructing departmental budgets. For example, Worksheet A gives a clear breakdown of departmental expenses (nursing, radiology, pharmacy, dietary, etc.), which can serve as benchmarks for future spending.

2. Departmental Cost Trends

By reviewing multiple years of Worksheet A, hospitals can track expense growth by department. This helps identify high-growth areas—whether due to patient volume increases, staffing changes, or inefficiencies—that should be addressed in the budget cycle.

3. Overhead Allocation Planning

The step-down allocation (Worksheet B series) illustrates how overhead costs are distributed to revenue-generating departments. During budgeting, finance leaders can evaluate whether internal allocation practices align with cost report methodologies. This is critical when departments contest the fairness of overhead charges.

4. Revenue Forecasting

Multiple Cost report worksheets break down revenue and expense by provider subunit and service line. For instance, WS G-3 indicates revenue from rental vending machines, often a surprising high number. Hospitals can use these trends to project estimate future reimbursement. This is especially useful when forecasting the impact of shifts in Medicare Advantage, Medicaid, or commercial payer volumes.

Operational Management Applications

Beyond budgeting, the cost report schedules can serve as tools for monitoring and improving day-to-day operations.

1. Departmental Efficiency Analysis

Because the Worksheet A and B series pair expense data with allocation statistics, hospitals can assess fully loaded unit costs (e.g., cost per lab, cost per meal served). Tracking these unit costs over time helps operational managers pinpoint efficiency gains or losses.

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Unlocking the Value of Medicare Cost Report Financial Schedules:
A Guide for Budgeting, Operations, and Financial Analysis (continued from page 19)

2. Overhead Consumption

The step-down allocations in Worksheet B series reveal how much overhead each department absorbs. Operations leaders can use this to challenge whether space, maintenance, IT, or administrative resources are being used optimally.

3. Compliance and Benchmarking

Because all hospitals must file cost reports in a standardized format, organizations can benchmark themselves against peers using cost-to-charge ratios, wage indices, and departmental expense ratios. This comparative analysis can guide management decisions about staffing, technology investment, or outsourcing.

Financial Analysis and Ratios

The cost report's financial statement schedules can also support traditional financial analysis, allowing hospitals to calculate and monitor key ratios. While audited financial statements are typically the first source for such measures, the cost report provides an additional, standardized reference point especially useful for comparison purposes either with other hospitals or with prior years.

1. Liquidity Ratios

From Worksheet G (Balance Sheet), hospitals can calculate:

- *Current Ratio* = Current Assets ÷ Current Liabilities
- *Days Cash on Hand* = (Cash + Investments) ÷ (Operating Expenses ÷ 365)

These metrics assess the hospital's ability to meet short-term obligations.

2. Profitability Ratios

Using the Statement of Revenues and Expenses, hospitals can calculate:

- *Operating Margin* = (Operating Income ÷ Net Patient Revenue)
- *Total Margin* = (Excess of Revenues over Expenses ÷ Total Revenues)

These ratios highlight the hospital's profitability from both core operations and overall performance.

3. Leverage Ratios

- *Debt-to-Equity Ratio* = = Total Liabilities ÷ Net Assets)
- *Capitalization Ratio* = Long-Term Debt ÷ (Long-Term Debt + Net Assets)

These provide insights into the hospital's reliance on debt financing.

4. Cost Structure Ratios

Worksheet A enables calculation of labor costs as a percentage of total expenses, or departmental costs as a share of total operating expenses. These ratios allow comparison with industry norms and peer institutions.

5. Medicare-Specific Measures

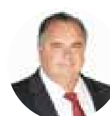
Because the cost report isolates Medicare costs and revenues, hospitals can calculate the Medicare margin (Medicare Revenue – Medicare Costs) ÷ Medicare Revenue. This is vital for understanding the financial sustainability of serving the Medicare population.

Practical Tips for Finance Teams

- **Integrate into Budget Packets:** Include cost report-derived departmental cost benchmarks in annual budget templates to encourage accountability.
- **Develop Dashboards:** Translate select cost report ratios into dashboards for monthly or quarterly review.
- **Educate Department Leaders:** Many managers are unaware of how cost report data impacts reimbursement. Sharing these insights can improve decision-making at the departmental level.
- **Leverage Peer Data:** Publicly available cost reports allow benchmarking against hospitals of similar size, location, or teaching status.

Conclusion

The Medicare Cost Report is far more than a compliance exercise. Its financial statement schedules offer a rich, standardized view of hospital operations and finances that can be applied directly to budgeting, operations management, and financial analysis. By integrating these insights into daily financial practices, hospitals can uncover inefficiencies, improve profitability, and strengthen their long-term sustainability. In a challenging healthcare environment, ignoring this resource is a missed opportunity—while embracing it can provide a critical edge.



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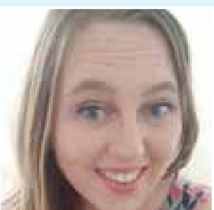
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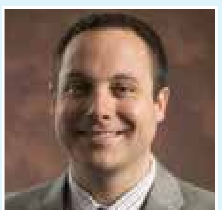
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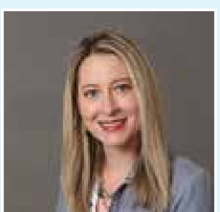
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First Illinois Chapter HFMA News

From Complexity to Confidence: Level Up with CHFP

The healthcare landscape is getting more complex by the day with consistent tighter margins, shifting regulations, new payment models, and growing demand for value-based care. With so much change, it's not just about keeping up anymore, it's about leading. This is where the Certified Healthcare Financial Professional (CHFP) credentials come in! Whether you are in revenue cycle, decision support, finance or even operations, the CHFP can be a valuable tool for sharpening your skills, boosting your confidence, and positioning yourself for growth.

Why get Certified?

The CHFP builds on existing knowledge. It's designed for professionals who already have experience in finance, revenue cycle, or related roles. The content helps connect the dots between what you do everyday and the boarder financial picture in healthcare. Having a certification like CHFP behind your name can also help show that you are serious about your profession. It can make a difference when you are going for a promotion or looking to take on more responsibilities. While not mandatory, the CHFP is respected by healthcare organizations and leaders and it helps show that you understand key concepts in finance, strategy, and operations.

Tips for CHFP Success

The certification is structured to be practical, not overly academic which is great news if you've been out of "study mode" for a while.

There are two (2) modules:

- **Module I:** Business of Healthcare – An overview of how the healthcare system works (finance, delivery, reform, etc.)
- **Module II:** Operation & Finance Acumen – Scenario-based and a bit more challenging, this applies your knowledge to real-world situations.

What Comes After?

Once you earn you CHFP, you're likely notice that you have a better understanding or have refreshed your knowledge on how finance fits into larger organizational decisions – which can help when you're working cross-functional teams and making impactful decisions. You'll be part of HFMA professional community, which offers learning, events, and opportunities to connect with other finance professionals. If you're thinking about a long-term path in healthcare finance, CHFP is a solid steppingstone.

The CHFP certification isn't a magic bullet but it's a meaningful way to invest in your professional development and grow. To learn more or get started visit: https://www.hfma.org/certified-healthcare-financial-professional/

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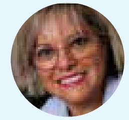

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First Illinois Chapter HFMA Event Photo Recap

2025 Top Golf & Scholarship Event, August 22, 2025

First Illinois Chapter HFMA Event Photo Recap

2025 Women in Leadership Retreat, June 12, 2025

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2025 Women in Leadership Retreat, June 12, 2025, cont'd

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2025 Transitions Dinner, July 17, 2025, Rosemont,IL

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