

SEPTEMBER 2021

healthcare financial management association
hfma.org

ANNIVERSARY EDITION

FEATURING

Robert Broadway
David Canfield
Richard L. Clarke
Michael Doody
Joseph J. Fifer
Nikki Harper
Shirley Heavlin
Geraldine Hoyler
Cathy Jacobson
Joanne Judge
Lisa Keffer
Sue Ketter
Mark Knight
Ronald Kovener
Rosalind Lewis
John McGuire
Joe Pajor
Marjorie Parker
Eric Reese
Pete Sabal
Dave Timpe
John Travis
James Whitman



Healthcare Receivables
Management Specialists

PROVEN.

Increased clients cash collections by over \$1.6 million which primary agencies were unable to collect.

TRUSTED.

Servicing 600+ client locations with uncompromising ethical standards and the highest levels of compliance.

INNOVATIVE.

Combining artificial intelligence with layers of robotic process automation, MDS allows recovery specialists to focus on more complex recovery opportunities, while our many online and mobile-friendly payment options ensure convenience for your patients.



SMARTER, QUICKER COLLECTIONS

EXTENDED BUSINESS OFFICE



Get the help you need on self-pay, residual balances, insurance follow-up and A/R conversion projects

PRIMARY AND SECONDARY COLLECTIONS



Keeping compliance top-of-mind, our sophisticated technology and screening processes accurately focus on those most likely to pay and give those who aren't a variety of alternatives

ACCOUNTS RECEIVABLE SYSTEM CONVERSION AND CLEANUP



MDS can handle legacy accounts to let your team focus on a successful system conversion

contents

SEPTEMBER 2021 ISSUE

hfma

- 6 FROM THE CHAIR**
Boldly promoting health equity is key to a better tomorrow
TAMMIE L. JACKSON, HFMA, CHFP, MHA
- 10 INSIDE HFMA**
HFMA's editorial team earns 16 awards for excellence
DEBORAH FILIPEK
- 16 CHAPTER NEWS**
Leaders attend unique training event
CRYSTAL MILAZZO
- 18 PEOPLE**
HFMA members Thompson and Pundarika earn *ABF Journal* recognition
CRYSTAL MILAZZO
- 71 HFMA 2021-22 Leadership Directory**

news

- 20 NEWS BRIEFS**
NICK HUT
- 22 EYE ON WASHINGTON**
Two infrastructure bills have significant implications for healthcare and bipartisanship
KEN PEREZ

features

- 26 COVER STORY**
HFMA marks 75th anniversary
CRYSTAL MILAZZO
- 36 EXPERT REVIEWED**
Weighing the feasibility of an LLC-owned retail pharmacy enterprise
NATHAN HAGEN
IAN MACDONALD
LINDA TYLER
NANCY NICKMAN
- 44**
How to engage with patients where they are by balancing automation with the human touch
DAY EGUSQUIZA
- 50 MAP AWARDS**
How 3 healthcare organizations are focusing on access and transparency to drive revenue cycle performance
LAURA HEGWER
- 54 RESEARCH HIGHLIGHT**
HFMA survey: 61% of hospitals say future compliance with price transparency will impact financial processes
LISA ERAMO, MA

contents

SEPTEMBER 2021 ISSUE

columns

- 62 LEADERSHIP**
What the pandemic taught us about leadership
JILL GEISLER
- 64 INNOVATION**
Want to foster innovation in healthcare? Give it a foster home
JEFF HELTON, PhD, FHFMA, CMA
- 66 PHYSICIAN PERSPECTIVES**
Why rekindling the romance in medicine could spur innovation
MARTIN H. BLUTH, MD, PhD
- 68 CAPITAL FINANCE**
Why bond insurance is making a comeback in healthcare
JOHN ANDERSON
- 88 FROM THE PRESIDENT**
A 'necessary evil' no more
JOSEPH J. FIFER, FHFMA, CPA

Download the *hfm* app today!



SPONSORED CONTENT

- 8 Business Profile**
Athenahealth: Pandemic era requires flexible revenue cycle solutions
- 14 Affinity Group**
Grant Thornton: How human capital analytics can help providers attract and keep top talent
- 19 Peer Review Spotlight**
Ensemble Health Partners: Ensemble helps healthcare organizations remove payer barriers, streamline processes and systems and implement strategies to increase patient loyalty
- 34 Business Profile**
Ambu: Single-use endoscopes offer a safe way for healthcare providers to catch up on backlog of nonemergent care procedures
- 58 Roundtable**
Pure Storage: Financing digital transformation during COVID-19 and beyond
- 70 Peer Review Spotlight**
Pelitas: Virtual Intake Management® by PELITAS provides a digital experience with self-service options helping providers financially clear more than 75% of patients before service
- 82 Affinity Group**
Syntellis: Pressure rising: COVID-19's ongoing impacts on healthcare labor trends
- 86 Research Report**
Guidehouse: Survey — Hospitals and health systems prioritize automation technology and cybersecurity to battle pandemic



NORCAL POLICYHOLDERS **treated fairly**

protecting **doctors**
nurses cardiologists
practice managers family physicians
infectious disease specialists
internists **anesthesiologists**
otorhinolaryngologists
long term care specialists
neurosurgeons pulmonologists
epidemiologists oncologists urologists
pediatricians **general surgeons**
obstetricians & gynecologists
allergists hospital administrators
emergency physicians nurse practitioners
pathologists endocrinologists
orthopaedists immunologists
radiologists geriatricians and more

On May 5, 2021, NORCAL Group joined forces with ProAssurance.

With similar values and a shared commitment to putting policyholders first, uniting the expertise of these two leading providers of medical professional liability insurance was a smart decision.

Now, as the nation's third-largest MPLI carrier with claims and risk management expertise in every major healthcare region, our ability to provide options and solutions across state lines has grown even stronger.

Welcome to best in class, where the principle of fair treatment guides every decision we make and every action we take in defense of our medical professionals.



**Healthcare Professional Liability Insurance
& Risk Management Services**

For information regarding the NORCAL Group acquisition >>>

ProAssurance.com



HFMA'S MONTHLY MAGAZINE

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.



Senior Vice President, Content and Professional Practice Guidance **Rick Gundling**

Senior Vice President, Member Experience & Business Development **Bill Casey**

Director of Content Strategy **Brad Dennison**

Senior Editors

Paul Barr – Deborah Filipek – Erika Grotto – Nick Hut – Crystal Milazzo – Eric C. Reese

Graphic Designer **Linda Chandler**

Operations Specialist **Tony Davies**

Director, Channel Assets **Rita Walker**

Manager, Client Services **Heather Hennessy**

Senior Classified Sales Specialist **Sharon Malik-Specht**
Tel (708) 492-3386 smalik@hfma.org

Copyright 2021, Healthcare Financial Management Association. All rights reserved. Printed in the USA. Volume 75/Number 6. ISSN 0735-0732.

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.

Advertising Representatives & Offices

National Office (and West Coast) Healthcare Financial Management Association

Three Westbrook Corporate Center, Suite 600
Westchester, IL 60154-5732
Tel (708) 531-9600 Fax (708) 531-0032 hfma.org

East Coast

Dianne Lach HFMA, Business Development Executive
dlach@hfma.org Tel and Fax (708) 492-3343

Central

Cindy Dudley CLD Associates
cdudlev@hfma.org Tel (847) 295-0210 Fax (847) 574-5836

Southeast

Steve Roth Powercast Media
vroth@hfma.org Tel (520) 742-0175 Fax (847) 620-2525

Readers service

For all reader services, write to HFMA's National office at Three Westbrook Corporate Center, Suite 600, Westchester, IL 60154-5732, or call (800) 252-HFMA.

Back issues

are available at \$18 per copy (\$21 per copy outside the United States).

To order, contact Jennifer Novoseletsky at reprints@hfma.org

Expert Reviewed

Feature Stories in **hfm**® bear the Expert Reviewed stamp, which indicates that content has been evaluated by an independent panel of healthcare professionals who have the expertise to ensure accuracy, credibility and usefulness of information.

Disclaimer

Material published in *hfm* is provided solely for the information and education of *hfm* readers. The Healthcare Financial Management Association (HFMA) does not endorse the published material or warrant or guarantee its accuracy. The statements and opinions in articles and columns in *hfm* are those of the authors and not those of HFMA. References to commercial manufacturers, vendors, products or services that may appear in such articles or columns do not constitute endorsements by HFMA.

Subscription Inquiries/Address Changes. For all inquiries about existing subscriptions, including address changes, renewals and missing issues, contact the Member Service Center at HFMA's National office address or at ext. 2. Notice of address changes should include the old as well as the new address, including zip code. The local postmaster also should be notified. Allow six weeks for address changes to become effective. Notice to HFMA members: Member address changes should be directed to the Member Service Center at the HFMA National office address or at ext. 2. Member address changes are effective for all HFMA mailings; no separate change of address is needed for *hfm*.

Manuscript Submission. Unsolicited manuscripts are welcome. Manuscripts submitted for potential publication are peer reviewed. Final decisions regarding publication rest with the editors. Inquiries and article ideas are encouraged and should be directed to the editors. To access writers' guidelines, go to hfma.org/authorinfo

It is a violation of federal copyright law to reproduce all or part of this publication or its contents, in any form by any means, without permission.

hfm® (ISSN 0735-0732) is published monthly except for January, July and August by the Healthcare Financial Management Association (HFMA), Three Westbrook Corporate Center, Suite 600, Westchester, IL 60154-5732. Subscription rates/orders: Subscription within the United States are \$260 per year. Outside the United States, North American subscriptions are \$270 per year, and other foreign subscriptions are \$280 per year. Institutional subscriptions are \$150 per year. Periodicals postage paid at Maywood, IL 60153 and additional mailing offices. POSTMASTER: 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 6.

Letters to the Editor. **hfm**® welcomes letters to the editor.

Letters should be addressed to the Editor and sent to Brad Dennison at bdennison@hfma.org. Sending a letter to the editor will be construed as permission to publish the letter, in full or in part. If it is determined that the letter will be published, the editor reserves the right to edit the letter before publication.

Reprints and Permissions. Photocopying of one copy of an article or column for personal use is permitted by the publisher. Individual copies made by libraries must bear a notice of copyright. Permission to photocopy more than one but fewer than 100 copies for internal or personal use can be obtained through the Copyright Clearance Center, provided that the specified fee is paid directly to the Copyright Clearance Center, 222 Rosewood Drive, Danvers, MA 01923. To order 100 or more copies, contact Jennifer Novoseletsky at the HFMA National office address or at ext. 387. This publication also is included among the products of the information resource company EBSCO Publishing, Inc., Ipswich, MA.

Requests for permission to reprint articles, columns or portions thereof in other printed or electronic works should be submitted to Jennifer Novoseletsky at reprints@hfma.org.



healthcare financial management association

2021-22 Officers

National Headquarters Office

Three Westbrook
Corporate Center
Suite 600
Westchester, IL 60154-5732
Tel (708) 531-9600
Fax (708) 531-0032

Washington, D.C., Office

1090 Vermont Avenue NW
Suite 500
Washington, DC 20005
Tel (202) 296-2920
Fax (202) 849-3645

www.hfma.org

Chair: Tammie L. Jackson, FHFMA, CHFP, MHA
Vice President, TransUnion Healthcare, Chicago
Chair-Elect: Aaron R. Crane, FHFMA, CPA, MHA, Executive Vice
President, Seattle Cancer Care Alliance, Seattle
Secretary/Treasurer: Dennis Dahlen, CHFP, CPA, CFO, Mayo
Clinic, Rochester, Minn.
President and CEO: Joseph J. Fifer, FHFMA, CPA,
Healthcare Financial Management Association, Westchester, Ill.

2021-22 Directors

Abby Birch, CRCR, Regional Vice President, Business
Development, Revint Solutions, Fort Lauderdale, Fla.
Colleen M. Blye, CPA, Executive Vice President/CFO, Montefiore
Health System, New York
Maureen A. Clancy, FACHE, CPC, Senior Vice President,
Operations, Privia Health, Washington, D.C.
Matthew E. Cox, CHFP, CPA, Senior Vice President/CFO,
Spectrum Health, Grand Rapids, Mich.
James L. Heffernan, FHFMA, Senior Vice President and Treasurer,
Massachusetts General Physicians Organization, Boston
Jeffrey T. O'Malley, System Vice President, Strategic Growth
& Governance, CommonSpirit Health, Chicago
Cindy Price, FHFMA, CEO, HCA Parallon Shared Services,
Houston
Margaret L. Schuler, Senior Vice President of Revenue Cycle and
Practice Operations, Aspen Dental Management, Chicago
Mimi Taylor, CIO and Corporate Vice President of Information
Technology, Baptist Health South Florida, Coral Gables, Fla.

hfm® is published nine times annually by HFMA.

Editorial Mission

hfm® supports the mission of the Healthcare Financial
Management Association by serving as a key resource for
individuals involved in the financial management of healthcare.

Editorial Position

hfm® is written and edited principally for finance professionals
in health service organizations all along the continuum of care,
including hospitals and health systems, managed care and ac-
countable care organizations, physician organizations, outpatient
service centers, and post-acute care providers. It also is directed to
professionals in law firms, accounting firms, banks and consulting
firms that have an interest in healthcare finance. hfm® covers the
full range of topics related to healthcare finance. Key topic areas
include strategic planning, hospital-physician alignment, payment,
revenue cycle, patient financial services, enterprise risk, business in-
telligence, information systems, network development, accounting
practices, leadership development, management issues, legislative
and regulatory issues, capital finance, cost management, consolida-
tion and affiliation, and emerging financial trends.

About HFMA

The Healthcare Financial Management Association (HFMA)
provides the resources healthcare organizations need to achieve
sound fiscal health in order to provide excellent patient care.
With more than 71,000 members in 64 chapters, HFMA is
the nation's leading membership organization of healthcare
finance executives and leaders. Membership in HFMA provides
opportunities to attend educational seminars and conferences,
to access technical and management information, to obtain
professional certification, to interact and network with colleagues
and to gain other professional benefits. For information about
annual membership dues, which include a \$30 allocation to hfm®,
contact Member Services at (800) 252-HFMA, ext. 2.

CMS PENALTIES FOR NON-COMPLIANCE ARE INCREASING IN 2022



Looking for a single vendor that offers hospital, physician, pharmacy and CMS price transparency services to meet your pricing needs? Look to the leader.

WE'RE PANACEA.

**One source. One leader.
The power of one.**



www.cmspricetransparency.com | 866-926-5933

REVIEW YOUR CURRENT COMPLIANCE STATUS WITH A NO-COST CONSULTATION. CALL TODAY.

Boldly promoting health equity is key to a better tomorrow



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

“It’s good to see you!” Two years ago, this customary greeting might have been muttered with little to no thought. That was before.

But when chapter leaders gathered July 25-27 in Orlando for HFMA’s 2021 Leadership Training Conference (LTC), the greeting was exclaimed with heartfelt sincerity, because it was true! While we were careful to exercise social distancing, it was refreshing to gather with our chapter leaders to plot our path forward. We talked about what defined “before” for us as healthcare professionals, what we learned over these past 18 months or so and how we can be better.

What has resonated with me during the pandemic is the incredible disparity we witnessed in disease prevalence, mortality rates and access to care as a result of the risks associated with social determinants of health (SDoH). Although health disparities have been well documented for years, the pandemic revealed these issues in undeniable ways.

When it comes to SDoH, one might think, “This problem is too big,” or “It’s not mine to fix,” or even as LTC keynote speaker Anton Gunn, the former head of the Office of External Affairs at the U.S. Department of Health and Human Services, said, “If someone gets ahead, it means I will lose something in exchange.”

In fact, none of that is true. Yes, the problems are big, but we can — and should — have an impact. And we certainly can promote health equity without losing.

We can track data across socioeconomic metrics to ensure our revenue cycle processes and practices do not exacerbate SDoH in inequitable ways. Our digital front doors provide an opportunity to meet patients where they are with transparency and customizable options that can reduce their financial burden. Even telehealth, when intentionally deployed to be inclusive, can provide such promise for all patients regardless of challenges. Health equity — simply put — means we all have an equal opportunity to be healthy. This premise does not describe today’s reality, and we can no longer claim we are not aware of that fact. As healthcare finance professionals, we must be bold in thought and approach.

It is not lost on me that this month will mark the passage of two decades since another tragic event that changed our lives forever: Sept. 11, 2001. So much loss that day and so much lost — such that we will never forget. I remember rushing to pick up my son early from preschool that day. It’s interesting that much like the sentiment back in July at LTC, it was critically important that I hug him and tell him so sincerely, “It’s good to see you!” May we all recall that kind, empathetic sentiment as we forge this *Bolder. Brighter. Better.* path forward. ■





Choose a payment solution that helps you keep patients at the heart of what you do.



With 11.7 million cardholders and 30 years of making care possible, the CareCredit healthcare credit card allows you to offer patients promotional financing to pay their out-of-pocket healthcare expenses over time.[^]

The CareCredit healthcare credit card is a time-tested payment solution that can help your health system:



Streamline your revenue cycle



Build trust and improve patient satisfaction



Offer seamless billing and collections at every point of care



Reduce collection risk with non-recourse payment[†]



Ready for a payment solution that helps your staff focus on care and patients manage cost? Learn more about CareCredit today! carecredit.com/hfmmagazine

^{*} HFMA staff and volunteers determined that this product has met specific criteria developed under the HFMA Peer Review Process. HFMA does not endorse or guaranty the use of this product.

[^] Subject to credit approval.

[†] Subject to the representations and warranties in your Agreement with CareCredit, including but not limited to only charging for services that have been completed or that will be completed within 30 days of the initial charge, always obtaining the patient's signature on in-office applications and the cardholder's signature on the printed receipt.



Pandemic era requires flexible revenue cycle solutions

In this Business Profile, Serene Munroe, executive director, product management at athenahealth, explains why flexible billing solutions are crucial now more than ever.

How do you help healthcare organizations?

Something we keep top of mind is how we can make our solutions more efficient and reduce our customers' cost to collect. This is crucial for meeting their business metrics and to expand their mission and grow as a healthcare organization.

Our athenaIDX™ enterprise revenue cycle management solution is known for its ability to deliver operational success for customers. It offers tools and solutions organizations need to lower or even eliminate touch and leverage best-practice workflows that drive efficiency. Organizations are increasingly shifting to management of complex billing cases, so it is even more important to simplify repetitive functions.

What are some of the biggest challenges for healthcare organizations, and how do your service offerings help address these needs?

The market is consolidating, and healthcare organizations are dealing with increased complexity as they scale-up.

Many healthcare organizations are managing multiple types of payment models and are looking to cut costs, while ensuring they get accurately compensated for services billed. Taking on new customers, expanding provider networks and managing multiple complex billing environments at the

right level quickly, efficiently and gracefully are challenges many of our customers are facing. Our solution enables the ability to add on new providers easily and manage that complexity with the right tools.

The shift to remote-based workforces during the COVID-19 pandemic has been another challenge organizations have been facing over the past year. With the remote model, different management styles and analytics are needed. Organizations are looking to ensure they keep remote employees engaged and that the quality of the work and productivity stays high.

Additionally, burnout is a big problem. Simplifying complex billing processes as much as possible for staff is important to minimize burnout.

Did you introduce new services to address changing needs arising during the COVID-19 pandemic?

Our strategy has always focused on reducing the number of touches each user must do to complete a task. We streamline workflows and surface tasks for the right staff, so there is not a lot of verbal or manual handoff needed between individuals. For remote workforces, this is even more important; you do not want employees repeating unnecessary processes.

Before the pandemic hit, we were working on a cloud-based gamification application that allows organizations to analyze their

employees' workflows in real time and boost revenue cycle performance. Dubbed athenahealth Gamify, this solution launched last September.

Employees win the game by working their tasks more efficiently and effectively than their peers. Managers can see how productive their employees are, where they are spending time and where the potential roadblocks are. It changes the culture of revenue cycle management, enabling employees to engage with their managers and peers at a whole different level. The work is not repetitive; it is fun.

Having that tool ready to bring to the market at a time when people were moving to remote work was a huge win for us and our customers. One customer gained an 18% increase in hold bills productivity and 3.3 days of output per user per month, reducing operating costs.

What are some key considerations for healthcare leaders when choosing this type of product or service?

When looking at a revenue cycle solution, healthcare organizations need to make sure to look at things that will make a difference in their environment. It is important to partner with a solutions provider that is a good partner in your ecosystem who can accommodate your unique needs. Is your workforce as productive as possible and do you have the right tools to make sure that

happens? Having a partner like athenahealth and solutions such as athenaIDX and athenahealth Gamify let you create best practices and consolidate workflows.

Another key consideration is scalability. Having a platform that enables the organization to scale – and being able to do it at a lower cost – is paramount.

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

I would look at how healthcare is changing. Workforces are shifting to partially or fully remote models. There is an increasing focus on value-based care arrangements. Payers are coming up with new requirements around telehealth and other new visit types that are becoming more predominant. Consolidation is increasing. I think organizations must have a partner that addresses these needs in the healthcare market. Having insight about what the business landscape will look like tomorrow and five years from now – not the previous five years – is going to be critical for success.

Can you elaborate more on value-based arrangements, and how your solutions meet needs in this area?

We have a single, integrated platform that works across many models of care. One

element of our solution is our Financial Risk Manager that lets organizations manage various value-based care arrangements, so it becomes seamless for them to manage member groups with different risk models on athenaIDX. Employees have full visibility into the current status of patients and what their benefit plans are. On the financial side, they know the level of reimbursement and how claims are being paid

What are your expectations for telehealth post-pandemic?

Payers are still learning how to handle telehealth reimbursement, but we are getting to a place where people know what to expect. Certainly, providers and patients are becoming more comfortable with the concept, and the billing models are following. We are seeing stronger and more consistent reimbursement on claims for those kinds of visits. I expect telehealth is here to stay.

As healthcare organizations integrate your product or service into their day-to-day operations, what advice would you offer to set themselves up for success?

Through athenahealth's Advisory Services, we make sure that customer needs are met and that our revenue cycle solution is optimized for their organizations. If we see

potential actionable trends in their data, we work with them to help identify the root cause and whether they need recommendations or services from our team as each customer has a slightly different model of operating. We tailor our approach depending on their needs.

Do your customers interact with each other?

athenahealth offers several forums for customer collaboration including topics such as value-based care, patient access, workflow management, and best practice tips and tricks. In addition, we facilitate community groups and host in-person user events.

What educational materials have you developed to help healthcare providers in these efforts?

We have various materials on our community portal, including training videos, webinars, documentation on new features and case studies. The industry can also stay up to date with our news on Twitter @athenahealth. Our experts are always welcoming conversations on how we can support the healthcare industry; all are encouraged to reach out. ■



Serene Munroe is executive director of product management at athenahealth.



athenahealth partners with medical organizations across the country to drive clinical and financial results. Our vision is to create a thriving ecosystem that delivers accessible, high-quality, and sustainable healthcare for all, and we are pursuing this through our medical record, revenue cycle, patient engagement, and care coordination service offerings. Our expert teams build modern technology on an open, connected ecosystem, yielding insights that make a difference for our customers and their patients. For more information, please visit athenahealth.com.

This published piece is provided solely for informational purposes. HFMA does not endorse the published material or warrant or guarantee its accuracy. The statements and opinions by participants are those of the participants and not those of HFMA. References to commercial manufacturers, vendors, products, or services that may appear do not constitute endorsements by HFMA.

HFMA’s editorial team earns 16 awards for excellence

The Winter 2020-21 *hfm* cover story about deferred healthcare earned an Azbee National Gold Award in the print feature category and the Stephen Barr Award.



DEBORAH FILIPEK
dfilipek@hfma.org

So far this year, HFMA’s editorial team has earned a total of 12 awards for articles published in *hfm* and four awards for episodes of the Association’s “Voices in Healthcare Finance” podcast produced in 2020:

- Eleven of the honors — five national awards and six regional awards — were presented by

The cover story of the Winter 2020-21 issue of *hfm* earned two national Azbee Awards: Gold Print Feature and the Stephen Barr Award.



the American Society of Business Publication Editors (ASBPE).

- Five of the wins were presented by the Association Media & Publishing Network.

“I am always so proud of the editorial content we share with HFMA members via our magazine, daily online news posts, blogs, newsletters and podcasts because I know it is valuable to our members’ careers,” said Rick Gundling, HFMA’s senior vice president of content and professional practice guidance. “The fact that this content has been recognized this year reinforces the value of our content in helping our members stay on top of the news, best practices and trends affecting the financial management of healthcare.”

AZBEE AWARDS OF EXCELLENCE

HFMA was honored with five national Azbee Awards of Excellence, presented by ASBPE at its online celebration May 13:

- **National Gold Award – Print Feature** (10 or more issues per year): “Healthcare organizations prepare for sicker patients in 2021 due to deferred care,” the *hfm* Winter 2020-21 cover story.
- **National Silver Award – Q&A**: “Hard truths about the state of the healthcare industry,” the *hfm* January 2020 cover story.
- **National Silver Award – Magazine/Newspaper Redesign**: The January 2020 issue of *hfm*, which featured a cover portrait of HFMA President and CEO Joseph J. Fifer and the magazine’s new, easier-to-read redesign.
- **National Bronze Award – Podcast**: The “Voices in Healthcare Finance” episode, “Election special: As the votes are tallied, we look at what the possible outcomes mean for healthcare.”
- **The Stephen Barr Award**, which recognizes the best article across all feature writing categories, was presented to Rich Daly, then a senior editor at HFMA, for his cover story “Healthcare organizations prepare for sicker patients in 2021 due to deferred care.”



■ The January 2020 issue of *hfm* earned two national Azbee Awards of Excellence: National Silver in the Magazine/Newspaper Redesign category and National Silver in the Q&A category for its “Hard Truths” cover story.

According to the ASBPE Foundation, which distributes the award, “Daly’s article was very timely and offered development on one of the biggest concerns in the health care finance business.”

“Rich is a reporter with a real knack for finding untold stories and was one of the first reporters to shine a light on the issue of deferred care,” said Brad Dennison, HFMA director of content strategy. “I’m really proud of the journalistic ground that was broken with this story and so pleased that ASBPE judges recognized just how special it was.”

Daly, who discussed the award-winning story during the online event, said he was honored by being recognized with the Stephen Barr Award. ■

About the author

Deborah Filippek is a senior editor at HFMA, Westchester, Ill.

Regional Azbee Awards

HFMA earned the following regional Azbee Awards in April, which slated the entries as national competition finalists:

- **Regional Gold Award – Print Feature:** “Healthcare organizations prepare for sicker patients in 2021 due to deferred care,” Winter 2020-21 *hfm*
- **Regional Gold Award – Podcast:** “Election special: As the votes are tallied, we look at what the possible outcomes mean for healthcare”
- **Regional Silver Award – Q&A:** “Hard truths about the state of the healthcare industry,” January 2020 *hfm*
- **Regional Silver Award – Magazine/Newspaper Redesign:** January 2020 *hfm*.
- **Regional Bronze Award – Front Cover Design:** “Directing innovation in the supply chain,” November 2020 *hfm*
- **Regional Bronze Award – Podcast:** “Telehealth opportunities in oncology, and Stever Robbins shares the secret to tackling email overload”

AM&P EXCEL Awards

HFMA was also honored with five EXCEL Awards from the Association Media & Publishing (AM&P) Network during a June 16 virtual awards presentation. The AM&P Network awards earned by HFMA staff were:

- **Gold EXCEL Award – Digital Media – Podcast:** “Election special: As the votes are tallied, we look at what the possible outcomes mean for healthcare”
- **Gold EXCEL Award – Magazine – Redesign:** *hfm* Winter 2020-21 issue
- **Silver EXCEL Award – Journals – Design Excellence:** *hfm* Q4 2020 editions
- **Silver EXCEL Award – Journals – General Excellence:** *hfm* Q4 2020 editions
- **Bronze EXCEL Award – Magazines – Design Excellence:** *hfm* Q4 2020 editions

“These awards are great validation for a team doing amazing work,” said Brad Dennison, HFMA director of content strategy. “It’s worth mentioning that in both competitions, we were competing against some big national names, so all the more impressive. We are fortunate to have a world-class editorial team and an organizational culture that paves the way for this level of work. I’m very proud of our achievements and HFMA.”

ASBPE is a national organization whose purpose is to serve and advance the profession of editing for business publications and to encourage the highest ethical standards at those publications.

The **AM&P Network** unites media, content and publishing sectors across B2B, association media and specialized information publishing.

HFMA recognizes the winners of its 2020-2021 **Best Article Award**

The award-winning articles were selected by a panel of five leaders in the healthcare industry who review each expert-reviewed article published in *hfm*.



DEBORAH FILIPEK
dfilipek@hfma.org

HFMA is pleased to recognize the winners and runners-up of the Helen Yerger/L. Vann Seawell Best Article Award for outstanding editorial achievement in *hfm* magazine in fiscal year 2020-2021. Articles are judged on the writers’

demonstration of technical quality and writing skills and contributions to the literature of healthcare finance professionals.

The following three articles are the FY21 recipients of HFMA’s Best Article Award. The runners-up are recognized together.

BEST ARTICLE | May 2021 *hfm*

“The economics of a telehealth visit: A time-based study at Penn Medicine”

Summary: Research into the costs of delivering telehealth versus in-person visits by the Department of Orthopaedics at Penn Medicine sought to answer the health system’s questions about the long-term economic viability of telemedicine services, and to help inform their conversations with payers about how much they should appropriately be paid for the services.



NEIL RAVITZ, MBA



SEAN LOOBY, MHA



CALVIN JORDAN, MBA



ANDREW KANOFF, MHA

BEST ARTICLE | October 2020 *hfm*



“Telemedicine is exploding, but where is the ROI for health systems?”

Summary: As a result of the COVID-19 crisis, telehealth has gained broader acceptance and use than was seen at any time prior to the pandemic. Yet

barriers and challenges continue to impede its widespread adoption. Economic models used by leading health systems provide insight into how to overcome these barriers to achieve a successful ongoing virtual enterprise.



EZRA MEHLMAN, MBA



DAVE TAMBURRI, MBA

RUNNERS-UP, BEST ARTICLE

“How to leverage the telemedicine surge to create a profitable telehealth model”

Lucy Zielinski
Daniel J. Marino

Summer 2020 *hfm*

Summary: Healthcare finance leaders can help their organizations establish profitable telehealth programs following the COVID-19 pandemic by focusing now on the economic and operational drivers that will determine the success or failure of such programs.

“Optimal use of APPs can enhance a health system’s post-COVID-19 financial recovery”

Zachary Hartsell, DHA, PA-C
Dane Ficco
Laurie English

Summer 2020 *hfm*

Summary: A strategy by Excela Health in Pennsylvania, which focused on integrating and optimizing the advanced practice provider workforce, offers a practical road map for how best to pursue such an undertaking.

“340B Program success depends on the quality of self-auditing”

Brian Matney, CHFP, CPA

February 2021 *hfm*

Summary: Healthcare organizations participating in the 340B Drug Pricing Program should self-audit their compliance with the program to ensure its ongoing success and effectiveness.

BEST ARTICLE | September 2020 *hfm*

“How to develop a winning pricing strategy in the post-COVID-19 consumer market”

Summary: Providers and health plans should prepare for federally imposed price transparency mandates by developing comprehensive pricing strategies tailored to their specific market positions, financials and operational objectives. These organizations should consider key implications of the price transparency rule and market trends when designing such a strategy.



KEVIN SEARS, MHA



CHRISTOPHER SUKENIK, MBA



How human capital analytics can help providers attract and keep top talent

As anyone who works in the sector knows, healthcare faces intense financial and workforce pressure in the wake of the pandemic. The AHA estimates that hospitals and health systems lost \$323 billion in 2020. At the same time, competition for a shrinking pool of qualified talent has deepened now that the worst of the crisis is over. Three of 10 front-line healthcare workers, many of them reporting symptoms of PTSD, indicated they're considering leaving the field.^a

Add these sobering numbers to the well-documented shortage of healthcare workers that existed long before COVID-19, and it's clear that healthcare organizations have hurdles ahead.

With a rapidly aging population and burgeoning demand for medical services, healthcare providers can't afford to lose their most capable skilled and unskilled people. To remain competitive in an environment of heightened uncertainty and worker scarcity, they need fresh ways to make smarter, more judicious use of their workforce, keep their best talent, differentiate themselves as a rewarding place to work and motivate the most qualified candidates to climb on board.

Differentiation builds loyalty

Employee benefits and total rewards packages are vital to an organization's ability to edge out the competition in attracting and retaining qualified people.

The range and types of benefits and rewards offered also send messages to potential candidates as well as existing

employees about the organization's values and attitudes toward its people.

Benefits and rewards can allow organizations to meaningfully differentiate themselves in the market. That differentiation can build loyalty and bolster attraction and retention.

When it comes to developing benefits and rewards programs, however, providers tend to focus on benchmarking — measuring how well their offerings compare with those of competing organizations and the industry overall.

This approach makes sense, to an extent. Providers need to know how their benefits stack up against the competition. But benchmarking isn't enough, particularly in a post-pandemic world of financial precariousness and employee ambivalence.

"The health crisis has spurred organizations to start rethinking talent attraction and retention," said Tim Glowa, a principal, and employee listening and human capital analytics lead at Grant Thornton.

Preference analytics

In addition to benchmarking externally, providers are beginning to look internally at their rewards and benefits and listen to their workforce using an analytics-driven strategy called *employee preference optimization*.

"The typical organization in the United States wastes about \$5,000 per employee per year by giving people benefits and rewards they don't value," Glowa said. "We can help providers change that."

Employee Preference Optimization (EPO) is a tool that organizations can use to deliver more value to employees while also saving money. EPO can be applied broadly to optimize an organization's

total rewards plan or can be focused only on specific program or employee markets (executive rewards, expat optimization or executive MBAs).

"Using this approach, we can help organizations design programs that 70% to 80% of employees think are better than what they have today and that potentially save \$2,000 to \$3,000 per person per year," he said.

The preference analysis is customized to organizations' specific priorities and parameters and will yield reliable insights, not only illustrating which rewards employees want most, but the trade-offs they are willing to make, as well. They cannot realistically have everything, but EPO can pinpoint the mix of benefits and rewards that most closely matches employees' needs, given where they are in their careers or personal lives.

What benefits would a specific population of employees prefer and what would they be willing to trade for those more meaningful benefits instead? How can the organization provide that optimal mix of benefits and rewards more cost-effectively by shifting financial resources to the programs that matter most?

Listening closely

"It's really important to understand what those preferences are," said Ashley Edwards, senior manager, Human Capital Services. "And it's not just about benefits and compensation. Things like career progression, learning and development programs, and work-life balance also come into play. For instance, organizations could offer a sabbatical for employees who are in danger of burnout to keep them engaged. The key is listening, and we can use this employee-

a. "AHA report: Hospital financial losses from COVID-19 expected to top \$323 billion in 2020," June 2020, and "Burned out by the pandemic 3 in 10 healthcare workers consider leaving the profession," Washington Post, April 22, 2021.

listening technique to better understand what employees really value.”

EPO is based on conjoint analysis, a type of statistical analysis often used in marketing to understand how customers (in this case, employees) value different components or features of their products or services (benefits and rewards).

Which would they prefer, for example: twice the amount of life insurance or an extra week of vacation per year? An increase in pay at 2%, 4% or 6% or three visits per year at the health system’s center of excellence for an aging parent or a fitness benefit for themselves at a given dollar value per month?

“We work with our clients to understand the population they’re having concerns with,” Edwards said. “We target the population by working with the HR team to understand their areas of interest and can focus on specific employee groups.”

Modeling scenarios

Insights gleaned from preference survey data can help organizations pinpoint where resources are being wasted on benefits and programs that employees would be willing to give up for more meaningful alternatives. A health system might see huge enrollment in one program versus another that is costing the organization a lot of money but generating little interest. The organization can improve attraction and retention by shifting resources to the preferred benefit, reducing costs in the process.

Preference survey findings led one health system to implement a program that

provided a certain number of medical visits per year to the aging parents of a subset of employees, according to Edwards.

Providers can also dive into specific benefit areas to understand what their people value. “An organization may believe employees want additional employer retirement contributions but discover through a preference survey that they really value having more flexible work arrangements, such as four-day summer work weeks,” she said. “We’re able to see those preferences in real time.”

The analytics platform enables modeling of the cost implications of various hypothetical benefits scenarios as well. The simulations help providers identify cost-saving opportunities while developing programs that more closely mirror the preferences of specific employee populations or the workforce at large.

Predicting ‘flight risk’

In many cases, organizations offer benefits purely based on what seems attractive or what the competition is offering. However, a preference survey may reveal that there are certain benefits that are a significant cost to the employer, but that employees consider disproportionately less important. That number may be large enough to warrant replacing the benefit with another option (e.g., a larger professional development stipend) that reduces the total cost of benefits per employee per year as well.

Machine learning can be used to predict, with a high degree of reliability, the

employees who are at high, moderate and low risk of leaving the organization within given time frames. Providers can proactively target individuals in the flight-risk group who are high-performing employees with specific benefit and reward offers, based on their preferences, that could motivate them to stay with the organization, rather than move to a competitor.

“Benchmarking is not enough, particularly in a post-pandemic world of financial precariousness and employee ambivalence; differentiated benefits and rewards that are meaningful to employees are inconsistent with benchmarking to the 50th percentile,” Glowa said.

“Not surprisingly, aligning total rewards with the market median often does not result in offerings that are meaningful to your employees or that differentiate your programs from your competitors.

“We can help organizations design a program holistically and support the communication, change management and rollout to employees that goes with it,” Glowa said. “But we can also drill down to the level of an individual employee by understanding what that individual cares about. Don’t offer that person a higher retirement plan contribution if what’s important to them is work-life balance and more vacation time with their kids. That’s the hot button you need to press to engage them and motivate them to stay. Our goal is to help organizations make better decisions about their most important asset, their people, and to give them the data that they need to make those decisions with confidence.” ■



Grant Thornton

Our clients take advantage of our collective knowledge, gained from long experience in and with healthcare organizations. More than 400 Grant Thornton healthcare professionals deliver solutions focused on growth, transformation, and protecting core assets.

This published piece is provided solely for informational purposes. HFMA does not endorse the published material or warrant or guarantee its accuracy. The statements and opinions by participants are those of the participants and not those of HFMA. References to commercial manufacturers, vendors, products, or services that may appear do not constitute endorsements by HFMA.

Chapter leaders attend unique training event

Like so many things this year, HFMA's 2021 Leadership Training Conference (LTC) was a little different.

CRYSTAL MILAZZO
cmilazzo@hfma.org

Approximately 350 leaders from HFMA's 63 chapters gathered July 25-27 in Orlando, Florida, for the 2021 LTC. Chapter officers attend the annual event to learn more about their volunteer roles and plan for the coming year. The LTC also provides an opportunity to interact with other leaders from across the country, exchange ideas and share best practices. This

year's event was also a reunion of sorts, as it had been more than two years since the last in-person LTC.

"The HFMA chapter volunteer leadership community really is an extended family," said Brianna Engeseth, a programs administrator who works with HFMA's chapters at the national level. "So it was like a big family get-together."

WHAT WAS DIFFERENT

The 2021 LTC was unlike previous years in that it was a hybrid event, offering content both in person and virtually. This approach provided another way for more leaders to participate, including those who couldn't be there in person whether due to health and safety concerns, travel restrictions or other reasons. According to Engeseth, 115 attendees chose the virtual option.

"Those who attended virtually were grateful for the option," she said. "It enabled volunteer leaders who typically don't get to attend the LTC to participate."

Another difference this year due to planning the LTC during the height of the pandemic was the lack of a conference-wide networking activity. Past such events, which included chapter team competitions often tied to a charity, have been a highlight of the LTC. Engeseth said many regions and chapters took advantage of the free time to go out and network with their local peers.



LTC keynote speaker Anton Gunn stressed the importance of socially conscious leadership.

WHAT WAS THE SAME

As in previous years, LTC attendees participated in office-specific training sessions as well as programs on more general leadership-related topics such as accountability, communication and member engagement. General session speakers included Joseph J. Fifer, HFMA’s President and CEO, and Tammie L. Jackson, HFMA’s 2021-22 National Chair. Anton Gunn, a former state legislator and senior adviser to President Barack Obama, was the 2021 LTC keynote speaker.

WHAT TO EXPECT

Engeseth said local chapter members can look forward to a great year as a result of what their leaders learned at the 2021 LTC.

“Members can take heart in knowing that their local volunteer leaders are highly engaged and ready to provide excellent education and networking opportunities — whether virtually or in person,” she said. ■



▼ As a part of health and safety precautions, LTC attendees sat in pre-assigned, socially distanced seats.

WORLD CLASS COMPLIANCE FOR YOUR SELF-PAY BILLING PROGRAM.

With the dynamic regulatory climate, it's important to have the right team to handle your patient accounts. PFC USA's legal counsel, dedicated compliance staff, and world-class quality assurance program - QA360 - ensures your self-pay billing and recovery programs are compliant with the ever-changing medical billing legislation. Partner with a credentialed agency and recover your patient balances with confidence.



HFMA members Thompson and Pundarika earn *ABF Journal* recognition



Amanda Verner Thompson and **Vasanta Pundarika** have been named to *ABF Journal's* 2021 Top Women in Asset-Based Lending — a list of influential and innovative professionals from multiple disciplines, including strategic advisors, lenders, private equity, accounting and legal. In announcing the inaugural class list, *ABF* said the women on it will help shape the future of asset-based lending. Thompson and Pundarika currently serve as co-heads of healthcare investment banking for Matrix Capital Market Group. Thompson is a member of HFMA's Maryland Chapter, and Pundarika is a member of the Metro New York Chapter.



▲ Amanda Verner Thompson (top) and Vasanta Pundarika (bottom) were recognized recently as leaders in asset-based lending.

Gray and Seale join Kemberton

Two HFMA members recently assumed new positions with Kemberton, a provider of technology-enabled revenue cycle management services.

Deanna Gray, FHFMA, CRCS I/P, is the firm's new senior vice president of customer success. Gray, a member and past president of HFMA's Iowa Chapter, previously held leadership positions with Millennia and Change Healthcare.



Roze Seale, CRCR, also joined Kemberton as a regional vice president of sales. Prior to joining Kemberton, she was regional sales vice president for Promedical. Seale currently serves as secretary of HFMA's Alabama Chapter.



Hancock named Sentara's first CAO

Melinda S. Hancock, MBA, recently joined Sentara Healthcare in Norfolk, Virginia,



as senior vice president and the company's first chief administrative officer (CAO). She previously served as CAO and CFO for the VCU Health System, where she had been since 2016. A member of the Virginia-Washington D.C. Chapter, Hancock also served as HFMA's 2015-16 National Chair.

Isacksen is new CFO at Trinity Health



Daniel P. Isacksen, Jr., MBA, has been named executive vice president and CFO of Trinity Health in Livonia, Michigan. In the new role, he will lead all financial functions for the system and across the national organization's health ministries. Isacksen, a member of HFMA's First Illinois Chapter, was previously with Loyola Medicine in Maywood, Illinois.



Sanders assumes role with Friday Health Plans

Scott Sanders, MSHCA, recently joined Friday Health Plans as the director of contracting and provider relations for the state of Oklahoma. He previously served 10 years with the Oklahoma Heart Hospital in bundled services, payer relations and credentialing. Sanders is the immediate past president of HFMA's Oklahoma Chapter.

Hall promoted at Crowe LLP

Colleen O. Hall, CPC, CPMA, CIRCC, has been named managing partner of the healthcare services group at Crowe LLP. In the new role, she influences the market strategy of Crowe's full range of healthcare industry services including tax, audit, advisory and consulting. Hall is a member of HFMA's Western Pennsylvania Chapter.



St. Francis Medical Center taps Hicks as CFO

Terri Hicks, MBA, is the new CFO at St. Francis Medical Center in Monroe, Louisiana. Hicks, a member of HFMA's Louisiana Chapter, has more than 30 years of experience in the healthcare industry and entrepreneurship. She previously served as St. Francis' vice president of procedural services. ■



To have your professional announcement published in People, contact Crystal Milazzo at cmilazzo@hfma.org.



Ensemble helps healthcare organizations remove payer barriers, streamline processes and systems and implement strategies to increase patient loyalty

How do you help healthcare organizations navigate the biggest challenges in healthcare?

Ensemble partners with more than 380 hospitals and 8,000 providers across the country to drive an average of 5% net revenue lift, allowing healthcare organizations to reinvest in their communities and deliver on their mission.

As the highest scoring revenue cycle outsourcing company in KLAS Research history and the recipient of the Best in KLAS designation for the past two years, Ensemble prides itself on its consistent ability to deliver exceptional revenue cycle results, exceed client expectations and ensure continued client satisfaction.

We are committed to bringing every provider that we support to the peak of revenue cycle performance excellence through our combination of innovative revenue cycle technology, 1,100+ documented best practices and 100% credentialed operator staff.

Our goal is to redefine the possible in healthcare by partnering with clients to

remove payer-placed barriers, streamline processes and systems to increase efficiency and reduce cost, and implement new strategies to increase patient loyalty by meeting the changing demands of modern healthcare consumers.

Our team of healthcare experts stays up to date on the everchanging regulatory environment and constantly shifting market dynamics to proactively partner with healthcare providers and ensure they can navigate reimbursement complexity, adapt to payer changes and overcome obstacles in order to continue delivering on their missions in the communities they serve.

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

Embrace the opportunity to explore a partnership that will support your mission, complement your people and provide results. Be open to speaking with someone who can help you more quickly and effectively identify and resolve the critical gaps in your revenue cycle with tried and tested methods. Find a

partner who can validate what you are doing well and give you tools you need to close the gaps, not simply restate the problems you already know about.

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

Don't rely solely on scorecards and metrics, they don't paint the complete picture. Spend time in each department – walking around, talking to associates and observing the patient experience at your facility. Data can't replace an understanding of what it's like to be an associate, a patient or a physician in your organization. ■

3 years on the Short List
89% of peer reviewers agree or strongly agree Ensemble exceeds expectations



ENSEMBLE
HEALTH PARTNERS

Ensemble Health Partners is a leading provider of technology-enabled revenue cycle management solutions for healthcare providers. We purposefully built our end-to-end revenue cycle management platform to deliver significant and sustainable financial performance improvement for our clients, improve the patient experience, and allow providers to focus on clinical care. We offer end-to-end revenue cycle solutions and a comprehensive suite of point solutions to clients throughout the U.S. Recognized with multiple industry awards and as a Becker's Healthcare Top Workplace, Ensemble is setting a new standard for revenue cycle management—redefining the possible in healthcare by empowering people to be the difference.

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

news

NEWS BRIEFS EYE ON WASHINGTON

NICK HUT

Senior editor
nhut@hfma.org
@HFMANickHut

Photo by Caroline Brehman/CQ Roll Call via AP Images



Under the leadership of Administrator Chiquita Brooks-LaSure, CMS has pulled back on recent changes to site-of-care regulations.

CMS plans to reinstate policies pertaining to the inpatient-only and ASC covered-procedures lists

The 2022 proposed rule for the **Outpatient Prospective Payment System (OPPS)** includes a reversal of two 2021 policies that some hospital stakeholders had opposed: A phase-out of the **inpatient-only (IPO) list** and a relaxation of the criteria for adding services to the ambulatory surgical center covered-procedures list (ASC CPL).

The changes indicate that CMS under the leadership of first-year Administrator Chiquita Brooks-LaSure is less likely than the Trump administration was to look to expand site-of-care options if doing so means overturning longstanding protocols.

The 2021 OPPS rule had established that the IPO list would be eliminated over a three-year period, starting

with the removal of 298 primarily musculoskeletal-related services this year. Now those services would be added back to the IPO list for 2022, meaning Medicare covers them only if they take place in the inpatient setting.

The 2021 rule also had added 267 procedures to the ASC CPL after revising longstanding patient safety criteria. The 2022 rule proposes to reinstate the criteria and remove 258 of the procedures that were added for 2021.

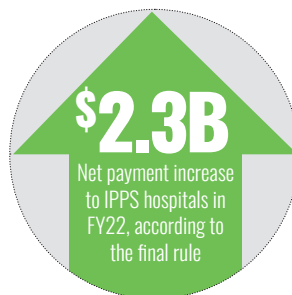
Comments on the proposed rule are due to CMS by Sept. 17.

FY22 Medicare payment increase finalized for IPPS hospitals

CMS on Aug. 2 issued a final rule that sets FY22 Medicare payment and policy changes for hospitals paid through the **Inpatient Prospective Payment System (IPPS)** and for long-term care hospitals.

The overall payment increase for IPPS hospitals that successfully participate in the Inpatient Quality Reporting Program and that are meaningful users of electronic health records will be 2.5%, down from the earlier proposed rate of 2.8%. The change stems from updated economic-forecasting data.

The reduction in uncompensated care payments will be \$1.1 billion, instead of \$660 million as stated in the proposed rule issued in April. As previously decided, CMS will distribute FY22 uncompensated care funds based on a single year of a hospital's data on **Worksheet S-10** of FY18 cost reports.



New surprise billing regulations place restrictions on balance billing

Hospital revenue cycle departments should get up to speed on balance-billing restrictions that will take effect Jan. 1, 2022, in accordance with a new federal rule.

Even in various situations where balance billing will remain permissible, hospitals will have to implement additional procedures involving **notice and consent** unless they are in a state where such regulations already exist.

Following emergency care, for example, balance billing will be allowed for **post-stabilization services** if the attending emergency physician or treating provider determines that the patient is capable of traveling to an in-network facility.

If a patient is deemed fit to travel for care and still chooses to receive post-stabilization services on an out-of-network basis, the patient may be balance-billed if the provider follows the notice-and-consent procedures established in the rule.

CMS is preparing to make price transparency noncompliance much more expensive

Proposed 2022 regulations for the Outpatient Prospective Payment System include tougher penalties for violating price transparency mandates that took effect this year. Namely, the \$300 per day penalty for noncompliance would rise significantly for **larger hospitals**.

The \$300 rate would remain for hospitals with 30 or fewer beds. The penalty would rise by \$10 per day for each additional bed, with a maximum allowable penalty of \$5,500 per day.

Thus, for hospitals that remain

FY22 Inpatient Prospective Payment System: National Adjusted Operating Standardized Amounts

HOSPITALS WITH A WAGE INDEX GREATER THAN 1:
67.6% LABOR SHARE/32.4% NONLABOR SHARE

Hospital submitted quality data and is a meaningful EHR user (Update = 2%)		Hospital submitted quality data and is <i>not</i> a meaningful EHR user (Update = -0.025%)	
\$4,138.28	\$1,983.43	\$4,056.12	\$1,944.05
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
Hospital did <i>not</i> submit quality data and is a meaningful EHR user (Update = 1.325%)		Hospital did <i>not</i> submit quality data and is <i>not</i> a meaningful EHR user (Update = -0.7%)	
\$4,110.89	\$1,970.30	\$4,028.74	\$1,930.93
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related

HOSPITALS WITH A WAGE INDEX LESS THAN OR EQUAL TO 1:
62% LABOR SHARE/38% NONLABOR SHARE

Hospital submitted quality data and is a meaningful EHR user (Update = 2%)		Hospital submitted quality data and is <i>not</i> a meaningful EHR user (Update = -0.025%)	
\$3,795.46	\$2,326.25	\$3,720.11	\$2,280.06
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
Hospital did <i>not</i> submit quality data and is a meaningful EHR user (Update = 1.325%)		Hospital did <i>not</i> submit quality data and is <i>not</i> a meaningful EHR user (Update = -0.7%)	
\$3,770.34	\$2,310.85	\$3,695	\$2,264.67
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related

Source: CMS, FY22 Hospital Inpatient Prospective Payment System final rule

noncompliant for an entire year, the penalty would range from \$109,500 to **slightly more than \$2 million.**

Study: In price negotiations with hospitals, self-insured employers lack leverage

Hospitals have the advantage in negotiations with self-insured employers, which struggle to exert market power in a way that affects prices, according to a new study.

As reported in the July 2021 issue of the *American Journal of Managed Care*, researchers examined the association between an employer’s market power and negotiated **hospital prices.** The association “becomes statistically insignificant once the models control for hospital wages,” wrote researchers with the Bloomberg School of Public Health.

The researchers quantified employer market power through a complex calculation that was described as similar

to the **Herfindahl-Hirschman Index (HHI).**

During the study period, 2010-16, “the average employer market was very unconcentrated,” the researchers wrote. The average value of employer market power on the research team’s scale was 62, compared with 5,410 for hospital market power; a market score of 2,500 or higher in the HHI is considered “highly concentrated.”

Fitch describes the heightened risk posed by cyberattacks on NFP hospitals

Not-for-profit (NFP) hospitals increasingly will face revenue and expense pressures from cyberattacks, according to Fitch Ratings.

In a July 22 news release, Fitch noted the “historic increase” in the volume and severity of cyberattacks over the past 18 months.

“Ransomware pay-outs and efforts to protect or ‘harden’ healthcare systems and cyber defenses are affecting hospital financial flexibility by increasing ongoing operating expenses,” Fitch wrote. “Attacks may also hinder revenue generation and the ability to recover costs in a timely manner, particularly if they affect a hospital’s ability to bill patients when financial records are compromised or systems become locked.”

Full restoration of systems required an average of 236 days per attack in 2020, Fitch reported. ■

About the author

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

55%
Increase in cyberattacks on healthcare entities in 2020 compared with 2019, according to Bitglass

Two infrastructure bills have significant implications for healthcare and bipartisanship

Congress' handling of two mammoth bills may well determine the political tone in Washington and whether there will be any room for bipartisanship for the remainder of President Joe Biden's term.



KEN PEREZ
ken.perez@omnicell.com



One of the bills was recently passed by Congress, but the future of the second, much larger bill remains very much in question.

PHYSICAL INFRASTRUCTURE

The recently passed bill, which had bipartisan sponsorship, is focused on physical infrastructure, including transportation, water systems, broadband, power grids and other areas. It has no provisions directly pertaining to healthcare. The bill carried a price tag of \$1.2 trillion, including \$550 billion in new spending, with the remainder, which is baseline spending, subject to regular congressional review.

The Senate passed the bill on Aug. 10 by a wide bipartisan majority vote of 69-30, as 19 Republican senators joined Democrats in supporting the initiative, including Susan Collins (Maine), Lisa Murkowski (Alaska), Rob Portman (Ohio) and Mitt Romney (Utah), but also conservative Senate Minority Leader Mitch McConnell (Ky.). The bill's passage was widely hailed as a triumph of bipartisanship.

HUMAN INFRASTRUCTURE

The Democrats' \$3.5 trillion human infrastructure spending plan could be a rather different story. It would provide hundreds of billions of dollars for a wide range of progressive priorities, spanning tax credits, climate change, education, housing, healthcare and immigration. Sen. Bernie Sanders (I-Vt.) has described it as "a huge bill ... a complicated bill ... a transformative bill."^a The health provisions, which progressives consider must-haves, include:

- Enhancing Medicare to cover dental, vision and hearing services
- Expanding home care
- Funding healthcare for the roughly 2 million people living in the red states that have refused to expand Medicaid

Senate Democrats plan to use budget reconciliation, an arcane process that would prevent the Republicans from filibustering and require just 50 votes for passage of the bill, given Vice President Kamala Harris's tie-breaking role as president of the Senate.

^a Caitlin, E., et al., "Climate, immigration, Medicare lead progressive highlights in Dems' \$3.5T budget plan," POLITICO, July 14, 2021.



Listen to Episode 4 of HRG's Revenue Cycle Review Podcast featuring Jenny Guthrie, Drew Memorial's Revenue Cycle Director
hrgpros.com/revenue-cycle-review-podcast/episode-four



"HRG has been a good partner for our hospital organization. They work collaboratively and effectively with our staff, which has proven to be a huge factor in achieving the outstanding revenue cycle results. Working with HRG has had a significant impact on our cash, continually increasing year over year. We are very pleased."

Scott Barrilleaux, MHA | CEO | Drew Memorial Health System | Monticello, AR

CUSTOMIZED SOLUTIONS

When you partner with HRG, you get a team of specialists committed to your success.



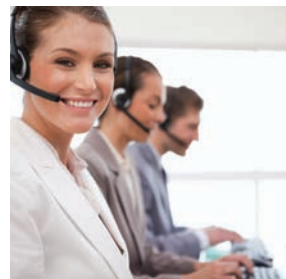
COMPLETE BUSINESS OFFICE

Strengthen your entire revenue cycle with efficient workflows



EXTENDED BUSINESS OFFICE

Our team is equipped to handle the toughest AR



EARLY OUT SELF-PAY

Increase patient collections and satisfaction




REMOTE MEDICAL CODING

The perfect match of quality and production

\$1.2 trillion

Amount of spending authorized
by the physician infrastructure bill
passed by Congress on Aug. 10



Not surprisingly, Republicans in the Senate are strongly and uniformly opposed to the bill, which means that the Democrats will need to secure the support of every member of their caucus of 50 senators for it to pass. Some moderate Democrats have expressed concerns about the spending plan's high overall price tag and the potentially large tax increases needed to pay for it. Thus, the fate of the bill probably is in the hands of a handful of moderate Democratic senators, including Sens. Joe Manchin (W.Va.), Kyrsten Sinema (Ariz.), Maggie Hassan (N.H.) and Jon Tester (Mont.).

POSSIBLE SCENARIOS

With the passage of the physical infrastructure bill, there are various scenarios with respect to the legislative outcomes for the human infrastructure bill, with significantly different implications for bipartisanship on Capitol Hill.

If the human infrastructure bill passes along party lines, the level of partisan acrimony in Congress would likely rise, poisoning the well of bipartisanship at least for the remainder of this year.

However, if the human infrastructure spending plan is significantly amended or blocked because of moderate Democrats' concerns, such scenarios could signal to Republicans — especially moderates such as Collins, Murkowski and Romney — that the Democrats recognize they need to be willing to compromise, at least within their caucus and potentially across the aisle.

RELEVANCE TO HEALTHCARE

In addition to sucking up all the oxygen in Washington for several months, the fate of the two bills will impact the prospects of much less costly, but still important, common-sense bipartisan healthcare initiatives.

For example, the Pharmacy and Medically Underserved Areas Enhancement Act (H.R. 2759/S. 1362), introduced in the House on April 22 and in the Senate on April 26 with bipartisan sponsorship, would add pharmacists to the list of providers whose patient care services, when delivered in medically underserved areas (MUAs), are covered by Medicare Part B. This change would help to ameliorate the nation's current shortage of 15,000 primary care physicians and improve access to care for the 44 million Americans living in MUAs.

A POTENTIALLY BIG ROLE FOR MODERATES

Given the current composition of the Senate, which is split equally between Democrats and Republicans, it is clear that bipartisanship will be required to pass significant legislation, as seen with the physical infrastructure bill. Without some measure of bipartisanship, common-sense bills could stall for the remainder of 2021, resulting in legislative gridlock that will not sit well with most voters. Amid a climate of voter dissatisfaction, moderates from both political parties could succeed in passing less-ambitious bipartisan bills, since most members of Congress want to be able to cite some legislative accomplishments before the 2022 midterm elections. ■

About the author

Ken Perez is vice president of healthcare policy, Omnicell, Inc., Mountain View, Calif., and a member of HFMA's Northern California Chapter.

RESET YOUR TRUE NORTH

Reconnect with your community and catch up on
the latest industry trends and best practices.

3-Day Program

8 Content Tracks

14 CPE Credits!



ROBERT PEARL, MD
Stanford University professor,
Forbes contributor, bestselling author



DAVID SHULKIN, MD
Physician, Ninth Secretary of U.S. Dept.
of Veterans Affairs, Author



CELESTE HEADLEE
Internationally recognized journalist
and communication expert



2021
Annual Conference
November 8-10

JOIN US IN MINNEAPOLIS OR ONLINE

hfma.org/annual-mn



FREE REGISTRATION!

Executive connections is a matchmaking program
that connects you to solution providers.

Find out if you qualify!

hfma.org/annual-mn



Registrants of the first Annual Institute on Hospital Accounting gathered at Indiana University in 1941 and began to discuss the idea of an organization for hospital accountants. The event was organized by one of HFMA's founding fathers, Stanley Pressler, associate professor of accounting at IU (front row, sixth from the left). All but three attendees at the institute are pictured. Other founders of HFMA who attended this historic event were Graham Davis (front row, 8th from the left) and Robert H. Reeves (second-to-last row, second from the right).

A MAJOR MILESTONE

This year marks **HFMA's 75th year** of promoting the profession and practice of healthcare finance. The not-so-secret key to the Association's longevity? **The people.**

CRYSTAL MILAZZO
cmilazzo@HFMA.ORG

David Canfield, FHFMA, the first business partner to serve on HFMA's national board of directors and as National Chair, attributes much of his success to the organization. "HFMA was strong because of the people who were involved," Canfield said. "Everybody had their whole heart in it."

Canfield, who established "It's personal" as the theme for his term as HFMA's 2003-04 National Chair, is not alone in attributing personal achievement to the Association's support. "Being part of HFMA has been one of the most significant professional steps of my career," said Cathy Jacobson, FHFMA, CPA, president and CEO, Froedtert Health, Milwaukee, and 2009-10 HFMA National Chair. "My opportunity to participate and lead at the national level and the support and development I received from HFMA staff and my colleagues was ... instrumental."



David Canfield, FHFMA, served as HFMA's National Chair from 2003-04.



Cathy Jacobson, FHFMA, CPA, was HFMA's 2009-10 National Chair.

NEXT PAGE



Geraldine Hoyler, CSC, FHFMA, is one of five Catholic Sisters who've served as the Association's National Chair.

In recognition of HFMA's 75th year of existence, more than 20 people involved with HFMA — from well-known leaders like Canfield and Jacobson to others who've worked behind the scenes — reflect on their experiences.

HEALTHCARE FINANCE AS A MISSION

Just as Catholic Sisters were early leaders in caring for patients and financing and running hospitals, they also were instrumental in launching and growing HFMA. And they didn't just have a seat at the table — they often were at the head of it. During a pivotal period, four different nuns served as the elected leader of HFMA from 1954 to 1970, and one more was elected in 1989.

The five Catholic Sisters who have served as HFMA's top elected leader are:

- Sister Mary Gerald (1954-1955)
- Sister Loretta Marie (1960-1961)
- Sister Mary Assunta (1964-1965)
- Sister Mary Bertrand (1969-1970)
- Sister Geraldine Hoyler (1989-1990)



Ronald Kovener, FHFMA, 1972-73 National Chair, was the first director of HFMA's Washington, D.C. office.

Sister Geraldine, CSC, FHFMA, a former CFO of Holy Cross Health System and Catholic Health Initiatives and currently a healthcare consultant with Christian Brothers Services in Romeoville, Illinois, said HFMA fostered innovation among its members by creating an environment where they could think out loud about the right course of action. "Through HFMA, I had peers who

would say, 'That doesn't make one iota of sense,' or 'This is how we do it,' or 'Yes, I think that would work,'" said Sister Geraldine. "You serve better, in my case the ministry, because you're not thinking in your own little box. Your box is much broader, and it has many more points of view."

The Catholic Sisters helped to create an organization that encouraged that kind of dialogue, Sister Geraldine said. "Leading and speaking out was never something that we feared to do," she said. "It was always just part of what we did. And we didn't have to worry about politics as women religious [sic]. We were there for the mission."

Sister Geraldine said the need for more advanced financial management of healthcare institutions evolved after World War II with the advent of health insurance. People had to figure out how to deal with those health insurance plans, and the Catholic Sisters, who had served in key hospital positions, were poised to lead the effort. "Why wouldn't they just step forward, and tell people, 'We need to do this and let's do it'?" Sister Geraldine said. "They were used to working together, and they were experienced leaders. They went and did what needed to be done. It was a comfortable position for them, and there was never an issue of acceptance."

INNOVATING IN WASHINGTON, D.C.

Ronald Kovener, FHFMA, was the Association's trailblazer in 1973 when the decision was made



Joanne Judge, FHFMA, CPA
Stevens & Lee, P.C.
1991-92 HFMA National Chair
Reading, Pa.



HFMA opened my eyes to the similarities and differences in the way that healthcare is delivered and financed in different parts of the United States and the world. As a professional association, HFMA is viewed by decision-makers as knowledgeable, innovative, forward-thinking, and an organization that can be trusted to consider impact for many segments of the industry."



Robert Broadway, FHFMA
2008-09 HFMA National Chair
West Palm Beach, Fla.



HFMA has been the foundation of my career, providing education and content. From *hfm* to chapter meetings to our Annual Conference, HFMA has always been there for me. And most importantly, all along the way I was 'Making Connections' with members for a lifetime."



Joe Pajor,
FHFMA
Retired healthcare
executive
Westbrook, Conn.



HFMA has served as the beacon for all healthcare finance industry stakeholders. Whether it be providing a loud industry voice, charting new strategies or spotting industry threats, HFMA has consistently been the conduit for healthcare financial collaboration, education and communication.”



Lisa Keffer
Relationship Manager,
Meduit
McKinney, Texas



I originally joined HFMA to stay informed of the ever-changing dynamics in healthcare. After joining the South Texas Chapter, it became much more of a team environment, and this motivated me to increase my involvement in HFMA by taking on a leadership role. I have learned so much through networking and being a part of this outstanding association.”

to establish an office in Washington, D.C.

“Nixon’s price freeze had been very unfavorable to the healthcare field, and we felt we needed more of a presence in D.C. to learn what was going on,” said Kovener, who had just finished a term as HFMA president. “So I put up my hand and said, ‘I’d like to do that,’ and they took me up on it.”

Initial goals for the new Washington office included collecting information about legislation and regulations that impacted healthcare finance and disseminating it to HFMA members, providing input into the development of such proposed bills and regulations, and coordinating efforts with related organizations.

“Getting HFMA well-recognized in Washington was a goal, and I think that happened very thoroughly,” said Kovener, who headed up the office for more than 20 years. “I had the great advantage of having many other healthcare associations there in D.C., and we got together regularly.”

To keep members informed, Kovener created WASHLINE — a weekly three-minute recorded phone message that provided an update on what was going on in the nation’s capital related to healthcare finance. “At that time, when you made a long-distance phone call, you paid a fixed amount for three minutes,” said Kovener. “Anything over that was at a variable rate, so I devised this tape-recorded message that was exactly three minutes long. I scripted it very

carefully and then recorded it on a reel-to-reel tape recorder.”

WASHLINE became popular not only with HFMA members but also with some of the bigger hospitals and other associations that recorded the taped phone message and distributed it to their own staff and members.

AN INDEPENDENT FORCE

HFMA adopted a corporate structure in 1978. It included hiring a salaried president and CEO who could bring credibility and presence to negotiations with other groups. Four individuals have held the position in the past 43 years: James Whitman, Michael Doody, Richard L. Clarke and Joseph J. Fifer. Each spearheaded initiatives that moved HFMA forward in its mission to lead the financial management of healthcare.

Whitman, who served as president and CEO from 1978-82, said one of the biggest challenges he faced was addressing the concern that it was time for HFMA to move out from under the shadow of the American Hospital Association, both figuratively and literally, as the two organizations were located close to one another on North Lake Shore Drive in Chicago.

“There were those who believed we’d never recover if we moved the HFMA offices away from the Chicago lakefront where AHA was located,” said Whitman. “And there were others of us who



James Whitman,
FHFMA,
was HFMA’s
first salaried
president and
CEO.

NEXT PAGE

HFMA logo through the years



1947



1968



1982



1984



2001



2017

▶ Visit hfma.org/about-hfma/75th-anniversary.html to watch a video series highlighting HFMA's history



Michael Doody, HFMA's second president and CEO, served from 1983-86.

felt we needed to become recognized in our own right, representing the chief financial officers and others working in healthcare finance. The profession was growing in stature, and we felt it needed to be an independent organization that was recognized for what it brought to the field."

The opportunity to make a move presented itself in 1980 when the owners of the building at 666 North Lake Shore Drive where HFMA had its offices decided to convert it into condominiums. "We decided to move to Oak Brook [Illinois], and that made a very significant difference," said Whitman. "We were able to put the organization on a whole new footing at that point."

A NEW PERSPECTIVE

Michael Doody, who served in the role from 1983-86, was HFMA's only CEO who didn't have

a finance background but rather had leadership experience with state and national healthcare associations, including AHA and the American Osteopathic Hospital Association. Doody's background positioned him to take on the major project of developing a strategic plan.

A second, more controversial issue that Doody tackled was the location of the Annual National Institute (ANI). At the time, the event took place every year at the University of Colorado in Boulder — a site popular with the attendees who liked to take advantage of the location to add on a family vacation. "I thought it was curious that an organization with 25,000 members in all 50 states had an annual meeting in a facility that could accommodate only 500 attendees," said Doody. "It became immediately obvious that we were missing an opportunity."



Mark Knight
CEO, HFMA U.K.



As global leaders, the USA and UK have a 'special relationship' amongst nations. This is mirrored by HFMA where for nearly 60 years the two Associations have remained close friends. Through our various programs over the years and our continued dialogue, we have learnt from each other and grown together."



Nikki Harper,
Vice President,
Patient Business Services,
Trinity Health
Farmington Hills, Mich.



In every difficult moment in my career, I have leaned on my HFMA circle. A grad school professor gave the best advice: 'Choose wisely who you associate with. There are people that will help you excel by pushing you to be the best version of you. These aren't the people that tell you what you want to hear. These are the people that will challenge you to work harder, get results faster and never stop learning.' And he was right. That is the value of HFMA, and I cannot imagine my career without it."



John Travis, FHFMA
Vice President,
Regulatory Strategy,
Cerner Corp.
Kansas City, Mo.



HFMA is one of the most respected voices in our industry for sound policy development and guidance, not just to its membership but to regulators and lawmakers at the state and federal level. The standing HFMA has enjoyed makes it a strong voice for advocating for reasoned, pragmatic approaches to solving the fiscal and delivery system structural challenges in the U.S. healthcare system.”



John P. McGuire, FHFMA
1994-95 HFMA
National Chair
St. Louis, Mo.



HFMA membership means leadership opportunities, professional growth and friendship.”

Doody believed both the lack of space and the expense of getting to Boulder from other parts of the country were prohibiting interested members from attending the conference. He also maintained that more space would allow the inclusion of business partners, which could be an important source of revenue. The chapter presidents agreed and also recommended the event be moved.

Despite some complaints from members, the change was ultimately approved, and the 1985 ANI was held in Philadelphia. One year later, business partners were added, and ANI attendees had the opportunity to spend time on the exhibit floor during meals and cocktail hours.

RESPONDING TO AN EVOLVING INDUSTRY

When Richard L. Clarke, FHFMA, DHA, was hired as HFMA’s third president and CEO in 1986, his plan was to stay in the position for five years. He retired from the job more than two decades later in 2012.

According to Clarke, the most challenging time during his 26-year tenure was the mid-1990s to mid-2000s. Medical group management companies were developing large networks of physicians, and insurance companies were consolidating, resulting in stand-alone hospitals merging into increasingly larger systems. The relationship between the stand-alone CFO within a market and the local chapter started to change

as large systems began to consolidate financial operations.

“Finally, the financial collapse of many IT startups in 2000 drove the economy into recession,” said Clarke. “All of this resulted in a significant decline in HFMA membership. We had to compress national operations through a reduction in force, but still help chapters and members deal with the changing market dynamics.

“We came through that challenge and grew stronger, but it was a turning point from what was a fragmented cottage industry of providers, facilities and insurance companies into very large organizations.”

Clarke believes one of HFMA’s most important accomplishments was quickly adjusting to the changes in the industry by reframing how HFMA was perceived in the market and by members. “We emphasized being a voice for healthcare finance and contributing to the debate on key issues,” he said. “We increased our presence in Washington, D.C., on the regulatory side and started the Patient Friendly Billing project, followed by increased involvement in accounting policy issues with AICPA and FASB.”

LEADING THROUGH A PANDEMIC

HFMA’s current president and CEO — Joseph J. Fifer, FHFMA, CPA — says it was a dream come true when presented with the opportunity



HFMA’s third president and CEO was Richard L. Clarke, FHFMA, DHA. He held the position for 26 years.

NEXT PAGE

Working for HFMA: What it's really like

Throughout HFMA's 75-year history, dedicated staff have worked alongside members to advance the healthcare finance profession and industry. Five of the Association's longest-serving employees recently shared their experiences.



Marjorie Parker

Office Manager,
Washington, D.C.
Employee since 1983

Why she's stayed: "I have learned so much being here at HFMA and have grown so much in my life and profession. I always say 'HFMA raised me.'"

Biggest changes witnessed: Staff changes. "Being here for more than 35 years, you see a lot of people come and go."

Favorite HFMA memory: When the Washington, D.C., and Westchester office staff had a joint team-building session at the McDonald's Lodge. "It was so much fun and a really nice bonding experience."

Best thing about working for HFMA: "Opportunities to learn and grow into this person I am today. I've made some lasting relationships with staff, HFMA members and their assistants. HFMA made my world bigger, and better. I am grateful for the journey, and it continues."



Rosalind Lewis

Technical Analyst,
Washington, D.C.
Employee since 1992

Why she's stayed: Learning opportunities and relationships. "I have also found HFMA to be a family-friendly work environment. I don't feel like I have to sacrifice being present for my family in order to fulfill the requirements of the job."

Biggest changes witnessed: Strategic and directional changes.

Favorite HFMA memory: Attending the annual meetings and getting an opportunity to match names to faces and interact with members.

Best thing about working for HFMA: Working alongside talented individuals dedicated to helping members on their quest to deliver quality healthcare to the patients they serve. "I also enjoy interacting with members, finding out what their needs are and how I can help address those needs."



Sue Ketter

Salesforce Analyst,
Westchester, Ill.
Employee since 1994

First position: Member Service Center Associate. "I started as a temp in 1993 when my friend and neighbor asked if I was interested in helping out and then was hired as a full-time employee in 1994."

Why she's stayed: "The people! Both my co-workers and our customers. I always like to say that it is like having friends all over the country."

Biggest changes witnessed: The change from iMIS to Salesforce and the automation of so many processes that were once manual.

Favorite HFMA memory: HFMA's 50th Anniversary. "Bob Shelton — 'Mr. HFMA' — came into the office and could tie HFMA history to his family history. It was interesting and highly entertaining."

Best thing about working for HFMA: The people and the challenges.



Eric Reese

Editor and Writer,
Westchester, Ill.
Employee since 1997

Why he's stayed: HFMA's emphasis on fostering a collaborative culture and abiding respect for staff expressed from the top down.

Why working for HFMA has been such a good experience: The members. "So many of them testify openly how HFMA has been a meaningful, even indispensable, part of their lives."

A favorite HFMA memory: Working with Glen Kazahaya, a long-time member and past president of HFMA's Southern California Chapter, on a two-part series he hoped could serve as a legacy of his work in healthcare. Part two, published shortly before Kazahaya's death, was a winner of HFMA's Helen Yerger/L. Vann Seawell Best Article Award for FY2019-20.



Shirley Heavlin

Certification Operations,
Westchester, Ill.
Employee since 2000

Why she's stayed: HFMA's commitment to its members and volunteers.

Biggest change witnessed: The successful digital transformation in 2019, including the new website and new membership model.

Recent accomplishment: The seamless implementation of HFMA's digital badging program for its certification programs. "The HFMA/Credly credentialing digital badging program was initiated parallel with the launch of HFMA's digital transformation initiative. I was honored to be asked to write an article on this project for *hfm*, explaining my role and the project goals."

A favorite HFMA memory: The retirement events hosted for Dick Clarke, former HFMA president and CEO, at the 2012 Annual Conference.



Dave Timpe, FHFMA
Retired healthcare executive
Hartford, S.D.



HFMA's most important contribution to the profession of healthcare finance is providing opinions and guidance from member experts that can be put into action."



Pete Sabal, FHFMA
Senior Vice President,
Network Contracting,
Optum Care
Las Vegas, Nev.



HFMA has always been an organization that has helped keep me informed on relevant issues and trends in healthcare. It also has kept me connected with the most knowledgeable people."

to succeed Clarke in 2012. "Many years of volunteerism and involvement led me to the CEO position," said Fifer, who also served as HFMA's 2006-07 Board Chair. "But what emotionally led me to it was passion. I've loved HFMA. It's been so meaningful to me my whole business career."

Fifer's HFMA experience was crucial in 2020 when the Association faced what Fifer says was the biggest challenge of his entire career: the COVID-19 pandemic. "It took everything I had to remain calm," said Fifer. "We were talking about not being able to do the Annual Conference, and we had canceled or rescheduled spring events for the fall, naively not knowing the future.

"Our first modeling of what the pandemic could mean to us showed that the moderate-level scenario was in excess of an \$8 million loss," he said. "You can't just cut your way out of that."

Fifer credits one of his mother's sayings — "Don't worry about the money" — with helping him stay calm and think clearly about how to manage through the pandemic-related challenges. "I can't say I didn't worry," he said. "But it wasn't completely driven by just financials."

With that mindset, Fifer worked with the HFMA Board and staff to make decisions and implement changes that enabled the organization to survive the challenges.

LOOKING TO THE FUTURE

Fifer's next challenge is leading the organization in determining what it needs to do to remain

relevant and successful. That includes promoting cost-effectiveness of health as an underlying strategy. "I don't think success in the future will come from being exactly the way we have been for the first 75 years," Fifer said.

"Society is changing in all kinds of ways, and we need to change accordingly. We need to be even more of a solve-based organization, both for today's issues and tomorrow's challenges." ■

About the author

Crystal Milazzo is a senior editor at HFMA



A former HFMA National Chair, Joseph J. Fifer, FHFMA, CPA, is the Association's current president and CEO.



The California Chapter received its charter in 1953. As listed in *From Acorn to Oak*, Frances B. Ducey, an AAHA board member (at far left), presented the charter to (left to right) Lucy Gorton, Charles W. Cullen, Elmer O. Messmann, Gardner E. Burke and Alfred E. Maffley, the Chapter's president.

Single-use endoscopes offer a safe way for healthcare providers to catch up on backlog of nonemergent care procedures

Patients and healthcare organizations alike are playing catchup for nonemergent care procedures that were put off during the COVID-19 pandemic, and providing patients with safe, affordable and accessible care is top of mind for providers.

Ambu A/S, headquartered in Ballerup, Denmark, created the world's first disposable video endoscope in 2009, and now offers a wide spectrum of single-use endoscopes for hospital-based procedures in the operating room, emergency room, intensive care units and at the bedside. Their products have been used for millions of endoscopy procedures performed in office and outpatient clinic care settings, as well.

"We give [healthcare organizations] the ability to grow an endoscopy department and become more efficient without hurting the balance sheet," said Ambu CFO Michael Bavonese.

Today, Ambu's complete line of single-use endoscopes includes 2021 Red Dot Award-winning duodenoscopes and cystoscopes as well as rhinolaryngoscopes and fourth-generation bronchoscopes. Ambu also replaces a traditional video endoscopy tower's size and expense with a compact, portable platform that is significantly less expensive.

Benefits of single-use devices

"We have a health economics team that works closely with healthcare organizations," Bavonese said. "What their analyses show is that when all the benefits of single-use are considered – including streamlining operations, improving workflow and efficiency, and reducing cross-contamination and patient

infection risk – single-use is cost neutral or even saves money for many facilities."

There also is a cost for the time, personnel and materials used to clean reusable devices. In addition to these maintenance expenses, staff and devices are unavailable for other procedures during the cleaning process.

"It's become more and more evident how difficult it is to clean reusable devices," said Jens Kemp, Ambu's vice president of marketing. "There is no way to guarantee that scopes are 100% clean."^a

Reprocessing endoscopes can take up to two hours to complete and includes up to 100 steps, which must be strictly adhered to for adequate disinfection. The U.S. Food and Drug Administration has acknowledged in several safety communications that reprocessed endoscopes pose a risk for cross-contamination and patient infection.

In the latest communication from the agency to address reprocessed bronchoscopes, single-use bronchoscopes were recommended for use on patients at high risk for transmitting infection or when reprocessing is not immediately available. The FDA also encouraged providers to consult COVID-19-related recommendations from the American Association for Bronchology and Interventional Pulmonology on the use of single-use bronchoscopes in coronavirus cases.

FDA safety communications about reprocessed duodenoscopes and urological endoscopes have also included information

a. Devices for which a 510(k) should contain validation data (Reprocessing Final Guidance Appendix E.), U.S. Food & Drug Administration, March 23, 2018.

about outbreaks traced back to contaminated scopes.

In addition to the patient impact, an outbreak related to a contaminated endoscope could be financially and reputationally devastating. With single-use devices, healthcare facilities are able to remove cross-contamination and infection risks.

Kemp also pointed out that older technology, like a fiber scope that an ear, nose and throat doctor (ENT) may use, would put the doctor in close proximity to each patient. Maintaining safe distance, particularly after the pandemic, is a priority for doctors and patients.

"Our video technology allows more distance [between the clinician and] the patient," he said.

In the wake of the pandemic, the distance, cleanliness and accessibility of single-use endoscopes are especially significant.

"COVID has shown that sometimes external factors happen that influence demand for services to the hospital," Kemp said, referring to an almost complete stop of revenue-generating services during the pandemic.

"Reusable equipment is sitting on a balance sheet incurring costs even with no activity."

"Because reusable equipment costs are generally fixed – depreciating capital investments, reprocessing operations and repair contracts – if procedures slow or stop, those costs don't decline to match the loss in income," he said.

By contrast, single-use endoscopes are considered supplies, and costs therefore vary by procedure volume, creating predictable margins. Because they're supplies, they

do not depreciate and stay on a balance sheet for years like reusables.

“There is a real cost to maintenance agreements that you have to pay out,” Bavonese said, pointing out that single-use scopes relieve that financial burden because you only pay for a scope when you have a procedure.

Facing the backlog of procedures

Now, as medical providers face more than a year’s worth of backlogged procedures, they need resources efficient enough to make up for lost time without the long-term financial commitment of reusable items.

“How can you expand capacity for a temporary period of time without investing in capital you might not need 12 months from now?” Kemp asked.

Single use is the answer. Single-use flexible endoscopes are sterile and patient-ready out of the package. They offer a system that is always ready when needed, without the risk of cross-contamination and without the delayed clinical workflow from cleaning and reprocessing.

“The ability to do procedures efficiently is really important,” Bavonese said. “Our product is about as efficient as you can get.”

Healthcare organizations can start a program with Ambu efficiently and with low capital investment.

In fact, Ambu hosts a team of clinical training specialists who provide continued support for customer training and education. This

team also collects client feedback to guide new developments that meet market needs.

The long lifespan of reusable devices also leads to slower adoption of new technologies — a hurdle not faced with single-use products.

Ambu’s track record of innovation

“A key feature for healthcare organizations to know is our track record of innovation in the medical device industry,” said Kemp. “That includes our ability to rapidly accelerate the introduction of new technologies with shorter product life cycles.”

Ambu has been around for more than 80 years and is widely known for the self-inflating resuscitator bag developed by founder Holger Hesse and anesthesiologist Henning Ruben in 1956. The Ambu ventilation bag is widely used for emergency medicine and hospital care.

Now, they’re Frost & Sullivan’s 2021 Global New Product Innovation Award winner thanks to their work on single-use endoscopy.

They take advantage of rapid technology advancements with image sensors, materials, artificial intelligence and image enhancement. By pairing innovation with high-scale, low-cost manufacturing, Ambu is always improving.

“Our short product life cycles are unique,” said Kemp. “As soon as a product has launched, in most cases, we’ve already started developing the next generation.”

Ambu is on contract with the United States’ four major group purchasing organizations (GPOs), with recent contract expansions giving 90% of the country’s hospitals access to the complete line of single-use endoscopes and giving 98% of the hospitals access to their rhinolaryngoscopes, bronchoscopes and cytosopes.

“If a hospital goes to a single-use model, they need to be confident there’s not going to be a supply issue,” Kemp said. “They want to make sure manufacturers are able to meet the demand.”

Ambu has that advantage, he said, noting they sold nearly 1.1 million endoscopes last year. Their closest competitor sold about one-fifth of that.

Since the pandemic, they’ve doubled their manufacturing capacity to meet the significant spike in demand.

“All of our products are single use. That’s all we do. That’s what gives us this advantage, this manufacturing scale,” Bavonese said. “This ability to manufacture and sell at a fair price is very important.” ■

To learn more about Ambu products, visit www.ambuusa.com

To access some of their latest insights, as well as flexible endoscopy news and analysis, visit Ambu’s learning centers:

- www.ambuusa.com/webinars
- www.ambuusa.com/the-single-use-endoscopy-leader
- www.singleuseendoscopy.com
- learning.singleuseendoscopy.com

Ambu

Ambu has been bringing the solutions of the future to life since 1937. Today, millions of patients and healthcare professionals worldwide depend on the efficiency, safety, and performance of our single-use endoscopy, anesthesia, and patient monitoring & diagnostics solutions. Headquartered near Copenhagen in Denmark, Ambu employs approximately 4,500 people in Europe, North America, and the Asia Pacific. For more information, please visit www.AmbuUSA.com.

This published piece is provided solely for informational purposes. HFMA does not endorse the published material or warrant or guarantee its accuracy. The statements and opinions by participants are those of the participants and not those of HFMA. References to commercial manufacturers, vendors, products, or services that may appear do not constitute endorsements by HFMA.



EXPERT REVIEWED



Weighing the feasibility of an **LLC-owned** retail pharmacy enterprise

University of Utah Hospitals and Clinics (UUHC) in Salt Lake City performed research to assess the feasibility of moving its 340B covered-entity pharmacy enterprise to a Limited Liability Corporation (LLC). An important focus was on risks that needed to be factored into the decision.

**NATHAN HAGEN**

nathan.hagen@hsc.utah.edu

**LINDA TYLER**

linda.tyler@hsc.utah.edu

**IAN MACDONALD**

ian.macdonald@hsc.utah.edu

**NANCY NICKMAN**

nancy.nickman@pharm.utah.edu



Other organizations that are considering a similar move can benefit from adopting or emulating UUHC's approach, which included financial modeling. Although UUHC found the strategy feasible and worth pursuing, other organizations might have different circumstances

that lead them to a different conclusion. Recent volatility in the contract pharmacy area of the 340B program has caused UUHC to delay making the move to an LLC, but the approach it used to assess the opportunity remains sound.

FACTORS PROMPTING UUHC TO CONSIDER THE MOVE

As an academic medical center (AMC), UUHC is a covered entity under the 340B program's *disproportionate care hospital (DSH)* designation. The AMC has numerous "child site" clinics (i.e., clinics owned and operated by the covered entity in the surrounding communities), and it operates 17 retail pharmacies, two of which are specialty pharmacies. With this

large ambulatory presence, UUHC saw a strong potential for significant 340B savings to better serve the community.

However, recent actions by pharmaceutical benefit managers (PBMs) caused UUHC to consider a different approach. The PBMs asked 340B-covered entities to mark 340B-eligible prescription claims when processing them. But the covered entity may not know at that time whether the prescription qualifies for 340B, making compliance extremely difficult. The PBMs also looked to decrease payment on 340B-eligible claims, effectively taking for themselves the 340B financial benefit that the covered entities had enjoyed, thereby also reducing the entity's resources available to help the communities it serves.

THE PROBLEM OF THE 340B PRICING CONSTRUCT

UUHC had hoped that by growing its retail, specialty and home delivery presence, it could better support the outreach efforts of its parent company, University of Utah Health (U of U Health), which also includes a health plan and other healthcare-related enterprises. U of U Health was seeking to expand its presence within the region through affiliations with other health systems and hospitals. The problem was that the current 340B pricing construct would not allow UUHC's pharmacy to efficiently service *en masse* the non-340B patient prescriptions that outreach efforts would generate.

Under the pricing construct, a 340B pharmacy owned by a covered entity must purchase drug products in one of two ways:

- At the discounted 340B price
- At the wholesale acquisition cost (WAC)

WAC is a considerably higher cost than what non-340B pharmacies would pay. For prescriptions not eligible for 340B, drug products would have to be purchased at WAC, and insurers' payment rates would rarely cover the cost. Thus, when factoring in labor and overhead, covered-entity-owned pharmacies often fill non-340B prescriptions at a loss, severely limiting

12,700

Number of covered entities participating in the 340B Drug Pricing Program in 2020

Source: GAO, "Drug pricing program: HHS uses multiple mechanisms to help ensure compliance with 340B requirements," December 2020



their ability to care for patients not having 340B-eligible prescriptions.

A PROPOSED SOLUTION

UUHC determined it could address this problem by moving its 17 retail pharmacies into an LLC under U of U Health. The move would enable the retail pharmacies to purchase all pharmaceuticals at a contracted rate instead of sometimes having to buy at WAC. The LLC retail pharmacies would sign agreements to become contract pharmacies of UUHC to maintain the covered entity's 340B benefit.

This new medication procurement model would allow the pharmacies to partner with the U of U Health's expansion. Medication purchased for prescriptions written by providers outside of covered entity clinics (non-340B eligible prescriptions) would be procured at a less expensive cost than WAC, and PBMs would have a reduced ability to take 340B savings away from UUHC because they would no longer process claims for the AMC as the covered entity.

RESEARCH REQUIRED

But UUHC also recognized that this change in the corporate structure of the 340B retail pharmacies might come with disadvantages that outweighed the benefits. UUHC searched the literature for relevant insights and found no articles related to this topic. Research clearly was needed not only to inform UUHC's strategy but also to fill this gap in the literature.

NEXT PAGE

The AMC therefore undertook research comprising three parts:

- A financial model based on an ROI analysis
- An analysis of risks from restructuring
- A survey of AMC pharmacy directors

Following are key considerations and findings from each part of the research.

FINANCIAL MODELING THROUGH ROI ANALYSIS

Although payment rates would theoretically remain the same, many drug costs would be different. Moreover, the true costs in setting up an LLC would come in the form of time, effort and other related factors. Variables considered in the ROI analysis included:

- Current drug costs (340B and WAC)
- Future state drug costs (contracted rate)
- 340B benefit to covered entity (current state)
- 340B benefit to covered entity (future state)
- Loss of access to specialty/oncology medications

Although 340B pricing is confidential, financial modeling is possible using a two-part formula using these ROI variables rather than using actual numbers (see above right).

Current cost

$$\begin{aligned} &(\text{average 340B claim})(\text{number of claims}) \\ &+ \\ &(\text{average WAC claim})(\text{number of claims}) \end{aligned}$$

Future cost

$$\begin{aligned} &(\text{average 340B claim})(\text{number of claims}) \\ &+ \\ &(\text{average contracted-rate claim})(\text{number of claims}) \\ &+ \\ &(\text{additional audit expense})(\text{risk}) \end{aligned}$$

Red = WAC drug cost
Green = contracted-rate drug cost

Using this formula, any organization can input its own data and draw its own conclusions based on its unique circumstances. The formula shows that if WAC drug expense is greater than the combined contracted-rate drug cost, audit expense and risk, then the move would be financially feasible.

UUHC found that, although 340B drug expense remained constant in a move from internal to contract pharmacy, the WAC would be greater than a contracted-rate drug cost. The exhibit below shows two examples of applications of the



Financial model examples

		340B drug cost		WAC drug cost		Total drug cost			
Example 1: 50/50 Mix	Current cost	\$10,000,000	+	\$10,000,000	=	\$20,000,000			
		340B drug cost		Contacted-rate drug cost (-25%)		Total drug cost	Drug cost savings	Additional audit expense	Risk
	Future cost	\$10,000,000	+	\$7,500,000	=	\$17,500,000	\$2,500,000	\$200,000	?
Example 2: 80/20 mix		340B drug cost		WAC drug cost		Total drug cost			
	Current cost	\$16,000,000	+	\$4,000,000	=	\$20,000,000			
		340B drug cost		Contacted-rate drug cost (-25%)		Total drug cost	Drug cost savings	Additional audit expense	Risk
Future cost	\$16,000,000	+	\$3,000,000	=	\$19,000,000	\$1,000,000	\$320,000	?	

financial formula depicting how 340B/non-340B eligible prescription mix can influence drug cost savings.

Added expense under the LLC model. The formula shows the new model also carries additional auditing expenses, given that claims from a contract pharmacy require additional auditing oversight to ensure compliance. UUHC estimated this expense at 2% of the 340B drug cost, as shown in the exhibit on the previous page.

One-time expenses. Converting an entity-owned retail pharmacy to the LLC model requires work from many different departments, including legal, finance, contracting, supply chain, 340B oversight and leadership. An organization must consider whether it can make the change with existing personnel and consider it a *sunk cost* (although also an *opportunity cost*) or whether it would need to add personnel to complete the transition. It also should consider whether to assign a project manager to the project. The formula did not consider such one-time expenses.

RISK ANALYSIS

Also assessed were the following areas of risk associated with the move to LLC-ownership:

- Maintaining the 340B benefit during the calendar quarter required to make the move
- Licensing, registering and contracting all retail pharmacies to avoid a lapse in service during the transition
- Ensuring the seamless continuation of all operational aspects, including employees, systems and operations support
- Maintaining access to all medications, especially oncology, specialty and limited-distribution medications
- Avoiding political risk, either within the institution or in the larger healthcare regulatory landscape^a

a. A state-owned LLC entity could be seen as politically tenuous if business-competitiveness concerns were raised around its expansion.

Sample timeline of key events

Jan. 1	<ul style="list-style-type: none"> • Create LLC • Pharmacy ownership bill of sale/contract for a future date (June 1)
Jan. 1 – March 1	<ul style="list-style-type: none"> • Pharmacy licensing (state) for future date (June 1) • Contract pharmacy agreement between covered entity and future LLC pharmacies created/signed • PBM contracting (as possible)
March 1-15	<ul style="list-style-type: none"> • Register new contract pharmacies with HRSA
June 1	<ul style="list-style-type: none"> • Go-live date • Pharmacy ownership transferred to LLC • Continue PBM contracting

UUHC would have to develop a detailed plan to address each of these risks, which would work their way back into the financial modeling formula as risk expenses. If any risk could not be resolved, the move would not be feasible.

Planning and timing risks. Impeccable planning and timing in making the move to an LLC is necessary to ensure it is seamless in the eyes of both patients and the organization.

The Health Resources and Services Administration (HRSA) requires that covered entities register new LLC contract pharmacies three months in advance of their effective date. Before registration is possible, however, a fully executed agreement must be in place between the covered entity and the LLC. The LLC must be set up well in advance, before the change in pharmacy ownership.

During registration, the covered entity’s current Drug Enforcement Agency (DEA) numbers would be used, and the entity should maintain close contact with HRSA to explain the anticipated change of ownership. The entity also should develop a close relationship with the state pharmacy-registering body concerning change-of-ownership and licensing requirements based on individual state regulations. (See the exhibit above for a sample timeline).

Contracting with PBMs through an ownership change is an additional obstacle to avoiding a

NEXT PAGE

Responses from pharmacy director survey

Questions	Yes N (%)	No N (%)
Is your organization a 340B 'covered entity'? N=23	23 (100%)	0 (0%)
Does your organization have retail pharmacies? N=23	22 (96%)	1 (4%)
Are you currently looking at changing how your retail pharmacies are set up? N=22	4 (18%)	18 (82%)
What model does your organization use with their retail pharmacies? N=22	Model in use N(%)	
<ul style="list-style-type: none"> ● Organization-owned pharmacies ● Rent to external pharmacy provider ● LLC/Owned by parent organization ● Other 	17 (77%)	0 (0%)
	4 (18%)	1 (5%)

quarter-long 340B benefit gap. A change in ownership requires new licenses, National Provider Identifier numbers and National Council for Prescription Drug Programs numbers, in a process that could take months. A possible solution might be to stagger the move of individual pharmacies to the LLC. The organization then could spread the workload, minimize PBM contract disruptions with creative use of other pharmacies in the organization, and better identify and correct transition issues encountered along the way.

Risk related to specialty medication access.

An organization's *class of trade* determines what products its pharmacies can purchase. An organization in the *hospital* class of trade can access most specialty and oncology products for its patients. Moving the pharmacies away from being hospital-owned into a separate LLC would change the class of trade to *retail*.

This change might cause a specialty oncology pharmacy to lose access to many oral oncology products it had been dispensing as a hospital-owned pharmacy, for example. To maintain specialty product access, this pharmacy might best be excluded from the LLC and allowed to continue operating as an entity-owned pharmacy. The same situation holds true, but to a much lesser extent, regarding specialty drug access for

a specialty pharmacy. This risk expense should be represented in the financial formula.

Political risk. Key “political” considerations include a nonprofit organization’s appetite for moving part of its business to a for-profit LLC and for expanding its business with non-340B eligible prescriptions, which could be filled for a positive margin.

Another political risk, however, lies with the federal government and how it might yet change the 340B program, as it did with contract pharmacy expansion several years ago. Starting in mid-2020, six pharmaceutical companies excluded contract pharmacies from obtaining 340B pricing, with another restricting 340B pricing in 2021. The actions taken are currently being discussed in the courts. These types of changes must be monitored, as they could completely alter the financial formula regarding the feasibility of an LLC approach.

THE SURVEY

UUHC sent an online survey to a sample group of pharmacy directors to identify the different models and structures they were using for retail pharmacy networks and to find out whether they were looking to make a change. Responses are shown in the exhibit above left.

MAKING THE CASE FOR CHANGE

The rationale for making this type of business reorganization may seem straightforward to those who understand 340B and how it works. But those less familiar with 340B, including C-Suite executives, may question the idea of moving the 340B benefit away from the covered entity. Advocates for the change should point to the importance of the agreement between the LLC and the covered entity, which determines how everything looks on future financial statements. The future LLC’s strategic purpose also should be considered, whether it is to unleash the retail pharmacies’ potential to promote business expansion, to create a more nimble business group that can truly compete in the retail pharmacy world, or simply to reduce drug

NEXT PAGE



Searching for top talent in healthcare finance?

HFMA's Job Bank is a niche recruiting site that attracts all levels of healthcare finance and revenue cycle professionals. Job postings are listed online and promoted in HFMA e-newsletters to a targeted audience of over 160,000.

Fill positions quickly and cost-effectively.

Contact

SHARON MALIK-SPECHT

708.492.3386 smalik@hfma.org

hfma.org/jobbank



340B program facts to know

The 340B program was enacted as part of the Veterans Health Care Act of 1992 to enable covered entities to stretch scarce federal resources to reach more patients and provide more comprehensive services.^a Organizations that can qualify for the 340B program include critical access hospitals, children's hospitals, cancer facilities, disproportionate share hospitals (DSHs), federally qualified health center clinics and hemophilia treatment centers among others.^b DSHs are hospitals serving a significantly disproportionate share of low-income patients.^c A DSH must have 11.75% of Medicare and Medicaid

a. Health Resources & Services Administration, 340B Drug Pricing Program, updated May 2021.

b. 340B Health, *Overview of the 340B Drug Pricing Program*, accessed July 1, 2021.

c. CMS, *Medicare Disproportionate Share Hospital*, MLN fact sheet, March 2021.

admitted inpatient days to qualify and be registered and enrolled to participate in the 340B program.^d When participating in the 340B program, covered entities (i.e. qualified and registered health systems) can order medications at a discount for 340B eligible outpatient administered medications and retail prescriptions. To qualify for eligibility, orders and prescriptions must be:

- Written for a patient of the covered entity
- Written by a provider of the covered entity
- Written at one of the locations falling under the covered entity

Covered entities are closely monitored both internally and externally. The Office of Pharmacy Affairs, under the Health Resources and Services Administration, oversees the 340B program and conducts audits of covered entities.

d. Health Resources & Services Administration, 340B Eligibility, last updated May 2018.

expense while keeping existing oversight structures in place.

Since 2010, when HRSA authorized expansion of contract pharmacy use and the subsequent increase in 340B benefit to covered entities, PBMs and pharmaceutical companies have sought to claw back some of that benefit.^b Although making business structure adjustments and voicing concerns to local government representatives may help to keep the 340B benefit intact, covered entities can expect to see more aggressive means used to lessen the benefit. Given that contract pharmacies have been the key target for pharmaceutical industry's recent takeback strategies, another key feasibility consideration is that reversing the LLC change would take as much time as moving to an LLC in the first place.

b. HHS, "Notice regarding 340B Drug Pricing Program—contract pharmacy services," *Federal Register*, March 5, 2010.

In the end, the risk/reward decision is not an easy one and can be determined only through financial modeling and due diligence, following UUHC's approach, in coordination with the organization's top leadership and visionaries. ■

About the authors

Nathan Hagen, PharmD, MS, is director, community pharmacy, University of Utah Health, Salt Lake City.

Ian Macdonald, MBA, MHA, is director, pharmacy finance, University of Utah Health, Salt Lake City, and a member of HFMA's Utah Chapter.

Linda Tyler, PharmD, is professor of pharmacotherapy, University of Utah College of Pharmacy, Salt Lake City. At the time of this project, Tyler was the chief pharmacy officer for University of Utah Health.

Nancy Nickman, BS Pharm, MS, PhD, is professor of pharmacotherapy, University of Utah College of Pharmacy, Salt Lake City.



SEARCH
THE SHORT LIST.

**PEER
REVIEWED**
— by HFMA —



QUALITY



TECHNICAL
SUPPORT



CUSTOMER
SERVICE



VALUE

When products, services, and ROI calculators earn the designation “Peer Reviewed by HFMA,” you know they have been rigorously evaluated. Only those earning top marks make it on **THE SHORT LIST**.

Find your next solution.

hfma.org/peerreview

hfma™ | Peer Review



EXPERT REVIEWED

How to engage with patients where they are by balancing automation with the human touch

The ability to maintain strong personal relationships with patients is a defining characteristic of successful provider organizations. In addition to having highly developed automated systems, a dedicated staff whose role is to personally engage with patients is important for providers.



DAY EGUSQUIZA
daylee1@mindspring.com

As the nation has contended with the COVID-19 public health emergency, including the long time when face-to-face encounters became nearly impossible, the healthcare industry has been profoundly creative in finding new ways to reach our patients through automation. Now, as the country struggles to achieve a higher level of vaccination, we need to take stock of the future of those innovations and how they will affect patients' perceptions of their care.

Implemented effectively, automated systems can improve healthcare processes, from both a clinical and administrative standpoint, while also improving the healthcare experience for patients. Despite these clear benefits, however, organizations should not lose sight of patients' deep desire and need for a personal connection with their providers, which is not possible through automation alone.

An organization's approach to automation and communication with patients should flow from its understanding of the patient's circumstances. Thus, any strategy for automating patient processes also requires a human face, as reflected in the role of the patient navigator, which is discussed later in this article.

First, however, organizations must fully grasp *why* empathy should be the cornerstone of their overall strategy.

THE NEED FOR EMPATHY

Engaging with patients means meeting patients *where they are*. It means being highly aware that the patient may be scared of receiving a new diagnosis, scared from uncertainty about how they will pay for their care, scared of how it will impact their lives and overwhelmed when faced with the many business facets of healthcare. They are confronted with forms to be signed, required prior authorizations for many services, payment arrangements and many uncoordinated provider statements/bills. The need for integration of information among unconnected providers — labs, rehab facilities, hospitals and providers not employed by the hospitals — is monumental, and it should not be left to the patient to coordinate. It would pose a challenge for many of us even within the healthcare world, and it is one important goal of automation. But patients also need to be assured that this coordination is being managed for them, and that requires a personal touch.

Meeting patients where they are means understanding how to communicate with them in ways they understand. Industry catch phrases like “value over volume” or “interoperability” have little or no meaning for most patients. And when patients hear, for example, that their coverage for care has been “denied for lack of medical necessity” or that “the insurer has denied prior authorization even though your provider believes this procedure is needed,” they might feel the healthcare system is not focused on, or even interested in, their health. Providers therefore should take care not to bombard patients with terms they don’t understand and are embarrassed to ask about.

Providers also should recognize that each generation has its own preferences and barriers. It is not enough to tell patients, “Just use our portal” or “Visit our easy-to-access webpage with multiple drop-down choices” or “Set up your own payment plan online.” Some patients will love the

online options. But many others will just want to talk with a real person. And all patients are likely to want a personal connection with their provider when they are ill, because accessing healthcare is rarely a choice, and it can involve a life-altering health event.

Automation also means very little to a patient who may not have access to the internet and who feels overwhelmed and ‘stupid’ when they do not understand the multiple bills, EOBs, provider letters, and how they tie together. Moreover, factors such as social determinants of health may pose a challenge for reaching patients through automated processes (see the sidebar on page 46).

Patient engagement must be highly flexible, so maintaining it within a world of automation presents a true balancing act for today’s revenue cycle leaders.

CASE EXAMPLE OF MEETING PATIENTS WHERE THEY ARE

The ability to meet this challenge is the mark of a true leader. Here’s how one hospital’s revenue cycle director responded to that challenge.

She learned a powerful lesson from what at first was thought to be a great ‘win’ for the hospital (saved money and labor costs) but was actually perceived to be a great ‘loss’ by the community. Her organization had decided, at her prompting, to discontinue itemized statements for outpatient services and incorporate them into once-a-month statements. The hospital achieved the money- and time-saving objective — and loved it!

Then, as part of the commitment to community outreach, the revenue cycle director scheduled a visit to an area senior center on aging to provide a 20-minute, lunch-hour presentation on the difference between Medicare and Medicaid. At the end of the presentation, the director asked for questions. None of the 100 plus attendees raised their hand, so the director thanked the attendees and prepared to depart. But one of the center’s staff members stopped her and asked, “Don’t you want to help them with all the information they brought?”

NEXT PAGE

Engaging the patient means recognizing SDoH

Another powerful area of opportunity for healthcare organizations to coordinate automation with personal attention to patients' healthcare is in addressing *social determinants of health (SDoH)*. For the public, it is just another catch phrase. But for hospitals, SDoH is a critical concern, and when we examine its impact on the revenue cycle, we begin to see how focused health efforts on it can impact a patient's costs.

Consider the following case example of lessons learned, which was shared anecdotally with the author at an HFMA Chapter meeting.

Two hospitals came together to focus on re-admissions to the emergency

department (ED) for patients with diabetes. They had identified a geographical area where there was a high incidence of such ED visits, many of them also involving bad debt. There also was no grocery store within walking distance of the residents. With the presence of only convenience stores, it seemed clear that a diet and nutritional deficit were contributing to diabetes-related emergency visits.

The two hospitals pooled resources, found a bus and paid a driver for gas and insurance to shuttle residents for Saturday grocery shopping at a nearby supermarket. The community was informed of the service through outreach efforts, and residents began being bused to where they could get nutritious food.

When tracking the results, the hospitals found that, over a 90-day period, ED

visits decreased significantly. It seemed clear that the residents' health was being positively impacted by a simple community outreach. Yet the funding for the bus and driver became jeopardized by the difficulties the finance department faced in identifying an ROI.

The clinical team that spearheaded the initiative with the revenue cycle team to find a way to communicate to the finance department the significance of the reduction in ED visits and possible accompanying decrease in bad debt.

The value that can be achieved when revenue cycle processes allow for a focus on SDoH is evident in the experience by these two partner hospitals. Partnerships between SDoH clinical teams and revenue cycle teams represent another area that holds the promise of important wins for hospitals.

5 categories of SDoH

The Centers for Disease Control and Prevention defines *social determinants of health (SDoH)* as “the conditions in which people are born, grow, live, work, and age.”



Source: CDC, “Social determinants of health,” Public Health Professionals Gateway, Page last reviewed Oct. 23, 2020



Team learning delivered your way.

Transform team performance
with HFMA Organizational Learning.

- Bring industry expertise to your team
- Ensure staff has consistent foundational knowledge
- Increase collaboration with interactive team-building learning experiences
- Experience rich content and multi-disciplinary collaboration

Empower your team with the tools to better manage costs, enhance efficiency and integrate financial information with the delivery of healthcare. HFMA Organizational Learning has flexible programs to transform your teams and meet the unique needs of your organization.

Get Started Today.
hfma.org/learning

She had noticed the shoe boxes and paper bags and thought, “Perhaps it was craft day.” But no, the seniors had gathered together all their statements, itemized bills from the hospital and many related invoices from durable medical equipment, hospice, physician practices and outpatient rehab — and *now* they were ready to have their questions answered.

The revenue cycle leader had a humbling experience as each senior took the opportunity to *teach her* what amounted to two important lessons:

- They were confused by and hated the combined statements.
- They had many ideas on ways to simplify the billing process for patients.

As a result, the leader was able to resolve the seniors’ problems with the statements, and she gained a new appreciation of the importance of seeking to understand a patient’s perspective when making such decisions.

THE CENTRAL ROLE OF THE PATIENT FINANCIAL NAVIGATOR

When we seek to listen to patients in an effort to *meet patients where they are*, we can find many exciting ways to reach the full diversity of the patients we serve. One important way we can better engage with patients is by creating the role of an onsite patient financial navigator, which complements the traditional role of financial counselor, to help guide patients through the complexities of our healthcare system. The navigator can explain to patients:

- How their insurance works
- What different terms mean and how those terms affect patients (e.g., what *prior authorization* means and why a service might be denied because it is not deemed *medically necessary*).
- How the revenue cycle process will work for them
- How estimates work and how to create a payment plan
- How to appeal insurance denials or reduced payments by payers

- How to understand and access the Affordable Care Act marketplace exchange option
- How to navigate the Medicaid option
- Whether and how the patient might qualify for charity care (as appropriate)

A hospital can go a long way in reducing the occurrence of bad debt and uncompensated care by providing such a person as a resource and ensuring the public is aware that this resource is available to them.

The navigator also can promote the organization’s efforts toward automation by helping patients understand how best to use the automation that will streamline their needs. It is important to emphasize, however, that organizations should not rely on patient navigators to fill all the gaps created by ineffective automation, which might require a huge navigator workforce, thereby negating the benefits of both approaches.

GET THE WORD OUT

When patients feel well cared for, they will want to pay their bills. And that readiness to pay will be greater if they believe the revenue cycle team is committed to addressing their concerns, as evidenced by having an onsite financial navigator readily available to guide them not only through their hospital bills, but also with navigating all facets of the business of healthcare.

Keeping the automation in sight while maintaining a personal, human touch in guiding patients through the revenue cycle processes will help an organization achieve the crucial win for both the patients and the organization. But it also is important to tell your public, repeatedly, about the navigator program and all the ways it can help. ■

About the author

Day Egusquiza is president and founder, AR Systems, Inc., and the Patient Financial Navigator Foundation, Inc. (a not-for-profit community-service organization) in Twin Falls, Idaho.

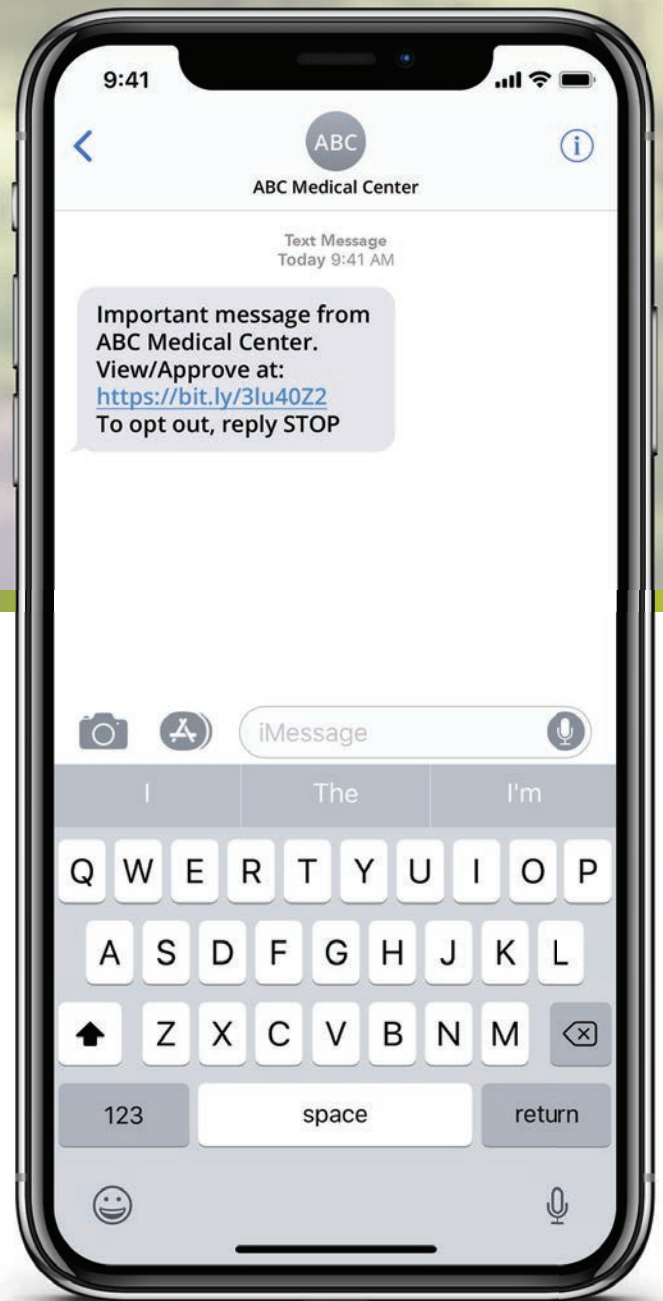
Are you ready for no-surprise billing?

Safeguard compliance, elevate the patient experience, and boost collections with the XIFIN RPM patient responsibility estimator.

The No Surprises Act goes into effect January 1, 2022. Violations can expose providers to civil monetary penalties of up to \$10,000 per violation.

Plus, survey data suggest patients are more likely to pay in full if they are happy with the billing process.*

With XIFIN RPM you are covered. The patient responsibility estimator maps current CPT-level costs, by payor, to real-time patient eligibility information. Out-of-pocket costs are then displayed as they would be in an explanation of benefits (eob). And, XIFIN offers text messaging with an integrated patient portal to enable 24/7 self-service.



Go to www.XIFIN.com/Engage to learn more.

*www.benefitspro.com/2018/10/18/consumers-more-likely-to-pay-hospital-bills-if-cos/

How 3 healthcare organizations are focusing on **access and transparency** to drive revenue cycle performance

Three winners of HFMA's 2021 MAP Award share their innovative and effective strategies to build a strong revenue cycle amid uncertainty.



LAURA HEGWER

hfm contributor

laura@vitalcomgroup.com

[LHegwer](#)

This year's winners of the Association's MAP Award for Higher Performance in Revenue Cycle represent organizations of vastly different sizes and scope, yet they all share a commitment to improving price transparency and patient access. Their momentum toward change has helped them maintain robust revenue cycles, even during the uncertainty of the recent COVID-19 pandemic.

Here, revenue cycle leaders of three organizations — an integrated delivery system (IDS), an individual hospital and a critical access hospital (CAH) — describe how they are using innovative strategies to improve their organizations' financial performance and patient experience.

PRIORITIZING PRICE AND NETWORK TRANSPARENCY

"When I think about pricing transparency, it really hits the trifecta of improving revenue, reducing costs and improving the patient experience," said Sarah Knodel, senior vice president of revenue cycle for Dallas-based Baylor Scott & White Health, which won the MAP Award in the IDS category.

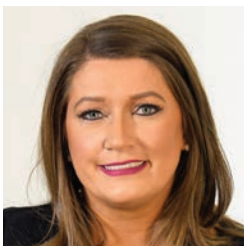
Knodel and her team partnered with clinical leaders on new processes and tools designed to help patients understand their out-of-pocket costs and improve point-of-service (POS)

collections. This effort included rolling out their automated price estimation tool, which had already been adopted by the system's hospitals, to hundreds of clinics within the health system. Knodel met with the president, CFO, chief medical officer and vice president of clinic operations in each region to explain the goal of the initiative and get their buy-in.

"It took a significant amount of collaboration to say, 'Look, this is a priority,'" she said.

From 2018 through 2020, her team gradually rolled out the new process, which included conducting more than 200 training sessions for registration staff at the clinics (who don't report to the IDS's revenue cycle department). Training focused on educating patients about their financial responsibility and available payment options, including interest-free payment plans. As a result of their efforts, clinic POS collections have improved 47% since FY2017.

Network transparency also has been a focus after the revenue cycle team noticed an uptick in out-of-network denials and complaints from patients about not being notified for out-of-network care. Knodel partnered with a vendor to create a custom, real-time alert that notifies scheduling, pre-registration and registration staff if a patient is out of network. Once out-of-network patients are identified, staff can explain to the patients how their insurance works and



Sarah Knodel partnered with clinical leaders at Baylor Scott & White to develop ways to help patients understand their out-of-pocket costs.

inform them about the cost implications of proceeding with out-of-network care at the health system.

“We want to make sure we’re having that conversation at the earliest possible point in time,” Knodel said. “We had to really focus on scripting because we didn’t want to alienate our patients ... we wanted to make sure that we were educating them.”

Another change was the creation of a dedicated out-of-network team to negotiate one-time agreements with payers on behalf of patients requiring specialized services, such as open-heart surgery. Thanks to the revenue cycle team’s efforts, Baylor Scott & White Health has seen an 88% reduction in scheduled out-of-network volume since FY2017.

Knodel said her current priorities are optimizing net revenue, reducing the cost-to-collect (in part by leveraging automation) and improving the patient financial experience. Future initiatives include integrating price estimates into the patient portal and mobile app, so the estimates are automatically sent to patients 14 days in advance of their procedures and providing price guarantees for select services.

Knodel believes these and other innovative projects will help her team maintain a robust revenue cycle even during times of uncertainty like the ongoing pandemic. “You can’t wait until you’re in a crisis,” she said. “You’ve got to have the strong foundational pieces in place and strong, consistent leadership to help you manage during changing and challenging times.”

ENSURING BETTER ACCESS FOR CANCER PATIENTS

Improving the experience for cancer patients was a priority for revenue cycle leaders at The Valley Hospital in Ridgewood, New Jersey, which won the MAP Award in the Individual Hospital category.

“[Patients] had a great medical experience, and on the back end, we wanted to make sure that the revenue cycle experience went just as well, and that they felt happy,” said Josette

Portalatin, assistant vice president of revenue cycle for Valley Health System.

To do this, Portalatin partnered with clinical leaders to create a team of oncologists, executive staff and nurses who met weekly for six months and then monthly. Together, they reviewed data on denials, charge capture and underpayment and identified process changes from scheduling to staffing. One change included hiring more staff to address the growing number of payer requirements related to authorizations, which helped improve access as well as payer yield and collections. The team also added a patient advocate in oncology to help cancer patients find assistance from drug companies to help cover the costs of medication.

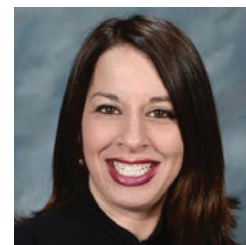
Leaders at The Valley Hospital also rolled out an initiative focused on POS collections in patient access and the emergency department, increasing POS collections by \$100,000 in FY2020. In both areas, they implemented new collection policies and practices and relocated staff under patient access leadership.

The Valley Hospital’s success comes from understanding the root causes of patient complaints and barriers to care, according to William Klutkowski, CFO and vice president of finance for Valley Health System. “We truly listen to the front end because that’s where most of the problems start,” he said.

Klutkowski said his finance team is eager to “get back to the norm as well as move forward.” In the future, making the most of available technology will be a priority.

In particular, the revenue cycle team plans to implement a patient engagement and financial technology platform to deliver a more personalized billing and payment experience for patients. The tool will allow the hospital to send digital bills and communicate with patients via text, emails and ringless voicemails based on their preferences. Patients also will receive denial explanations automatically and have the option to self-enroll in configurable payment plans.

Portalatin said her team also plans to implement artificial intelligence and automation into



Josette Portalatin focused on making sure patients’ revenue cycle experience was of the same high quality as their medical experience.



William Klutkowski attributes Valley Hospital’s success in increasing point-of-service collections to understanding the root causes of patient complaints and barriers to care.

NEXT PAGE

2021 HFMA MAP Award Winners

In June, 32 hospitals and health systems were honored with HFMA's MAP Award for High Performance in Revenue Cycle. Presented as part of HFMA's Annual Conference Virtual Preview, the awards recognize organizations that have used innovative and effective strategies to achieve excellence in revenue cycle performance.

Winners are selected based on their demonstrated ability to:

- Meet industry-standard revenue cycle benchmarks as measured by HFMA's MAP Keys
- Implement the patient-centered recommendations and best practices described in HFMA's Healthcare Dollars & Sense initiatives
- Achieve outstanding patient satisfaction

The winners spanned five categories:

Physician practice management (5 winners)

- Genesis Medical Group, LLC, Zanesville, Ohio
- Norton Medical Group, Louisville, Ky.
- Privia Medical Group, Arlington, Va.
- State of Franklin Healthcare Associates, Johnson City, Tenn.
- Virginia Eye Institute, Richmond

Critical access hospitals (4 winners)

- Cass County Memorial Hospital, Atlantic, Iowa
- Dignity Health – Mercy Medical Center Mt. Shasta (Calif.)
- Henry County Health Center, Mount Pleasant, Iowa
- Van Diest Medical Center, Webster City, Iowa

Individual hospitals (7 winners)

- Dignity Health – Community Hospital San Bernardino (Calif.)
- Houston Physicians Hospital, Webster, Texas
- Legacy Good Samaritan Medical Center, Portland, Ore.
- Princeton Baptist Medical Center, Birmingham, Ala.
- South Shore Health, South Weymouth, Mass.
- The Valley Hospital, Ridgewood, N.J.
- University of Texas MD Anderson Cancer Center, Houston

Hospital systems (12 winners)

- Adena Health System, Chillicothe, Ohio
- Bellin Health, Green Bay, Wis.
- Bon Secours Mercy Health, Cincinnati
- The Christ Hospital Health Network, Cincinnati
- Cottage Health, Santa Barbara, Calif.
- Mass General Brigham, Somerville, Mass.
- Methodist Health System, Dallas
- OhioHealth, Columbus
- Spectrum Health, Grand Rapids, Mich.
- St. Elizabeth Healthcare, Edgewood, Ky.
- ThedaCare, Inc., Appleton, Wis.
- Trinity Health of New England, Hartford, Conn.

Integrated delivery systems (4 winners)

- Baylor Scott & White Health, Dallas
- Presbyterian Healthcare Services, Albuquerque, N.M.
- Saint Francis Health System, Tulsa, Okla.
- SCL Health, Broomfield, Colo.

their patient intake processes. New tools will allow for online scheduling, electronic registration and online payment, boosting efficiency. The hospital also will add new software to automate precertifications and preauthorizations.

While technology is important, so are the people who keep the revenue cycle running smoothly. The revenue cycle team at The Valley Hospital has had a morale committee for the past 20 years. Each month, the group finds ways to celebrate employees — even when the team worked remotely during the pandemic. Their efforts have helped the revenue cycle team score in the 99th percentile for employee satisfaction.

LEVERAGING TECHNOLOGY AND AN ENGAGED STAFF

Cass County Memorial Hospital in Atlantic, Iowa, won the MAP Award in the CAH category for the first time in 2021. Cindy Petty, CRHCP, revenue cycle director for Cass Health, said developing metrics and engaging staff has been the key to their improved performance. In particular, sharing key performance measures and boosting staff productivity helped her team improve their net A/R by 30 days in FY2020. “There’s no reason to hide anything that we’re doing within the revenue cycle,” she said. “Staff have great ideas on how to improve processes.”

That transparency applies to patients as well. Prior to July 1, 2021, the revenue cycle team at the CAH only provided estimates on an as-needed basis. But now, it offers estimates for all scheduled procedures in their surgery clinic. Staff use a tool that is integrated with the organization's electronic health record to pull estimates based on charges from similar patients, she said.

By the end of the year, Petty and her team plan to expand estimates throughout the facility.

"We're focusing on that communication with patients, validating the estimates and working with each department so that they feel comfortable with our process," Petty said.

Although she appreciates the value of the estimator tool, she also sees a need for a workflow that follows the estimate to validate its accuracy. "It's important that we gain our patients' trust in the process," she said. "We hope that education and working with the patients will support greater collection and increased patient satisfaction."

Petty said a strong partnership with their early-out collections vendor also has helped to identify opportunities to improve the patient financial experience. When patients express frustration on the phone for any reason, the vendor will send them back to the hospital's own patient financial services team to address their concerns directly, which potentially enables them to increase collections of patient's out-of-pocket costs as well.

"As a small entity, that's where we can win over the larger hospitals," she said.

Within patient access, new technology has expanded what patients can accomplish through the patient portal. Now, patients can check in electronically by validating their insurance and personal information and speed up the registration process.

Patients also can request estimates through the patient portal. "Our goals this year within patient access are to increase MyChart registrations and to really use the tools that we have so that patients can navigate their healthcare," Petty said.

Another top revenue cycle priority for the rest of 2021 is addressing out-of-network patients so that the hospital will be ready for new regulations banning surprise billing that go into effect Jan. 1, 2022.

During the past 18 months, the revenue cycle team at Cass County Memorial Hospital has proven they can be agile even during times of uncertainty. Petty, who spent 19 years in public health before moving to the revenue cycle, kicked into "emergency preparedness mode" at the beginning of the pandemic. "Basically, as the admin team was running their own incident command, we had our own incident command within the revenue cycle," she said.

In the early days of the pandemic, Petty led daily huddles with revenue cycle staff to address pressing concerns and make sure that her team felt safe.

"With patient access, you can't really go remote, so we supported staff through that, making sure they were comfortable and giving them the tools they needed," she said.

About half of her team was sent home to work remotely and kept in the loop with daily communication. Today, many staff are still working from home.

"COVID pushed us to a future state that in a small community we probably didn't foresee happening," Petty said.

DEMONSTRATING COMMITMENT

As these three MAP-Award-winners' stories exemplify, dedicated and resourceful revenue cycle professionals across the nation, in healthcare organizations of all sizes, are making a difference in improving patients' financial experience with their healthcare while also ensuring the financial success of their organizations. ■



Cindy Petty, CRHCP, noted that the key to improving revenue cycle performance at Cass County Memorial Hospital has been in developing metrics and engaging staff.

About the author

Laura Hegwer is a freelance healthcare writer and editor based in Lake Bluff, Ill.

61% of hospitals say future compliance with price transparency will impact financial processes: HFMA poll

An HFMA-Strata survey found three in five hospitals and health systems are revamping financial processes in light of price transparency.



LISA ERAMO, MA
leramo@hotmail.com

Actions organizations are taking to revamp their financial processes include more closely tracking patient financial responsibility, total cost of care and negotiated rates, and rethinking commodity-service prices. These results were identified in a March 2021 survey of 275 healthcare finance executives, sponsored by Strata Decision Technology, which also found:

- 60% of respondents are working more closely with operations to impact the total cost of care.
- 20% of respondents said their approach to pricing has changed, with 17% citing plans to overhaul their chargemaster in the future.
- 35% of respondents plan to negotiate rates above current levels for all or certain payers.
- 60% of respondents are working more closely with operations to impact the total cost of care.

These results appear against the backdrop of CMS's proposal to increase the penalty for some hospitals that do not comply with the Hospital Price Transparency final rule.^a Specifically,

a. CMS, CMS proposes rule to increase price transparency, access to care, safety & health equity, Press release, July 19, 2021.

CMS proposes to set a minimum civil monetary penalty of \$300 per day for hospitals with a bed count of 30 or fewer and \$10 per bed per day for hospitals with a bed count greater than 30, not to exceed a maximum daily dollar amount of \$5,500.

What does this mean for a full calendar year of noncompliance? The minimum total penalty amount would be \$109,500 per hospital, and the maximum total penalty amount would be \$2,007,500 per hospital.

Even without these financial implications, there are compliance-associated challenges.

“Price transparency really brought to light a number of issues in terms of being able to provide patients with good, trusted, market-sensitive pricing for procedures or services they want to receive,” said Elizabeth Kirk, senior vice president of Strategic Services at Strata Decision Technology. “What we’ve found in working with numerous clients is that there are a number of problems that need to be addressed before health systems are even ready to post prices publicly.”

ADDRESSING PRICE TRANSPARENCY CHALLENGES

Perhaps the biggest challenge is that most chargemasters are not designed for user-friendly price lookups. That’s because a number

of different charges must come together for a single procedure or service. A knee replacement, for example, must include charges for pharmaceuticals, supplies, staffing cost and physician services. A single line item in a chargemaster doesn't provide an accurate picture of total charges a patient would incur, she added.

Applying payer rates is also a challenge for many organizations. "You can't just take charges for a group of services and multiply them by a payer's reimbursement rate," Kirk said. "There are a number of complicated payer rules. It may be that drugs and implants are paid differently from medical services, for example." To provide an estimated price for one procedure for one patient, it is often necessary to apply multiple payer rules. The complexity of doing this for many different types of procedures and payers is a barrier for many health systems.

In addition, the chargemaster doesn't take patient-specific circumstances into account. "The biggest challenge is coming up with a good number," said Tim Cashman, CFO at Estes Park Health, a 23-bed critical access hospital (CAH) in Estes Park, Colorado. "It really depends on the patient's specific needs. Every bill is going to be different."

Although Estes Park Health is in a rural area, Cashman said nearly 4.8 million people come through the community annually, mostly in the summer, to go hiking in Rocky Mountain National Park. His organization sees its fair share of hiking-related injuries as well as high-altitude pulmonary edema — neither one is easy to predict from a cost perspective.

To meet the price transparency requirement, Estes Park Health partnered with a vendor to make its chargemaster available to the public. However, Cashman admitted it's not an ideal solution because the prices that patients see are estimates — not fixed quotes.

At Truman Medical Center in Kansas City, Missouri, internal teams worked together to launch a price transparency tool that includes payer-specific estimates. "This is a major step toward getting consumers the information

How to work with operations to manage the total cost of care

As organizations think about price transparency, they're also focused on the total cost of care, said Alina Henderson, senior director of Advisory Services at Strata Decision Technology.

"To really understand true total cost of care, especially as we're seeing volumes shift from inpatient to outpatient, you need to understand the combined inpatient and outpatient cost of care," Henderson said. "You need to be able to bring together provider billing and hospital billing data."

Henderson says many organizations are shifting toward a horizontal, encounter-level view while also putting more onus on operational leaders to control and reduce costs.

"Operational leaders are increasingly being held responsible for managing not just labor expenses for their departments but also the utilization of resources for specific types of services," she said. "To that end, operational leaders are engaging with clinical teams and finance to better understand and affect the cost of care.

However, this shift requires a different operating model, said Henderson. "This is where organizations are really leaning in," she said. "If you don't set expectations and create a model where people feel empowered and supported to collaborate and make decisions that will reduce the cost of care, then you're not going to see sustainable change. You're going to see ad hoc improvements."

Henderson provided several questions to consider as organizations make this shift:

- How will the organization coordinate efforts between service line leaders at multiple hospitals within the single system?
- To what financial metrics will operational leaders and service line leaders be held accountable?
- What type of data analytics will operational leaders need to monitor these metrics?
- Will operational leaders own the profit and loss statement for their service line? Will they participate in clinical strategy discussions? Or both?

NEXT PAGE

“It’s unfortunate that price transparency came along at the same time as COVID-19 because the pandemic has obviously taken much of the attention away from the effort.”

— Seth Katz, vice president of HIM and revenue cycle at Truman Medical Center

they need to make proper decisions,” said Seth Katz, vice president of HIM and revenue cycle at Truman. “It’s not the final step. We want to keep refining it to some extent — to include more than the required 300 shoppable services and give consumers a more interactive experience.”

Katz says the organization’s philosophy is that price transparency is what’s best for patients and the marketplace, which is why it has complied with the regulation since day one. “Consumers expect this, and we should accommodate [them],” he said. “They want to know what they’re getting for their money just like they do in any other service industry.”

BECOMING MORE STRATEGIC WITH PRICING

Despite these challenges, organizations are forging ahead with a more strategic approach. That’s exactly what Truman Medical Center is doing. For example, Katz said the organization is looking at high-utilization services such as mammograms and trying to be more strategic with its pricing.

“Being able to see what other hospitals are charging is important. As long as we can cover costs and make a profit, there will be more of an effort to come in under the competition,” Katz said.

Being able to market the organization as a low-cost provider where patients can save money is paramount. “We want to be able to say, ‘Come here to get high-quality care, and you’re not going to get price gouged for it,’” Katz said.

However, in order for price transparency to foster competition, most or all hospitals must comply and make their data available, said Katz. “It’s unfortunate that price transparency came along at the same time as COVID-19 because the pandemic has obviously taken much of the attention away from the effort,” he added.

Truman Medical Center is also paying attention to Medicaid charges in light of the state’s recent Medicaid expansion. “We need to adjust our charges to make sure we’re going to maximize revenue for these patients who are finally going to have healthcare coverage,” Katz said.

Health systems are also starting to look at how they can clean up their chargemaster, says Strata’s Kirk. “They’re looking at how they can bundle charges together, so the information is more patient-friendly.” Organizations are also partnering with technology vendors to estimate the negotiated reimbursement by payer at the line-item level so patients can see any specific out-of-pocket expenses they might incur, she added.

Kirk’s advice for organizations that are overhauling the chargemaster is to look at high-volume shoppable procedures for which there are varying prices across the health system. For example, is an unplanned X-ray in the ED the same price as a scheduled X-ray? Is the same procedure priced higher in a facility that is in an economically disadvantaged neighborhood when compared to facilities in more affluent neighborhoods? “These are the things that don’t reflect favorably on an organization when prices are published,” she said.

She also says to look at cost versus price versus reimbursement. “If the price is ten times your cost of what you’re reimbursed, that’s a signal that you can bring down the cost without having a lot of financial impact,” she said.

NEGOTIATING MORE FAVORABLE PAYER CONTRACTS

Organizations are also using price transparency as a bargaining tool to negotiate more favorable contracts with payers. For example, if an organization’s prices are lower than those of other

275

The number of healthcare finance executives who took part in the HFMA survey sponsored by Strata Decision Technology

providers in the local marketplace, but its quality metrics are equally as good or better, it makes sense to advocate for higher payments using data to support the argument, Kirk said.

That's what Truman Medical Center is doing. As a safety net hospital, the organization treats everyone regardless of their ability to pay, and commercial payers represent less than 20% of its total payer mix. Katz said price transparency will help the hospital understand payer variances within the Kansas City marketplace and gain leverage with payers. "If we can see that commercial payers are paying neighboring hospitals at a much higher rate — and we have the data to back that up — that might assist us in improving our rates and growing that line of business," Katz said.

CONCLUSION

As organizations strive to comply with price transparency requirements and reduce the total cost of care, they'll need to involve operational leaders, engage in strategic pricing strategies and negotiate more favorable payer contracts. All of this requires a data-driven approach and industrial-strength analytics tools. Price transparency has accelerated the need for advanced analytical and reporting tools to better prepare providers for the short- and long-term. ■

About the author

Lisa Eramo, is a freelance healthcare journalist.

YEAR-ROUND LEARNING AND TALENT DEVELOPMENT FOR YOUR ENTIRE TEAM.

Learn more + hear stories
from real Enterprise members.

hfma.org/enterprise



Enterprise
Solutions

Financing digital transformation during COVID-19 and beyond

As organizations move forward with a digital transformation strategy, healthcare finance leaders must be prepared to answer tough questions related to ROI, cybersecurity, employee engagement and more. In this roundtable, sponsored by Pure Storage, several revenue cycle and technology leaders discuss their financial strategies.

In what areas of digital transformation are you currently investing?

Joe Avelino: College Medical Center is a 221-bed acute care hospital, but we focus primarily on behavioral health services. Our number one focus area is cybersecurity. Last year, we spent \$45,000 to perform a security risk assessment. We also started using the HITRUST cybersecurity framework that's regularly revised to include HIPAA-related data protection requirements. Our second focus area is technology to enable more efficient denial management, making sure we have an interface between our electronic health record and our health plans. This was crucial during the COVID-19 pandemic when we saw a lot of MediCal HMO Managed Care Organizations deny payment and authorization for inpatient behavioral health admissions.

Fahd Benjalil: We're a 181-bed acute care hospital that's part of Sharp Healthcare. From an IT-as-a-service perspective, we continue to invest in telehealth as an organization among

other investments. We've had a tenfold increase in telehealth usage compared to prior to the pandemic.

Jon Kimerle: There is clear investment around building a more consumer-centric experience in healthcare. This includes the telehealth expansion we saw in the past eighteen months. Among many other impacts, the pandemic has elevated consumers' expectations of how they experience healthcare. We are seeing interest in moving into other areas of delivering care and wellness in the home. Secondly, it is all about the data and using it to improve outcomes. We are seeing significant investment increases in areas from organic data growth, data protection, incorporating non-medical data and leveraging advanced analytics like artificial intelligence and machine learning to improve outcomes.

What role does organizational agility play, if any, as you consider various IT investments?

Avelino: We want to be as nimble as possible. What's critical for organization-

al agility is having a structured committee that can help us make efficient and informed decisions. For us, it's the IT steering committee. It's a multi-disciplinary team made up of me, the CIO, CNO, VP of ancillary services, CFO, HIM director and quality director.

Benjalil: The agility piece is pretty significant. When COVID-19 hit, we had to change the way we did everything. We had new federal and state data reporting requirements, labor ratio adjustments and more. While we were doing that, cybersecurity was a huge threat. Luckily, we have an amazing IT team. What we've learned in the last 18 months is how to collaborate a little bit faster. While we still have steering committees and other committees, we have learned to make decisions quicker. With that said, the process of acquiring medical equipment takes longer. If the device connects to our network, it must go through the new technology committee before we can make the purchase. It takes a more robust investigation.

Kimerle: There are two ways I would answer this question. One is going forward

“From IT infrastructure, I believe in taking a longer view in total cost of ownership (TCO) calculations on new investments as well as leveraging enterprise architecture.”

— Jon Kimerle, global alliance executive, PureStorage

and the other looking backwards. As organizations make new investments, they are starting to prefer *as-a-service* models that can increase their optionality and agility. Looking backwards at the legacy IT portfolio, simplification and consolidation continues to be a great IT strategy for most organizations to reduce cost and complexity.

How will you ensure organizational agility going forward?

Benjalil: In terms of ensuring the next generation embraces organizational agility, it's about embedding that agility into the culture of the organization. Just as we focus on providing a consistent patient experience (similar to that of a franchise), we must provide a consistent employee experience focused on agility at the forefront. We were challenged to be nimbler during the pandemic. Let's not go back to the old way. Let's continue to adapt to the market and industry.

Kimerle: From IT infrastructure, I believe in taking a longer view in total cost of ownership (TCO) calculations on new investments as well as leveraging enterprise architecture. A three-year TCO will not factor in the legacy IT business models that are built on obsolescence and rebuying what was already bought with disruptive migrations. A six-plus-year

TCO that incorporates all expenses on core platforms will help uncover these previous hidden issues.

As your digital transformation continues to unfold, how do you ensure employee engagement and buy-in?

Don Courville: We always talk about what our patients want (for example, easy access and a frictionless experience), but our employees also want that. They want it to be easy to work at Sharp. They don't want to push paper or deal with clunky processes. They want a modern employment experience. The goal of technology-as-a-service is to enable staff to be more agile and productive. We're interested in megaplatforms that give us seamless process and data integration. This is a trend that will continue into the foreseeable future. The past 18 months have only elevated these expectations. With that said, we need to maintain our culture and stay connected whether it's digital, in-person or a mix. We're still figuring this out. Our patients and employees continue to push us forward in this regard.

Kimerle: Pure Storage has been going through a transformation, and senior leadership frequently talks about the **why** behind the effort. Effective participation usually strengthens adoption, buy-in and engagement.

HFMA Roundtable Participants



JOE AVELINO
Chief executive officer at College Medical Center in Long Beach, Calif.



FAHD BENJALIL
CFO and COO at Sharp Coronado Hospital in Coronado, Calif.



DON COURVILLE
Chief technology officer at Sharp HealthCare in San Diego, Calif.



JON KIMERLE, MHA
A global alliance executive at Pure Storage in St. Louis, Mo.

As you think about leveraging the cloud, is it a destination or an operating model? If an operating model, what are its characteristics?

Courville: We very much look at the cloud as an operating model. However, you need the right governance in place. We are still working on this. As with anything that's highly complex and has a lot of moving parts, if you don't have the right buy-in and plan associated with it, you're not going to arrive at the intended destination. That's why architecture is the cousin of governance. You need the right blueprint in place. Analytics also come into play. Everybody knows about the shift from CAPEX to OPEX. When you have variable cost consumption, subscriptions and other concepts that are basically brand new to the way organizations pay for IT, you need data-driven insights. Otherwise, you can find yourself in big trouble really quickly. With the cloud, there are ways to optimize your spend, but there are probably ten times more ways to get bad financial surprises if you don't have these other elements in place.

Avelino: We use cloud computing, meaning we store and access data and programs over the internet. We've looked at Microsoft® Azure, Google Cloud and Amazon Web Services, but these options have all been cost prohibitive.

Kimerle: As we look at more digitally mature industries outside of healthcare, we see a focus on hybrid and multi-cloud strategies. Healthcare, in general, has less experience in leveraging the public cloud for its strengths. Only in the last couple years has healthcare had direct experience with public cloud initiatives. A smart strategy is to be crystal clear on the business or clinical

outcomes desired and put the IT workload where it makes the most sense. A foundation that enables hybrid and multicloud seems to have the strongest strategic value to most organizations through increasing flexibility, optionality and agility while reducing risk.

In the past year, healthcare organizations have seen an increase in the number of ransomware attacks. How important are investments in cybersecurity at your organization?

Avelino: We've actually had a couple of incidents at our organization prior to the pandemic. In one case, it had to do with payroll direct deposit. In another case, it had to do with an equipment repair. Then the pandemic came along. We knew we needed to establish a more robust process for cybersecurity. That's when we performed our security risk assessment. This assessment was critical. We're probably more at risk than other organizations simply because of the behavioral health population we serve.

Several recommendations emerged from that assessment. First, we established a cybersecurity framework. Within this framework, we assessed the current condition, evaluated the current state of controls and understood our risk. Next, we analyzed gaps in security best practices and established information security policies such as an information security governance and charter, information security risk management policy, information security awareness policy, communications and outreach policy, asset inventory policy, asset category policy, privilege accounts and password management policy, network security policy and encryption policy. Finally, we established a risk-assessment process to identify threats and vulnerabilities,

identify existing controls, determine the impact and develop an incident-response infrastructure.

Courville: Ransomware is an epidemic. We've been supported by our executive team to be aggressive in terms of protecting ourselves. The ransomware activity has forced us to take a COVID-like response to cybersecurity. Before the pandemic, we might have said, 'Let's put that in next year's budget and roll it out over 12 months.' Now we're saying, 'Let's buy it immediately and get it deployed in a month.'

We have put a lot of emphasis on guarding the front door — putting protections around the core systems like electronic health records and the enterprise resource planning systems. But people sneak in through phishing emails or other systems. We've got to pay attention to these systems along with biomedical devices. With biomedical devices, the reality is that we need to do a lot of the protection ourselves. We need to invest in technology safeguards for devices throughout the enterprise. As we pursue new digital health strategies with more dynamic connectivity requirements and new security concerns, we also need network technology as a service that allows us to ensure secure bidirectional data flow. Legacy security and network paradigms don't lend themselves to this level of flexibility and security.

Kimerle: Cybersecurity, in general — and ransomware in particular — is a board-level topic in most organizations. There is only so much effective investment that can be made at preventing and detecting these types of attacks. The reality is that it is a matter of when — not if — you will experience a successful attack. As a natural consequence, we are seeing increased interest in the ability to rapidly recover from immutable

backups. In many of the publicized ransomware attacks, we saw healthcare organizations take close to a month to be fully back up across all applications. Engineering a rapid recovery process can turn recovery from an attack into hours instead of days and weeks. There is significant economic value in having this capability.

Has your organization created a financial impact assessment of these and other types of attacks?

Benjalil: We haven't created a formal financial impact; however, we are definitely aware of how an attack could impact us. When another local health system was attacked by ransomware, they basically had to cease all operations. A lot of their volume shifted to Sharp. All of their computer systems were down. Their networks were down for weeks. Attackers also stole patient information, and now there are pending lawsuits. You have to think about not only the lost revenue and increased expenses during the attack itself but also the impact on your market share. Patients may actually go elsewhere if they feel their information is not safe. It's the big picture that we need to think about.

Kimerle: In working with customers to identify the value of rapid recovery

solutions, we have built quite a few ROI models for organizations. For the past few years, we used several different industry benchmarks that ranged from \$7,000 to \$16,000 per minute of outage, depending on the size of the organization. Recently, the duration of ransomware outages are expanding, and this is increasing the economic impact. The idea of core applications being unavailable for up to 30 days has serious impact. As an example, United Healthcare Services noted in their financial statements that the economic impact of their attack was \$67 million. That's about 1% of their annual revenue.

If you could solve one problem with acquiring information technology infrastructure, what would it be?

Benjalil: I would want a cloud-based platform that allows managers of different departments to perform real-time productivity analysis — a tool that would allow department managers to make staffing decisions on the fly. Labor is such a huge amount of your total operating expenses. There's a huge opportunity to improve in this area. There are solutions out there that do some of this, but they don't cover every aspect of what I'm looking for.

Avelino: I would want to address the rising costs of IT. When we negotiated with

our electronic health record vendor, we had to hire an attorney to negotiate the terms. We ended up with a seven-year agreement that cost a couple million dollars. In the long run, the seven-year agreement will make it more manageable, but it doesn't negate the overall exponential cost.

Courville: I would want to create an easier way to measure value delivery or ROI. You shouldn't spend money unless you're going to get something for it. For example, did you see improved patient outcomes? An increase in patient volume? An increase in productivity? I think we can do a better job of drawing a solid line between investments and outcomes. Just installing technology is a good way to *not* get value. Each technology brings new data, processes and capabilities. If you haven't adjusted jobs and processes to work with that new system, you're probably not going to get what you want out of it.

Kimerle: The clear problem I would choose is around realizing the full value of IT investments. It's an organizational discipline improvement. Often the business or clinical outcomes are not fully understood. Additionally, the proposed solution needs to be fully developed with all the people, process, technology and culture complements to enable the desired outcome. ■



PURESTORAGE®

Pure Storage (NYSE: PSTG) delivers a Modern Data Experience that empowers organizations to run their operations as a true, automated, storage as-a-service model seamlessly across multiple clouds. Pure's Modern Data Experience enables digital transformation across the entire healthcare landscape to maximize the value of data, improve care delivery and reduce costs. www.purestorage.com/healthcare

This published piece is provided solely for informational purposes. HFMA does not endorse the published material or warrant or guarantee its accuracy. The statements and opinions by participants are those of the participants and not those of HFMA. References to commercial manufacturers, vendors, products, or services that may appear do not constitute endorsements by HFMA.

columns

LEADERSHIP

INNOVATION

PHYSICIAN PERSPECTIVE

CAPITAL FINANCE

FROM THE PRESIDENT

What the pandemic taught us about leadership: **Key takeaways**

The calendar tells us it's the traditional back-to-school time. Workplace homecomings are also underway as organizations return to the office and look to design their spaces and structures for today and beyond.



JILL GEISLER
@JillGeisler

Do you have questions or topics you'd like Jill to address in a future column? Email **Crystal Milazzo**, HFMA senior editor, at cmilazzo@hfma.org.

What a leadership moment this is: an opportunity to merge the best adaptive ideas from the last 18 months with past concepts that have stood the test of time and distance. So what are some key lessons the pandemic taught us? And how can leaders use them to help their staff adjust to being back in the office — even if on a hybrid basis?

4 THINGS WE LEARNED DURING THE PANDEMIC

1 Remote work and productivity are friends, not enemies. Managers who feared employees would slack off if not in their line of sight or “clocking in” and “clocking out” on traditional time schedules learned an important lesson. People can be trusted to get things done when working from afar. Several studies found productivity was the same or better among remote workers.^a

a. Chandni, K. and Hastwell, C., “Remote work productivity study finds surprising reality: 2-year analysis,” Great Place to Work, Feb. 10, 2021, and Maurer, R., “Study finds productivity not deterred by shift to remote work,” *SHRM*, Sept. 16, 2020.

2 Distance impedes communication. We learned that working apart from one another can lead to communication misfires and personal misunderstandings. Overcommunicating is essential to ensure people feel included, not just informed. Managers who weren't good at sharing clear information before the pandemic really struggled during it. What a great reminder of the power of clear, consistent communication strategies moving forward.

3 Empathy is essential. The pandemic traumatized people. They endured fear, grief, isolation, loneliness and depression. Every person has a story of some way the pandemic affected their health and happiness. Managers who acted with caring outreach, deep listening and thoughtful responses helped their employees through the darkest times and built trust and loyalty that benefit everyone.

4 People re-evaluated and recalibrated. During the pandemic, many took a fresh look at what matters most to them. They tallied up the time lost in commuting, doing jobs they didn't love, the cost of child care or their distance from friends and family. It led them to rethink their futures. Some are inclined to quit their jobs, opt for less business travel or ask for

remote work. Have good conversations with these employees, and be open-minded about what's possible. Don't lose good people because they think you're unapproachable or unwilling to make changes.^b

APPLYING THE LESSONS TO POST-PANDEMIC WORK

Clearly, you have a business to run that must be functional, reliable and fully focused on quality and service. Employee-friendliness is compatible with those goals. To that end, keep a few other things in mind in this season of change.

Make the return to the office meaningful and memorable, especially for those hired during the pandemic.

Consider a "re-onboarding" process that introduces them to spaces they've never seen and faces they've only known on camera. Unlike colleagues picking up where they left off, new hires have far fewer shared experiences with coworkers and would benefit from a plan to make them feel not only smart about the way things operate, but truly a part of the team.

Be transparent about how hybrid work is approved or assigned. This is essential to avoid perceptions of unfair treatment or unwise planning. If you're doing a hybrid trial run, be clear about how you'll measure success or failure, taking into consideration individual and team performance and, of course, how the model serves your clients or customers. And be upfront about the metrics you will use.

Ensure you don't set up two classes of people — the "near" and the "far." It's easier to coach a colleague, knock down rumors and give feedback in the moment when we can easily see or serendipitously bump into people in the office. We must make a conscious effort to do that with people working apart from us. Be intentional as

a leader. Don't "love the ones you're with" more than others.

Identify when *all hands on deck* is imperative.

It could range from seasonal work demands to training to team retreats. Plan for in-person events early, so people can plan for them.

Ensure people know what's going on. Use or improve your calendar, chat and project-tracking tools so everyone has access to information about the organization and each other. The pandemic shift to remote work caused tech-resistant employees to learn new software skills. Don't backslide.

Provide spaces to gather. If you downsize office space because more folks are working remotely, don't scrimp on common areas where people can meet. Ensure such spaces include good connectivity and audiovisual tools, so remote staff can join you virtually.

STRONGER, SMARTER POST-PANDEMIC LEADERS

Finally, if the pandemic wrought changes among employees, it surely did the same for leaders who experienced many of the same human emotions and challenges during the worst of times and did so while simultaneously caring for their teams. For that, leaders deserve a special measure of appreciation.

Moving forward, those who led through the pandemic and its aftermath are likely to be stronger and smarter for it. They'll have a Plan B for every Plan A. They will be adept at leading change, including fast pivots. They'll be better communicators and value emotional intelligence as a core skill for all staff, especially managers. And as they see employees re-evaluating what job satisfaction really means, they'll win the war for talent with creativity and care. ■

About the author

Jill Geisler is the Bill Plante Chair in Leadership & Media Integrity, Loyola University Chicago, and a Freedom Forum Institute Fellow in Women's Leadership.

b. Durbin, D., Groves, S., Olson, A. and Pisani, J., "Changed by pandemic, many workers won't return to old jobs," *AP News*, May 18, 2021, and Hsu, A., "As the pandemic recedes, millions of workers are saying, 'I quit,'" *NPR*, June 24, 2021.

Want to foster innovation in healthcare? Give it a foster home

Being an innovator in healthcare is not for the faint-hearted. The risks of failure are great, particularly for a health system that put its limited funding and resources on the line to develop an innovative project that holds promise but offers no guarantee of success.



**JEFF HELTON, PhD,
FHFMA, CMA**
jhelton2@msudenver.com

There is a way to mitigate the risk, while still enjoying the benefits, of a successful innovation. Instead of developing innovative projects on their own, healthcare organizations may find fostering innovation in others brings rewards that make it worthwhile.

FEAR OF FAILURE OR SLOW RETURNS

Organizations shy away from innovation because of the political risks from its not meeting expectations — or just plain failing. It takes a lot to make a business case for committing resources to try something unproven and then marshaling resources to deliver on the promise. Many healthcare organizations are not willing to take the risk even if an idea has merit on paper.

The same short-term need for returns we see with capital investments can also be a challenge. We must be attentive to margins and to reaping returns on invested resources in the new innovation.

A DIFFERENT MINDSET

These concerns are reasonable. But there's a way to strike a balance. Instead of "parenting" an innovation, you could "foster" it. Many startup companies have the entrepreneurial spirit to take a risk and develop innovations to improve care. Many are working to address the challenge of patient engagement that providers struggle with in their population health strategies, for example. Others are providing transportation services to help patients with follow-up appointments that help prevent readmissions. What many of these organizations require besides entrepreneurial spirit, however, is a laboratory to develop and refine the concept.

An organization that wants to be innovative, but at a reduced risk, could benefit from identifying a partner that can foster its innovative idea. Working with a start-up to pilot a new idea, for example, can allow the organization to avoid initial legwork needed to develop the idea, while preserving capital for other patient care investments. An entrepreneur that believes in the innovation can take the lead — and perhaps do it better because they are independent and unfettered by biases or limitations that exist within a larger organization.

If your leadership team sees value in community relationships, for example, then incentivizing development of new patient care innovations in the community could further that value. With such a partnership, you would simply define the problem and the needed solution and let your community lead the innovation. Many local businesses, colleges and entrepreneurs are ready to step in and help solve the challenges of delivering care.

Here are just two options to consider.

Seek connections with an innovation ecosystem. Such an organization may be working in your state or region on solutions to problems of interest to healthcare organizations (see for example, the sidebar on the next page). A good way to build a relationship with these

\$2B

Equity funding across 121+ healthcare AI startup deals in Q3 of 2020, according to CB Insights (*State of Healthcare Q3 '20 Report*)

organizations is by mentoring them to help them refine their healthcare-related ideas. They might assume that healthcare organizations are paid billed charges and that revenues aplenty therefore await development of their ideas. Helping entrepreneurs understand the structure and financing of the healthcare business enables them to separate good ideas from the unpromising ones and then shape those ideas into truly viable solutions to healthcare’s challenges.

Making such connections and sharing insights doesn’t mean discouraging entrepreneurs from testing ideas just because we don’t think they are possible. A fresh set of eyes could bring some valuable new insight for a business solution that may not have occurred to us.

Develop your own innovation ecosystem. This could be a good project for an underused project management office (PMO), where you could simply identify your needs and then let the PMO see what entrepreneurs can rise to the challenge. You could even make a small investment in the ideas and let your PMO manage the details. A relationship with a local university could open the door to resources for developing concepts.

PRELIMINARY CONSIDERATIONS

Before embracing such an approach, it is important to ask questions to validate your readiness:

- Do we have the management resources who can be freed up to lead the cooperative relationship with an external entrepreneur? (This would be a great assignment for an administrative resident, if you have one.)
- Do we have managers who can take time to share ideas with an entrepreneur and then work with them on a pilot study?
- If the project needs capital, can we make a capital investment without violating our existing investment policies?
- Will our board support such a community partnership, even if it does not yield immediate profits or could see an initial downside loss?

Fostering innovation: A case example

The Prime Health collaborative in Denver is an example of a healthcare innovation ecosystem that helps organizations with intriguing healthcare delivery ideas get those ideas on their feet and ready for market. Resources available to healthcare innovators through the ecosystem include an innovation academy, funding for services, support for healthcare entrepreneurs, a summit meeting with state government leaders and industry executives to provide insights on policy directions, and help for innovators to make connections with venture capital investors.

The collaborative has hosted a competition for the past eight years where several dozen start-up companies vie for mentoring from other entrepreneurs, consultants and industry leaders to refine their ideas and their investor “pitch.” They then compete for seed money provided by local foundations to help bring those ideas to life. The next step is to identify a place to develop the proof of concept and a business case. The partnerships that emerge from this process can be rewarding for both the startup and the organization that hosts a pilot test of the innovation.



- Do we have a culture that will allow us to use the failure of one idea as a learning experience for redefining it so we might ultimately achieve a solution?

BOLDNESS IS A KEY INGREDIENT

Fostering innovation this way is not easy, and it is not for everyone. But for the right organization and the right idea, providing a pilot site for an entrepreneur can create a viable path to innovation. Establishing a foster home in your organization for innovators seeking support to grow and succeed may be the best way you become a force for healthcare innovation. ■

About the author

Jeff Helton, PhD, FHFMA, CMA, is clinical professor of healthcare finance in the University of Colorado Denver Business School.

Why rekindling the romance in medicine could spur innovation



MARTIN H. BLUTH,
MD, PhD
mbluth@med.wayne.edu

When I mentioned to colleagues and friends recently that I have been thinking about the idea of romance in medicine, some were confused. They thought the topic of *romance* seemed a little outside the realm of healthcare. They wondered if I was talking about things like Romeo and Juliet, and Humphrey Bogart and Ingrid Bergman in Casablanca?

Not quite. I have been thinking more about history and the ideas that have inspired great accomplishments in medicine.

The Romantic Medicine movement of the late 1700s to mid-1800s is just one manifestation of this idea. The movement was part of the larger Romanticism movement, where writers became interested in the great promise of science and medicine for deepening our understanding of what it means to be human. The vision was to achieve a more enlightened approach to medicine by uniting material natural science and subjective clinical practice.

But romance in medicine is much more than that. More broadly, with the word *romance*, I am referring to the passion, awe and wonder that has blossomed at various times in history. Romance is reflected in the deep wonder and optimism with which healthcare's great visionaries explored the mysteries that lay beyond the limits of human understanding in their times. (See the sidebar on next page.)

LESSONS FOR TODAY

Amid the challenges of the pandemic, we should take time to reflect on the profound developments we have witnessed as diverse peoples, organizations and even industries have come together collaboratively, surpassing anything we have ever seen. The need for a response has given rise to what I would suggest is a new romantic spirit of unity and possibility, allowing for astonishing innovations.

Just consider how much has occurred in the past year in healthcare due to out-of-the-box thinking and passion fueled by necessity:

- Major establishments, such as the auto industry, have retooled their efforts to make personal protective equipment for healthcare.^a
- Whiskey manufacturers have produced hand sanitizers.^b
- Laboratories have pooled efforts to create and streamline testing for diagnosing COVID-19.^c

Such things would have seemed improbable just two years ago.

a. Valdes-Dapena, P., "Automakers are still cranking out masks and other PPE as Covid roars back," CNN Business, Dec. 8, 2020.

b. Distilled Spirits Council of the United States, "Distilleries making hand sanitizer to fight COVID-19," Page accessed July 9, 2021.

c. Boyle, P., "Coronavirus testing: How academic medical labs are stepping up to fill a void," AAMC, March 12, 2020.

50,000

Target number of ventilators Ford and General Electric have jointly worked to produce to help meet the challenge of COVID-19 under a contract with the U.S. Department of Health and Human Services

Source: CNN Business, Dec. 8, 2020

4 who exemplified romance in medicine

The history that gave rise to recent tectonic shifts in modern medicine is populated by visionaries from both the distant and more recent past. Here are just four who exemplify the romantic ideals that have inspired so many in their pursuit of understanding healthcare’s greatest mysteries:

- The Roman architect Marcus Vitruvius Pollio (Vitruvius, c. 80-70 BC to c.15 BC), who applied

his knowledge of principles of architecture to understanding the human anatomy

- Leonardo da Vinci (1452-1519), whose drawings of human anatomy were inspired by Vitruvius
- Werner Forssmann (1904-1979), whose work paved the way for cardiac catheterization
- Wallace Coulter (1913-1998), whose Coulter Principle helped revolutionize science and medicine

Many of healthcare’s greatest visionaries had obstacles to overcome, while some enjoyed a rare level of

support in their efforts or brought unique perspectives to bear. And in each case, these efforts were founded on what I would suggest are romantic ideals.

Da Vinci, for example, resided in Florence under the protective influence of the Medici family, which fostered ingenuity and creativity. And Coulter adapted his understanding and application of colloidal homogeneity required for painting Navy ships to characterization of blood cells, which is a staple of the hematology discipline.

HOW TO FOSTER THE ROMANTIC SPIRIT

Here are some ways healthcare finance leaders can nurture and sustain the romantic spirit that has made such developments possible.

Promote interplay of free thought. Healthcare organizations can foster such creativity by sponsoring symposiums that address lessons learned from the COVID-19 experience regarding the future direction for hospital needs.

Provide seminars on the history of medicine that shaped today’s financial realities. Bring in an inspirational speaker. Although such an initiative might seem out of touch with today’s practical concerns, significant value could be gleaned from instilling healthcare professionals with wonder at the profound human accomplishments on which today’s healthcare benefits are founded — framed in the context of today’s economic truths. Fostering understanding of the what drove healthcare’s great discoveries can inspire new thinking about today’s issues.

Create consortia with other entities to promote unique visions of the future. Such

approaches, with players who are unaccustomed to collaborating with each other, can create an amalgam of innovation greater than the sum of its parts.^d

A NEW FLOWERING OF MEDICAL ROMANCE

We can only hope that COVID-19 will eventually recede. For now, we should reflect on the many disparate entities that came together as never before to quickly address the pandemic’s impact. This is modern-day romanticism in medicine at its best. The passion and zeal behind these efforts should inspire our ingenuity, awe and romance and lead us to improve humanity in mind, body and spirit in unimagined ways. ■

d. “12 innovations that will change health care and medicine in the 2020s,” *TIME*, Oct. 25, 2019.

About the author

Martin H. Bluth, MD, PhD, is the founder of Bluth Bio Industries, chief of transfusion medicine, assistant director of laboratories and director of translational research for the department of pathology, Maimonides Medical Center, Brooklyn; professor of pathology at Wayne State University School of Medicine, Detroit; and global medical director for Kids Kicking Cancer, Southfield, Mich.

Why bond insurance is making a comeback in healthcare

Capital reserve requirements for bond insurers have recently changed, making bond insurance once again a viable option for hospitals or health systems seeking credit enhancement on their fixed-rate debt issuance. Before pursuing this option, however, healthcare bond issuers should understand the context for these changes.



JOHN ANDERSEN
jandersen@kaufmanhall.com

The bond insurance industry, which historically served primarily as insurers of municipal bonds, was turned upside down during the financial crisis of 2008-09. Many bond insurers had expanded to insuring collateralized mortgage obligations among other structured products. The implosion of these structured products caused the major rating agencies — which had rated many of the insurers AAA — to downgrade most of the bond insurance industry, essentially eliminating the value of most insurers' credit to the healthcare marketplace.

In 2017, Puerto Rico officially declared bankruptcy, leaving bond insurers exposed to billions in potential claims from multiple Puerto Rico borrowing entities — a situation that remains in litigation and is an unresolved risk to the industry. That year, the par amount of healthcare bonds with bond insurance had dwindled to less than 1% of acute not-for-profit healthcare bonds.

Since then, there has been significant growth in insured healthcare bonds. Assured Guaranty,

the market leader in healthcare bond insurance, provided credit enhancement to about 10% of acute not-for-profit healthcare bonds in 2020.

This growth was driven primarily by a 2019 change in the capital charges required by Standard & Poor's for insurers of healthcare bonds. Bond insurer ratings are essentially a proxy for the strength of an insurer's capital reserves, and a high rating is essential to writing new insurance business. The 2019 capital charge modification reclassified acute care providers to a lower-risk category, leading to a reduced cost of insuring acute care bonds. As a result, bond insurance has become viable again in healthcare as bond insurers have been able to reduce the premium they charge for insuring acute care bonds to a level more acceptable to the market. Nonetheless, the value to acute care borrowers depends not only on the insurer's premium charged but also on the value investors find in the credit enhancement. (See also the sidebar "How bond insurance works" in the online version of this column, at hfma.org/hfm.)

POTENTIAL BENEFITS OF BOND INSURANCE

The primary benefit of bond insurance to providers is a lower overall cost of capital. Providers also gain an improved ability to market the bond and to manage needed changes over its lifetime.

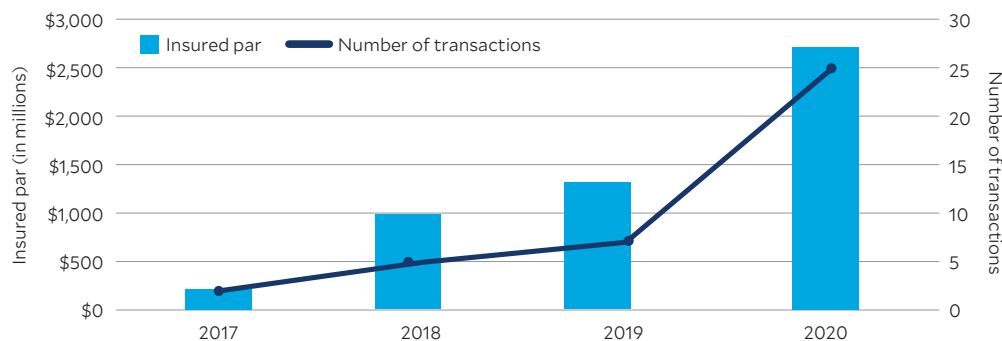
For lesser-known or less-frequent issuers, bond insurance can support market access and investor breadth. Large buyers of healthcare bonds are often big funds (e.g., mutual funds, exchange-traded funds, hedge funds) that typically require credit preapproval prior to purchasing bonds issued by a hospital or health system. Because large funds already have active bond insurers on their preapproved list, they may be more willing to consider insured bonds from a lesser-known issuer.

Bond insurance can also promote international demand for hospital and health system bonds. The insurer's credit analysis can provide added due diligence beyond a rating agency review, which may give comfort to sovereign

25

Number of bond insurance transactions in healthcare in 2020

Growth in bond insurance activity for healthcare revenue bonds, 2017-20



Source: Refinitiv SDC and Bloomberg. Data includes corporate-CUSIP transactions, which are regarded as public finance business by the insurer, Assured Guaranty.

wealth funds less familiar with the nuances of the U.S. healthcare system. In some cases, foreign governments reduce the required capital charges for holding U.S. bonds if they are insured, making these bonds more attractive to international funds.

The backstop that bond insurance provides reduces risk to investors and supports bond prices in the secondary market. A credit-enhanced bond is more likely to hold its price even if the hospital's credit is downgraded, which can add to its relative marketability and lower the hospital's interest cost at issuance.

Finally, bond insurance can help ease the process of obtaining changes, waivers or consents over the life of the bond. Since most MTIs allow for a majority creditor (as defined by the bond documents) to act on the behalf of all other bondholders, the bond insurer can serve as a sole *investor* for the hospital or health system to deal with for the life of the transaction.

WHEN BOND INSURANCE MIGHT NOT MAKE SENSE

Bond insurance is not always the best option.

“The decision to use bond insurance really depends on the credit profile of the issuing hospital or health system, market dynamics at the time of the deal and how the provider values

any of the non-monetary benefits of bond insurance,” says Leigh Nader, managing director of healthcare for Assured Guaranty. Importantly, bond insurance's value also primarily relies on an investor community that finds value in the insurer's credit enhancement.

The market for bond insurance in the U.S. today is practically limited to public fixed-rate bonds. As long as interest rates stay low relative to historical averages, this will likely remain the primary market. Bond insurance has been applied to new debt instruments in the past, so the market may expand in the future as new financial instruments are developed.

Hospitals and health systems should first confirm that bond insurance would lower their overall cost of capital. In estimating this benefit prior to pricing, organizations should not only make historical comparisons but also examine current market indications. Borrowers should also consider the impact of any incremental covenants against this benefit. If the overall benefits look promising, bond insurance may prove to be an effective means for credit enhancement. ■

About the author

John Andersen is a vice president, Kaufman, Hall & Associates, LLC.

Virtual Intake Management® by PELITAS provides a digital experience with self-service options helping providers financially clear more than 75% of patients before service

How do you help healthcare organizations navigate the biggest challenges in healthcare?

Consumers demand convenience. Healthcare providers that are not leveraging digital innovation to engage their patients and provide virtual self-service options will find themselves on the outside looking in as consumerism continues to penetrate the healthcare landscape.

Our personal devices have long since transformed from luxury items into necessities. However, healthcare has been slow to embrace digital transformation despite multiple studies confirming the need:

- 80% of satisfied consumers would switch providers based on convenience alone
- 90% of consumers will leave a current provider over an unsatisfactory digital experience
- 81% of consumers prefer providers with digital scheduling

COVID-19 changed everything, accelerating an already-rising demand for an enhanced virtual patient access experience. Providers can differentiate themselves, now and beyond

COVID-19, by adopting digital patient-intake tools, creating a convenient experience that will increase both satisfaction and loyalty.

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

PELITAS offers a holistic approach and has the only fully proprietary patient access technology platform that was not developed through acquisitions. This means comprehensive workflows and outstanding service and support. In addition to having HFMA Peer Reviewed status since 2018, PELITAS was named Best in KLAS for Patient Access in 2019 and 2020 and is currently ranked #1. With a proven track record like this, healthcare leaders can be confident in the technology and service that PELITAS provides.

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

Patient access does not have to be a disjointed and frustrating process for your

team and patients. But with many disparate systems, that's what happens and at an expensive price. PELITAS provides a patient-centered, end-to-end solution with step-by-step guidance and a single point of access. Powered by intelligent rules and exception-driven workflows, the Integrated Patient Access Solution (iPAS) integrates seamlessly with any EHR or PMS and eliminates redundancy, providing a better experience for patients and team members.

With Virtual Intake Management, patients can complete scheduling, pre-service and intake steps from anywhere on any device. By providing convenience, safety and choice, this patent-pending solution delivers the consumer-inspired, digital experience patients expect, now and beyond COVID-19. ■

4 years on the Short List

87% of peer reviewers would recommend the Integrated Patient Access Solution (iPAS) to their colleagues.



PELITAS provides technology solutions to help hospitals, physician practices, and specialty groups improve patient experience, maximize revenue, and eliminate inefficiencies throughout the revenue cycle. Awarded Best in KLAS in 2019 and 2020, and ranked #1 currently, its Integrated Patient Access Solution® (iPAS®) is designed to financially clear patients at the first point of contact by improving the accuracy of registrations, increasing point-of-service payments and reducing denials.

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

2021-22

LEADERSHIP DIRECTORY

HFMA's annual listing of the Association's national, regional and chapter leaders



CHAIR

Tammie L. Jackson
FHFMA, CHFP, MHA
Vice President
TransUnion Healthcare
Chicago, Ill.



CHAIR-ELECT

Aaron R. Crane
FHFMA, CPA, MHA
Executive Vice President
Seattle Cancer Care Alliance
Seattle, Wash.



SECRETARY/TREASURER

Dennis E. Dahlen
CHFP, CPA
CFO
Mayo Clinic
Rochester, Minn.



PRESIDENT/CEO

Joseph J. Fifer, FHFMA, CPA
Healthcare Financial
Management Association
Westchester, Ill.

NATIONAL BOARD OF DIRECTORS (CONTINUED)

TERMS EXPIRE 2022



James L. Heffernan, FHFMA

Senior Vice President
and Treasurer
Massachusetts General
Physicians Organization
Boston, Mass.



**Cindy Price
FHFMA**

CEO (retired)
HCA Parallon Shared Services
Houston, Texas



Mimi Taylor

CIO and Corporate Vice
President of IT Baptist
Health South Florida
Coral Gables, Fla.

TERMS EXPIRE 2023



**Abby Birch
CRCR**

Regional Vice President,
Business Development
Revint Solutions
Fort Lauderdale, Fla.



Jeffrey T. O'Malley

System Vice President
Strategic Growth
and Governance
CommonSpirit Health
Chicago, Ill.



Margaret L. Schuler

Senior Vice President, Revenue
Cycle and Practice Operations
Aspen Dental Management Inc.
Chicago, Ill.

TERMS EXPIRE 2024



**Colleen M. Blye
CPA**

Executive Vice President/CFO
Montefiore Health System
New York, N.Y.



**Maureen A. Clancy
FACHE, CPC**

Senior Vice President,
Operations
Privia Health
Washington, D.C.



**Matthew E. Cox
CHFP, CPA**

Senior Vice President/CFO
Spectrum Health
Grand Rapids, Mich.

REGIONAL EXECUTIVES

REGION 1



Robert Gilbert
FHFMA, COC, MBA

Senior Manager,
Healthcare Consulting
Baker Newman Noyes
Portsmouth, N.H.

REGION 2



Barbara Piascik
FHFMA, CHC

Vice President/Chief
Compliance Officer
Bergen New Bridge
Medical Center
Paramus, N.J.

REGION 3



Benjamin Gleason

Vice President
ARx Healthcare
Doylestown, Ohio

REGION 4



Jessica Poston

Director, Strategic Pricing
Carilion Clinic
Roanoke, Va.

REGION 5



Michele Tynes Napier
FHFMA

Chief Revenue Officer
Orlando Health
Orlando, Fla.

REGION 6



William Sharp
FHFMA, CPA

Partner
Plante Moran PLLC
Columbus, Ohio

REGION 7



Nikki S. Harper, FHFMA

Vice President, Patient
Business Services
Trinity Health
Farmington Hills, Mich.

REGION 8



Cindy Fischer, CHFP

Corporate Responsibility
Officer
CommonSpirit Health
Fargo, N.D.

REGION 9



Tracy Young
CPA

Partner
BKD, LLP
Little Rock, Ark.

REGION 10



Terrence Brennan
FHFMA

Retired
Prescott, Ariz.

REGION 11



Tammy Dumlao

Director of Revenue
Cycle, Hawaii Health
Systems Corporation
Honolulu, Hawaii

NATIONAL ADVISORY COUNCIL



Fahd Benjalil
FHFMA, MBA

CFO and COO
Sharp Coronado Hospital
Coronado, Calif.



Vanessa Couch-Laguana
CPC

Director, Revenue
Cycle, Hawaii Region
Kaiser Permanente
Honolulu, Hawaii



Michelle N. Crunk

Vice President,
Revenue Cycle
Kettering Health Network
Kettering, Ohio



Martin J. D'Cruz
FHFMA, MBA

Vice President,
Managed Care & Value
Based Payments
Baptist Health System
Louisville, Ky.



James Travis Dowell
FHFMA, MBA, FACHE,
FACMPE

President and CEO
Memorial Physician
Services
Springfield, Ill.



Michelle T. Farrell

Assistant Vice President,
Revenue Management
Orlando Health
Orlando, Fla.



Shawn K. Gretz
FHFMA, CRCR

President
Americollect, Inc.
Manitowoc, Wis.



Lee J. Handke
PharmD, MBA

CEO
Nebraska Health Network
Omaha, Neb.



Kelli J. Harbert

Vice President,
Healthcare Solutions
TransUnion
Sandy, Utah



Nikki S. Harper
FHFMA

Vice President, Patient
Business Services
Trinity Health
Farmington Hills, Mich.



Rhea Heath
MBA

Senior Vice President,
Revenue Cycle
Management
PathGroup
Nashville, Tenn.



Maria Jayoussi
FHFMA, MBA

Vice President
Nicklaus Children's
Pediatric Specialists
Miami, Fla.



Aren Laljie
FHFMA, CPA, MBA

CFO
Miami Children's
Health Plan
Miami, Fla.



Jeff Mincher
FHFMA

Vice President, Revenue
Cycle Operations
Texas Health Resources
Arlington, Texas



Billie Jean Mounts
FHFMA, CRCR, CSMC

Chief Revenue Officer
Bon Secours Mercy Health
Cincinnati, Ohio



L. Shawn Nelson
FHFMA, CPA

CFO
Lifelong Health
Riverside Health System
Newport News, Va.



Dan J. Phippen
FHFMA

Market General Manager
Cloudmed
Atlanta, Ga.



Bryan W. Redick
FHFMA, CPA, MBA

Vice President of
Operations/Finance
Norton Healthcare
Medical Group
Louisville, Ky.



Richard R. Rhine

Executive Vice
President/CFO
Grady Health System
Atlanta, Ga.



Richard M. Russo

Vice President, Finance
Atrius Health
Newton, Mass.



Monica Schmude

President
Cigna Mid-Atlantic
McLean, Va.



Christina Steiner

Director – Healthcare
Industry Group
Alvarez & Marsal
Holdings, LLC
New York, N.Y.



Ryan E. Thompson

Senior Vice President,
Revenue Cycle
CHRISTUS Health
Irving, Texas



Barbara S. Viskochil

Retired
University of Utah
Hospital & Clinics
Salt Lake City, Utah

CHAPTER PRESIDENTS

REGION 1

CONNECTICUT



Denise Smith

Medicaid Audit
TCORS
New London, Conn.

MASSACHUSETTS/RHODE ISLAND



**Annamarie Monks
CHFP**

Manager, Washington
COVID-19 Contact
Tracing Partnership
Mansfield, Mass.

NORTHERN NEW ENGLAND



**Erin Cutter
CRCR, MBA**

Manager, Revenue
Integrity
Concord Hospital
Concord, N.H.

CENTRAL NEW YORK



**Amy Blatt
FHFMA**

Reimbursement Manager
Mohawk Valley
Health System
Utica, N.Y.

REGION 2

HUDSON VALLEY NEW YORK



**Christina Santullo
CRCR**

Director, Client Services
Quality Billing Service, Inc.
Poughkeepsie, N.Y.

METROPOLITAN NEW YORK



**Sean Smith
FHFMA, CPA**

Senior Associate, Vice
President Finance/
Deputy CFO
University Hospital
SUNY Downstate
East Meadow, N.Y.

NORTHEASTERN NEW YORK



Rebecca Slagle

Controller
Albany Medical
Center Hospital
Hudson, N.Y.

PUERTO RICO



**Henry Flores
CPA**

Audit & Consulting
Director
FPV & Galindez, LLC
San Juan, Puerto Rico

ROCHESTER REGIONAL



**Ryan McGinnis
CHFP, MBA**

Manager, Decision
Support
Rochester Regional Health
Rochester, N.Y.

WESTERN NEW YORK



Lori Condo

Assistant Controller
Orleans Community
Health
Medina, N.Y.

REGION 3

CENTRAL PENNSYLVANIA



**Danielle Cerminaro
CHFP, MBA**

Associate Vice
President of Central
and Northcentral
Financial Reporting
Geisinger Health System
Danville, Pa.

METROPOLITAN PHILADELPHIA



**Edward Chiosso
FHFMA**

Partner
KPMG
Chalfont, Pa.

NEW JERSEY



Jill Squiers

Policy & Regulations
Manager
AmeriHealth Insurance
Company
Cranbury, N.J.

NORTHEASTERN PENNSYLVANIA



Brian Babilon
FHFMA, CRCR

Manager, Revenue
Management Professional
Operations
Geisinger Health System
Roaring Brook
Township, Pa.

WESTERN PENNSYLVANIA



Richard Nagy
FHFMA

Vice President, Managed
Care Contracting
Allegheny Health Network
Beaver Falls, Pa.

KENTUCKY



Becca Meredith
CHFP

Manager
Blue & Co, LLC
Louisville, Ky.

REGION 4

MARYLAND



Linker Mills
FHFMA, CRCR, CSBI

Director, Finance &
Revenue Management
MedStar Franklin Square
Medical Center
Baltimore, Md.

NORTH CAROLINA



Cameron Thomason

Assistant Vice
President, Strategy &
Strategic Alliances
Labcorp
Lexington, N.C.

VIRGINIA-WASHINGTON, D.C.



Christopher McMillan
FHFMA, CSAF,
CSMC, CRCR

Associate Director
Impact Advisors LLC
Charlottesville, Va.

WEST VIRGINIA



Marcia Leighton

Firstsource
Patient Matters
Baltimore, Md.

ALABAMA



Matt James

Patient Access Director
Jack Hughston
Memorial Hospital
Smiths, Ala.

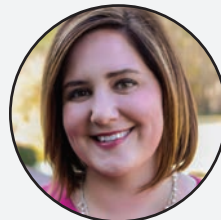
FLORIDA



Govind Goyal
CRCR

Executive Vice President,
Financial Services and
Revenue Integrity
Panacea
Trinity, Fla.

GEORGIA



Elizabeth Richards
FHFMA

CEO
Altum Healthcare
Solutions
Atlanta, Ga.

SOUTH CAROLINA



Danielle Gori
FHFMA

Manager, Audits and
Appeals, Ensemble
Health Partners
Greenville, S.C.

REGION 5

CHAPTER PRESIDENTS (CONTINUED)

REGION 5 continued

TENNESSEE



Rodney Adams

Associate Administrator
of Finance
Williamson
Medical Center
Santa Fe, Tenn.

REGION 6

MICHIGAN GREAT LAKES



Jason Williams
FHFMA

Director, Corporate
Reimbursement
Henry Ford Health System
Brownstown, Mich.

CENTRAL OHIO



James Monroe

Senior Payment Adviser/
Vice President
Keybank
Cleveland, Ohio

NORTHEAST OHIO



Brianna Ashley

CFO
Net Revenue Associates
Hudson, Ohio

NORTHWEST OHIO



Richard Bame

Controller
Wood County Hospital
Bowling Green, Ohio

SOUTHWESTERN OHIO



Michael Haas

Corporate Healthcare
Banking
Fifth Third Bank
Cincinnati, Ohio.

REGION 7

FIRST ILLINOIS



Rich Schefke
FHFMA, CPA

Director of Financial
Planning Analysis &
Decision Support
Northwest Community
Healthcare
Arlington Heights, Ill.

INDIANA PRESSLER MEMORIAL



Shannon Ebenkamp
FHFMA, CPA

Director of Finance
Memorial Hospital
& Health Center
Jasper, Ind.

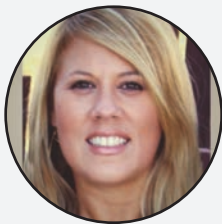
MCAHON-ILLINI



Jared Heim
CHFP, CPA

Partner
Eide Bailly LLP
Dubuque, Iowa

SOUTHERN ILLINOIS



Jennifer Granados
FHFMA

Finance Manager
Southern Illinois
Healthcare
Carbondale, Ill.

WISCONSIN



Tracy Quinn

Director of Client Services
State Collection
Service, Inc.
Madison, Wisc.

GREATER HEARTLAND



Kevin Bohnert

Manager, Contracts
Administration Technical
BlueCross BlueShield
of Tennessee
Hixson, Tenn.

REGION 8

IOWA



David Muhs
FHFMA

CFO
Henry County
Health Center
Mt Pleasant, Iowa

MINNESOTA



Hannah Wieshalla
CHFP

Senior Director QI &
Network Support
CentraCare Health System
Browerville, Minn.

NEBRASKA



Shelly Soupir

Senior Sales Director
Change Healthcare
Omaha, Neb.

NORTH DAKOTA



Ashley Brandt-Duda
CPA

Partner
Eide Bailly LLP
West Fargo, N.D.

SOUTH DAKOTA



Stan Knobloch
CHFP

Director of Finance
Sanford Health
Rock Rapids, Iowa

SUNFLOWER (KANSAS)



Patrick Whisennand

Director of Business
Development
Account Recovery
Specialists, Inc. (ARSI)
Wichita, Kan.

ARKANSAS



Michael Westerfield
FHFMA, CPA

Director
BKD, LLP
Little Rock, Ark.

LONE STAR



Jorge Fernandez

Vice President
Business Development
Cloudmed
Flower Mound, Texas

REGION 9

LOUISIANA



Anthony Verdicanno

President
Transfinancial
Companies, Inc.
Baton Rouge, La.

MISSISSIPPI



Andres Posada
CHFP

Manager
Horne LLP
Ridgeland, Miss.

OKLAHOMA



Louise Kiper

Vice President of
Sales & Marketing
American Collection
Services
Oklahoma City, Okla.

SOUTH TEXAS



Mike Trostel
CPA

Vice President of
Reimbursement and
Financial Analysis
Signet Health
Dallas, Texas

CHAPTER PRESIDENTS (CONTINUED)

REGION 9 continued

TEXAS GULF COAST



Miguel Lopez

National Director of Business Development
Centering Healthcare Institute
Katy, Texas

REGION 10

ARIZONA



Joan Goda

Vice President, Payer Strategy and Relations
American Oncology Network LLC
Oro Valley, Ariz.

COLORADO



Jonathan Wiik
CHFP

Principal of Healthcare Strategy, TransUnion Healthcare
Transunion Parker, Colo.

IDAHO



Bill Shrum

Vice President of Finance and Accounting
Delta Dental of Idaho
Boise, Idaho

MONTANA



Kelly Akkerman
CHFP

Patient Financial Services Director
Marcus Daly Memorial Hospital
Victor, Mont.

NEW MEXICO



Peter Seaman
CPA

Vice President, Finance
Gerald Champion Regional Medical Center
Alamogordo, N.M.

UTAH



Brandon Floyd

CEO
Rubicon
Salt Lake City, Utah

WYOMING



Shelly Larson
CHFP

CFO
Hot Springs County Memorial Hospital
Thermopolis, Wyo.

REGION 11

HAWAII



Sheri Richard

Revenue Cycle Manager
Waikiki Health
Honolulu, Hawaii

NEVADA



Holly Gavin

COO
Professional Medical Consultants
Las Vegas, Nev.

NORTHERN CALIFORNIA



Wende Weckbacher
HFHMA

CFO
Epic Care
Martinez, Calif.

OREGON



Tammie Coon

Vice President, Business Development
Ensourage
Vancouver, Wash.

SAN DIEGO-IMPERIAL



Basak Kaya
FHFMA, CHFP, MBA

Vice President,
Revenue Cycle
Vituity
San Diego, Calif.

SOUTHERN CALIFORNIA



Gretchen Works

Manager
Progressive
Management Systems
West Covina, Calif.

WASHINGTON/ALASKA



Jesse Maier
FHFMA, CSBI, CSMC,
CSPPM, CPA

Finance Manager
The Polyclinic
Seattle, Wash.

Promote Yourself.

**Healthcare
finance education,
on-demand.**

hfma.org/education

HFMA Membership Benefit.



Pressure rising: COVID-19's ongoing impacts on healthcare labor trends

Across nearly every industry, the COVID-19 pandemic has reshaped how and where people work. For hospitals and health systems, early efforts to stem the virus's spread spurred organizations to limit the number of individuals moving in and out of care facilities and to abruptly shift non-clinical personnel to remote work environments.

More than a year later, healthcare leaders continue to assess the long-term implications of the pandemic on staffing, overall hiring practices and operations. A national survey of more than 140 HFMA members found that many anticipate workforce changes propelled by the pandemic will become permanent.

Syntellis Performance Solutions partnered with HFMA's Financial Analytics Leadership Council (FALCO) to conduct the May 2021 survey and host subsequent roundtable discussions for insights on how the pandemic is affecting hospital labor trends now and into the future. Five key findings include:

- Health systems continue to shift non-clinical positions to remote work
- Organizations are casting wider nets for recruiting
- Many healthcare leaders expect labor expenses to increase over the next year
- Hospitals are testing creative solutions to address workforce shortages
- Finance experts are optimistic that key measures of profitability will return

The actual, long-term repercussions of COVID-19 on the healthcare industry remain to be seen. Still, these findings highlight how healthcare leaders nationwide are responding to the disruptions of the past year and preparing for future uncertainties.

Expanding remote work

While the transition to remote work was driven by necessity during the pandemic, healthcare leaders say it enabled them to grow comfortable with the model and gain a new appreciation for the opportunities it offers. Having greater flexibility about where employees work can help reduce costs and attract new talent.

Fifty-five percent of HFMA members responding to the survey said their organizations closed facilities within the past 12 months where they could move staff to remote work. One-third said they plan to close additional facilities and transition more personnel to work remotely in 2021 and 2022. Nearly a quarter (23%) said they combined offices over the past year with plans to eventually bring remote workers back, and 30% said they would do so this year or next.

One FALCO member said his organization is completely rethinking its facility needs as a result of the pandemic. While top executives will remain onsite, many of the health system's non-patient-facing employees will shift to permanent remote work. By 2022, those changes will allow the health system to vacate several buildings that it leases and increase occupancy in buildings it owns.

Some organizations are taking a hybrid approach, with positions like billers and coders moving fully remote, and other clinical support personnel working a combination of at-home and in-office days. The CEO of one Midwest health system intends to use a hybrid model to reduce by 25% the organization's square footage facility needs. Having fewer employees onsite also allows many organizations to cut back on equipment leases for printers, copiers and other standard office items.

Casting a broader net

The demands of the pandemic exacerbated national healthcare workforce shortages. More and more, organizations rely on recruiting beyond their immediate market areas. Fifty-seven percent of survey respondents said they hired temporary or contract staff during the pandemic, and more than a third (34%) said they hired outside their regions for such positions. One-quarter of survey respondents said they plan to look outside their regions to fill additional temporary positions in 2021 and 2022, while 27% plan to hire permanent staff from other areas.

Having the ability to recruit employees regardless of where they live opens up the talent pool at a time when many health systems are struggling to fill key positions, one FALCO member said. It also has allowed his health system to retain employees who want the option to move, he said.

Some executives who were resistant to remote work previously said the pandemic has completely changed their perspective. "If you asked me a year ago about remote work, I would have told you I was uncomfortable with it – I like that face-to-face interaction with my employees," one member said. "My position has changed. I have a team of 50 now that is entirely remote, and they are just as productive – if not more productive – working remotely than they were in the office."

Rising labor expenses

Hospitals and health systems nationwide saw labor expenses rise in 2020 as they sought to minimize staff reductions in the face of unpredictable volumes and expand their nursing pools in response to surges in COVID-19 cases.

Nearly half of survey respondents said they expect labor expenses to continue to increase. Another 30% anticipate labor costs will decrease over the next several months compared to last year's highs, and 23% said they will remain unchanged. During a roundtable discussion, multiple FALCO members said they anticipate 2021 labor expenses will increase compared to pre-pandemic levels, but they are working hard to reduce the exceptionally high costs seen in 2020.

One finance executive estimates labor costs at her health system jumped 20% during the pandemic as the organization paid incentives and bonuses to retain clinical personnel and increased its reliance on temporary staffing agencies to fill nursing needs as COVID-19-related hospitalizations rose. "We got hit in December and January from the COVID-19 surge in the Midwest," she said. "The labor costs were just insane at up to \$180 an hour for contract nursing. That is not a sustainable cost."

Survey respondents reported significant volume declines across multiple service lines in 2020, contributing to higher per-patient labor costs. Nearly three-quarters saw declines in emergency department visits, 66% reported declines in inpatient orthopedic cases, and 65% saw declines in outpatient surgeries and screenings or visits for chronic conditions.

Addressing staffing shortages with innovative efforts

Demand for registered nurses (RNs) remains high. More than half (55%) of HFMA members responding to the survey said the need for RNs increased over the past 12 months, and 43% expect the need to increase in 2021 and 2022. Forty-two percent reported an increased need for ancillary staff, such as housekeepers and nursing assistants, during the pandemic.

Health systems continue to explore a variety of efforts to address staffing shortages and reduce their reliance on contract labor. In addition to nurses, finance executives say that filling low-paying clinical and non-clinical positions is increasingly difficult. One FALCO member said turnover within the first year at his organization is as high as 90% for some entry-level positions. He and other executives said their health systems are raising starting salaries in response and offering performance incentive programs to help boost pay and recruit and retain a reliable workforce.

To reduce the need for contractors, one health system is offering bonuses and additional per-hour incentive payments for nurses and other clinical personnel to work extra hours. Others have established more flexible staffing models, and internal float pools to shift clinical staff to other facilities as needs arise. In one case, an executive said her health system is developing an automated online scheduling system akin to an Uber

or "gig economy" model that would allow workers flexibility to pick up shifts when they choose.

Optimism for the future

Despite the myriad challenges and ongoing repercussions of COVID-19, many healthcare leaders remain optimistic that their organizations will recover. More than half of survey respondents predict key measures of profitability will return to pre-pandemic levels:

- 53% anticipate a return in patient volumes
- 51% expect expenses will drop
- 53% anticipate revenues will increase

In response to mounting pressure from patients, providers and payers to hold down costs, healthcare leaders must closely evaluate pricing strategies, especially for outpatient services where they face the most competition from retail providers, private equity entities and others.

Healthcare leaders must apply the lessons learned during the pandemic to prepare for future unknowns. Many are making fundamental changes to their financial planning processes. Some top priorities cited by survey respondents include introducing rolling forecasting capabilities, streamlining operational budgeting and integrating comparative analytics to inform planning decisions. Such initiatives will help organizations remain agile and informed in the face of any new disruptions that may emerge. ■












Syntellis Performance Solutions, previously Kaufman Hall Software, provides innovative enterprise performance management software, data, and analytics solutions for healthcare organizations. Syntellis' solutions include Axiom and Connected Analytics software, which help finance, clinical, and operations professionals elevate performance by acquiring insights, accelerating decisions, and advancing their business plans. For more information, please visit www.syntellis.com.

This published piece is provided solely for informational purposes. HFMA does not endorse the published material or warrant or guarantee its accuracy. The statements and opinions by participants are those of the participants and not those of HFMA. References to commercial manufacturers, vendors, products, or services that may appear do not constitute endorsements by HFMA.

THE SHORT LIST

HFMA Peer Reviewed products and services have been evaluated by users like you for quality, technical support, customer service, and value—all the things you look for to make smart purchasing decisions.

SERVICES

 AMN Healthcare	Managed Services Provider (MSP) – Workforce Solutions amnhealthcare.com		Healthcare Bad Debt Recovery by PFC Rev pfcusa.com
 BESLER	Revenue Integrity Solutions besler.com/revenue-integrity		Self-Pay Early Out Services by PFC First pfcusa.com
 cloudmed	Revenue Integrity Service cloudmed.com		Technology-enabled Revenue Cycle Management Services r1rcm.com
 ENSEMBLE HEALTH PARTNERS	Full Revenue Cycle Services including Facility Patient Access Services, Pre-Arrival Services, Health Information Management, Revenue Integrity & Chargemaster Services, and Central Business Office Services ensemblehp.com		Complex Claims Management Solution Underpayment Review for Commercial and Governmental Payers revecore.com
 FIRST AMERICAN AN RBC/CITY NATIONAL COMPANY	Financing Solutions offered by First American Healthcare Finance fahf.com		Debt Collection Services for Healthcare simonsagency.com
 ELP Financial PATIENT FINANCING SOLUTIONS	Patient Financing Solutions helpfinancial.com		Healthcare Collection Services statecollectionsservice.com
 MedData	MedData Eligibility Services meddata.com		Healthcare Technology Financing tfcapitalsolutions.com
 PARALLON	Revenue Cycle Outsourced Services parallon.com		Accounts Receivable Management Service (ARMS) trubridge.com
 Professional Credit	Professional Credit Healthcare Collection Service professionalcredit.com		

PRODUCTS



Easy Work Papers
besler.com/easywp



CareCredit Credit Card by Synchrony Financial
carecredit.com/hfma



ChargeAssist® by Holliday & Associates—including:
 CDM Auditor™, Price Analyzer™, Change
 Monitor™ and Ultimate Research Center™
chargeassist.com



AP Card
 Health Services Financing (HSF®)
 RemitConnect®
commercehealthcare.com



Chargemaster Toolkit®
craneware.com



CDMauditor.com Hospital Zero-Base Pricing®
panaceainc.com



Patientco Billing and Payment Platform
patientco.com



iPAS® - Integrated Patient Access Solutions®
pelitas.com



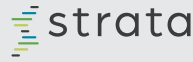
PMMC ESTIMATOR PRO
 PMMC CONTRACT PRO
pmmcconline.com



ERP
premierinc.com/solutions/finance-operations



Sage Intacct Cloud Accounting Software
sageintacct.com/healthcare-accounting-software



Budget Manager
 Cost Manager
 Product Line Analyst
 StrataJazz® Financial Analytics
 and Performance Platform
stratadecision.com/our-solutions



Axiom Healthcare Suite
syntellis.com/software/healthcare



TransUnion Healthcare Clear IQ® Patient
 Payment Estimation
 TransUnion Healthcare Insurance Discovery
 STINGRAY™ Medicare Bad Debt
 STINGRAY™ Medicare Disproportionate Share
 STINGRAY™ Transfer DRG
 STINGRAY™ Shadow Billing Compliance
transunionhealthcare.com



TruBridge RCM Product Suite
trubridge.com



Revenue Cycle Intelligent Automation Platform
 – including Eligibility, Estimation, Authorization,
 Revenue Capture, Patient Pay Optimization, and
 Claims/Clearinghouse + Medicare solutions
waystar.com

ROI CALCULATOR

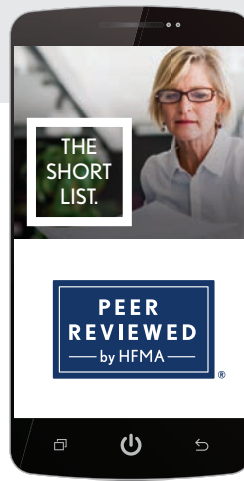


ClearBalance® ROI Value Model™
clearbalance.org

hfma™ | Peer Review

Learn More!
hfma.org/peerreview

*HFMA staff and volunteers determined that these healthcare business solutions have met specific criteria developed under the HFMA Peer Review process. HFMA does not endorse or guarantee the use of these healthcare business solutions or that any results will be obtained.



hfma™
hfma.org

Survey: Hospitals and health systems prioritize automation technology and cybersecurity to battle pandemic

Cost-conscious healthcare leaders seeking to increase efficiency in corporate services are generating success through automation technology, but most hospitals and health systems have yet to optimize their use of technology to full effect. That takeaway comes from a recent Healthcare Financial Management Association (HFMA) survey in which 112 healthcare leaders shared their views and projections about corporate services and health IT. The survey was fielded earlier this year, and participants included CFOs and other financial and revenue cycle executives. Through its Center for Health Insights, Guidehouse analyzed the research conducted by HFMA, and the following sections discuss key takeaways.

Automation technologies gaining steam

The use of automation technology among hospitals and health systems is on the upswing, with 82% of respondents already on their automation journey. The majority of those are still in the early stages, either testing the technology or already deployed and actively monitoring results. But 19% report that their automation investments have driven positive results, and they are expanding their capabilities.

The increased use of automation as a cost-reduction strategy includes organizations that lack the resources needed to deploy the technology themselves, said Bill Jones, a Guidehouse partner and managed services leader.

“For these providers, leveraging vendor partnerships and outsourced services is a

strategic investment to successfully achieve economies of scale and realize the benefits of automation,” he said.

Optimization opportunities abound

Only 8% of hospitals and health systems are using a fully optimized enterprise resource planning (ERP) system, the survey found. About 32% of health system leaders said they have deployed a system, but it is not optimized yet – but just 16% of hospitals are at that point.

Although the Office of the National Coordinator for Health IT has made regulatory moves that improve interoperability – allowing providers to easily and securely exchange data and automate technologies – many providers have yet to take full advantage of the opportunity, according to Guidehouse leaders. One example: 30% of providers report they may be at least two years away from deploying

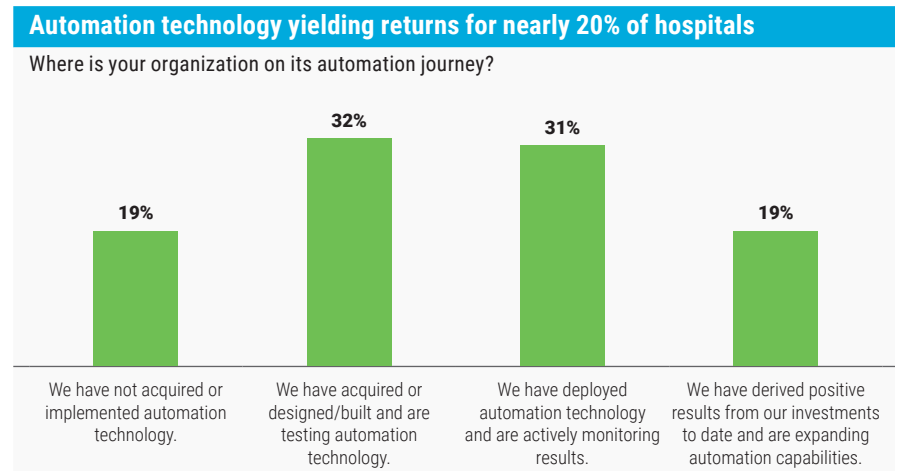
an ERP system, and 15% say they have no plans to do so.

Providers can drive efficiency gains, especially in corporate services, by optimizing technology, said Subra Sripada, a Guidehouse partner and Health IT Solutions co-leader.

“Underperforming or underleveraged ERP assets, for instance, significantly slow down operations, productivity and employee engagement,” said Sripada, a former health system chief information officer. “In many cases, providers are not taking full advantage of the benefits their technology investments offer to solve their greatest business challenges – and it’s working against them in terms of efficiency and security.”

Cybersecurity emerges as a growing priority

Nearly 30% of survey respondents identified cybersecurity as their top priority for



technology enhancement over the next year. About 43% of providers cited using modern security technology to monitor network and device anomalies as their top strategy.

Yet very few respondents reported taking basic steps to improve their organization's cybersecurity. As they grow through mergers and acquisitions, health systems increase their risk of cybersecurity attack if they layer on new technologies instead of replacing old ones. The survey found that just 1% of providers are tracking their technology assets and only 9% have removed legacy software.

Cybersecurity attacks can disrupt the ability of a hospital, health system or physician group to provide patient care, said Katie Gilfillan, MSW, HFMA's director of Healthcare Finance Policy, Physician and Clinical Practice.

"If access to care is interrupted, this creates a risk to the surrounding community and patients' privacy, health and safety," she said. "Creating a culture of patient safety within the organization, which includes a focus on cybersecurity, will help to maintain a focus on this growing risk to healthcare providers and the patients they serve."

Leaders focus on corporate services spend

On average, corporate services account for 10.38% of total operating revenue for hospitals and health systems. The COVID-19

pandemic has intensified pressure for health systems to focus on their financial and operational performance, said Michele Mayes, Guidehouse partner and Operational Effectiveness solutions leader.

Nearly half (47%) of respondents expect their organization's corporate services budget will increase by up to 10% in the next 12 months, while 25% of respondents project decreased spending. Although budget tightening is always painful, a majority of survey respondents believe they can reduce spending on corporate services without hurting service quality or efficiency. In fact, 45% of respondents think they could reduce spending by up to 10%, and 20% think they could reduce spending even more with no ill effect.

Providers are targeting the supply chain, IT and revenue cycle management as the three top priorities for reduced spending. While supply chain and revenue cycle management are key areas to target, Mayes points out that optimizing can improve efficiency and create a more resilient future. "The technology itself won't solve the problem, but wrapping better processes and structure around an optimized solution will," she said.

Nurse shortage tops staffing challenges

The pandemic has taken a heavy toll on providers' staffing efforts. A full 69% of executives said nursing shortages have worsened

compared to a year ago. The next-biggest hit: behavioral and mental health providers, with 32% saying shortages have increased in the past year.

Survey respondents also identified staffing shortages for advanced practitioners, coding/revenue cycle experts, physicians and IT-related experts such as data scientists and engineers.

The nursing supply will likely continue to be a challenge, particularly in rural areas and for certain types of patient care needs, including mental and behavioral health and long-term care, Gilfillan said. The pandemic required hospitals and health systems to rapidly shift workforce resources to meet surges in demand for care. This required nurses to take on new roles and responsibilities, highlighted scope of practice issues, and created new ways that patients access care and engage with providers such as through telehealth.

"As health systems reset after the pandemic, considering these factors has become important for optimizing the resources available and planning for future care needs," HFMA's Gilfillan said. ■

With 11 KLAS #1 rankings, the Guidehouse Health team helps hospitals and health systems, government agencies, life sciences companies, and payers strategically redesign, revitalize, and transform their operations.



Guidehouse is a leading global provider of consulting services to the public and commercial markets with broad capabilities in management, technology, and risk consulting. We help clients address their toughest challenges and navigate significant regulatory pressures with a focus on transformational change, business resiliency, and technology-driven innovation. Across a range of advisory, consulting, outsourcing, and digital services, we create scalable, innovative solutions that prepare our clients for future growth and success. The company has more than 10,000 professionals in over 50 locations globally. Guidehouse is a Veritas Capital portfolio company, led by seasoned professionals with proven and diverse expertise in traditional and emerging technologies, markets, and agenda-setting issues driving economies around the world. For more information, please visit: www.guidehouse.com.

This published piece is provided solely for informational purposes. HFMA does not endorse the published material or warrant or guarantee its accuracy. The statements and opinions by participants are those of the participants and not those of HFMA. References to commercial manufacturers, vendors, products, or services that may appear do not constitute endorsements by HFMA.

from the president

A ‘necessary evil’ no more



JOSEPH J. FIFER
FHFMA, CPA
President and CEO, HFMA
@HFMAFifer

According to the late HFMA luminary Robert M. Shelton, hospital administrators viewed accounting as a “troublesome and necessary evil” back in the 1930s. I’ll take Shelton’s word for it. (I should note that the term “bean counter” never appears in *From Acorn to Oak*, Shelton’s account of the first 45 years of HFMA history.)

After the societal upheavals wrought by the Great Depression and World War II were over, a few leading hospital accountants believed the time was ripe for change in their profession. In 1945, William Follmer, who would be instrumental in launching HFMA’s predecessor group, the American Association of Hospital Accountants (AAHA), wrote, “Something must be done to elevate the position of hospital accounting to its proper place and the important part it plays in hospital finance.”

A year later, something *was* done: AAHA was born. Leading the financial management of healthcare — which you may recognize as HFMA’s current mission statement — was an idea whose time had come. And not a moment too soon.

In the 1950s, the growth of employer-sponsored health insurance took off. That was followed by a series of seismic shifts in healthcare, including the enactment of Medicare in 1965, the rise of managed care and the advent of prospective payment in the 1980s, the consumer-driven backlash against managed care in the 1990s and the passage of the Affordable Care Act in 2010.

For HFMA, fulfilling our mission throughout this long and eventful period meant becoming the go-to

experts on ever-changing and highly detailed technical information. In the early days of AAHA, technical questions from members were answered by a cadre of volunteers who served on an Accounting Reference Committee. From those humble beginnings, HFMA’s voluntary Principles and Practices Board evolved as an authoritative resource on the unique financial reporting needs of healthcare organizations.

There is also a big-picture side to HFMA’s mission. HFMA analyzes change drivers and root causes of national healthcare trends and challenges and identifies solutions.

For example, HFMA recognized that the managed care backlash of the 1990s was just the beginning of the consumer era. We developed the Patient-Friendly Billing initiative, followed by the best practices of Healthcare Dollars & Sense, to provide the field with a foundation for consumer-centered healthcare.

In addition, HFMA realized early on that unsustainable increases in national healthcare spending must drive transformational change. Our pioneering research on improving healthcare value, known as the Value Project, was designed to guide healthcare finance leaders in navigating the transition to value while ensuring the financial viability of their organizations.

Those initiatives, along with many others HFMA has undertaken over the years, are still relevant. The work goes on. As we mark our 75th anniversary year, excellence in healthcare finance has never been more necessary than it is now. And HFMA is once again positioning itself to get ahead of the trends. What’s next for HFMA? Stay tuned. You’ll be hearing much more in the months to come. ■



To be part of history in the making, go to annual.hfma.org to register for the HFMA Annual Conference 2021 in Minneapolis and online Nov. 8-10.

A low-angle photograph of two hikers on a rocky mountain peak. One hiker is on the left, leaning over the edge, and the other is on the right, reaching up. They are both wearing blue jackets and backpacks. The background shows a vast, cloudy sky and distant mountain ranges.

Right.

Your HIM department is responsible for critical details that need to be right or things go wrong. Imagine having the right staff at the right time, who get the job done right the first time.

Now you can with expert Medical Coding Service from TruBridge®. Available on a short- or long-term basis, this supplemental service can be a lifeline when projects pile up, employees go on leave, or a staffing position hasn't been filled yet. Find relief knowing the pros are just a phone call away.

What else can happen if everything was all right, all the time?

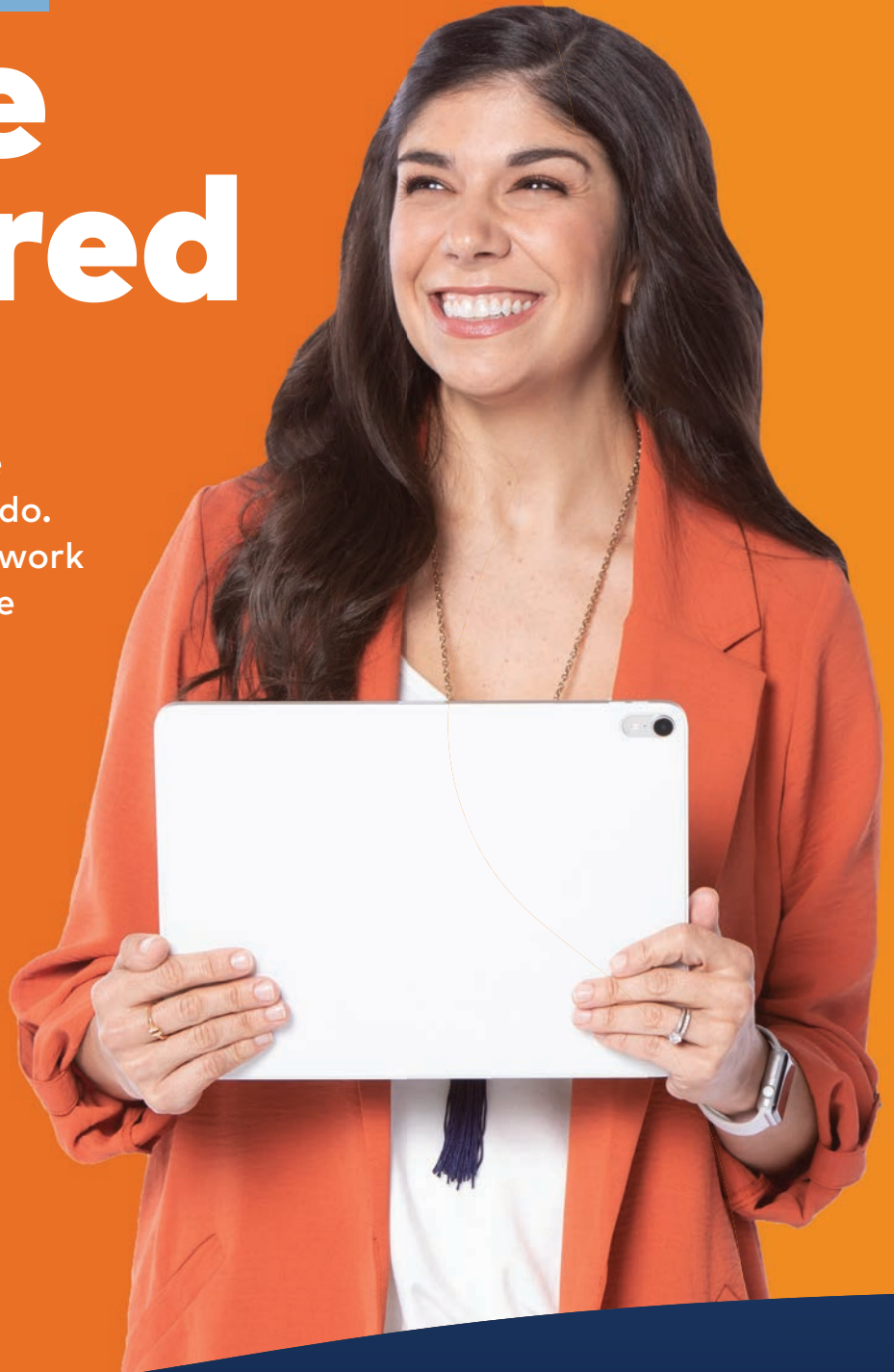


trubridge.com/right
1-877-543-3635

together we're inspired

Your patients are at the heart of everything we do. We're here to listen, to work together to better serve your communities.

we're better
together



go.parallon.com/bettertogether

 PARALLON®