hfma
first illinois chapter

February 2026

FIRST ILLINOIS SPEAKS

IN THIS ISSUE

To View the Provider Payer Symposium - February 26, 2026 In-Person Event

To View Chapter News
CLICK HERE

To See Our Upcoming Upcoming Events
CLICK HERE

HFMA First Illinois Chapter and
Chicago Health Executive Forum's

Provider & Payer Symposium

Healthcare Leadership in Unprecedented Times

University Club of Chicago
76 E. Monroe | Chicago, IL 60603

February 26, 2026
8:30am-4:30pm

First Illinois HFMA and CHEF Present

Healthcare Leadership in Unprecedented Times

Insights, innovation, and executive perspectives at First Illinois HFMA's flagship Provider & Payer Symposium

Kicker:
Join us February 26 at the University Club of Chicago for a full day of timely education, bold perspectives, and meaningful connection.

This year's theme, H***ealthcare Leadership in Unprecedented Times,*** brings timely perspectives on the forces reshaping healthcare today.

Why attend?

- 7.5 CPE credits
- 8:00 a.m.–4:30 p.m. program
- Complimentary networking reception

Featured Voices & Sessions

- AJ Wilhelmi, President, Illinois Hospital Association – Keynote address
- Northwestern University Institute on AI – AI in Healthcare
- Advisory Board – a deep dive on OBBBA insights and implications
- Government Programs Panel – Leaders from Rush Health, Endeavor Health, University of Illinois Health, Sinai Health System, and Medical Home Network
- Real-world case studies –Population Health 3.0 – Silver Cross Hospital with Phamily
- Price Transparency in Practice – Forvis Mazars and PayerSet
- Executive Leadership Panel – C-suite executives from University of Chicago Medicine, Endeavor Health, Carle Health, and Humboldt Park Health

7.5 CPE credits | Program + Networking Reception

If you've attended before, you know the value. If not, this is the year to join us.

Look forward to seeing you on February 26!

Scan the QR code to view the full agenda and to register

Scan the QR code to view the full agenda and register now!

Case Study: The Link Between Mission, Margins, and Growth: Lessons in Bold Leadership and Commitment to Healthier Communities

A successful strategic plan relies on a clear mission and strong leadership. Yet for many hospitals and health systems, executing these plans has become increasingly difficult. Margins are thin, the workforce is strained, and the pace of change is unrelenting. In this environment, bold, disciplined leadership is not optional—it is essential.

A large multi hospital health system recently achieved more than **$100 million in margin improvement within 18 months while remaining focused on its mission.** While approaches to margin improvement vary across organizations, leaders involved in this work observed that the common driver of outsized results is leadership, specifically leaders who remain committed to mission while focusing on financial discipline and strategic agility to adapt to evolving market conditions.

Several years earlier, this health system created a long term strategic plan to modernize facilities. Execution of that plan was threatened first by the COVID 19 pandemic in 2020 and later by a historic regional flood in 2022. Despite these setbacks, the organization's leaders stayed focused on their strategic goals. The team's conviction and urgency were foundational to achieving lasting benefits for their communities.

Organizational Sustainability Requires Investment in the Triple Aim

The health system operates in one of the most challenging environments in the country. The local economy has declined, opioid misuse is rising, and large portions of the region are food deserts because geography limits access to fresh produce. The only growing demographic is adults 65 and older, many of whom rely heavily on government payers.

Against this backdrop, the health system's mission—to improve the health and well being of its residents—remained the guiding force. To pursue this mission, leadership developed a strategic plan grounded in three pillars:

1. **Grow communities from within**
2. **Provide a distinguished experience**
3. **Curate high value services that emphasize value based care**

These pillars align directly with the Triple Aim: improving population health, enhancing patient experience, and reducing healthcare costs. Despite limited human and financial resources, leadership recognized that investing in these areas was central to long term sustainability. Without high quality care and strong patient experience, maintaining financial stability would be impossible.

Executing Strategy Through Key Enablers

Labor shortages have plagued healthcare for years, leading this system to rely heavily on costly contract labor. Recognizing this was not sustainable, leaders took a long term approach by investing in workforce development and strengthening recruitment pipelines through partnerships with academic institutions.

continued on page 4

Case Study: The Link Between Mission, Margins, and Growth: Lessons in Bold Leadership and Commitment to Healthier Communities (continued from page 3)

The organization also made significant investments in **data and analytics,** incorporating new decision-support tools, a modern cost accounting system, and external benchmarks. Wise investments in data allow leaders to quantify opportunities, focus on high impact areas, and improve organizational performance.

Margin Management as a Catalyst for Strategic Investment

Over 18 months, the health system identified and implemented more than $100 million in margin improvements, representing a comprehensive reboot of its operations.

To protect revenue, leadership focused on ensuring accurate reimbursement through improved coding and documentation, stronger prior authorization processes, and enhanced denials management.

On the expense side, two major areas were targeted:

1. Reducing Contract Labor

Leadership introduced a new productivity model and prioritized reducing patient length of stay. Benchmarking against CMS data and optimizing post acute utilization helped lower average length of stay by more than a day per acute admission. These changes allowed leaders to right size staffing needs and reduce contract labor dependency by about one third–saving roughly **$10 million per month** during the last half of FY 2023.

2. Lowering Non Labor Costs

The system launched several initiatives focused on meaningful impact, resulting in **$40 million in savings.** Projects included:

- Implementing water conservation technology
- Strengthening the group purchasing organization (GPO) partnership
- Reimagining dietary and housekeeping services
- Evaluating employee benefits, pharmacy operations, and the 340B program

Though many systems struggle to staff dietary and housekeeping roles, this organization simultaneously **reduced costs, increased FTEs, and improved food quality.** Working more strategically with the GPO yielded millions in savings without major operational changes. Similarly, re-examining the 340B program using benchmarking and analytics highlighted opportunities that informed management and investment decisions.

Lessons and Best Practices for Healthcare Leaders

Today's healthcare environment is dynamic, requiring teams to move decisively in multiple directions. Success depends on clarity about the organization's capacity for change. The featured health system's leaders demonstrated the discipline to ensure every decision aligned with the strategic pillars.

Continuous improvement and adaptability are essential for hospitals and health systems to thrive. More organizations are now revisiting strategic plans annually, focusing on higher margin projects, and investing in analytics to understand which service lines deliver the strongest returns–and which may require pruning.

Crucially, strategic planning alone is not enough. True progress also requires disciplined execution. Leaders must see initiatives through to contract to realize savings.

Support from external consultants helped accelerate the progress, The organization was able to quickly identify savings opportunities beyond common tactics like product standardization, enabling leaders to focus their limited bandwidth on the most impactful initiatives. Many margin improvements required minimal changes to products, services, or vendors–demonstrating the power of **data driven decision making.**

Looking back, the featured health system's chief financial officer reflected on the key success factors. "Data and benchmarking were key enablers to identify what could be done. Engaging with outside resources to assist us with the lift and with the skills to achieve savings with low change was a catalyst to realizing the savings we continue to see. The results helped us not only reach our margin goals, but exceed them so we could invest in other strategic priorities for our organization."

Looking Ahead: The Interdependence of Margins and Growth

As hospitals plan for the future, controlling financial health will be essential. Margins and growth are deeply intertwined; investing in one strengthens the other.

Forward thinking healthcare executives treat their organizations as value driving engines. Higher margins are key to unlocking strategic potential. The health system showcased here exemplifies this mindset–doubling down when needed, staying focused, and remaining committed to its mission despite adversity.

About the Authors

Eric Rogers *is a Principal at Forvis Mazars. You can reach Eric at eric.rogers@us.forvismazars.com.*

Peter Stille *is a Managing Director at Forvis Mazars. You can reach Pete at peter.stille@us.forvismazars.com.*

How to manage your healthcare organization's third-party cyber-risk

The healthcare ecosystem is complex, and providers and suppliers are deeply integrated with each other. Here are seven steps your organization can take to prepare against the next third-party incident.

Key takeaways

- Malicious actors often target third-party service providers with connections to many healthcare organizations to multiply the impact and reward of ransomware incidents and other cybercrimes.
- Many third parties are not required to adhere to the same security standards as healthcare organizations and may unwittingly engage in practices that increase cyber-risk.
- Third-party risk management is an essential tool in protecting your organization from cyberthreats that originate with third-party products or connected systems.

The healthcare industry has long been a target of malicious cyberactors. The life-preserving care it provides, the vast amounts of sensitive patient data it uses and stores, and the proliferation of connected devices means it is particularly susceptible to attacks. Since 2011, the industry has consistently suffered the highest average financial costs of data breaches ($9.77 million in 2024).[1] One study found a 27% increase in ransomware incidents in 2024 from the year before.[2]

There is some good news for the industry. The cost of data breaches declined in 2024 from an all-time high the year before. Healthcare organizations have invested heavily in security solutions, and many are better prepared to identify and block malicious activity before incidents lead to disruptions of service or data compromises.

But the bad actors have noticed this trend and, perhaps as a result, are increasingly focusing on third parties that support healthcare organizations, including device manufacturers, software platforms and service providers.

continued on page 7

How to manage your healthcare organization's third-party cyber-risk (continued from page 5)

A massive 2024 ransomware and data breach showed why hackers are incentivized to target third parties. By compromising a technology company with connections to almost every hospital in America, a ransomware gang ensured that operational disruptions were widespread and that the data breach involved millions of patients.

190 million Number of people whose data was exposed in a 2024 ransomware incident[3]

But no matter how many organizations a third party works with, healthcare organizations need to maintain oversight over its approach to cybersecurity and its willingness to partner in the defense of patients' care and information.

Managing third-party risk requires a careful review of how your organization is connected to other entities, what digital services it relies on and what security standards – if any – the third party complies with. All this information should inform and improve your organization's third-party risk management plan (TPRM). Here are seven ways you can build or reinforce a healthcare-focused TPRM.

Components of a third-party risk management plan

- **Create incident response plans.** Start with the assumption that a breach will happen and plan accordingly. Your company should start by focusing on suppliers and partners with the greatest access to company systems and data. Document steps each organization should take during and after a cyber incident, including communications, reporting protocols and identifying stakeholders. Designate a representative in your organization who will oversee third-party security practices and incident response.

- **Identify, track and govern your most valuable data.** Your organization should create systems that help identify who is using critical data – like patient records and payment information – and set controls to protect data in transit, in use and in storage. The inventory should detail which third parties have access to data or storage systems.

- **Measure third-party risks.** Undertake a full risk assessment associated with third parties and identify those that could present the most serious threat to your organization's data or reputation in the event of a cyber incident. Assess the extent to which these partner organizations must comply with regulations that govern data usage or security protocols.

41% Percentage of data breach incidents in the healthcare industry that began with a third party (highest percentage among industry sectors)[4]

- **Evaluate third-party security standards.** Conduct assessments of your most important partners and service providers and the security controls they provide for any of your company's assets. To improve security in their products or services, consider partnering with third parties – such as device manufacturers – to ensure they are not using outdated or commercial software.

- **Bind security protocols to contracts.** Be proactive in building security requirements into supplier contracts and business associate agreements, including protocols for reporting potential security incidents and remedial steps third parties are obligated to initiate in the event of an actual cyberthreat.

- **Maintain oversight of third-party security.** Cybersecurity requires continuous monitoring and updates to tool sets and protocols as needed. Build performance reviews and key performance indicators into your company's most important third-party contracts. Work with third parties to ensure their business processes are aligned with best security practices.

- **Emphasize the shared responsibility of protecting patients.** Stress the importance of collaboration during the review process to frame cybersecurity as a shared objective that has a real impact on patient outcomes and the reputation of every organization involved in patient care.

Notes:

[1] IBM, "Cost of a Data Breach Report," 2024.

[2] Black Kite, "Healthcare Under Ransomware Attack," 2025.

[3] American Hospital Organization, January 27, 2025.

[4] Black Kite, "Black Kite Third-Party Breach Report 2025."

First case on-time starts:

A proven strategy to improve your OR efficiency

Maximize your operating room revenue by starting and staying on time. Here's our expert strategy for tracking and improving first case on-time (FCOT) operating room rates.

As labor and supply costs continue to rise and reimbursement structures struggle to keep pace, healthcare organizations are searching every corner for cost-saving measures to maintain margin and profitability. The operating room (OR), which often generates 60–65% of patient revenues at an average hospital, also comes with substantial cost. Maximizing OR efficiency is a key opportunity for healthcare organizations to minimize costs and improve margins.

Maximizing OR efficiency is a key opportunity for healthcare organizations to minimize costs and improve margins.

Considering labor hours, equipment, supply costs, and general overhead, the cost of one minute of OR time can range from $50 to $150. At this rate, even slight delays in throughput can translate to significant costs (or savings opportunities) when annualized. And, as OR managers know well, if the first case goes off the blocks late, there is a cascading effect throughout the day. That late start leads to additional delays, stress on staff to make up for lost time, and unhappy providers and patients. For this reason, first case on-time starts (FCOTs) are a core measure of OR efficiency and commonly tracked measure among hospital administrators. High-performing organizations strive for a FCOT rate of 90% or greater.

Falling below the industry standard of 90% can have significant cost implications. Consider, for example, a facility that has a 50% FCOT rate for a 10-room OR that starts on average 15 minutes late. Achieving the industry standard of 90% would create an annualized impact of $1.56 million at $100/minute/OR. If your organization isn't tracking FCOTs, it's likely you have a high percentage of canceled or delayed cases, frustrated staff, as well as large overtime spend that is eating into your bottom line.

If your organization isn't tracking FCOTs, it's likely you have a high percentage of canceled or delayed cases.

A simple, but powerful method to optimize your OR schedule for FCOTs that meet the industry standard of 90% or greater is to implement a daily

continued on page 9

 (continued from page 8)

multidisciplinary OR planning huddle. Facilitated by the OR board runners, these huddles typically occur in the afternoon with the goal to review the morning cases to find out what went well, what did not, and how the team can better prepare for tomorrow.

They are intended to be brief calls, with the most efficient huddles lasting roughly 15 minutes. In that time, the team reviews the following day's lineup and ensures all stakeholders are aware of any concerns that may lead to a delay or cancellation. But the huddle goes beyond information sharing. The intended outcome of each huddle is to adjust the following day's lineup whenever necessary to optimize for FCOTs; that is, to ensure first cases are clean and ready to go.

The intended outcome of each huddle is to adjust the following day's lineup whenever necessary to optimize for FCOTs.

Clean cases are those in which:

- Financial and medical clearances are obtained.
- Pre-admission testing processes are complete.
- All necessary test results are in and the anesthesia plan is reviewed.
- Preference cards are attached and ready to be picked.
- Vendor trays are in house with enough time to sterilize.
- Any safety concerns are known, communicated, and addressed.

Three considerations for a successful multidisciplinary huddle

- **Finding the right people:** Take time to review your OR value stream and pull together the key stakeholders involved in getting a patient to an on-time surgery. The exact composition of personnel differs slightly for each organization, but the list below is a good starting point.

- **Where and when to meet for huddle:** It's critical to have all team members present and ready to report for each huddle. For huddles that take place in person, choose a place where everyone can gather **outside the RED line.** This allows representatives from nonclinical areas to join and makes it easier for everyone to attend the huddle on-time. Virtual formats can work well but require extra vigilance in preparation and facilitation to ensure the team's full attention. The huddle should occur before the pre-op charge nurse leaves for the day, but early enough to ensure adequate time to contact physician offices and address any potential issues before they close. Many hospitals choose a time around 1:00 p.m. for these reasons.

- **How to measure progress:** "Tracking and posting" FCOT data is a crucial factor to the success of multidisciplinary huddles. Most electronic medical records have a perioperative dashboard (e.g., OR manager in Epic) that can be leveraged for this purpose. Metrics should be posted where your huddle meets or displayed during huddle for review as part of a virtual discussion. The team should set and track a daily goal for each metric and the actual numbers from the previous week to measure progress against. Recommended daily measures to track include:

  - Number of scheduled cases.
  - Number of add-on cases.
  - Huddle attendance level.
  - Number of rooms starting before 9 a.m.
  - Today's FCOTs percentage achieved.
  - Number of same-day cancels

A common data gap to watch for is incomplete or nonstandard use of delay codes when FCOT delays occur. Well understood and consistent charting of delay codes by the perioperative staff is essential. This enables OR directors to strategically address barriers to meeting FCOT goals.

The potential payoff

So, what can you expect to gain from well-executed multidisciplinary OR huddles? If your organization is struggling with FCOTs and can't reach the industry-standard 90% rate, a well-executed multidisciplinary planning huddle is a powerful tool to move the needle. The improvement can result in significant improvements in OR utilization and decreased overtime spend. Benefits also include substantial nonfinancial factors such as reduced staff stress and patient frustration from canceled or delayed cases.

Bottom line

Navigating operational improvement in multidisciplinary fields is challenging, and as with most process improvement projects, success rates rise when there's a strong leadership focus and buy-in from the team. With OR facilities generating significant revenues and costs for health systems, implementing a multidisciplinary planning huddle to improve FCOT rates is a piece of "low-hanging fruit" that's well worth the time and investment.

About the Author

Tyler Gregory *is a Senior Manager at Plante Moran. You can reach Tyler at Tyler.Gregory@plantemoran.com.*

Measuring What Matters:
Building an AI Strategy That Delivers Results

Healthcare finance leaders are no longer debating whether AI belongs in revenue cycle management—they're determining which investments will deliver measurable returns. With denial rates climbing and payer tactics growing more sophisticated, the question is what your AI strategy should look like and how to measure its success.

The Denials Crisis by the Numbers

Initial denial rates climbed to 11.81% in 2024, up 2.4% from the previous year, according to Kodiak Solutions data analyzing more than 2,100 hospitals[1]. More concerning is what's driving these denials. While authorization-related denials fell 7.7%, denials tied to medical necessity and requests for more information surged by 5% and 5.4% respectively[1].

The financial impact extends beyond denied revenue. True accounts receivable days increased 5.2% year-over-year, directly affecting cash flow[1]. Meanwhile, providers collected just 34.46% of amounts owed by insured patients in 2024, down from 37.58% the previous year[1].

These trends reflect a fundamental shift. Payers are pulling back from prior authorization friction points only to redirect scrutiny to the backend through increased medical record requests and sophisticated denial algorithms—achieving reduced claim spend through different means.

Why 60% of Denials Went Unworked

For years, approximately 60% of denials went unworked due to high appeal costs. Writing an effective appeal requires pulling together information from multiple sources—medical records, denial letters, coding guidelines, payer policies, and contracts. Expert review could take hours or days, making low-dollar denials economically unviable.

Recent advances in large language models are changing this equation. These systems can parse unstructured information in minutes rather than hours, dramatically lowering the threshold at which working denials becomes economically viable and opening the door to addressing cases that previously went untouched.

The Right Metrics Framework

Effective AI implementation begins with clearly defining the problem and establishing baseline metrics. Four key performance indicators provide a comprehensive framework:

- Claim threshold: AI should enable you to profitably address accounts that previously fell below your operational threshold.
- Time to cash: Leading implementations are achieving approximately 40-day improvements from account placement through final payment.
- Success rate: Well-implemented AI solutions are consistently delivering 10-20 percentage point lifts in overturn rates.
- Appeals per bill: AI should reduce the need for second and third appeals by approximately 20% through more thorough initial submissions.

It's important to understand current limitations of human-driven processes before implementing AI. Technology should meet or exceed human performance in throughput, speed, and success rate before expanding. This baseline-and-validate approach allows hospitals to measure ROI at each stage.

Setting Realistic Expectations

AI is not magic. While large language models represent powerful technology, they make mistakes. The most effective implementations don't rely on AI alone. Instead, they build platforms with appropriate guardrails that integrate authoritative data sources—code sets, payer policies, clinical guidelines—providing subject matter experts with a strong foundation for their work.

Hospitals should expect incremental improvement rather than overnight transformation. Start by structuring medical records for easier review. Then teach the system to pre-answer standard questions. Each piece improves efficiency while allowing quality validation. You don't need a fully developed solution to begin seeing ROI.

Build, Buy, or Partner?

Four factors should guide implementation decisions:

- Capacity: Do you have bandwidth and budget to sustain AI solutions over multiple years, competing for talent with pure-play AI companies?
- Capabilities: With large language models, the challenge is developing the right applications to leverage vendor models effectively.
- Culture: Building in-house requires organizational comfort with experimentation and course correction.
- Conviction: Building internally requires a five-year commitment. Organizations needing results today should consider buying or partnering.

The global market for AI in healthcare revenue cycle management is projected to grow more than 24% annually, reaching approximately

continued on page 12

Measuring What Matters: Building an AI Strategy That Delivers Results (continued from page 11)

$180 billion by 2034—up from about $26 billion in 2025[2].

The Adoption Gap

Despite growing awareness, actual adoption remains low. According to Experian Health's State of Claims 2025 report, 67% of providers believe AI can improve claims processing, yet only 14% are currently using AI to reduce denials[3]. Among those who have implemented AI, 69% report reduced denials and increased resubmission success[3].

A Sage Growth Partners survey found 75% of healthcare executives believe AI can reduce operational costs, while 77% say it's improving revenue cycle operations[2]. Government data shows 71% of hospitals used predictive AI in 2024, with the fastest growth in revenue cycle: billing automation jumped from 36% to 61%[2].

The Time to Act

Denial rates continue rising as payers push more denials to the backend, knowing most health systems lack capacity to fight them at scale. Healthcare providers still fighting denials without AI technology are falling behind.

Healthcare finance leaders should begin by defining problems and establishing baseline metrics. Identify specific denial categories where AI can create immediate results. Ensure historical claims data is accurate and accessible. Select solutions that integrate with existing workflows. Equip staff to partner effectively with AI.

The goal isn't replacing human expertise but amplifying it—allowing experienced team members to focus on strategic appeals requiring judgment while AI handles data processing and repetitive tasks. Most importantly, recognize that the conversation has moved beyond whether AI belongs in revenue cycle operations to implementing solutions that deliver results.

Your revenue cycle team deserves tools that work as effectively as those deployed against them. Your patients, and your hospital's financial health, depend on it.

About the Author

Damian Franklin *a Client Success Director at Aspirion. You can reach Damian at* damian.franklin@aspirion.com.

Notes:

[1] "Rate of initial denials of medical insurance claims continued to rise in 2024, Kodiak Solutions' proprietary data show," Business Wire, May 21, 2025

[2] Matt Szaflarski, "AI and the Healthcare Revenue Cycle," Kodiak Solutions Insights, October 31, 2025

[3] "State of Claims 2025: The Denial Problem (and Is AI the Answer?)," Experian Health, September 23, 2025

CMS Changes to Hospital Price Transparency

On November 21, 2025, CMS finalized updates to Hospital Price Transparency regulations in the CY 2026 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Final Rule. These changes will affect the information hospitals must disclose in their machine-readable files (MRFs). These changes will become effective on January 1, 2026, with enforcement beginning on April 1, 2026.

What are the major Price Transparency changes included in the CY 2026 OPPS Final Rule?

Beginning on January 1, 2026, Hospitals must utilize electronic remittance advices (ERAs) to calculate the allowed amounts for the median, 10th, and 90th percentile for rates that are expressed as percentages or algorithms from the previous 12 to 15 months before posting the MRF.

Hospitals will be required to report the median, 10th percentile, and 90th percentile allowed amounts when a payer-specific negotiated charge is based on a percentage or an algorithm. Hospitals will also be required to report the number of allowed amounts that were used to calculate the median and percentile values. These values will replace the "estimated allowed amount" field in the current MRF format.

The attestation statement in the MRF must be updated to confirm that the hospital "has included all applicable payer-specific negotiated charges in dollars that can be expressed as a dollar amount, and for payer-specific negotiated charges that cannot be expressed as a dollar amount in the MRF or are not knowable in advance, the hospital has provided in the MRF all necessary information available to the hospital for the public to be able to derive a dollar amount, including, but not limited to, the specific fee schedule or components referenced in such percentage, algorithm, or formula." (CMS-1834-F, Hospital Price Transparency Policy Changes). Hospitals are also required to include the name of the hospital's senior official designated to oversee the encoding of true, accurate, and complete data.

Hospitals must also include all active type 2 NPIs (National Provider Identifiers) in a newly created MRF data element for any NPIs associated with the hospital or hospital units.

Considerations for Compliance with the New Price Transparency Requirements

- Can your system retrieve payer remittance (i.e., ERAs/835) files for the 12 to 15-month period preceding the publication of the MRF?
- Do you have tools or processes to calculate median and percentile values for payer-specific negotiated charges based on a percentage or an algorithm?
- Do you have resources available to update the hospital MRFs to include the newly required data elements, such as median and percentile values, number of service line items included in the percentile calculation, hospital NPIs, attestation statement modifications, etc?

Bottom line: The CY 2026 OPPS Final Rule materially raises the operational bar for Hospital Price Transparency, particularly around data integrity, remittance-based calculations, and governance accountability. Hospitals should begin validating ERA data availability, analytics capability, and MRF update workflows now to avoid last-minute compliance risk. Given the January 1, 2026 effective date and April 1, 2026 enforcement start, organizations that wait will likely struggle to operationalize percentile calculations, attestations, and NPI completeness in time. Proactive readiness testing in 2025 will be critical to ensuring timely, accurate, and defensible compliance.

About the Author

Scott Treida, MT(ASCP), CPC *is a Director at Blue & Co., LLC. You can reach Scott at* STreida@blueandco.com.

The OBBB's Medicaid Work Requirements and the Hidden Risks for Hospitals

The One Big Beautiful Bill (OBBB), passed this summer, contains a provision of great consequence for hospitals: Medicaid work requirements. The new law requires a subset of beneficiaries to log at least 80 hours of employment, volunteering or schooling each month to maintain coverage.

The changes carry significant administrative and reputational risk for health systems. And they could be costly. One analysis found that hospitals in Medicaid expansion states could see operating margins reduced by an average of up to 13.3%. Operating margins for safety-net hospitals could shrink by an average of up to 29.6%, and even more in certain states and in rural areas.

Whether it will work is another question. Georgia's experience offers a cautionary tale. The state piloted a work requirement for Medicaid in 2023; political leaders proclaimed it a success, but the policy resulted in disenrollment, and not in greater employment, according to an independent investigation. Many who would have qualified lost coverage because they could not navigate reporting portals or missed paperwork deadlines. As a result, hospitals were left treating patients who assumed they were covered, only to discover their benefits had lapsed. Meanwhile, Georgia spent more than twice as much on administration as it spent to provide healthcare to enrollees, according to a U.S. Government Accountability Office study.

Arkansas is the only other state to have attempted Medicaid work requirements on a broad scale. That program ended in 2019 after a judicial ruling. Researchers found that that state's policy was associated with an increase in uninsurance but no significant change in employment.

The OBBB creates the possibility that these patterns may be repeated on a national scale.

Challenges for hospitals: What's old is new again

The likely result will be a spike in uninsurance. This isn't ideal, of course, but hospitals have lived through a version of this story before. In the years before the Affordable Care Act (ACA), millions of patients cycled in and out of coverage, creating a steady stream of uninsured and underinsured cases that strained revenue cycle operations and placed additional pressures on margin.

The OBBB reintroduces that dynamic, with new reporting burdens layered on top. Hospitals must start preparing for possible fallout as patients lose Medicaid coverage for failing to meet the new requirements or navigate complex reporting systems.

Hospitals face challenges in four distinct ways.

1 Financial exposure. The most immediate effect will be on margin. As more patients lose insurance, hospitals will see increases in charity care and bad debt. Some patients will transition to self-pay, complicating collection efforts. Even with updated sliding scales and discounts, revenue losses are likely.

continued on page 16

The OBBB's Medicaid Work Requirements and the Hidden Risks for Hospitals

(continued from page 15)

2 Operational complexity. Scheduling staff and eligibility teams will be tasked with validating coverage in a system in which rules vary by state and may change considerably over time. Patients may meet requirements through a patchwork of jobs, volunteer hours and classes, but documentation will be inconsistent and challenging. Responsibility for tracking and verifying this information will place a new burden on already stressed operations, with new strains on pre-service, patient access and financial counseling teams, which will be responsible for more frequent and real-time eligibility checks. More patients will arrive without coverage, requiring upfront deposits, self-pay arrangements or financial assistance screening.

3 Reputational risk. The ambiguity about coverage inevitably will lead to delays in or denial of elective care as patients navigate coverage lapses. Hospitals risk public criticism if they pursue collections too aggressively or deny care when coverage cannot be confirmed. This can create morale challenges as clinical staff may grow conflicted if they feel their organization's mission is compromised and their values are misaligned. Stories in the local media about patients being turned away can damage the public's trust quickly, and it can take years to undo that damage.

4 Policy uncertainty. The OBBB's Medicaid work requirements arrive as other changes loom. The potential expiration of enhanced ACA premium subsidies at the end of this year could reduce coverage even before Medicaid work requirements take effect in 2027. Cuts to Medicaid disproportionate share hospital (DSH) payments have been pushed back to Jan. 30, 2026. Each of these will likely increase financial pressure and compound the risks associated with Medicaid work requirements.

A strategic mindset: beyond revenue cycle

The OBBB will likely strain hospitals' margins, but the challenge is not purely financial. Policies designed only to protect the bottom line can backfire if they appear indifferent to patient realities. Hospitals will need to weigh decisions against their role as community stewards. Aligning strategies with boards and community leaders can help financial policies withstand scrutiny.

Timing matters. The work requirements are scheduled for 2027 (although states have the option to implement them sooner or can delay them until the end of 2028 if they are attempting to comply). But the impact of the expiration of enhanced ACA subsidies and Medicaid DSH cuts will come sooner. Systems that act now to shore up financial assistance, strengthen vendor partnerships and refine eligibility processes will be more resilient when multiple stressors converge.

The OBBB's Medicaid work requirements are no longer an abstract policy debate. They will determine who remains covered, how hospitals get paid and how communities perceive their providers. So hospitals will need to dust off their playbooks from the pre-ACA era. But this landscape is different.

Hospitals that act now to strengthen financial assistance, engage vendors and forge community partnerships will be better positioned to navigate the transition. Those that delay risk higher bad debt, greater reputational harm and reduced flexibility. Hospitals have a choice: prepare now or pay later.

What the law says

The changes to Medicaid eligibility contained in the One Big Beautiful Bill set a work threshold. Reporting and verification are left to the states. Here are some of the details:

The law requires adults age 19 to 64 to meet "community engagement standards" to maintain coverage. Beginning in 2027, most beneficiaries will need to document at least 80 hours each month of work, volunteering or approved education and training activities.

Compliance will be tracked in 3-month intervals; failure to meet the threshold risks disenrollment.

The law includes exemptions for pregnant and postpartum women, the elderly, people with disabilities and primary caregivers of children 13 or younger, and additional groups.

States may grant temporary hardship exemptions, and the OBBB specifically carves out protection for patients who must travel long distances to access care.

The law tightens Medicaid eligibility in other ways. States must redetermine eligibility every six months for expansion adults, doubling the previous frequency of verification. They are required to establish processes to prevent enrollment in Medicaid and Children's Health Insurance Programs in multiple states by verifying residency more frequently. And, the law places new restrictions on the definition of qualified immigrants.

The OBBB allows states to delay implementation until 2029 if they demonstrate good-faith efforts to comply with the new requirements.

How hospitals can prepare now for the OBBBA

Hospitals are not powerless in the face of the OBBB. A range of vendor solutions and internal strategies can soften the impact of the law's Medicaid provisions, including the following.

continued on page 17

The OBBB's Medicaid Work Requirements and the Hidden Risks for Hospitals

(continued from page 16)

Collaborate with vendors. Hospitals will likely need to coordinate closely with vendors to engage with patients at every level. Real-time data capture and eligibility checks will be critical to preventing gaps. Vendors that adapt to these realities will be valuable allies. Consider that:

- Medicaid eligibility vendors can help patients secure and maintain coverage
- Health Insurance Premium Program vendors can manage premium assistance for those eligible to transition into employer-sponsored plans
- Patient assistance and pharmacy programs from manufacturers and state agencies can cover the cost of some medications
- Propensity-to-pay vendors can provide analytics to assess which patients are most likely to meet obligations
- Charity organizations and foundations can offer targeted financial support, sometimes tied to diagnosis or equipment needs

Modernize financial assistance policies. This is an ideal time to update your charity care policies, sliding scales and prompt-pay discounts. Establishing payment programs or credit arrangements may be necessary. But proceed cautiously and evaluate patient impact carefully, particularly as interest rates remain high.

Explore community partnerships. Because the OBBB allows volunteer hours to count toward eligibility, hospitals can play a convening role by connecting patients with community organizations and tracking compliance. Coalitions can give patients options to meet the 80-hour threshold while also strengthening community ties.

Reprinted with permission from Kaufman Hall, a Vizient company.

About the Authors

Bart Richards *is a managing director in the Revenue and Operations Improvement practice at Kaufman Hall, a Vizient company, in Chicago, IL. You can reach Bart at* bart.richards@kaufmanhall.com.

Cedrial Moore *is a senior vice president in the Revenue & Operations Improvement practice at Kaufman Hall, Chicago, IL.*
You can reach Cedrial at cedrial.moore@kaufmanhall.com.

First Illinois Chapter 2025-26 Officers and Board of Directors

Officers

Sue Marr
President

Brian Kirkendall, CHFP, CPA
President-elect

Meagan Appleby CHFP, CRCR
Secretary/Treasurer

Matt Aumick, CHFP, CPA,
Immediate Past President

Board of Directors

Greg Burdett

Shelby Burghardt, CPA

Ryan Downs, CPA, CHFP, CRCR

Kristen Refness, MBA, CHFP

Michael Sisti,

Jared Swiecicki, FHFMA

Sara Weisenberg, CHFP

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 https://www.hfma.org/chapters/region-7/first-illinois/volunteer-opportunities/
2. Check out the **Volunteer Opportunity Description**
3. Fill out the **volunteer form** and become more active today!

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

Stand out with HFMA Certifications

In today's fast evolving healthcare finance landscape, staying competitive takes more than simply keeping up. That's where Healthcare Financial Management Association (HFMA) certifications can help you stand out. HFMA offers a suite of respected credentials built for every career stage, from emerging professionals to seasoned executives, signaling credibility, commitment, and practical expertise across the healthcare financial ecosystem.

Certified Healthcare Financial Professional (CHFP)

HFMA's credential, CHFP, validates comprehensive knowledge across the business of healthcare, including finance, operations, quality, and strategy. It's ideal for professionals seeking a well-rounded foundation and a common language across clinical, financial, and operational teams.

Other Specialized HFMA Certifications

For those looking to deepen expertise in other targeted areas, HFMA offers specialized credentials such as:

1. **(New) Certified Specialist Ambulatory Practice Management (CSAPM) –** Covers ambulatory revenue cycle, budgeting, projections, cost accounting, systems, payer contracts
2. **(New) Certified Hospital Cost Report Specialist (CHCRS) Exam -** Complete prerequisites, CHCRS exam for finance leaders
3. **(New) Certified Hospital Cost Report Specialist (CHCRS) Training –** Prepares healthcare finance professionals for CHCRS certification exam credential
4. **Certified Specialist Business Intelligence (CSBI) –** Helps demonstrate ability to find, inspect, and clean, transform, and model data to clarify issues and conclusions
5. **(International) Certified Revenue Cycle Representative (CRCR) – GCC –** Earn GCC revenue cycle certification, recognized expertise
6. **Certified Specialist Payment & Reimbursement (CSPR) –** Demonstrate managed care reimbursement expertise, online, included
7. **Certified Revenue Cycle Representative (CRCR) –** Focused on front-end and back-end revenue cycle fundamentals
8. **Certified Specialist Accounting and Finance (CSAF) –** Demonstrate mastery in analyzing financial reports and statements, risk-sharing arrangements, managed care contracts, and profitability ratios
9. **Certified Specialist Physician Practice Management (CSPPM) –** Tailored to ambulatory and physician enterprise leaders

Each certification aligns with real-world roles and challenges, making them immediately applicable and highly relevant. Whether you're early in your career or preparing for your next leadership step, HFMA certifications give you a clear, confidence-building path to level up then prove it with a credential.

Learn more and register here or if you have any questions, please feel free to reach out to Connor Loftus (connor.loftus@kaufmanhall.com) or Sara Weisenberg (sweisenb@nm.org).

About the Author

Teresa Vargas, MHA, CHFP *is Manager, Life Sciences and Health Care at Deloitte & Touche LLP. You can reach Teresa at at* tvargas@deloitte.com

Upcoming Chapter Events

Date	Event	Location
February 26	First Illinois HFMA & Chicago Health Executive Forum Provider & Payer Symposium	University Club of Chicago
April 9	HFMA First Illinois Golf and Fitness Workshop	The Golf Warehouse, Burr Ridge, IL
May 28	First Illinois HFMA Spring Symposium	Prentice Women's Hospital, Chicago, IL
June 18	Women in Leadership Retreat	Cantigny, Wheaton, IL
July 18	Transitions Dinner	Ruth Lake Country Club, Hinsdale, IL
August 28	Topgolf & Scholarship Event	Topgolf, Naperville, IL
October 22-23	Region 7 HFMA Midwest Conference (IL, IN, and WI Chapters)	Chicago/Oak Brook Hilton Resort & Conference Center, Oak Brook, IL

Scan the QR code for event details

Interested in Sponsorship Opportunities?
Contact Eileen Crow at
ecrow@firstillinoishfma.org

First Illinois Chapter Partners

The First Illinois Chapter wishes to recognize and thank our 2026 Partners for all your generous support of the chapter and its activities. **CLICK HERE** to learn more about the chapter's robust partnership program.

hfma™
first illinois chapter

Platinum Partners

CPAs / ADVISORS blue

forvis mazars

RSM

plante moran

Silver Partners

ANNUITY HEALTH

Gulf Coast REVENUE CYCLE MANAGEMENT

HARRIS & HARRIS

PRONTO

Xsolis

Gold Partners

aspirion

Bank of America Merrill Lynch

KaufmanHall

WAYSTAR

Bronze Partners

enablecomp

Great Lakes MEDICAID, Inc.

HUMATA HEALTH human+data

You've Got This Now! KNOWTION HEALTH

POWERS + MOON

Revecore®

Law Offices of Stephenson Acquisto & Colman

salud revenue partners

WINTRUST GOVERNMENT, NON-PROFIT HEALTHCARE

hfma™
first illinois chapter

Chapter Partners Make it Possible!

Become a First Illinois Annual Partner today!

CLICK HERE to view our robust partnership package or contact ecrow@firstillinoishfma.org to set up a 30-minute call to learn more.

FIRST ILLINOIS SPEAKS

Publication Information

Editor
Jim Watson jlwatsoninc@outlook.com

Partnership Chair
Jared Swiecicki jswiecicki@uchicagomedicine.org

Design
DesignSpring Group, Kathy Bussert kbussert@designspringinc.com

First Illinois Chapter HFMA Editorial Guidelines

First Illinois Speaks is the newsletter of the First Illinois Chapter of HFMA. *First Illinois Speaks* is published 3 times per year. Newsletter articles are written by professionals in the healthcare industry, typically chapter members, for professionals in the healthcare industry. We encourage members and other interested parties to submit materials for publication. The Editor reserves the right to edit material for content and length and also reserves the right to reject any contribution. Articles published elsewhere may on occasion be reprinted, with permission, in *First Illinois Speaks*. Requests for permission to reprint an article in another publication should be directed to the Editor. Please send all correspondence and material to the editor listed above.

Founders Points

In recognition of your efforts, HFMA members who have articles published will receive 2 points toward earning the HFMA Founders Merit Award.

Publication Scheduling

Publication Date	Articles Received By
June 2026	May 1, 2026
October 2026	September 1, 2026
February 2027	January 2, 2027

Upcoming Events

First Illinois Chapter

Check out our calendar now

Stay informed about exciting happenings!

Scan the QR code to view the full calendar & RSVP