

The graphic features three overlapping circles on a dark blue background. The top-left circle is partially obscured by the larger bottom-left circle. The rightmost circle is the largest and contains the main text. Each circle is outlined with a thick, multi-colored ring that transitions from yellow to green to blue. The text is centered within the rightmost circle.

***Beyond
the
Numbers***

hfma™ | Est. 1946

Celebrating the 80-year history of the
Healthcare Financial Management Association

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Foreword



C. Ann Jordan, JD

As we reflect on 80 years of HFMA, what stands out most is not just how much has changed — but how consistently our members have risen to meet the challenges of the moment throughout our history.

Since 1946, when a small group of visionaries came together to form what would become HFMA, our profession has been in constant evolution. What began as the American Association of Hospital Accountants has grown alongside a healthcare system that is more complex, more data-driven and more essential than ever. This book tells that story — of a profession, an Association and a community adapting and advancing together.

From the creation of Medicare to today’s rapidly shifting landscape, HFMA has been a steady presence for its members. Through each new challenge and opportunity, the Association has continued to listen, to learn and to lead, helping healthcare finance professionals do what they do best: support the delivery of better care and better outcomes.

This volume builds on earlier histories, including *From Acorn to Oak* and *From Acorn to Oak and Beyond*, which remain important reflections on HFMA’s early years. Here, the focus turns to more recent decades — and to the people, ideas and innovations that are shaping where we go next.

What has not changed is our purpose. HFMA exists because of the commitment of its members — individuals and organizations dedicated to improving health and healthcare in their communities. It is a privilege to serve alongside them.

As we mark 80 years, we do so with gratitude for our history and for our members. The challenges facing healthcare are significant, but so is the potential to make meaningful progress.

C. Ann Jordan, JD

President and CEO

Healthcare Financial Management Association

CHAPTER 1: 1940s-50s

The foundation

It shouldn't be surprising that HFMA does not trace its origins to the early 1900s, when Americans started turning to hospitals in times of illness, rather than being cared for by family members at home. In the 1930s, according to HFMA historian Robert M. Shelton, FHFMA, hospital



Accountants gather at Indiana University for the 10th Annual Institute of the American Association of Hospital Accountants.

administrators viewed accounting “not as a valuable tool but as a troublesome and necessary evil.” The impetus to form a membership group for hospital accountants corresponded with the elevation of accounting within the management structure of hospitals, which would not occur until years later.

“Something must be done to elevate the position of hospital accounting to its proper place and the important part it plays in hospital finance.”

— William Follmer

Seizing the moment. As the Second World War came to an end and a period of relative economic stability began, attitudes about the art and science of management began to change. Management guru Peter Drucker influenced business culture with his notion that organizations should seek to bring out the best in people, which was a

Association Leader

Frederick C. Morgan

Fred Morgan joined the Association in 1948. From the start, he worked tirelessly as a volunteer, including a six-year tenure as volunteer secretary-treasurer from 1949-55. In addition to [launching a lending library service](#), Morgan concentrated on the formation of chapters, and by 1955, 42 chapters had been organized and there were 2,620 members. As Association historian Robert Shelton wrote, “The Association flourished through the dedicated nourishment and tender loving care of Fred Morgan, buttressed by enthusiastic and hard-working elected officers and directors and appointed committees.”

radical idea for those times. Drucker maintained that employees who knew more about certain subjects than their bosses did could work in harmony with others in large organizations.

Meanwhile, in hospital circles, Shelton tells us that administrators began to realize that accountants could save operating dollars and invest those resources in capital improvements and equipment. Yet the field of hospital accounting was still in its infancy. As future Association leader William Follmer put it, most hospital accountants “[didn’t] know a debit from a credit.” They had little more than a high school education. In 1945, Follmer wrote, “Something must be done to elevate the position of hospital accounting to its proper place and the important part it plays in hospital finance.”

Launching the Association. Determined to follow through on his vision for the profession, Follmer assembled a group of 16 colleagues in June 1945 to explore the merits of a national association that could address the specialized needs of hospital accountants. This group became the Organizing Committee that eventually approved a constitution and bylaws for the new organization, called the American Association of Hospital Accountants

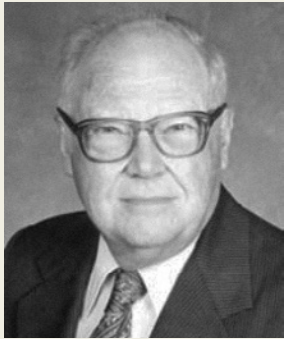
“The completion of the organization of The American Association of Hospital Accountants is the fruition of the hopes, dreams, aspirations and planning of many serious-minded accountants who conscientiously believe the hospital accountant and [their] profession deserves a prominent place in the constellation of other hospital specialties.”

— *Frederick T. Muncie, CPA,
first AAHA board president*

(AAHA), in 1946. That summer, the Association held its first meeting at Indiana University, with seven board members in attendance.

Through a combination of active recruitment by the board and the efforts of Frederick T. Muncie, CPA, who was elected as AAHA’s first board president in 1946, the Association boasted a total of 284 members by September of its first year in operation. Nearly a year later, after membership certificates were mailed and the inaugural issue of *Hospital Accounting* was distributed, AAHA head of

About Robert M. Shelton



Robert M. Shelton, FHFMA

Robert M. Shelton, FHFMA, began his career in healthcare financial management at Mercer Hospital in Trenton, New Jersey, in 1949, and later rose to

controller. In 1953 he became administrator of a 50-bed orthopedic hospital, also in Trenton. Two years later, he helped organize AAHA's New Jersey chapter and served as its first president. Shelton was elected to the AAHA National Board of Directors in 1956, and for two years served as Chair of the Board's Committee on Chapters.

Shelton's career accelerated in 1958 when he was elected President of the AAHA Board of Directors. In 1959, he was appointed as

the Executive Director of the AAHA national office, a position he held until 1978.

Over Shelton's 19 years as Executive Director, the Association's membership grew sixfold from 3,200 to more than 18,000. His tenure was marked by his early embrace of reforms needed to implement Medicare, aggressive expansion of state and local chapters, and the launch and development of the Association's Annual National Institute.

"During (Shelton's) tenure, the financial people in healthcare were brought up from being the backroom accountants to being a very critical part of the management team," said the Association's 1981-82 Chair, Raymond J. Cisneros, FHFMA, CPA. "A lot of what he did to improve the education, training and involvement of these people made that happen."

The Association's 1978-82 Board President, James T. Whitman, FHFMA, said, "He had a

real heart for seeing the profession develop as a profession, and he devoted his entire life to making that happen."

"(Shelton) was very instrumental in developing educational programs that helped people in the field make that transition from a little bookkeeping operation to true financial management," said the Association's 1986-2012 President and CEO, Richard L. Clarke, DHA, FHFMA. "He had a very positive impact in the continuing professional development in finance. The level of professionalism that is in the field would not be there if not for the efforts of Bob."

After a 1978 restructuring, Shelton became the Association's vice president. He retired in 1981. Ten years later, Shelton completed [*"From Acorn to Oak: A History of the Healthcare Financial Management Association."*](#) He remained active until he passed away in 2003 at age 85.

Source: Finkel, E., "2004 Health Care Hall of Fame: Education First," *Modern Healthcare*, March 1, 2004.

publicity Helen Yerger wrote a press release marking the Association’s accomplishments. Muncie celebrated the establishment of AAHA as validation of the Association founders’ belief that hospital accountants could make meaningful contributions to healthcare.

Laying the foundation. The early years of AAHA focused on developing the basic services that a professional membership group needs. Building a robust association would take years and financial wherewithal. Looking back on the occasion of the Association’s 25th anniversary in 1971, 1952-53 Association President John M. Stagl acknowledged that a lack of funds had precluded the AAHA from engaging in broad scope programs in its early years. Indeed, the *Hospital Accounting* journal alone consumed more than half of AAHA’s annual dues revenue in the early 1950s.

That period, wrote Stagl, was the time “in which the solid foundation was laid on which the Association built to become a professional group with leadership status in financial management.” For AAHA, the foundation included finding office space and developing membership benefits such as professional education, a journal and a lending library.

Starting out small. In 1955, the AAHA headquarters office moved from Association cofounder Robert Reeves’ business address at New York’s Rochester General Hospital to Chicago, where executive secretary William Pierce set up shop in a 13-by-18-foot space at Michael Reese Hospital. The \$35 monthly rent included electricity, air conditioning, housekeeping and local phone service. Pierce’s desk was set up in a hallway. It would be four more years before the Association moved to more suitable office space in the American Hospital Association building in downtown Chicago. When AAHA made that move, Shelton’s tenure as Association executive director began.



The AAHA headquarters space in 1955 was a single room at Chicago’s Michael Reese Hospital.

Association Founders and Cofounders

Graham L. Davis



Together with Stanley A. Pressler, Graham L. Davis organized Indiana University’s institute on hospital

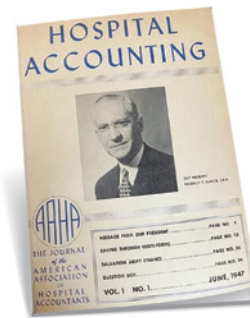
accounting in 1941. During preliminary discussions about creating a professional association for hospital accountants, Davis was among the first to offer full support. He served as a member of the AAHA Organizing Committee, which developed the Association’s constitution, bylaws, charter and membership qualification profile, and as an AAHA director-at-large from 1946-48. Davis was elected president of the American Hospital Association in 1948.

Introducing professional education. To begin providing the education needed by the nascent hospital accounting profession, AAHA launched a three-tier correspondence course program, in collaboration with Indiana University, that comprised principles of hospital accounting, intermediate hospital accounting, and hospital cost analysis and budgeting. Most of the 281 registrants in the first AAHA course offered in 1955 were bookkeepers or administrators.

The popularity of AAHA's correspondence courses continued to grow into the early 1960s, thanks to local chapters that set up study groups. Small groups gathered regularly to discuss an assignment with a tutor and other

The popularity of AAHA's correspondence courses continued to grow into the early 1960s, thanks to local chapters that set up study groups.

group members before handing in an assignment to the university faculty member for grading. This approach not only helped members learn the material but also provided them with the encouragement they needed to finish the course.



Launching a professional journal.

AAHA's journal, as it was known in the early years, would turn out to be the Association's flagship publication and the leading

source of information about all topics related to healthcare finance. But in 1947, *Hospital Accounting: Official Journal of the American Association of Hospital Accountants* got off to a rocky start. The production quality of the first issue was poor. On top of that, when the printer tried to ship the journals to Chicago for binding, they were lost. Nonetheless, AAHA was proud of the first few issues, which were modest in size and appearance, averaging less than 20 pages.

In 1949, the journal started reporting on AAHA chapter activities. Chapter coverage expanded as more chapters joined the ranks. Information

Association Founders and Cofounders

William G. Follmer



In 1945, William G. Follmer gathered a group of colleagues together to discuss the merits of forming an association for

hospital accountants. Based on that discussion, he formulated a plan of action and began to organize the AAHA. In addition to establishing the AAHA's Organizing Committee, he was elected as AAHA secretary-treasurer in 1946. Follmer died in a car accident in 1950.

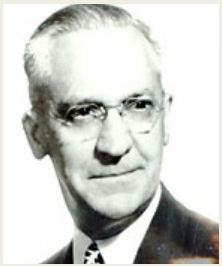
and announcements about Association activities were mixed with a selection of three or four technical articles per issue.

Operating a lending library. Between 1950 and 1955, AAHA cofounder Frederick C. Morgan responded personally to numerous requests for information, aided by the extensive library of articles, original papers, pamphlets and books

he had accumulated. When the Association moved to Chicago in 1955, Morgan donated his collection to launch a lending library service. The new library included more than 2,700 documents cataloged under 52 headings. Individuals who requested information received AAHA's entire folder of material on the subject on a 30-day loan. Library privileges were not restricted to AAHA members.

Association Founders and Cofounders

Frederick T. Muncie



Frederick T. Muncie was part of the original group called on by Follmer to discuss prospects for forming a

professional association. He served as a member of the first Organizing Committee. In 1946, he was elected as AAHA's first president. Muncie also played a key role in bringing together Chicago-area accountants to form the AAHA's First Illinois chapter in 1948.

New materials were continually added to the folders by AAHA office staff, but the Association lacked the resources to remove material as it became outdated. Additionally, the subject index, which Morgan had developed on his own, was not updated. Over the years, the volume of material multiplied. Because users paid no charges, the Association subsidized all costs. The lending library service was ultimately discontinued in 1979.

In recognition of Morgan's contributions to AAHA the Frederick C. Morgan Individual Achievement Award, the Association's most prestigious individual honor, was named in his honor in 1959. The award recognizes a single individual for outstanding contributions to the Association over the course of a career.

Recognizing professionalism. At a 1954 AAHA board meeting, the Association's 1954-55 Chair, Sister Mary Gerald, noted that designating a core group of members who had achieved predetermined standards of excellence could be the impetus for a higher class of membership and a higher level of professionalism within the Association.

The following year, a committee recommended that AAHA develop the membership classification of Fellow and appointed a Board of Examiners to handle the myriad details and decisions necessary to develop a fair and comprehensive examination.

The Board of Examiners solicited input from 75 hospital accounting experts nationwide and the national office offered all 42 chapter presidents the opportunity to provide input on the new, eight-hour Fellowship examination. Of the 47 candidates who took HFMA's first Fellowship exam in 1957, 24 were female, of whom 21 were Catholic Sisters.

Eligibility requirements for Fellowship, examination policies and protocols, and certification maintenance criteria changed frequently over the years and new professional certifications were developed in the decades that followed. The volunteer [Board of Examiners](#), established in 1955, continues to review the Association's professional certification examinations for accuracy, appropriateness and timeliness and administer the Association's expanded [certification programs](#).

Establishing a code of ethics. AAHA's Constitution and Bylaws Committee adopted its first code of ethics in 1959, inspired by an idea articulated by Salvation Army Major Floyd Freeman to AAHA cofounder Follmer, according to Association historian Shelton.

Association Founders and Cofounders

Stanley A. Pressler

Stanley A. Pressler, CPA, joined the AAHA in 1945 as a member of the Organizing Committee. As an associate accounting professor at Indiana University, he facilitated the agreement to have AAHA cosponsor educational programs on the university campus, which were held from 1949-62. Pressler played a key role in developing the accounting correspondence courses that were offered to AAHA through Indiana University.

The principle, in essence stated that everyone — members of the public, clients and colleagues — deserves equitable treatment and continuity of services and that “as members of a profession serving the public in a confidential manner, we must strive first to observe these principles and [to] seek no success that is not founded on the highest justice to all.”

The code of ethics promulgated in 1960 evolved into a concise, seven-point [pledge](#) to promote the highest standards of professional conduct, to which all Association members subscribe.

Establishing local chapters. Association officers agreed that a group of 10 or more could form a chapter of the national organization. The appeal of local AAHA chapters was clear and the number of chapters grew quickly, starting in 1948 with the incorporation of the aptly named First Illinois chapter. A total of 59 state and regional AAHA chapters were established throughout the country in the 1940s and '50s.

Welcoming women to Association leadership roles. Catholic sisters played important roles in the early years of AAHA, at a time when few women worked in the field of hospital administration outside of clerical roles. AAHA



Helen Yerger

Yerger continued to push herself and to push Follmer and Muncie to keep at the work of forming the Association even when faced with what seemed to be insurmountable obstacles.

cofounder Helen Yerger, who held the title of hospital administrator, was an exception.

Yerger brings AAHA skills and determination.

Yerger was in the vanguard of women in hospital administration. In her paid job, she was administrator of Arnold Gregory Memorial Hospital in Albion, New York.

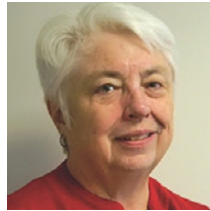
On a volunteer basis, Yerger served as AAHA's director of publicity and public relations. In that capacity, she developed AAHA's first membership certificate and was instrumental in arranging cosponsorship of the first AAHA

institute with IBM in 1948. Yerger also authored the lead article in the first issue of *Hospital Accounting* and was a frequent contributor to the journal.

Yerger was known for her persistence. According to Shelton, her commitment to making the AAHA a reality “cannot be overstated. She continued to push herself and to push Follmer and Muncie to keep at the work of forming the Association even when faced with what seemed to be insurmountable obstacles.”

Catholic sisters bring experience and leadership skills. Just as Catholic sisters were early leaders in caring for patients and financing and running hospitals, they also were instrumental in launching and growing AAHA. And they didn’t just have a seat at the table – they often were at the head of it. Between 1952 and 1969, four nuns served as the elected leader of HFMA.

Reflecting on this period for an *hfm* [interview](#) on the occasion of the Association’s 75th anniversary in 2021, 1989-90 Chair Sister Geraldine Hoyler, FHFMA, a former CFO of Holy Cross Health System and Catholic Health Initiatives, said the need for more advanced



Geraldine Hoyler, FHFMA, is one of five Catholic sisters who have served as the Association’s National Chair.

financial management of healthcare institutions evolved after World War II with the growth of employer-sponsored health insurance. Accountants had to figure out how to work with health plans, Hoyler pointed out, and the Catholic sisters, who had served in key hospital positions, were poised to lead the effort. “[The sisters] were used to working together, and they were experienced leaders,” she said. “They went and did what needed to be done. It was a comfortable position for them, and there was never an issue of acceptance.”

Prepared for what the future may bring. By the end of the 1950s, AAHA had established an infrastructure that positioned the Association for continued growth and expansion. With a membership of about 13,000 accounting and finance professionals in 1959, the young Association was ready for whatever might lie ahead.

With a membership of about 13,000 accounting and finance professionals in 1959, the young Association was ready for whatever might lie ahead.

Association Founders and Cofounders

Robert H. Reeves, FHFMA



Robert H. Reeves, FHFMA, worked closely with William G. Follmer in the early days of AAHA. He helped draft the

constitution and bylaws, chaired the first Nominating Committee from 1946-51 and was elected president of the AAHA in 1956. From 1950-53, he served as associate editor of the AAHA’s journal, *Hospital Accounting*.

1946-59 Association Milestones

American Association of Hospital Accountants (AAHA) is established.



First AAHA chapter, First Illinois, is incorporated.

Hospital Accounting Clinic and Workshop, co-sponsored with Indiana University, draws 75 registrants from 13 states.

First Graham L. Davis Award for Chapter Achievement is presented to the AAHA Tennessee chapter.

AAHA is incorporated in the state of Illinois.

...

William M. Pierce is hired as the Association's executive secretary.

...

Newsletter for chapter officers, *Notes from National*, is launched

First AAHA Fellowship examination takes place.

1946

1947

1948

1949

1950

1951

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1957

1958

1959

Inaugural issue of *Hospital Accounting*, AAHA's official journal, is published.



Institute on Hospital Financial Control (i.e., punch card accounting) is held at an IBM facility in Endicott, New York.



An employee is shown using an IBM accounting machine with punchcards.

AAHA conference held at Indiana University, featuring three week-long courses, draws 170 registrants from 32 states and four Canadian provinces.

First Frederick C. Morgan Individual Achievement Award is presented to Charles G. Morgan.

...

AAHA adopts a code of ethics.



CHAPTER 2: 1960s

The advent of Medicare

The 1960s have been celebrated and memorialized as a decade of revolutions: social, cultural, political and even musical. But the annals of AAHA history make no mention of Woodstock (the musical event of the decade), the Vietnam War or the rise of a “hippie” counterculture. The Association was focused on major changes that were disrupting



President Lyndon B. Johnson signs the 1965 Medicare Bill.

the healthcare finance field, both at the individual level, as a college degree became the norm for hospital accountants, and at the systemwide level, with the enactment of legislation establishing Medicare and Medicaid. AAHA’s challenge was to respond to both of these major developments.



During the 1960s, a college degree became virtually a prerequisite for hospital accountants

Educating the college-educated. During the 1960s, a college degree became virtually a prerequisite for hospital accountants. According to Association historian Robert M. Shelton, FHFMA, by the end of the decade, at least 85% of professionals who entered the field of hospital finance held undergraduate degrees or were CPAs. These professionals may have had accounting and finance expertise, Shelton tells us, but they lacked hospital-specific knowledge.

AAHA's correspondence programs of the 1950s no longer met the needs of these "qualified and experienced newcomers." To help college-educated accountants understand the intricacies of hospital finance, and to help the hospital field catch up with contemporary accounting methods, the Association developed a sophisticated educational program with presenters from the American Hospital Association (AHA), the Blue Cross Association, CPA firms and hospitals. A continuing influx of experienced accountants into the healthcare field, as well as increasing government regulations, ensured the popularity of the

Institute for Experienced Accountants New to the Field. AAHA chapters, especially those in metropolitan areas, also held programs for accountants who were new to healthcare.

Additionally, the Association collaborated with the AHA on development of a two-day workshop on hospital budgeting procedures. More than 60 of these workshops were conducted from 1964-68.

Rocking the world of healthcare finance. The Great Society programs of the 1960s, which sought to eliminate poverty and racial injustice, had one result that reverberated through healthcare finance and accounting circles: the enactment of Medicare and Medicaid in 1965.

Prior to Medicare, only about 60% of people older than 65 had health insurance, with coverage often unavailable or unaffordable to many others — older adults paid more than three times as much for health insurance as younger people. Medicare changed all of that. In Medicare's first year, 19 million individuals signed up.

In 1961, fewer than 1% of hospitals were engaged in cost finding, the function that today is known as cost accounting.



Tools of the trade.

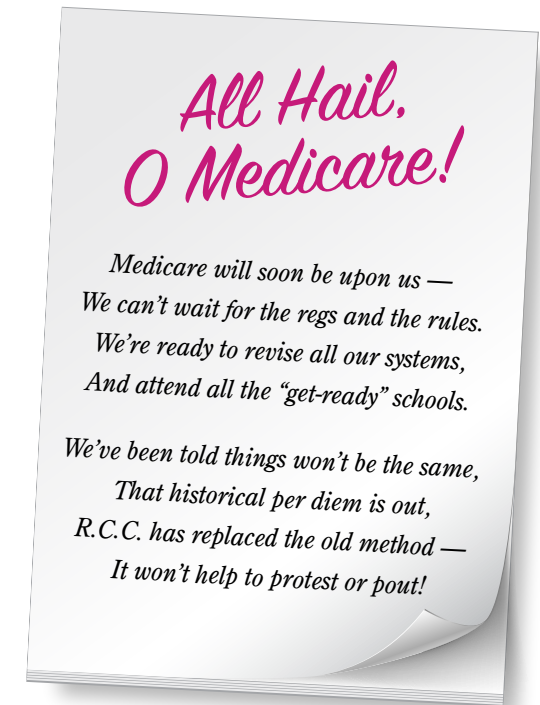
Even changes that are widely beneficial can disrupt business practices. This was certainly the case with the advent of Medicare, which led hospitals to further professionalize their accounting practices and pushed AAHA into the limelight, according to Shelton. A lack of solid, official information on implementation of this revolutionary healthcare program prompted AAHA to publish what Shelton characterized as a “history-making” journal issue in June 1966 and to become increasingly involved in cost report filing.

Hot off the presses. The June 1966 issue of the Association’s journal, then called *Hospital Accounting*, was dedicated to helping the field prepare for the new law. The issue’s 14 articles had to be written in record time because the first public information about the program was not released by federal officials until May 2 of that year. Demand for copies, which were sold for \$1 each, was so great that a second printing of 2,500 copies was necessary. Several hundred copies were purchased by the Social Security Administration and distributed to field personnel across the country.

Meanwhile, an AAHA newsletter featured a 28-verse poem written by AAHA member Floyd A. Kinkead, controller of Philadelphia’s Nazareth Hospital, exemplifying the mixed emotions but overall good cheer with which some hospital accountants greeted the arrival of Medicare.

Cost-finding finds its way into hospitals. In the early years, Medicare’s cost reimbursement method allowed hospitals and physicians to capture nearly all of their costs in treating beneficiaries. But Medicare also brought new and unprecedented cost reporting requirements that hospitals were not prepared to meet. In 1961, fewer than 1% of hospitals were engaged in cost finding, the function that today is known as cost accounting. As Shelton wrote, “Medicare would soon awaken the entire healthcare field to the need for stronger management and change forever the nature of healthcare.”

AAHA collaborated with the AHA on a pilot study to identify the challenges of cost-finding and develop a strategy for implementing cost-finding practices in hospitals. They had to start with fundamentals, down to the level of developing the definition of a meal.



The full version of an AAHA member's ode to Medicare is available on [HFMA's website](#).

In cooperation with the AHA, the Catholic Hospital Association and the Blue Cross Association, and with support from the Social Security Administration, AAHA trained 16 qualified accountants as faculty members to teach the nuts and bolts of meeting the statistical and financial requirements for Medicare reimbursement. Over the next year, 3,000 enrollees from 1,800 hospitals attended

A new name for a new era

In 1968, AAHA changed its name to Hospital Financial Management Association, highlighting that the scope of financial management had extended well beyond accounting while the hospital remained the focal point of patient care. Members approved the new name by a 20-to-1 margin.



the two-day workshops that these newly trained instructors conducted throughout the country.

The information era begins. The challenges of Medicare inspired Irwin M. Jarett, Ph.D., CPA, to proclaim, somewhat tongue in cheek, “The hospital accountant is dead” in his lead story in the September 1968 issue of HFMA’s journal. Jarett followed up in the next journal issue—the first to be published as *Hospital Financial Management* — with “the good news” to counter the bad: “The hospital information specialist is born!”

The journal had been covering various phases of data processing since 1964. HFMA’s Board established a Data Processing Technical Committee to help members develop technical expertise with computers. This early focus on computing could be regarded as prescient, given the transformative impacts of automation in the decades that followed and the fact that the highest-profile computers of the 1960s, those that NASA relied on to send humans to the moon in 1969, had less than a [millionth of the power](#) that smartphones would have 50 years later.

“The hospital accountant is dead. The hospital information specialist is born.”

— AAHA member Irwin M. Jarett, Ph.D., CPA



At the time that HFMA’s Board established a Data Processing Technical Committee to help members develop technical expertise with computers, this early desktop computer was among the first to be available to the general public. It weighed 65 pounds and was the size of a typewriter.

Emerging from a decade of change. The 1960s had brought changes to the healthcare finance workforce, which was largely college-educated by the end of the decade. With the support of HFMA's continuing professional education, hospital finance leaders were well equipped to handle the challenges associated with the advent of Medicare and Medicaid. But new challenges loomed as the benefit coverage expansion and resulting growth in healthcare utilization led to an era of tightening economic controls in the 1970s.

Chapters were very interested in the concept of regional institutes and flooded the national office with requests to become sponsors.

Chapter and regional conferences: The early days

The chapter and regional conferences that became a mainstay of HFMA educational programming in later years had their roots in 1959 when the Philadelphia, Appalachian and New Jersey chapters sponsored the Eastern Regional Conference in Philadelphia, drawing 171 people from 14 states.

In the early years, according to Shelton, the business model was very different:

- *Location.* The national Association chose a geographic location and then approached chapters for assistance or accepted invitations from them.
- *Programming.* Chapters chose one-third of the conference's programming while the national office selected two-thirds.

- *Process.* National staff and the officers of sponsoring chapters typically met beforehand to plan program content and then customize it to meet the needs of local hospitals.
- *Revenue.* The national Association received all income from conference registrations.

Chapters were very interested in the concept of regional institutes and flooded the national office with requests to become sponsors. Eventually, chapters and regions started sponsoring conferences independently of the national Association. The lasting legacy of the early regional meetings was the valuable practical experience that chapters gained in program planning and conference management.

1960s Association Milestones

William G. Follmer Merit Award is created to recognize members for service to HFMA at the chapter level.



ANI is held at the University of Chicago Center for Continuing Education for the first time. It continued at that location through 1966.

The lending library overhauls its indexing system, establishing more than 100 categories with key letters and numbers. A secretary-librarian is hired.

1960

1961

1962

1963

1964

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1966

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1968

1969

Final Annual National Institute (ANI) located on the Indiana University campus is held.

AAHA Educational Foundation is incorporated for educational and research purposes.

AAHA's first director of education is hired.

ANI is moved to Ohio State University.

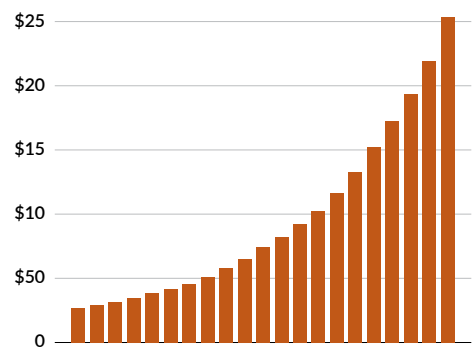


AAHA changes its name to Hospital Financial Management Association. The Association's journal changes its name from *Hospital Accounting* to *Hospital Financial Management*.

CHAPTER 3: 1970s

An era of economic controls

The 1970s were a period of rapidly escalating healthcare costs, due in part to unexpectedly high Medicare expenditures, high inflation in the overall economy, and the invention of medical technologies, such as computerized axial tomography and magnetic resonance imaging. Measures designed to control costs and prices — in the early 1970s, economywide, and in the latter half of the decade, healthcare-specific — shaped HFMA’s



National Health Expenditures, 1960–1980
(\$ in billions)

Source: [Centers for Medicare & Medicaid Services](#)

course during this period. After several years of intensifying involvement in Medicare issues, HFMA had established a technical services department in 1970. The new organizational capability came not a moment too soon: A decade of federal legislation that would impact the evolution of hospital finance was beginning.

Measures designed to control costs and prices — in the early 1970s, economywide, and in the latter half of the decade, healthcare-specific — shaped HFMA’s course during this period.

Responding to cost controls. The Economic Stabilization Act of 1970 authorized President Nixon to stabilize prices, rents, wages, salaries, interest rates and dividends as part of the far-reaching Economic Stabilization Program (ESP).

Productivity became a critical issue during the ESP years. The Association focused on creating educational programs that measured and controlled hospital productivity.

In cooperation with representatives of most of the Big Eight (in 2021, the Big Four) accounting firms, HFMA launched a series of two-day Institutes on Hospital Economic Controls in 1973. The following year, HFMA's Board of Directors Award was presented to the American Institute of Certified Public Accountants (AICPA) in recognition of its contributions to the hospital industry during the ESP period.

Calling all hands on deck. After the ESP ended in 1974, community hospital expenses increased at an annual rate that was 8.7% higher than the overall rate of inflation from 1975 through 1977. Rising healthcare costs were among the top three domestic concerns of Americans, according to public opinion polls.¹

When the Hospital Cost Containment Act of 1977 was proposed under the Carter administration in a new effort to curb hospital cost growth, HFMA joined the American Hospital Association (AHA), the Federation of American Hospitals and the American Medical Association in opposing the bill. A heavy outpouring of protest letters from association members and others in the field succeeded in forestalling the legislation. In lieu of a mandate, industry groups agreed to a voluntary cost containment program that became known as the Voluntary Effort, which was implemented in 1977.

In *From Acorn to Oak*, HFMA historian Robert M. Shelton, FHFMA, goes into detail about how HFMA swung into action and leveraged all available channels to make the Voluntary Effort successful over the next few years.

- **Collaboration.** Along with more than a dozen healthcare groups, HFMA participated in an AHA-led advisory panel charged with developing strategies to implement the Voluntary Effort.

HFMA swung into action and leveraged all available channels to make the Voluntary Effort successful.



The Association focused on creating educational programs that measured and controlled hospital productivity.

- *Idea generation.* HFMA formed a national Committee on Cost Containment to generate ideas for the national Voluntary Effort and develop recommendations for national and chapter-based educational programming in this area.
- *Chapter engagement.* Each HFMA chapter was asked to form a Cost Containment Committee and was provided with suggested assignments in working with hospitals, state hospital associations and the general public. Chapters were urged to conduct educational programs on cost containment. The national office sent chapters extensive bibliographies on the topic as a reference.
- *Publications.* A cost containment booklet was developed and distributed at the Annual National Institute (ANI), where attendees could also visit a cost containment information booth. The HFMA journal carried articles that focused on the philosophy of cost containment and effective strategies and techniques.

- *Friendly competition.* A cost effectiveness contest was launched in 1976 and continued through the mid-1980s. Selected ideas that HFMA members could easily replicate or adapt were featured in HFMA's journal and published in a notebook. In 1978, the national committee praised the winning entry in the cost effectiveness contest for taking ownership of the cost effectiveness challenge: “[This winning entry embodies the idea that] the most effective attack on cost-related problems can be waged only when the department manager accepts it as part of his or her job.”

Health expenditures rebounded quickly after the Voluntary Effort ended, leading some to label it as a failed initiative.² In any event, the collaboration and grassroots activism that characterized HFMA's response to the Voluntary Effort set the stage for initiatives that HFMA undertook to improve the healthcare payment system in the decades that followed.



Choosing a theme for the chair's leadership year had been an Association tradition since 1953. In the 1970s, logos were developed to accompany the taglines. HFMA 1976-77 Chair Clarence F. Legel, FHFMA, chose a patriotic theme to mark the occasion of the Association's 30th anniversary.

“The most effective attack on cost-related problems can be waged only when the department manager accepts it as part of his or her job.”

Formalizing a structure for technical guidance.

In 1975, HFMA established the Principles and Practices (or P&P) Board. This group of 12 dedicated HFMA volunteers was charged with developing positions on technical issues relating to accounting and financial reporting.

The HFMA Board subsequently approved an expanded scope of work for the P&P Board in 1995. In order to establish a consistent perspective for advocacy efforts and to facilitate a more timely response to emerging issues, the P&P Board began preparing issues analyses in addition to position statements.

The P&P Board works with the American Institute of Certified Public Accountants, the Financial Accounting Standards Board and the Government Accounting Standards Board to address the unique financial reporting needs of healthcare organizations and improve consistency in accounting and financial reporting. A list of guidance developed by the P&P Board over the years is in the [Appendix](#).

HFMA opens a Washington, D.C., office

The ESP spurred the establishment of HFMA's Washington, D.C., office. "Nixon's price freeze had been very unfavorable to the healthcare field, and we felt we needed more of a presence in D.C. to learn what was going on," said Ronald Kovener, FHFMA, who had just finished a term as HFMA president when he moved from Chicago to the nation's capital to open the office in 1973. "So, I put up my hand and said, 'I'd like to do that,' and they took me up on it."

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

To keep members informed, Kovener created WASHLINE, a weekly three-minute recorded phone message that provided an update on



what was going on in the nation's capital related to healthcare finance. "At that time, when you made a long-distance phone call, you paid a fixed amount for three minutes," said Kovener. "Anything over that was at a variable rate, so I devised this tape-recorded message that was exactly three minutes long. I scripted it very carefully and then recorded it on a reel-to-reel tape recorder."

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

Delving into graduate education. Another major initiative undertaken by HFMA in the 1970s involved a collaboration with universities to offer graduate education in healthcare management. Given that a college degree had become a prerequisite for hospital accountants in the 1960s, an advanced degree was the next logical step as the knowledge base in the field continued to grow.

Leveraging grant funding. In 1975, the HFMA Educational Foundation, in conjunction with four participating universities, was the recipient of a multi-year \$680,000 grant from the Kellogg Foundation for the purpose of developing an intensive healthcare management program at the graduate level. In its role as overseer, the HFMA Educational Foundation insisted on adhering to strict entrance requirements and close monitoring of off-campus study. Eventually, an executive graduate program network evolved from the Kellogg grant program. The network added three more universities to the mix.

Advancing higher education. In Shelton’s account of HFMA history, he observed that healthcare financial management’s development as a specialized area of scholarship in the 1970s paralleled an era of rapid and complex changes in the field. HFMA and its foundation played a profound role in influencing these changes. Fifty years later, HFMA would continue to be in the vanguard of graduate education, partnering with [Boise State University](#) on an innovative [master’s degree in population and health systems management](#).

Moving on to the next industry challenge.

The proposed Hospital Cost Containment Act of 1977, along with the Voluntary Effort implemented in lieu of that legislation, were presented to Congress as interim measures to curb hospital spending growth while a prospective payment system was being developed. In the early 1980s, prospective payment for Medicare would come to fruition.

CHAPTER 3 ENDNOTES

¹ Gold, M., Chu, K., Felt, S., et al., “Effects of selected cost-containment efforts: 1971-1993,” *Health Care Financing Review*, Spring 1993, pp. 183-225.

² Catlin, A.C., and Cowan, C.A., “[History of health spending in the United States, 1960-2013](#),” Nov. 19, 2015.

“If there is to be any concern for rational allocation of resources between the health field and other national priorities, if there is to be any notion of maximizing human welfare through quality healthcare, the rational development of competent financial managers is imperative.”

— Robert DeVries, programming director,
W.K. Kellogg Foundation

1970s Association Milestones

ANI moves to University of Boulder (Colorado).



HFMA opens an office in Washington, D.C.

HFMA is incorporated in the state of Illinois.

1970

1971

1972

1973

1974

1975

1976

1977

1978

1979

First Board of Directors award is presented to Stanley A. Presser.

Principles & Practices Board is established.



Upon Robert Shelton's retirement, James T. Whitman, FHFMA, CPA, is hired as HFMA's first full-time salaried CEO, with the title of president.

CHAPTER 4: 1980s

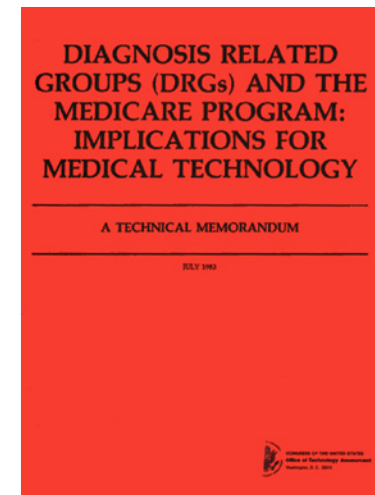
The introduction of prospective payment

Medicare introduced the Inpatient Prospective Payment System in 1983 in an effort to curb hospital spending growth. Between 1965 and 1984, overall Medicare costs increased by 1,400%, as compared with a 242% growth in the consumer price index during the same period.³ It had become evident that the fee-for-service payment model was economically unsustainable for the Medicare program.



Making the payment model transition on a system level.

DRGs, the cornerstone of the prospective payment system (PPS), were built around a seemingly simple concept: Medicare began paying hospitals a flat fee for an entire hospital stay. The hospital was then at risk for the money it spent on caring for Medicare patients; it had to absorb the extra costs if it spent more than Medicare paid. And it could keep the extra money if it could discharge a patient before the Medicare payment was expended.



This technical memorandum published by the U.S. Congress Office of Technology Assessment concluded that in the long run, the success of DRG payment would rest on its flexibility and adaptability to changing costs and technologies.

DRGs may not sound like a dramatic change to readers in the 2020s. HFMA 2002-03 Chair Phyllis Cowling, FHFMA, CPA, puts it in perspective. “When Medicare initially switched to prospective payment, contractual allowances were a write-up to revenue for some organizations,” Cowling said. “In other words, Medicare payments exceeded hospital charges. However, with changes to chargemasters and prospective payment rates, contractual allowances quickly became revenue write-downs.”



Through the mid- to late 1980s, the prospective payment system seemed to achieve its goals. Medicare hospital payment growth

dropped from 16.2% a year in 1980-83 to 6.5% annually in 1984-87, while hospitals compensated by increasing efficiency. Patient outcomes were apparently not affected. The cost reduction expertise that finance leaders had acquired in the [Voluntary Effort](#) of the late 1970s was put to good use as hospitals scrambled to cut costs further. Areas such as

The cost shift would stick, and it would have ramifications for healthcare finance for decades to come

labor and supply chain were frequent targets for cost-cutting initiatives. (A focus on reducing the cost of patient care and reengineering care models was still years away.)

Experiencing unintended consequences. In 1992, health researchers Robert Coulam and Gary L. Gaumer teamed to write a [review of the professional literature on the prospective payment system](#). They found that “dire consequences” (for both patients and hospitals) had not materialized from DRG-based payment, but they cautioned that there was reason to be concerned about the financial health of hospitals because payment rates were not keeping pace with cost growth.

Their point was well taken. In a review of a 2006 [book](#) by Rick Mayes and Robert A. Berenson, the authors describe how below-cost Medicare hospital reimbursement rates precipitated a cost shift by hospitals from Medicare to private payers.

...The mother of unintended consequences in [Medicare] history is Congress’s eventual discovery that the annual DRG update factor could be a very powerful and convenient deficit reduction tool.... No matter how much the hospitals hollered, Congress could ratchet down the updates as needed to meet budget targets. By the end of the decade, Medicare’s hospital expenditures were 20% lower than pre-PPS projections... Once Congress appropriated the update mechanism to slash deficits, hospital payments from Medicare began to fall below costs, and hospitals responded by raising their charges to private payers. Thus, *costs per se were not necessarily out of control; but private employers and insurers were on the receiving end of a cost shift precipitated by the effectiveness of Medicare’s new spending discipline* [emphasis added].⁴

As it turned out, the cost shift would stick, and it would have ramifications for healthcare finance for decades to come, as employers and other care purchasers pursued different strategies for reducing the cost of health insurance premiums and their overall healthcare spend.

Adapting to the new payment model on an individual level. In 1983, healthcare finance professionals needed to get up to speed on Medicare DRGs and do it quickly. In New Jersey, which had adopted DRGs for all payers in 1978, several years before the advent of Medicare DRGs nationwide, the state’s HFMA chapter had stepped up to meet the need for professional education. “Our local HFMA chapter became an essential training ground for hospital financial managers,” said HFMA 2011-12 Chair Gregory M. Adams, FHFMA, who was CFO at Beth Israel Hospital in Passaic, New Jersey. “The chapter developed programs to educate staff and provide networking opportunities for CFOs and others to exchange ideas. Since this predated the [merger and consolidation era](#) there was less competition among hospitals and more of a cooperative effort to help each other manage under this new system.”

In Adams’ view, the introduction of DRGs provided up-and-coming finance professionals with an opportunity to demonstrate their value to their organizations and advance quickly in their careers. “Being in the early stages of my career, the transition to DRGs provided a huge opportunity for professional growth,” said Adams. “Those of us who were eager to learn were able to develop the new skills needed and advance very rapidly in our careers. I don’t think I could have become a CFO at age 27 without the opportunity to meet a challenge of this magnitude.”

The change played a significant role in elevating the role of finance professionals within the hospital hierarchy, according to Adams. “In my opinion, this major shift in payment models spurred the elevation of the CFO’s role from that of an accountant, whose primary responsibility was to ensure that financial statements were accurate and balanced, to a strategic thinker who needed to look at how different variables impacted the financial performance and viability of a hospital,” Adams said.

“In my opinion, this major shift in payment models spurred the elevation of the CFO’s role from that of an accountant to a strategic thinker.”

— Gregory M. Adams, FHFMA,
HFMA 2011-12 Chair

Cowling agrees with Adams. “Prospective payment changed the role of healthcare finance professionals,” she said. “Before that, finance was all about retrospective reporting. Finance started working as a true partner to operations when prospective payment was introduced. It created an incentive for cost management, which emerged as a necessary skill for finance. Management information systems, medical records, and documentation and coding all became important to finance professionals.”

Developing capabilities for financial benchmarking.

For HFMA members, along with a need to understand the mechanics of prospective payment and strategies for cost reduction came an interest in benchmarking an organization’s financial results against peer organizations.

After more than three quarters of HFMA members expressed interest, an HFMA-sponsored ratio analysis service was developed under the direction of William O. Cleverley, Ph.D., founder of Cleverley & Associates, who was then associate professor of hospital and

health services administration at Ohio State University. The service provided detailed profiles of financial statements, analyzed trends and compared data from groups of hospitals of similar size or in common geographical areas. The financial analysis service grew to include 29 ratios presented in an easy-to-follow format on a trend and peer-comparison basis. After 11 years, the 1990 version of the database boasted more than 2,500 hospitals and its companion database had grown to more than 1,100 subscribers. The Financial Analysis Service was a precursor to HFMA’s [MAP initiative](#), which would be launched in 2010.

Expanding the scope of research. In addition to developing benchmarking capabilities, HFMA started building its research capabilities and partnerships in the mid- to late 1980s, a trend that would continue in the decades that followed. Research projects during this period addressed the state of the art in cost accounting, profiled success factors for healthcare financial management executives and assessed the impact of hospital marketing practices on financial management.



HFMA developed a financial ratio analysis service.



The challenge of adapting to the new Medicare payment model was captured in the theme developed by HFMA 1980-81 Chair Gerald W. Fuller, FHFMA.

Changes at HFMA. In addition to guiding members through major changes in the healthcare industry, big changes were in store for HFMA as an organization during the 1980s, including changes in its name and executive leadership.

HFMA changes its name – again. Spurred in part by the change in economic incentives and by advances in medical technology, healthcare delivery in the 1980s was shifting from inpatient settings to outpatient facilities, including physician offices and ambulatory surgical centers. In 1981, HFMA's board recommended that the Association change its name to more appropriately reflect “the industry in which we now function.” The

Hospital Financial Management Association was no longer exclusively geared to hospital-based finance professionals.

So, just 13 years after the American Association of Hospital Accountants changed its name to the Hospital Financial Management Association, the organization voted to change its name once more. From 1982 on, it would be known as the Healthcare Financial Management Association, a name which would still be relevant in 2021. Some 90% of the Association's 21,000 members endorsed the name change.

Changes in executive leadership. HFMA's first salaried president and CEO, *James T. Whitman*,

FHFMA, CPA, held the position from 1978-82 and presided over the Association's move from the AHA headquarters building in downtown Chicago to a suburban Chicago location.

Whitman was followed by *Michael Doody*, who held the office from 1983-86. Doody was instrumental in changing the location of the Annual National Institute (ANI) from the University of Colorado in Boulder, which could accommodate only 500 attendees, to a major metropolitan hotel site, facilitating the participation of business partners and the introduction of the ANI Exhibit Hall in 1986.



1982



1984



2001



2017

Clarke assumes CEO role.

In 1986, Richard L. Clarke, DHA, FHFMA, was named as HFMA's third president and CEO. Although his plan was to stay in the position for five years, he would retire from the job more than two decades later, in 2012. Clarke brought solid academic credentials, including a doctorate in health administration, and an in-depth knowledge of the Association. He had attained Fellowship in HFMA in 1983, had served as president of HFMA's Colorado Chapter and was a member of HFMA's Principles and Practices Board.



Richard L. Clarke, DHA, FHFMA, pictured in 2007, was HFMA's president and CEO from 1986 until his retirement in 2012.

Moving into the 1990s. With Clarke at the helm, HFMA was well positioned for the 1990s, a decade when healthcare industry challenges related to cost containment would continue, leading HFMA and the industry in new directions.

CHAPTER 4 ENDNOTES

³ Freeland, M., and Schendler, C., "[Health spending in the 1980s: integration of clinical practice patterns with management](#)," *Health Care Financing Review*, Spring 1984, pp. 1–68.

⁴ Cunningham, R., "[Prospective Payment: Medicare's Secret Success Story](#)," (book review). *Health Affairs*, May/June 2007.

Working toward standardization in billing: The UB-82 saga

In an increasingly complex third-party payment environment, the value of having a single billing form and standard data set, accepted by all providers and payers in the nation, would seem to be readily apparent. Yet, the process of developing a uniform billing form was long and circuitous. HFMA's efforts to standardize billing forms for all payers dates back to the 1950s. HFMA's persistence brought results, in the end.

- **1957:** HFMA lauds its South Carolina chapter for collaborating with the South Carolina Hospital Association on a standard billing form that was accepted by many stakeholders in the state.

- **1968:** HFMA leaders spoke with the director of the Medicare program about the development of a uniform bill and offered HFMA's services in executing the program.
- **1968-75:** HFMA and the AHA went through an on-again, off-again process of developing and refining a uniform bill that would be acceptable to all parties.
- **1982:** After many years of debate and discussion on data/policy issues, the National Uniform Billing Committee (NUBC) voted to accept the UB-82 data set for implementation as a national uniform bill.

As of 2021, HFMA continued to have a representative on the NUBC.

1980s Association Milestones



Richard L. Clarke, DHA, FHFMA, is named president and CEO of HFMA.

The Hospital Financial Management Association changes its name to the Healthcare Financial Management Association.

Joint seminars with the U.K. Association of Health Service Treasurers are launched in London.

First Robert M. Shelton Award for Sustained Chapter Excellence is presented. The Massachusetts chapter is the first recipient.



HFMA moves from the AHA headquarters building in downtown Chicago to a suburban Chicago location.

ANI is held in Boulder, Colorado, for the last time.

ANI is held in a hotel for the first time (in Philadelphia). Meetings in subsequent years were held in destination cities like Anaheim, New Orleans, Las Vegas and Orlando.

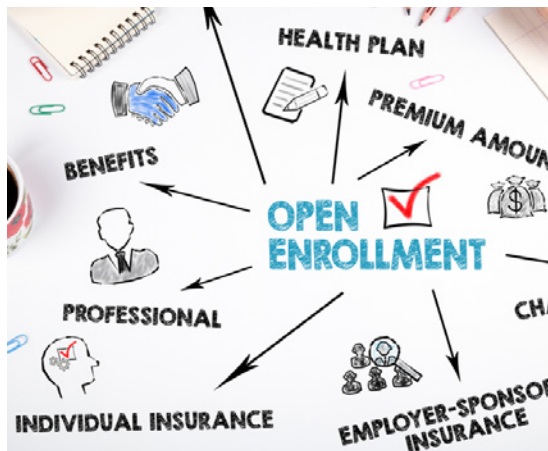
Exhibitors participate in ANI for the first time. Thirty companies are represented.



CHAPTER 5: 1990s

Trends converge

Sometimes, a number is worth a thousand words. Here is that number: 14%. Only 14% of Americans with employer-sponsored insurance still had traditional fee-for-service health coverage in 1998, down from 71% in 1988.⁵ Many employees were converted to HMOs and other managed care plans by their employers, who were seeking relief from rapidly increasing



premiums for traditional plans. The federal government had switched to prospective payment for Medicare in the 1980s in an effort to curb the rate of growth in its healthcare spending; the “managed care revolution” of the 1990s could be viewed as employers’ effort to do the same in the private sector.



HFMA 1989-90 Chair Sister Geraldine Hoyler, FHFMA, chose a theme and logo that reminded members that their choices would shape the future.

Assessing the impact of managed care.

Policymakers and practitioners alike have debated the impacts of managed care on costs, prices, quality of care and patient outcomes during the 1990s. Toward the end of the decade, the focus of the discussion expanded to the consumer backlash against managed care, and an analysis of what went wrong.

HFMA 2011-12 Chair Gregory M. Adams, FHFMA, views the consumer reaction to managed care in the 1990s as a moderating force that helped the industry move forward. “In my experience, there was more of a pushback than a backlash,” said Adams. It became apparent that consumers in our market did not want to be in restrictive managed care networks such as HMOs but preferred more consumer-friendly PPO networks. Managed care evolved into a less restrictive model of care and continued to grow market share with this change.”

For many healthcare finance professionals, managed care contracting quickly became an important skillset. Relationship dynamics

between payers and providers grew more complicated, as did those between physicians and hospitals. Pricing strategies also became more important to provider organizations.

HFMA adds resources on managed care and quality. The Association developed resources to support members in acquiring the skillsets they needed for the managed care environment. For example, the 1992 Annual National Institute (ANI) lineup included a new seminar on managed care and the financial manager, and a program called “Developing Profitable and Competitive Ambulatory Surgical Services,” which addressed the continuing shift in care delivery toward outpatient settings. In addition, the increasing complexity and importance of physician relations in a managed care environment led to a new course track at the 1994 ANI. When it became clear that managed care was here to stay, HFMA launched a certificate program called Certified Technical Specialist in Managed Care.



HFMA 1991-92 Chair Joanne Judge's theme for her leadership year reframed quality-related expenditures as an investment, not an expense, a concept that would still be relevant 30 years later.

The focus on reducing cost also gave rise to a growing awareness of the relationship between cost and healthcare quality. Quality initiatives “will translate not only to greater customer satisfaction but to bottom line improvements,” said HFMA 1991–92 Chair Joanne Judge, Esq., FHFMA, CPA. “Quality remains only a vague ideal unless it can be measured and compared to something else, a task perfectly suited to financial managers. ... When you look at the cost of poor quality, it’s amazing.” The first Annual National Institute (ANI) linking quality and finance was held during this period.

Managed care drives industry consolidation.

The conventional wisdom is that managed care led to what was later called the first wave of hospital consolidation by reducing the demand for inpatient care, changing the bargaining power of hospitals relative to health insurers and enhancing the value of contracting with an integrated hospital system. The “merger mania” of the 1990s ensued, in which both hospitals and physician practices were rolled up into hospital systems.

Watching consolidation unfold. In his role as senior vice president of Jewish Hospital in St. Louis, HFMA 1994-95 Chair John P. McGuire, FHFMA, CPA, watched as mergers ramped up in that area. “There are 42 hospitals in the metropolitan St. Louis area,” McGuire explained in a 1994 interview published in *hfm*. “Until Barnes Hospital and Jewish Hospital established our affiliation in November 1992, there were no ‘systems’ as such...But the escalating costs of healthcare are changing all that. [In the past couple of years] two other groups have announced affiliations. What is happening in

St. Louis is a microcosmic example of what is happening around the country.”

HFMA 2011-12 Chair Gregory M. Adams, FHFMA, recalls this period as one of both opportunity and risk. “From a CFO perspective, the opportunity was to continue to grow as a professional by gaining the responsibility of managing the financial operations of multiple hospitals, bearing in mind the different characteristics of each hospital and the impact on overall system financial performance,” Adams said. “The risk arose from how quickly the cultures of each organization meshed from standalone hospitals to an integrated health system.”

Experiencing the ripple effects. As the healthcare finance workforce was disrupted by waves of consolidation and the price squeeze of managed care, HFMA responded, both to support members and to ensure its own continuing financial viability.

In 1993, the Association set up a scholarship fund that acknowledged the growing number of newly unemployed members. Funds were made available for HFMA internships, study at accredited master’s degree, professional development and certification programs.

As the healthcare finance workforce was disrupted by waves of consolidation and the price squeeze of managed care, HFMA responded, both to support members and to ensure its own continuing financial viability.

The first of what would ultimately become 25 chapter scholarship programs were established that year.

HFMA also embraced significant numbers of finance people working outside of acute care, particularly in managed care and in physician group practices. “There will be an increasing need for education to help members who are leaving hospital-based positions and moving into other areas of healthcare financial management,” said HFMA 1995-96 Chair William H. Nelson.

Putting a difficult time into perspective. Looking back, HFMA President and CEO Richard L. Clarke, DHA, FHFMA, viewed the mid-1990s to mid-2000s as the most challenging period of his tenure at HFMA.

“The draconian changes made to Medicare payment policies in the Balanced Budget Act of 1997 caused a significant shortfall for many hospitals,” said Clarke, referring to legislation that had included the largest payment cuts in the history of Medicare.⁶

“At the same time, managed care organizations had developed quite a bit of negotiating power, so it was becoming very difficult to get price increases on the commercial side. And one of the first things hospitals do when they get into financial difficulty is to cut memberships, travel and education — and that’s what we sell.”

For the first time, HFMA membership went down — a 10% drop in just one year. As Clarke said, “We had the double whammy of really needing to be there to help our members deal with a significant environmental challenge at a time when they couldn’t pay for the resources we were offering.”

Guiding the healthcare industry to get back on track

Revelations of corporate fraud and abuse in the late 1990s, heralded by headlines about whistleblower lawsuits, Medicare fraud charges and Office of Inspector General audits, resulted in rapid growth in regulatory oversight. Never an organization that avoided tough topics or critical conversations, HFMA developed multiple educational resources on compliance, including a dedicated full-day program at ANI, a sold-out compliance conference, training tapes, a publication and a special interest forum.

“It was a situation that could have gone very badly,” reflected Lawrence A. Laddaga, Esq., FHFMA, when he was interviewed in *From Acorn to Oak and Beyond*, years later. “But HFMA approached it proactively...HFMA

was out in front, educating its members—providing them with the information they needed to develop and implement sound compliance plans, persuading them that this was something they needed to do.”

HFMA 1999–2000 Chair Richard J. Henley, FHFMA emphasized the importance of going beyond compliance: “The image of the healthcare industry is tarnished. My advice is to be proactive: Develop a culture that supports and mandates ethical behavior.” Henley’s chair theme, shown below, embodied that advice.



Entering the Internet era. The 1990s brought opportunities for HFMA as well as challenges. With the launch of its first website in 1995, the Association’s ability to deliver timely information was transformed overnight. New membership benefits were added frequently as the website expanded and navigation became easier.

The Association conducted a member needs survey every year and tracked website activity so it could respond swiftly and thoroughly. HFMA technical staff began meeting regularly with its three [national advisory councils](#), or NACs, which provide professional perspective to the Association on thought leadership topics that are important to HFMA members. The focus of these councils would change over the years. In 2021, the NACs focused on strategy and innovation, payment models and revenue cycle, respectively.

Shaping regulations governing electronic transactions. The advent of new technology often brings new legislation and regulations. HFMA played a role in shaping the far-reaching federal HIPAA legislation, which was enacted in 1996 to create standards for the use and dissemination of healthcare information.

The HIPAA administrative simplification provisions mandating uniform use of electronic transaction standards include language that was a direct result of HFMA’s work with various legislative and regulatory groups over a multi-year period, including drafting bills, testifying, and providing analysis and commentary.

Over the years, HFMA went on to develop a number of resources on HIPAA, ranging from an e-learning course on HIPAA basics and a [sample job description](#) for a HIPAA compliance coordinator to [tips](#) for staying HIPAA compliant on social media.

Launching a diversity initiative. As a workforce issue, diversity predated the 1990s by several decades. However, the 1990s saw initiatives related to workforce diversity move beyond regulatory compliance to a recognition of the core principles of social justice and the benefits a more diverse workforce could bring. In the early 1990s, HFMA created a National Diversity Task Force, which was chaired by Dalton A. Tong, FHFMA, CPA. It is believed that Tong was the first Black member of the HFMA Board (though HFMA does not have records on the race of Board members.)



With the launch of its first website in 1995, the Association’s ability to deliver timely information was transformed overnight.

In a 2021 *hfm* [interview](#), Tong, who also had served on the HFMA Board from 1993 to 1995, reflected on a 50-year career spent serving in various roles in healthcare finance practice and education.

In the interview, Tong spoke of seeing progress and improvement over the years, as well as the need for new efforts to bolster low-income, minority patients and attract more Black professionals into the field.

“Why do Black students want to go to engineering school? They see Black astronauts,” Tong said. “Why do they want to go to medical school? Why do they want to become lawyers? They see pictures, they see evidence of the



HFMA 1993-95 Board member Dalton A. Tong, FHFMA, CPA, pictured in 2021.

investments and the rewards. Healthcare finance should do the same thing.”

Tong’s hard-won insight on challenges and opportunities for improvement stems from nearly three decades spent working in various healthcare finance and leadership roles in the Baltimore-Washington, D.C., region followed by 20 years instructing new generations of students on the intricacies of healthcare finance.

Learning from experience. Looking back on the wave of provider consolidation in the 1990s, an [HFMA thought leadership piece on payment reform](#) published 10 years later in 2009 concluded that cultural differences between affiliation partners — such as rural versus urban cultures or religious versus secular views — contributed to the failure of many organizations that attempted to integrate during that time.

HFMA 2002-03 Chair and United Regional Health Care System President and CEO Phyllis Cowling, FHFMA, CPA, was CFO of St. Anthony’s Hospital in Amarillo, Texas, in 1996 when St. Anthony’s merged with Baptist Hospital to form Baptist St. Anthony’s Healthcare System. “In any merger, you spend an inordinate amount of time on both legal and financial matters,”

Cowling said. “But, in my opinion, it really comes down to culture. The ability to blend cultures — or develop a new one — is ultimately what makes or breaks a merger.”

HFMA later advised finance leaders to take these “soft” considerations into account both in its 2009 payment reform report and in its subsequent research on [mergers and acquisitions](#), which was published in 2016.

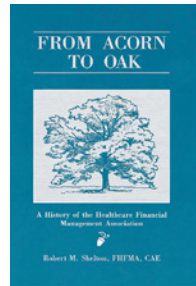
HFMA also leveraged the lessons the industry learned from the 1990s, when many consumers resisted HMO processes that consumers found difficult to understand and accept, such as gatekeepers and prior authorization requirements. Starting with HFMA’s [PATIENT FRIENDLY BILLING® initiative](#), the Association’s consumerism initiatives of the 2000s and ’10s would emphasize the importance of clear, consistent, accurate and respectful communication about price information and other financial matters.

CHAPTER 5 ENDNOTES

⁵ Stanford Graduate School of Business, “[Managed care: What went wrong? Can it be fixed?](#)” Nov. 1, 1999.

⁶ Vladeck B.C., “[Plenty of nothing—a report from the Medicare commission.](#)” *New England Journal of Medicine*, May 13, 1999, pp. 1503–1506.

1990s Association Milestones



From Acorn to Oak: A History of the Healthcare Financial Management Association is published.

HFMA's first website is launched at hfma.org.



Davis Chapter Management System is introduced, honoring chapters for their own achievements without inducing competition among chapters.

Citi, HFMA and the American Hospital Association cosponsor the First Annual Not-for-Profit Healthcare Investors Conference.

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1991

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1995

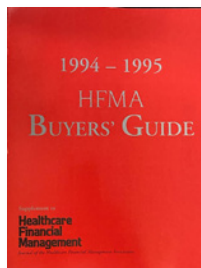
1996

1997

1998

1999

HFMA's Chapter Advancement Team of trained volunteer consultants is established, with a mission to build stronger chapters, one chapter at a time.



The first *hfm Buyer's Guide* is published.



Certified Healthcare Financial Professional designation is added to the certification program.

HFMA comes together with six other groups serving the C-suite to form the Health Leadership Alliance, which goes on to develop the *HLA Competency Directory*, identifying 300 professional competencies across five major domains of healthcare management.

CHAPTER 6: 2000-11

The volume-to-value shift begins

In 2001, the U.S. economy fell into recession. During the early 2000s, the pace of mergers and acquisitions slowed and many of the physician practices hospitals had acquired in the 1990s were divested. Meanwhile, national health expenditures as a percentage of GDP jumped from 13.3% in 2000 to 16.1% in 2005, after increasing at a moderate rate during the 1990s.



In the wake of the 1997 Medicare payment cuts and the 2001 recession, many hospitals were struggling financially. At the same time, pressure was growing on provider organizations to squeeze more efficiencies out of their operating budgets. The revenue cycle provided a logical opportunity area for finance leaders.



During difficult times, the theme chosen by HFMA 2000-01 Chair Connie S. Cape, FHFMA, CPA, inspired HFMA members to imagine the possibilities for a better future.

Exploring revenue cycle improvement strategies.

As Michael Allen, FHFMA, CPA (who would go on to become HFMA's 2019-21 board chair) said, “[Hospitals] realized that, in order to survive, they were going to have to make their operations as clean and efficient as possible, and they began to look much more closely at their revenue cycle.”

HFMA President and CEO Richard L. Clarke, DHA, FHFMA, agreed. “Hospitals and health systems need to do more with less,” [said](#) Clarke. “In the revenue cycle, operating efficiently and securing appropriate payment are imperative.”

During the early 2000s, HFMA tackled revenue cycle improvement by developing information

sheets about streamlining payment processes, conducting audioconferences and offering Annual National Institute (ANI) sessions with top revenue cycle experts who addressed the topic on a strategic level.

Developing a reputation as the authoritative source on revenue cycle. During the 2000-11 period, HFMA developed revenue cycle offerings that included publications, certification, an educational conference, and eventually a comprehensive revenue cycle performance improvement initiative that recognizes organizations for revenue cycle excellence.

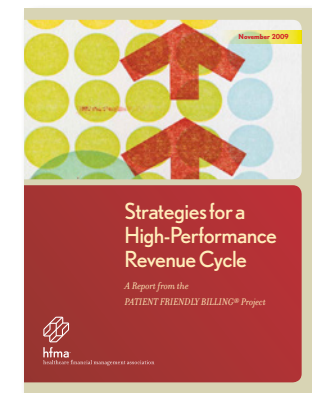
HFMA's early revenue cycle education

Program lineups at ANI in the early- to mid-2000s included sessions that addressed revenue cycle from a variety of angles, including:

- Key performance indicators
- Clinical aspects of revenue cycle management
- Quality and safety as revenue cycle drivers
- Maximizing employee competencies and resources
- Outsourcing revenue cycle functions
- Linking revenue cycle and supply chain
- Hospital financial turnaround and the revenue cycle
- Extreme revenue cycle makeover
- Leading the “ultimate revenue cycle revolution”

“Hospitals and health systems need to do more with less. In the revenue cycle, operating efficiently and securing appropriate payment are imperative.”

— 1986-2012 HFMA President and CEO
Richard L. Clarke, DHA, FHFMA



This 2009 HFMA report identified key revenue cycle differentiators for achieving high patient satisfaction and financial performance.

Publications. In 2004, HFMA's *Revenue Cycle Strategist* newsletter was launched, updating its *Patient Accounts* newsletter, which dated to 1978. A research-based report, *Strategies for a High-Performance Revenue Cycle*, was published in 2009. The report was informed by visits to high-performing sites nationwide and interviews with executives and revenue cycle staff. It included case studies demonstrating practical applications of high-performance strategies.

- **Certification.** In 2009, the Certified Revenue Cycle Representative (CRCR) certification program was introduced. Educational materials covered reducing denials, simplifying collections, understanding regulatory compliance, increasing interdepartmental cooperation and building confidence, among other topics. The CRCR certification offered a way for staff to be recognized as valued contributors to their organization's revenue cycle performance.
- **Educational conference.** In 2010, HFMA hosted the first MAP Event/Revenue Cycle Conference, which became a mainstay of its educational programming in this area.
- **Performance improvement initiative.** HFMA's comprehensive [MAP initiative](#), launched in



After HFMA extended the MAP Award for High Performance in Revenue Cycle to physician practices, four physician practice representatives were among the winners accepting awards at the 2015 ANI.

2010, draws its name from the tools it offers for measuring revenue cycle performance, applying evidence-based improvement strategies and performing to standards of excellence. There are several components to the MAP initiative.

- **MAP App.** HFMA built on the benchmarking expertise it had gained through the [financial ratio analysis service](#) it had offered in the 1980s to develop the [MAP App](#) in 2010. The MAP App enables hospitals to track performance at each stage of the revenue cycle, compare their results with those of peer groups and the industry, and identify proven strategies to achieve revenue cycle excellence.
- **MAP Keys.** The MAP App is built around a series of publicly available strategic key performance indicators, known as the

MAP Keys, which were developed by a task force of industry leaders led by HFMA and vetted with HFMA's Board of Directors and members of its National Advisory Councils. Originally designed for acute care hospitals and health systems, the MAP Keys were later expanded to apply to ambulatory providers, physician organizations and integrated delivery systems.

- **MAP Awards** for High Performance in Revenue Cycle, launched in 2011, recognize organizations whose innovative and effective strategies have enabled them to achieve excellence in revenue cycle performance. Originally based solely on revenue cycle performance, award criteria were later extended to include adoption of the [patient financial communications best practices](#) published by HFMA in 2014.

Recognizing the importance of a consumer-friendly revenue cycle. In the 1990s and 2000s, hospital business practices were oriented toward third party payers rather than consumers. In light of the rise of consumerism in the 1990s, HFMA made a strategic decision to guide the industry toward a more consumer-centric revenue cycle.

Starting the consumerism journey. In 2001, HFMA convened a task force on [patient friendly billing](#) in 2001, in collaboration with the American Hospital Association, the Medical Group Management Association, and other leading provider and professional organizations. The objective of the task force was to promote clear, concise and correct patient-friendly communications. Over the next six years, the task force produced several reports and practical tools, including two in 2006-07 that had a lasting influence on the field.

- *Reconstructing Hospital Pricing Systems* addresses consumerism on a macro level. Because of the complex way that healthcare payment and service pricing evolved, the authors wrote, “the resulting pricing of

services is almost impossible for the general public to understand, inhibiting transparency, price comparisons and trust in healthcare institutions.”

- *Consumerism in Health Care* focuses on what providers can do to improve billing and payment processes on an organizational level. “Billing is a fairly narrow area, but the concept really applies to all areas of the patient’s financial experience,” said project leader Terry Allison Rappuhn, CPA.

Keeping the revenue cycle focus on patients.

In 2006, HFMA released a training program designed for frontline employees and others with direct patient contact, called *Excellence in Customer Service*.

HFMA 2009-10 Chair Cathy Jacobson, FHFMA, CPA, emphasized the importance of the human aspects of the patient financial experience as she began her term. “Often, a patient’s first impression of a healthcare facility comes from someone in the finance department,” [Jacobson wrote in 2009](#). “People who come to a healthcare facility may be sick, scared and afraid they’ll have trouble paying for their care.

“Some strategies [in *Consumerism in Healthcare*] can be enacted in the short term. Others will take longer and include significant changes in structures and processes from multiple parties... It is up to all of us to start now to embrace consumerism.”

— 1986-2012 HFMA President and CEO.
Richard L. Clarke, DHA, FHFMA, writing the preface to the report in 2006.

hfma:
it's personal

The theme chosen by HFMA 2003-04 Chair David Canfield, FHFMA, captured the sense of belonging that was as important to HFMA members as the more tangible membership benefits.

We have the opportunity to allay some of these fears, center the experience according to the patients' needs, and help patients feel more comfortable from the start.”

Gaining recognition as a thought leader. Revenue cycle and capital access are areas that fit squarely within the healthcare finance domain. By the mid-2000s, HFMA was well positioned to address broader healthcare industry challenges on a strategic level.

HFMA Senior Vice President Richard L. Gundling, FHFMA, CMA, had responsibility for management of the Association's thought leadership efforts, led its Washington, D.C. activities and served as staff liaison to HFMA's [Principles and Practices \(P&P\) Board](#). “In the 2000s, as HFMA started engaging more with thought leaders both within our membership and from all sectors of healthcare, we expanded the scope of our initiatives,” said Gundling. “We develop thought leadership resources for members and their organizations as they navigate the changing healthcare landscape. At the same time, we serve as an important source of factual information and informed perspectives to legislators and policymakers.”

Developing resources to facilitate capital access

During the financially challenging period of the early 2000s, capital access became a pressing concern for many hospitals. To address the need for resources in this area, HFMA codeveloped an innovative conference and published a series of reports.

Connecting capital seekers with investors. In 1999, Citi, HFMA and the American Hospital Association had piloted the *Not-for-Profit Health Care Investor Conference*, held in New York, to provide a forum for not-for-profit hospitals and health systems to engage with investors. The conference format included a series of rapid-fire presentations to investors by provider organizations. The three sponsoring groups continued to host the conference every year thereafter.

“Put yourselves in the shoes of a mutual fund credit analyst who covers 50+ unique investments, or a private equity associate making her first investment in a not-for-profit healthcare organization,” [wrote](#) Citi's Brian S. Carlstead on the occasion of the conference's 20th anniversary in 2019. “Making their job

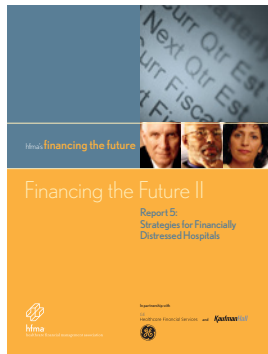


easier by consistently providing streamlined information and access to management will encourage investors to make an investment and maintain it over time.”

Providing strategic guidance. In 2003-04, HFMA published *Financing the Future*, a series of reports that featured key stakeholders sharing knowledge about and producing solid empirical evidence of healthcare capital needs and availability, as well as factors associated with capital access. Its cornerstone principle is this: Adherence to a rigorous corporate finance process is critical to a hospital's ability to increase access to capital, make wise investments in the organization's future and improve financial performance.

Results of HFMA's thought leadership initiatives have been used by hospitals, rating agencies, regulatory agencies, legislative committees, accounting standard-setting bodies, state hospital associations and other government and industry leaders.

Branching out into healthcare strategy at a macro level. The 2000s marked the release of environmental assessments, the development of various forums for thought leaders to share ideas and the publication of thought leadership on healthcare payment reform.



Assessing the environment. *Healthcare Finance Outlook* was a series of reports that offered a forecast of the likely state of the healthcare industry, leading indicators of industry change and practical strategies for margin and mission success in a changing environment.

Selected groups that have tapped HFMA for thought leadership and technical expertise

ENTITY	TOPIC
Committee on Energy and Commerce	Hospital pricing and billing
Committees of the House of Representatives	Sustainable growth rate
Congressional leaders	Support for maintaining the Oct. 1, 2015, ICD-10 compliance date
Consumer Financial Protection Bureau	Medical debt best practices
Costs of Care	Collaboration on annual story contest, which illustrates the importance of cost awareness in healthcare
Families USA	Opportunities to collaborate on consumerism
Federal Trade Commission and U.S. Department of Justice	Impact of healthcare competition
Financial Accounting Standards Board	Proposed accounting standards updates
Governmental Accounting Standards Board	Proposed statement on leases
Health Resources Services Administration	340B Drug Pricing Program
HHS	Collaboration on "A Bill You Can Understand" challenge
HHS Learning Action Network	Alternative payment models
HHS Office of Intergovernmental and External Affairs	Provider Relief Fund
Institute of Medicine Roundtable on Value and Science-Driven Health Care	Participation in the group
IRS	501(r) regulations
MedPAC	Cost-to-charge ratios
National Center for Health Statistics	Applicability of HIPAA Privacy and Security rules to the banking industry
National Quality Forum Measure Applications Partnership	Representation in the group
Office of Management and Budget	Proposed regulations on tax-exempt hospitals
U.S. House Committee on Ways and Means	Chargemasters
U.S. Senate Finance Committee	Recovery audit programs
U.S. Supreme Court	Qualifications for tax-exempt status for not-for-profit hospitals (amicus brief filed with other healthcare organizations)

Developing forums for thought leaders. HFMA developed several innovative forums that facilitated sharing of ideas among thought leaders during this period.

- The *Thought Leadership Retreat* was launched in 2007 as an annual event designed for senior clinical, financial and health plan executives to collaboratively discuss and develop strategies to address emerging trends. The event is held in partnership with the American Association for Physician Leadership, the Alliance of Community Health Plans and the American Organization for Nursing Leadership. Summary [reports](#) are available on hfma.org.
- The *Health Leadership Council* (HLC) was created in 2008 to provide the HFMA Board with perspectives that are typically outside the scope of HFMA members. By providing access to a broader array of thought leaders and developing linkages with key organizations, the HLC elevates the role of HFMA within the healthcare ecosystem.
- The *Large System Revenue Cycle Council* was chartered in 2009 to facilitate networking and the exchange of high level, noncompetitive

information on issues of concern to senior revenue cycle executives of large, multi-faceted health service organizations. The group also serves as a sounding board or focus group on financial issues, a research incubator and a professional network.

By the mid-2000s, HFMA was well positioned to address broader healthcare industry challenges on a strategic level.

HFMA's Principles and Practices Board provided timely guidance on charity care

In 2006, HFMA's P&P Board updated its Statement No. 15, which provided a basis for differentiating between charity care and bad debt and addressed congressional and legal issues concerning the reporting of bad debt by tax-exempt hospitals. The update was made in response to a 2006 report from the IRS regarding not-for-profit hospitals' compliance with the community benefit standard, a method the IRS used to determine if a hospital is exempt from federal income tax.

Pursuant to the IRS report, hospitals' tax-exempt status had come under scrutiny by policymakers. A [Congressional Budget Office report](#) had acknowledged that there was little consensus about what constitutes

a community benefit or how to measure such benefits. (Charity care, also known as uncompensated care, is one element of community benefit.) Differentiating charity care from bad debt often was a stumbling block for hospitals.

In 2009, the P&P Board also developed sample 501(c)(3) hospital charity care and financial assistance policy and procedures. The sample policy was updated in 2010.

The P&P Board would go on to update Statement No. 15 again in 2012 and 2019, with the latter update adding implicit price concessions as a third category along with charity care and bad debt, within uncompensated care.

Publishing thought leadership on healthcare payment reform. HFMA's Third Annual Thought Leadership Retreat in 2009 focused on payment reform. Keying off discussion that took place at this event, HFMA led an initiative to identify principles for reforming the nation's healthcare payment system and competencies that providers would need to succeed under

healthcare reform. The initiative's findings and recommendations are summarized in [four reports](#), the last of which was published in 2010.

As it became evident that federal legislation was imminent, later reports in the series emphasized the importance of collaboration among stakeholders across the care continuum, particularly between physicians and hospitals.



HFMA 2004-05 Chair Joyce Zimowski, FHFMA, CPA, suggested that finance leaders should go beyond the numbers in their decision-making process.

The Affordable Care Act: HFMA guided finance leaders through uncertain times

Many healthcare finance leaders remembered the 2009-10 period as one of great uncertainty as the major federal healthcare legislation of the decade was debated in the halls of Congress and in healthcare conference rooms.

During this period, HFMA provided its members with detailed summaries and analyses of the Patient Protection and Affordable Care Act's (ACA's) implications for

healthcare finance, while avoiding dwelling on the political aspects of the issue.

HFMA's 2010 Annual National Institute (ANI) in June was held just three months after the ACA was signed into law. At the conference, physician and former Senator Bill Frist delivered a keynote address focusing on how healthcare stakeholders could maximize value in healthcare delivery and use knowledge-based tools to rein in healthcare spending growth.

The passage of the ACA in 2010 did not end the debates about the merits of the legislation. After the 2016 presidential election, HFMA developed several resources to help the industry make sense of challenges to the law's constitutionality. The Association also assembled a blue-ribbon panel and hosted a web-based policy discussion during Inauguration Week in January 2017.

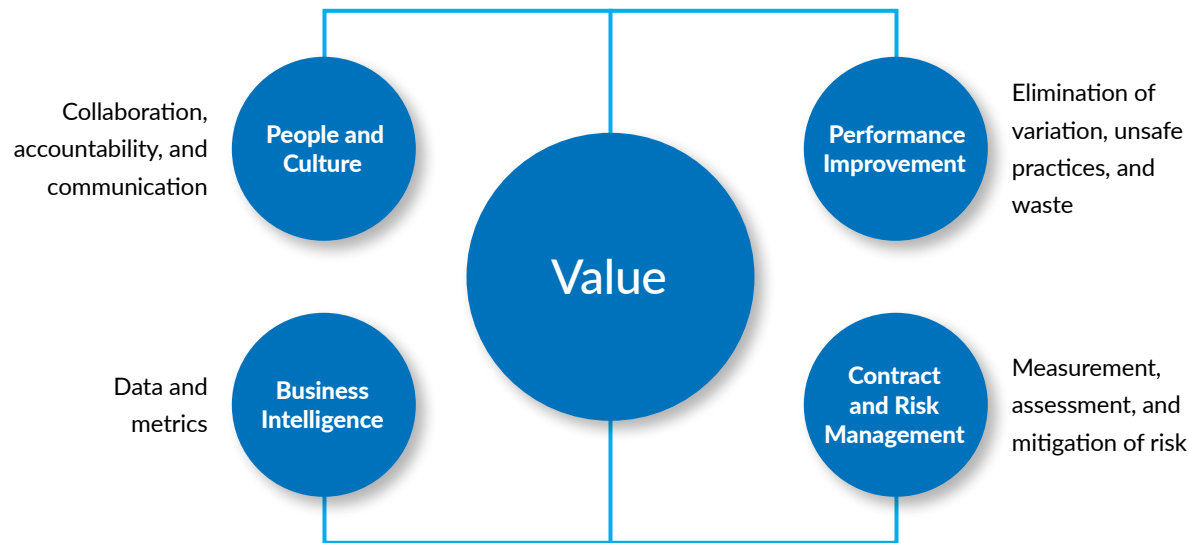
The authors also identified strategies providers could use to accelerate development of key competencies for success under payment reform. HFMA’s subsequent research on [delivering high-value healthcare](#) evolved from this work.

Thought leadership on payment reform informed research on value. During this period, HFMA undertook a multi-year initiative on [improving value in healthcare](#). More than a dozen hospitals

and health systems and several business partners provided intellectual and financial support for this research. Known as the Value Project, the research aimed to help guide the transition from a volume-based to a value-based healthcare payment system. The first series of reports, published in 2011, delved into building organizational capabilities for value.

Results from the [second phase](#) of HFMA’s value research would be published starting in 2012.

Encouraging members to take an active role in shaping the future. After an eventful decade, HFMA encouraged finance leaders to pursue value as a guiding principle. HFMA’s message to members was consistent: Don’t wait to see how external events play out. Focus on what your organization can do to build its capabilities for delivering high-value healthcare to patients and other care purchasers.



HFMA’s value research identified four key organizational capabilities for delivering high-value healthcare.

The Value Project research aimed to help guide the transition from a volume-based to a value-based healthcare payment system.

2000-2011 Association Milestones

Patient-Friendly Billing initiative is launched.



Consumerism in Health Care is published.

First Thought Leadership Retreat is held in Washington, D.C.



Credentialed Revenue Cycle Representative certification program is introduced.

MAP Initiative is launched.



2000

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Peer Review Program is launched, offering HFMA members a way to identify the healthcare business solutions their peers are using to deliver organizational savings and performance improvements.



Chapter Balanced Score Card is introduced.



Reconstructing Hospital Pricing Systems is published.

Large System Revenue Cycle Council is created.



HFMA releases a series of reports on improving the value of healthcare.

CHAPTER 7: 2012–2021

The pace of change accelerates

New eras don't necessarily correspond to new decades. HFMA President and CEO Richard L. Clarke, DHA, FHFMA, retired in 2012, after 26 years of outstanding leadership. During Clarke's tenure, HFMA had experienced membership and operating revenue growth and had developed a reputation for expertise in improving healthcare efficiency and effectiveness.



HFMA 2014-15 Chair Kari Cornicelli, FHFMA, CPA, presents Clarke with HFMA's highest achievement award at the 2012 annual conference.

Recognizing Clarke's many contributions. As tributes came in from the field, Clarke gave credit to HFMA members, with characteristic modesty. "Every day, I have been impressed by the dedication of HFMA members not only to the Association, but also to their role in improving our nation's health," Clarke said. "It has been an honor to serve with them and to support the mission of HFMA."

At the 2012 Annual National Institute (ANI), Clarke received the Board of Directors Award for outstanding contributions to healthcare. The award was renamed in his honor.

"Dick has touched the lives and helped shape the careers of generations of healthcare leaders. Over the years, we have all struggled to make sense out of our nation's increasingly complex and challenging healthcare delivery system. We have relied on Dick's analysis, insights and perspectives to help us chart a course forward."

— HFMA 2014-15 Chair
Kari Cornicelli, FHFMA, CPA

In presenting Clarke with the award, HFMA 2014-15 Chair Kari Cornicelli, FHFMA, CPA, said, “Dick has touched the lives and helped shape the careers of generations of healthcare leaders. Over the years, we have all struggled to make sense out of our nation’s increasingly complex and challenging healthcare delivery system. We have relied on Dick’s analysis, insights and perspectives to help us chart a course forward.”

Fifer takes the helm. Clarke had provided a year’s notice of his retirement plans, giving the search committee ample time to recruit a successor.

When Joseph J. Fifer, FHFMA, CPA, came on board as HFMA’s chief executive in 2012, he brought an in-depth knowledge of the Association, having served as HFMA 2006-07 Board Chair. He also brought experience as a finance leader in provider organizations, having spent more than two decades working in the field.

When Fifer made his first remarks as CEO at the 2012 ANI, he expressed confidence in the strength of HFMA as an organization. “Finance is in the spotlight as never before, with healthcare organizations challenged to drive down unsustainable costs while improving

About Joseph J. Fifer, FHFMA, CPA



Prior to assuming his role as President and CEO of HFMA, Joseph J. Fifer, FHFMA, CPA held executive financial leadership roles at

Michigan-based hospitals and health systems, including Spectrum Health, McLaren Health Care Corporation and Ingham Regional Medical Center. During his 11 years at Spectrum Health, an early adopter of consumer-facing price transparency, Fifer was a champion and key architect of the health system’s transparency initiative. He started his career with nine years at Ernst & Young, also in Michigan.

After joining HFMA, Fifer quickly became a sought-after speaker on consumerism, collaboration, value and other strategic topics at national conferences. In both his presentations and his writings, Fifer emphasized the need to look at the healthcare financial experience through

a consumer’s eyes, to value patients as healthcare consumers, and to focus on both long-term and short-term solutions to industry challenges. Fifer’s bylined articles have appeared in publications such as the Governance Institute’s *BoardRoom Press*, the Society for Healthcare Strategy and Market Development’s *Futurescan*, and the American College of Healthcare Executives’ *Frontiers of Health Services Management*. His industry insights also have been featured in *Modern Healthcare*, *Forbes*, *The Wall Street Journal* and other leading publications.

Fifer was Chair of the HFMA Board of Directors in 2006-07. An HFMA member since 1983, he served as a chapter president and for two terms as an HFMA Board member. He has received HFMA’s Medal of Honor and the Follmer Bronze, Reeves Silver and Muncie Gold merit awards.

A Fellow of HFMA and a CPA, Fifer received his bachelor’s degree in business administration from Saginaw Valley State University.

quality,” he said. “I am honored to assume this role at a time when finance professionals can deliver significant industry improvement. HFMA is in an outstanding position to lead these changes because of the foundation built by strong staff leadership, Board vision and member commitment.”

In discussing plans for the future direction of HFMA, Fifer said he intended to build on HFMA’s value and consumerism-related initiatives, and he affirmed that HFMA would continue to convene stakeholders to address other healthcare industry challenges. Fifer also talked about the importance of change leadership in a dynamic healthcare environment. “Don’t sit back and wait for changes to happen to you,” Fifer told attendees. “Create the future yourselves.”

The concept of embracing change would become a central organizing force in HFMA’s initiatives – both externally and within the Association – in the years that followed. Those change leadership initiatives centered around four themes.

- **Delivering value.** Both legislative and private-sector efforts to reduce healthcare spending in previous years had made it evident to HFMA

leadership that driving the delivery of high-value healthcare to care purchasers was imperative.

- **Collaborating with other healthcare stakeholders.** The complexity and scope of the healthcare industry’s long-term challenges had made it clear that no stakeholder could solve them alone.
- **Transforming experiences.** Changing societal expectations had led the Association to prioritize transforming the patient financial experience as well as the HFMA membership, learning and chapter leadership experiences.
- **Building capabilities for success.** HFMA aimed to continue expanding its offerings geared to supporting success on both the individual and organizational levels in an environment where the pace of change was continually accelerating.

Delivering value. When Fifer took the helm, HFMA was in the midst of a multi-year initiative known as the [Value Project](#). The project brought together leading health systems to explore the implications of the nation’s transition from a payment system that rewards volume to one that rewards value. Underlying HFMA’s guidance on the value transition was



All reports that are part of HFMA’s value initiative are compiled in this sourcebook.

an assumption that growing accountability for care outcomes in a value-based system would spur providers to continue the trend toward integration and assuming more risk for population health.

HFMA developed guidance on several aspects of the value transition:

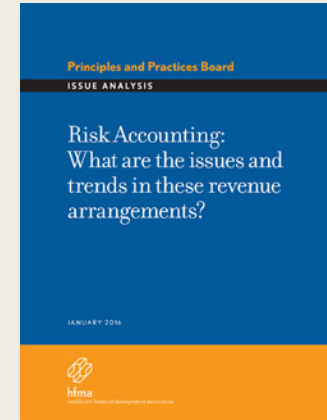
- Demystifying value-based payment models
- Accounting for risk
- Identifying key drivers and outcomes of provider consolidation
- Reconfiguring hospital and health system cost structure
- Analyzing impacts of value-based payment on the total cost of care

Demystifying value-based payment models. A 2012 HFMA report, *Defining and Delivering Value*, identified a range of strategies that combine various degrees of integration and risk. The report described key capabilities, benefits and challenges for each strategy.

Sharing experiences with value-based payment models. HFMA’s National Payment Innovation Summit, offered from 2016-18, brought together representatives from hospitals and health systems, physician practices and health plans to discuss topics related to evolving value-based payment models. It was hosted in collaboration with the Altarum Center for Value in Health Care and Catalyst for Payment Reform.

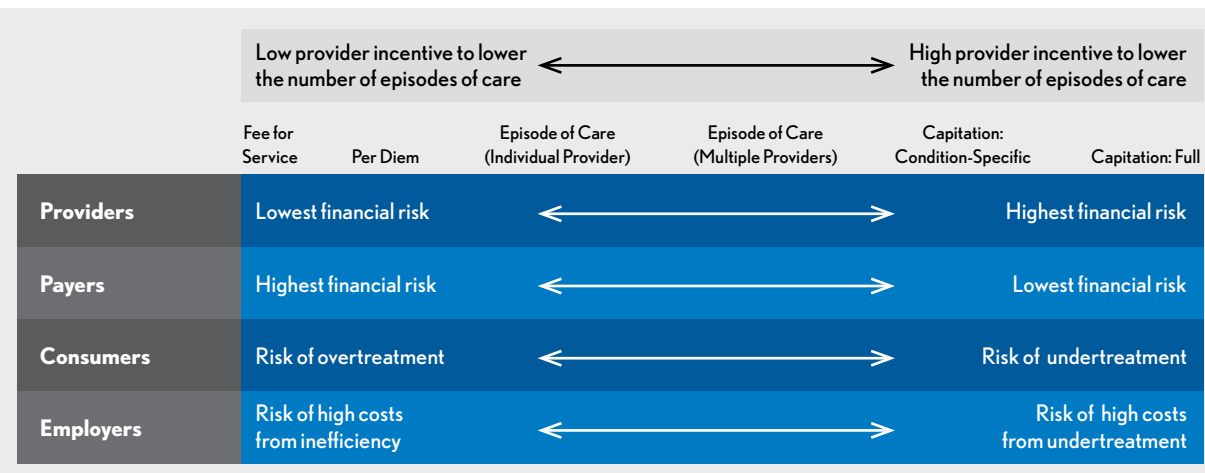
Identifying key drivers and outcomes of provider consolidation. A 2014 HFMA report, *Acquisition and Affiliation Strategies*, delved into the key drivers behind providers’ pursuit of mergers and other affiliations. The research revealed a movement toward mergers and acquisitions between financial equals. These value-focused strategies were geared toward improving the quality or cost-effectiveness of care, as opposed to dominating markets or adding acute inpatient capacity.

In 2017, HFMA, together with the Deloitte Center for Health Solutions, tackled a consolidation-related issue that had become a topic of great debate in healthcare circles: How mergers affect a hospital’s performance.



HFMA developed technical guidance for risk accounting

In addition to identifying strategies for experimenting with value-based payment, HFMA developed technical accounting guidance in this area. In 2016, HFMA addressed recognition of revenues and expenses and accrual of losses for risk contracts in a Principles and Practices Board issue analysis, *Risk Accounting: What Are the Issues and Trends in These Revenue Arrangements?*



HFMA’s research on healthcare value depicted alternative payment models in the context of shareholder risk.

Working independently of HFMA's Value Project study, researchers sought to determine whether the second wave of hospital mergers, which had begun in 2010, enabled hospitals to achieve economies of scale. In the report, *Hospital M&A: When done well, M&A can achieve valuable outcomes*, they concluded that higher operating margins for acquired hospitals did not immediately follow a merger. When market and hospital-specific characteristics were factored in, acquired hospitals experienced a post-transaction decline in operating margins, revenue and expenses that lasted two years, on average.

Many hospital financial executives who were interviewed for the study acknowledged that they had underestimated important cultural, competitive and market differences of acquired organizations, confirming findings from earlier HFMA research initiatives. Some said that overcoming cultural barriers can take years. "This study makes it clear that mergers are unlikely to succeed unless leaders tackle the tough decisions early on," commented Fifer when the report was released. "Prospective merger partners should sit down together and figure out what the organizational structure

and management team will look like after the merger. They should also recognize that it takes sustained effort to blend organizational cultures."

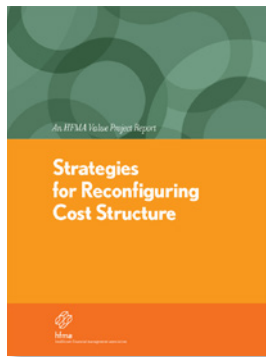
Reconfiguring hospital and health system cost structure. To prepare for the transition to value-based payment, HFMA recommended that hospitals and health systems shift resources away from established operations and services to enable investments in infrastructure for managing risk and population health.

HFMA recommended that hospitals and health systems shift resources away from established operations and services to enable investments in infrastructure for managing risk and population health.

HFMA research analyzed impacts of value-based payment on total cost of care

In 2018, it may have been too early for value-based payment to have had an impact on reducing the total cost of care. Also, payment models that included incentives for managing the total costs of care were few and far between, and such incentives were not yet aligned between the system and clinician levels. These were among the reasons posited for the lack of a correlation between the penetration of value-based payment models and reduction in the total cost of care in an HFMA study. The findings of the study, which was conducted by HFMA, Leavitt Partners and McManis Consulting, informed HFMA's ongoing initiatives in this area.





Strategies for Reconfiguring Cost Structure described an imperative to prepare for the emerging value-based payment and care delivery environment, which

would necessitate investments in IT and analytics, primary care services, care coordination and related technological capabilities.

Collaborating with other healthcare stakeholders

Early in his tenure, Fifer introduced a strategy to promote collaboration among hospitals and health systems, physicians and other practitioners, and health plans. HFMA also sought to promote collaboration within healthcare organizations and among HFMA members.

Collaborating with physicians and health plans.

To engage physician and health plan leaders, HFMA offered discounted memberships, developed targeted content and educational programs, added [affinity groups](#), secured

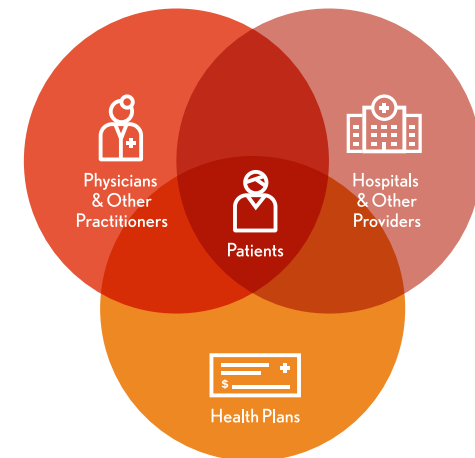
approval for continuing medical education (for designated courses) and facilitated interdisciplinary collaboration at conferences.

In 2015, HFMA and the American Association for Physician Leadership (AAPL) jointly convened a meeting of clinical and financial leaders of hospitals and health systems across the country. The primary goal was to facilitate a preliminary conversation between executives who had not often had the cause to work closely together in the past. A report, “Designing the New Healthcare System: The Need for CMO and CFO Collaboration,” covered the most salient topics that emerged from the meeting. HFMA content experts subsequently began teaching courses in healthcare finance and executive decision making for AAPL members and served as faculty for other programs where physicians sought education on healthcare finance topics.

HFMA’s focus on collaboration was also evident at the 2016 ANI, where an educational program brought executives from the health system, physician group practice and health plan sectors together to explore ways to create successful value-based partnerships.

Collaboration with physicians and other clinicians was also the focus of HFMA’s 2016 Thought Leadership Retreat, “[Transforming Relationships to Transform Health Care.](#)” A key takeaway from the retreat was the importance of engaging clinical leaders in efforts to transform care delivery.

To supplement web pages tailored to [physician leaders and physician practice managers](#) and health plans, an e-newsletter, *Physician Business Adviser*, was launched in 2016 with a circulation of 40,000 physicians, including chief medical officers, clinical department directors and other physician leaders.



Fifer introduced a strategy to promote collaboration among major healthcare stakeholders.

Collaborating with nurses and other clinicians.

In 2015, HFMA partnered with the American Organization of Nurse Executives (AONE) to deliver a series of finance workshops as part of a [certificate program for senior nursing executives](#). The two-day intensive workshops were designed to prepare nursing leaders to actively participate in executive-level financial discussions. AONE (which was later renamed the American Organization for Nursing Leadership, or AONL) honored HFMA with its Industry Partner Award in 2017 in recognition of this well received continuing professional education program.

In 2017, HFMA worked closely with the Institute for Healthcare Improvement (IHI)/ National Patient Safety Foundation (NPSF) to develop *Optimizing a Business Case for Safe Health Care: An Integrated Approach to Safety and Finance*, a [toolkit](#) that guides collaboration between safety and finance leaders to demonstrate the value and return on investment for providing safer, high-quality care.

Also in 2017, HFMA presented its highest individual honor, the Richard L. Clarke Board of Directors Award, to Tejal Gandhi, MD, MPH, CPPS, formerly president and CEO of the NPSF,

in recognition of her advocacy for patient safety at the national level. Dr. Gandhi assumed the role of chief clinical and safety officer at the IHI after IHI's merger with NPSF.

In 2020, HFMA coauthored with AONL and the American Nurses Association (ANA) a report advocating for evidence-based allocation of nursing resources. *The Business of Caring: Promoting Optimal Allocation of Nursing Resources* concluded that a collaborative approach to nursing resource allocation would help hospitals and health systems prioritize quality of care, consider organizational resource allocation holistically, yield more reliable data for decision-making, and prevent and resolve conflict.

Also in 2020, HFMA partnered with Case Western Reserve University, ANA and AONL on an innovative five-part program designed to enhance and expand the development of senior nurse executive leaders. The Coldiron Senior Nurse Executive Fellowship Program was developed by the [Marian K. Shaughnessy Nurse Leadership Academy](#) of the Frances Payne Bolton School of Nursing at Case Western Reserve University. It welcomed its first incoming class of nurse executives in August 2020.



*Many team members contribute to the safety-finance team, as recommended in *Optimizing a Business Case for Safe Health Care*.*

“We are pleased to partner with our nursing colleagues to leverage the strengths each organization brings to professional development,” Fifer said when the fellowship program was announced. “Interprofessional collaboration promotes better leadership, and better leadership is the key to delivering safe, effective, high-quality care.”



Collaborating with policymakers. Between 2012 and 2021, HFMA submitted nearly 90 [comment letters](#) to CMS and other regulatory

and legislative entities on a wide range of topics, such as the annual Inpatient and Outpatient Prospective Payment System proposed rules, various value-based payment programs and the Recovery Audit Contractor Program.

During approximately the same time period, HFMA published more than 200 [fact sheets](#) that summarize complex proposed and final rules issued by agencies such as CMS, the IRS, the Financial Accounting Standards Board and the Governmental Accounting Standards Board.

All HFMA fact sheets, comment letters to regulatory agencies, P&P Board guidance and related information were accessible from a [web page](#) that was created in 2016.

Innovating on an academic collaboration. HFMA’s history with academic partnerships dates back to the 1970s when it received a grant from the Kellogg Foundation to [develop a graduate degree program in healthcare management](#) in partnership with several universities. After the grant program ended, the Association continued to embed HFMA content and certifications into academic programs and provide guest speakers and adjunct faculty over the years.

In 2021, HFMA partnered with Boise State University on a first-of-its-kind [master’s degree program](#) in population and health systems management, which incorporated [four healthcare finance certificates](#) from HFMA.

The degree fulfilled an unmet need for an in-depth master’s-level program focused on value-based healthcare. Program faculty brought broad experience in clinical, operational and financial management in hospital, health system and health plan settings.



“HFMA is proud to partner with Boise State on this innovative master’s degree program,” said HFMA Director, Professional Practice and Partner Relationships and Chief Partnership Executive Todd Nelson. “The unique blend of current and emerging payment models in this curriculum provides the skills and knowledge base that tomorrow’s healthcare finance leaders need.”

Promoting collaboration within healthcare organizations. In 2018, HFMA introduced a membership program designed to provide all employees in an organization with access to HFMA’s content and educational resources. Through an organizational membership program called Enterprise Solutions, all finance and accounting, clinical and operational staff in an organization could align their efforts by improving their collective knowledge of the business of healthcare.

“HFMA’s Enterprise Solutions group membership program allows us the opportunity to engage, develop and retain talent in a cost-effective manner,” said Hugh Chisholm, FHFMA, CPA, vice president of finance at Rochester Regional Health. “Our team level-sets knowledge by leveraging HFMA’s award-winning online education and embedding certification programs into employee development plans. At a time when discretionary spending is being scrutinized, this program allows us to bring together the best that HFMA has to offer in a way that positions us to optimize organizational results.”



Enterprise members included leaders with roles in strategic financial planning, training and education, talent development, patient access and revenue integrity. These professionals leveraged Enterprise member benefits to build staff competencies and drive organizational performance.

“The Certified Revenue Cycle Representative program was a major factor in becoming an Enterprise member,” said WVU Medicine Assistant Vice President of Hospital Revenue Cycle Leah Klinke when her organization joined. “We’ve integrated HFMA’s industry education into our career development program to help our employees succeed.”

By October 2021, 172 organizations were active in the organizational membership program. Total HFMA membership exceeded 75,000, a growth of nearly 55,000 members since the Enterprise program was launched.

Promoting collaboration among HFMA

members. This period marked the introduction of several avenues for members to share ideas with each other, including affinity groups and an online community.

Affinity groups. Affinity groups were launched in 2014. Group members had similar roles within their organizations, share common professional interests, or both. By 2021, there were nine affinity groups (which were renamed Executive Councils) with plans to add more. Groups met both in person and virtually.

“Interprofessional collaboration promotes better leadership, and better leadership is the key to delivering safe, effective, high-quality care.”

— Joseph J. Fifer, FHFMA, CPA
President and CEO, HFMA

Online Community. When HFMA’s website was relaunched in 2019, an online community was introduced that offered members a platform to engage with peers nationwide, solve problems, collaborate and network. From the Community home page, members could browse the Open Forum or join more than a dozen forums focusing on topics ranging from revenue cycle to rural health.

Advancing international collaboration. HFMA had a presence in the international healthcare finance community since at least the 1970s, when HFMA speakers were represented at a major conference in Norway. At about the same time, three HFMA textbooks were translated into Portuguese for accounting instruction in Brazil. In 2020-21, HFMA expanded its outreach to the international health community.

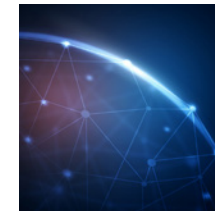
Connecting with colleagues across the pond. HFMA enjoyed a longstanding tradition of exchanging visits with its British counterpart, [HFMA-UK](#), at their respective annual conferences. In some ways, the payment systems in the two nations could not have been more different. But the similarities were also striking, as reflected in HFMA-UK 2015 President Sue Lorimer’s remarks on the trend toward collaboration at ANI that year. “[The National Health Service] is more and more about collaboration... to treat people closer to their own homes in community settings and to reduce the use of hospital care,” said Lorimer. “Resources will have to be moved around the system between organizations. I believe that we have to work together to deliver the transformation in care that is needed.”

Connecting with Southern hemisphere colleagues. In 2016, after several discussions with the Australian Health Services Financial Management Association (AHSFMA), HFMA’s Nelson traveled to Australia to meet with AHSFMA’s Board of Directors, present opening remarks at its Annual Conference and attend its awards banquet. After the Board meeting, the association renamed and rebranded its organization HFMA Australia and formally announced the change to its membership at the awards banquet. In 2017, HFMA Australia sent a delegation to HFMA’s Annual Conference and began the tradition of study tours to learn more about each nation’s payment models and share speakers and knowledge. In 2019, HFMA explored with CMS the idea of implementing an alternative to the chargemaster system based on the Australian Independent Hospital Pricing Authority’s cost-finding process.

Connecting with colleagues in the Middle East. In 2020, in collaboration with AHIMA International (the American Health Information Management Association), HFMA’s Fifer spoke on revenue cycle topics at two virtual international conferences geared to Saudi Arabian healthcare

In 2021, HFMA joined the G20 Health and Development Partnership with plans to focus on the organization’s health-related agenda, including sustainable financing of health.

finance audiences. Prior to 2020, in collaboration with AHIMA International, HFMA presented a live workshop in Abu Dhabi on denials management as well as multiple virtual presentations.



Expanding HFMA offerings and support to the global community. In 2021, HFMA expanded offerings and support to the international

community and began participating in global initiatives to improve health for all. The Association joined the G20 Health and Development Partnership with plans to focus on the organization’s health-related agenda, including sustainable financing of health.

In addition, HFMA joined the [International Hospital Federation](#) (IHF) a not-for-profit, nongovernmental organization that promotes international hospital and healthcare organization collaboration. HFMA's activities with the IHF included chairing a panel at the organization's 2021 World Congress in Barcelona, Spain, developing educational opportunities for the federation's Young Leaders program and serving on its Award Committee.

"We are in a better position than ever before to both learn and share in the international community," said HFMA Senior Vice President of Corporate Strategy Mary Mirabelli, FHFMA. "HFMA's mission and vision are evolving to more broadly support financial sustainability in the U.S., and across the global health and healthcare ecosystem."

In October 2021, HFMA launched an international membership option that included access to website content and webinars as well as discounts on curated courses and certifications that were applicable to international markets. In addition, HFMA planned to develop programming for countries with emerging revenue cycle markets.

"Many countries are facing the financial sustainability question of health and healthcare," Mirabelli said. "With that comes changing payment models, new rigor around the management of healthcare finance, new complications and the demand for new skills. HFMA will be providing international members the opportunity to build competencies around new processes and models."

Transforming experiences

As the online world continued to change societal expectations and ways of conducting business, the Association explored opportunities to transform both the patient financial experience and the HFMA membership, learning and chapter leadership experiences.

Transforming the patient financial experience.

The [consumer backlash against managed care](#) that had started in the 1990s evolved into a generalized dissatisfaction with the difficulty of obtaining healthcare price information and the "hassle factor" that characterizes the patient financial experience. Hospital pricing, billing, payment and collection policies had become frequent topics for complaints on social media and targets for investigative

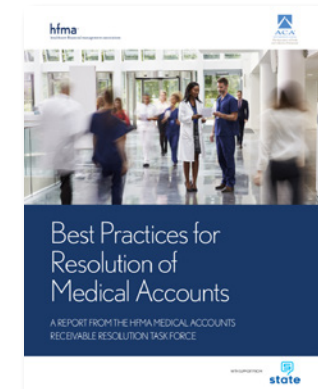
By the 2010s, it was clear that the time had come to take HFMA's Patient-Friendly Billing work of the early and mid-2000s to the next level.



The consumer backlash against managed care that had started in the 1990s evolved into dissatisfaction with the patient financial experience.

journalists. Understanding health insurance coverage continued to be challenging for many consumers. Healthcare finance leaders were looking for ways to elevate the financial experience and demonstrate that they value patients in their roles as consumers.

It was clear that the time had come to take HFMA's [Patient-Friendly Billing](#) work of the early and mid-2000s to the next level. As a longtime champion of consumerism, Fifer was ready for the challenge. He had been HFMA Board chair in 2006-07, when two early HFMA consumerism reports were published. Fifer was also inspired by his experience as a key architect of a price transparency initiative in his days at Spectrum Health, which was an early adopter of consumer-facing price transparency. "People everywhere want to be smart healthcare consumers, but information about healthcare prices is not easily accessible," said Fifer. "For too long it has been unclear how consumers should go about getting price information — who to ask, what to ask for, or what the information even means when they do receive it."



Building best practices. In 2014, HFMA published industry-consensus best practices for three key elements of the patient financial experience: Price transparency, patient financial communications and medical account resolution.

- *Price transparency.* Guiding principles and recommendations for price transparency developed by the [price transparency task force convened by HFMA](#) described roles for hospitals, physicians and health plans in sharing reliable information on healthcare prices with consumers.
- *Patient financial communications.* Developed with guidance from a blue-ribbon [steering committee](#), these best practices brought consistency, clarity, and transparency to

patient financial interactions by establishing guiding principles and steps to help patients understand the cost of services they receive, their insurance coverage and their individual responsibility.

- *Medical account resolution.* A task force of industry experts designed these voluntary [best practices](#) for use by healthcare providers, business affiliates and credit bureaus. The emphasis was on educating patients and ensuring that they understand the account resolution process. The best practices were updated in 2020 to include recommendations for modifying financial assistance policies in response to the COVID-19 pandemic.

HFMA made these resources available at no charge as part of its [Healthcare Dollars & Sense®](#) initiative to improve the patient financial experience for all. To help providers operationalize the best practices, HFMA also rolled out a communications training program geared toward frontline patient access staff and their managers, covering interactions prior to and at the time of service and in the emergency department.

Committing to consumerism. From the beginning, HFMA encouraged providers to formalize their adoption of HFMA’s Patient Financial Communications Best Practices as a public way of [signifying their commitment](#) to creating a positive financial experience for patients. Best practice adopters were [recognized](#) on HFMA’s website. Some early adopters were featured in a report that highlighted their approach to creating a positive patient financial experience.

Fifer applauded organizations that had adopted the best practices. But in 2017, three years after they were published, Fifer observed that the financial experience still lagged behind other sectors and that more providers should be taking steps to embrace consumerism. “For providers, the first step in building trust is

to ensure that patients are consistently treated with respect and empathy, receive timely and accurate price information, and know their payment and financial assistance options,” Fifer wrote. “The best practices provide a roadmap for achieving these goals. Use it.”

The importance of looking at the financial experience through a consumer’s eyes became a theme of Fifer’s writings and presentations in the years that followed.

HFMA reached out to consumers

HFMA encouraged consumer-facing organizations to download the Association’s first-ever resources designed for consumers, which were also available in Spanish, and make them available to consumers.

- *Understanding Healthcare Prices: A Consumer Guide* offered a step-by-step process for obtaining price estimates and provided tips to help consumers manage their out-of-pocket expenses and obtain information on healthcare quality. The guide was published in 2014 and updated in 2015.



- In *Avoiding Surprises in Your Medical Bills: A Guide for Consumers*, published in 2018, HFMA helped consumers understand steps they could take to help avoid receiving an unexpected out-of-network medical bill.

“For providers, the first step in building trust is to ensure that patients are consistently treated with respect and empathy, receive timely and accurate price information, and know their payment and financial assistance options. The best practices provide a roadmap for achieving these goals. Use it.”

— Joseph J. Fifer, FHFMA, CPA
President and CEO, HFMA



Putting all the pieces together. With a comprehensive suite of best practices for improving the patient financial experience in place, the next step was to integrate them

into a self-assessment tool that enabled healthcare providers to identify organization-specific areas for improvement. Published in 2020, HFMA’s [consumerism maturity model](#) did that and more by incorporating information

“I think it is high time that physicians and health systems listen and learn from patients. Let’s understand what patients are telling us.”

— *Maureen Clancy, a member of the HFMA Consumerism Maturity Model Task Force and Senior Vice President for Operations, Privia Health*

on state-of-the-art business processes along with selected [MAP Keys](#). The tool was the culmination of 18 months of work by a task force that provided guidance to organizations looking to improve the financial experience. “I think it is high time that physicians and health systems listen and learn from patients,” [said](#) Maureen Clancy, a member of the HFMA Consumerism Maturity Model Task Force and Senior Vice President for Operations, Privia Health. “Let’s understand what patients are telling us.”

Streamlining the HFMA membership experience. In an interview conducted soon after Fifer began as HFMA CEO, he commented on the importance of leading change without losing the intangibles that make an organization unique. “It’s important to strike a balance between building on our core strengths and branching out in new directions as the industry changes,” said Fifer. “You have to be comfortable with change. Great opportunities are out there but if you want things to stay exactly the same as they are today, you’re in the wrong business. That applies to HFMA as well. We should build on our strong foundation, but we also have to keep our eyes and ears open and change along with the industry.”

Switching to an all-inclusive membership model.

Fifer followed through on his commitment to change leadership within HFMA with the launch of an [all-inclusive annual membership model](#) in 2019. Until then, online education, certification programs, forums, newsletters and other digital products had been available for additional fees. The new model included those formerly paid extra services in annual membership dues, shifting away from transactions toward experiences and simplifying the member experience.

“Our research and member feedback told us additional offerings for extra fees was frustrating,” said HFMA Senior Vice President of Member Experience and Business Development Bill Casey. “The all-inclusive model allows us to focus our efforts solely on adding value to the member experience.”

With the new model came a new website to enhance member experience, including personalization tools, easier navigation, improved search functionality, and an expanded online community experience.

“We made an ambitious commitment to a greatly improved and simplified member experience, and I’m proud of the results,” said Fifer. “But this is not the end of an initiative. It’s the beginning of what will be an ongoing effort to stay more aligned than ever with the needs of our members.”

In recognition of this organizational transformation initiative, HFMA in 2019 received an award for innovation from .orgCommunity, a Chicago-based network dedicated to shaping the future of associations.

Transforming the HFMA learning experience.

During the late 2010s, HFMA undertook initiatives to transform both its Annual Conference and online learning experiences.



The theme chosen by HFMA 2018-19 Chair Kevin Brennan, FHFMA, CPA, encouraged members to focus on the future.

The Annual Conference experience. During this period, HFMA’s premier annual event for healthcare finance introduced a number of innovations designed to add value and make the experience more engaging, educational and enjoyable. These innovations included the Career Center, Innovation Labs, an innovation competition and a program connecting provider executives with HFMA business partners.

- **Career Center.** Introduced in 2014, the ANI Career Center provided resume reviews, professional headshots, social media training and executive coaching.
- **Innovation Labs.** These highly interactive sessions, launched in 2014, engaged participants with both industry experts and peers to create “next practices” to implement at their organizations. The Annual Conference tagline in 2016: “Whatever your role in delivering value, if it’s essential to innovation in healthcare, you’ll find it at ANI.”
- **Innovation competition.** The 2018 Annual Conference introduced a Virtual Pitch contest, which highlighted healthcare start-ups that showed promise for reducing the rate of healthcare cost growth. ANI attendees voted

“Our research and member feedback told us additional offerings for extra fees was frustrating. The all-inclusive model allows us to focus our efforts solely on adding value to the member experience.”

— *Bill Casey, Senior Vice President of Member Experience and Business Development, HFMA*

to choose a winner after listening to brief pitch presentations. By 2021, the contest, renamed the Start-Up Cup, had become a regular feature.

- **Connecting executives with business partners.** By the late 2010s, the Exhibit Hall at HFMA’s Annual Conference was many times the size it had been in 1986, when 30 companies were on the roster. HFMA introduced Executive Connections as an option for executives looking for an efficient way to hear about multiple solutions to their organization’s challenges. The program matched participants with companies that had solutions geared to the organizational needs that providers identified.

“You have to be comfortable with change. Great opportunities are out there but if you want things to stay exactly the same as they are today, you’re in the wrong business. That applies to HFMA as well.”

— Joseph J. Fifer, FHFMA, CPA
President and CEO, HFMA



In 2016, HFMA introduced a podcast featuring interviews with a wide variety of thought leaders.

Upgrading online education. In 2020, an HFMA team began looking at how to upgrade members’ online education experience. Against the backdrop of a global pandemic and the halting of live events, it was clear that online learning would be more critical than ever.

The platform that went live in January 2021 centralized the catalog and improved the search function. It also provided personalized suggestions for learning paths and courses and introduced an element of fun by enabling learners to earn trophies and status within the system.

Enterprise member organizations could offer courses under their own branding and use tools to do simulations in which employees demonstrated skills and received real-time feedback from their managers.

Introducing a healthcare finance podcast experience. In 2016, HFMA introduced its first-ever podcast, *Voices in Healthcare Finance*, featuring interviews from a wide variety of thought leaders. Technology had come a long way since HFMA’s first audio communication, [WASHLINE](#), in the early ’70s. No more voice mail or reel-to-reel tape recorders needed. Podcast episodes were available [online](#).

Reinventing the HFMA chapter leadership experience.

In 2015, HFMA undertook a multi-year initiative to transform the chapter leadership experience. HFMA’s 2010-11 Chair Debora Kuchka-Craig, FHFMA, led a steering committee comprising volunteer leaders from each region of HFMA. Identifying ways to provide chapters with more administrative support was a key objective of the initiative. By reducing the administrative burden on volunteers, they would be able to spend more time on activities that advance mission and core purpose.

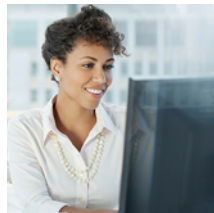
Toward that end, in 2017, HFMA rolled out an online event registration platform for virtual, hybrid and onsite meetings sponsored by chapters and regions. The Association entered into an overarching agreement with a vendor, which included discounted pricing.

In 2021, HFMA implemented the “One HFMA” concept, providing digital event services and website creation and support services for chapters and regions. The initiative to standardize chapter sites was undertaken to improve the user experience while presenting a more uniform look and feel. The Michigan Great Lakes chapter and First Illinois chapter were among the early adopters with [Region 2](#) being the first region to launch a website.

HFMA's annual Leadership Training Conference remained an integral component of chapter leadership. In 2021, HFMA pivoted to a hybrid conference to allow more chapter leaders to attend despite potential travel restrictions during the pandemic.

Building capabilities for success.

In 2015, HFMA articulated plans to develop new and enhanced resources and tools for supporting individual professional development and improving organizational performance. At the individual level, HFMA updated its career strategy resources and realigned its certification programs. The Association also took steps to support women in healthcare leadership roles.



Updating career strategy resources. In the mid-2010s, HFMA developed career support resources targeted to early careerists and

those new to the field, in addition to those at management and executive levels. The Association also restructured its online Career Center to include job and resume postings and tools designed to help members plan and advance in their careers.



When HFMA's online learning platform was revamped in 2021, linkages were established between eight healthcare finance [career pathways](#) and the proficiency goals and online courses recommended by HFMA for each one. The integration of individual self-paced resources with career pathways was designed to bring more meaning to the learning process and create purpose-driven goals that were applicable at the individual, team and organizational levels.

HFMA also developed [career self-assessments](#) that enabled members to identify their unique strengths and areas of improvement for their current role or ones to which they aspired. The three-step online skill assessments were geared to professional staff, mid/senior management and executive levels.

Realigning certification programs. Two of HFMA's most popular certification programs were revamped during this period.



Certified Healthcare Financial Professional. In 2015, HFMA realigned its flagship professional certification, the [Certified](#)

[Healthcare Financial Professional](#) (CHFP), to better reflect the contemporary healthcare business environment and the competencies and skills needed to address evolving healthcare payment and delivery models.

Earning this certification indicated a level of knowledge and expertise across four essential pillars: business acumen, collaboration, financial strategy and understanding future trends. The CHFP was geared toward financial professionals, clinical and nonclinical leaders, and health plans — all those whose jobs required a deep understanding of the financial realities of healthcare.

The redesigned CHFP program included two online learning modules — the *HFMA Business of Health Care*® and Operational Excellence — that highlighted the shift from volume to value-based payment and care

models and featured coursework on the intersection among financial data, clinical decision-making and health plan activities.

“HFMA’s goal is to build a broad understanding of healthcare finance together with leadership skills, business acumen, practical knowledge and a collaborative spirit – skills essential for succeeding in today’s environment,” said Fifer.



Certified Revenue Cycle

Representative.

HFMA’s Certified Revenue Cycle Representative (CRCR) was

updated in 2021 with a new design for improved functionality and enhanced user experience. CRCR provided a national-level certification for addressing the patient-centric revenue cycle.

Starting in 2019, individuals who completed any HFMA certification or certificate program earned a digital badge that could be displayed in email signatures, electronic resumes and social media profiles.

HFMA offered other specialty certifications in accounting and finance, business intelligence, managed care and physician practice management.



In addition, achieving the status of [Fellow of HFMA](#),[®] the first professional accomplishment certified by HFMA in 1957,

continued to attest to an individual’s financial expertise and leadership. Fellowship was awarded to HFMA members who demonstrated these qualities through the use of personal financial knowledge and skills in voluntary community service.

Starting in 2019, individuals who completed any HFMA certification or certificate program earned a digital badge that could be displayed in email signatures, electronic resumes and social media profiles. The badge contained metadata describing the individual’s qualifications and credentials, including how they earned this achievement.

Supporting women in leadership roles. As a growing number of women took their place in healthcare finance leadership roles over the years,



they were well represented in HFMA’s volunteer leadership. Women served as board chairs for 11 terms between 2000 and 2022. Some found inspiration in those who had gone before.

HFMA 2014-15 Chair Kari Cornicelli, FHFMA, CPA, remembers HFMA 1989-90 Chair [Sister Geraldine Hoyler](#) as her first career mentor. “Sister Geraldine was a dynamic leader and very mission-focused,” [wrote](#) Cornicelli. “She impressed upon me the importance of setting high standards for myself and for our finance team, and to hold ourselves and others accountable to achieving our goals. She also highly recommended that I join HFMA and encouraged me to not only attend HFMA meetings but to also get involved as a volunteer. So I did.”

In 2015, HFMA launched an initiative that aimed to inspire and support women and men invested in the professional development of women leaders in the healthcare field. As a key element of the initiative, HFMA hosted the first national HFMA HERe Women’s Leadership Conference in Fort Lauderdale, Florida, facilitated by nationally known media personality, author and motivational speaker Mel Robbins.

The conference was designed to equip women leaders with insights and tools that would enhance their professional and personal lives, empowering them to reach out to their peers, mentees and communities to advance the experience for women at all career stages within the business of healthcare.

Leadership labs on creating a professional presence and the art of negotiation at HFMA’s 2017 ANI were inspired by HERe.

Other elements of the HERe initiative include a website, toolkit and a monthly digital newsletter that was published from 2015–18.

Building organizational capabilities. HFMA had always sought to maximize the synergies between building capabilities for success on the individual and organizational levels. Achieving HFMA’s professional certifications, for example, helped people be more effective in their professional roles, which in turn helped the organizations for which they work. Likewise, many of the initiatives HFMA pursued to drive improvement of the nation’s healthcare system, such as improving price transparency, fostered success at the organizational level as well.

This applied to the environmental assessments HFMA undertook from time to time, starting with [Healthcare Finance Outlook](#) in 2007.

In 2016, HFMA published [Health Care 2020](#), a four-part series that provided healthcare business and finance leaders with forward-looking information about how to prepare for major healthcare market trends in four key areas: Value transition, consumerism, consolidation and transformative innovation. The series offered insights about organizational capabilities for success that remained relevant



Attendees listened to a presentation by 2015 HERe conference facilitator Mel Robbins.

women lead
her^e.

in 2021. For example, one report described how organizations can help promote a state of “health ownership” among consumers. Another report offered action steps for developing a cultural and technical infrastructure that supports innovation.



Five years later, HFMA published the [Healthcare 2030](#) series, featuring results of a healthcare CFO survey on where the industry was headed for the rest of the decade. Report topics included the CFO of the future, workforce, consumerism and strategic investments. The scope and focus of this series reflected the strategic nature of the roles of senior finance executives in U.S. hospitals and health systems.

The tumultuous period of 2020-21 led HFMA to expand its focus on organizational capabilities to include *building resilience* and *promoting diversity, equity and inclusion* in healthcare finance.

Building resilience: Managing through the COVID-19 pandemic. Of all the success capabilities that HFMA helps individuals

and organizations develop, resilience could be considered among the most important. Resilience helped finance leaders manage through the economic downturns and other disruptions that had occurred over the 75 years since the Association was established. However, the COVID-19 pandemic of 2020-21 required unparalleled levels of resilience from everyone in the healthcare community.

For providers, the pandemic had negative impacts on the balance sheet, operating budgets, patient volumes, capital access, workforce and many other areas, both tangible and intangible.

As the months wore on, Fifer advised healthcare finance professionals to mind the intangibles. “We can’t cure pandemic fatigue,” Fifer [wrote](#) in a February 2021 *hfm* column. “But we can be supportive of each other as we each navigate these challenging times. Last spring, a saying made the rounds on social media: ‘We are all in the same storm, but we are not in the same boat.’ That message still resonates. Simple active listening shows that you care. And sometimes that’s enough to make a difference.”



“We can’t cure pandemic fatigue. But we can be supportive of each other as we each navigate these challenging times.”

— Joseph J. Fifer, FHFMA, CPA
President and CEO, HFMA

Providing support to the field. Robust news coverage tailored to the financial aspects of the pandemic, researched and written by HFMA staff, kept members apprised of the latest developments. HFMA also developed resources to help members manage through an extended public health emergency that threatened organizations' financial viability.

These [resources](#) include detailed [accounting and financial reporting guidance related to COVID-19 relief](#) under the federal CARES Program, Medicare updates, and information on reimbursement for COVID-19 testing, treatment and vaccinations. In collaboration with America's Health Insurance Plans, HFMA also developed



HFMA's online community provided a forum for members to share ideas and strategies.

billing and coding guidance for outpatient and inpatient services rendered in temporary, alternative sites.

In addition, HFMA's online [Community](#) provided a peer-to-peer forum for sharing ideas and strategies for managing through the pandemic.

Finding the silver linings. Many HFMA members found that working remotely was more efficient than they had anticipated. In Spring 2021, when it seemed like the pandemic was ebbing, nearly two-thirds of participants surveyed by HFMA reported that they planned to increase their organizations' work-from-home technology and workflow capabilities going forward.

Overall, finance professionals and their clinical colleagues identified and implemented a wide range of innovative tactics and strategies to help their organizations and communities weather the pandemic storm.

Managing through the impact on the Association.

Fifer described the COVID-19 pandemic as the biggest challenge of his career. "Our first modeling of what the pandemic could mean to us showed that the moderate-level scenario was in excess of an \$8 million loss," Fifer said.

HFMA's online community offered healthcare finance leaders a pandemic lifeline

- More than 600 COVID-19 related discussions, replies and resources were shared in the Community during the first 12 months of the pandemic.
- A COVID-19 group for business partners was launched.
- Space on the Community homepage was dedicated for COVID-19 discussions.
- Top COVID-19 topics:
 - Telehealth strategies and impacts
 - CARES Act and Provider Relief Fund
 - Guidance related to billing codes
 - Adapting to revenue cycle changes
 - CMS updates
 - Work-from-home implementation

HFMA reimaged the Annual Conference as a virtual event, mitigating that projection significantly. Fifer worked with the HFMA Board and staff to make other decisions and implement changes that enabled the organization to survive the challenges.

To provide continuity of governance for HFMA during the pandemic, HFMA 2019-21 National Chair Michael Allen, FHFMA, CPA continued for a second year in his leadership role.

Promoting diversity, equity and inclusion. Most health systems have only recently made the connection between diversity in the C-suite and the social determinants of health that drive health disparities, according to a 2021 *hfm* [interview](#) with John Bluford, former president and CEO of Truman Medical Centers and former chair of the American Hospital Association. Bluford estimated that perhaps 14% of healthcare administrators in C-suite positions were Black or Hispanic, compared to a minority patient base of 32%. “Even though there has been a focus on increasing the diversity of the workforce, we have made little progress. Not nearly enough.” Bluford said.

2020 Annual Conference pivoted to virtual format

When the COVID-19 pandemic forced the cancellation of HFMA's Annual Conference, which had been scheduled for June 2020 in San Antonio, Texas, the Association reimaged the conference as a six-day virtual event held over a three-month span and offered as a membership benefit.

The innovative format for the Digital Annual Conference enabled members to continue tending to their regular healthcare finance duties during the public health emergency. It also allowed HFMA members who otherwise would not have attended to be part of it and to earn continuing professional education credits. At least 2,600 people registered for each of the six days, with more than 3,600 joining on each of the last three days.



Educational programming was designed to help healthcare finance leaders deal with COVID-19 revenue and expense pressures as well as market challenges. Topics covered included updates, strategies and best practices in accounting and compliance, margin growth, financial diversification, the revenue cycle, analytics and transformation.

Recognizing the scope of the problem. Marcus Whitney, a keynote speaker at HFMA’s 2019 Annual Conference, pointed out that equity issues are not limited to any one field. “Inequality of opportunity is just pervasive,” Whitney [told hfm](#) in November 2020. “It goes across all areas where power and wealth are concentrated.” A prominent venture capitalist based in Nashville, at the time of his *hfm* interview Whitney had recently launched a fund in the hopes of addressing disparities that he says lead both to a lack of opportunity for Black-led healthcare businesses and to care-related inequity.

In an October 2021 *hfm* feature on workforce issues, Duane Reynolds, CEO of Just Health Collective, a consultancy working to build health equity, [called](#) healthcare CFOs to action: “You, as the CFO, should understand the social determinants of health that are going to impact your organization financially,” said Reynolds. “And you, as the CFO, have to be thinking strategically.”

Necessity as the mother of innovation: How HFMA members responded to COVID-19

“We converted [a decommissioned hospital building] in two weeks back to a hospital, and we got temporary licensure for that hospital. It stands fully equipped and ready to go at a moment’s notice. The licensure has been extended through the pandemic, not knowing what a future surge would look like.”

– 2015-16 HFMA Chair Melinda S. Hancock, FHFMA, CPA, former chief administrative and financial officer, VCU Health System

“Caregivers on the front lines have been very disrupted. Their families have been disrupted. Yet our caregivers have stepped up and said: ‘If I’m working in surgery and I don’t have anything to do, I will work in another part of the organization to provide a support for drive-thru test collection stations, COVID-19 hotlines and other areas that need additional support.’”

– Kerry Gillespie, CPA, CFO for specialty-based care, Intermountain Health, Salt Lake City, explaining that thousands of caregivers were redeployed during periods when scheduled procedures were canceled to open up capacity for COVID-19 patients

“Patients are asked to self-isolate for two weeks, then come and get tested [for COVID-19]. Then once we have the test results, we schedule their surgeries very quickly. So it’s reinventing the way surgeries work in the sense of preop scheduling.”

– Fahd Benjalil, FHFMA, CFO and COO, Sharp Coronado Hospital, San Diego, describing a process the hospital created for patients undergoing surgery for low- and medium-risk conditions

“In less than three weeks, OSF HealthCare designed and implemented a 24/7 Digital Pandemic Response Center; a pandemic health worker program; a chatbot offering digital symptom tracking with connectivity into a toll-free OSF intake phone line; and nurse-to-provider escalation workflow that enabled seamless handoffs into provider care.”

– HFMA 2019-21 Chair Michael M. Allen, FHFMA, CPA, CFO, OSF HealthCare, describing his Peoria, Illinois-based health system’s COVID-19 response during virtual presentations to HFMA chapters

Bringing the message home. HFMA's Fifer had come to that conclusion independently in 2020. The death of George Floyd, an unarmed Black man, at the hands of a White police officer in Summer 2020 should be a catalyst for action, he said. In Fifer's first [message](#) to the HFMA community on this topic, he urged members to realize that racism is rampant in American society, and it's not always overt. "We need to do our part to improve diversity and inclusion within our organizations," Fifer wrote. "Learn about your organization's efforts and how you can contribute. The finance field, including healthcare finance, has a long way to go in this arena."

Fifer addressed diversity again, urging members to stop, listen and care about racism. "We should pause and set aside our ideas about racism when an opportunity arises to listen to others," wrote Fifer. "When we listen with curiosity and empathy, and without defensiveness, we may learn what microaggression feels like. We may discover that someone's lived experience as an employee is not consistent with the values our organization purports to hold. We must

HFMA honored Kevin Lofton for his work on addressing healthcare disparities



Kevin E. Lofton with HFMA 2014-15 Chair-Elect Melinda S. Hancock, FHFMA, at ANI in June 2014

Catholic Health Initiatives CEO Kevin E. Lofton was honored with HFMA's 2014 Richard L. Clarke Board of Directors Award in recognition of his extensive and far-reaching work in the area of healthcare disparities and his longtime, ongoing leadership in creating healthier communities. During Lofton's tenure as chair of the American Hospital Association (AHA) in 2007, AHA convened a Special Advisory Group on Improving Hospital Care for Minorities and developed resources for increasing the diversity of hospital governing boards, along with a Web-based toolkit to enable hospitals to collect race, ethnicity and primary language data in a uniform way.

then summon the energy to care enough about what we've heard to follow through with action, when appropriate.”

Fifer directed HFMA staff to form an internal committee on diversity, equity and inclusion. The mission of the committee was to foster a climate of mutual respect and inclusion among employees by bringing awareness of different cultures and experiences and identify ways to safely share and converse in a manner that promotes the equal value of all people.

Looking forward. As the world grappled with a global pandemic and the nation continued to address longstanding healthcare industry challenges, HFMA remained committed to equipping its members with the skills and tools they need to succeed and to lead change. HFMA also continued to take an active role in collaborating with other stakeholders to improve health.

2021-22 Chair Tammie Jackson calls for focus on diversity, equity and inclusion

In a speech at HFMA's 2021 Annual Conference, Tammie L. Jackson, FHFMA, MHA, CHFP, called on healthcare finance leaders to focus on reducing healthcare disparities and promoting health equity in the wake of the COVID-19 pandemic, which she referred to as a before-and-after event. “Health disparities have long been part of

our ‘before’ narrative, well researched and documented for decades,” said Jackson, “No matter your role in this industry, there is much we can each do to make bold decisions and promote health equity. If we are well informed, well educated and well intentioned, our future looks brighter. As an industry, we can be better than we were before.”



HFMA 2021-22 Chair Tammie Jackson, FHFMA, CHFP. The theme Jackson chose for her leadership year inspired members to work toward creating a better future.

2012-2021 Association Milestones



Joseph J. Fifer, FHFMA, CPA assumes the role of HFMA President and CEO upon the retirement of Richard L. Clarke.

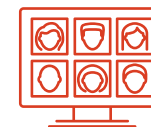
HFMA unveils Healthcare Dollars & Sense. ... Patient Financial Communications Training Program for frontline staff is developed.

Understanding Healthcare Prices: A Consumer Guide is published, incorporating information on healthcare quality.

Voices in Healthcare Finance, a podcast featuring insights from leading industry experts, is launched.



Enterprise Solutions organizational membership program is introduced.



HFMA shifts its Annual Conference to a virtual format due to the COVID-19 pandemic. ... Digital certification badges are introduced.

Standardizing Denial Metrics is published.

2012

2013

2014

2015

2016

2017

2018

2019

2020

2021



Mobile app version of *hfm* magazine is launched.

HFMA joins the National Quality Forum Measure Applications Partnership, a collaborative effort to improve health and healthcare quality through measurement.

here.
HERE, a national conference for women leaders in healthcare finance is held.

HFMA hosts the first National Payment Innovation Summit, offered in Memphis and virtually. Also, approval is received to offer continuing education credit to physicians, nurses and other clinicians for selected programs.

Renamed and reimagined Annual Conference is introduced, sunsetting the ANI name.



HFMA introduces the L7 Cost Accounting Model to help providers measure the adoption and utilization of advanced cost accounting methods. ... All-access membership model is introduced.



hfm magazine is completely redesigned, featuring more people stories, visuals and chapter news.

2022–2026

HFMA tackles industry's toughest challenges with bold — and collaborative — action

The need for more advanced financial management of healthcare institutions evolved after World War II with the advent of health insurance. Back then, people had to figure out how to deal with emerging health insurance plans.

Since then, HFMA has evolved into an organization where innovation is fostered by facilitating an environment where our members collaborate with key stakeholders across healthcare, government and other industries. The goal: to advance the right actions for the future of healthcare.

It's the reason HFMA invests in thought leadership reports and discussions on topics such as "Hospital of the Future," "CFO of the Future," "C-Suite of the Future" and "Revenue Cycle of the Future."

It's also why HFMA launched Vitalic Health, an initiative designed to stimulate bold new thinking and collaboration in the pursuit of healthcare affordability and sustainability.

As HFMA celebrates its 80th anniversary, we reflect on key milestones over the past five years.



C. Ann Jordan, JD, President and CEO, HFMA



New Era of Leadership

C. Ann Jordan, JD, began her tenure as HFMA's new president and CEO on June 6, 2023. In doing so,

C. Ann Jordan, JD she became the first female chief executive of the Association throughout its 77-year history.

"Ann is passionate about achieving cost effectiveness of health and about continuously raising the bar on delivering value to members," HFMA 2022-2023 Board Chair Aaron Crane, FHFMA, MHA, said at the time of her appointment. "She also brings a wealth of experience in the pursuit of quality and expertise in contemporary association leadership."

Indeed, in taking over the helm from former HFMA President and CEO Joseph J. Fifer, FHFMA, CPA, Jordan — who formerly served as CEO of the American Society for Quality — set out to tackle two of healthcare's biggest challenges: affordability and sustainability of care and care delivery systems.

New solutions for healthcare's top pain points

In 2025, under Jordan's direction, HFMA introduced Vitalic Health, designed to bring

together diverse stakeholders to work toward meaningful action.

"If you're a systems design expert, this is the ultimate problem-solving opportunity for good to impact lives," Jordan said. "Vitalic Health is not about improving performance metrics. It's about aligning competing stakeholders around a shared commitment toward ensuring the vitality of our communities.

"Through the lens of system design and solve-based convening, we can collectively find ways to eliminate fragmentation and variability, which threaten outcomes, increase costs and erode public trust," she said.

In 2025, Vitalic Health developed the first tool for measuring the health of the U.S. healthcare system.

Known as the "U.S. Healthcare Vitals Tracker," the tool leverages 25 universally accepted metrics in examining the state of healthcare affordability and the health span of the American population. The Vitals Tracker scores affordability and health span dating back to 1997, the last year of a federal budget surplus.

Jordan described the Vitals Tracker as "a single source of truth" for the industry.

"The rallying call of Vitalic Health is meaningful action, lower costs and healthier lives."

— C. Ann Jordan, JD
President & CEO



U.S. Healthcare Vitals Tracker

“We have the largest economy in the world, and we’re spending trillions of dollars on healthcare, yet there had never been an effort at the macro scale to measure and understand the components of the U.S. healthcare system economically, year over year, to state, ‘Are we getting better or worse, and why? What does all this mean?’” Jordan said.

Having spent most of her career outside healthcare, she found this reality surprising.

“That was eye-opening to say the United States healthcare industry did not have a measurement or index device to grade its own performance,”



HFMA held its first Vital Collective in September 2025.

Jordan said. “We wanted not only to inform a national dialogue that very much needed to occur, but also to monitor whether the U.S. healthcare system was meeting present and future demands for care. From there, we would take those learnings to build solutions for the future.”

Released for public comment in fall 2025 and shaped based on industry feedback, the Vitals Tracker found the healthcare industry is in a state of “serious condition.” Despite continual investments in innovations meant to strengthen efficiency and quality of care, the tracker points to persistent declines in affordability and the health span of the U.S. population.

David Johnson, CEO of 4sight Health, a healthcare advisory company, and a former member of HFMA’s National Board of Directors, suggests that what most stands in the way of supporting better health outcomes at sustainable cost is the design of the U.S. healthcare system. It’s a system built for treatment, he said.

In 2023, Johnson chaired HFMA’s Healthy Futures Task Force, which served as the basis for Vitalic Health.

Vitalic Health

powered by hfma

“Vitalic Health emerged from HFMA’s Healthy Futures Task Force. The idea was to create a vehicle where HFMA could engage the entire industry in a conversation about promoting health: How do we enable both payers and providers to invest in pro-health activities and generate a return for it?”

— David Johnson, CEO of 4sight Health and former chair of HFMA’s Healthy Futures Task Force

Vitalic Health was established with four pillars, each of which is designed to address the industry’s most complex challenges.

- **Impact Measurement Institute**, with the Vitals Tracker being its first output
- **Swarm Studies**, which bring together diverse stakeholders to explore new solutions for pressing issues, including around the need for standardized payer edits (February 2026)
- **The Payment Model Consortium**, which will explore innovative payment models to test and scale
- **The Solutions Studio**, which will focus on developing transformational products and services

At its core, Vitalic Health will address what Johnson calls “a reverse tragedy of the commons in healthcare.”

To describe this idea, Johnson said: “Our very public good is investing in pro-health activities. When we do it, it generates a huge return for society. But providers don’t do it because when they invest in pro-health activities, they lose volume, they lose money. And payers don’t do it because when they invest in pro-health activities, their premiums go up, and their members switch plans.

“We need to come up with payment models and metrics that enable both payers and providers to invest in pro-health activities to specifically address this reverse tragedy of the commons problem we all live with,” he said.

Industry guidance

In 2023, HFMA completed a three-year look into how healthcare organizations and their leaders should prepare for a new era of care.

The “Healthcare 2030” series unpacked the challenges and opportunities for CFOs and other healthcare leaders created by the evolving industry, looking ahead to 2030. Topics ranged from consumerism in healthcare, the role of public health in the healthcare delivery system of the future, the continued need to emphasize health and wellness over treatment of disease, the impact of moves around precision medicine and social determinants of health, and more.

**Healthcare 2030
Volume 1**

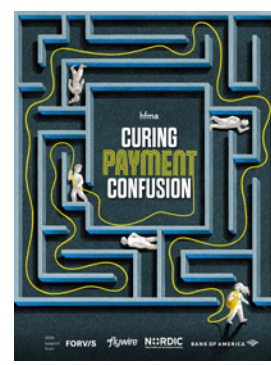
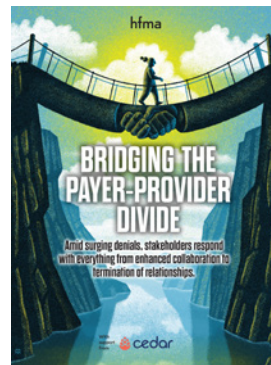


**Healthcare 2030
Volume 2**



**Healthcare 2030
Volume 3**





Other reports designed to provide industry guidance in a rapidly evolving healthcare environment included:

- **The Healthcare CFO of the Future**, which explored the new competencies CFOs must possess and how leaders in this space are preparing for the future. Released in 2025, this report remains one of HFMA's most popular reports, with continued web views.
- **The Healthcare C-Suite of the Future**, which examined new, must-have capabilities that were emerging for C-suite leaders, especially in the areas of innovation and transportation, AI competency, digital technology and payer relations.
- **Bridging the Payer-Provider Divide**, which discussed the need for a strong move toward payer-provider collaboration to alleviate

animosities that sow widespread confusion around payment across the nation's healthcare system. This report was released in November 2024, just three weeks before UnitedHealth CEO Brian Thompson was murdered, underscoring national public dissatisfaction with the healthcare system. In the wake of Thompson's death, HFMA published a follow-up to this report in February 2025, "Where do we go now? Action needed to address public dissatisfaction with U.S. healthcare."

- **Curing Payment Confusion**, which examined why hospitals are losing the battle to create a financial experience that doesn't confuse, confound or enrage patients.

These reports were fueled by HFMA surveys of healthcare leaders, pinpointing top areas of concern and shifts in approach.

News and reports

HFMA's award-winning editorial team introduced new ways to bring timely resources to healthcare finance leaders during a dynamic period in the industry. These included:

- **FastFinance**, a popular weekly newsletter developed specifically for health system CFOs and focused on original analysis of policy and regulatory news; it is complemented by the *FastFinance* podcast, launched in late 2025
- **HFMA Daily**, a newsletter providing the most up-to-date information on the latest in healthcare finance news, as well as key editorial outputs
- **Voices in Healthcare Finance** podcast, offering industry insights and in-depth stories about hot topics in healthcare finance

In spring 2025, HFMA's *FastFinance* newsletter, *HFMA Daily* newsletter, *Voices in Healthcare Finance* podcast and various articles and reports were recognized as finalists for awards for editorial, research and design excellence.



A vibrant – and growing – member community

Since the enterprise membership model was introduced in 2018, HFMA has grown from about 40,000 members in 2010 to more than 145,000 members. The enterprise membership model allows entire organizations to become members, increasing access to HFMA education, content and resources to strengthen the financial management of healthcare.

Today, enterprise members include leaders with roles in strategic financial planning, training and education, talent development, patient access and revenue integrity. These professionals leverage member benefits to build staff competencies and drive organizational performance.

HFMA's member roster ranges from large multi-hospital systems to critical access hospitals to business partners, Indian Health Services organizations, government health organizations and more.

Members remain the lifeblood of HFMA. At the chapter, regional and national level, HFMA helps healthcare finance professionals meet the challenges of the modern healthcare environment by:

- Providing education, analysis and guidance
- Building and supporting coalitions with other healthcare associations to ensure accurate representation of the healthcare finance profession
- Educating a broad spectrum of key industry decision-makers on the intricacies and realities of maintaining fiscally healthy healthcare organizations
- Working with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices and standards

Leading the way forward

As the need for a more affordable and sustainable system of care creates urgency for change, HFMA is at the forefront of reimagining what care delivery systems and payment models could look like for the future.

“We all have to recognize that affordability of care is an imperative, and it's an imperative that everybody has to have ownership in,” said Robin Damschroder, FACHE, president of value-based enterprise and CFO for Henry Ford Health and a member of the HFMA National Board.

Through initiatives like Vitalic Health, Jordan envisions a bold, constructive space where healthcare is “no longer a fragmented battleground of conflicted stakeholders, but rather a mosaic that is diverse by design and united in purpose.

“The reality is that no single stakeholder can solve the challenges of affordability, care delivery and quality outcomes,” Jordan said. “No one stakeholder can bend the curve. This needs to be a united effort, and that starts with a collective mindset for change.”

2022-2026 Association Milestones

HFMA hosts its first in-person annual conference since the COVID-19 pandemic. The conference took place in Denver.



Aaron Crane, formerly executive vice president of the Seattle Cancer Care Alliance, is named HFMA National Chair.

HFMA launches the Healthy Futures Task Force to explore the financing and metrics associated with population health payment models.

HFMA kicks off its Vitalic Health initiative, designed to bring together healthcare's diverse stakeholders in addressing healthcare affordability and sustainability.

Kiran N. Batheja, FHFMA, director of patient registration and financial counseling at University Hospital in Newark, N.J., is appointed HFMA National Chair.



Marjorie Parker, HFMA's longest-tenured employee, retires from HFMA after 43 years of service as an office manager for HFMA's Washington, D.C., team.

Vitalic Health kicks off the Payment Model Consortium with a report focused on the state of the transition to value-based payment models in U.S. healthcare.

2022

2023

2024

2025

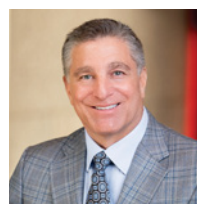
2026

HFMA redesigns its website to strengthen ease of navigation, visual appeal, mobile experience and quality of content, later winning a Swaay Health award for its efforts.



C. Ann Jordan, JD, is appointed HFMA President and CEO upon the retirement of Joseph J. Fifer, FHFMA, CPA, after 11 years of service. She becomes the first woman to lead HFMA in the Association's 77-year history.

Dennis Dahlen, FHFMA, CPA, CFO, Mayo Clinic, is named HFMA National Chair.



Marc B. Scher, FHFMA, CPA, a former partner for KPMG, becomes HFMA National Chair.

HFMA releases The Vitals Tracker, the nation's first tool for measuring the health of the U.S. healthcare system.



HFMA's Vitalic Health initiative launches its first Swarm Study – designed to facilitate “solve-based convening” around healthcare's toughest challenges – on standardizing claim edits. More than 50 providers and payers participated.



Matthew E. Cox, FHFMA, CPA, executive vice president and CFO, Corewell Health, becomes HFMA's new National Chair.



Acknowledgments

First and foremost, HFMA wishes to express its deepest appreciation to its volunteer leaders, both those whose words appear in these pages and those we were not able to mention. The dedication and leadership acumen our volunteers have brought over the years made the Association what it is today.

We would also like to acknowledge the journalistic talents of staff writers and editors Rich Daly, Nick Hut and Jeni Williams, whose coverage of Association history was adapted and incorporated into the last chapter. Many people reviewed or otherwise contributed to this section of the manuscript, including Brad Dennison, Deb Filipek, Brian Goins, Erika Grotto, Rick Gundling, Jean Hodges, Eric Reese and Todd Nelson.

The early chapters of this book draw extensively on *From Acorn to Oak: A History of the Healthcare Financial Management Association* by the late Robert M. Shelton, which provided a trove of factual information about Association history prior to 1991. The 2006 update, *From Acorn to Oak and Beyond*, written by Lauren Phillips, was also helpful. This book supplements the historical record of those earlier publications.

Thanks also to graphic designer Todd Douglas at Bold Yellow.

Appendix

HFMA Principles & Practices Board Position Statements and Issue Analyses

Prior to issuance, a proposed position statement follows an extensive process. An exposure draft is released for public comment for at least 60 days. These comments are analyzed and reviewed by the Principles & Practices (P&P) Board.

Issue analyses are designed to provide short-term practical assistance on emerging issues in healthcare financial management. Issue analyses are factual, but nonauthoritative. To expedite information to the industry, issue analyses are not sent out for public comment.

Additional interpretive guidance on all issue analyses and position statements may be released as circumstances evolve. Consultation on these matters with independent auditors is highly recommended.

In addition to those listed below, as of October 2021, the P & P Board had published 14 statements, dating to 1977, which were subsequently replaced by updated statements listed below or withdrawn.

All P&P Board Issue Analyses and Position Statements may be accessed from the [“Regulatory and Accounting Resources”](#) section of hfma.org.

Issue analyses

1995: *Acquisition of Physician Practices*

1997: *Assessing Managed Care Contracting Risk*

1998: *Compliance with Laws and Regulations for Healthcare Organizations*

2002: *Recognition of Other-Than-Temporary Decline in Investments for Tax-Exempt Organizations*

2005: *The Relationship of Community Benefit to Hospital Tax-Exempt Status*

2009: *Sample 501 (c)(3) Hospital Charity Care & Financial Assistance Policy and Procedures*

2010: *Accounting for Recovery Audit Contractor Audit Adjustments and Exposures*

2011: *Medicare Incentive Payments for Meaningful Use of Electronic Health Records Accounting and Reporting Developments*

2015: *Questions and Answers on the Affordable Care Act’s Premium Stabilization Programs*

Appendix (continued)

2016: *Risk Accounting: What Are the Issues and Trends in These Revenue Cycle Arrangements?*

2019: *Revenue Recognition, Including Implicit Price Concessions and Bad Debt Considerations, for Healthcare Organizations: Accounting Issues and Trends*

2019: *Revenue Recognition Under Topic 606 for Provider Tax Programs and Similar Arrangements*

2019: *Revenue Recognition Implications Under Topic 606 for Capitation and Risk Sharing Arrangements*

2020: *Current Issues and Considerations in Accounting for Leases*

Statements

1989: *Accounting and Reporting by Institutional Healthcare Providers for Risk Contracts*

1993: *Classifying, Valuing and Analyzing Accounts Receivable Related to Patient Services*

1994: *Assessments and Arrangements Similar to Taxes on Tax-Exempt Institutional Healthcare Providers*

1994: *Public Disclosure of Financial and Operating Information by Healthcare Providers*

1997: *Healthcare Mergers, Acquisitions and Collaborations*

2019: *Valuation and Financial Statement Presentation of Charity Care, Implicit Price Concessions and Bad Debts by Institutional Healthcare Providers* (Original 2006; first revision 2012)

Industry white papers

[OBBBA Medicaid impacts: How to navigate state-directed payment revenue reduction](#) (Dec. 18, 2025)

[Community benefit, 340B and Medicare Advantage: Top financial reporting challenges facing hospitals](#) (June 19, 2025)

[Reviewing the Current Expected Credit Losses \(CECL\) In Healthcare](#) (May 16, 2024)

[Assessing Reality in Healthcare Financial Information](#) (April 14, 2023)

[Medicare-Medicaid Crossover Bad Debt Accounting Operational Overview](#) (Sept. 3, 2019)

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The Healthcare Financial Management Association (HFMA) equips its more than 145,000 members nationwide to navigate a complex healthcare landscape. Finance professionals in the full range of work settings, including hospitals, health systems, physician practices and health plans, trust HFMA to provide the guidance and tools to help them lead their organizations, and the industry, forward. HFMA is a not-for-profit, nonpartisan organization that advances healthcare by collaborating with other key stakeholders to address industry challenges and providing guidance, education, practical tools and solutions, and thought leadership. We lead the financial management of healthcare.

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