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Region 7 Is Almost Here – and the Momentum Is Building!

The countdown is on for the **HFMA Region 7 Fall Conference, October 21-23**, bringing together healthcare finance professionals from Illinois, Indiana and Wisconsin for three days of education, connection and collaboration.

And the momentum continues to build.

More than 200 attendees are already registered, with healthcare providers representing **30+ organizations**. More than **60% of our registered provider audience** is Director-level or above, including Directors, Vice Presidents and C-Suite executives, with strong representation across **finance, revenue cycle, managed care and operations**.

A Strong Program. An Even Stronger Community.

Region 7 will bring together healthcare leaders, industry experts and colleagues from across the Midwest for timely education, fresh perspectives and conversations about the issues impacting healthcare finance today. But some of the best learning happens outside the sessions. Region 7 is also about making new connections, exchanging ideas with peers and strengthening the relationships that make HFMA such a valuable professional community.

Our Business Partners Are Showing Up, Too!

The response from our business partner community has been tremendous. **Exhibit space is officially sold out**, along with many of our featured sponsorship opportunities.

A limited number of sponsorship opportunities are still available for organizations looking to connect with this highly engaged audience.

Three Days. Three States. One Region 7.

Whether you're coming for the education, the connections, the conversations – or all three – **Region 7 is the place to be this October**.

Haven't registered yet? There's still time to join us.

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Message From Our Chapter President

Dear Friends and Colleagues,

Looking Ahead While Building on Our Momentum

As we move into the fall season, I continue to be energized by the momentum across the First Illinois Chapter of HFMA. Over the past several months, our volunteers, board members, sponsors, and members have demonstrated what makes this chapter so special: a commitment to professional excellence, meaningful connections, and service to the healthcare finance community.

October is always an exciting time for HFMA, and this year is no exception. Many of our members will be attending the HFMA Region 7 Conference later this month, where healthcare finance leaders from across the Midwest will come together to share ideas, discuss challenges, and explore opportunities shaping the future of our industry. I am particularly excited to participate in several conference activities and to showcase the strong leadership and engagement that First Illinois continues to bring to Region 7.

While conferences and educational events are important, our chapter's greatest strength remains its people. One of my goals this year is to continue developing the next generation of chapter leaders. We are

fortunate to have a deep bench of talented volunteers who are stepping into new roles, bringing fresh ideas, and helping ensure the long-term success of our chapter. Strong succession planning and leadership development are critical to maintaining the vibrant organization we all enjoy today.

This fall also brings several opportunities to connect with your peers. Whether through educational programming, networking events, volunteer activities, or committee involvement, I encourage every member to find a way to engage. Some of the most valuable professional relationships and career opportunities I have experienced have come through my involvement with HFMA. The connections made through this organization extend far beyond individual events and often become trusted professional networks that support us throughout our careers.



Brian Kirkendall

2026-27 President, First Illinois HFMA Chapter

Partner, RSM US LLP

Brian.Kirkendall@rsmus.com

Upcoming Events

First Illinois Chapter

Check out our calendar now

Stay informed about exciting happenings!

Scan the QR code or click the link below to view the full calendar and RSVP.

<https://www.hfma.org/chapters/region-7/first-illinois/partners/>



Hospital Financial Outlook 2026:

Revenue Growth, Margin Pressure, and Shifting Payor Mix



The headline number from mid-2026 is technically encouraging: hospital revenue is growing.

But revenue figures can obscure the more complicated margin picture.

Expense growth is running close behind revenue growth; the payor mix has worsened materially as federal Marketplace subsidies expired, and a growing share of patients are deferring procedures they would otherwise be scheduling.

For hospital finance teams, the 2026 story is really about the distance between topline performance and bottom-line stability.

Revenue Is Growing, But Expenses Continue to Eat It Away

Strata Decision Technology's May 2026 benchmarks show not-for-profit health systems posting a year-to-date operating margin of 0.4%, with individual hospitals improving operating margins by 0.2 percentage points year over year – a real gain, though one that still leaves very little financial cushion.

Gross operating revenue increased 5.9% year over year, with inpatient up 5.7% and outpatient up 6.1%.

The challenge is that expenses grew nearly as fast. Total hospital expenses climbed 5.5%, driven primarily by:

- Supplies: +4.0%
- Labor: +3.9%
- Pharmaceuticals: +3.3%

Inflationary pressure has eased somewhat since the post-pandemic peak, but the spread between revenue and expense growth has

narrowed to the point where most hospitals are operating with very limited financial slack.

The Payor Mix Is Moving in the Wrong Direction

The more significant story developing this year involves the ACA Marketplace. When enhanced federal subsidies ended, enrollment fell by nearly 3 million people.

The working assumption among many health system finance teams was that those individuals would find their way into employer coverage, Medicaid, or some other product. The Q2 earnings calls largely told a different story.

A substantial portion of those patients became uninsured while continuing to seek care, a pattern that's now visible in the actual financials.

HCA Healthcare reported Marketplace admissions declining 15%, with approximately 22,000 patients shifting into self-pay status rather than transitioning to other coverage. The impact was direct: second-quarter income before income taxes declined by approximately \$400 million.

Tenet Healthcare saw comparable pressure.

Marketplace admissions were down 13.5%, resulting in approximately \$65 million in lost revenue. Community Health Systems also reported a sharp increase in self-pay, prompting leadership to revise portions of its 2026 financial guidance.

For not-for-profit hospitals, the aggregate effect showed up in uncompensated care, which increased 9.3% year over year.

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Hospital Financial Outlook 2026: Revenue Growth, Margin Pressure, and Shifting Payor Mix

(continued from page 4)

The care is being delivered. What's shifted is who ultimately absorbs the cost, and increasingly, the answer is the hospital.

Patients Are Delaying Elective Procedures

Orthopedic cases provide an instructive window into what's happening with elective procedures more broadly.

When a patient's deductible has gone up and household finances are tighter, a hip replacement tends to get postponed. That calculus is now showing up across multiple service lines.

HCA reported emergency surgeries increasing even as elective inpatient cases declined. CHS confirmed similar softness in orthopedic and certain cardiac procedures.

Leadership across these systems pointed to a consistent set of pressures: more patients now lack insurance, deductibles have risen in both Marketplace and employer-sponsored plans, and the broader economic uncertainty of 2026 has made significant out-of-pocket spending feel riskier than it otherwise would.

Even cardiac procedures aren't immune. Patients are postponing cardiology visits and recommended screenings that would, under different financial circumstances, typically lead to intervention.

Importantly, most organizations are still seeing growth in clinic visits, imaging studies, and outpatient evaluations. Patients haven't stepped back from the healthcare system; the deferral is happening between the initial evaluation and the higher-cost procedure that follows from it.

Outpatient Volumes Pause While Inpatient Demand Holds Up

The not-for-profit outpatient picture adds another layer worth watching.

After years of consistent growth, outpatient volumes fell 1.8% year over year and dropped 8.4% in the single month from April to May. Emergency department visits also declined modestly.

Whether that reflects seasonal variation, a utilization shift linked to the insurance disruptions described above, or some combination remains unclear.

Inpatient volumes, by contrast, grew 2.4% year over year, which partially offset the outpatient softness on the revenue line.

Demand for Acute Care Remains Strong

Despite all of the near-term margin pressure, the long-term demand thesis remains intact.

HCA, Tenet, and CHS all pointed to the same structural tailwinds on their earnings calls: population growth, an aging demographic, and rising rates of chronic disease.

HCA's expansion plans make that conviction concrete. The system is planning to add roughly 1,000-1,200 inpatient beds and 250-300 new outpatient sites.

Tenet made a parallel case for the demand environment. Surgical volumes softened slightly, but revenue per case in its USPI ambulatory segment grew approximately 6.3%, reflecting a deliberate shift toward higher-acuity procedures and the revenue quality that comes with it.

CHS echoed the broader picture: clinic visits, orthopedic imaging, and diagnostic testing volumes are all growing at a healthy pace.

The friction, in other words, isn't at the front door of the healthcare system. It's in the interval between an initial evaluation and the higher-acuity procedure that follows. The gap is where the financial performance of the current moment is ultimately being decided.

Bottom Line

Taken together, the 2026 data reflects a structural gap between where revenue growth is landing and where it needs to be to actually strengthen hospital financial performance.

The 5.9% topline gain looks solid until you account for expenses running nearly as fast, uncompensated care up 9.3% as millions of newly uninsured patients continue seeking care, and a meaningful share of elective procedures being deferred rather than canceled outright. This is still affecting current-period revenue, just more gradually.

The underlying demand is real. Patients are showing up for evaluations, imaging, and diagnostic work, and the demographic and chronic disease trends that major systems are committing capital against are not going away.

What hospitals are navigating is the distance between that first-touch engagement and the reimbursable, higher-acuity services that actually move the financial needle. By reducing the economic friction that's keeping patients from proceeding to the next step of care, closing the gap is the central operational challenge of the current environment.

About the Author



Michael Koening is a Senior Manager and the Managed Care Service Line Lead within the Healthcare Reimbursement practice at Blue & Co., LLC. You can reach Michael at mkoening@blueandco.com

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Why “Resolved” Accounts Are Draining Your DRG Revenue

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The revenue integrity gap between what you billed and what you’re actually keeping

Your paid rates look fine. Your denial rate looks manageable, your dashboard is green, and yet more dollars than you’d care to admit are slipping out of your revenue cycle every year. The money is not lost to formal denials you can see and work. It disappears into a window that most revenue cycle programs were never built to watch.

This article shows you where that revenue goes after a claim is paid, and gives you a simple way to measure the problem yourself, using one analyst and a few days before you call a vendor.

The number that should worry you

DRG downgrades increased nearly 57% between 2022 and 2023. They are now one of the fastest growing payer tactics in the industry, and most of them never arrive as denials at all.

Industry data puts downgrade related losses at up to 2% of net patient revenue. On a \$500 million system, **that is \$10 million a year, and that figure is a floor, not a ceiling.**

Why the money hides after payment

Hospitals moved upstream. Utilization review, CDI, concurrent coding, and prebill validation all work hard before the claim drops. Those functions matter, but payers quietly shifted their scrutiny downstream, into the post bill window after a claim is paid and closed.

That window, from payment through timely filing, is the prebill blind spot. Your workflows have stopped running. The AR is zero, the account looks resolved, and no standing process is watching what the payer does next.

Here is what the payer does. A downgrade rarely comes back as a formal denial. Instead, you get a payment on a closed claim at a lower amount than your submitted DRG should have generated. The revenue difference disappears into the noise of closed claims nobody reviews.

There are two forms of this silent problem. In a partial payment, the payer keeps your code but pays less. In a downcode, the payer reassigns your DRG to a lower weight code. Both arrive quietly, and neither trips the standard denial workflow.

This is not a temporary enforcement spike. Payers have shifted from a denial economy to an audit economy, because running AI against millions of paid claims now costs less than the revenue it claws back, and that math only gets more favorable for them.

The second problem in the same window

Downgrades are only half of it. In high acuity cases, secondary diagnoses often sit in nursing and dietitian notes, clinically present and documented, yet never queried and never coded.

Severe malnutrition is the most consistent example. A patient admitted for respiratory failure may show an albumin of 1.8, muscle wasting, and a dietitian note for severe malnutrition. If nobody queries it, the claim drops without that MCC, and the revenue stays buried in the chart.

Why your dashboard cannot see any of this

Your dashboard measures what you billed and collected—not what you should have collected. If a payer downgrades your MS DRG and pays accordingly, your paid rate and denial rate both still look fine. Clean claim rate tells you the claim went out correctly, not whether it came back correctly, and net collection rate erodes too slowly for anyone to trace.

This is a visibility problem first—it becomes a cash problem quietly, over time.

There’s a downstream cost too: systematic downgrades flatten your Case Mix Index, weakening staffing justifications and distorting severity assumptions in value-based and risk contracts.

How to find it in your own data this week

You do not need a vendor to see whether this is material. Start with a question, not a solution. Ask whether anyone currently reconciles what you submitted against what was actually paid on closed claims, not denied claims.

If the answer is no, and it usually is, you have a visibility gap to close first. Then run the analysis below.

1. Pull your 835 remittance data for your top 20 DRGs by volume over the last 18 months.
2. For each closed claim, compare the MS DRG on the submitted 837 against the MS DRG reflected in the 835 payment.
3. Flag every claim where either the DRG codes don’t match, or the codes match but the paid amount is lower than expected reimbursement for that DRG weight and your contracted base rate. The first catches downcodes. The second catches partial payments.
4. Sort those flagged claims by DRG cluster and by payer and look for a pattern rather than outliers.

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Why “Resolved” Accounts Are Draining Your DRG Revenue (continued from page 7)

5. For payers that don’t consistently populate the adjudicated DRG field in the 835, supplement with remit detail or EOB data so those downgrades aren’t missed.

A good analyst can run this in a few days, with no special tooling. Sepsis, acute respiratory failure, AKI, and severe malnutrition are the clusters to watch. UHC, Optum, and Elevance tend to be the most aggressive payers.

When a claim clears the screen, triage before you appeal. Weigh these things: Is the clinical evidence strong enough to beat the payer’s objection? Is the dollar value worth the review time? Are you still inside timely filing?

Winning appeals are built on clinical evidence, not billing arguments. You translate the physician story into the framework the payer audited against. An appeal that only restates the original claim is a resubmission with a cover letter, and it loses.

Then close the loop back to CDI and physicians. Skip the scorecard. **Hand the physician a specific chart: what they documented, what the payer required, and the exact gap.** Feedback framed around a case reads like education, not accusation.

The honest obstacle

Timely filing is the real enemy. Every quarter without a standing post bill function is a quarter of claims permanently exiting the filing window. The cost of waiting isn’t flat. It compounds, and part is irreversible.

About the Author



Kelsey Taylor, BSN, RN, is the Vice President of Solutions Engineering at EnableComp. You can reach Kelsey at ktaylor@enablecomp.com.

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Before the Bill: When Does Patient Financial Risk Start?

From the hospital's perspective, patient financial risk may begin when a patient's insurance claim is adjudicated and a balance becomes "patient responsibility." It may become more visible when a statement goes unpaid, an account ages, or a balance eventually moves to bad debt.

From the patient's perspective, it can begin much earlier.

It may begin the moment a physician says, "You need surgery." Or when a patient learns they need an MRI, a specialist visit, or a course of treatment. Before the patient ever reaches a hospital registration desk, they may already be wondering: What will this cost? What will my insurance cover? Can I afford my deductible? What happens if I can't pay?

The hospital may not see a financial risk yet, but the patient does, and that distinction matters a great deal in revenue cycle.

A recent KFF Health News report highlighted a growing practice among hospitals and providers: requiring patients to pay some or all their expected out-of-pocket responsibility before receiving planned care. The practice is understandable. As patients assume more financial responsibility, hospitals have less confidence that they will collect those balances after care is delivered. Is this a new financial strategy, or a visible symptom of a much larger problem?

The underlying issue is that patients are carrying more financial risk—and hospitals often recognize that risk only after it has become institutional risk. Consider the traditional revenue-cycle timeline: registration → claim → submission, adjudication → patient responsibility → statement → payment (or nonpayment) → collections → bad debt.

The patient's timeline is markedly different: Diagnosis → treatment recommendation → uncertainty about cost → questions about insurance → concern about affordability → decisions about whether and when to seek care.

These timelines can begin weeks or months apart, and by the time the hospital sees a patient balance, the patient may have been carrying financial uncertainty for quite some time. Financial stress and uncertainty are part of the patient experience and that is not simply an economic problem.

Patients who are already dealing with an illness, injury or frightening diagnosis may also be trying to understand how they will pay for the care they need. Financial stress becomes another burden layered onto an already difficult experience, and it can influence behavior.

A patient who is worried about cost may delay care, avoid a recommended service, postpone treatment or simply disengage because the financial consequences feel overwhelming.

The hospital may eventually see the result as an unpaid balance, but the patient experienced it as a barrier to care. This is why patient financial risk deserves to be considered as more than a collections issue.

Hospitals cannot control the cost of every service, the structure of every insurance plan, or the size of every deductible. They cannot make every patient's financial responsibility disappear, but they can influence how much uncertainty surrounds that responsibility.

They can make sure information is accurate. They can explain what the patient

is being asked to pay and why and they can identify patients who may qualify for financial assistance. They can provide reasonable paths to payment. They can help patients understand their options before financial uncertainty becomes financial distress.

Revenue cycle management is very good at measuring what happens after a balance exists. We measure days in A/R, collection rates, bad debt, charity care, self-pay balances, and payment performance. Those outcome measures are important because they tell us what happened, but they don't tell us why something happened.

They don't tell us if the patient's insurance information is accurate, or if the claim is adjudicated correctly. They don't tell us whether the patient's responsibility was calculated correctly, whether the patient understood what they were expected to pay, or whether they could realistically afford the balance.

That distinction is becoming increasingly important as patients assume more of the cost of their healthcare. KFF's reporting on prepayment requirements illustrates the tension: hospitals are seeking payment earlier because they anticipate difficulty collecting later. Moving the collection point earlier, however, does not eliminate the underlying financial risk, it simply changes when the risk becomes visible to the hospital.

All this creates an opportunity to rethink one of the basic questions in revenue cycle management, which is "did we collect the patient's balance?" A more useful question may be, "did we create a reasonable path for this patient to successfully pay what they owe?"

Patient payment success requires more than a correct balance. It requires accurate information, understandable communication, appropriate financial assistance, accessible payment options, and an experience that encourages patients to engage with the organization rather than avoid it.

This does not mean hospitals should stop collecting. It means collection should be viewed as the final stage of a much larger financial process and indeed, as a component of the continuum of care—not the point at which patient financial risk begins.

From the hospital's perspective, when the process breaks down and the hospital absorbs the balance as bad debt or charity care, what began as patient responsibility ended up as institutional financial risk. As noted, though, the patient's experience started much earlier, and that's the gap healthcare organizations need to close. This may require hospitals to think less about patient balances and more about patient financial risk as a continuum—one that begins before registration and extends beyond the final statement.

The question is not simply how effectively an organization can collect what patients owe, it's whether the organization understands the financial risk patients are carrying, recognizes where that risk is created, and provides a reasonable path through it.

About the Author



Elizabeth Hargrove is Communication Lead at Salud Revenue Partners, LLC. You can reach her at eharwood@saludrevenue.com

Coordination of Benefits (COB) Denials: The Most Preventable Revenue Leakage in the Revenue Cycle

Coordination of Benefits (COB) denials represent one of the most preventable yet financially impactful sources of revenue leakage in the healthcare revenue cycle. While organizations often focus heavily on clinical and authorization denials, COB denials continue to erode cash flow quietly, frequently going unaddressed until accounts reach early-out or bad debt.

The Reality: COB denials are not complex. They stem from gaps in coverage identification, payer sequencing errors, and fragmented ownership.

Despite their preventable nature, COB denials consistently rank among the highest denial categories by both volume and dollars. Health systems that implement structured COB programs (combining automation, dedicated workflows, and payer-specific expertise) are achieving the following outcomes:

- **70-80%** - Resolution Rate Achieved
- **40%** of COB denials are avoidable with proactive processes
- **65%+** of COB denials are never corrected and resubmitted

The COB Denial Problem: High Volume, Low Visibility, High Impact

COB denials occur when a payer determines that another insurer should be primary. While this may appear to be a simple eligibility issue, it often reflects deeper breakdowns in coverage discovery, payer coordination, and workflow ownership.

Common Root Causes:

- Outdated or incomplete insurance information at registration
- Failure to identify secondary or tertiary coverage
- Payer database mismatches or inaccuracies
- Coverage changes due to employment or life events

- Misalignment in primary vs. secondary payer determination
- Missed indicators for motor vehicle accidents (MVA), workers' compensation (WC), or liability claims

Why COB Denials Go Unresolved

Despite their financial impact, COB denials often remain unworked due to structural gaps in revenue cycle operations:

- 1. Fragmented Ownership**
COB spans across multiple departments, patient access, denials management, early-out vendors, and bad debt collections. Without a single designated owner, accountability is lost and accounts fall through the cracks.
- 2. Misclassification as 'Patient Responsibility'**
Organizations frequently defer COB issues to patients, delaying resolution and increasing the likelihood of write-offs. This misclassification is both operationally costly and harmful to the patient's experience.
- 3. Lack of Coverage Discovery**
Without automated insurance discovery, hospitals rely on patient-reported information, which is often incomplete or inaccurate. Hidden coverage remains hidden, and denials follow.
- 4. Absence of Standardized Workflows**
COB is treated as a general denial category instead of receiving a specialized, rules-based approach. Without its own playbook, COB denials accumulate in shared queues and age out unresolved.

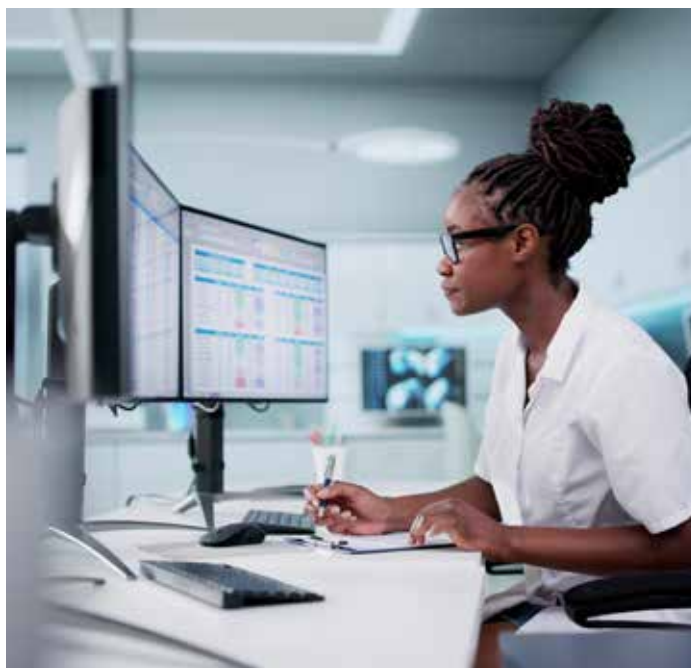
The Operational Model: How High-Performing Organizations Solve COB

Organizations that successfully reduce COB denials implement a structured model built on three core pillars:

Pillar 1 Early & Continuous Coverage Discovery	Pillar 2 Dedicated COB Resolution Workflow	Pillar 3 Short-Cycle Intervention Before Patient Billing
Automated tools identify unknown or undisclosed coverage, Medicare/Medicaid/commercial overlaps, MVA, liability, and WC indicators. Coverage discovery is the single most effective way to prevent COB denials before they occur.	Specialized teams trained in payer sequencing rules, standardized follow-up processes, direct payer and patient outreach, and escalation pathways for payer inaccuracies. COB requires its own playbook, not a shared denial queue.	A focused 10 to 14-day resolution window prior to early-out placement can resolve a significant portion of COB-denied accounts, reducing patient confusion, incorrect billing, and bad debt transfers.

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Coordination of Benefits (COB) Denials: The Most Preventable Revenue Leakage in the Revenue Cycle (continued from page 10)



The Critical Role of COB Ordering Rules

At the center of COB accuracy is correct payer sequencing. Misapplication of ordering rules is one of the most common – and most preventable – causes of denial. Key examples include:

- Active employer plans vs. Medicare, based on employer size
- Coordination between group health plans and COBRA
- Medicaid is always designated as payer of last resort
- Birthday rule for determination of primary coverage for dependent children
- Liability, MVA, and workers' compensation taking precedence over health plans

Federal Program Complexity

The complexity of COB ordering increases significantly when federal programs are involved. Medicare, Medicaid, VA, and TRICARE each carry specific coordination requirements that, if misapplied, result in immediate denials and delayed reimbursement.

The Future State: From Reactive Cleanup to Proactive Prevention

The shift in the industry is clear. COB is no longer a back-end cleanup function. It is a front-to-back operational discipline that directly impacts cash flow, working capital, and patient experience.

Organizations that succeed will:

- Integrate coverage discovery into the front end of the revenue cycle
- Establish dedicated COB ownership with clear accountability
- Apply payer-specific rules with precision and consistency
- Use analytics to identify patterns and prevent repeat denials
- Resolve accounts before they reach the patient

About the Author



Janice McGoldrick is Vice President of Revenue Cycle at Harris & Harris. For more information, you can reach Janice at jmcgoldrick@harriscollect.com.



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Patient access practices: Positioning for value in ambulatory care



Improving patient access practices to maximize throughput and capacity is key to positioning for value based care arrangements. Here are four expert strategies to consider.

Patient access within our healthcare delivery system is a delicate balance between supply and demand. Supply is the time and resources available to care providers for provision of services, and demand is the population's need for care. Ambulatory care leaders know this balance is a tough one to hold, but today's healthcare environment with challenging labor conditions, rising costs, and regulatory shifts have made it feel unachievable.

To meet these challenges, the industry has accelerated its push toward value based care models in the ambulatory enterprise that emphasize appropriate, safe, and coordinated care at lower cost. The success of these delivery models is predicated on efficient and effective patient access practices that support providers in maximizing patient throughput and capacity.

Efficiency begins with patient access. Understanding how to align and position your ambulatory care access operations is vital to the financial health and operational growth of your organization. Below are four things ambulatory leaders should consider to best position for a value based world.

1. Establish access standards through a robust review of internal data

First, evaluate your organization's available data and identify critical measures that are necessary to achieve optimal accessibility. Your goal is to establish access standards around each of those identified areas.

Setting forth standard visit types and durations for visits by department is a key access standard. When providers utilize custom appointment specifications, there's often a learning curve for scheduling staff to understand all of the individual nuances and ultimately leads to scheduling errors, administrative rework, and delays in care. Creating access standards around appointment specifications, like visit types and durations, reduces variation among providers and creates a more streamlined

process for patients to get on scheduling books.

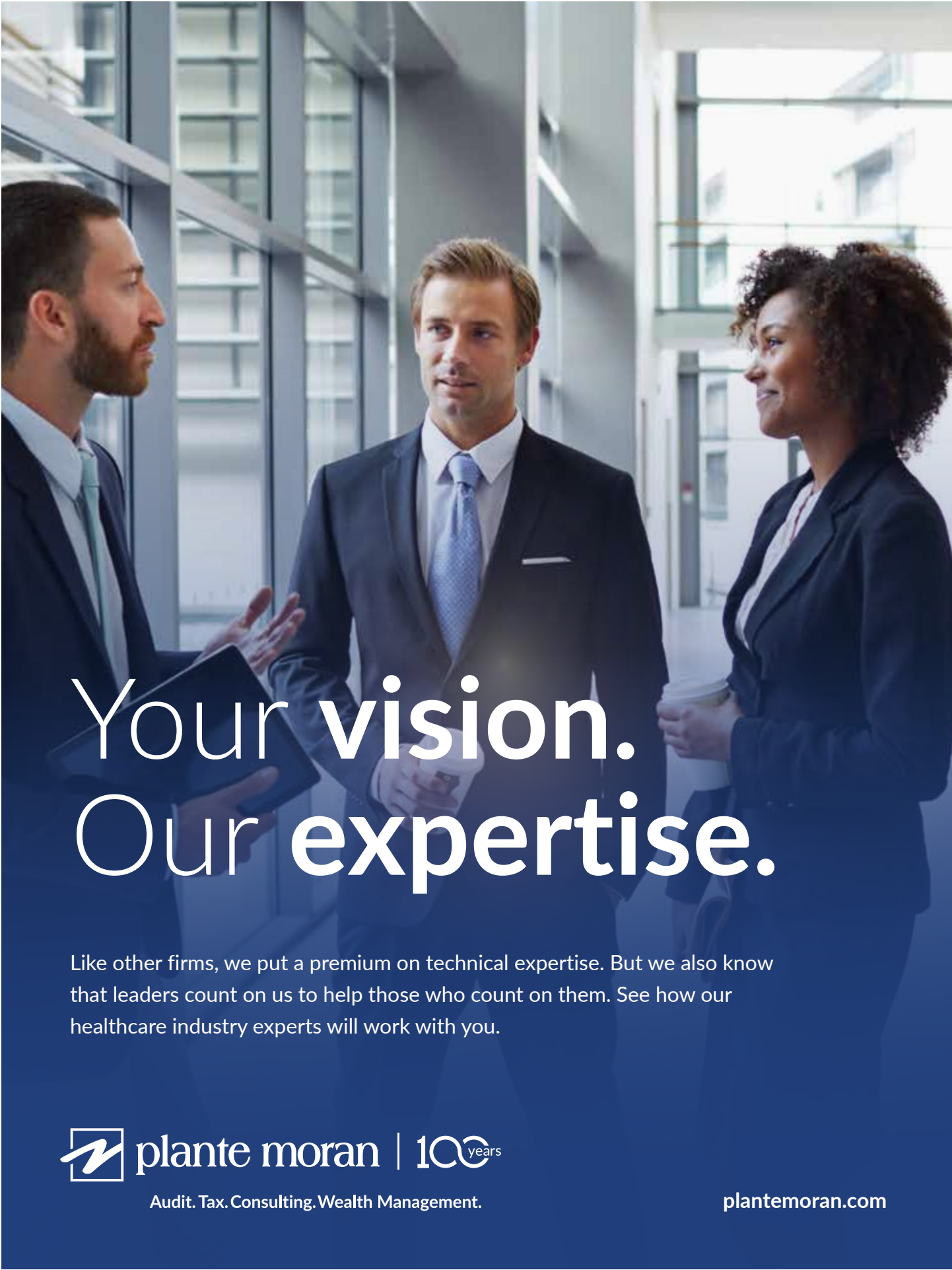
These access standards will become the foundation for managing and monitoring performance across the enterprise.

2. Prepare to manage demand

Demand for outpatient services in healthcare has steadily increased and, according to Advisory Board, is expected to grow another 7% by 2026. This, alongside the proliferation of value based arrangements, will force health systems to rethink their strategy around managing demand in the outpatient setting. The following are successful strategies to manage fluctuating demand:

- **Develop contact centers:** Clinic staff should focus their time and attention on the delivery of care. Organizations that develop contact centers appropriately allocate the management of patient communication to an administrative group whose primary purpose is to achieve optimal patient access and efficient scheduling. By segmenting these administrative tasks, ambulatory leaders not only free up time for clinic staff to work top of their license, but they also create opportunity to better measure staff performance and productivity.
- **Optimize omnichannel strategy:** Use and maximize the functionality of patient portals, texting enhancements, and other technological resources to encourage efficient communication between patients and care teams. The ability to connect with your patient population through multiple communication channels promotes patient satisfaction, minimizes the possibility of no-show and cancelled appointments, and encourages multifactor accessibility to healthcare services.
- **Monitor the market:** Fluctuations in demand can easily create bottlenecks in access, regardless of the established foundational mitigation resources put into place (contact centers and omnichannel communication methods). To manage the potential for fluctuation, coordinate with marketing resources to monitor current and future demand for services. Implementing request-for-care website functionality provides insight into both current and future demand and allows for preparation to meet it.

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3. Evaluate capacity management standards

Managing capacity in the healthcare setting is how you manage time as a resource and is the offset to balancing fluctuating demand. High-performing organizations recognize that how they use time as a resource is the most important element of optimized patient access. Here are three key factors in managing capacity:

- **Template management:** This includes regular evaluation and maintenance of providers' schedules to ensure that they're built to support demand. It includes setting forth clinical FTE expectations and holding staff accountable to meeting them as a primary measure of productivity.
- **Slot utilization:** Once templates are created and a maintenance strategy determined, organizations should work to efficiently use appointment slots to prevent access delays. Waitlists, schedule blocks, and automatic releases are proven methods to avoid schedule gaps and maximize utility of electronic health records (EHR).
- **Online scheduling:** Ambulatory leaders shouldn't overlook the value of their virtual front door. This is just as important as focusing on access to your physical one. Enhanced EHR capabilities, such as ticket scheduling, allow patients direct access to schedule care while also defining appointment criteria to ensure appropriate scheduling and avoid any further delays in care.

4. Recognize the importance of continuous improvement

Building and maintaining a patient access strategy that ebbs and flows with both the market demand and provider supply (i.e., time and resources) is essential for long-term success. By focusing on not only managing demand and capacity but also sustaining and continuously improving efforts over time, you remain agile in a dynamic market. Below are three key components of continuous improvement in patient access:

- **Panel management:** Regular review and maintenance of patient panels by provider removes access limitations – by encouraging thoughtful care progression planning and promoting patient engagement and autonomy in their care. A panel maintenance strategy ensures that providers are able to see the right patients at the right cadence to promote good condition management and success to value based agreements.

- **Transition of care coordination:** Continuity of care is more than just a buzzword in the healthcare space – it's an essential component of risk management. Continuity of care helps avoid unnecessary readmissions and promotes comprehensive disease management in a multidisciplinary team setting. Effective transition of care coordination between providers needs to be regularly evaluated due to constantly shifting clinical trends in the healthcare market.
- **Proactive peer reviews:** The key word here being "proactive." Peer reviews don't always have to be reactive to misses in clinical care. Establishing a cadence of proactive clinical reviews encourages physicians to provide accessible, safe, and high-quality care (all measures that are evaluated under value based arrangements).

The bottom line

Patient access is a dynamic and challenging concept that comes with a unique set of complexities that make it difficult to achieve at an optimal level. While current industry trends such as labor shortages and cost instability have created additional barriers to access, ambulatory leaders can best position for a value based world both in meeting today's challenges as well as in a value based future by establishing and evaluating access standards, developing strategies to manage demand, and embracing a culture of continuous improvement.

About the Authors



Tyler Gregory is Senior Manager at Plante Moran.

For more information, you can reach him at

Tyler.Gregory@plantemoran.com



Shailee Smith is a Manager at Plante Moran.

For more information, you can reach Shailee at

Shailee.smith@plantemoran.com



Sharon Ulep is a Partner at Plante Moran.

For more information, you can reach her at

Sharon.Ulep@plantemoran.com



The Revenue-Cycle AI Scorecard:

Are You Measuring the Automation or the Problem?

Healthcare organizations are under tremendous pressure to have an AI strategy. But in revenue cycle, I think the more useful question is simpler: What problem are we actually trying to solve?

It is easy to measure AI by what the technology is doing. How many accounts did it touch? How many appeals did it draft? How many tasks did it automate? Those metrics show how much activity the technology performs. They don't, by themselves, show whether it reduces total human effort or improves financial results.

That is why I believe a useful AI scorecard should start outside the AI itself and focus on three dimensions: **problem coverage, earned autonomy and business impact.**

Problem Coverage: How much of the problem can it actually address?

When we build automation, one of the first things I want to understand is the total opportunity. How big is the problem, and how much of it can the technology realistically address?

An AI tool may draft highly accurate appeals for one denial type while staff still prepare every other type. Its performance within that narrow

scope may be excellent. But leaders also need to know what share of the workload it handles and how much financial opportunity those accounts represent.

Revenue cycle makes this particularly challenging. Payers have different policies. Contracts introduce additional requirements. Government programs and states operate differently. Data comes from different systems with varying levels of quality.

So I am interested not only in success rate, but in coverage and whether worthwhile coverage is expanding. Maybe today we can address 20% of the opportunity. With the next improvement, 40%. Eventually, perhaps 70%.

But maximum coverage should not automatically be the goal. Leaders also need to ask: **How much additional value could we capture by expanding coverage, and what would it cost to get there?**

Data quality factors into coverage, too. Poor or incomplete data can shrink the portion of the opportunity the technology can safely address. And the remaining opportunity may be disproportionately complex and expensive

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The Revenue-Cycle AI Scorecard: Are You Measuring the Automation or the Problem?

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to automate. The goal is not to automate everything. It is to expand where the economics justify it.

Earned Autonomy: Is the technology earning greater trust?

We can think about AI like training a dog before letting it off leash. You establish expectations, observe behavior and build confidence. As the dog demonstrates reliability, you give it more freedom.

AI should earn autonomy in much the same way.

Human review at the beginning of an implementation is not necessarily a failure. It provides the evidence needed to determine whether greater autonomy is warranted.

The primary question is whether the technology is consistently producing work at the required level of quality. Alongside that, leaders should measure the human effort required to review, correct and rework its output. As quality becomes demonstrable, does oversight decline? Are exceptions and defects decreasing? Can people move from reviewing everything to reviewing only exceptions?

If quality is not consistent, the technology may not be ready for additional autonomy. But those exceptions are valuable, too. They show us where the model, data or workflow needs to improve.

Recent KLAS Research illustrates why this distinction matters. In interviews with leaders at 30 Epic customer organizations, KLAS found some of the same AI tools cited among both the most and least impactful. The difference often came down to workflow fit, configuration, validation and adoption.¹

The technology can work and the implementation can still fail to create value.

Business Impact: Did the outcome actually change?

Revenue-cycle leaders need operational details such as coverage, automation rates, exceptions, defects and human intervention. A CFO ultimately needs a different view:

Net financial benefit: What value is the solution creating through additional collections and cost savings, after accounting for technology, implementation, maintenance and oversight costs?

Cash acceleration: How much sooner are we receiving payment, and how much cash does that release from receivables?

An initiative does not have to increase collections to create value. It may reduce costs, improve collections, or do both. Cash acceleration should be considered separately because faster payment can create meaningful value even when the ultimate collection amount does not change.

We also need to be realistic about timing. An automation may perform a task today, but in revenue cycle we might not know the financial outcome for 30 or 60 days. That means distinguishing between near-term indicators of progress and the business outcomes that follow.

Activity tells us whether we are moving. It should not be confused with proof that we have arrived.

Let the scorecard tell you what to do next

The value of a scorecard is not simply knowing the score. It should help determine the next action.

If **problem coverage is limited**, evaluate the incremental opportunity. What additional value could greater coverage create, what will it cost, and can the same quality be maintained?

If **coverage is growing but quality is inconsistent or human effort remains high**, learn from the exceptions before granting greater autonomy.

If **operational performance looks strong but net financial benefit does not**, reconsider whether the technology is solving a valuable enough problem or whether its total cost is justified.

And sometimes, **maintaining a profitable application within its current scope is the right answer.** More coverage is not inherently better. Expand where the incremental value, cost and quality justify it.

David Chou recently wrote in Forbes that healthcare's AI challenge is increasingly one of execution, not access to technology.² I agree. But good execution requires being precise about both the problem and what success looks like.

The organizations that create the most value from AI may not be the ones that automate the most work. They will be the ones that know which problems are worth solving, how much technology can reasonably address and what evidence warrants giving it more responsibility.

AI shouldn't be measured by how much activity it produces. It should be measured by how meaningfully it changes the problem we brought it in to solve.

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About the Author



Matt Haberman is Chief Technology Officer at Annuity Health. For more information, you can reach Matt at Mhaberman@AnnuityHealth.com

Get Paid What You're Owed: Smarter Contracting, Internal Alignment Can Reduce Denials

Hospitals and health systems are grappling with rising denial rates, particularly among commercial and Medicare Advantage plans. Years ago, denials might have been isolated friction points in the billing process; but as rates rise, denials have become a strategic-level issue with measurable impact on financial performance.

Historically, denial mitigation efforts tended to focus on revenue cycle operations: tracking codes, improving documentation, training internal tracking teams and optimizing appeals processes. But this approach, while important, treats the symptom, not the source. Many denials originate not from internal missteps but from contractual ambiguity and opaque, payer-driven rule changes.

The price that providers pay is high. Health systems spend millions of dollars every year managing denials—and in some instances, not recouping losses—that often could have been prevented with better payer accountability and alignment. The dollars at stake could mean the difference between a positive and a negative margin, elevating the issue from an operational matter to a strategic imperative.

There are critical success factors for both preventing and appealing denials. We'd like to call attention to one area that warrants greater attention: contracting strategy. By strengthening contract language and improving internal collaboration between managed care and revenue cycle teams, providers can significantly reduce preventable denials—and get paid what they're owed.

The hidden power of the provider manual

Most hospital leaders are familiar with what's in their payer contracts: covered services, rates, payment timelines. But they may not realize that much of what Get Paid What You're Owed: Smarter Contracting, Internal Alignment Can Reduce Denials governs actual reimbursement behavior lives outside the four corners of the contract. That would be the payer's provider manual.

The provider manual functions as a detailed instruction guide for how claims are submitted, reviewed and reimbursed. It outlines processes for prior authorization, documentation, coding, appeals and more. These manuals are typically posted online and updated frequently, often with minimal notice to contracted providers.

This dynamic—frequent updates with minimal notice—creates a moving target. Health systems must track not only what they've negotiated, but also the evolving set of rules that determine how and when they actually get paid. Few organizations have the infrastructure or capacity

to consistently monitor and reconcile these updates across multiple payers.

Most contracts do not explicitly protect providers from adverse or unilateral changes to provider manuals, so denials often result from unknowing noncompliance with recently modified instructions. In essence, hospitals are penalized for failing to follow rules they were not clearly advised had changed.

What's missing in many contracts

It's not just what's in the contract that matters. It's what's not there. Many payer agreements lack provisions that would give hospitals greater visibility, predictability and recourse in the face of denial risk. Specifically, many contracts are vague about notification timelines for provider manual updates, accountability measures for payer-driven denials, standardized prior authorization protocols, and reconsideration and appeal process standards and timelines.

These omissions leave hospitals vulnerable. Without enforceable requirements around transparency and timelines, payers can revise policies unilaterally and leave providers scrambling to comply.

But, here's the good news: these are negotiable terms. Hospitals can and should push for stronger contract language that formalizes expectations, limits ambiguity and provides tools for redress. When contracts clearly define how denials will be handled, including what notice must be given before rules change, providers are in a better position to reduce surprises and capture more of the revenue they have earned.

Three steps to reducing denials

1. Inventory contracts and provider manuals

Understand where risks are hiding by reviewing terms and tracking manual updates across all major payers.

2. Close the language gap

Negotiate contract language that addresses provider manual updates, notification timelines and payer accountability.

3. Create an internal escalation model

Build a shared framework in which managed care and revenue cycle collaborate, share data and speak with one voice to payers.

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When contracts clearly define how denials will be handled, providers are in a better position to reduce surprises and capture more earned revenue.

A smarter approach: Contracting and alignment as denials mitigation tools

Smarter contracting is only part of the solution. Internal alignment is equally important. In many health systems, managed care and revenue cycle teams operate in silos, in which one team negotiates the contract and another handles the fallout.

Thus, when denials occur, the insights gained by revenue cycle rarely make their way back to inform future negotiations. Meanwhile, payer relationships are strained by miscommunication, finger-pointing and a lack of escalation pathways.

There is a better way. Leading organizations are starting to treat denials mitigation as a shared strategic function, not just a cleanup task. Strategies to consider include:

- Auditing contracts and provider manuals to identify gaps;
- Negotiating specific utilization management terms and notification standards into agreements;
- Establishing formal escalation processes that trigger payer accountability when denial thresholds are exceeded; and
- Using denial data to inform future payer negotiations.

Ultimately, hospitals must shift their approach to denials management from a reactive posture to a proactive one. The goal: stop chasing denials and start preventing them.

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About the Authors



Gina Simmons is Vice President at KaufmanHall. For more information, you can reach Gina at gina.simmons@kaufmanhall.com



Jim Sabolik is Vice President at KaufmanHall. For more information, you can reach Jim at jim.sabolik@kaufmanhall.com



Martin Kelley is a Assistant Vice President at KaufmanHall. For more information, you can reach Martin at martin.kelley@kaufmanhall.com

HRSA Takes Steps to Implement a 340B Rebate Model

August 24, 2026

See how 340B covered entities can prepare for the drug rebate pilot program.

On July 31, 2026, the Health Resources and Services Administration (HRSA) issued a new 340B Rebate Model Pilot Program notice implementing an updated pilot effective January 1, 2027. Under the pilot, qualifying drug manufacturers, with approval from the Department of Health and Human Services (HHS), will be allowed to use a post-dispense rebate model for select pharmaceuticals instead of the current 340B discount model. The new pilot comes on the heels of HRSA's previous attempt at a 340B rebate model, which was finalized in fall 2025 but blocked by a federal court ruling.

Approved rebate models will apply to all covered entity types for the eligible drugs. HRSA will require participating manufacturers to allow covered entities to continue ordering selected drugs through existing distribution mechanisms, including 340B wholesaler accounts with wholesale acquisition cost (WAC) prices loaded, to preserve existing purchasing infrastructure. Covered entities will then need to submit standardized claims-level data to support a rebate equal to WAC minus the 340B ceiling price on the date of dispense.

Based on our estimates, at least 30% of a covered entity's 340B drug purchasing may be subject to the rebate model. This will require a significant operational shift.

This article explores the details of the 340B Rebate Model Pilot Program and how covered entities can prepare.

Which Drugs Will Be Included in the 340B Rebate Model Pilot?

The pilot is limited to the 11-digit National Drug Codes (NDCs) of active selected drugs included on CMS' Medicare Selected Drugs and Negotiated Prices list for initial price applicability years (IPAYs) 2026 and 2027. HRSA states that the model applies regardless of payor or indication, but only during the selected drug's effective dates for negotiated prices.

Medicare Drug Price Negotiation Selected Drugs Included in 340B Rebate Model Pilot Program Scope

IPAY	Selected Drugs	Manufacturers
2026 ¹	Eliquis	Bristol Myers Squibb
	Jardiance	Boehringer Ingelheim
	Xarelto	Janssen Pharms
	Januvia	Merck Sharp Dohme
	Farxiga	AstraZeneca AB
	Entresto	Novartis Pharms Corp
	Enbrel	Immunex Corporation
	Imbruvica	Pharmacyclics LLC
	Stelara	Janssen Biotech, Inc.
	NovoLog; Fiasp	Novo Nordisk Inc.
2027 ²	Ozempic; Rybelsus; Wegovy	Novo Nordisk Inc.
	Trelegy Ellipta	GlaxoSmithKline Intellectual Property Development Ltd. England
	Xtandi	Astellas Pharma US, Inc.
	Pomalyst	Bristol Myers Squibb
	Ibrance	Pfizer Inc.
	Ofev	Boehringer Ingelheim
	Linzess	AbbVie Inc.
	Calquence	AstraZeneca UK Limited
	Austedo; Austedo XR	Teva Branded Pharmaceutical Products R&D LLC
	Breo Ellipta	GlaxoSmithKline Intellectual Property Development Ltd. England
	Tradjenta	Boehringer Ingelheim
	Xifaxan	Salix Pharmaceuticals Inc.
	Vraylar	AbbVie Inc.
	Janumet; Janumet XR	Merck Sharp Dohme
	Otezla; Otezla XR	Amgen Inc.

What Are the Requirements for Drug Manufacturers in the 340B Rebate Model Pilot?

To participate, eligible manufacturers must submit a plan to implement a rebate model to HRSA/the Office of Public Affairs (OPA) by August 24, 2026. HRSA states it will approve manufacturers' plans by September 24, 2026 for a January 1, 2027 effective date. Manufacturers may not implement a rebate plan without first receiving HHS approval.

Among other requirements, manufacturer plans must identify the IT platform that covered entities will use for data submission and ensure that all costs of that platform are borne by the manufacturer. The plan must provide covered entities and other affected stakeholders with at least 90 calendar days' notice before implementation, including instructions for registering for applicable IT platforms.

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Manufacturers also must demonstrate that their plans protect covered entity data. HRSA requires plans to include assurances that data collection will be limited to the elements necessary to provide 340B rebates and that IT platforms will protect protected health information (PHI) and other personally identifiable information consistent with applicable federal privacy and data security laws, including HIPAA.

Operationally, manufacturers must support real-time reconciliation reports, provide quarterly 340B price files for each relevant 11-digit NDC, submit periodic reports to HRSA/OPA, pay rebates at the unit level, and calculate the rebate as WAC minus the 340B ceiling price on the dispense date.

What Data Will Covered Entities Be Required to Submit to Receive 340B Rebates?

Similar to HRSA's previous attempt at a 340B rebate model, the updated pilot will require providers to submit both pharmacy and medical claims data. The required elements from the notice are listed below.

Pharmacy Claims Data ³	Medical Claims Data
Date of service	Date of service
Date prescribed	Claim line number
Rx number	Claim number
Fill number	Unit of measure
NDC-11	NDC-11
Quantity dispensed	Quantity
Prescriber ID	Rendering physician ID
Service provider ID	Service provider ID
340B ID	340B ID
Rx Bank Identification Number (BIN)	Health plan name
Rx Processor Control Number (PCN)	Health plan ID
	Health plan ID qualifier (if available)
Xtandi	Astellas Pharma US, Inc.
Pomalyst	Bristol Myers Squibb
Ibrance	Pfizer Inc.
Ofev	Boehringer Ingelheim
Linzess	AbbVie Inc.

The HRSA notice states that manufacturers must submit data definitions for each field with their plan for HRSA approval and make those definitions available to covered entities. To the extent that participating manufacturers are allowed to use a unique definition for each of these data elements, it will increase costs for covered entities and the risk of administrative denials for rebates.

What Are the Data Submission & Payment Time Frames for 340B Rebates?

Covered entities must be allowed at least 45 calendar days from the dispense date to submit required data, with allowances for extenuating circumstances and claim adjustments, including changes in 340B status.

Once a covered entity submits complete data, the manufacturer must either pay the rebate or issue a documented denial within 10 calendar days. If the submission is returned as incomplete, the 10-day payment clock restarts when all necessary data has been submitted.

It is unclear from the notice whether a documented denial restarts the 45-day submission clock or if the data must be resubmitted within 45 calendar days from the dispense date. Covered entities should consider designing their systems to submit a rebate request as soon as possible to allow for rework related to denials within the initial 45-day window.

How Will HRSA Monitor 340B Rebate Denials & Payment Delays?

HRSA's previous attempt at a rebate model did not establish a formal appeals process for denied rebate requests. Instead, covered entities were instructed to report denials they believed were inappropriate to HRSA, which could remove a manufacturer from the pilot if it determined the manufacturer had improperly denied rebate requests.

In a change from the previous rebate model, HRSA requires manufacturers in the new pilot to document and report denied claims, including the basis for each denial and the status of any associated dispute. HRSA intends to use this information to monitor denial patterns, assess whether rebate determinations are applied consistently and appropriately across participating manufacturers, and remove manufacturers from the pilot when appropriate.

HRSA's notice states that if covered entities report that a manufacturer consistently denies rebate payments without acceptable justification, HRSA could review a sample of affected transactions over a period, such as 10 calendar days. If a significant portion, such as 5% or more, were denied without acceptable justification, HRSA could initiate removal proceedings for noncompliance. The time frames and denial

HRSA Takes Steps to Implement a 340B Rebate Model (continued from page20)

thresholds referenced in the notice are provided for illustrative purposes and are not intended by HRSA to be a statement of policy or procedure.

In addition, HRSA's notice clarifies that manufacturers' plans must ensure that rebates are not denied based on eligibility or compliance concerns with diversion or Medicaid duplicate discounts.

HRSA also intends to monitor payment delays. If covered entities report that a manufacturer consistently exceeds the 10-calendar-day payment threshold, HRSA could review a sample of affected transactions and initiate removal proceedings if a significant portion were delayed without justification.

HRSA will create a defined pathway for covered entities to challenge denied claims, including specified time frames for review and response. HRSA states that tools for reporting rebate denials will be made available within 30 calendar days of the pilot's effective date, and unresolved disputes may proceed through the 340B Administrative Dispute Resolution process.

How Can Covered Entity Executives Prepare for the 340B Rebate Model Pilot Program?

The 340B rebate model pilot will require covered entities to create a "rebate cycle" for medical claims, similar to the revenue cycle. Covered entities will need to capture, validate, transmit, reconcile, and monitor claims-level data within compressed timelines. The 45-day submission window and 10-day manufacturer response requirement create a new operational cadence that will require coordination among pharmacy (both in-house and contract), finance, compliance, and IT teams. As a result, covered entities will incur operational costs associated with the staffing, technology, and compliance infrastructure necessary to manage the rebate cycle.

In addition to creating the work and data flows necessary to submit the required pharmacy and clinical claims data, covered entities will need to build the infrastructure to monitor timely processing, denial rates by claim count and dollar value, administrative expense, and rebate cycle key performance indicators (KPIs), and to share relevant experiences with HRSA and elected officials as HRSA evaluates whether to expand the model.

Covered entities should also anticipate cash flow issues related to having to pay WAC upfront and wait for the rebate. While HRSA's notice downplays the risk of floating the upfront cost, our experience with similar rebate programs, such as Maximum Fair Price (MFP) rebates, suggests that denials and delays can extend the average time to payment well beyond established payment windows.

The pilot will shift some operational risk from acquisition to reimbursement. Covered entities that cannot reliably identify eligible dispenses, generate required data, submit timely claims, monitor denials, and escalate disputes may leave 340B savings unpaid or delayed. Organizations should begin designing a repeatable rebate cycle process before January 1, 2027, including data readiness testing, contract pharmacy coordination, denial management protocols, cash flow monitoring, and clear accountability for rebate performance.

How Forvis Mazars Can Help With 340B Performance

Our 340B professionals at Forvis Mazars are committed to helping healthcare organizations achieve regulatory excellence and financial discipline by understanding and adapting to the impact of evolving HRSA regulations on covered entities. If you have questions about how the 340B Rebate Model Pilot Program may affect your organization or how you can prepare, please reach out to our team contact-us today.

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¹"Medicare Drug Price Negotiation Program: Negotiated Prices for Initial Price Applicability Year 2026," [cms.gov](https://www.cms.gov), August 2024.

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About the Authors

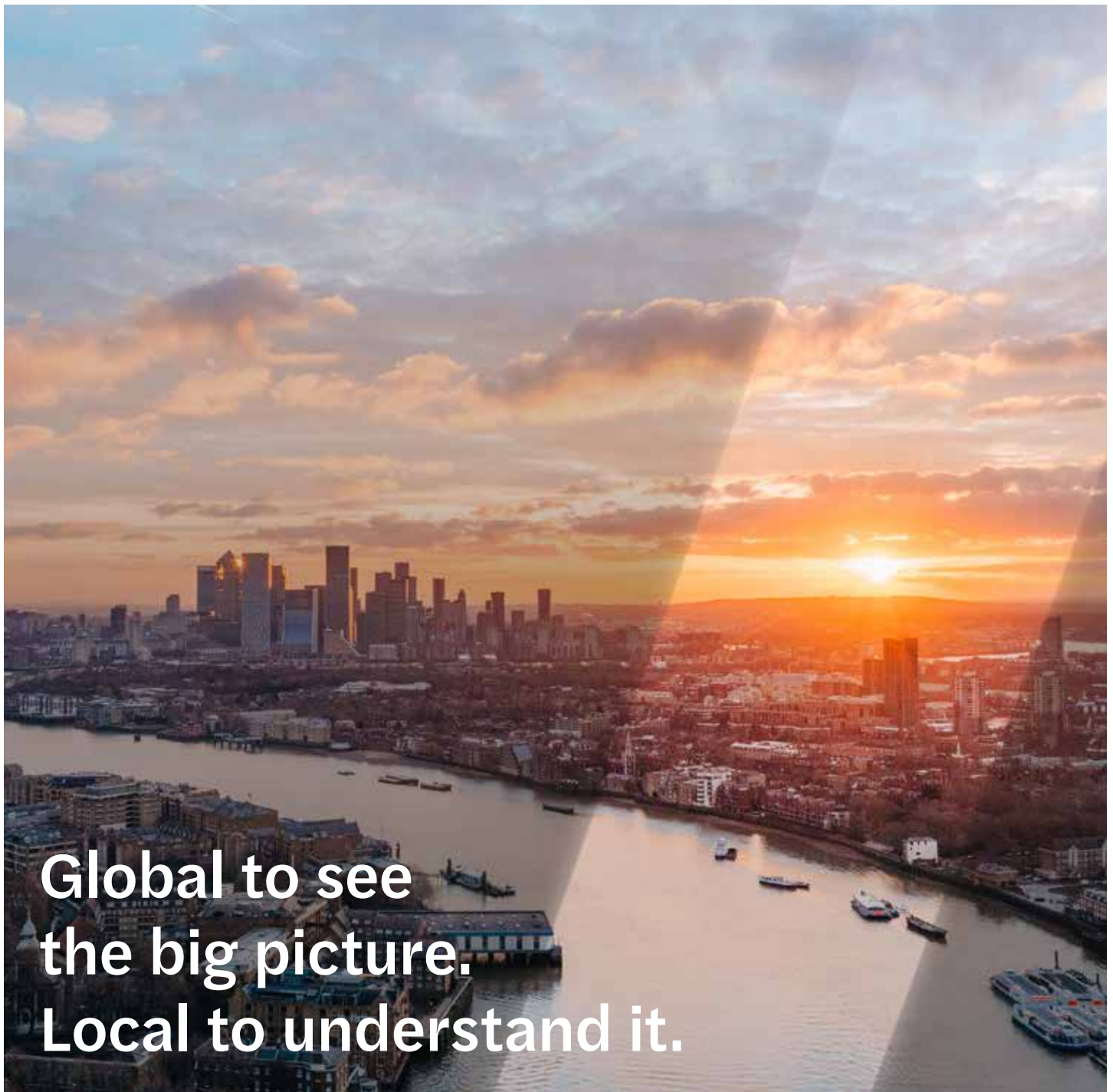


Brian Bell is a Principal at Forvis Mazars. For more information, you can reach him at Brian.Bell@us.forvismazars.com



Chad Mulvany is a Director, Healthcare Specialty Reimbursement, at Forvis Mazars. For more information you can reach him at Chad.Mulvany@us.forvismazars.com





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Turning the Year-End Scramble Into a 12-Month Audit Readiness Discipline

Finance teams can reduce audit disruption by treating reconciliations, support schedules, and control evidence as monthly operating work rather than year-end cleanup.^[1]

Year-end audit pressure usually starts months before fieldwork. Unreconciled accounts, outdated schedules, undocumented estimates, missing approvals, and unresolved variances accumulate during the year. Finance teams then absorb the cost in overtime, delayed reporting, repeated auditor requests, and last-minute adjustments.^[1,2]

The ideal discipline is; prepare evidence when the accounting activity occurs, review it during the close, and keep it current through year-end.^[1,3]

The Hidden Cost of the Year-End Scramble

The year-end scramble converts routine accounting work into compressed remediation work.^[1,2]

A bank reconciliation left unresolved for three months requires reconstruction. A fixed-asset schedule updated only at year-end forces the finance team to trace additions, disposals, and depreciation across 12 months at once. An accrual with no documented basis becomes a research project when the auditor asks for support.^[4,5]

Four costs follow. Staff spend more hours retrieving support. Management loses time answering avoidable questions. Audit adjustments increase when reconciliations and estimates have not been reviewed consistently. Board or funder reporting can move later because the audit cannot advance until open items are resolved. Additional audit work can also increase fees when missing support expands the work required.^[2]

Audit readiness reduces that compression by moving the work back to the month in which the transaction, estimate, or control activity occurred.^[1]

What being “Audit-Ready” Means Month to Month

An audit-ready close produces records that can be tested without rebuilding the accounting history. Four conditions define that standard: reconciled accounts, current supporting schedules, documented estimates, and evidence that key controls operated.^[3,6,7]

Reconciled accounts include cash, receivables, payables, payroll liabilities, debt, and investments. Supporting schedules include fixed

assets, prepaid expenses, accrued liabilities, deferred revenue, leases, and grants.^[1,4]

Documented estimates explain both the amount and the methodology. Allowances, accruals, allocations, and valuation adjustments require a clear basis that another reviewer can follow.^[6] Control evidence includes approvals, review sign-offs, reconciliations, exception follow-up, and documentation of process or system-access changes.^[7]

Audit Readiness Is Evidence Readiness

*An account balance is not audit-ready simply because the general ledger is correct. **Audit-ready evidence allows another qualified reviewer to trace the balance from the financial statements to the supporting records and understand how significant judgments were determined.***^[3,6]

For material accounts, retain 4 elements:

- **Reconciliation** to the general ledger
- **Supporting documentation** for the underlying transactions
- **Review evidence** showing who prepared and approved the work
- **Calculation methodology** for significant estimates and judgments

Missing one of these elements can create additional questions during fieldwork even when the recorded balance ultimately proves correct.

Each monthly close needs to leave behind an audit trail that remains usable months later.^[3,5]

A 12-Month Calendar

A 12-month calendar distributes audit preparation across the year instead of concentrating it after year-end.^[1]

During the first quarter, finance leaders can close prior-year open items, roll forward standing schedules, confirm recurring auditor requests, and assign ownership for each major account. The second quarter provides a checkpoint for balance-sheet reconciliations, capital activity, debt agreements, grant schedules, revenue recognition, and significant estimates.^[1,4]

The mid-year point is the right time for a controls review. Finance teams can test whether approvals, reconciliations, user-access reviews,

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Turning the Year-End Scramble Into a 12-Month Audit Readiness Discipline

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segregation-of-duties controls, and management reviews are operating as designed. Control changes can then be documented while the people involved still remember why the change occurred.^[1,7]

5 Controls to Test Before Year-End

A mid-year controls review gives finance leaders enough time to correct process gaps before the annual audit. The review needs to confirm both that the control exists and that evidence shows it operated consistently.^[1,7]

Check these 5 areas:

1. *Approval controls: Required transactions contain documented authorization.*
2. *Account reconciliations: Material accounts are prepared and independently reviewed.*
3. *Segregation of duties: No single employee controls incompatible accounting functions without a compensating control.*
4. *System access: Finance-system permissions remain appropriate for current employee responsibilities.*
5. *Exception follow-up: Identified variances, errors, or control exceptions have documented resolution.*

The distinction between a documented policy and an operating control matters. A written procedure alone does not demonstrate that the control actually operated during the period.

The third quarter provides time to resolve unusual transactions, update legal and contract files, review related-party activity, and identify new accounting issues. The final quarter becomes a pre-audit dry run. The finance team can complete a preliminary PBC package, identify missing support, review year-to-date variances, and assign every open request before year-end.^[1,8]

Building the Monthly Close That Feeds the Audit

The monthly close becomes the engine of year-round audit readiness when audit support is built into the close itself.^[4,5]

Every material balance-sheet account needs a defined reconciliation, preparer, reviewer, due date, and retained support. Trial-balance tie-outs must agree to supporting schedules. Roll-forward schedules must carry beginning balances, current-period activity, adjustments, and ending balances that reconcile to the general ledger.^[4]

A living prepared-by-client list strengthens the process further. Instead of waiting for the annual request list, finance teams can maintain a standing inventory of recurring items such as bank reconciliations, debt schedules, board minutes, revenue support, lease schedules, fixed-asset activity, payroll reports, and significant contracts.^[8]

Each item can carry an owner, frequency, storage location, and review status. That structure turns the PBC (Provided By Client) list from an

audit-season document into a monthly accountability tool.^[1,8]

Metrics That Prove Progress

Audit readiness improves when finance leaders track a small set of operational measures consistently.^[1,5]

The first metric is days-to-close. A stable close timeline shows whether reconciliations and reviews are completed on schedule. The second is the number of audit adjustments. Repeated

adjustments in the same accounts identify weaknesses in monthly accounting or review procedures.^[2,5]

The third metric is PBC completion by the agreed deadline. The fourth is auditor follow-up requests caused by missing, inconsistent, or unsupported information. The fifth is on-time delivery against board, lender, grantor, or funder deadlines.^[1,8]

These measures show whether the close is becoming more disciplined, support quality is improving, and recurring bottlenecks remain.^[1,5]

A year-round audit discipline can start with 8 recurring checks:^[1,3-8]

1. Reconcile every material balance-sheet account.
2. Tie supporting schedules to the general ledger.
3. Update roll-forward schedules for recurring accounts.
4. Document significant estimates and calculation methods.
5. Retain evidence of reviews, approvals, and control performance.
6. Update the standing PBC list and assign every open item.
7. Investigate unusual transactions and material variances promptly.
8. Review readiness metrics before the next close begins.

Audit is not an extra project added to finance operations. An effective Audit is the result of a disciplined monthly close, current documentation, and accountable review throughout the year. Organizations that maintain those habits enter year-end with fewer unresolved questions and a clearer path through fieldwork.^[1,4,5]

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Turning the Year-End Scramble Into a 12-Month Audit Readiness Discipline

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Turning the Year-End Scramble Into a 12-Month Audit Readiness Discipline

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About the Author



Mohammad Mujtaba Sheikh, CPA, ACCA, U.S. is a Tax Court Practitioner at Sheikh Osher Scott, CPA & Advisors P.C.. For more information, you can reach him at msheikh@soscpas.com

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First Illinois Chapter HFMA News & Events

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Or simply drop us an email at hfma.org/chapters/region-7/first-illinois

First Illinois Chapter HFMA Event Photo Recap

2026 Women in Leadership Retreat, June 18, 2026

Thank you to our generous sponsor, **Annuity Health**, and to everyone who joined us for an inspiring day of networking, learning and connection!

Adding to a great day, our raffle baskets raised \$3,000, which was shared between the First Illinois Chapter Scholarship Fund and Equal Hope. Thank you to everyone who participated and helped support these important causes.

Mark your calendar! The 2027 WIL Retreat will be held at the Lincoln Park Zoo on September 16, 2027.

For information and sponsorship opportunities, contact education@firstillinoishfma.org.



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A woman in a white shirt is standing and speaking into a microphone. She is addressing a group of people who are seated at a round table. The setting is a bright room with large windows.

Four women are seated in a row of chairs, facing forward. They appear to be part of a panel discussion or a formal meeting. They are all dressed in professional attire.

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First Illinois Chapter HFMA Event Photo Recap

2026 Transitions Dinner, July 16, 2025, Hinsdale, IL

Congratulations to our **2026–27 Board of Directors, scholarship recipients, and award recipients**, who were recognized at the Chapter's annual Transition Dinner.

Thank you to our generous sponsors and everyone who joined us for this special evening of celebration and recognition.

Mark your calendar! We'll be back at **Ruth Lake Country Club** on **July 15, 2027** for next year's Transition Dinner.

For information and sponsorship opportunities, contact education@firstillinoisfhma.org.



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First Illinois Chapter HFMA Event Photo Recap

2026 Top Golf & Scholarship Event, August 28, 2026

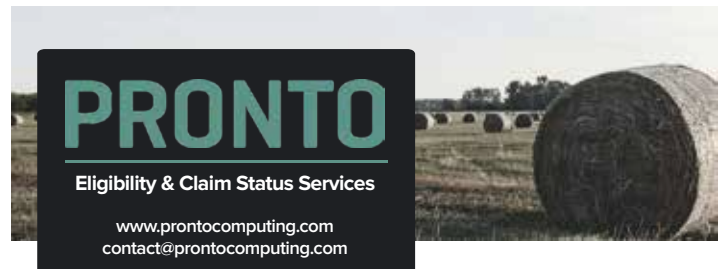


Congratulations to our **Health System Top Team – Northwestern Medicine**, taking the honor for the second year in a row, and to our **Business Partner Top Team – Aspron and Blue & Co.**

Thank you to all our generous sponsors and everyone who joined us on the greens! **Together, we raised more than \$23,000 for the Chapter's scholarship program.**

Mark your calendar! We'll be back at Topgolf on **August 27, 2027.**

For information and sponsorship opportunities, contact education@firstillinoishfma.org.



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Scan the QR code to view the full calendar & RSVP

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

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