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**OUTLOOK IS
MIXED
FOR HOSPITALS
IN THE YEAR
AHEAD**

— GAIL WILENSKY

**WHY LEADERS SHOULD
WORK TO ESTABLISH A
CULTURE OF ETHICS**

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hfm® (ISSN 0735-0732) is published and distributed nine times per year (February through June and September through December) by the Healthcare Financial Management Association (HFMA), Three Westbrook Corporate Center, Suite 600, Westchester, IL 60154-5732. Subscription Rates/Orders: Subscriptions within the United States are \$260 per year. Outside the United States, North American subscriptions are \$270 per year. Other foreign subscriptions are \$280 per year. Institutional subscriptions are \$150 per year. Postmaster: Periodicals postage paid at Bellwood, IL 60104, and additional mailing offices. Send address changes to HFMA, Three Westbrook Corporate Center, Suite 600, Westchester, IL 60154-5732. Copyright 2021, Healthcare Financial Management Association. All rights reserved. Printed in the U.S.A. Volume 75/Number 5.

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hfm® is published nine times per year (February through June and September through December) by the Healthcare Financial Management Association (HFMA), Three Westbrook Corporate Center, Suite 600, Westchester, Illinois 60154-5732.

hfm® is indexed in Hospital Literature Index (AHA), Accounts' Index (AICPA), Cumulative Index to Nursing & Allied Health (CINAHL), and EMBASE/Excerpta Medica. **hfm**® is available in microform from University Microfilms International, 300 North Zeeb Road, Ann Arbor, MI 48106.



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Subscription Rates/Orders. Individual subscriptions within the United States are \$260 per year. Outside the United States, North American subscriptions are \$270 per year. Other foreign subscriptions are \$280 per year. All foreign subscription orders must be prepaid in U.S. dollars. Institutional subscriptions are \$150 per year. Bulk subscription rates (10 copies or more) are available upon request. To order, contact the Member Service Center at HFMA's national office address, or call (708) 531-9600, ext. 2.

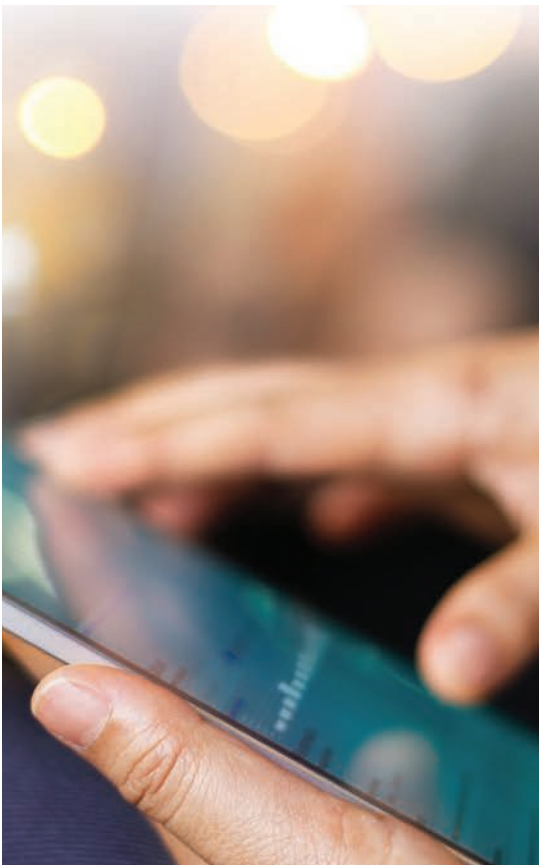
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New National Chair envisions brighter future for the healthcare finance industry



TAMMIE L. JACKSON
FHFMA, CHFP, MHA
Chair, HFMA

We each have those events in our lives that forever serve as a filter for the before and after. Individually, that may be a marriage, the birth of a child, the loss of a loved one or the moment we got that dream job. As a society, we share the filters of World War II, the assassination of JFK, 9/11 — and now 2020. Everything from this point forward will be viewed through a lens of “before” or “after.” But what does this mean for our industry, our society and our association?

Our industry, still dealing with a global pandemic, has been forced to quickly assess problems, improvise solutions, plan, execute, then repeat.

As finance professionals, we have acted boldly and forged a brighter path forward for our organizations, our communities and our employees. Our work is not done, however, and lessons remain to be learned. I believe the resiliency we have demonstrated these past many months assures us that we are strong. And I believe we can be even better.

Our society — which is in the throes of extreme divisiveness and social injustice such as many of us have never seen — has been forced to confront those thoughts, perspectives and norms that, while usually unspoken, are well understood and conceded. We have begun to boldly engage in uncomfortable conversations, acknowledge uncomfortable truths and make bold commitments to change — to be better. Our

willingness to continue the hard work validates that we are resilient.

And even our beloved HFMA, 75 years old and grappling with a landscape shifting beneath its feet, continues to challenge its own norms and delivery models. We boldly embarked on a journey to do better and change how we respond to our members’ needs. Our courage to challenge much of what is dear to us at HFMA, and certainly what is comfortable for us, means we are resolute.

Our circumstances and the future also look brighter. For all of these reasons, I have chosen a theme that pays homage to our journey while also serving as a *North Star* for who and what we can be: *Bolder. Brighter. Better.*

I am beyond humbled to serve as your National Chair this year at this most pivotal time. Over these next 12 months, let’s begin to answer what follows the *after*. With a bright outlook, let’s determine what *better* looks like for our organizations, for our communities and for HFMA.

On all fronts, I’ve seen it. We are bolder. We are brighter. And we can be better than before.

So now, what about you? What does your *better* look like? ■



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HFMA collaboration with Boise State creates innovative master's program



TODD NELSON
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For more than a decade, HFMA has worked with leading health systems, industry experts, associations and universities to evaluate and accelerate the move toward value-based care — primarily through the HFMA Value Project, but in other ways too. As the thinking and work has evolved, HFMA has shifted to talking about the cost effectiveness of health (CEoH) and how to transform the industry from its path of continuous growth to becoming more cost effective as a long-term goal.

Central to this CEoH goal is recognition that the U.S. healthcare system must expand from addressing patients' acute care needs to managing all aspects of patient health.

To shift the culture and standards of practice of care — from emergent medicine to population health and chronic care management programs — requires a complete modernization and overhaul of the global healthcare industry.

PHSM PROGRAM DETAILS

To that end, HFMA has unveiled a collaborative program co-created and delivered by Boise State University — the Master in Population and Health Systems Management (PHSM) degree. Having a world-class faculty composed of physicians, actuaries, payment model experts and financial experts will help bridge the gaps between the clinical, operational and financial fields. And it will assist in delivering

an education focused on optimizing health outcomes while overcoming constraints and mitigating risk to find real solutions to current and future community health needs.

This partnership is an industry game-changing opportunity because the degree addresses the modern needs in healthcare education through the lens of population health, risk mitigation and finance. It explores the relationship between epidemiology and actuarial science in the context of population health, and then operationalizes the theory and brings to practice the business intelligence and management skills necessary to be successful in the changing healthcare landscape. Students will examine the basics of insurance with analysis at the patient

4 keys to achieving cost effectiveness of health

Just what does the cost effectiveness of health (CEoH) entail? It includes going beyond just treating patients' physical needs when they are sick to moving interventions upstream through preventive health initiatives, and addressing social and behavioral health needs, too. It's about creating a system with a focus on connecting the care system, reducing complexity and creating efficiencies.

The four keys to achieving CEoH are:

- Shift in traditional care models from reactive to proactive delivery mechanisms
- Measurement of medical outcomes versus risk with cost analysis
- Payment reform
- Revenue streams for primary care models and patient engagement with a focus on wellness and health planning



To learn more about the Master in Population and Health Systems Management program, visit www.boisestate.edu, type PHSM in the search bar and click on the link.

PHSM degree course descriptions

The following is a summary of courses in the HFMA/Boise State Master in Population and Health Systems Management (PHSM) program:

- **Actuarial Science and Epidemiology in Determining Patient Outcome I:** Explores the relationship between epidemiology and actuarial science in the context of dynamic population health. Examines the basics of insurance with analysis dissecting to the patient level to create care plans that mitigate risk and promote best patient outcomes.
- **Actuarial Science and Epidemiology in Determining Patient Outcome II:** Principles of epidemiology and actuarial sciences are further explored.
- **Management of Population Focused Healthcare:** Introduction to the management of multiple aspects of population-focused healthcare.
- **Principles of Healthcare Business I:** Overview of healthcare accounting and finance to strengthen competencies and address financial reports and statements unique to healthcare. Provides a practical overview of risk-sharing arrangements, managed care contracts and profitability ratios.
- **Principles of Healthcare Business II:** Explores the evolution of healthcare service delivery and payment and highlights healthcare transformation, including the shift from volume to value, quality, patient satisfaction, competition on cost and the evolution of the payment system.
- **Healthcare Finance Mastery:** A broad range of essential business and financial skills are explored. Provides an overview of modern healthcare business dynamics and theories of application.
- **Health System Business Intelligence:** Framework for analyzing data and tools to facilitate decision-making in healthcare organizations.
- **Healthcare Business Analytics in Revenue:** A systematic overview of how to inspect, clean, transform and model data with the goals of highlighting useful information, suggesting conclusions and supporting decision-making within the healthcare revenue cycle.
- **Revenue Cycle Mastery in Healthcare:** An overview of the entire revenue cycle and its influence on the financial outcomes of the healthcare organization is provided.
- **Project:** Execution of a substantial exercise that demonstrates the ability to successfully and independently carry out a professional activity that is similar to what is encountered in the professional workplace.

level to create care plans and best practices that mitigate risk and promote best patient outcomes.

HFMA CERTIFICATIONS AS PART OF THE DEGREE

Graduates of this program will have the opportunity to earn the four industry-recognized certifications from HFMA (CHFP, CSBI, CSAF and CRCR) incorporated into this master's degree. To learn more about the certifications, visit www.hfma.org, click on "Education & Events," and then on "Certifications."

Although the courses in the program will incorporate the examinations related to the certifications, the program will provide much more, including:

- A richer understanding of the concepts
- Group activities, which contribute to student learning
- Interactions with expert faculty
- Insight from guest lecturers
- Exercises not covered in the individual certification exams

The first class will be welcomed to this hybrid learning experience in August 2021. ■

About the author

Todd Nelson is HFMA's director of partner relationships, content and professional practice guidance.

Iowa Chapter hosts its first hybrid event

January 2020 was the last time the Iowa Chapter had hosted an in-person event. And that ended early due to a winter storm.

CRYSTAL MILAZZO
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The long hiatus from face-to-face events ended April 15-16 with the Iowa HFMA Spring Meeting and Women's Conference. It was a hybrid event, allowing members to attend either in person or virtually.

"It had been well over a year since the majority of us had seen each other in person," said Joe Splinter, CPA, a partner with Eide Bailly and the Iowa Chapter's 2020-21 vice president and programming chair. "With the hospitalization rate low in Iowa and most of us having gotten our vaccines, we decided it was time. With the virtual option, our members could choose which means worked best for them."

Approximately 25-35 attended either in person or virtually both days for a total of 50-70 per day. Splinter said the Chapter was pleased with the turnout as it normally would have 75-100 people attend a pre-pandemic, in-person event.

HOSTING IN A POST-PANDEMIC WORLD

The Chapter worked closely with the venue to ensure a safe environment for those attending in person. They used a larger-than-normal conference room, set for just two people per table. Attendees kept their same seat the entire day. Masks were required, and hand sanitizer was provided. Food selections included pandemic-friendly options such as box lunches, individually served snacks and bottled water.

"We also eliminated sponsor exhibits and, instead, displayed sponsor names throughout the day and went with a swag bag concept so sponsors could provide items for our provider attendees," said Jenny Peterson, FHFMA, who planned the event with Splinter. Peterson is a decision support analyst III with CommonSpirit Health and 2020-21 Chapter secretary. "This allowed us to recognize our sponsors and still socially distance."

PARTNERING WITH HFMA

In addition to the attendees who participated via Zoom, two speakers presented virtually. Splinter and Peterson worked closely with HFMA Chapter Relations to ensure the technology worked.

"We had a lot of support from HFMA National and couldn't have pulled it off without our support from the Chapter Relations team," said Splinter. "They gave us great advice, helped with the Zoom links and sent some mics for us to use."

ENGAGING VIRTUAL ATTENDEES

One Zoom link was used the entire day, so virtual attendees could come and go as needed. Peterson said she particularly enjoyed interacting with virtual attendees and monitoring the chat box. She also noted one speaker was particularly good at engaging virtual attendees and getting them to turn on their cameras.

ENCOURAGING OTHER CHAPTERS

Peterson and Splinter urge others interested in hosting a hybrid event to step out of their comfort zone. "We had to start somewhere," said Peterson. "We had to take a step and see how our members responded."

Thanks to engaged Chapter volunteers, HFMA National support and venue flexibility, the response was positive.

"Planning and testing all the technology took more time, but it allowed us to proceed without any issues," said Splinter. "Overall, we're happy. Will we make some adjustments? Absolutely. But now we can say we've done this." ■



Iowa Chapter President Abbey Stangl was recognized for her service during the hybrid event.



TransUnion's Transfer DRG solution simplifies the underpayment process

How do you help healthcare organizations navigate the Transfer DRG recovery process?

Identifying Transfer DRG underpayments can be a challenging, tedious process. Hospitals must validate post-acute care activity, adjust discharge disposition codes and track rebill payment status, all while maintaining compliance with Medicare regulations. These challenges are tough to overcome without a dedicated solution or partner.

TransUnion's Transfer DRG solution simplifies this process by leveraging its STINGRAY™ platform, a unique Software as-a-Service (SaaS) solution for managing the Transfer DRG process. STINGRAY's superior processing and data integration capabilities help hospitals identify and recover more Transfer DRG underpayments, even when coming in behind other vendors. We have a 99% success rate in getting Transfer DRG claims paid.

11 years on the Short List
100% of peer reviewers would recommend TransUnion Healthcare's Transfer DRG service to a colleague

In our experience conducting hundreds of post-acute care reviews, we have historically seen 2% of Medicare discharges eligible to be rebilled for full DRG payments under Medicare's transfer DRG rules. At an average incremental recovery amount of approximately \$2,800 per claim, this is a reimbursement opportunity too big to ignore.*

What advice would you offer to healthcare leaders when choosing among vendors for a Transfer DRG solution?

Maximizing reimbursement for complex Medicare payment issues requires leading-edge technology that can gather, validate and integrate disparate data sets from multiple sources. STINGRAY's seamless integration and analysis of these data sets, plus superior algorithms that maximize Medicare Beneficiary Identifier lookup and claims scraping, allows TransUnion Healthcare to identify Transfer DRG reimbursement opportunities missed by other vendors.

Many hospitals use multiple vendors for Transfer DRG, running in first, second and third place. If your current vendor isn't converting approximately 2% of Medicare claims, there is likely revenue left on the table.

Consider how the vendor validates post-acute care activity, as this will affect

* Based on historical client results.

their payment success rate. TransUnion Healthcare interfaces directly with Medicare to automatically identify important eligibility and claims data, then our Transfer DRG team verifies the patient "level of care" directly with post-acute care providers.

Partners should also provide flexible delivery options. We offer fully outsourced consulting or Software-as-a-Service for Transfer DRG, with the option to outsource the billing and/or billing follow-up to our team.

What is some advice you can give providers for a successful implementation of a new product or service?

A Transfer DRG partner should communicate up front what data they need to complete your project, be available and responsive when you have questions and be proactive in resolving any issues that may arise. Our seasoned Transfer DRG team provides consultative, high-touch client support and leverages long-standing relationships with MACs to expedite the recovery process.

For our outsourcing clients, we average two weeks to extract patient data by using pre-built scripts for most Patient Accounting Systems. Our hands-on data extraction team works with each client to configure automated, recurring data feeds – eliminating the need to engage scarce IT resources year after year. ■



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To learn more about HFMA's Peer Review program, visit hfma.org/peerreview



To celebrate HFMA's 75th anniversary, we offer this special monthly look at key milestones.

It's not just about hospitals anymore

HFMA expands its focus to all of healthcare

“What’s in a name?” That was the question HFMA’s 1981-82 Chair, **Raymond J. Cisneros, FHFMA, CPA**, put before the Association’s membership in the January 1982 issue of *hfm*. Cisneros’ “Time to Act” column would mark the start of another momentous year in the Association’s history, as he called upon members to vote for what would be the most significant change in the Association’s identity to date.

For its first 38 years, HFMA was a solely hospital-centric association. It initially served hospital accountants, but then broadened its perspective in 1968 to encompass hospital finance. In 1981, HFMA’s board looked around and saw a changing world of healthcare: It was time, they said, for HFMA’s name to more appropriately reflect “the industry in which we now function.”

Cisneros wrote, “The hospital will continue as a focal point of the healthcare delivery system. As some hospitals diversify their activities, certain functions previously considered part of the hospitals will no longer be hospital operations but they will be part of the overall services rendered in a broader system or healthcare organization.”

In his rallying call to members, Cisneros said, “We again face an important decision in which it is Time to Act. The choice is before you and the decision is yours. If you look at where we are and where the industry is going, the decision should be clear.”

With that, in June, to start the new fiscal year, a new chair, **Park H. Haussler, FHFMA, CPA, CMPA**, pointed readers to the masthead of the journal, bearing its new name, *Healthcare Financial Management*,



HFMA’s 1981-82 Chair Raymond Cisneros called on members to vote for a name change for the Association.

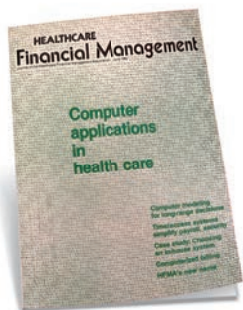


HFMA’s 1982-83 Chair, Park H. Haussler, was the first Chair to lead HFMA under its new name.

reflecting the Association’s new name: the Healthcare Financial Management Association. Haussler noted that 90% of the Association’s 21,000 members had endorsed the board’s recommended “by-laws change.” He also aligned his Chair’s theme with this move: “We will meet the challenge and accept the change with *Positive action*.”

Haussler wrote, “This change now more accurately reflects our membership than the old name. ... In many areas, we are presented with the challenge to change — in our delivery system; in our payment patterns; in our emphasis, such as inpatient-outpatient or sickness-wellness; in our relationships with other healthcare professionals.”

These comments, as well as much of the content of the journal at the time, seem to presage much of the same topics of focus we see in healthcare today (see the sidebar, “Perennial areas of focus for healthcare finance”). The topic of the June 1982 issue in which Haussler shared his perspectives was “Computer applications in health care.” And the cover story, “Computer modeling helps decision makers,” by John P. Harris, included a case study on how data analytics helped inform one hospital’s strategy around building an ambulatory care facility. ■



With the June 1982 issue, HFMA inaugurated its new name, shifting the Association's focus from only hospitals to all of healthcare.

Number highlight 572

The record number of healthcare finance professionals who attended HFMA's June 1982 Annual National Institute in Boulder, Colorado



Boulder, Colorado's Flatirons created the beautiful backdrop of HFMA's 1982 Annual National Institute.

Did you know?

While *hfm* has long had its eye on Washington — Washington has had its eye on HFMA

HFMA has long been viewed by national political leaders as an important forum for discussing key points of healthcare policy.

The January 1982 issue of *hfm* — the same issue in which appeared the announcement of the plan to change the Association's name to the Healthcare Financial Management Association — included an article by Congressman Richard Gephardt (D.-Mo.) describing the Voluntary Medicare option, a key part of bipartisan legislation that he and Congressman Willis Gradison Jr. (R.-Ohio) had introduced in Congress.

Although the legislation would not be passed into law, among the more than 2,000 resolutions and bills Gephardt would introduce to Congress, he would go on to cosponsor and see passed many healthcare-focused resolutions and two major pieces of healthcare legislation in ensuing years:

- Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991
- Medicare and Medicaid Patient and Program Protection Act of 1987

Ultimately, Gephardt would go on to serve as House Majority Leader from 1989 to 1995 and Minority Leader from 1995 to 2003.



Richard Gephardt, former U.S. Congressman for the state of Missouri and Speaker of the House, is one of many U.S. national political leaders who have shared commentaries in the pages of *hfm*.

Perennial areas of focus for healthcare finance

A look at some of the topics addressed in *hfm* in 1982 shows that amid vast changes that have occurred since then, some things have evolved while others have hardly changed at all.

- **Medicare**
"Viewing the future of Medicare" January 1982
Herman A. Kohlman, FHFMA, predicts a grim future for Medicare and its ability to keep pace with healthcare costs.
- **Capital Finance**
"Bond market forecasting: What can hospitals expect in the 1982 financial market?" January 1982
Bruce D. Mandsorf, Joseph R. Marion and Alex Rorke offer a glimpse into bond market expectations.
- **Clinician-Administrator Relationships**
"Reductions in hospital capacity: Physician behaviors and the administrators' challenge"
Miron Stano, PhD, Ronald M. Horowitz, PhD, CPA, and Ralph Aten offer a solution to the spiraling cost of healthcare expenditures by cutting overbedding and predicting some reactions from physicians and other policymakers.
- **Leadership**
"Organizational cultures: Sensitive managers can improve the working environment" March 1982
- **Medicare**
Leland R. Kaiser, PhD, describes how the workplace influences the growth of individuals and how healthcare executives can change their environments to nurture their employees.
- **Capital Management**
"For timely decision making: A capital equipment acquisition process" April 1982
Richard J. Oszustowicz proposes an alternative procedure to help decision-makers in capital acquisitions.
- **Computerized Billing**
"Using automated systems for hospital-based physician services" June 1982
Joel Dalva and Thomas Reinke discuss the development of automated billing systems for hospital-based physician services.
- **Debt Capacity**
"Using big business tactics: Hospital debt capacity in a competitive environment" July 1982
M. King Deets and Susanna E. Krentz compare the healthcare industry to the airline industry in light of possible deregulation.

In a win for hospitals, CMS removes a rate-reporting requirement from the Medicare FY22 IPPS

NICK HUT
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The pending requirement for hospitals to disclose privately negotiated Medicare Advantage (MA) payment rates on their Medicare cost reports was withdrawn in the recently issued FY22 proposed rule for the Inpatient Prospective Payment System (IPPS) and long-term care hospitals.

The requirement was established by the Trump administration in the FY21 final rule. Hospitals would have had to report the median MA payer-specific negotiated charge for each MS-DRG.

The idea was to use the data in setting Medicare payment rates, but the requirement would have added an estimated 64,000 hours to hospital administrative workloads.

CMS likewise is proposing to repeal the market-based MS-DRG relative-weight methodology that was supposed to take effect in FY24. Instead, the existing cost-based methodology will remain.

HFMA expressed support for those decisions. “This proposal will avoid imposing additional burden on hospitals,” said Rick Gundling, senior vice president of healthcare financial practices.

In written comments on the FY21 final rule, HFMA said its members “fail to see how transitioning to a system that uses median MA ‘payer-specific negotiated charges’ achieves the stated policy goals or improves the accuracy of the Medicare IPPS.”

HFMA also stated, “[W]e do not see the utility of requiring hospitals to report their ‘payer-specific negotiated charges’ as part of the Medicare cost report and strongly encourage CMS not to finalize a proposal that increases provider administrative burden — contrary to the administration’s ‘Patients Over Paperwork Initiative’ — and collects information that CMS is already requiring hospitals to publicly post.” ■

Acute care hospitals to get a 2.8% payment increase in FY22

Hospitals paid through the Inpatient Prospective Payment System (IPPS) will see their payments rise by 2.8% if they successfully participate in the Hospital Inpatient Quality Reporting Program and fulfill meaningful-use criteria with respect to electronic health records, according to CMS’s proposed rule for FY22.

The increase is based on a 2.5% update in the projected hospital market basket, with a 0.2-percentage-point reduction as a productivity adjustment and a 0.5-percentage-point statutory increase.

The base update does not include potential payment adjustments via Medicare pay-for-performance programs such as the Readmissions Reduction Program and Hospital-Acquired Condition Reduction Program.

The percentage increase equates to a \$3.4 billion payment hike for IPPS hospitals, although that total is projected

to decrease by \$900 million due to reductions in Medicare disproportionate share hospital (DSH) payments and uncompensated care payments.

On a separate note, the FY21 final rule established that in FY22, uncompensated care funds will be distributed based on a single year of uncompensated care cost data from Worksheet S-10 of hospitals’ FY18 cost reports. ■

\$660M

Decrease in uncompensated care payments to Medicare DSH hospitals in FY22, based on projected changes to the uninsured rate

New HRSA funding is available to providers that administer the COVID-19 vaccine and don't receive full payment from a health plan

The Health Resources and Services Administration (HRSA) announced a new program to reimburse healthcare providers for administering COVID-19 vaccines to patients whose health plans either do not cover vaccination fees or require cost-sharing.

A HRSA statement noted that because providers are prohibited from billing patients for vaccination fees, the COVID-19 Coverage Assistance Fund (CAF) was instituted to address “an outstanding compensation need for providers on the front lines vaccinating underinsured patients.”

Even though the government has funded the full cost of vaccines, providers incur costs in areas such as training, staffing and storage, HRSA noted in a news release. Federal guidelines prohibit billing patients for vaccine administration. Providers may seek reimbursement from



Medicare payment rate for administering a two-dose COVID-19 vaccine. Payment for a one-dose vaccine is \$40

a patient's health plan, but the plan may deny payment or withhold the patient's cost-sharing amount.

Going forward, “Providers should submit their COVID-19 vaccine administration fee claims for reimbursement consideration to the CAF. To be eligible for reimbursement, the provider must have first submitted the claim to the individual's health plan for payment and had the claim denied or only partially paid,” according to the news release.

HRSA notes that claims must be submitted electronically and are subject to available funding, which is sourced from the Provider Relief Fund.

Providers that administer the vaccine to uninsured individuals have been eligible to submit claims to the HRSA COVID-19 Uninsured Program. ■

Study finds haphazard hospital compliance with 2019 rule on posting chargemaster prices

In a large study, more than half of hospitals had not posted a machine-readable file with chargemaster information in the first 18 months since they were required to do so.

A federal rule that was implemented in 2019 required hospitals to make charges available in a machine-readable format for all listed services. The rule was a precursor to requirements that took effect Jan. 1, 2021, and required additional information to be posted, including discounted cash prices and payer-specific negotiated charges, along with a “consumer-friendly” display of prices for at least 300 shoppable services.

Among 5,288 hospitals surveyed between June and November 2020 for a study that was published May 14 in

JAMA Network Open, 2,723 (51.5%) did not have an online chargemaster in a machine-readable format. That group included 305 hospitals (5.8%) with broken links or incorrectly linked files and 138 (2.6%) that provided only an online cost estimator.

To drill further down into the usability of information, two nonmedical reviewers in the research group analyzed 25 shoppable items in the chargemasters of the 100 largest hospitals by bed number. Among the 2,500 items, 330 prices (13.2%) were identified by both reviewers.

“Even when publicly accessible, chargemasters were frequently buried within websites and difficult to use accurately,” the authors wrote. ■

HFMA's Cost Effectiveness of Health Summit: Why health spending must become more cost-effective

For stakeholders across healthcare, the cost effectiveness of health increasingly is becoming a topic that can't be ignored.

"It's a term you'll hear more and more about in the coming years," said HFMA President and CEO Joseph J. Fifer, HFMA, CPA.

For HFMA, in fact, cost effectiveness of health is "so important that you might consider it our new 'just cause,'" Fifer said. "It's based on a societal challenge I believe we all have in the world of healthcare."

The focus should not be specifically on reducing costs or bending the cost curve, Fifer said. Instead, HFMA defines *cost effectiveness of health* as "minimizing the costs associated with delivering optimal health outcomes." Achieving that balance will transform the industry to the benefit of all stakeholders.

At HFMA's inaugural Cost Effectiveness of Health Summit on May 6-7, attendees heard from leading industry experts about both the need and the opportunities for the industry to attain a more sustainable model. The event was sponsored by EY, Strata and Vizient.

DATA HIGHLIGHT INEFFICIENCIES

Per capita, the U.S. spends nearly twice as much on health as comparable countries: \$10,637 to \$5,527, according to 2018 data analyzed by the Kaiser Family Foundation. Inpatient and outpatient care amount to \$6,624 in the U.S. and \$2,718 in comparable countries. Administrative costs are \$937 in the U.S. and \$201 elsewhere.

As an example of the opportunity cost of excessive health-care spending, Fifer cited the long-running policy debates about the country's infrastructure.

2021

Cost Effectiveness of Health Summit

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"Without getting into politics or opining on the merits of various proposals, could it be that we're falling behind [on] investment in infrastructure because we spend so much money on healthcare?" Fifer said. "Regardless, there's a clear frustration about the amount we spend on healthcare, and like it or not, that's just not going away."

THE CENTRAL ROLE OF PAYMENT MODELS

Some gaps in U.S. healthcare stem from the fee-for-service payment system. In response to a poll question on the biggest opportunity to improve the cost effectiveness of health, more than half of summit attendees cited *changing the payment system to reward healthy behaviors* from among four options.

Of national health expenditures, 90% are on healthcare and 9% are on behavioral and societal factors. That allocation is disproportionate as indicated by epidemiological analyses that have found 60% of health hinges on social, behavioral and environmental factors.

"In the long run, can we afford to overlook what might be the single biggest cost driver?" Fifer said. "Alternatively, we can construct payment models in which stakeholders truly share the risk and responsibility of managing to social determinants and aligning incentives accordingly."

Only 30% of providers are involved in risk-based payment models, according to a summit presentation, including 5% in capitated models. But organizations should be preparing for those shares to rise, said Blair Bellamy, partner, health consulting with EY.

THE IMPACT OF THE PANDEMIC AND BROADER TRENDS

S&P Global Ratings kept a negative credit outlook for the not-for-profit hospital sector heading into 2021. That decision stemmed in part from pressure on margins and cash flow.

"Really the focus is on the operations. That's the biggest risk that we see over the next couple of years," Suzie Desai, senior director with S&P, said during a summit presentation. "The balance sheets are fine."

As the pandemic subsides, Desai said, a renewed emphasis on costs can be expected in the outlook for the sector and for individual organizations as the government and employers seek to rein in spending. ■

Looming changes to quality reporting in the MSSP draw strong push back from healthcare providers

CMS's pending overhaul of quality reporting for accountable care organizations (ACOs) has generated a negative response, with healthcare providers predicting a significant increase in administrative burden and no corresponding quality improvement.

The Medicare Shared Savings Program (MSSP) is undergoing major changes to its quality-related processes after CMS pushed through updates in the 2021 final rule for the Medicare Physician Fee Schedule. The rule was finalized after a comment period during which many stakeholders expressed strong concerns about the proposed modifications.

Starting in 2022, MSSP participants must report on three electronic clinical quality measures (eCQMs)/Merit-based Incentive Payment System (MIPS) CQMs:

- Diabetes: Hemoglobin A1c poor control (>9%)
- Preventive Care and Screening: Screening for depression and follow-up plan
- Controlling High Blood Pressure

That requirement likely would lead to massive costs and increased burden without enhancing care quality, according to a letter from 11 leading provider associations to Xavier Becerra, secretary of the U.S. Department of Health and Human Services.

To share in savings starting in 2022, ACOs will have to collect the three new measures via their electronic health records (EHRs) unless they report MIPS CQMs through a qualified registry.

Because the organizations that comprise an ACO likely use distinct EHRs, ACOs face the prospect of paying additional vendor fees to aggregate data, according to a statement from the National Association of ACOs (NAACOS), one of the signatories of the letter along with the American Hospital Association and American Medical Association.

Among other changes, the 11 healthcare associations are asking Becerra to delay the mandatory reporting of the three new CQMs for at least three years. ■

Amid the pandemic, research finds hospitals looking to capitalize on 'systemness'

Large health systems appear to have significantly outperformed smaller organizations in surgical volume recovery during the COVID-19 pandemic, and the discrepancy may be partially attributable to the advantages gained through "systemness."

In an Advisory Board survey that was conducted in early February and drew on responses from 83 hospital strategic planners, those who worked at systems with more than five hospitals were substantially more likely to report that their volumes had reached or exceeded pre-COVID-19 levels.

"This is perhaps a factor of being more diversified across markets," Colin Gelbaugh, a director

42%

Share of survey respondents with large health systems who said patient care revenue returned to pre-pandemic levels as of February

with Advisory Board, said during an April presentation of the survey data and insights.

Larger organizations "can use the full capacity of their system. If one hospital was nearing capacity, they might perform a surgery somewhere else with excess capacity rather than postponing the procedure," Gelbaugh added.

Such trends indicate the advantage that larger organizations can derive from implementing a cohesive strategy across their sites of care.

"You're really talking about leveraging the value of systemness," said Christopher Kerns, vice president of executive insights with Advisory Board. ■

The 2021 outlook for hospitals: Reviews are mixed

Few would disagree that 2020 was a challenging financial year for hospitals. Although most industry voices are predicting 2021 will also be financially challenging, not everyone holds that view.



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Some voices are sounding more positive, given the availability of vaccines in most parts of the country and the substantial number of people who have already been vaccinated in the United States. As of April 26, CDC tracker data indicated 94.8 million Americans had been fully vaccinated. Although this is only 28.5% of all Americans, it represents 45% of Americans over the age 18, who up until recently were the only ones eligible to receive the vaccine.^a Furthermore, 132 million have received at least one dose, and 80% of people over the age of 65 — the vast majority of those who are the most vulnerable to death or serious illness — have already been fully vaccinated.

A recent report projects U.S. hospital revenue in 2021 will fall somewhere between \$53 billion and \$122 billion short of where it had been prior to the pandemic.^b The optimistic side of this projection is based on a recovery of patient volumes and a smooth roll-out of vaccinations leading to

reduced COVID-19 hospitalizations. The most pessimistic scenario assumes an only partial recovery in patient volume and a delayed vaccine rollout, leading to additional surges of COVID-19.

Even with the high numbers of vaccine-hesitant individuals — 13% having said they will definitely not get vaccinated and 17% taking a wait-and-see attitude — so many Americans have already been vaccinated that the pessimistic scenario seems unlikely.

OUTLOOK FOR OUTPATIENT REVENUE

Under the optimistic scenario, 39% of U.S. hospitals are still expected to operate in the red in 2021, with rural hospitals being especially hard-hit. A projected loss of \$27 billion in outpatient revenue would pose a difficult challenge, given that outpatient services provided a substantial source of pre-pandemic revenue.

Although it may seem like a distant memory, hospitals ended 2019 with an increase in profitability, helped by increased net patient revenue and service volumes. Some researchers saw a comeback for outpatient care, projecting the baseline for outpatient visits at the start of 2021 would be 5% over the volumes observed in the second half of 2019.^c Researchers projected the baseline for ED visits and inpatient visits, however, would be 22% and 7% lower, respectively, on a year-over-year basis. In early 2020, the picture was quite different, when ED and outpatient visits were up by 2% and 6%, respectively.

LEGISLATED FUNDING HELPS, BUT FURTHER INTERVENTIONS NEEDED

Despite the significant financial challenges hospitals and other providers continue to face, they also have received significant funding through legislation during the past 12 months. These funds are intended to alleviate both the revenue loss from delayed patient care and additional costs COVID-19 has imposed on providers.

a. As of May 10, the FDA has expanded eligibility to anyone over the age of 12.

b. Kaufman, Hall & Associates, LLC, COVID-19 in 2021: The potential effect on hospital revenues, February 2021.

c. LaPointe, J., "Will hospital patient visits return to normal in 2021?" *RevCycle Intelligence*, January 29, 2021.

Hospital spending by the end of 2020 was only 0.1% higher than it was at the end of 2019. Meanwhile, Congress provided additional protection to hospitals (along with other healthcare providers) by waiving the automatic 2% reduction in Medicare payments that was scheduled to restart in April 2020 as part of sequestration and postponing it until the end of the year.

As of mid-April 2021, \$178 billion of funds have been legislated for providers, giving all types of providers grants amounting to at least 2% of their previous annual patient revenue. Distributing the funds based on each hospital's pre-COVID-19 revenue favors hospitals that receive a higher percentage of their revenue from private insurance, because private insurance pays hospitals at higher rates than Medicare and Medicaid. Nonetheless, safety-net hospitals, hospitals with many COVID-19-afflicted patients and skilled nursing facilities, have also qualified for an additional \$25 billion of funding.

Congress, however, has not exempted the required response from PAYGO rules, which have been blocked to date. These rules would require any payment increases or tax cuts that add to the national deficit be offset by spending cuts. If Congress does not proactively intervene, PAYGO would require that Medicare payments be reduced by 4% in 2022 under the American Rescue Plan. Although Congress seems likely to intervene, this point is a reminder that hospitals continue to face negative forces near term.^d

CMS has attempted to assist hospitals by accelerating their advance payments. Although ultimately these funds will have to be repaid, the move provides hospitals with additional funding in the interim. To recoup what hospitals owe, Medicare will begin to withhold a portion of new Medicare claims, but the amount withheld will not exceed 25% of their revenue, at least during the first six months of repayment.

d. Schwartz, K., and Neuman, T., "Funding for health care providers during the pandemic: an update," Kaiser Family Foundation, April 20, 2021.

\$178M

Federal funding allocated through legislation for U.S. providers in response to COVID-19 as of April 1

Source: U.S. Department of Health & Human Services



A POSITIVE OUTLOOK FOR SOME

It now seems likely that some of the largest hospitals will emerge from the pandemic generally unscathed by COVID-19. Tenet and HCA, both for-profit systems, reported higher profits in the first quarter of 2021 as a result of higher patient acuity and a rebound in ambulatory care.^e And some of the nation's largest not-for-profit hospitals also ended up doing well, largely because of the federal bailout money, according to an article in the April 1 *Washington Post*.^f HHS's attempts in the fall to limit how much aid hospitals could keep based on their finances was stopped by industry and the Congress.

The Biden administration has said it is reviewing programs from the Trump administration, including unspent funds from previously allocated legislation, as well as the \$8.5 billion that was included in the American Rescue Act. Redirecting funding, in the face of political pressure, has never been easy. There is no reason to expect this to change because of the pandemic. ■

e. King, R., "Tenet posts \$97M in profit in Q1 as hospitals 'exceeded expectations,'" *Fierce Healthcare*, April 21, 2021.

f. Rau, J., and Spolar, C., "Some of America's wealthiest hospital systems ended up even richer, thanks to the federal bailouts," *The Washington Post*, April 1, 2021.

About the author

Gail R. Wilensky, PhD, is a senior fellow at Project HOPE; a former administrator of the Health Care Financing Administration, now CMS; and a former chair of the Medicare Payment Advisory Commission.

USA Senior Care Network provides hospitals with incremental patient volume and increased revenue



In this Business Profile, USA Senior Care Network's Senior Director of Hospital Partnerships Rita Marti discusses how the company helps their Medigap carriers drive a larger volume of fully insured patients to hospitals and uses a patented process to keep premiums affordable for patients with Medigap insurance.

How do you help healthcare organizations?

For hospitals that join our network, our Medigap carriers provide an incremental volume of patients and the incremental revenue generated by those patients. We help health systems grow their market share without risk of bad debt. In addition, our Medigap carriers' seniors know that by using doctors and hospitals within our network, their premiums stay affordable, so they are more willing to change hospitals to find one within our network.

Though our clients' population of seniors is financially stable, they're also still on a fixed income. They have enjoyed a high level of coverage prior to turning 65, and they still want choices now that they're over 65, which is why they've selected Medicare Supplemental Insurance, also known as Medigap.

USA Senior Care Network has patented a process to keep premiums affordable for patients with Medicare Supplemental Insurance. Savings from our program are applied by our 130 insurance carrier clients toward keeping a lid on future rate increases for more than 10.5 million seniors nationwide.

What are some of the biggest challenges you see affecting healthcare organizations?

Certainly, COVID-19 is right at the top of our list as it is for everyone. It has changed our world, and every area of a hospital has been affected, from operations to finances. Related to COVID-19 is the decrease in the number of patients seeking care for something other than COVID during the pandemic. Because hospitals weren't seeing fully insured patients for elective procedures as they had in previous years, and as people began being vaccinated, fears eased for some patient services – a hip replacement, for instance – causing a demand for such services. As seniors are deciding where to go to have certain elective procedures done, hospitals have to position themselves to be attractive to patients.

There are also additional challenges for healthcare organizations.

- An increase in uninsured or underinsured patients due to job losses and other pandemic-related factors has made it more difficult to recoup money lost in 2020.
- Hospitals in highly competitive markets that existed even before the pandemic are pressed now more than ever to differentiate themselves from the competition, bring in patients that are insured and to build different services to attract those patients.

How does your product or service offering(s) help address these needs?

Our Medigap carriers help drive volume to hospitals at a time when it's needed most.

Seniors that held back on elective procedures are more likely to be fully vaccinated, so they're returning to hospitals and seeking out providers that are in our network. From a hospital standpoint, our clients not only bring the patients, but drive a larger volume of fully insured patients. While our program cannot be used as a marketing tool to solicit new policyholders, USA Senior Care Network becomes a wonderful tool to attract our Medigap carriers' existing policyholder membership. Why? Because seniors know that by choosing one hospital over another for an elective procedure, the in-network choice with USA Senior Care Network is going to keep their premiums down.

We help hospitals combat the issue of uninsured patients by bringing fully insured patients into the hospital and creating that brand awareness within their families. Many seniors have adult children, who are also more likely to be fully insured and who know that their parents are receiving high-quality care at your hospital, so they are more likely to seek care there as well. A successful hospital in our network could position itself to see an increased number of insured, younger family members.

We're the only service doing this with the process patent, and we're gaining market share within the Medicare Supplement realm. Through our unique network, our Medigap carriers are able to channel patients to contracted facilities per Core Based Statistical Area (CBSA). We have contracts in rural areas as well as major metropolitan areas, including rehab hospitals and critical-access hospitals. Wherever there are seniors in the U.S., we are looking to engage additional

facilities. All of the stakeholders – insurance carriers, hospitals and other healthcare entities, and patients – benefit from this program.

What are some key considerations for healthcare leaders when choosing this type of product or service? Are there key product/service features that people should know about?

We launched in 1992, and there is really no one else providing the same service. Sometimes that can be a double-edged sword. When you're the only one doing something, you get some raised eyebrows. But we're happy to present our client list and the insurers that we've contracted with and grown relationships with to show how it works.

Collaboration between the hospitals and the insurance companies provides the best healthcare. Both sides give up a little – and work together – for the benefit of the patient. This group of patients is already stable because they're already paying out-of-pocket every month for Medigap. Our clients' seniors appreciate having a network "home" through our contracted hospitals. By expanding their access to providers associated with Accountable Care Organizations (ACOs), it allows our clients' policyholders to continue to receive quality healthcare and adds Medigap covered lives to the ACO. Plus, there are no additional costs to

sign up. There's no burden to the hospital's revenue cycle side to chase money. Simply bill Medicare, which will automatically bill Medigap for any overage, and the bill is paid. It's seamless, easy, and it's all revenue. *We're bringing the patients, not the problems.*

What advice would you offer to healthcare leaders when choosing among vendors?

Leaders need to ask themselves: "Do we want to win or not with the Medigap population in our market?"

When we meet with hospital leaders, we've already put together a projected revenue report. With hospitals that aren't in our network yet, the first thing we look at is an admissions report. Let's use a three-hospital system in California as an example. From 2017 to 2018, this system lost \$2.6 million as admissions of Medicare Supplement policyholders dropped by 16% across all three hospitals. The system signed with USA Senior Care Network in December 2018. One year later, the three hospitals saw an increase of 64.5% of those Medigap supplemental policyholders, which translated to \$7.1 million in additional inpatient revenue.

If your quality of care is comparable to other hospitals in your market, then these patients within the USA Senior Care Network will make a shift – not all of them right away, but probably about 15-20% in the first year – because they know the advantage of seeking

care at in-network hospitals. They know that by using your services, they're going to get insurance that's affordable for years to come.

As healthcare organizations implement use of your product or service into their day-to-day operations, what advice would you offer so they can best set themselves up for success?

We know that hospital administrators are already overburdened, and we don't want to add any administrative burden. We don't ask for pre-approvals or prior authorizations that wouldn't already be expected under Medicare. We won't hand over a thick manual for admitting or billing patients, because it is standard Medicare billing and there are no extra changes to how money is collected. There are also no Part B waivers or discounts, and providers can count on being reimbursed at the full Medicare rate. This is traditional Medicare, and the biggest thing that hospitals are going to gain is revenue.

How can healthcare organizations learn more about your company?

Organizations are encouraged to take a look at the Southern California case study at www.USASCN.com/hospital01/. We also plan to attend the HFMA Conference in the fall as COVID-19 restrictions allow. ■



USA Senior Care Network brings together Medicare Supplement Insurance carriers and quality healthcare facilities in a nationwide network for Medicare Supplement policyholders. Our innovative network benefits everyone by managing costs, keeping premiums affordable for a growing senior population, and channeling these Medigap policyholders to participating hospitals. Thousands of credentialed hospitals and other medical facilities have contracted with USA Senior Care Network to gain patient volume and revenue on inpatient and outpatient procedures and services.

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features

COVER STORY EXPERT REVIEWED FEATURES

Ready for the moment

Tammie Jackson's appointment as HFMA National Chair is historic for the Association, and she's excited to get to work on some of the most pressing issues facing members.

NICK HUT

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It's "serendipity," said Tammie Jackson, FHFMA, CHFP, that she's moving into the role of HFMA National Chair at this moment in history. As the healthcare industry and the world at large increasingly focus on issues of social justice, Jackson on June 1 became the first Black person to serve as Chair in HFMA's 75-year history.

Even though the timing is happenstance, Jackson is eager to seize the opportunity to make an impact in FY21-22.

"This year, I would like us to begin to answer, 'Now what?' We have arrived at an inflection point and have a real opportunity to determine what our 'better' looks like and to move forward boldly," Jackson said.

NEXT PAGE



PHOTOS BY MARSHALL CLARKE



“

HFMA has always been, for me, a safe place to learn and a safe place to ask questions. It has allowed me to tap into incredibly resourceful and super-smart people, and really tap into a pool of innovation.”

— Tammie Jackson

A ‘BOLDER’ THEME FOR A CHANGED WORLD

The opportunity for bold action in pursuit of a better healthcare system is something Jackson, vice president of go-to-market strategy and sales with TransUnion Healthcare, wants to emphasize over the next year. But such a message is different from what she initially envisioned as the theme for her Chair tenure.

That’s because Jackson was supposed to become Chair in June 2020. When the COVID-19 pandemic struck a few months prior, HFMA asked FY19-20 Chair Mike Allen to remain in his role for a second year.

Before that decision was made, Jackson had chosen “Lead by Design” as her Chair theme for FY20-21. In an industry being rocked by change — even pre-pandemic — healthcare organizations could navigate choppy waters by relying on sound, informed decision-making, she explained.

That notion certainly still applies. But given what the industry has endured over the last 15 months, Jackson thought a different theme was appropriate. She settled on “Bolder. Brighter. Better.”

“It just felt as though we needed a north star — a more optimistic outlook,” Jackson said. “Whereas ‘Lead by Design’ was much more of a call to action, this one is also an acknowledgment of what we’ve been through and then forward-thinking: Where are we going?”

The industry, still dealing with a global pandemic, has been forced to quickly assess problems, improvise solutions, plan, execute and then repeat, she explained. Organizations have taken bold steps during the pandemic to maintain sustainability and serve consumers. Now they can use those lessons to keep pushing forward and emerge with a brighter outlook and better ways of doing business.

CHANGING THE COMPLEXION OF THE INDUSTRY

Issues of diversity, equity and inclusion represent an area in which bold steps continue to be called for, Jackson said. Many companies and industries have been more closely examining their performance in that sphere since the death of George Floyd in May 2020, and the topic resonates in healthcare because of documented disparities in access and outcomes.

Jackson hopes to use her Chair year to explore ways for HFMA to encourage greater diversity in healthcare finance. That’s an important step toward ensuring the industry mirrors its patient populations, a key to achieving culturally competent care.

“Because our membership reflects the complexion of the healthcare industry in general, it’s not very diverse,” Jackson said. “When traveling as an [HFMA] officer to various chapter meetings, I could literally go to three or four meetings in a row and be the only person of color.”

“As a membership association, we can sit back and go, ‘Well, we reflect the industry, so there’s not too much we can do about that.’ Or we can try to dig in and provide tools and resources to help. There are opportunities certainly that we can help to foster.”

HFMA can circulate tools and best practices and establish measures of accountability. The goal would be to help organizations first understand the value of cultivating diversity with respect to all underrepresented groups, and from there examine why they may be falling short. Possible issues include biases that inadvertently may be present in tools, conferences and curricula, Jackson said.

“Whether it’s forums or courses or certifications, even some kind of an assessment that we’re able to package,” Jackson said, “are there things that we can put together that can really help organizations move the needle?”

She added, “This is not a challenge where you just say, ‘Oh, by the way, there are jobs over here,’ and then all of a sudden there’s this diverse group. It’s a really, really tricky problem. I can’t change — nor can HFMA change — the diversity of provider organizations. But what we can do is give them tools to assess where they’re at. Give them a road map as to how they might be able to change that.

“It may take longer than many of us would like, but we have to be bold and put the goals out there. That’s how we get better.”

A SOLUTION-ORIENTED MINDSET

Such approaches epitomize Jackson’s intent to help HFMA further establish itself as a solution-based organization and an engine of innovation.

“HFMA has always been, for me, a safe place to learn and a safe place to ask questions,” she said. “It has allowed me to tap into incredibly resourceful and super-smart people, and really tap into a pool of innovation.”

Membership in HFMA means access to “knowledge and tools that become your own. I always encourage people that it’s a way to invest in yourself.”

Jackson likes to reflect on HFMA’s theme for the past fiscal year: “Your Challenge. Our Mission.” That pledge will remain relevant as the industry emerges from the pandemic and practical, actionable solutions become increasingly vital in areas such as the social determinants of health (see the sidebar at right).

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Key issues facing healthcare finance professionals over the next year

NICK HUT

In her role with TransUnion Health, Tammie Jackson spends ample time mulling ways to mitigate the impact of social determinants of health (SDoH). As HFMA’s new Chair, she hopes she can help disperse solutions throughout the industry.

“I’m incredibly passionate about true community-based population health management, really trying to improve the health and wellness of the communities we all serve,” Jackson said.

Jackson says solutions to SDoH issues start with frank appraisals. Inequities are entrenched in the U.S. healthcare system and have been exacerbated during the COVID-19 pandemic.

“We have to sit back and look at ourselves,” Jackson said. “We have to be honest about the biases that may be inherent within our own systems and policies and ensure they do not create or perpetuate disproportionate access to care.”

Tackling SDoH is just one of many urgent challenges that the industry is facing. Jackson hopes HFMA also can make an impact in the following areas.

- **Cost effectiveness of health.** As anyone who follows the healthcare industry knows, many hospitals were struggling financially before the pandemic and have endured significant setbacks since. Achieving a sustainable recovery will require the industry to consider new ways of operating, Jackson said. “Whether it’s care-related services or whether it’s functions within a revenue cycle, [the pandemic has] really helped us to isolate those things and get honest about how to deliver them most effectively.”

- **Value-based payment.** Jackson said the industry’s transition to value needs to accelerate even amid ongoing challenges. “Everyone still has to continue to deliver care while we’re figuring all this stuff out,” she said. “It’s hard to kind of change the engine on the plane while it’s flying. And so I see us as being a real resource to hospitals in being able to do some of that work.”

- **Surprise billing.** This issue long has been a shortcoming in patient billing practices, Jackson said. “We can’t seem to get a patient-friendly bill out the door.” Recently passed federal legislation may help, she said, but healthcare providers should strive to be more proactive about implementing consumer-oriented best practices than they traditionally have been.

- **The healthcare workforce.** Before the pandemic, Jackson said, “It would have taken us years to make that kind of a quick pivot” to remote work. The innovation seen over the past 15 months is laudable, she said, but now healthcare finance leaders need to establish a long-term model while also striving to support clinicians and other staff who have been dealing with higher rates of stress and burnout.



Tammie Jackson Career Highlights

CURRENT POSITION

- Vice president, go-to-market strategy and sales at TransUnion Healthcare

EDUCATION & CERTIFICATION

- MHA, George Washington University
- BS, Finance, Florida Atlantic University
- Certified Healthcare Finance Professional
- Fellow, HFMA

HFMA SERVICE

- Board of Directors
- National Advisory Council
- President, South Texas Chapter
- Member, First Illinois Chapter and Gulf Coast Chapter

HFMA AWARDS

- Founders Medal of Honor
- Frederick T. Muncie Gold Award
- Robert H. Reeves Silver Award
- William G. Follmer Bronze Award

“How do we do things better? How do we do them faster? How do we do them most cost-effectively? Those are the questions I would like us to ask,” Jackson said.

“HFMA is perfectly positioned to convene stakeholders that can begin to put together the playbooks that can answer those questions. When presented with an issue, we can help collect the different ways that that problem is being solved, distill down the best ways to solve it, and then be able to push that out and share it.”

A ‘SURREAL’ SITUATION

While preparing for the responsibilities that await her over the next year, Jackson has taken time to appreciate the opportunity. In a landmark anniversary year for HFMA, her appointment is another milestone.

“It feels very surreal,” Jackson said. “I would have never imagined myself in this role, and I wonder if somebody had come before me, maybe I would have been more easily able to imagine it.

“I hope I can help start a conversation that puts us on a different path. Maybe if people see somebody that looks like me in this role, that will allow people to feel like there’s a place for them too, that there’s a place to engage, that there’s something that they too can achieve.” ■

About the author

Nick Hut is a senior editor with HFMA, Westchester, Ill.

6 things about Tammie Jackson

NICK HUT

1

The launch of her career in the healthcare industry wasn't by intent. In an earlier stint with TransUnion, she worked in the legacy credit business, and the sales team was organized by industry. Jackson ended up with healthcare because she was "the low man on the totem pole and nobody else wanted it."

2

She joined HFMA to start building a knowledge base. Early in her career, Jackson began attending monthly meetings of the Gulf Coast Chapter. "It wasn't about sales or even networking," she said. "I was just learning about the industry."

3

She derives fulfillment from mentoring and coaching. In her role as go-to-market leader at TransUnion, Jackson oversees an organization that includes direct and channel sales, client management and sales operations. "TransUnion is a safe place where people can learn, feel comfortable asking questions and not be afraid to 'fail fast' — that's the culture I want to foster," she said.

4

Her original Chair theme reflected her life's credo. "Lead by Design" — which was Jackson's planned theme before the pandemic-induced, year-long delay of her Chair tenure — represents how she approaches her life and career. "Bringing a level of consciousness to the decisions that we make every single day, all day long, really opens up your world," she said. "Instead of feeling subject or victim to everything that happens to you, it empowers you to make decisions and own those decisions."



5

Her hero is her late mom, Paula Kingsbury. "She was a role model for what it means to be a strong, independent woman," Jackson said. "She raised two kids, pretty much all on her own. She bettered herself through education and worked herself up the ladder at her job. In addition to the importance of education, my mom taught us values that weren't material and provided us with a faith foundation, which is really important to me."

6

Her greatest achievement is her son, Christian. "I think I raised a pretty incredible kid. He's passionate about giving back and currently is working for Conifer while he goes to seminary and also runs his own 501(c)(3). Say what you want about this millennial generation, but they want to — and will — change the world. I'm proud of who Christian is becoming and enjoy watching him mature and dream."

—Reporting by Crystal Milazzo, HFMA senior editor

“Bringing a level of consciousness to the decisions that we make every single day, all day long, really opens up your world. Instead of feeling subject to everything that happens to you, it gives you the freedom to make decisions and own those decisions.”

— Tammie Jackson



EXPERT REVIEWED

We must stop relying so heavily on benchmark tables to set **physician pay**

Healthcare organizations that depend on survey benchmark data alone when setting physician compensation may be risking budgets and relationships with physicians, especially in times of great uncertainty.



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A

2018 analysis found that about 55% of physicians received at least some compensation based on their personal productivity.^a Moreover, the author’s experience corroborates this finding, having presented ample evidence that many hospitals, health systems and medical groups now pay physicians for their clinical services using some variation on the following formula:

$$\begin{aligned}
 &\text{Clinical compensation} \\
 &= \\
 &(\text{National median compensation per wRVU benchmark for physician's} \\
 &\text{specialty from most recent physician compensation survey report}) \\
 &\times \\
 &(\text{Physician's personally performed wRVUs}) \\
 &+ \\
 &(\text{Compensation for meeting specified clinical quality targets})^b
 \end{aligned}$$

a. Rama, A., “2012-2018 data on physician compensation methods: Upswing in compensation through the combination of salary and bonus,” *Policy Research Perspectives*, American Medical Association, 2020.

b. wRVU stands for work relative-value unit, a measure of the time, skill, training and intensity necessary to perform the various clinical services.

There are three compelling reasons for the widespread adoption of the productivity-based portion of this model:

- It creates an incentive for physicians to see more patients and do more procedures, which inevitably leads to more revenue in a system dominated by fee-for-service reimbursement.
- It offers an expedient approach to setting compensation levels.
- By tying the value of each unit of service to a publicly available survey report, it helps create an impression of impartiality and correctness.

THE PROBLEM WITH RELYING ON BENCHMARKS

These impressions overlook a fundamental flaw in the model: General benchmark data cannot, by definition, reflect the reality of each organization’s unique situation. In relying solely on such data, an organization effectively relinquishes control of one of its largest expenses.

Consider the hypothetical examples presented in the exhibit below.^c Based on the data in the exhibit, when the 2017 edition of this hypothetical survey report was released, a productive pulmonologist with 8,500 wRVUs and a productive neurosurgeon with 13,000 wRVUs paid using the median compensation per wRVU ratio for their specialty would suddenly have found themselves making about \$37,000 and \$70,000 more,

c. Note that these examples use hypothetical data based on widely used survey reports. The intent is simply to illustrate the concepts presented.

respectively, for the same amount of work. It is unlikely that the market for physician services in these specialties or the organization’s financial situation would have changed dramatically enough in such a short period to justify these substantial changes. More important, while the physicians would have welcomed these increases, their organizations could not have budgeted for them — nor could they have prepared the physicians for the decreases coming in the next year.

Some might consider averaging data points from multiple years of a survey report or blending multiple survey reports to be an effective solution for smoothing out such aberrations. But again, such an approach cannot account for unique factors affecting any specific organization, such as its payer mix, payer contracts, utilization of advanced practice providers or overhead expenses.

WHY IS THIS PARTICULARLY IMPORTANT NOW?

The COVID-19 pandemic’s effect on volume, revenue and physician compensation in 2020 will doubtless have a massive impact on the data shown in the survey reports,^d as will the recent changes in the 2021 Medicare physician fee schedule (including the wRVUs assigned to

d. While the exact impact is not yet clear, it is reasonable to assume that wRVUs in the 2021 surveys will likely be lower than in 2020 while physician compensation levels will remain the same or at similar levels for significantly reduced production because many organizations provided some level of compensation guarantees to their physicians in 2020.

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Percentage changes in compensation for two physician specialties over 5 years based on hypothetical benchmark data

		2015	2016	2017	2018	2019
Pulmonology – general and critical care	Reported median compensation to wRVU ratio	\$60.10	\$59.09	\$63.45	\$62.47	\$69.36
	Percentage change from prior year		-2%	7%	-2%	11%
Neurosurgery	Reported median compensation to wRVU ratio	\$82.04	\$83.56	\$88.97	\$87.24	\$89.08
	Percentage change from prior year		2%	6%	-2%	2%

common CPT codes). In the wake of the disruptions caused by COVID-19, the weakness inherent in these compensation models tied to survey data have become more evident. Organizations now face difficulties not only in foreseeing the changes in benchmark data but also in predicting physician compensation expenses. Such uncertainties also create an unnecessary stressor for physicians, who need a sense of stability like anybody else.

Taken together with the challenges outlined in the sidebar on page 31, these forces raise questions about whether the survey reports for 2021, 2022 and even 2023 will provide a reliable look at the market for physician services. Though the surveying organizations are trying to “smooth out” the benchmarks, continuing to rely upon these data in physician compensation calculations could expose organizations to significant unpredictability. Simply put, healthcare organizations need a more sustainable model.

A BETTER SOLUTION

Healthcare organizations can take three broad actions, as detailed in the remaining discussion, to strengthen their productivity-based physician compensation model and prepare for an uncertain future. The approach described herein can be used by organizations large or small for a group of similar physicians within a specialty or for individual physicians.^e

e. Although the approach may seem daunting for small organizations, the author’s experience has shown that the complexity of the work tends to correlate to the size of the organization involved, so smaller organizations should find it manageable using their relatively limited resources.

1 REPLACE COMPENSATION FORMULA VARIABLES TIED TO BENCHMARKS

The goal is to replace the general formula from the start of this article with the following formula:

$$\begin{array}{c}
 \text{Clinical compensation} \\
 = \\
 \text{(A fixed \$XX per wRVU for a given specialty,} \\
 \text{specific to a given organization)} \\
 \times \\
 \text{(Physician's personally performed wRVUs)} \\
 + \\
 \text{(Compensation for meeting specified} \\
 \text{clinical quality targets)}
 \end{array}$$

Though this model is straightforward, identifying and justifying the “right” number takes some work. Organizations should invest time and resources in a careful four-step process, led by executives responsible for physician services.

- STEP 1 Identify and analyze every aspect of physicians’ work and pay.** The organization must first collect all relevant data, documents and other information from throughout the organization. This may involve the following areas:
- Legal (e.g., written agreements between the organization and physicians)
 - Human resources (e.g., payroll data for employed physicians)
 - Accounts payable (e.g., payments to independent contractor physicians)
 - Revenue cycle (e.g., volume and revenue for physicians’ billable clinical services)
 - Compliance (e.g., timesheets for physicians’ administrative services, if applicable)
 - Operations (e.g., schedules and burden for physicians’ call coverage services, if applicable)

Proposed formula for clinical compensation



Gathering insights from physician and non-physician administrators helps the organization understand the whole story and resolve questions and “blind spots” regarding what physicians do and/or how they are paid. For example, these discussions could reveal important information at a level of detail rarely described in contractual agreements, such as the specific types of work a surgeon does on an inpatient and outpatient basis and while on call.

Taking time to gather and deeply understand this information allows the organization to present a revised compensation model that accomplishes three purposes:

- Assures physicians that the organization has considered the full value of their services
- Responds to any objections they might have
- Anticipates how changes to the compensation model will impact physicians’ pay in various scenarios (as discussed further below)

STEP 2 Determine what can and what should be paid. Some organizations have internal policies or guidelines on what can be paid for physician services. Others consult a healthcare valuation expert to determine the fair market value (FMV) of services provided, to ensure compliance with applicable laws and regulations.

In either case, the outcome will be a ceiling for what can be paid, which may then be adjusted downward to account for factors specific to the organization, such as its financial situation within the physicians’ specialty, historical compensation to the physicians and internal equity. For example, while the FMV of the clinical services provided by internists may be \$55 per wRVU, relatively low reimbursement and/or relatively high overhead may keep the organization from paying that full rate.

At this point, the organization has a clear understanding of:

- What the physicians’ overall compensation *should be*
- What the physicians are doing to earn that compensation

The shortfalls of publicly available survey reports: What they are and what they are not

Publicly available survey reports are generally the best resource we have for understanding the market for physician services, but they are not perfect. Each report typically contains a lengthy introduction regarding how and from whom the information was gathered, and the limitations of the data. It is all too easy to skip over these pages and move directly to the data tables.

At a minimum, it is important to understand that:

- Survey reports are based on a voluntary response and are not necessarily representative of the relevant market
- Data are self-reported, and different respondents may interpret the same survey question differently
- The reports are backward-looking (i.e., reports released in mid-2021 will discuss compensation paid in 2020)
- The organizations doing the surveying can perform only so much quality assurance on the data

Accordingly, it is best not to use survey reports alone in setting compensation, but as one input alongside others.

- How that compensation is broken down into various forms (e.g., biweekly base salary, annual incentive payments, hourly administrative rates, daily call stipends, etc.)

STEP 3 Back into an appropriate compensation per wRVU factor. While it is tempting for an organization to simply set a payment rate at or below a national median compensation per wRVU benchmark derived from multiple market

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survey data reports, the organization’s circumstances may pose an obstacle to this approach. For example:

- Non-cash benefits (e.g., paid time off, continuing medical education, retirement plans) may be relatively “rich.”
- Recruitment incentives (e.g., signing bonuses, moving allowances, loan repayment) or clinical quality incentives may be substantial.
- The physicians may be unusually productive.
- Payments for call coverage, physician administrative or other non-clinical services may be above the FMV of those services.
- The organization may be located in a market where physicians are paid considerably below national rates for their services.

In such circumstances, the payment rate per wRVU would need to be adjusted downward to ensure total remuneration to the physicians is reasonable for the totality of their services. Likewise, the payment rate per wRVU could be adjusted upward if, say, the benefits were relatively “lean” or payments for non-clinical services were relatively low. Ultimately, the payment rate needs to be set correctly to ensure that the overall compensation model stays in balance.

STEP 4 Simulate and adjust the model. The importance of simulating and adjusting the compensation model cannot be overstated. After completing the previous steps, the organization should have all the necessary information to

perform this step. For example, if the organization was updating the compensation model at the beginning of 2021, it might use the following data from 2020:

- Actual full-time equivalency (FTE) status, wRVUs, call coverage shifts, medical director hours, quality scores and any other factors that drive compensation in either the current or proposed compensation models
- Actual total compensation under the current model

Comparing actual total compensation from 2020 under the current model with the expected total compensation under the proposed model for each physician, changing nothing but the model, helps leaders understand and explain the impact of the change on each physician.

At this time, the organization should also perform a scenario analysis to understand how elements such as higher or lower productivity, or more or less paid call, impact the proposed model. These simulations allow organizations to anticipate potential issues and adjust as needed.

2 IMPLEMENT A THOUGHTFUL, TRANSPARENT PHYSICIAN COMPENSATION OVERSIGHT PROCESS

Creating a compensation oversight process that physicians trust is a best practice and can be a critical success factor when an organization moves away from relying solely on publicly available survey reports.

The form of the process and the extent to which physicians are involved will vary. However, an effective process encompasses two key aspects.

Evaluation of the physician compensation model on a regular basis. The model should be evaluated every two or three years to determine whether changes are needed. This evaluation should account for various inevitable changes in factors, including:

- Trends in wRVU production, quality scores or any other factors that drive compensation

28.6%

Percentage of physicians in 2018 for whom more than half of their compensation was based on their personal productivity

Source: American Medical Association, 2020

Compensation policies should be simple enough that any provider can immediately say what is expected of them, how they are paid and what they could do to earn more.



- How the financial situation within a specialty (e.g., payer mix, payer contracts, overhead expenses) may have changed
- Equitable pay among similar physicians
- Market data gathered during recruitment and exit interviews
- Trends in applicable metrics from multiple relevant survey reports

Clear and timely communication to affected physicians about the results of the review.

Physicians should be fully informed about what the review process entailed, what changes are being made and why.^f Physician satisfaction tends to be higher when physicians feel that someone is looking out for them, even when that someone must deliver bad news.

3 REMOVE PAYMENT FORMULAS FROM PHYSICIAN CONTRACTS

Including the finer points of the physician compensation model within a physician's contractual agreement is potentially problematic for two reasons:

- Organizations must amend the agreement every time they need to make even minor changes to the compensation model, which can be an administrative headache.
- The physician may think they can negotiate the compensation model, which is often not the case (as doing so would be inequitable).

The best practice in this area is to reference a standard compensation policy for a given physician's specialty and to attach the current policy, which is subject to change. Compensation policies should be simple enough that any provider can immediately say what is expected of them, how they are paid and what they could do to earn more. Of course, each organization should consult its legal and compliance departments on the right approach.

BRINGING IT ALL TOGETHER

Physician compensation models tied directly to survey reports have become pervasive, due to their perceived benefits. This situation may create hesitation in organizations around moving away from reliance on surveys out of a fear they are moving away from the market.

In truth, taking a more tailored approach can help them create a more grounded, sustainable compensation model that reflects their specific needs, with less risk to their financial standing and the quality of their relationships with physicians. This process helps position organizations for success in uncertain times — an outcome that is well worth the investment. ■

About the author

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f. This regular review also provides a good opportunity to study whether the model itself should be changed to rely less on productivity and more on other factors, such as clinical quality.



EXPERT REVIEWED

Physicians and finance: Managing the differences is critical to building clinical value

For finance and clinical leaders to work together effectively, they must not only understand but also acknowledge the benefits to be gained from their different perspectives on what constitutes success.



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A basic premise of value-based care is that success depends on both physicians and finance leaders bringing their critical skills to the table. To control costs while improving patient outcomes, these leaders must work together to build efficient and effective systems of care.

Unfortunately, this collaboration often must contend with a fundamental point of tension within healthcare: *mission versus margin*. Although both physicians and finance leaders ultimately share the same objective, they have very different approaches for achieving it. Chief medical officers (CMOs) drive clinical performance to optimize patient outcomes. CFOs drive financial performance to optimize business sustainability.

Many healthcare leaders see this difference as a negative because it can lead to confrontation and often ends in frustration. To avoid these problems, they seek to remove the tension by sidestepping controversies and difficult conversations. This is a mistake. Seeking to avoid discussions of differences is tantamount to not respecting them. It ignores the important premise that a healthy level of tension is essential to high performance in any organization.

Thus, we contend that success under value-based care depends on physician and finance leaders' ability to manage their differences effectively with a clear understanding of why

organizational tension can be a positive. We propose that physician-finance teams who work together with a full recognition of their differences are best able to control costs, improve clinical outcomes and deliver the greatest value for patients. (See the online sidebar, “The upside of tension,” for additional perspectives on the importance of balancing tensions, as reflected across various industries.)

**UNDERSTANDING THE DIFFERENCES:
2 CASE EXAMPLES**

The following two scenarios illustrate how embracing clinical-financial differences can propel a healthcare organization to delivering greater value.

Scenario No. 1: Learn how to manage differences around cost. Consider that a hospital enters a bundled payment contract for pneumonia, where a key to success is in controlling the cost of inpatient stays for covered patients. The goal is to reduce excess inpatient costs for this population while maintaining or improving patient outcomes.

Note that inherent to this goal is a built-in tension between *reducing cost* versus *improving care*. Clinical and financial leaders can choose to avoid the tension, or they can decide to manage it.

Avoiding the tension could mean that physicians refuse to consider that their practice patterns might produce unnecessary costs. It could also mean that finance leaders take a “hands-off” approach to anything that touches on patient care. For teams that choose to *manage* their differences, the first step is to understand what each group wants from the other.

In general, finance leaders want physicians to engage fully with cost-of-care issues. In turn, physicians want the finance department to provide them with cost information that is simple, understandable, actionable and relevant to their practice.

An all-too-common challenge for finance in this scenario is the lack of access to advanced decision-support capabilities for managing costs, leaving finance leaders without effective cost accounting systems at the labor, supply and physician resource level. Meanwhile, physicians need to see that cost data reflects patient acuity, exacerbating this challenge.

One possible solution is to build finance-physician communication around Medicare-severity diagnosis-related groups (MS-DRGs).

In the pneumonia bundled payment scenario, finance leaders could develop customized reports on MS-DRG 193 (simple pneumonia and pleurisy with MCC). For example, a report can be broken

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MS-DRG 193: Inpatient pneumonia cost and profitability by physician

Physician	Cases	Per case average (mean)							
		ALOS	Case mix index	Total charge	Actual payment	Variable cost	Contribution margin	Fixed cost	Net income
Green	10	4.80	1.1291	\$27,050	\$8,512	\$3,076	\$5,436	\$3,487	\$1,949
Black	7	4.00	0.7054	\$17,779	\$1,404	\$2,618	(\$1,214)	\$2,896	(\$4,110)
Rose	6	5.17	1.1291	\$28,205	\$10,785	\$3,410	\$7,375	\$3,535	\$3,840
White	5	2.40	0.7054	\$11,428	\$2,248	\$2,136	\$112	\$2,624	(\$2,513)
Brown	5	7.40	1.1291	\$30,042	\$5,431	\$4,165	\$1,266	\$4,207	(\$2,941)
Grey	5	7.40	1.1291	\$25,596	\$5,417	\$3,865	\$1,552	\$3,796	(\$2,245)
Gold	4	5.25	1.1291	\$27,154	\$9,862	\$3,306	\$6,556	\$4,017	\$2,539
Average	6	5.20	1.0080	\$23,893	\$6,237	\$3,225	\$3,012	\$3,509	(\$497)

Source: Lumina Health Partners, 2021

Troubleshooting physician-finance dynamics

Managing physician-finance differences is more of an art than a science. Here are some practical strategies for managing the inevitable obstacles to effective collaboration.

PROBLEM Bedside clinicians express interest in being involved in financial processes, but they do not attend meetings set up to discuss financial inputs and outputs.

SOLUTION Work through department leaders to engage rank-and-file physicians. For example, the chief of surgery could be enlisted to act as an intermediary in an initiative to control surgical supply costs to credibly emphasize for physicians the value of standardizing supplies and other expenses. Members of the surgical staff are more likely to pay attention to a respected clinical leader on these issues, especially if the leader can meaningfully convey the initiative's positive impact on patients. One caveat: Providing the leadership intermediary with data that links cost to quality is imperative.

PROBLEM Finance leaders have created forums for discussion with clinical leaders, but trust between the two groups is not increasing.

SOLUTION Many finance leaders expect to manage physician discussions through large meetings

with dozens of participants. However, large-meeting dynamics do not facilitate trust and often undermine it. Finance leaders should have more one-on-one discussions with physician leaders. Small meetings give physicians a greater incentive to show up and more scope to participate. Make sure there is real information sharing and time to allow physician input. This approach enables a true back-and-forth discussion, facilitating the decision to trust and laying the foundation for transparency.

PROBLEM Finance and clinical leaders agree on shared goals, but work toward these goals often fails to gain traction.

SOLUTION When progress stalls, it is often because finance leaders have not selected their physician partners carefully enough or have failed to prepare them to engage in financial initiatives.

For example, finance might avoid working with the challenging personalities within the medical staff. The problem is that these personalities often hold the key to making things happen. A better approach would be to identify the key players in the medical staff and *strongly* engage them in clinical-finance initiatives.

Conversely, finance sometimes avoids working with junior physicians — the idea is that only seasoned physician leaders can sway the organization. Unfortunately, this approach can

alienate the medical staff. From the point of view of bedside physicians, senior leaders issue “dictates” that add to their workload and do not reflect the realities of the current practice environment.

A better approach in this case would be to selectively recruit junior physicians to participate in shared clinical-finance projects.

At the same time, however, it is important to make sure all physician partners are adequately equipped to lead complex clinical-finance initiatives. Often, the perfect growth opportunity for an up-and-coming physician leader turns into a trial by fire that few can survive. The resulting failure demotivates other physicians and jeopardizes future attempts to build clinical value.

The finance department can, instead, help cultivate clinical leaders by setting up small workshops for physicians who are interested in financial policies and practices. Senior physician leaders can also play a role by mentoring younger physicians about healthcare business and finance issues. Ultimately, executives should develop a plan for aligning both finance and physician leaders with value-based strategy. The plan should be based on identified knowledge gaps within the leadership team, and it should include training in communication, change management and proven techniques for solving real-world challenges in value-based care.

down by admitting physician, and include data on length of stay (LOS), charges, payment and costs (see the exhibit on the previous page).

While this report relates directly to profitability by physician within an MS-DRG, other physician reports can include readmission numbers, discharge placement data or any other

clinical/quality information included in standard electronic health records (EHR) datasets, which are usually extensive.

The value of this approach is that the cost data is already severity-adjusted and normalized within the MS-DRG. Discussions between financial leaders and clinicians should focus on direct

variable costs, the major part of inpatient costs that physicians can control. Being provided with this information empowers physicians to work with their peers to examine utilization of supplies, tests and inpatient days. The physicians will see that lower costs often correlate with the same or better patient outcomes.

Finance can help focus this work by examining goals in terms of various cost targets. For example, looking at the MS-DRG 193 exhibit on page 35, consider what would happen if four of the seven physicians in this group achieved a direct variable cost per case equal to the *mean* of their peers? What if they were able to lower costs to the peer *best practice* level?

An academic medical center in the Midwest used this strategy to reduce costs on its joint replacement service line. The finance department developed a MS-DRG 470 report that drilled down on contribution margin at the patient level. The report showed a clear threshold where decreasing LOS flipped margins from negative to positive. Subsequently, surgeon efforts to reduce LOS led to a significantly improved profitability.

This same approach can also be used in other initiatives that depend on finance-physician collaboration, such as efforts to better allocate labor resources, standard supplies, adopt less costly supply alternatives and reduce clinical variation.

Scenario No. 2: Learn how to manage differences around clinical improvement. Consider in this case that clinical leaders have developed a strategy for improving care for patients with congestive heart failure (CHF). The strategy includes a behavioral intervention to address patients' personal barriers to medication compliance. The shared goal for clinical and financial leaders is to understand how to fund and operationalize an effective program. But again, each group brings different perspectives to the table, which leaders could choose to avoid or manage.

For finance leaders, *avoiding* these differences might involve accepting ROI as the only factor for approving or denying the program. Or physician leaders might disregard these differences by

refusing to engage with the budget implications of their proposal.

But what could they do, instead, to *manage* these differences? They could come together for a robust discussion around patient and organizational benefits.

Again, the first step is to understand what each group wants from the other. Broadly, physicians want finance to understand the value proposition in terms of patient benefit. In turn, finance leaders want physicians to understand the budget trade-offs involved and be ready to make difficult decisions.

With the proposed CHF program, therefore, an effective strategy might be for the leaders to work together to develop a business plan for the program that includes both clinical and financial measures of performance. For example, program metrics might include the following metrics:

Clinical outcome metrics

- Readmission rates at 30, 60 and 90 days
- Infection rates
- Complication rates
- Mortality rates
- Rates of unplanned returns to the emergency department or operating room
- Documentation of echocardiogram, stage or classification
- Patient survey ratings and quality-of-life measures (if available)
- Other relevant clinical metrics reported on the Medicare Care Compare website

Financial performance metrics

- Number of admissions per year
- Cost per case
- LOS
- Medicare spending per beneficiary
- Contribution margin (patient net revenue less direct and variable expenses)
- Net margin (patient net revenues less all operation expenses)

A strong business plan with such well-defined success metrics offers several advantages:

77%

Percentage of healthcare leaders responding to a 2019 survey who said their organizations use a physician-administrator dyad leadership model

Source: Comstock, N.H., "Better together: Most healthcare leaders report using a dyad leadership model," *MGMA Stat*, Oct. 31, 2019

- Even if the leadership group determines that the program will lose money, they will be able to quantify anticipated losses and expected patient benefits.
- Leaders will be able to compare the value of the proposed program with that of other care initiatives under consideration.
- If they proceed with the CHF program, the performance measures will help establish accountabilities for program performance.

When assessing such program proposals, it also is important to be mindful of differences in how leaders view the timing required for success. Finance leaders sometimes think of ROI in terms of the hospitalization period, while physicians may be looking at costs and benefits over a much longer time frame.

A FOCUS ON INNOVATION

The same approach as described above for a clinical improvement initiative can be applied to healthcare innovation in general. In the current environment, hospitals must embrace innovation to move forward. Yet some finance leaders struggle with the risk posed by new technologies and new delivery models.

One solution is to establish an annual budget for investing in the most promising proposals. Another is to develop a model for calculating innovation risk, including elements such as the following:

- Cost of implementation
- Potential financial upside
- Risk of failure
- Potential for success

An innovation risk model would be subjective, but at least it would allow physician-finance leadership teams to weigh investment alternatives in a sensible fashion.

Such an approach can be used in discussions of capital spending. In these discussions, finance leaders want physicians not only to identify the capital items that are truly necessary for providing state-of-the-art care, but also to recognize that financial resources are limited.

Physicians, in turn, want a clear understanding of the hospital's margin. Some physicians tend to focus on the hospital's gross revenue, which is a misleading number because it does not relate to cash inflows. The question then becomes, "Why can't this \$3 billion enterprise spare \$30,000 or \$300,000 or \$3 million for my program?"

The solution is to share key information about hospital margin and profitability. Core concepts for physician education include contribution margin and net margin, and making sure clinical leaders understand what profitability really means and whether profit covers recapitalization and other costs. Physicians should receive training on these concepts, so they understand the hospital's total capacity to invest in capital spending opportunities.

One caution: If finance leaders decide to share margin data, they should do so consistently. Physicians are likely to become cynical if a hospital shares this information only when margins are thin, and then buries the profitability data when business is up.

PARTNER FOR VALUE

Overcoming the obstacles to collaboration is a challenge for both clinicians and finance professionals. However, simply trying to side-step the obstacles is to miss an important opportunity. Finance leaders and physicians who learn how to manage their differences can create powerful management teams. These dynamic teams are essential to controlling costs, improving patient outcomes and delivering greater value for patients. ■

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90% of peer reviewers agree they would recommend the service to a colleague.

to first diagnose the root cause of poor revenue cycle performance and then make professional recommendations for improvement which could be any combination of people, process or product improvements.

What advice would you offer to healthcare leaders when choosing among vendors?

First and foremost, the vendor should have a proven track of improving the exact problem or challenge. Second, the vendor should offer a shared risk contract that ties performance to payment. Third, relationships matter, so the vendor should operate as an extension of your operation.

What is some advice you can give providers for a successful implementation of a new product or service?

First, document the exact metrics or key performance indicators that need

“The ability for the TruBridge RCM software to catch billing errors before the claim goes out the door is simply phenomenal, and the result is we are receiving payment in a record time frame for us. We generated \$2 million in additional cash.”

—Tiffany Huston, director of Patient Financial Services at Door County Medical Center

to improve prior to contract signing, and tie vendor contract terms to improving those specific metrics. Second, build your implementation around the metrics. Third, assign and empower an internal leader that can hold both parties accountable to achieve the goals set forth in the implementation plan. ■



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Pilot and Trinity Health COO Ben Carter offers leadership lessons for **turbulent times**



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As a pilot and flight instructor with 2,300 hours of flight time, Ben Carter is prepared for the unexpected.

“When you’re flying, you always have a forecast,” Carter said. “But when your actual conditions are different from the forecast, you have to adjust your flight plan.”

That was certainly the case when Carter moved from CFO to COO for Trinity Health in Livonia, Michigan, on Jan. 1, 2020 — just as the world was learning about a cluster of patients with “viral pneumonia of unknown cause” in Wuhan, China. Soon after, COVID-19 patients started appearing in the U.S., including in Trinity Health’s 92 hospitals in 22 states.

During the past 18 months, Carter, FHFMA, CPA, and his operations team have weathered the impact of three COVID-19 surges. This includes having 40% of the system’s revenue disappear when governors around the country temporarily halted non-emergent care during the first surge. In this most recent surge, Carter said the main challenge has been clinical staffing because of the national nursing shortage.

CHARTING THE PATH TO COO

Prior to becoming COO, Carter had served as executive vice president and CFO of Trinity Health since 2010. He said being an “operationally minded CFO” helped him make a smooth transition to the COO role, even in the midst of the pandemic.

Carter held numerous finance and nonfinance roles at organizations like Oakwood Health

System and Detroit Medical Center (DMC) before joining Trinity Health, which has \$19 billion net revenue. At both Oakwood and DMC, he helped lead financial turnarounds and strategic merger and acquisition deals. He also partnered with his COOs and volunteered to take on assignments to develop his operational acumen. That broad experience helped him move beyond reporting financial news to being a “newsmaker,” which he believes is critical for all operational leaders.

As soon as Carter moved from CFO to COO at Trinity Health, he brought all of the local hospital CEOs and his other direct reports together to determine the best way to manage the change ahead.

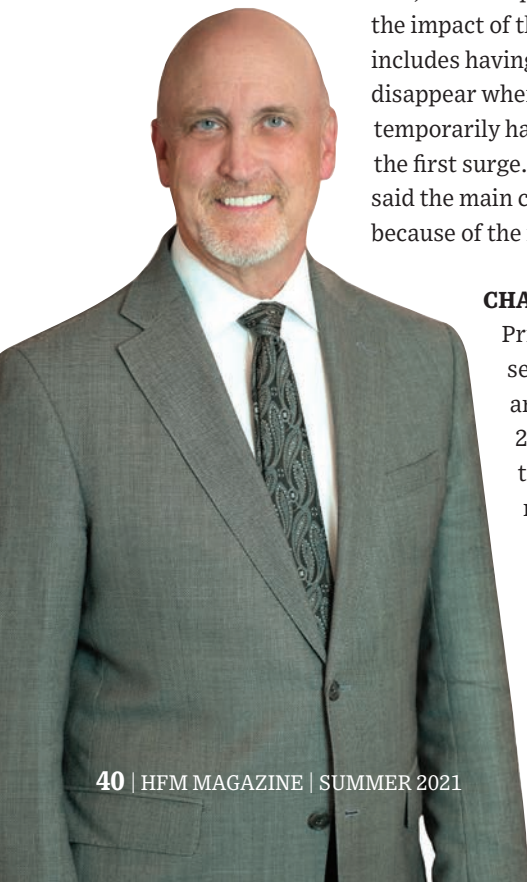
“They learned about how best to work with me, and I learned about how best to work with them, including how to support them,” Carter said. Establishing this process just before the pandemic helped him manage and communicate with his team more effectively during the crisis.

“Particularly in a crisis, you need to be clear about your expectations of all of those people who are in your chain of command, Carter said.”

During the chaotic first surge, Carter and his team had to make quick decisions. “We bought 1,000 beds. We bought 2,000 ventilators,” he said. “I was making \$25-million, \$50-million purchasing decisions on the spot.”

Carter said his financial acumen prepared him to consider the implications of those decisions, such as whether the system could potentially resell new ventilators that were no longer being used.

As COVID-19 affected regions differently and at different times, Carter used situational leadership to adjust his style to the conditions at hand. “It’s a skill of knowing when to be hard





Ben Carter said flying planes like this Piper Navajo Chieftain has taught him how to stay calm when conditions change in the sky or on the ground. (Submitted photo)

and heavy, knowing when to be light, knowing when to push harder and knowing when to let your foot up,” he said.

LESSONS FOR LEADING DURING UNCERTAINTY

Carter offers some additional advice to financial and operational leaders on guiding their teams through times of change.

Keep an eye on both “business engines.” When pilots fly twin-engine planes, they have to monitor the dials gauging the performance of both engines. In recent months, healthcare leaders have been in a similar situation as they try to manage their COVID and non-COVID businesses. Leaders can work with their teams to ensure they are focused on both priorities.

Exude a sense a calm. “Being a pilot teaches you to not over-react to anything, because when you do, your field of vision tends to narrow,” Carter said. “You want to keep a full field of vision so that you’re considering all possibilities.”

Sometimes, a pilot will lose an engine during a flight. For these situations, Carter teaches his flight students to calm themselves by adjusting their clocks first and then running through their checklist. “It’s a way to bring calm to yourself, so then you can turn back to the matter at hand,” he said.

Help your team weather the storm by building resilience.

Leaders should aim to establish hope, trust, compassion and stability if they want to help their teams sustain the energy they need to work through stressful times. Open, transparent communication can help establish the foundation for these four elements, Carter said.

Stay focused on the horizon. As his organization begins FY22 on July 1, Carter believes healthcare leaders will ease out of crisis mode and be able to focus more on operations and performance metrics that were disrupted by the pandemic. “Those are the engine dials that we would normally focus on,” he said. “We’re going to go back to a number of strategic initiatives that we have going forward, which is a combination of entering new markets and new service lines and focusing more on digital health.” ■

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Why success in cost reduction is a matter of trust

Achieving and sustaining healthcare cost savings depends on trusted data and clinician engagement, but some organizations struggle to find the right mix.

The financial punch of the pandemic continues to depress hospital margins, demanding that healthcare organizations tighten their focus on cost reduction this year. But hospital leaders say they face internal barriers to cost reduction – and it's holding them back from cost saving success.

Sixty-three percent of respondents to an HFMA/Craneware survey say their biggest barriers to achieving cost savings are physician resistance to change and lack of visibility into actionable data. Yet just 31% of organizations always involve clinicians in these discussions. Further, more than half are seeking to improve their cost analytics solution.

"Healthcare leaders can't tackle cost reduction without support from clinicians, and they can't engage clinicians unless they provide data that clinicians trust," said Pietro Ferrara, senior vice president, Craneware. "To move the needle on cost reduction, leaders must seek ways to more actively engage clinicians in discussions around cost. They also must strengthen their ability to help clinicians visualize cost-savings opportunities and understand the action steps needed for improvement."

Deepening relationships and data insight

The survey found that organizations that more frequently engage clinicians in discussions around cost reduction are better prepared to achieve their cost-reduction goals.

"Clinical and financial collaboration is one of the conduits to cost-savings success," said Richard Gundling, senior vice president

for HFMA. "When leaders take the time to obtain clinician input regarding savings opportunities, they come away from these discussions with a better understanding of why cost variance exists. They also build connections with clinicians that heighten engagement and lead to longer-term success."

For example, consider a hospital where two physicians performing heart valve replacements at a large hospital achieve nearly the same margin per case. However, a deeper dive into the data reveals that Physician A's patients have ICU stays that are 26 hours longer, on average. Meanwhile, Physician B uses more expensive drugs to treat heart-valve patients.

"While the math shows a similar overall margin per case, having a costing solution that adopts an activity-based costing methodology tells a different story," Ferrara said.

At this hospital, leaders shared the analysis with the physicians, who were not aware that such differences existed. Physician A was targeted to reduce ICU time by 50% with small modifications. Meanwhile, Physician B learned that his colleagues used other brand-name drugs that were less expensive yet achieved similar outcomes.

"The hospital saved nearly half a million dollars with this process improvement project," Ferrara said. "So many times, clinicians do not have access to this level of actionable information. It would have been easy for the hospital to look at margin alone. By using an activity-based costing system to examine where variances existed, leaders were able to share insights and data that the physicians trusted, and it led to decreased costs and better care."

Eighty percent of survey respondents agree that cost reduction should be a strong focus for their organization this year, with nearly 58% saying they are equally focused on cost reduction and revenue enhancement (exhibit not shown).

However, one-in-three respondents say they are not well-prepared to achieve cost-reduction goals.

Further, 56% plan to make changes to their cost accounting solution within the next year, another indication that leaders aren't satisfied with the degree of insight they currently receive. (See the exhibit on the next page.)

These deficiencies – combined with the low percentage of organizations that always involve clinicians in cost-savings discussions – put organizations' efforts to reduce expenses and bolster their bottom line at risk.

"Healthcare has been very late to the game in involving those who are directly involved in operations – from physicians to nurses to technicians – in expense reduction," said Neal Peterson, CRCR, sales executive, Craneware. "In other industries, like manufacturing and the automotive industry, it's intuitive to approach people on the production line to uncover opportunities to reduce costs."

For cost reduction to happen at the resource level, clinicians need data they can relate to and trust – for example, clinical operational data rather than revenue cycle data. The data also should enable physicians to make comparisons to their peers, internally and externally.

The move toward activity-based costing

More and more, healthcare organizations are finding that traditional methods for making cost-cutting decisions, such as ratio of costs to charges (RCC) or relative value units (RVUs), do not provide the level of accuracy they need.

"RCCs can lead a hospital to believe a service isn't profitable when it actually is," said Naveed Ismail, vice president, customer management, Craneware. "The data also aren't meaningful to clinicians, as they don't reflect all of the activities involved in caring for a patient, providing a less-than-complete picture of a clinical event."

Instead, activity-based costing, which captures each service in the patient journey, provides a more accurate picture of resource consumption. It uses clinical, financial and operational data to capture costs at the individual encounter level.

However, even among organizations that have begun to use activity-based costing, some still show room for improvement.

“We spoke with one health system that incorporates some elements of activity-based costing, but staff perform them manually – and it takes them weeks to gather the information and analyze the data,” Peterson said. “If you have an application that can support you in that effort, you can produce more results and more actionable information, which is key to gaining clinicians’ trust.”

Ferrara likens the difference between costing approaches as the difference between doughnuts and croissants. “Finance professionals have been selling doughnuts to the C-suite for a long time, but in a post-pandemic world, doughnuts no longer make the cut,” he said. “Moving from RCCs to activity-based costing is like going from doughnuts to croissants: It’s a dramatic switch, but it is more effective, and it provides the clinical operational data that physicians and clinicians seek.”

But gaining the most from an activity-based costing solution requires that health systems have access to data analysts who are experienced in marrying financial, clinical and operational data to capture a

holistic view. They must also be committed to engaging clinicians in discussions around profitability, rather than asking clinical leaders to make blanket cuts, such as across-the-board expense reductions of a certain percentage.

Restoring trust for a better bottom line

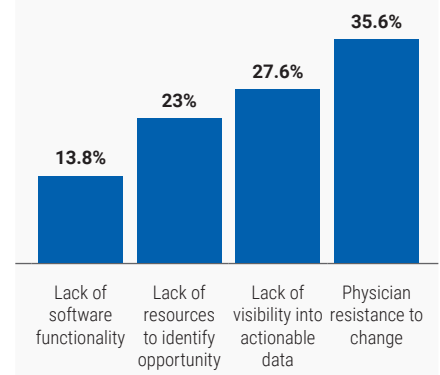
How can healthcare finance leaders best engage clinicians in cost-cutting initiatives? Following are three approaches to consider.

Determine whether you have the staff expertise to deploy an automated solution effectively. Most organizations do not have the bandwidth to stand up an activity-based costing tool on their own. In purchasing an activity-based costing solution, leaders should look for a tool that is easy to implement and light on infrastructure requirements, such as cloud-based solutions that can refresh data quickly. They should also partner with a vendor that can teach them how to use this tool well. Without this education, organizations will struggle to make the most of their investment.

Prioritize which areas to measure. Activity-based costing is resource-intensive, and organizations might not have the data analytics support to examine all areas at once. Determine which service lines present the highest areas of concern related to resource consumption and variation in care. Then, assemble a team of clinicians who can help you dig deeper into the data, uncovering

Healthcare leaders identify biggest barriers to cost-savings success

When thinking about your cost reduction strategy, what is your organization’s single biggest barrier to success?



nuances in care that can add expense without significant improvements in quality.

Meet with clinicians in these areas regularly. Once you’ve determined your top areas of focus, meet with clinicians at least once every two weeks to discuss the data and examine where opportunities for cost improvement exist. This keeps the group’s efforts top of mind, helping to ensure that clinicians are invested in the project. It also builds trust between finance and clinicians and buy in around the data itself. When the data view presented accurately reflects the patient journey, finance and clinicians will be better positioned to not only reduce cost, but also improve value. ■



Craneware (AIM: CRW.L), the leader in automated value cycle solutions, collaborates with all U.S. healthcare providers to plan, execute and monitor financial and operational performance so they can continue to drive better outcomes for the communities they serve. Craneware’s Trisus platform combines revenue integrity, cost management and decision enablement into a single SaaS-based platform. Our flagship solution, Chargemaster Toolkit®, continually earns KLAS recognition in the Revenue Cycle – Chargemaster Management category and is part of our value cycle management suite, which includes charge capture, strategic pricing, claims analytics, patient engagement, revenue recovery and retention, and cost and margin intelligence solutions. Learn more at craneware.com

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columns

LEADERSHIP INTEGRATION PHYSICIAN PERSPECTIVE PEOPLE FROM THE PRESIDENT

Think beyond ‘compliance’: Why leaders should work to implement a **culture of ethics**

By linking rules and regulations to principles and purpose, organizations can gain the trust of their employees and the public and establish a reputation for integrity.



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Do you have questions or topics you'd like Jill to address in a future article? Email **Nick Hut**, HFMA senior editor, at nhut@hfma.org.

To work in an ethical culture is to show up each day knowing that from the very top of the organization on down, there is a shared understanding of what *doing the right thing* means.

But it's not about just memorizing rules or having a clear set of standards. It's not even about having a code of conduct. All of those are very important, but alone, they represent a culture of compliance.

In a compliance culture, people know the rules of the road and the consequences of breaking them. But compliance cultures generally are focused on regulations, restrictions and legal definitions of *right* and *wrong*.

The best ethical cultures do more than enforce awareness of and obedience to rules. They view rules and codes as starting points but aim higher. They connect ethical conduct to their guiding principles and purpose as an organization.

GOING BEYOND COMPLIANCE

One of my favorite writers on business ethics, Harvard's Lynn S. Paine, differentiates between cultures of compliance and cultures of integrity,

and has written about why integrity is far more meaningful:^a

From the perspective of integrity, the task of ethics management is to define and give life to an organization's guiding values, to create an environment that supports ethically sound behavior, and to instill a sense of shared accountability among employees. The need to obey the law is viewed as a positive aspect of organizational life, rather than an unwelcome constraint imposed by external authorities.

In the integrity approach, mission, purpose and values are drivers of the organization's ethical compass. And believe me, we need a navigational tool, because many ethical decisions aren't as clear-cut as "Don't lie, cheat or steal." For example:

- Acting swiftly versus acting deliberately
- Promoting transparency versus protecting personal privacy
- Protecting the bottom line versus donating to the community
- Thinking about short-term success versus focusing on long-term sustainability

a. Paine, L.S., "Managing for organizational integrity," *Harvard Business Review*, March-April 1994.

2 examples of how to use ethics to guide difficult organizational decisions

Here are two real-life scenarios that show how an ethical culture can help organizations deal with challenging situations.

1 The pandemic caused many businesses to pivot to remote or hybrid work environments. They couldn't apply rules that were made for a pre-COVID-19 world. They had to consider the safety of their employees and of those whom they served.

CDC guidance was helpful but not all-encompassing. For instance, employers had to rely on their core values to decide how to support employees who were struggling with home pressures — or illness or grief — while still keeping the business running smoothly and as profitably as possible.

2 When organizations have policies that come under public scrutiny, how do they respond? It happened to FedEx in April, when its no-cell-phones-while-on-duty rule was questioned after the mass killing at its Indianapolis plant.

In such a situation, does the organization weigh the competing

values as it determines whether to change or continue the policy? FedEx is reportedly keeping the policy and has explained what it believes to be the important safety values involved.^a Other safety- and productivity-minded companies have considered the issue and shared their decisions.

This openness addresses ethicist Sissela Bok's "test of publicity": Could your decision withstand the scrutiny if it were made public for everyone, especially those affected by it, to see?

^a Tuohy, J., "FedEx has no plans to rescind cellphone policy after Indianapolis shooting. Here's why," *Indianapolis Star*, April 18, 2021.

THE ROLE OF LEADERS

Whether issues involve personnel, policy or the response to scandal, tragedy or breaking news, leaders should model the values of the organization in their actions.

The best leaders respect the laws that govern their industry, but they know that laws don't require empathy. Or apologies. Or changing things that are perfectly legal but perfectly wrong, like workloads that burn people out or supervisors who are relentlessly negative or disorganized.

Employees may bristle when they're told about codes, rules and regulations and then asked to sign statements documenting that they've been briefed. They may feel that the real goal isn't a values-driven organization, just one that protects the company from harm and allows the organization to blame the staff, not the leadership, if things go wrong.

When people at the top of the organization embed values and purpose in their everyday conversations and decisions, the codes and rules become part of a bigger infrastructure of integrity, rather than just tools of compliance.

REAPING THE GAINS

Creating and sustaining a strong ethical culture may seem daunting, especially if you feel you lack sufficient education in ethical decision-making, but you can do it. If you need help, there's a great free resource from the Markkula Center for Applied Ethics at Santa Clara University (full disclosure: I serve on one of the center's volunteer advisory boards).^b

A healthy culture of ethics and integrity pays benefits. Those you serve have greater confidence in your trustworthiness. Your staff members aren't just proud of their standards but also can articulate and act on them.

To this day, I remember what one of my staff members told me after he'd been faced with a tough ethical decision in the field that had to be made in a split second. "I just thought about our values," he said. "Then I knew just what to do." ■

^b "A framework for ethical decision making," Markkula Center for Applied Ethics, Aug. 1, 2015.

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Integrated delivery systems are due for a self-assessment

Given the waves of change that have swept over healthcare in recent years, it's time to step back and think again about integration — and how to maximize its impact and optimize care.



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It's been more than 30 years since physician groups, hospitals and many health plans began forming integrated delivery systems (IDSs). For some (e.g., Kaiser Permanente and Geisinger), it has been longer.^a There have been many course adjustments and refinements along the way.

Dean Coddington, Beth Fischer and I wrote our first book describing 10 IDSs, their accomplishments and their differences in 1994. Since then, we and others have worked with, written about and helped shape today's IDSs.

With three decades of change behind them, including one year of unprecedented turmoil, it's time for IDSs to take a new look at themselves. And each IDS should start by tailoring the assessment questions to reflect the factors that differentiate it from other IDSs.

Consider those differences. IDSs answer to different interested parties from market to market. Some are actually “systems of systems.” Some serve a range of populations and communities with specific problems and opportunities. They may be academic or community health systems serving large or small markets with regional or rural boards, with private,

a. Kaiser Permanente began in the run-up to WWII, and Geisinger began in 1915.

community, state or local ownership. Many cross state borders (or even national borders) and need to accommodate different legal issues and ways of doing business.

5 AREAS OF FOCUS FOR SELF-ASSESSMENT

The self-assessment should address, at a minimum, the following issues.

1 The degree to which the system's macro-elements (e.g., physicians and other caregivers, hospitals and other care environments, and payers) fit together well. This interconnectedness is the core idea (and to a degree, the legal justification) behind an IDS's existence. Thus, recognizing that each element has its own economics (its own revenues, expense requirements, revenue cycles, variance of market factors), the assessment should consider the extent to which they complement each other. Key questions to ask are:

- Do they support each other in hard times?
- Do they support the ongoing needs of each other and have clear lines of communication from the top on down?
- Do they share a common culture — or recognize and appreciate each other's culture?
- Is there appropriate revenue and cost sharing among the three macro-elements?

An important consideration is whether the “glue” that holds the elements together is optimized for today's environment. Information and communications systems, including current and planned artificial intelligence (AI), should be structured to ensure the hospitals, physicians and payers work well together. When one component leaps ahead, there should be a clear plan for bringing the other two along that makes sense to them. Attention also should be given to how well the macro-element leaders are working together:

- Do the physician and hospital leaders like each other?

- Is there meaningful diversity (e.g., gender, age, ethnicity) among them?
- Does the system CEO show a lack of favoritism across the three?

2 The strength of the IDS’s performance in its recent stress test with COVID-19. It is important that the system’s macro-elements worked well together through the pandemic. Points to consider include whether they communicated about and distributed the vaccine well together, both internally and externally, and whether they are united on issues pertaining to communities, government entities, professional societies and associations.

3 The balance and performance of the IDS’s sub-elements, including physicians. Regarding the physicians, a key concern is whether their numbers are right-sized for the other elements:

- Is primary care optimized (for the IDS’s specialists, market and hospital system)?
- Are the ratios of referrals inside versus outside the system within acceptable limits?
- Do primary care physicians have a workable professional life — given, for example, the increased after-hours work as electronic messaging and documentation continue to grow?
- Are specialists of the caliber, mix and collaborative culture to take the IDS to its next level?

In today’s healthcare environment, it also is critical that the complement of hospitals and other facilities work well together. The assessment should look at how well the hospitals cover the market area, and whether they have the optimally sized market area (e.g., with sufficient opportunities for growth and increased scale).

The IDS’s payer strategy also should be considered. A key question: Is the payer element sized well relative to other system elements to allow the system to achieve its growth potential? (Often the answer is, “no.”) For systems that do not include a health plan, the question is, Should they?

4 The relationship between the IDS’s internal elements and those outside the system.

Ideally, there should be appropriate give-and-take among physicians inside and outside the system, and where appropriate, physicians outside the system should be referring to the system’s physicians, hospitals and payers. Key considerations with respect to this relationship are whether contractual relations are good and outsiders respect the system.

5 The IDS’s growth trajectory. IDS leaders should assess the extent to which the system is innovating, improving and growing. The focus here should be on questions such as:

- Is the IDS delivering better care than it did three years ago?
- Is it happy with its growth trajectory?
- Is it performing well financially?
- How does the future look for the system?

Key points of focus include:

- How well it has hedged its bets against likely future scenarios (Does it need to do more?)
- Whether it meets community, state and regional needs better than seven years ago
- Whether it has a continually improving workforce
- The extent to which it takes advantage of the best thinking regarding innovation and is contributing to innovation

THE OVERARCHING GOAL

The broad purpose of the self-assessment, simply put, is to evaluate all of the IDS’s elements as a group to determine how well the system is living up to its promise. Despite their inherent differences, IDSs all have enormous potential. And to the extent that each one can assess and deliver on its potential, everyone benefits. ■

About the author

Keith D. Moore, MCP, is CEO of McManis Consulting, Denver, and a member of HFMA’s Colorado Chapter.

1K

Approximate number of IDSs in the U.S. in 2018

Source: Martin, R., “Integrated delivery networks: What pharmaceutical companies need to know before engaging them,” white paper, IQVIA Center of Excellence for IDN Insights, 2018

Canon Medical Systems: Trusted healthcare adviser status sets company apart



In this Business Profile, Satrajit Misra, senior vice president, chief sales and marketing officer at Canon Medical Systems, discusses

the key to gaining optimal value from a healthcare imaging partnership.

How do you work with healthcare organizations?

At Canon Medical Systems USA, we believe in constant innovation to meet healthcare's evolving challenges. However, our greatest strength lies in our ability to develop trusted relationships with healthcare organizations.

We believe we can do more for healthcare organizations by being a trusted partner. To achieve this goal, Canon continually seeks opportunities to move beyond a transactional relationship with customers toward a true partnership through our highly responsive, highly innovative approach to service, financing and education.

Naturally, customers' requirements have changed during the pandemic as we all seek to provide the safest environment possible for patients, clinicians and staff. Canon works with its clients to follow protocols around preventative maintenance calls and other activities that keep their systems running optimally.

What are some of the biggest challenges affecting healthcare organizations in the imaging space — and how is Canon responding to organizations' needs?

The COVID-19 pandemic brought unprecedented challenges to healthcare organizations around the world. Accurate and timely diagnostics save lives, and imaging technology — from CT scans to MRIs and ultrasound — is critical to clinicians' ability

to respond with speed and make highly informed decisions.

At Canon, we've successfully maintained the service times our company has become known for, even during the pandemic. With 40 parts depots located across the country, there was no change in our lead time for spare parts delivery during COVID-19. In fact, we proactively increased our in-country inventory to circumvent the impact of any uncertainties related to air travel or customs delays.

When we speak with healthcare organizations serviced by other medical imaging companies, we hear stories of long delays for service and, especially, parts. These delays put quality of care at risk by limiting clinicians' ability to understand and appropriately respond to patients' health conditions. We're proud that the foundation of continuity and agility for service delivery that Canon established prior to the pandemic empowers us to fulfill healthcare organizations' needs.

The pandemic also tightened financial pressures for hospitals and health systems as elective procedures were postponed and organizations invested in protective measures to stop the spread of disease. As a result, the financial arrangements that healthcare organizations entered into for imaging equipment prior to the pandemic may no longer be a good fit.

Canon owns its own financing arm, Canon Medical Finance, and that makes us unique in the medical imaging technology space. Most medical imaging vendors work with third-party banks to help healthcare organizations obtain financing for medical imaging products. At Canon, we work directly with healthcare organizations to customize financial instruments into a plan that meets their unique needs. During the pandemic, we proactively reached out to customers to understand the impact of COVID-19 on their business and their revenue

stream. We then helped restructure their debt and enabled them to defer payments to help alleviate cash-flow challenges.

What are some key considerations for healthcare leaders when choosing an imaging solutions vendor?

From our perspective, there are three key considerations for healthcare leaders in selecting the right imaging solutions partner.

Service. Canon is recognized nationally for its dedication in going above and beyond to support its customers. We've won "Best Service" awards for service for computed tomography (CT) scan, magnetic resonance imaging (MRI) and X-ray imaging in the 2020 IMV ServiceTrak™ Imaging Awards. These awards are presented to imaging system vendors that receive the highest percentage of highly satisfied customer responses.

During the pandemic, when minutes count, Canon's dedication to getting imaging services back in service quickly protects healthcare organizations' mission of providing high-quality care for those they serve. At Canon, our local service engineers and U.S.-based parts dispatch are available 24 hours a day, seven days a week to respond to healthcare organizations' concerns and get their system up and running quickly. We offer same-day parts delivery from 40 parts depots strategically located across the country, eliminating the lag times in parts delivery that frequently frustrate organizations — and we were able to maintain same-day delivery even during the pandemic. No other imaging company in the nation is capable of responding as quickly as we do to virtually any healthcare organization in the nation.

Just as important is the ability of a service provider to anticipate customers' needs before

a system goes down. At Canon, we do this through our e-Watch™ system. This system continuously monitors customers' imaging system room environment, checking power, temperature, and humidity levels and automatically alerting the organization to changes that are likely to cause issues. Continuous monitoring of the system's room environment helps optimize working conditions, ensuring high performance and cost efficiency.

We also take a highly proactive approach to combatting cybersecurity attacks. Canon addresses system vulnerabilities on all fronts with firewall and network protection, antivirus software, live monitoring, predictive technologies and a well-trained team that is ready to help customers withstand an attack. We safely secure patient information using a multilayered, proactive approach that sustains high levels of security, protects against unauthorized access, meets customer privacy expectations and guards against downtime caused by cyberattacks. These investments ensure the security of protected health information, maintaining patient trust. They also reduce cybersecurity costs.

Financing. Just as the right vendor will anticipate customer service needs, leading imaging services providers also anticipate customer financial needs. Through our financing arm, Canon Medical Financing, we help healthcare institutions implement Canon imaging equipment in a way that meets their goals for growth, long-term financial stability and above all, the care that patients need. We develop cost-effective plans that empower healthcare organizations to maintain their position as a healthcare technology leader in their community.

At Canon, we believe flexibility and customization in financing is key. Our dedicated healthcare finance experts partner with healthcare organizations from consultation through implementation, avoiding a one-size-fits-all mentality so that customers get the right financial plan, right now. We provide healthcare organizations with a range of financing solutions, including extensive financing product offerings, competitive interest rates, upgrade programs and prompt credit decisions.

One of the most exciting aspects of customizing a financing plan is that it often makes possible capital acquisitions that were initially thought to be impossible. Because we are not limited in the financial instruments we offer customers, many more potential solutions are in play to help healthcare organizations achieve their goals. These include service support leases, full ownership leases, operating leases, upgrade paths, tax-exempt leases and lines of credit.

Education. Purchasing new equipment for an organization is exciting, and it brings many positive changes. In today's fast-paced healthcare environment, keeping staff trained on the latest imaging innovations can be challenging. The right vendor will provide comprehensive education in a variety of formats that meet imaging techs where they are. Canon's groundbreaking approach to customer education guarantees that teams get the training they need when they need it.

Canon created Performance Pro, a multifaceted training program that presents personalized education for healthcare organizations. Rather than taking a one-size-fits-all approach to customer education,

Performance Pro is designed to work collaboratively with healthcare organizations to define and meet their educational needs. We provide continuous learning programs at the Canon Institute of Advanced Imaging, located in Irvine, California

Research shows that people learn by doing. At Canon Medical Institute of Advanced Imaging, we have invested in the industry's first and only interactive training classroom in the United States. Students work with real systems and gain real-time experience. With this unique hands-on instruction, students become true experts who return to their facility excited and confident to begin working with the new imaging equipment.

Customers also benefit from accredited webinars available on demand. Canon Medical On Demand provides a premier micro-learning experience to expand, reinforce or supplement customers training needs. Our courses are designed for physicians, imaging technologists, sonographers, biomedical engineers and healthcare leaders.

With its time-tested and satisfaction-guaranteed programs, Canon Medical Systems empowers technologists to become masters of their craft. We're so confident in our program that if customers are not completely satisfied with the results, we will retrain a customer's staff at no additional charge until satisfaction is fully achieved.

Where can readers go for more information?

For more information on Canon Medical's Solutions, visit our Medical Imaging Gallery at www.canonrsna20.com. ■



Canon Medical delivers innovative diagnostic medical imaging solutions, including CT, MI, VL, MR, X-Ray, Ultrasound and Healthcare Informatics across the globe. Additionally, Canon Medical is the industry leader in creating partnerships through service, education, and financial solutions that strive to improve the quality of life for all people.

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The understated value and potential of the clinical laboratory

Given the responsibility healthcare finance leaders bear for assessing the revenue potential of their organizations' clinical service lines, they should fix their radar on laboratory medicine.



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Clinical laboratory services constitute a promising revenue source for hospitals and health systems today. But to meaningfully tap into that revenue potential, these organizations' finance leaders must understand the potential of the laboratory service line as a conduit for improving population health and take the lead in raising consumer awareness of the opportunities it presents.

PUBLIC PERCEPTION OF LAB SERVICES VERSUS REALITY

Watch any medical TV show and you will see multiple scenarios involving laboratory testing ranging from the mundane (a family visiting a patient in a hospital bed) to the sensational (a response to a trauma event). In such scenes, the doctor typically tells the patient something like, "We're sending labs for ABC; that will tell us if you have XYZ."

In real-life, however, there's more to it than the physician simply ordering a test. Clinical

laboratories must be accredited, and pathologists and laboratory technologists must be licensed and certified to perform the functions of the laboratory. That means, for example, residents in actual hospitals don't have the freedom to order all the lab tests that Gregory House's residents are able to order in the TV medical series *House*. The oversight is in place to ensure each lab test is accurate, reproducible and consistent. (See the sidebar "Understanding the subtleties of lab testing" on page 51.)

Nonetheless, lab testing has evolved in recent years to become one of the most consumer-facing and readily accessible elements of healthcare, and that evolution has accelerated amid the COVID-19 pandemic. Now is an important time for finance leaders to take the lead in further advancing this service line's potential.

ASSESSING COST AND PROFITABILITY OF THE LAB SERVICE LINE

As with any service line, a key concern for any healthcare entity is the cost and revenue center relationship associated with laboratory medicine.

But the simple fact is that laboratory medicine can be quite lucrative. Consider, one cannot walk through a drug store without noticing direct-to-consumer lab testing approaches.^a These include tests for pregnancy, infectious disease and drug use, to name a few.

So how can finance leaders navigate the terrain of the laboratory system to provide optimal patient care while maximizing revenue? Here are some approaches.

1 Synergize lab services with the hospital's disease demographic. For example, if a hospital is a cardiac center of excellence, it could benefit from integrating cardiac testing with its clinical care to create a *diagnosis-and-testing*

a. Tolan, N.V., "An overview of direct-to-consumer testing," *Clinical Laboratory Medicine*, March 2020.

70%

Percentage of medical decisions that are based on lab results

Source: Quest Diagnostics, 2014

Understanding the subtleties of lab testing

Let's step back a moment and consider what lab tests are and how they work.

Laboratory testing ranges from annual checks (i.e., cholesterol) to a one-time instance where the physician orders the test to provide ancillary support for a diagnosis based on the patient's chief complaint and associated signs and symptoms (e.g., autoimmune disease, malignancy).

The value of testing is widely touted, with attestations that 70% of accurate diagnoses are based on lab test results, and that laboratory activity represents 5% of a health system's costs while guiding decisions that translate into 95% of the remaining costs.^a

In developed countries, laboratory testing is relatively inextricable from patient management: A patient won't receive a blood transfusion if

a. Hallworth, M.J. "The '70% claim': What is the evidence base?" *Annals of Clinical Biochemistry*, November 2011.

the hemoglobin is normal or be kept on an antibiotic if the infectious organism is *resistant* to it, but a patient will receive a thumbs up from the physician if the prostate-specific antigen or cholesterol result is within normal limits.

But it is important to understand that lab tests are not obtained from the magical "plug and play" instruments so often cavalierly depicted in the media. In reality, to be approved for use, lab tests must undergo the same types of painstaking trials as drug candidates must undergo. For vetting of a lab test intended for a specific disease state, afflicted individuals must be enrolled side-by-side with age- and gender-matched controls in a development trial to determine the test's sensitivity, specificity and predictive values. The data are then reviewed and subject to FDA approval.

Moreover, even with approved tests, "normal" results may differ in different populations, age, gender and disease states, so it is important to be mindful of such variations. It also is critical to understand *when*

to order a test and *what* that test result means for a patient's care. A physician's justification for ordering tests affects operational logic, costs of care, payment, staffing and clinical management.^b

Therefore, just as a physician might seek a second opinion for a diagnosis, the physician might request that another laboratory repeat a curious test to confirm results. This process can be confusing if the two labs use different methods, which could amount to comparing apples to pencils. It is therefore imperative that providers assess potential laboratory partners, looking not only at their methodologies, veracity and consistency of results but also at the responsiveness of their customer support in helping physicians or patients navigate their concerns about test results.^c

b. Wians, F.H., "Clinical laboratory tests: Which, why, and what do the results mean?" *Laboratory Medicine*, Feb. 1, 2009.

c. Masood, A., Karim, M.Y., "The clinical approach on receipt of an unexpected laboratory test result," *International Journal of Generalized Medicine*, 2020.

approach aimed at improving efficiencies and maximizing resources.

This approach can be accomplished by onboarding specific testing instruments into the clinical service or outsourcing to commercial laboratories, depending on revenue pro forma and ROI analysis.

2 Maximize collective bargaining and payment strategies with your payers. For example, by demonstrating how clinical diagnostic and laboratory testing can promote reduced length of stay and other disease-related costs as well as improved quality-of-life outcomes, a

center for inflammatory bowel disease can leverage better payment for lab tests.^b

3 Consider direct-to-consumer offerings. Certain tests can be used by patients and consumers to improve their health using a cash

b. Behling, K.C., Bierl, C., "Cost per case mix index-adjusted hospital day as a measure of effective laboratory utilization efforts in a growing academic medical center," *American Journal of Clinical Pathology*, March 1, 2019; Kautter, J., Pope, G.C., "Competitive bidding for Medicare Part B clinical laboratory services," *International Journal of Health Care Finance and Economics*, June 2014.



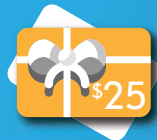
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payment, fee-for-service approach.^c A patient who wants to know if they have antibodies after receiving a COVID-19 vaccine may be willing to pay out of pocket to obtain this information. Such test offerings are not subject to the same state or federal reporting requirements as high-complexity tests such as the COVID-19 RT-PCR test (reverse transcription polymerase chain reaction), which was recently authorized by the FDA for emergency use.^d

AN UNSUNG HERO?

Laboratory testing is an efficient, ubiquitous and low-cost element of healthcare.^e It's not possible to obtain a drive-through appendectomy, but anyone can get tested for COVID-19 almost anywhere these days. Thus, laboratory testing has the potential to be one of the most revenue-generating components of a healthcare system.^f In today's healthcare climate, maturing and maximizing creative laboratory testing approaches may be the way to beckon the unsung hero all healthcare organizations long for. ■

c. Loring, C., et al., "Using fee-for-service testing to generate revenue for the 21st century public health laboratory," *Public Health Reports*, September-October 2013.

d. FDA, Emergency use authorization (EUA) summary COVID-19 RT-PCR test (Laboratory Corporation of America), May 11, 2021.

e. Fang, C., Otero, H.J., Greenberg, D., and Neumann, P.J., "Cost-utility analyses of diagnostic laboratory tests: a systematic review," *Value Health*, December 2011.

f. Adane, K., Abiy, Z., and Desta, K., "The revenue generated from clinical chemistry and hematology laboratory services as determined using activity-based costing (ABC) model," *Cost Effectiveness and Resource Allocation*, Dec. 8, 2015.

About the author

Martin H. Bluth, MD, PhD, is the founder of Bluth Bio Industries, professor of pathology at Wayne State University School of Medicine, laboratory director for Accutox Medical Diagnostic and global medical director for Kids Kicking Cancer.

Former HFMA National Chair Phyllis Cowling receives healthcare administration award



Phyllis Cowling served as HFMA's 2002-03 National Chair.

The Texas Hospital Association (THA) recently named Phyllis Cowling, FHFMA, CPA, MBA, as the recipient of the 2020 Earl M. Collier Award for Distinguished Health Care Administration. Cowling is president and CEO of United Regional Health Care System in Wichita Falls, Texas.

The award, presented at THA's 2021 Annual Conference and Expo, which was held virtually March 9-12, is the highest honor bestowed by THA. It recognizes outstanding executives who have distinguished themselves through their contributions to the healthcare industry and their profession. Recipients also are leaders in providing high-quality healthcare services and are active in THA and other industry groups.

In its announcement regarding the award, THA noted that Cowling's accomplishments reach far beyond hospital walls and that she emphasizes community health, ensuring that those in her area can get high-quality healthcare without traveling to a big city.

"I've had the honor of knowing and working with Phyllis for the last few decades," said Ted Shaw, president and CEO of THA. He noted Cowling is a dedicated, hard worker who exemplifies excellence in healthcare as well as a fervent advocate for access to quality care.

"I cannot think of someone more deserving of this year's Collier Award," said Shaw.

Cowling, a member and fellow of HFMA, served as the Association's 2002-03 National Chair. ■

Holder accepts new position with Children's Hospital of Philadelphia

Sophia Holder, CPA, recently joined Children's Hospital of Philadelphia as executive vice president and CFO. Holder, a member of HFMA's Metropolitan Philadelphia Chapter, brings more than 20 years of healthcare industry experience to the position. Most recently, she served as vice president of finance at Boston Children's Hospital.



Bertrand is new CFO at Gifford Health Care

Jennifer Bertrand, MBA, is the new CFO at Gifford Health Care in Randolph, Vermont. She previously served as CFO at Porter Medical Center in Middlebury, Vermont. Bertrand is a member of HFMA's New Hampshire-Vermont Chapter. She says Gifford's commitment to both patients and the community is what drew her to the new role.



Doctors Hospital of Manteca taps Garrison as CFO

Gregg Garrison, MBA, is the new CFO at Doctors Hospital of Manteca in Manteca, California. Prior to the new appointment, Garrison was CFO at Emanuel Medical Center in Turlock, California, a sister hospital of Doctors Hospital of Manteca. He will now serve as CFO over both hospitals. Garrison is a member of HFMA and the Texas Gulf Coast Chapter.



Bernal named Methodist Healthcare CFO

Enrique Bernal is joining the leadership team at Methodist Healthcare in San Antonio, Texas, as its new CFO. Bernal brings 16 years of CFO experience to the new position, including most recently at San Antonio's Methodist Hospital and Methodist Children's Hospital. He is a member of HFMA's South Texas Chapter. ■



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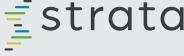






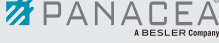







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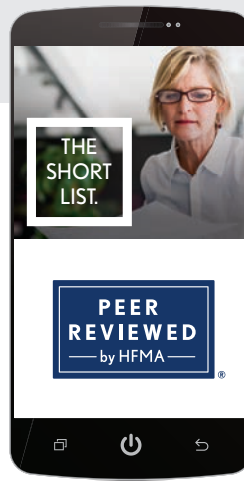
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from the president

Hypersensitivities only serve to suppress honest equity conversations



JOSEPH J. FIFER
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Recently, I was speaking to a group of mostly young adults — 20- to 30-year-olds of various races and ethnicities — where I was discussing the finance management role in health equity. And if I'm being honest about it, I struggled through it.

While I've worked hard to educate myself and stay in tune with the racial storylines and dialogue of the past year, I unexpectedly found myself afraid of making a mistake. *Afraid* of not using the most current and trendy vocabulary. *Afraid* my words would be misunderstood. And sadly, now I'm *afraid* my words didn't convey the thoughts I hoped to impart about very complex, very real issues that exist in society, and yes, healthcare.

It will come as no surprise that as a former CFO, I'm a data-driven guy. And I know the data around the racial disparities in this country — from education to criminal justice to employment to wealth to health, and so on. When it comes to healthcare finance, I have no problem articulating what I see in the data. Right or wrong, I speak my mind. Yet when it comes to discussing racial equity, even within the context of my own industry, it's hard for me.

The racial equity conversation needs to be had in this country, but like any debate, the hypersensitivity on either side can make it difficult. It can push people further left or right of issues, galvanizing

perspectives or even suppressing much-needed discussion altogether. Well-intended people need to be able to have this conversation without the fear of attack for not using the phrase of the day.

For the past year, I've been urging people to stop, listen and care when it comes to issues of race. A fine example of this approach is right on the cover of this month's *hfm* magazine. Tammie Jackson is taking over as the first Black chair of HFMA. That she's doing so at this particular time is, as she says, "serendipity." While Tammie has a full slate of healthcare industry issues to address in 2021-22, equity is certainly on the list. And in my experience, there's not an easier person than Tammie with whom to speak with about these issues. She listens without judgment and thoughtfully offers her perspective. A conversation with Tammie always feels like a perfectly safe space.

My hope is that together we can instigate a civil, enduring discourse within HFMA this year. As this conversation unfolds, I hope we can all remember that people are putting themselves in uncomfortable positions, but hearts and minds are in the right place. I hope we can focus more on intent than buzzwords and politics. I hope we can normalize this conversation, so it doesn't perpetually feel like treading on thin ice.

And my greatest hope is that you can put aside that same trepidation I felt and boldly join our conversation. ■



The HFMA Community has launched a new group dedicated to discussing issues of diversity, equity and inclusion. Join the conversation at community.hfma.org/diversity-equity-and-inclusion-forum/

career opportunities

Chief Financial Officer: Littleton Regional Healthcare located in Littleton, NH (www.littletonhospital.org) is the leading provider of health care services in northern and central New Hampshire and searching for a CFO. Qualifications: 10+ years of hospital financial leadership experience ideally serving in a CFO capacity (experience working as a Controller or Finance VP in a large, progressive organization may also be suitable); Bachelor's degree from an accredited college or university required, master's preferred and CPA preferred! **Email resume to: rarmbrust@qhr.com.**

Chief Financial Officer: Wilbarger General Hospital in Vernon, TX has an opportunity for a CFO to join an innovative and energetic management team with a new vision for hospital and a plan for growth. Qualifications: Previous CFO level or equivalent experience within an acute care environment required. Previous experience with a proprietary healthcare system highly preferred. Minimum 5 years financial/accounting progressive managerial experience in acute-care environment. CPA preferred. **Email resume to: rarmbrust@qhr.com.**

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