hfma
first illinois chapter

October 2021

FIRST ILLINOIS SPEAKS

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First Illinois HFMA

Fall Summit 2021

BOLD Transformation, BRIGHTER Future

October 26-27, 2021

Hilton Chicago/Oak Brook Hills Resort & Conference Center
3500 Midwest Road, Oak Brook, IL

We are back! This year's First Illinois Chapter HFMA Fall Summit returns to an in-person conference October 26-27 at the Hilton Chicago/Oak Brook Hills Resort and Conference Center, Oak Brook, IL. After a year and a half of virtual, hybrid, and canceled conferences, it was important to us to safely bring us back together for education and networking.

The theme of this year's Fall Summit, "BOLD Transformation, BRIGHTER Future," is focused on taking the lessons learned over the last year and forging forward. Moving back to an in-person event was a difficult decision and one that carried some unknowns. However, as the theme says, we are looking to be BOLD. We are proud of the event we have been able to craft!

This year's Fall Summit includes six dynamic keynote/general sessions, three panels of local hospital and systems CFOs and senior leaders, and breakout sessions focused on the areas that matter most to you as well as an exhibit hall and a "Reclaim Your Vacation" networking reception on October 26—not to mention 12 CPE credits for those attending the full slate of content. This truly exciting Fall Summit will be held October 26-27 at the Hilton Chicago/Oak Brook Resort and Conference Center in Oak Brook, IL. We are excited to be able to see all our vaccinated colleagues to learn and share together.

Click here for more information about the Fall Summit ***click here*** or send an email to education@hfma.org

Worry-Free Cancellation Policy

Should circumstances dictate that the conference be postponed or cancelled, we will refund registration fees to registered attendees, without any penalty.

Safety & Precautions

First Illinois HFMA cares about the safety and health of our members and event attendees and will abide by the recommendations of both the Centers for Disease Control and Illinois State Governor JB Pritzker. Accordingly, all attendees will be required to wear masks and show proof of vaccination at registration (vaccination card or a picture of vaccination card will be accepted). Whenever possible, conference rooms will be configured to allow for social distancing. Disposable masks and hand sanitizer will be provided at the registration desk.

Fall Summit 2021 Program Highlights

Registration and breakfast begin at 7:00 am each day. Educational sessions run from 8:00 am to 4:00 pm each day, with a mid-morning break, a lunch break, and a mid-afternoon break. The Reclaim Your Vacation networking reception on Tuesday will begin at 4:00 pm.

October 26, 2021

Keynote Session

9:00 AM **Bolder. Brighter. Better.**
Tammie L. Jackson, FHFMA, MHA, CHFP, Vice President, TM Strategy and Sales, TransUnion Healthcare, 2021-22 National Chair, HFMA

General Sessions

10:30 AM **Besting Burnout: Leading Teams in Times of Crisis**
Panelist: Tina Wheeler, Vice Chairman, Partner and US Health Care Leader at Deloitte; Eve Poczatek, MBA, Director, Strategic Initiatives, Rush Wellness, Rush University System for Health; Dr. Abha Agrawal, CMO of Humboldt Park Health. Moderator: Nicole Fountain, Vice President, Revenue Cycle, University of Chicago Medicine

1:45 PM **The Future of Managed Care Contracting & Value-Based Models**
Karen Janousek, Chief Population Health and Growth Officer, Sinai Chicago; Jim Watson, Principal, Health Advisory, BDO USA LLP

3:00 PM **CFO Panel: How Do You Ensure All Stakeholders Are Served?**
Panelists: Mumtaz Darbar, MS, CPA, Vice Dean Administration and Finance, University of Chicago Medicine; Dominic Nakis, Chief Financial Officer, Advocate Aurora; Moderator: Brian Pavona, CPA, Partner, BKD CPAs & Advisors

Breakouts

8:00 AM **Demystifying Data Analytics for Health Care Organizations in 2021 and Beyond**
Dr. Jamie McGlothlin, Health Care Analytics National Lead, RSM
The Psychology of Choice in Patient Payment: Behavior Change in Consumers and Providers Is Key
Stephen Scott, Senior Vice President, Solution Strategy and Implementation, AccessOne

12:45 PM **Provider Relief Panel**
Panelists: Matt Aumick, CPA, Director of Accounting and Financial Reporting, Ann & Robert H. Lurie Children's Hospital; Brian Kirkendall, CPA, Assurance Senior Manager, EY
Creative Alternative to Physician Relationships
Dr. Amish Desai, Medical Director, Oak Street Health; Gary C. Wainer, DO, CMO, Innovista Health Solutions

October 27, 2021

General Sessions

9:00 AM **Navigating Price Transparency and Surprise Billing**
Cassie Yarbrough, Senior Director, Medicare Policy, Illinois Health and Hospital Association

10:30 AM **Hiring Trends Through a Pandemic**
Chris White, Practice Director, Robert Half

1:30 PM **In Development**

2:45 PM **CFO Panel: COVID-19's Impact on the Future of Healthcare**
Panelists: Denise Chamberlin, CPA, MA Ed, Senior Executive Healthcare Finance Leader, Edward-Elmhurst Health; Doug Welday, CFO, NorthShore University HealthSystem; Moderator: Sue Marr, Principal, Plante Moran

Breakouts

8:00 AM **Mission Impossible? Keeping Patient Payment Plans Affordable Without Sacrificing Cash Flow**
Alex Kemmer, Director of Operations & Revenue Services, Gibson Area Hospital & Health Services; Joe Salmo, National VP Patient Finance, CommerceHealthcare®; Kevin Scott, VP Patient Finance, CommerceHealthcare®
Accounting and Audit Updates
Brian Kirkendall, CPA, Assurance Senior Manager, EY; Brian Pavona, CPA, Partner, BKD CPAs & Advisors
Managing Your Growing Observations Patient Population
Bart Richards, Managing Director, Claro Healthcare

12:30 PM **Avenues of Escalation Beyond Appeals: Case Study of a Provider's Use of Arbitration**
Rich Lovich, Co-Managing Partner, Law Offices of Stephenson, Acquisto & Colman; Marcus Morrow, Attorney, Law Offices of Stephenson, Acquisto & Colman
Illinois Senate Bill 1840
Adam Lynch, Interim Chief Financial Officer, Humboldt Park Health; Nick McLaughlin, FHFMA, CEO and Founder, Hospital Financial Assistance, LLC

Message From Our Chapter President

BY RICH SCHEFKE , FHFMA, CPA, 2021-22 PRESIDENT

Dear Friends and Colleagues,

What a great start to the new HFMA fiscal year! As we continue to navigate the pandemic, our knowledge of how to safely meet in person continues to grow. Many people saw each other for the first time in over a year at our chapter transition dinner. I could feel the pent up energy as we gathered as a group after having endured restricted travel and stay at home orders.

Our chapter does well with virtual events such as our CPE eligible webinars. However, being in person and hearing from scholarship recipients and chapter award winners was a more powerful showcasing of our present and future leaders. Following this successful event, we have enjoyed seeing people again at the Executive Golf/Scholarship Event and our Women in Leadership Retreat.

At the national level, the association is returning to in-person events. Your chapter leadership was able to gather with chapter leaders from other parts of the country in Orlando, Florida, in July to share ideas about giving our members the best experiences and value. One of the highlights was seeing the 75th anniversary commemoration video. Our chapter was the first formed chapter of the HFMA and has brought local healthcare finance perspective and content to the forefront for over seven decades.

In November, I will go to Minneapolis to attend the annual conference with the 75th anniversary celebration. If you are planning to be in attendance, please reach out to me as I would enjoy meeting in person.

You don't need to go to Minneapolis for high quality content because our chapter's premier education event, the Fall Summit, will be held later this month in Oak Brook. We would like to see everyone who is vaccinated and interested in healthcare finance attend this outstanding event. We have scheduled many interesting speakers such as national association chair Tammie Jackson along with many of the leading Chicago area health system CFOs. The Fall Summit will allow you to share ideas, get information to solve complex problems, and strengthen your careers. Those of you who are licensed CPAs can get a head start on the next reporting cycle with 12 CPEs available. **Please register today,** you won't regret it!

Our partners and sponsors help us keep down costs for our members, who wish to attend events and receive free educational content. As we enter our annual partner renewal season, I ask our members to continue to support them and let me know of good companies you work with who can help expand the scope and reach of our content. If you are a current or prospective chapter partner, I encourage you to renew or sign up today so that you may reach and support one of the largest chapters in the country. The better our partner base, the stronger our chapter becomes in being able to deliver on our vision of providing the best in high quality healthcare networking and education in the Chicagoland area.

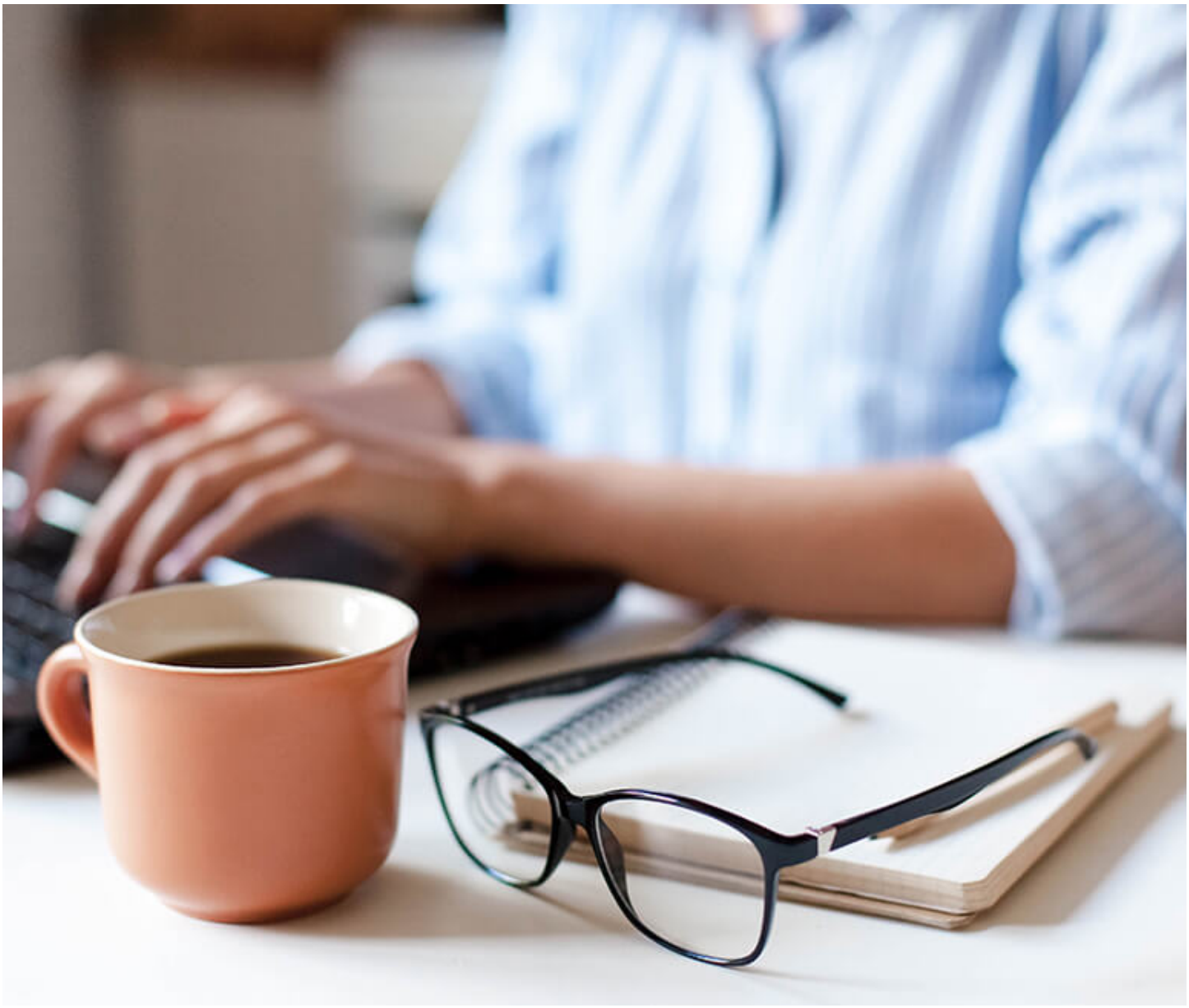
As of this writing, we are about halfway toward our $15,000 college scholarship goal. As you look towards your end of year giving, please consider a tax deductible donation to our fund. One hundred percent of all donations go to the scholarships, and the federal government this year allows for a charitable deduction even if you do not itemize. The recipients are all high caliber students of members' families. Your monetary gift is an act of stewardship that helps the next generation lead us to a brighter future.

Last month, we had our inaugural meeting of the Prior Presidents' Advisory Council led by our most recent past president, Bart Richards. It was great to virtually see these former leaders who left a strong chapter. If you are a former president and we did not have your contact information, please reach out and we'll add you to future meetings.

During the meeting we discussed the state of the chapter and gathered some great ideas. Everyone in attendance started out as a volunteer helping at an event. Each grew through the years to eventually lead our chapter and shared fond memories and insightful recommendations for others to follow in their footsteps. I ask everyone reading this to please help our chapter and volunteer. The more volunteers we have, the stronger our chapter becomes with greater diversity of thought and opportunities for your personal career growth, laying the groundwork for our next generation of Chicago area healthcare finance leaders.

We are all better as an industry and a region when we meet and share ideas together. Although we are the oldest chapter, we have never won the top overall chapter award of excellence and we need your help to get there. On any survey we are striving for the top score, so please let any officer know if we are falling short in any way. Better yet, I ask you to give some thought on what you can do to give back to the healthcare finance community and the First Illinois Chapter. There are so many needs and ways we can improve. It takes as little as a few hours or dollars a year to make our base more diverse and stronger, whatever you can give. Hope to see you in Oak Brook on October 26!

Rich Schefke, FHFMA, CPA
2021-22 FIHFMA President
Director of Financial Planning, Analysis and Decision Support at Northwest Community Healthcare a part of NorthShore HealthSystem
rschefke@NCH.ORG



How the U.S. Census Results Affect Your Healthcare Organization

Background

On August 12, the U.S. Census Bureau released detailed 2020 census results. Because the data publication was delayed by several months due to the COVID- 19 pandemic, the release sets off a nationwide race for state legislatures to complete redistricting ahead of the November 2021 election cycle. Furthermore, the new information will become the basis for significant portions of the nearly $1.5 trillion in annual federal budgetary spending.

A summary of key observations is highlighted in the graphics below.

Overall U.S. population increased from approximately 308.7 million in 2010 to 331.4 million in 2020, a 7.35 percent increase. A significant percentage of the increase occurred in the South and West, with six of the top 10 fastest- growing counties by population located in Texas, three in Florida, and one in Georgia.

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How the U.S. Census Results Affect Your Healthcare Organization

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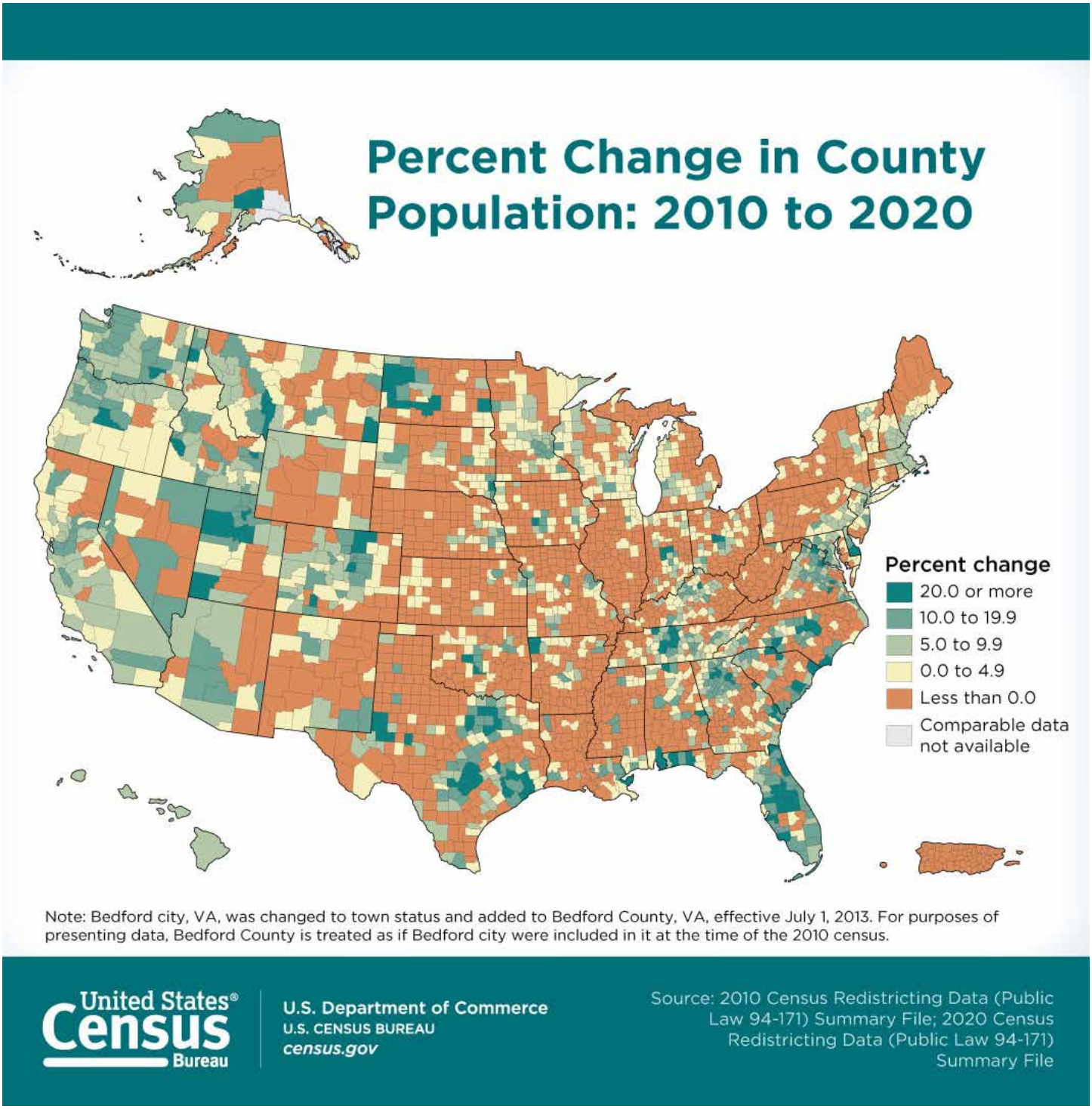

The rise of urban living continued. Census data showed that 312 of the 384 U.S. metro areas gained population between 2010 and 2020. Phoenix, Arizona, paced the nation among the largest cities, surpassing Philadelphia, Pennsylvania, to become the fifth-largest city in the United States.

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How the U.S. Census Results Affect Your Healthcare Organization

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The population migration to warmer, urban areas also affected apportionment of seats in the U.S. House of Representatives. Thirteen states will see either a gain or loss in Congress, with Texas leading after a pickup of two seats. Fluctuations in apportionment not only have the potential to change near- term party dynamics in Washington, D.C., but also will affect the Electoral College mathematics during the 2024 and 2028 U.S. presidential races.

U.S. Department of Commerce
U.S. Census Bureau

Table 1. APPORTIONMENT POPULATION AND NUMBER OF REPRESENTATIVES BY STATE: 2020 CENSUS

STATE	APPORTIONMENT POPULATION (APRIL 1, 2020)[1]	NUMBER OF APPORTIONED REPRESENTATIVES BASED ON 2020 CENSUS[2]	CHANGE FROM 2010 CENSUS APPORTIONMENT
California	39,576,757	52	-1
Colorado	5,782,171	8	1
Florida	21,570,527	28	1
Illinois	12,822,739	17	-1
Michigan	10,084,442	13	-1
Montana	1,085,407	2	1
New York	20,215,751	26	-1
North Carolina	10,453,948	14	1
Ohio	11,808,848	15	-1
Oregon	4,241,500	6	1
Pennsylvania	13,011,844	17	-1
Texas	29,183,290	38	2
West Virginia	1,795,045	2	-1

Footnotes:

[1] Includes the resident population for the 50 states, as ascertained by the Twenty-Fourth Decennial Census under Title 13, United States Code, and counts of U.S. military and federal civilian employees living overseas (and their dependents living with them overseas) allocated to their home state, as reported by the employing federal agencies. The apportionment population excludes the population of the District of Columbia. The counts of overseas personnel (and dependents) are used for apportionment purposes only.

[2] The U.S. Census Bureau prepared these calculations using the existing size of the U.S. House of Representatives (435 members) and the Method of Equal Proportions, as provided for in Title 2, United States Code, Sections 2a and 2b.

The Diversity Index, a measure of the overall population's racial and ethnic diversity, increased from 54.9 percent in 2010 to 61.1 percent in 2020. Hispanic and Asian population flow to areas such as California and Texas contributed the most to this rise.

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How the U.S. Census Results Affect Your Healthcare Organization

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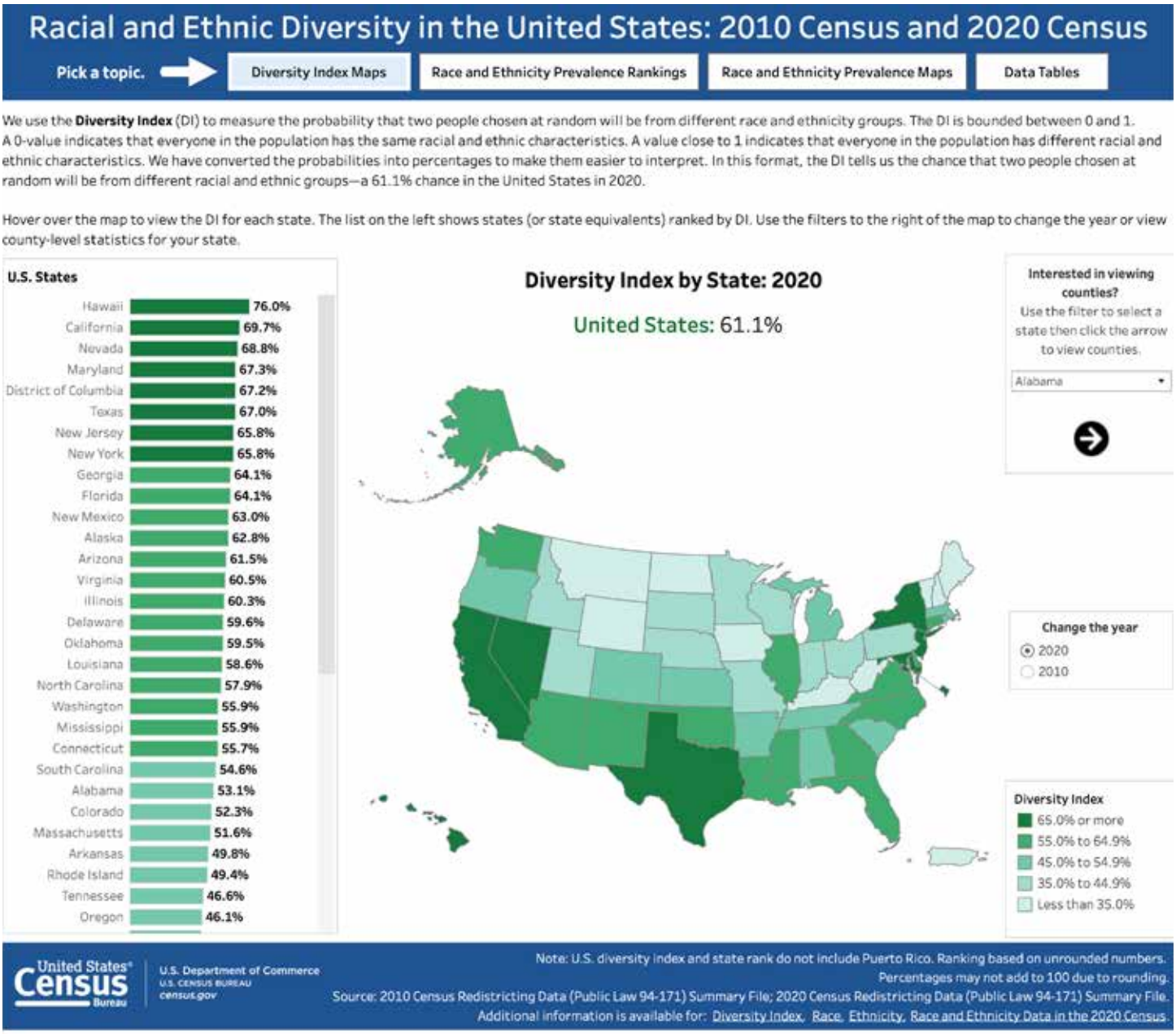

What Does This Mean for Healthcare?

Strategic Investment

Because so much of a healthcare organization's business is dependent on population in a localized geographical area, statistically significant increases or decreases can have far-reaching implications. Before beginning large-scale projects, especially those that require substantial investment of capital and/or onboarding of high-level clinicians or specialists, management teams should first review census data for insights into the viability of the potential return on investment or volume sustainability for new providers. Comparing trends by analyzing the 2000, 2010, and 2020 census information allows for ZIP code- level analysis of how population changed during a 20-year period. A similar review of patterns in population age also is salient to any projection around expected volume. Sizable initiatives have failed not because of payor mix, clinical quality, or poor execution but because there were not enough people in the area to yield the necessary number of services to support the new venture.

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How the U.S. Census Results Affect Your Healthcare Organization

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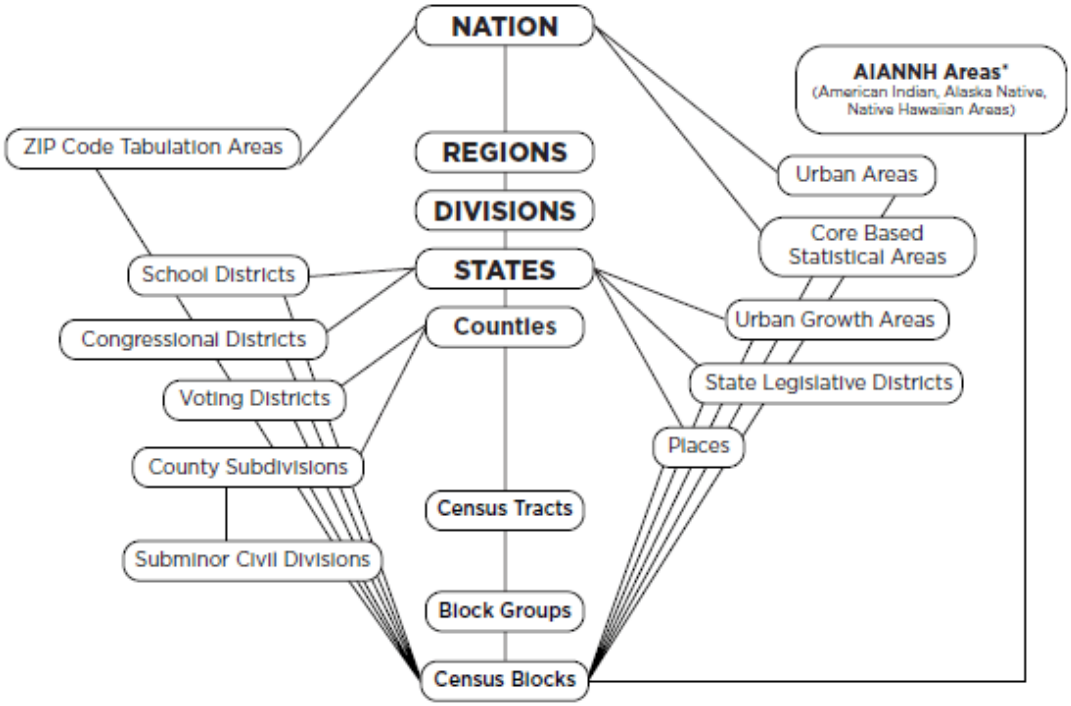
Diversification

With the country diversifying, healthcare entities should evaluate how well their existing infrastructure supports racial and ethnic minorities in their primary and secondary service areas. If trends indicate a dramatic increase in population flow in the immediate vicinity of the facility for a particular category, organizations can evaluate how well their infrastructure supports the provision of services to the growing segment. This strategy could help maintain a competitive advantage over other healthcare providers in your service area. Your organization can capitalize on a growing demographic by cultivating new or expanded services to meet their healthcare needs. The same can be said for other demographics within a particular service area, e.g., increases in elder populations could indicate a possible expansion of home health and long-term care services or changing gender demographics could result in strategic planning of women's health services.

Legislation

The redistricting process and change in congressional seats will likely affect future legislative agendas up and down the ballot. Furthermore, the tabulation of census tract data (see Figure 2-1 below) will subsequently flow into updated core-based statistical areas (CBSA), a critical component of Medicare Wage Index calculations.

Figure 2-1.
Standard Hierarchy of Census Geographic Entities



* Refer to the "Hierarchy of American Indian, Alaska Native, and Native Hawaiian Areas."

Final Observations

Even with the rise of telehealth services during the pandemic, physical location of the U.S. population remains one of the most important contributors to a healthcare entity's financial health. Entities now have a window to perform detailed evaluations of this data before it begins to age and should consider incorporating this into any strategic discussion about future plans to expand or evaluation of staffing needs, services offered, and clinician utilization. The public use files are available for use **here.**

For more information, reach out to your **BKD Trusted Advisor™** or submit the Contact Us form below.

About the Author

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Maximizing the Value of and Minimizing the Risk in Your Managed Care Contract Portfolio

Amid Transformative Times and Legislative Forces, the "Contractualization" of our Patient Base has Many Implications

Executive Summary:

In the years running up to the 2020 COVID-19 pandemic, the U.S. healthcare industry was thriving with growth and innovation. The industry players operated in a landscape characterized by steady and growing patient volumes, broad health insurance coverage, and generally adequate reimbursement and funding. The economics of the industry were centered around management and reduction of total cost of care while improving access and improving quality. Across patient segments (commercial, governmental) coverage increased and this coverage was increasingly via managed care contracts and other third-party managed care arrangements. This landscape allowed providers and payers to develop and implement value-based payment models and other innovative agreements within their managed care contract portfolios that often included sharing of risk and delegation of insurance responsibilities to providers. Everything we do and don't do is tied to the terms of these agreements, most importantly, how we get paid and how our performance is publicly displayed via payer websites and report cards.

In fact, this "contractualization" of our patient base is central to understanding the importance of managed care contract portfolios. In most major markets, 80-90% of patients' coverage is via managed care contracts; hence, the concept of "contractualization."

The Typical Managed Care Contract Portfolio and Risk Management

COVID-19 has fundamentally disrupted this landscape. As we slowly begin to move forward globally and emerge from the pandemic, in addition to struggling to get volumes back to pre-pandemic volumes, providers and payers are assessing the impact of the pandemic on their managed care contract portfolios, determining what needs to be "fixed" (in some cases retrospectively) and what new innovations are needed in the post-pandemic healthcare contracts.

Introduction:

Defining the Issues: What Are We Talking About Here

The pandemic has destroyed all 2020 budget assumptions (and to some degree 2021, 2022, and beyond) on all levels: revenue, expense, case mix, service mix, occupancy, and importantly, an organization's managed care contract portfolio and associated value-based care models. Each of these issues need to be considered in the context of the impact on value of your contract portfolio.

While CMS and other payers incurred additional, non-budgeted expenses in 2021 related to COVID-19, there are many statistics that bear discussion about their impact to reimbursement and spending, across the portfolio of risk-based and fee-for-service based contracts:

- **Drop in Spending:** Traditional Medicare spending was down 7% ($305B in 2020; $328B in 2019) with the most dramatic drop being between March and May 2020 when spending was down 48%. Spending for all payers between March and September 2020 was down 50-60%.
- **Short-Term Windfall Profits:** This created a windfall of profit for commercial insurers, triggering a series of state-mandated premium refunds to policy holders, issuing of additional benefits for members, and issuing of additional reimbursement for providers. Additionally, federal relief programs pumped billions of dollars into providers and payers over the course of 2020 and into 2021 (and probably beyond).
- **Telehealth Spend:** Before March 2020, telehealth visits represented less than .1% of CMS visits; for the period of March through December 2020 it rose to 16% of visits.
- **Significant Variances Across Localities and Physician Specialties:** As often is the case, there were significant variances across the U.S., in major markets and in rural areas, about spending trends and other COVID-19 related metrics.

A confluence of economic forces is manifesting themselves throughout our managed care contract portfolios. The major issues to consider include but are not limited to:

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Maximizing the Value of and Minimizing the Risk in Your Managed Care Contract Portfolio

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- Impact on performance periods under Value-Based Contracts (VBCs)
- Cost of care for risk assumed under capitated or risk contracts
- Adequacy of agreed to unit prices in negotiated agreements
- Invalid actuarial assumptions and financial modeling
- Increased retroactive disenrollment among patients
- Ability to perform administrative requirements that subsequently led to penalties
- Impact to publicly reported metrics and CMS star ratings

Stating the Objectives: What This Paper Hopes to Achieve

In this paper, the BDO Center for Healthcare Excellence & Innovation outlines some of the current trends and emerging issues that providers and payers are working through with respect to the contractual relationships defined in their managed care contract portfolios. We'll explore these issues and some strategies and recommendations for moving forward. Our objectives are simple:

1. Define the areas of potential impact of the COVID-19 pandemic on managed care contract portfolio value.
2. Outline other emerging transformative industry changes and how to successfully position your organization in the future healthcare landscape.
3. Provide insights, recommendations, and strategies on how to proactively address these issues and engage the appropriate stakeholders in defining the path forward.

The Impact of the COVID-19 Pandemic on Managed Care Contract Portfolio Value

Invalid Actuarial Assumptions and Financial Modeling

The actuarial assumptions and financial modeling around utilization and unit price that payers and providers relied upon in formulating reimbursement methodologies, rates, and incentive calculations are proving to be way off for 2020 and into 2021. These actuarial assumptions are critical for a percent of premium, capitation, and value-based care incentive arrangements. Examples include:

- Health insurance premiums
- Negotiated unit prices
- Capitation amounts
- Utilization of services
- Incentive period performance and payout estimations

Consider capitated or percent of premium risk share portfolios. On one hand, being on a capitated or percent of premium reimbursement methodology during this time is good in that you are still getting paid for services based on utilization assumptions pre-pandemic. Simply stated, less people accessing elective services equates to low claims expense which leads to higher margin. On the other hand, we've had to pay the costs of telehealth and costs of waived copays. How are we tracking that and getting made whole by the payer? Will the existing contracts track these costs?

A good example of the importance of actuarial value is in risk adjustment. The level of funding for Medicare Advantage plans is linked to risk adjustment scores and completion of member Annual Health Assessments (AHAs). These AHAs help capture the true risk score of the population of the MA plan, and the MA plans are paid by CMS on a risk-adjusted basis. We knew early in the pandemic that the disruption to utilization patterns would have both a short-term and long-term impact to risk scores, risk adjustments, AHAs, and other revenue and expense levers in healthcare. CMS recognized this early and as they did in many other important areas throughout the pandemic moved quickly to mitigate impact. One of the ways CMS achieved this is by allowing AHAs to be done via telemedicine visits. This means that the diagnoses documented in AHAs and other face to face visits facilitated via telehealth count toward the calculation of patients' risk scores. A patient's risk score is reflected in the reimbursement from the health plans retrospectively, so the risk score calculated from 2020 DOS directly impacts 2021's reimbursement. We can further conjecture on the impact of this on 2021 into 2022 and beyond and how this will all be reconciled between CMS, MA plans, and provider networks.

Similarly, the unprecedented shift in patient and service mix has rendered previously negotiated unit prices insufficient for most providers' post-pandemic budget needs. Payers and providers alike recognize that the disruption in actuarial and other assumptions that are the foundation of current managed care contracts warrant changes in contract pricing structures, reimbursement methodologies, and contractual terms.

Disrupted Value-Based Care and Pay-for-Performance Models

From CMS Medicare shared savings, ACO, and bundled payment programs to commercial insurer VBC/P4P programs, all these programs contain initiatives (clinical or administrative) that are tied to performance metrics, time periods, and economic consequences. The pandemic has disrupted providers' and payers' ability to manage these programs. Because of the disruption from COVID-19 providers may not be able to achieve performance, and comparisons to prior-period performance as a metric have become less credible. Providers' inability to satisfy

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performance metrics will adversely impact value-based compensation. CMS has made a couple of important updates related to their VBC/P4P models because of COVID-19:

1. **Bundled Payment Programs:** Bundled Payment for Care Improvement Advanced (BPCI-A), participants had two options: Option to eliminate both upside and downside risk for 2020 by forgoing any reconciliation in 2020, or if they wish to remain in two-sided risk, BPCI-A participants will be able to exclude from reconciliation clinical episodes with a COVID-19 diagnosis during the episode. As a result, the participants needed to perform significant analytical AI work to determine which option would be best for their program.

2. **Next Generation ACOs (NGACOs):** For those in the NGACO model, CMS made several accommodations available:
   - Reduce 2020 downside risk by reducing shared losses by proportion of months during the public health emergency
   - Cap NGACOs' gross savings upside potential at 5% gross savings
   - Remove episodes of care for treatment of COVID-19
   - Use retrospective regional trend, rather than prospective, for 2020
   - Remove 2020 financial guarantee requirement

Below is an example of a 2020 income statement of a commercial ACO, buoyed by both a drop in expenses and an increase in premium/capitation.

Risk-Based Illustration

	Budgeted	Actual	Variance
Covered Lives	1000	1000	0
Premium/Capitation-MA	$18,000,000	$21,000,000	$3,000,000
Expense-MA	$17,100,000	$14,700,000	$2,400,000
Medical Loss Ratio (MLR)	$15,300,000	$12,600,000	$2,700,000
Profit-Medicare Advantage	**$900,000**	**$6,300,000**	**$5,400,000**
Covered Lives	1000	1000	0
Premium/Capitation- Comm	$7,200,000	$7,200,000	$0.00
Expense- Comm	$6,120,000	$5,400,000	$720,000
Medical Loss Ratio (MLR)	$5,400,000	$4,320,000	$1,080,000
Profit-Commercial	**$1,080,000**	**$1,800,000**	**$720,000**
Covered Lives	1000	1000	0
Premium/Capitation-PA	$8,400,000	$9,240,000	$840,000
Expense-PA	$7,980,000	$8,778,000	$798,000
Medical Loss Ratio (MLR)	$7,140,000	$5,544,000	$-1,596,000
Profit-Public Aid	**$420,000**	**$462,000**	**$42,000**

Given the lag between performance and payout, the financial consequences may not be immediately obvious and will likely show up on financial reports later. Providers may feel this impact across multiple years, as many value-based care agreements are multi-year, with considerable revenue and reimbursement tied to year-over-year performance improvement.

Impact to Unit Prices and Network Stability

Payers and providers spend a significant amount of time and energy to negotiate contract terms. Often, agreements between large payers and large providers can take over a year's time to complete, and the terms of these agreements are increasingly becoming long term; 5-year and even 10-year agreements are becoming the norm, and a 3-year term of agreement is today's standard. These agreements represent assets that are meant to be maximized. Final financial and VBC/P4P terms in these agreements reflect an aggregation of dozens of methodologies and calculations, driven by actuarial and other assumptions on volume and service mix. The end result for providers and payers is Pricing Terms that meet their financial needs. The pandemic has upended Service Mix, Volume, and Stop Loss pricing assumptions to name a few. The table below illustrates the impact on one hospital's Commercial Managed Care Contract Portfolio:

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Fee-For-Service Illustration										
Commercial Payor	Service Line	Budgeted Volume	Budgeted Total Cost	Budgeted Payment	Budgeted Profit	Actual Volume	Actual Costs	Actual Payment	Actual Profit	Total Budget Variance
Inpatient	Medical	500	$15,000,000.00	$17,250,000.00	$2,250,000.00	900	$36,000,000.00	$41,400,000.00	$5,400,000.00	$3,150,000.00
Inpatient	Surgical	500	$37,500,000.00	$45,000,000.00	$7,500,000.00	100	$7,500,000.00	$9,000,000.00	$1,500,000.00	-$6,000,000.00
Inpatient Stoploss	Catastrophic	25	$2,500,000.00	$3,375,000.00	$875,000.00	10	$1,000,000.00	$1,350,000.00	$350,000.00	-$525,000.00
Inpatient	VBC P4P Incentive	Full Earn	$0.00	$0.00	$0.00	1010	$0.00		$0.00	
Inpatient Total			$55,000,000.00	$65,625,000.00	**$10,625,000.00**		$44,500,000.00		**$7,250,000.00**	-$3,375,000.00
Outpatient	ER	1,000	$1,000,000.00	$1,500,000.00	$500,000.00	300	$300,000.00	$450,000.00	$150,000.00	
Outpatient	Surgery	700	$3,500,000.00	$5,250,000.00	$1,750,000.00	200	$500,000.00	$750,000.00	$250,000.00	
Outpatient	Imaging	2,000	$600,000.00	$900,000.00	$300,000.00	500	$75,000.00	$112,500.00	$37,500.00	
Outpatient	Lab	5,000	$500,000.00	$750,000.00	$250,000.00	1000	$50,000.00	$75,000.00	$25,000.00	
Outpatient	VBC P4P Incentive	Full Earn		$0.00	$0.00					
Outpatient Total			$5,600,000.00	$8,400,000.00	**$2,800,000.00**	2000	$925,000.00	$1,387,500.00	**$462,500.00**	-$2,337,500.00
Grand Total					**$13,425,000.00**				**$7,712,500.00**	-$5,712,500.00
										-0.425512104

The impact of COVID-19 on this hospital's Commercial Managed Care Contract Portfolio:

- Adverse impact on return of 42.5%, or $5.7M in profit margin
- Decrease in Surgical Admissions of 80% for the Observed Period
- Increase in high cost Medical Admissions by 75% for the Observed Period
- Decrease in profitable Elective Outpatient Services
- Decreased/no earnings Value-Based Contracts/Pay-For-Performance arrangements (VBC/P4P)

The new reality is this: Because of the change in Volumes, Service Mix, and other underlying assumptions that produced the current Pricing Terms in our existing Managed Care Contract Portfolio, we may need to go back to the negotiating table to address unit prices that may no longer be sufficient for the "new world" budget needs (volumes, cost, mix of services, site of service changes). And this new reality can apply equally to either a provider or a payer, but the reaction may be different depending which side of the new reality you are on.

Increased Retroactive Disenrollment Among Patients

The full extent of the pandemic's impact on employment has yet to be seen. As more people lose their jobs, the percentage of the population covered by health insurance will fluctuate greatly. For some patients, their coverage may change multiple times within a plan year or shift from employer-based coverage to coverage through Medicare, Medicaid, or the Affordable Care Act's health insurance marketplaces. These market factors likely affect providers' Payer Mix and lead to increased retroactive adjustments to claims, eligibility, capitation and incentive earnings. For example, monthly capitated payments are retroactively adjusted for changes in membership, with some changes going back 90 or more days. Even the fee-for-service arrangements will not be completely immune from the impact of retroactive disenrollment as payers may seek to recover claims paid for patients who were retrospectively determined to be ineligible for coverage.

Other Emerging Transformative Industry Forces:

In addition to these Managed Care Contract Portfolio valuation considerations, there are several other emerging transformative forces in healthcare as we move into a "post-pandemic" era:

- **Price Transparency:** On January 1, 2021, CMS implemented the Price Transparency of Hospital Standard Charges regulation. The regulation's purpose to make it easier for consumers to shop and compare prices across hospitals and estimate the cost of care. The regulation requires hospitals to provide clear, accessible pricing information online about the services in two forms: Machine-readable file with all items and services and Consumer-friendly format of shoppable services. This is a major issue that not only impacts hospital operations, but also brand reputation and relationships with stakeholders.
- **Site of Service (SOS) Reimbursement Differentials:** SOS has become an area of emphasis among Payers before, during, and after the pandemic. Payers are increasingly leveraging this tactic to drive care to lower cost sites of care. Especially and specifically: Lab Services, Imaging Services, and Elective

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Maximizing the Value of and Minimizing the Risk in Your Managed Care Contract Portfolio

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Surgeries. Significant savings accrue to payers (including employers and patients) by directing services to these lower cost SOS whenever possible. Hospitals do not fare well under SOS changes on their own. Payers have implemented policies that require Prior Authorization and proof of medical necessity for providing these services in the hospital-based setting (i.e., MRIs, Surgeries). Physicians and hospitals have new opportunities to work together to take advantage of this trend by creating ASC joint ventures, creating incentives to increase its utilization of ASCs, and exploring joint- contracting strategies around SOS (i.e., Shared Savings for re-direction of services to lower cost settings).

- **Health Equity:** Increasingly across the USA, we are becoming both more aware and more enraged at the differences in access to healthcare, and the quality of care we access, when we look at it across communities. There are well known stories of Life Expectancy ranging from 90 years to 69 years across the span of 6 city blocks due to inequities in access to healthcare services across ethnic populations. COVID-19 further exposed and detailed these inequities, especially in its impact to African American and Latinx populations. Advancing Health Equity is becoming a major focus for healthcare payers and providers. One recent example of this is HealthCare Service Corporation (HCSC), one of the largest payers in the USA, announcing that is it investing $100M in 2021 to develop and implement community-based strategies to improve Health Equity.
- **Telehealth and Virtual Health:** Telehealth represents the future of medicine, and Virtual Health is Telehealth's cousin from the future. It is amazing to consider the rise of Telemedicine because of COVID-19; it has become the new "standard visit". It's even more amazing to consider the opportunities of Tele/ Virtual Health when integrated with Patient Portal, Wearables, and other transformative forces borne out of the pandemic to create a new connection with patients.
- **Digital Transformation:** Digital Transformation (DT) will touch everything in healthcare and will compete for resources and challenges with confusion with tech integration. But smarter organizations have and will embrace DT proactively to differentiate and create new "stickiness" with their patient bases (aligning and morphing with Tele and Virtual Health strategies).

Positioning Successfully in the Post Pandemic Healthcare World: Insights & Strategies

A healthcare organization's Managed Care Contract Portfolio represents any provider's largest source of revenue, profit, and volume. These assets need to be re-assessed now for impact, re-investment, and strategic re-affirmation as we move into this new post-pandemic world. As providers assess changes in their landscape and plan for economic recovery, providers would be well-served by being proactive in understanding impact and updating their Managed Care Contracts, but more globally, revising their overall Managed Care Strategy. Below are some insights and recommendations based on our engagement nationally with the issues of today.

Restructure Managed Care Contracts and Contract Portfolios

Providers should assess their Managed Care Contract Portfolio and quantify all these risks. Based on that assessment, many providers will likely realize that they need to open their Managed Care contracts for renewal negotiations to secure needed cash flow and reset pricing. When a negotiation makes sense for a provider, the provider should focus on addressing radically changing healthcare economics, optimizing reimbursement and securing appropriate contractual protections. Simply seeking rate increases is likely to be a shortsighted and unsuccessful strategy. Rather, providers should consider how their current reimbursement model might be reevaluated in the context of their Managed Care contracts.

For example, in light of the impact of the pandemic on the industry, providers should ask whether a fee-for-service arrangement is still right for their organizations or whether providers should explore alternative reimbursement methodologies, such as a greater mix of capitation, percentage of premium or other models. These methodologies may not only offer cash flow stability on a short-term and longer-term basis but also may mitigate against risk relating to significant shift of patient mix and services. Such an evolution in reimbursement will necessarily impact other contractual provisions such as term, termination, audit rights, prompt pay and offset and similar provisions.

Collaborate with Payers on Financial Relief Solutions and Additional Funding Sources

COVID-19 created significant cash flow impacts to providers. In addition to Provider Relief Funds (PRFs) available from the federal government, several national commercial payers have offered accelerated or advance payment programs for providers. While not all payers have formal programs, many of them are willing to work with their providers to craft a customized, provider-specific relief plan. Feasible options will be partly determined by the type of provider entity and the type of Managed Care contract held by the provider and could be in the form of future premiums, incentive accruals or estimates, current accounts receivable, or zero- or low-interest loans.

Providers may also consider other potential sources of financing by leveraging provider organizations, such as Accountable Care Organizations (ACOs), Clinically Integrated Networks (CINs), and Management Service Organizations (MSOs) among others. Many ACOs and CINs already had agreements in place with payers for shared savings or other value-based arrangements. They are in an ideal position

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to secure accelerated payments or advances from payers on behalf of their participating providers. Seeking new or maintaining existing affiliations with risk-bearing provider networks could also be a way for providers to seek additional revenue stability and obtain access to a more stable patient base. A further advantage of an ACO is the ACO's ability to utilize Stark Law and Anti-Kickback Statute waivers providing immunity from prosecution under these laws. These MSSP ACO waivers will survive the end of the public health emergency and can be used to create pro-Triple Aim incentive payments beyond current regulatory limits.

Diversify Services Through Telehealth and Other Remote Care Services

The COVID-19 pandemic has put telehealth and other remote care services (e.g., medical homes and remote care management) in the limelight. Stakeholders are predicting that a widespread adoption of telehealth and remote care services by patients and payers is now inevitable. Many payers have also been more willing to reimburse telehealth and remote care services. As providers consider requesting payers to add telehealth and remote care to their managed care contracts, they must have a solid understanding of the economics of such services, including market rates for managed care reimbursement and typical provider margins. To successfully implement these alternative remote care services, providers should strategically turn their existing telemedicine and remote care capabilities into full virtual health workflows and engage and activate their patient base to leverage virtual health options.

Limit Risk Related to Future Retroactive Disenrollment

The trend toward greater retroactive disenrollment could especially impact capitated and other risk-bearing providers in addition to fee-for-service arrangements. Given that such retroactive adjustments are likely to exceed normal levels and could result in severe provider financial stress, providers should seek to limit their risk related to future retroactive disenrollment, to the extent permitted by law, such as by limiting lookback periods, clawback rights, and other similar repayment terms.

Reassess Nonpayment Contract Terms

Looking ahead, the pandemic has highlighted the need for providers to build in contractual protections for pandemic and other national and local emergency events (floods, hurricanes, and the like). These events materially and adversely impact cost, access to services, and patient volumes. The structure of these provisions will depend on the overall economic model of the payer-provider relationship. By way of example, current force majeure clauses may not be designed to excuse performance temporarily or even permanently in response to this pandemic or other emergency events. Therefore, providers will need to analyze their contractual rights and obligations under each managed care contract with respect to these emergency situations.

Summary of the Issue	Suggested Solutions
Impact on Performance Periods Under Value-Based Contracts (VBCs) • You were paid excess premium during low utilization periods resulting in short term excess revenue • You incurred additional costs for Telemed visits that you were not paid capitation or premium for because it wasn't covered when the payer contract was negotiated • You incurred expenses for incentives that never materialized	• Know that this could work for you or against you • Understand your Performance Metrics and how your Incentives Earnings were impacted during Pandemic Performance Period (2020) • Negotiate Reconciliations and True-Ups on Additional Costs incurred • Seek to Reserve excess Premiums/Capitations • Increase IBNRs • Get current with AR and AP • Renegotiate Contract Funding for the Pandemic Periods and forward
Unit Price Adequacy in Negotiated Agreements • You spent considerable time and resource negotiating your new system-wide VBC with your largest Payer • Changes in patient and service mix have led to losses on your Payer Contract Portfolio • For example: More Medical Admissions at higher costs plus fewer Surgical Admissions at lower revenue plus loss of majority of Elective Outpatient significantly diminish Portfolio Value	• Meet with payers; revisit assumptions and models demonstrating intent, good faith negotiations, expecting commercially reasonable outcomes • Pinpoint exact areas of agreements where Actual is materially adverse to Budgeted • Seek immediate relief: o Value-Based Incentives and Unit Prices o Prices/terms Going Forward and Retroactive Adjustments • Address holistically (Hospital, Physician agreements; your issues and the payors' issues) • Correct invalid actuarial assumptions and financial modeling internally and with payors

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Maximizing the Value of and Minimizing the Risk in Your Managed Care Contract Portfolio

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Summary of the Issue	Suggested Solutions
Other High Impact Issues to Quantify/Address: • Increased Retroactive Disenrollment Among Patients • Inability to perform administrative requirements that subsequently led to penalties • Impact to Publicly Reported Metrics and CMS Star Ratings	• Seek waiver of Denials during Pandemic Period, especially those related to Prior Authorization, Extended LOS/Discharge Planning Issues, Inability to Transfer In Network • Seek to have Publicly Report Data Deleted or Not Disclosed (replace with Current Data instead) due to Pandemic Impact; contractually disclosure should be preventable under those circumstances

Prepare for Challenging Negotiations with Payers

Payers and providers are likely to have significantly different views on what contractual modifications should be implemented to address their mutual needs during the post-pandemic recovery. Accordingly, the industry is primed for a round of contentious contract renegotiations—many off renewal cycle—as health systems, hospitals, physician groups, and payers attempt to adapt to new financial realities.

Moving Forward Bravely into the New World

The remainder of 2021 is going to feel a bit like our first high school dance; we're going to be present, but we just don't really know what to expect. Certainly, our payer contracts are among our highest value assets to maximize, and we will continue to see the trend of "contractualization" of our patient bases, increasing the importance and value of those contracts.

But thinking proactively and positively, let's begin our fresh look at our managed care contract portfolios as outlined above in the context of a bigger, more global "strategic refresh."

Around the U.S. and around the world, BDO works with health systems and payers; large and small, commercial and governmental, city and rural. Our discussions always begin and end in "strategy." We believe that defining strategy has always been important in complex industries like healthcare, but even more so these days for all the reasons we've shared.

We look at strategy development centered around three Strategic Pillars and five Transformative Forces:

The Strategic Pillars:

- Financial Improvement
- Clinical Innovation
- Digital Transformation

The Transformative Forces are at play between the Strategic Pillars in today's U.S. health system:

- REIMBURSEMENT DETERMINED BY CLINICAL OUTCOMES: Regulators and payers are rewarding superior quality and penalizing underperformers
- PATIENTS AS CONSUMERS: Patient perceptions are now measured, analyzed, and factored into reimbursement levels, giving rise to new business models
- REDESIGNING "AT-RISK" ORGANIZATIONS: New regulations are requiring integrated financial and operational restructuring
- ACCELERATED Merger & Acquisition (M&A) and Private Equity (PE) Activity in Healthcare: Private equity's investments in the health sector have become increasingly diversified and frequent
- DIGITAL TRANSFORMATION: The impact of emerging technologies and big data to reach populations in need

A Call to Action

There are no positive things than be said about a virus that at press time has killed 3 million people worldwide. But COVID-19 has taught us that time is precious, and as time passes, we will be given time again to get out and do what we are passionate about. We hope this has been helpful in your pursuit of that mission. We would welcome an opportunity to talk with you about how we can pursue those missions together deploying our resources and solutions to enable your resources and solutions.

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Tales from the Telehealth Front Lines: 5 Key Insights

As health care providers learn to leverage the full digital transformation benefits of a telehealth strategy amid the coronavirus pandemic, key findings have emerged about patient acceptance and access to care. During a recent HIMSS- and RSM US LLP-sponsored telehealth focus group, five key insights were shared by a diverse panel that included 16 organizations ranging from large integrated health systems to smaller, focused providers. Here's what was discussed:

1. **There is a widely acknowledged digital divide among patients.** On the one side are the tech-savvy patients who have readily adapted to the switch to telehealth and who report high satisfaction for the convenience and safety benefits. On the other hand are patients who cannot access telehealth platforms due to a number of barriers such as limited broadband/Wi-Fi access, lack of access to a smartphone, technology that only supports English, no privacy to conduct telehealth visits, and general discomfort with technology. One provider estimated that at least 15% of their patients couldn't access telehealth.

   Closing this digital divide in order to provide equity in care is an important focus for many providers, especially those who support communities with high Medicaid usage. Reducing the technology barriers to telehealth will be difficult, but not nearly as hard as overcoming the social determinants which impact health care; improvements in that area will have to be a long-term focus.

2. **The explosion of telehealth visits is driving adoption of remote patient monitoring (RPM).** One innovative provider analyzed data on telehealth visits and determined that they could triage those patients who could easily implement RPM based on who was already participating in text and telehealth visits with smartphones. For these patients, for example, they could simply ship out blood pressure or pulse oximeter monitoring devices and connect them through their smartphones. In order to offer equity in RPM services to the rest of their patients, providers offer a more costly option of sending out home health services to address those more technology challenged. One provider is positioning RPM as their "hospital at home" experience which has significant appeal to both the provider and the patient. RSM sees RPM as the next wave of telehealth to take off after the tele visit. RPM will first be targeted for patients with specific conditions and will become more widespread over time as technology adoption ontinues.

3. **The jury is still out on whether or not we will be able to maintain the same level of quality using telehealth.** One prediction is that it will be another two-plus years before we have enough data to evaluate the true quality of telehealth versus in-person visits. Reliable studies on the quality outcomes resulting from telehealth will be useful not only to evaluate and refine telehealth delivery, but also to further accelerate provider acceptance of telehealth.

4. **Some providers are taking the path of least resistance and conducting their telehealth visits using the telephone.** However, there is a concern that COVID-19 waivers for telephone reimbursement parity will be lifted and telephone visits will no longer be reimbursed or reimbursed at a much lower rate. This will lead to an increase in denials for telephone visits improperly submitted and a decrease in telehealth visits that were only able to be conducted by phone. As a result, savvy providers are reviewing the data to determine which providers and patients are conducting telephone visits today and seeking to provide an intervention to convert these to video visits before expected changes are made in the reimbursement regulations. This effort is also important to promote equity in access to telehealth and avoid exacerbating the digital divide.

5. **There seems to be a recognized tradeoff between those telehealth platforms that offer the easiest and most user-friendly access versus those that provide the tightest integration with the electronic health record platform.** It was noted that the EHR-based telehealth solutions enable the smoothest and most thorough documentation of the visit. Organizations that originally opened their telehealth technology options to their providers are now rethinking offering all of those options in favor of those that promote better documentation. With experience, providers are also building new templates to document telehealth visits in their EHR and learning the best methods to document in their telehealth visits. RSM's view is that the number of telehealth solution vendors will consolidate over time and those solutions that are tightly integrated with the EHR will become more user-friendly and dominate the bolt on solutions.

   The panelists were bullish about the future of telehealth with one predicting that telehealth will represent in excess of 25 to 30% of their visits in three years. However, while we have made a major leap forward with telehealth post-COVID, there is still change on the horizon for telehealth to improve to meet consumer and provider expectations.

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Distressed Hospitals Can Succeed:
Initiating Financial Stability

Ongoing market challenges require leaders to confront potential financial distress and build plans to sustain their mission.

A year and a half into the COVID-19 pandemic, it's clear that for some hospitals and health systems, the effects have been both material and negative. While it was often an accelerator—not the cause—of declining metrics, the economic blow from the pandemic will prove tough to overcome.

For many leaders, the question that keeps them up at night is: "How can our organization continue to care for our communities?"

Distressed organizations are on the rise.

The American Hospital Association reports that just one-third of U.S. hospitals remain standalone or independent. Those based in rural areas fare worse than their urban or suburban neighbors, with one-in-four at a high risk of closure.

Last year, credit downgrades outpaced upgrades among not-for-profit hospitals for the first time since 2013. Fitch Ratings attributed 41% of the downgrades to those with precarious financial futures that stem from factors preceding COVID-19.

Some standalone providers are looking to partnership as a way out, and healthcare mergers and acquisitions (M&As) are quickly picking up steam. However, the field for healthcare M&A is getting more selective as buyers are more prone to decline offers than they have been historically.

Positioning a health system for a financial turnaround is highly complex work.

Decreased cash flow, market volatility, lack of scale, and insufficient capital have led to a new definition of risk in healthcare. Distressed organizations need an effective enterprise risk management strategy to combat further economic and operational uncertainty and to strengthen stability in this rapidly evolving, highly pressurized environment.

This requires leaders to be brutally honest—with themselves, their board members, and the communities they serve—about the actions needed to orchestrate a financial turnaround. It means working quickly to eliminate or downsize noncore activities that are draining resources. It also demands that leaders prioritize efforts on the areas that are likely to have the biggest impact, knowing everything cannot be fixed at once.

Those that are most successful in positioning their system for a

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Distressed Hospitals Can Succeed: Initiating Financial Stability

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turnaround first ask three questions:

1. Can the same team that got us into this get us out of it? Level set on whether you can continue your mission with the same team or if it's time to find a new partner to carry your organization through the storm.
2. Will a financial turnaround require that we divest certain assets? If so, decide which assets could be divested while still protecting access to care.
3. How can we ensure that we are making the right decisions for our organization and our community? You need an objective lens through which to base these decisions.

Amid post-pandemic disruption, leaders and boards with indicators of distress must make bold moves now—before their fate is determined by circumstance.

The window of opportunity for distressed organizations to shape their post-COVID future is limited.

The most effective leaders possess not only the ability to evaluate and execute strategic initiatives, but also to rally their teams around the synergies needed for transformational improvement. And they need to do so while protecting frontline workers from operational disruption as much as possible, ensuring the organization can continue to fulfill its mission.

As we've seen during the pandemic, healthcare leaders were shoved outside their comfort zone—and some struggled to respond. That's one reason why some hospital boards evaluate senior leaders more frequently during COVID-19. If a senior leader doesn't operate well under pressure, how effective will they be in bringing discipline to the organization's response and recovery efforts?

Ongoing market challenges require providers to confront potential financial distress and build plans to sustain their mission.

Leaders and boards must reforecast their long-term financial and operating positions recognizing continued regulatory, competitive, and demographic uncertainties. Developing plans to ensure long-term sustainability and the ability to make bold moves that generate a strong return—quickly—require preparing for multiple future-state scenarios. In some cases, outside expertise can also help providers shape a resilient and profitable future.

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Transformation Fuels Opportunities for Healthcare Leaders

Healthcare is ever evolving and constantly shifting in response to consumer trends, regulatory changes, and new technologies. Typically, these changes take place gradually with adoption rolling out bit by bit until finally reaching the tipping point among hospitals and health systems. We have observed this in recent years with transitions related to value-based care, electronic health records, and interoperability, to name a few.

The impact of COVID-19 on the healthcare industry is unlike any of the changes we have seen in recent years. The change was sudden, swift, and required immediate action from every healthcare provider regardless of size, setting, or demographics. The pandemic allowed no time for committees, focus groups, or research teams to develop lengthy strategic plans. As an industry, it tested our ability to adapt, act quickly, think creatively, and take calculated risks when necessary. The pandemic represents a sea change in healthcare that as leaders we are all just beginning to grasp.

Business Transformation

One area of significant change is the transformation in healthcare business models and connections between providers. Even before COVID, healthcare had observed a significant increase in merger and acquisition activity. The past year accelerated this trend as organizations form partnerships to better weather the lingering impacts of the pandemic.

Small hospitals that have taken bigger hits have sought to be acquired by larger health systems in order to survive. Conversely, large systems with more diversified portfolios and existing services such as virtual care and digital functionality are growing as a result of these new acquisitions, partnerships, and technologies. As organizations merge and seek to standardize their processes, there is a renewed focus on business function integration and centralization. The result is a more integrated delivery model with increased connections and data sharing between providers.

Collaboration

According to a recent PwC survey, 73% of healthcare executives said they were beginning to collaborate or had plans to collaborate with other care providers and payers as a result of the pandemic. Hospitals have significant opportunities for growth in this new environment of integration and collaboration.

As providers begin to share data on emerging services such as hospital-at-home and remote patient management, for example, hospitals can work together and with payers to help ensure that these services remain affordable for patients. Managed care contract discussions will also help providers learn how to build expenses into contracts and protect necessary reimbursement.

Data integration plays an important role in facilitating collaboration among providers. Sharing data between systems helps ensure that the right information is available to the right resources at the right time. It also helps automate common manual tasks by auto-populating patient data from one system to another. Care becomes more efficient, coordinated, and seamless as a result.

Data Security

While there is great reward, risk also accompanies shared access to patient data. Recent survey data suggest a strong correlation between security breaches and the number of patients willing to share their health data. In 2020, the number of reported patient data breaches in the U.S. was 447, a 36% increase since 2016. Somewhat correspondingly, just 71% of patients said they were comfortable sharing their health information among healthcare organizations in a 2020 survey, as compared to 84% in 2016. When data breaches trend upward, consumers are less willing to share their information.

Risks have amplified over the past year, as many organizations have been unable to invest in security projects during the pandemic. According to Becker's Hospital Review, "When hospitals' revenues declined due to canceled elective procedures in response to the pandemic, many organizations were unable or unwilling to finance large-scale security projects at a time when attacks were increasing."

As hospital revenues improve and data sharing becomes more prevalent, there is a greater need for vigilance in protecting the security of patient information. This is especially true as more healthcare employees now work in remote environments. Paperless environments and protected access to patient data are a must. Providers also need strong partnerships with their solution vendors and IT infrastructure teams.

All parties should understand the complexities of interpreting regulatory requirements and exchanging patient health data. For example, certifications from organizations such as the Health Information Trust Alliance (HITRUST) can help providers in selecting partners proven to appropriately manage risk by protecting and securing sensitive, private health data.

Care Delivery

Perhaps the most noticeable shift in patient care has been the widespread availability of telehealth services. According to a report released in March 2021 by Rock Health and the Stanford Center for Digital Health, 43% of 7,980 consumers surveyed used live video telemedicine in 2020. A recent survey from PwC showed that many health organizations plan to offer virtual visits in 2021, particularly for certain specialties such as mental health, family medicine, obstetrics and gynecology, and pediatrics. Overall, telehealth visits increased 33% in 2020 compared to the previous year, and the telehealth market is anticipated to reach $191.7 billion by 2025.

In addition to telehealth, the industry is seeing new entrants to the primary care space. Some companies sell telehealth and tech-enabled care delivery directly to employers. Others offer digital concierge services, promoting the ability to get a second opinion or prescription within 60 seconds, 24 hours a day. Still others provide surgery benefit navigation services, contracting with providers to offer bundled rates for self-insured patients. Even Amazon is in the mix, matching patients with medical teams in 50 states.

We're observing something unique in the industry – a paradigm shift in where patients go to get their care and how they receive it. We see it in telehealth, consumerism, and nontraditional delivery models nationwide. This movement, encompassing both technology and remote access, requires a change in how we engage patients and a continued focus on the consumer. As we step into this new territory, there is great opportunity through collaboration, integration, and innovation in healthcare.

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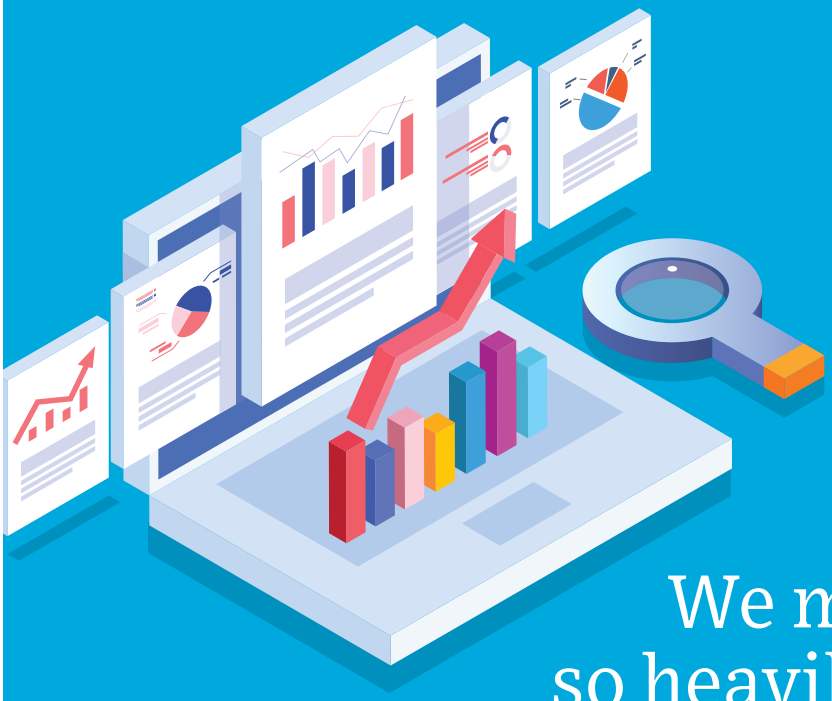

EXPERT REVIEWED

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

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

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

Clinical compensation
=
(National median compensation per wRVU benchmark for physician's specialty from most recent physician compensation survey report)
x
(Physician's personally performed wRVUs)
+
(Compensation for meeting specified clinical quality targets)[b]

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

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

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

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

THE PROBLEM WITH RELYING ON BENCHMARKS

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

Consider the hypothetical examples presented in the exhibit below.[c] Based on the data in the exhibit, when the 2017 edition of this hypothetical survey report was released, a productive pulmonologist with 8,500 wRVUs and a productive neurosurgeon with 13,000 wRVUs paid using the median compensation per wRVU ratio for their specialty would suddenly have found themselves making about $37,000 and $70,000 more, respectively, for the same amount of work. It is unlikely that the market for physician services in these specialties or the organization's financial situation would have changed dramatically enough in such a short period to justify these substantial changes. More important, while the physicians would have welcomed these increases, their organizations could not have budgeted for them — nor could they have prepared the physicians for the decreases coming in the next year.

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

WHY IS THIS PARTICULARLY IMPORTANT NOW?

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

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

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

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

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

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

Taken together with the challenges outlined in the sidebar on page 4, these forces raise questions about whether the survey reports for 2021, 2022 and even 2023 will provide a reliable look at the market for physician services. Though the surveying organizations are trying to "smooth out" the benchmarks, continuing to rely upon these data in physician compensation calculations could expose organizations to significant unpredictability. Simply put, healthcare organizations need a more sustainable model.

A BETTER SOLUTION

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

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

1 REPLACE COMPENSATION FORMULA VARIABLES TIED TO BENCHMARKS

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

Clinical compensation
=
(A fixed $XX per wRVU for a given specialty, specific to a given organization)
X
(Physician's personally performed wRVUs)
+
(Compensation for meeting specified clinical quality targets)

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

STEP 1 Identify and analyze every aspect of physicians' work and pay. The organization must first collect all relevant data, documents and other information from throughout the organization. This may involve the following areas:

- Legal (e.g., written agreements between the organization and physicians)
- Human resources (e.g., payroll data for employed physicians)
- Accounts payable (e.g., payments to independent contractor physicians)
- Revenue cycle (e.g., volume and revenue for physicians' billable clinical services)
- Compliance (e.g., timesheets for physicians' administrative services, if applicable)
- Operations (e.g., schedules and burden for physicians' call coverage services, if applicable)

Proposed formula for clinical compensation

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

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

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

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

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

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

- What the physicians' overall compensation *should* be
- What the physicians are doing to earn that compensation
- How that compensation is broken down into various forms (e.g., biweekly base salary, annual incentive payments, hourly administrative rates, daily call stipends, etc.)

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

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

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

At a minimum, it is important to understand that:

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

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

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

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

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

STEP 4 Simulate and adjust the model. The importance of simulating and adjusting the compensation model cannot be overstated. After completing the previous steps, the organization should have all the necessary information to perform this step. For example, if the organization was updating the compensation model at the beginning of 2021, it might use the following data from 2020:

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

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

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

2 IMPLEMENT A THOUGHTFUL, TRANSPARENT PHYSICIAN COMPENSATION OVERSIGHT PROCESS

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

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

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

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

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28.6%

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

Source: American Medical Association, 2020

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

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

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

3 REMOVE PAYMENT FORMULAS FROM PHYSICIAN CONTRACTS

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

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

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

BRINGING IT ALL TOGETHER

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

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

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

About the author

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Zero-balance account review:
Boost revenue integrity and lower cost-to-collect

Are you getting paid everything you deserve? Applying an analytics lens to your zero-balance accounts helps you uncover more opportunities to increase collections and strengthen revenue integrity.

The twin goals of revenue integrity – improving coding and charge capture while lowering compliance risk – are increasingly important in times of uncertainty. With healthcare organizations feeling heightened financial pressure from all directions, now is not the time to miss out on revenue you've already earned.

Healthcare payers are using increasingly complex algorithms and a myriad of other tools to reduce your payment levels – often erroneously. Continued high unemployment makes it even harder to collect from patients who are saddled with ever- increasing levels of responsibility for their healthcare bills. Add in the significant decrease in volume for profitable service lines as a result of COVID-19, and it all adds up to tremendous pressure to cut costs and simultaneously increase cash collections.

By not fully charging or by not fighting claims that may have been underpaid or denied, you're leaving money on the table. ***Up to 1% of net patient service revenue is lost due to charge integrity leakage —*** not to mention revenue lost to underpayments and improper denials. Finding and correcting these errors and oversights through zero-balance account reviews can have a dramatic and immediate impact to your bottom line.

Zero-balance account reviews: A booster shot for financial health

How do you know if you're getting paid everything you deserve? Are there denials that you wrote off too quickly? Charges that you could have billed, or billed at a higher rate? Were there instances where the payer downgraded or underpaid what they should have based on your contracts? Once accounts are closed and given a zero-balance status, these all-too-common issues oftentimes go unseen, and the revenue attached to them sits untouched.

> By not fully charging or by not fighting claims that may have been underpaid or denied, you're leaving money on the table.

As we approach fiscal year-end for many organizations, financial executives understandably focus on lowering the cost-to- collect ratio. While many margin improvement activities act like preventive medicine to improve long-term financial health, a zero-balance account review is like a booster shot. It infuses quick cash to boost your health system's financial immunity right when you need it, while also arming you with the analytics you need to improve revenue cycle operations on a go-forward basis.

Practical tips to stop revenue leaks, mitigate compliance risk, and lower cost-to collect

When you're searching for needles in a haystack, how do you distinguish the needles from the hay? With the amount of data most health systems have to sift through, the answer generally entails an analytic rules engine. Using sophisticated analytics to quickly and thoroughly identify anomalies in the data allows experienced revenue cycle team members to dig deeper to determine whether those "exceptions" are actually missing charges, preventable denials, underpayments, or even overpayments that open up the organization to compliance risk.

Consider the following tips to maximize the effectiveness and efficiency of your zero-balance account reviews.

1. Focus your search.

When you're looking for needles in a haystack, it helps to know which area of the haystack to look in. Isolating accounts that have been closed out within a given period (such as the past year) allows you to focus on a manageable population.

2. Apply analytics to quickly highlight problem areas.

A healthcare reimbursement rules engine consists of thousands of rules – or even tens of thousands in the case of large health systems – that indicate which codes tend to go together. For example, if a patient had a hip replacement surgery, you would expect to see a charge for an implant. Similarly, if a patient received a dose of a drug in the hospital setting, you would expect to see an administration charge for that same drug.

> A zero-balance account review infuses quick cash to boost your health system's financial immunity right when you need it.

By taking the population of accounts that was isolated in the previous step and running it through this engine, you quickly highlight accounts where something looks fishy: The encounter has a charge for a high-cost drug, but not for the administration of it. The hip replacement patient wasn't charged for the cost of the implantable device. Highlighting these anomalies, or "exceptions," allows you to take the next step of verifying that they really are reimbursement opportunities.

3. Identify accounts with dollars attached.

Just because an exception exists, it doesn't necessarily mean there are dollars attached to it. There's no point in rebilling for a missed charge if

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Zero-balance Account Review: Boost Revenue Integrity and Lower Cost-to-collect

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the encounter was part of a bundled payment or per-diem arrangement, for example.

At this stage, it's important to take the time to review every encounter manually, rather than automatically applying each rule across the board. A sophisticated reimbursement engine will factor in each payer's reimbursement practices and rules, but healthcare organizations must also invest in the right level of billing and collections expertise to process the data appropriately.

With the regulatory landscape shifting faster than ever, and with new codes for telehealth and for testing and treatment of COVID-19, staying up to date with coding updates is more important and more challenging than ever. Ensuring staff members are properly educated on the most up-to-date coding guidelines and billing practices, and that they have processes in place for cross-team collaboration, will improve your bottom line and staff satisfaction.

4. Find the golden needles.

Once you have a list of encounters with reimbursement tied to them, how do you know where you should spend your limited resources to capture the most revenue? Essentially, for each of the zero-balance accounts that have revenue-capture potential, you must answer the question: Is this the right thing to do?

We recommend creating a risk stratification profile to zero in on the accounts with the greatest compliance risk or revenue opportunity. For example, you might want to start with your most profitable service lines, or with the payers that have the tightest deadlines for timely filing. If you identify a population that is large and has a simple resolution step, then consider utilizing ***Robotic Process Automation*** (RPA) as a tool to assist your limited resources.

> Just because an exception exists, it doesn't necessarily mean there are dollars attached to it.

At a big-picture level, you'll need to weigh short-term financial gain against the long-term relationship with the payer. For example, in cases where claims are being audited or litigated, you will have to make a judgment call about the tradeoff between potential financial gain and the possibility of exacerbating an already strained relationship.

5. Take action to recover and prevent.

The beauty of the zero-balance account review is that it delivers financial benefit today and tomorrow. By running closed accounts through an analytics engine to identify exceptions, and then taking the appropriate resolution action (appeal, rebill, etc.) for each type of exception, you improve your collection rate and lower your cost-to-collect promptly. And by creating rules in your electronic health record system to flag exceptions as they occur, you can prevent those revenue leaks before the charge goes out the door.

Improve charge assurance, patient and physician satisfaction, and mission achievement

The benefits of zero-balance account reviews go beyond improving charge capture.

- **Charge assurance:** One of the core objectives of revenue integrity is protecting your organization from compliance risk.

  In addition to leaving cash on the table, erroneous coding also opens up the organization to "over-coding" scenarios, which may lead to costly audits by both commercial and government payers.

- **Patient satisfaction:** Patients are hesitant to come back to the hospital because of the fear of contracting COVID-19. Improving revenue integrity has an impact on patient satisfaction by decreasing the time it takes the claim to go out to the payer and patient. Limiting rebills due to late charges and unexpected patient balances from payer denials helps improve the patient's financial experience.

- **Provider satisfaction:** Coding and billing accurately the first time means that patients aren't bringing up financial conversations with their providers. When providers can focus on clinical conversations instead of answering billing questions due to a late charge or a denial, their satisfaction is greatly improved.

- **Mission preservation:** Ensuring that your revenue cycle is operating at maximum efficiency allows your organization to allocate resources to serving your community.

Recover revenue you've earned while improving cost-to-collect

Collecting more of the revenue that you have earned – in many cases at least 1% of NPSR – can help close the gap on the budgetary shortfalls stemming from COVID-19 while improving your cost-to-collect ratio. For every $1 of cost invested in the technology and human resources to perform zero-balance account reviews, we generally see an additional $4 or $5 of revenue collected.

How do you know you're not getting underpaid? In today's challenging environment, you can't afford to leave money on the table. Use these steps to improve revenue integrity and your cost-to-collect ratio, and let's talk if we can help.

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Healthcare Hiring Trends:
How to Turn Them to Your Advantage

With almost two years of work dominated by the pandemic, healthcare organizations have a lot to consider as they plan hiring strategies for 2022 and beyond. Trends that have surged since 2020, such as the expansion of telehealth and remote working, will remain on the agenda. Joining them are some perennial challenges, like the need to build workforces that can adapt to new digital tools and processes at the scale the market demands.

To succeed, healthcare leaders need resources to help them make smart, data-driven decisions on recruitment and compensation. The 2022 Salary Guide from Robert Half is one such tool. Drawing on some of the guide's key findings, here's how you can prepare your organization for what lies ahead.

Learn to navigate a candidate-led market

It's a good time to be a job seeker. Among workers polled by Robert Half, two-thirds (66%) said they're confident they could find a new job quickly, and almost 9 in 10 (87%) said their current skill set would help them land a new role. In this kind of market, talented candidates have the upper hand and often juggle multiple offers, putting them in a strong negotiating position.

But hiring managers aren't helpless. Here are some ways you can help your company appeal to top talent more than your competitors:

- **Polish the job description.** Drafting a compelling and thorough job description is critical to your chances of attracting the best candidates. In addition to the must-haves, include enough nice-to-have skills to discourage the underqualified, but not so many that you risk intimidating less-experienced job seekers who are well-suited for the role. And be clear about what's required and what you're flexible on.

- **Move quickly to make an offer.** Six in 10 professionals said they lose interest in a job if they don't hear back within two weeks of the initial interview. Almost half (49%) will ghost a potential employer if they feel strung along. To accelerate the hiring process, get decision-makers aligned on what you're looking for before talking to candidates, and avoid subjecting applicants to too many rounds of interviews and unnecessary aptitude tests.

- **Sweeten the pot.** Almost half of the employers polled by Robert Half are using signing bonuses and cash incentives to lure top talent. Candidates may also be swayed by benefits and perks, with health insurance, paid time off, and flexible work schedules most likely to move the needle.

Review your retention strategy

The challenge of securing new talent only underscores the importance of hanging on to your current MVPs. The pandemic hasn't helped: 38% of workers feel their career has stalled during the crisis. In a candidate-friendly market, what's to stop them from taking their skills elsewhere?

One answer is to align your offerings with the needs and desires of the modern workforce. Almost 9 in 10 (88%) HR managers reported that their company has added new perks due to the pandemic, ranging from wellness programs and mental health resources to additional paid family leave and childcare assistance. In short, if you can't raise employees' salaries, look for ways to improve their job satisfaction.

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Healthcare Hiring Trends: How to Turn Them to Your Advantage

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Lean into the remote work revolution

Once seen as a privileged perk, working from home has become the norm for millions of professionals since March 2020. Furthermore, over one-third of workers surveyed (34%) said they won't stay with organizations that don't allow remote options.

View this as an opportunity, not an obstacle. It's unlikely many of your employees will expect to work from home five days a week. What excites them is the potential to optimize their work-life balance with a blend of on-site and remote work. By embracing this hybrid model, you'll likely benefit from higher employee morale and better performance.

Another advantage of remote work is that it allows you to look farther afield when hiring for positions that may not require office time – clinical data managers, for example, or medical receptionists working multiline phone systems. Around 4 in 10 (39%) senior healthcare managers said they have recently expanded candidate searches to access a wider talent pool. And if your organization adjusts compensation for local costs of living, recruiting nationwide gives you the chance to find candidates with high-end skills and mid-range salary expectations.

Build a more flexible workforce

Seventy-four percent of senior managers in the healthcare industry said they will hire contract workers to support year-end initiatives. This marks a clear trend, with almost half of all companies (45%) now using contract professionals as the majority of their staff.

The advantages go beyond reducing your long-term labor costs. Project-based workers are often quicker and easier to hire than permanent ones. Furthermore, the process gives you some breathing space to evaluate whether the task being fulfilled by the contract professional merits a permanent position.

Embrace diversity, equity, and inclusion (DEI)

It's widely accepted that diverse, inclusive workforces have significant advantages over those that are homogeneous and restrictive. Diverse teams look at problems from different perspectives, driving innovation and improving decision making.

Leaders who neglect diversity risk a talent drain, with 71% of workers saying they'd leave a company whose values don't align with their own. Making DEI central to your corporate culture sends a message to highly skilled candidates that yours is an organization where they'll be welcomed, respected, and heard.

Ramp up digital transformation

These are the most in-demand skills sought by healthcare organizations right now:

- Coding and billing software
- CRM-based coding
- Data analysis
- Electronic medical records (EMR) software

Spot the common denominator? They're all digital specialties. Indeed, there are more open positions in such areas, like telehealth and remote patient monitoring, than skilled candidates to fill them, creating a headache for industry leaders.

There's no universal blueprint for building a workforce with the digital skills required to meet today's market challenges. Upskilling or reskilling existing employees in advanced technologies is highly worthwhile, but not every organization can commit the necessary time and resources right now. Hence the value of a thoughtful recruitment strategy based on the principles outlined in this article, implemented alone or in partnership with a talent solutions company.

Digital transformation, at least, is a known, slow-burning challenge. The pandemic was a shock to the system. Assume that more surprises lie ahead. Healthcare leaders expect job candidates to be agile, adaptable, and resilient. To drive success in your organizations, you need to be the same.

About the Author

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Worksheet S-10 Audits:
FFY 2018 Insights and Future Preparation Tips

Despite expectations, the federal fiscal year (FFY) 2018 S-10 audit process wasn't complete with all data uploaded to the Hospital Cost Report Information System (HCRIS) by December 31, 2020. At that date, however, the data of 1,540 of approximately 2,400 audited hospitals changed from their as-filed cost reports.

This provides significant information to reassess initial observations of the audits. These S-10 audits are complex and place additional burdens on hospitals to meet the stringent audit requirements.

Below, explore the results of changes visible at the year-end and how they can provide insight for hospitals facing future audits.

Audit Overview

Approximately 2,100 more S-10 Medicare Administrative Contractors (MAC) audits were performed during the 2018 round of audits than in previous cycles.

The FFY 2018 audits included all identified Disproportionate Share Hospital (DSH) qualified hospitals, plus sole community hospitals. It's anticipated that Centers for Medicare & Medicaid Services (CMS) will continue to instruct MACs to complete audits on this large group of hospitals in future years.

It appears that a large portion of the audits were complete by December 31, 2020, but not all. With that in mind, any analysis on the Q4 2020 Healthcare Cost Reporting Information System (HCRIS) file should note that not all audit results are present.

Additional information on the following items can be reviewed in our initial November 2020 audit assessment located at https://www.mossadams.com/articles/2020/11/ffy-2018-worksheet-s-10-audit-observations. Items include:

- The 2018 audit letter
- The requested year-over-year documentation requirement
- MACs' in-depth review of hospitals' charity and financial assistance policies
- Additional observations and challenges

New Audit Changes

Steps Taken Before Samples Were Requested

Once the requested information was provided, MACs generally performed several steps before requesting samples

- Reviewing the financial assistance policies
- Looking for duplicate claims, both within categories of provided data and between the various categories
- Tying out accounts within the provided template

Financial Assistance Policies

Of particular note, MACs spent significant time trying to understand transactions and transaction codes—and how they relate to charity and financial assistance policies.

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Worksheet S-10 Audits: FFY 2018 Insights and Future Preparation Tips

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As your hospital prepares for future audits, it's worthwhile to step back and assess your policies to verify they're clear, accurately represent the provided discounts, and actively followed.

Duplicate Claims

Hospitals encountered challenges with MACs as they worked through duplicate claims reviews.

Due to the fluid nature of the process across the revenue cycle, patient classifications change; write-offs are often reversed or revised based on new information. Care should be taken before concluding the presence of a patient duplication.

Tying Outpatient Claim Activity and Reconciling Accounts

Tying outpatient claim activity and reconciling accounts was perhaps the biggest challenge—one that will likely remain once new cost reporting requirements are active for periods beginning on or after October 1, 2020. Timing was one of the most prominent issues, among many, that contributed to the challenge. Though providers were afforded additional time compared to the initial requests in many cases, the amount of data to compile and additional steps to complete, like reconciliations, required even more.

Completing the reconciliation of the accounts within the MAC templates proved difficult due to the fluid nature of an account over time—and because activity can cross cost-reporting periods.

Steps Taken After Samples Were Requested

The categories sampled or the sample size weren't consistent across MACs. As a result, hospitals had different experiences depending on their MAC.

Documentation Requests

The documentation required for the charity review, however, was somewhat consistent across MACs. These included:

- Uniform Billing Form 04 (UB-04). These verify total charges and the exclusion of professional fees.
- Charity and financial assistance policies. These must identify the underlying support required, by policy, to grant the charity award. The hospital must then provide the underlying support once it's identified. This includes items like charity applications, presumptive eligibility score sheets, low-income status determinations, and support.
- Remittance advices or Explanation of Benefits (EOBs). These verify that the write-offs reported on line 20, column two were only the patient responsibility amounts.
- Patient account histories. These verify the write-off amount.

Documentation proved to be challenging for some hospitals, so it's strongly advised to investigate documentation for future audits as soon as possible.

For example, if your policy calls for 10 items of supporting documentation to reach a specific charity determination, anticipate that all 10 items will be requested. If your policy permits presumptive eligibility scoring, the score sheets are required.

Some significant proposed audit adjustments resulted from lack of supporting documentation issues.

Bad Debt Sample Reviews

Similar documentation was requested in support of the bad debt write-off claimed.

As part of the audit review, MACs identified cases in which:

- The bad debt write-off was more than the deductible, coinsurance, or copayment amount for insured patients.
- The self-pay discount wasn't applied before the bad debt amount was determined for accounts where insurance payment was recouped.
- The remittance advice or EOB couldn't be produced to verify patient responsibility.

Each of these items resulted in audit adjustments, and in some cases, material extrapolations.

Early Insights Based on the Data

To compile an idea of the audit result, we looked at FFY 2018 cost reports in HCRIS and compared the Q2 2020 HCRIS data to the Q4 2020 HCRIS data.

We identified line 30 changes for 1,539 hospitals out of the 2,389 eligible hospitals from the 2021 final Inpatient Prospective Payment System (IPPS) rule. Overall, line 30 dropped over $1 billion dollars, or 4.7%.

Following is a summary of the key components that contributed to that change.

Line 20 - Uninsured and Insured Charity Care Charge Changes

On line 20, total charity care charges, 1,393 hospitals experienced a change.

The revised amount for uninsured charity was $207 million greater than initially reported, only a .37% change.

Insured charity experienced a more dramatic change. The revised amount was $1.04 billion less than initially reported, or a 27% drop.

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Worksheet S-10 Audits: FFY 2018 Insights and Future Preparation Tips

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This is significant because insured charity charges aren't subject to the cost-to-charge ratio. Accordingly, the impact on actual uncompensated care cost reimbursement is dollar for dollar.

Line 22 - Patient Payments

For payments reported on line 22, 401 hospitals had updated numbers.

While the amounts were relatively modest compared to total charity dollars, the decrease was dramatic as both payments for uninsured and insured charity dropped over 90%.

Line 26 - Total Bad Debt Expense

With respect to bad debts, 1,415 hospitals experienced a change totaling a negative $2.2 billion dollars, or 7.4%.

While bad debt amounts weren't necessarily a focus item in the earlier audits, all MACs in this round worked on the bad debts claimed by hospitals.

Line 30 - Changes in Total Calculated Uncompensated Care

Overall, 1,050 of the 1,539 hospitals that experienced a change in line 30 saw a decrease in their numbers; 489 saw an increase.

The largest line 30 decrease was $93 million dollars; the largest increase was $47.4 million.

The actual reimbursement impact on these hospitals is significant, and given that the distribution of the pool is a zero-sum game, these changes impact all participants.

Other Considerations

Hospitals advocated that CMS audit the data once it signaled data would be used to distribute the uncompensated care pool, projected to be over $8 billion dollars for 2021.

Continued Plans to Audit All Qualified Hospitals

Initially, CMS audited approximately 25% of qualified hospitals. In this last round of audits, CMS audited the entire group and signaled that it plans to continue auditing all qualified hospitals each year.

Report Filing Instruction Changes[1]

In November 2020, CMS issued a Federal Register notice required under the Paperwork Reduction Act (PRA) of 1995 announcing an opportunity for the public comment to CMS'"intention to collect information from the public."

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Worksheet S-10 Audits: FFY 2018 Insights and Future Preparation Tips

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The information to be collected from this particular notice is associated with the CMS-2552-10 Hospital and Health Care Complex Cost Report and included proposed changes to cost report filing instructions related to data reported on S-10.

Proposed changes include:

- CMS is clarifying the definition of courtesy discounts and what should be excluded from Worksheet S-10.
- "Hospitals that received HRSA-administered Uninsured Provider Relief Fund (PRF) payments....for services provided to uninsured COVID-19 patients, must not include the patient charges for those services."
- The reported cost-to-charge ratio will now be for the general short-term hospital portion only—not the entire hospital complex—effective with cost reporting periods beginning on or after October 1, 2020.
- For cost reporting periods beginning on or after October 1, 2020, hospitals can no longer claim charges for services other than the general short-term acute hospital and now must exclude psychiatric unit, skilled nursing facility (SNF), home health agency (HHA), and end-stage renal disease (ESRD), for example.

For a thorough understanding of what's proposed regarding Worksheet S-10 instructions, a review of the full Medicare Provider Reimbursement Manual (PRM) issued with the notice is advised. Additionally, as the reporting and auditing of data for Worksheet S-10 has become more complex over time, these new instructions should be read in conjunction with MLN Matters SE17031 as well as CMS Questions and Answers for Worksheet S-10.

Given the significant redistributive nature of the pool distribution, hospitals should invest the time and resources necessary to verify CMS uses complete and accurate data.

Data Templates[2]

Effective with cost reporting periods beginning on or after October 1, 2018, hospitals were required to submit a listing supporting charity care claimed in the cost report. Failure to do so would result in the rejection of the cost report. However, CMS offered no standardized format for submitting the required data. That's being changed as a result of the aforementioned Federal Register notice. Effective for cost reporting periods beginning on or after October 1, 2020, CMS proposes a new Exhibit 3B, which represents the standard format for reporting charity care amounts claimed in the cost report. The new exhibit, which is found on page 127 of the CMS PRM Chapter 40, has 27 columns and includes data points with revised definitions.

In addition to providing charity care information at the detailed patient level in as-filed cost reports, effective for cost reporting periods beginning on or after October 1, 2020, information regarding non-Medicare bad debts must also be reported at the patient level on Exhibit 3C.

The new exhibit, which is found on page 129 of the CMS PRM Chapter 40, has 17 columns and also includes data points with definitions included in the proposed PRM.

Steps Hospitals Can Take to Prepare for an Audit

Continually evaluate charity and financial assistance polices to verify they're clear, complete, and cover actual self-pay discounts and charity discounts applied to patients.

To prepare for audits:

- Compile data at the patient level, not the general ledger level.
- Verify that supporting documentation used to make charity determinations is received from the patient and maintained on file.
- Consider conducting mock audits internally or through an independent resource.

Properly retain and be ready to retrieve necessary data when going through, or planning to go through, patient accounting system conversions.

To learn more about how proposed changes will affect your organization and Medicare cost reporting efforts, potential implications of S-10 audits, or for assistance filing amended worksheet S-10 data to stay compliant with cost report instructions, contact your Moss Adams professional.

About the Author

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Notes

[1] As of September 7, 2021, these proposed changes are still under consideration by CMS.

[2] As of September 7, 2021, these proposed changes are still under consideration by CMS.

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First Illinois HFMA Event Photo Recap

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2021 First Illinois HFMA Upcoming Educational Events

Education News

Visit the chapter website at firstillinoishfma.org for up-to-the minute chapter events and news.

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