



HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

HEALTHCARE PAYMENT REFORM

From Principles to Action

The most precious resource of any nation is its people, and the most important way to nurture that resource is to enhance the health of each individual. However, the payment system does not reward the very actions that will foster improved health. A new payment system is needed, and a broad multidisciplinary effort is under way to define it. The new system should be built on the principles of *quality, alignment of incentives, fairness/sustainability, simplification, and societal benefit.*

Inside, review the principles and the actions needed to transform our payment system.



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healthcare financial management association

Healthcare Payment Reform: From Principles to Action
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Correspondence: resourcecenter@hfma.org



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MESSAGE FROM HFMA PRESIDENT AND CEO

Real and sustainable healthcare reform depends on changing the incentives for service delivery. And those incentives must be contained in a reformed payment system that is driven by our national health goals and acceptable reform principles.

HFMA's *Healthcare Payment Reform: From Principles to Action* brings together the insights from a diverse group of system stakeholders and others to identify principles of payment reform, as well as payment elements that embody these principles.

HFMA would like to thank the major stakeholder representatives and others who took time to review and provide thoughtful comments on our approach. We believe this is the first major national effort to establish the principles and elements for overall payment reform with so many differing stakeholders.

Look for HFMA to continue bringing key groups together to help design and accomplish healthcare payment reform—for the benefit of providers, payers, employers, and the health of all our nation's citizens.



Richard L. Clarke, DHA, FHFMA
President and CEO
Healthcare Financial Management Association

MESSAGES OF SUPPORT

AMERICAN HOSPITAL ASSOCIATION

AHA believes that payment system reform is critical to comprehensive health system reform. We commend HFMA's efforts to focus attention on how the payment system can help achieve our nation's health goals and appreciate the report's review of the options and challenges payment reform must address.

THE COMMONWEALTH FUND

The Commonwealth Fund believes that payment system reform significantly factors into overall health system reform. We support HFMA's efforts to focus attention on ways the payment system can improve quality of care and individual health.

DMAA: THE CARE CONTINUUM ALLIANCE

DMAA: The Care Continuum Alliance was pleased to serve as a resource in the development of HFMA's *Healthcare Payment Reform: From Principles to Action*. DMAA agrees that payment system reform is a vital component of overall health system reform. We support HFMA's efforts to focus attention on how the payment system can support better health for our nation. HFMA's initiatives in this key policy area provide an important starting point for broader healthcare reform efforts.

MEDICAL GROUP MANAGEMENT ASSOCIATION

MGMA applauds the release of HFMA's *Healthcare Payment Reform: From Principles to Action*. We are particularly supportive of its emphasis on simplifying and standardizing the payment system. Our nation cannot afford to waste scarce resources on unnecessary administrative complexity. We look forward to working with HFMA and other stakeholders to make the principles set forth in the report the basis for a more efficient, effective healthcare system that can help our nation achieve better health.

THE NATIONAL BUSINESS GROUP ON HEALTH

The National Business Group on Health, a 300+ membership organization of mostly very large employers, believes that payment system reform is a critical and fundamental component of overall health system reform. We support HFMA's efforts to focus attention on how the payment system can better achieve our nation's health goals.

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Executive Summary

In many ways, the nation's current healthcare payment system blocks, rather than supports, the nation's health goals: The system does not effectively reward wellness or high quality. The system does not encourage societal benefit such as access to care. And the system creates financial instability by adding cost and complexity to health administration, by rewarding high-cost practices, and by focusing on expensive sickness-focused interventions rather than wellness.

The Healthcare Financial Management Association (HFMA) believes that achieving the nation's health goals requires effective reform of the payment system. To be useful, payment system reform should take place within a framework of principles that represent qualities of an ideal payment system for all stakeholders, including providers, payers, employers, and consumers.

With this in mind, HFMA has sought the input of these stakeholders through a variety of means, including a September 2007 retreat titled "Building a New Payment System." A result of these efforts has been consensus on principles addressing **quality** and **alignment** of incentives, as well as support of **fairness/sustainability**, **simplification**, and **societal benefit**.

Determining these principles is only part of the solution. Also needed is identification of stakeholder consensus and concerns related to the specific system changes that would put these principles into action.

With this paper, HFMA presents a number of payment types and elements that could support the agreed upon principles. In concept, these elements have broad consensus among stakeholders, but significant definition, development, and testing are needed around issues such as how evidence-based guidelines are agreed upon and administered, how a multistakeholder gainsharing arrangement is structured, how responsibility for societal benefit is apportioned, and how initial costs of financial incentives for prevention should be managed.

Achieving the payment system principles will require an unprecedented level of cooperation and trust among all the parties. This will be difficult because of the ramifications of redistributing the healthcare dollar. However, by operating within a framework of principles and goals, shared by all stakeholders, meaningful change is possible.

HEALTHCARE PAYMENT REFORM AT A GLANCE

NATION'S HEALTH GOALS	Wellness	High-quality care	Access to care and other societal benefit	Stable health system
	↓	↓	↓	↓
PAYMENT SYSTEM BARRIERS	Minimal incentive for prevention	Minimal incentive for quality and coordination	Limited payment for charity care or other community benefits	Limited incentives for efficiency; payment complexity adds expense
	↓	↓	↓	↓
PAYMENT REFORM PRINCIPLES	Quality Alignment	Quality Alignment	Societal benefit	Alignment Fairness/Sustainability Simplification Societal benefit
	↓	↓	↓	↓
EXAMPLES OF POSSIBLE PAYMENT ELEMENTS (most address several health goals and payment principles)	Periodic payment to cover management of preventive care services for a patient Provider financial incentives for preventive services /outcomes Patient financial incentives for prevention	Financial incentives based on use of evidence-based care Financial incentives based on patient outcomes, satisfaction Global payment that covers all care management for a patient with a chronic condition	Regionally established separate payments made by all payers to hospitals to cover their costs of providing societal benefits, including medical and public education, research, and uncompensated care	Provider financial incentives for preventive services /outcomes Patient financial incentives for prevention and treatment compliance Global payment that covers all care management for a patient with a chronic condition Standardized payment processes and transaction requirements
	↓	↓	↓	↓
NEXT STEPS (most apply to more than one goal)	Develop transition path to minimize cost of financial incentives for prevention	Develop agreed-upon evidence-based process Create multistakeholder gainsharing arrangements so that payers, providers, and consumers share equally in the long-term benefits of aligned, efficient, high-quality care	Define and determine how to apportion responsibility for societal benefits	Create multistakeholder gainsharing arrangements so that payers, providers, and consumers share equally in the long-term benefits of aligned, efficient, high-quality care Develop robust modeling to evaluate different payment methodologies



Introduction: The Importance of Payment System Reform

The most precious resource of any nation is its people, and the most important way to respect and nurture that resource is to enhance the health of those people. However, efforts to enhance health in the United States are thwarted by a healthcare payment system that does not reward the very actions among providers, payers, employers, and consumers that will foster improved health.¹

This paper—part of the Healthcare Financial Management Association’s (HFMA’s) payment reform initiative—identifies payment system principles that will support the goal of a healthy nation and that enjoy broad consensus among these stakeholders. In addition, the paper identifies examples of payment techniques that may help realize these principles, along with areas of consensus and concern regarding these techniques. Finally, the paper identifies key next steps for meaningful payment system reform.

Organizations and individuals throughout the United States are devoting knowledge, skill, and energy to improving the nation’s health.

THE NATION’S HEALTH GOALS

Recent times have brought many meaningful initiatives to promote wellness, access to care, high-quality care, and a financially sound healthcare system.

One example of such an initiative is Healthy People 2010. Coordinated by the U.S. Department of Health and Human Services, Healthy People 2010 is attempting to mobilize government agencies, professional groups, businesses, and communities around a unified set of goals for the nation’s health. The two overarching goals are:

- Help individuals of all ages to increase life expectancy and improve their quality of life
- Help our nation eliminate disparities in health condition and healthcare usage

Within those two goals are numerous contributing goals and specific objectives. For example:

- Reduce cardiovascular disease deaths among persons with diabetes. *Baseline: 332 per 100,000; 2010 target: 299 per 100,000*
- Increase the proportion of persons with a usual primary care provider. *Baseline: 77 percent; 2010 target: 85 percent*
- Reduce the proportion of nonsmokers exposed to environmental tobacco smoke. *Baseline: 65 percent; 2010 target: 45 percent*

Other initiatives focus on different dimensions of our nation’s health goals. For example, the Institute for Healthcare Improvement’s 5 Million Lives Campaign focuses on high-quality care by setting a goal of protecting patients from 5 million incidents of medical harm between December 2006 and December 2008. Also, the Institute of Medicine of the National Academies focuses on a range of wellness and quality-of-care goals, with its committees of experts mobilized to provide the best scientific information on hundreds of health-related questions. The Access Project works to enhance access to health care by supporting local initiatives to study and eliminate disparities in healthcare access, especially for vulnerable populations. In addition, The Commonwealth Fund promotes access to care as well as a stable healthcare system by researching and promoting improved effectiveness and efficiency in the health system.

However, achieving every one of these critical goals—wellness, high-quality care, access to care, and a stable healthcare system—is blocked by an especially pernicious barrier: the current healthcare payment system.

BARRIERS IN THE CURRENT PAYMENT SYSTEM

The mechanisms and incentives of the nation’s current healthcare payment system block, rather than support, the nation’s health goals. The system does not effectively reward wellness or high quality. The system does not encourage societal benefit such as access to care. And the system creates financial instability by adding cost and complexity to health administration, by rewarding high-cost practices, and by focusing on expensive interventions aimed at treating sickness rather than promoting wellness.

Barriers to Wellness

Research confirms that primary care supports improved health status.² Vaccines, preventive medication, screening, promotion of healthy lifestyles, and effective care of chronic conditions—all hallmarks of primary care

medicine—can achieve improved outcomes as well as cost savings. Yet, the payment system often discourages primary care while rewarding expensive and no more beneficial specialty services.

In addition, steep cost-sharing measures can discourage individuals from seeking preventive care or complying with medical guidelines, particularly if they have low or moderate incomes, require ongoing treatment for a chronic condition, or have inadequate levels of insurance.³

The mechanisms and incentives of the nation’s current healthcare payment system block, rather than support, the nation’s health goals.

As shown in Exhibit 1, most of the 15 conditions that generate the nation’s greatest healthcare expense are chronic in nature.⁴ Yet fee-for-service systems generally pay inadequately or not at all for the types of care coordination and ongoing management that are needed when treating those with chronic illness and addressing the complex care issues often associated. Little in the payment system encourages physicians and hospitals to work together to make sure patient care is coordinated for quality or efficiency.

Barriers to Quality

Despite significant advances in science in recent years, there is a gap between known effective care processes and the processes actually used. RAND Health researchers have found that U.S. adults receive about half of recommended healthcare services.⁵ Dartmouth Atlas Project researchers determined this failure to systematically comply with the treatment guidelines was largely due to insufficient means for their support.⁶ Simply put, providers are not compensated in ways that encourage evidence-based care, and health plan benefit designs do not encourage patients to seek out evidence-based care.

Exhibit 1.

TOTAL EXPENSES FOR SELECTED CONDITIONS BY TYPE OF SERVICE: UNITED STATES, 2005

Conditions	Distribution by Type of Service*					Total
	Hospital Outpatient or Office-Based Provider Visits	Hospital Inpatient Stays	Emergency Room Visits	Prescribed Medicines [†]	Home Health ^{††}	
Heart conditions	12,671.88	48,413.53	2,874.45	8,168.45	4,363.53	76,491.84
Trauma-related disorders	26,979.29	29,913.04	9,537.30	1,592.18	4,430.03	72,451.84
Cancer	33,559.39	29,923.19	519.11 [§]	3,365.76 [§]	2,310.61	69,678.05
Mental disorders	16,253.92	8,228.19	816.99	23,902.56	6,763.95	55,965.61
COPD, asthma	12,045.09	13,665.46	2,756.21	17,850.79	7,497.78 [§]	53,815.33
Hypertension	10,073.01	5,919.88 [§]	662.01 [§]	22,937.04	2,687.93	42,279.86
Diabetes mellitus	10,347.87	5,385.30	245.86 [§]	15,241.92	3,067.42	34,288.36
Osteoarthritis and other non-traumatic joint disorders	12,050.16	11,175.74	257.99	6,836.76	3,918.02	34,238.67
Back problems	17,598.68	8,834.78	728.77	3,957.72	1,367.82 [§]	32,487.77
Normal birth/live born	7,871.03	23,526.98	606.11	281.69	30.21 [§]	32,316.01
Kidney disease	14,633.31	12,829.51	1,265.82	1,761.44 [§]	595.40 [§]	31,085.48
Disorders of the upper GI	5,349.87	7,535.37 [§]	788.94	11,597.64	772.20 [§]	26,044.03
Hyperlipidemia	5,851.14	427.59 [§]	17.92 [§]	17,295.31	384.71 [§]	23,976.67
Skin disorders	6,965.23	10,717.62 [§]	514.68	3,127.09	2,370.60 [§]	23,695.22
Other circulatory conditions arteries, veins, and lymphatics	5,380.38	12,275.86	243.48	1,611.52	1,392.01	20,903.25

* Expenses are reported in millions.

[†] For prescribed medicines an event is a purchase.

^{††} A home health event is a month where home health was received.

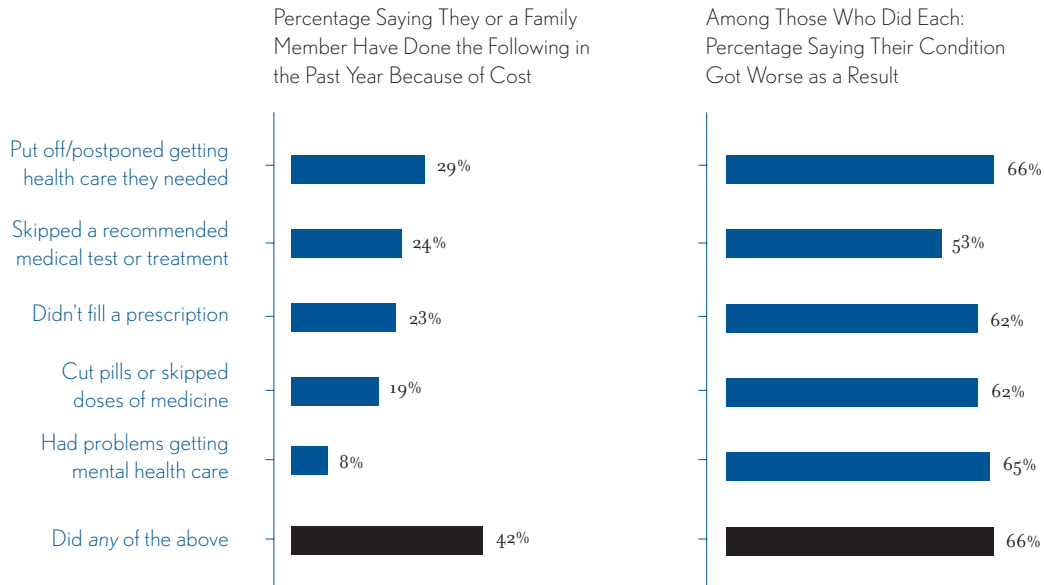
[§] Relative standard error equal to or greater than 30%.

SOURCE: Agency for Healthcare Research and Quality. Total Expenses for Conditions by Site of Service: United States, 2005. Medical Expenditure Panel Survey Component Data.

Many chronic conditions are among the most costly to treat.

Exhibit 2.

PROBLEMS ACCESSING HEALTH CARE DUE TO COST



SOURCE: Survey Brief: Economic Problems Facing Families (#7773). Kaiser Family Foundation, April 2008. This information was reprinted with permission from the Henry J. Kaiser Family Foundation. The Kaiser Family Foundation, based in Menlo Park, Calif., is a not-for-profit, private operating foundation focusing on the major healthcare issues facing the nation and is not associated with Kaiser Permanente or Kaiser Industries.

Consumers find cost to be a significant barrier to healthcare services.

In a volume-based payment system, hospitals, physicians, and others who provide high-quality, efficient care and thereby reduce the volume of patient services receive reduced payment. The payment system encourages competition among healthcare providers for high-margin services, leading to increased fragmentation and, in some cases, an oversupply—and overuse—of those services. It could even be argued that “in so far as poor outcomes lead to more treatments, which command more payments, the current payment system even rewards defective care.”⁷

Barriers to Access and Other Societal Benefit

Rising healthcare costs, due in large part to the current payment system, are weighing heavily on healthcare consumers—those with insurance and without. As a result of difficulties affording health care, many adults have reported delaying or not getting needed medical care. In a recent Kaiser Family Foundation survey, more than four

in 10 said that in the past year, they or a family member have done at least one of the following because of costs (see Exhibit 2):

- Postponed getting needed health care (29 percent)
- Skipped a recommended test or treatment (24 percent)
- Not filled a prescription (23 percent)
- Cut pills in half or skipped doses of a medicine (19 percent)
- Had problems getting mental health care (8 percent)

Among those who reported taking one of these actions, two-thirds said their medical condition got worse as a result.

The uninsured are particularly likely to experience cost as a barrier to accessing health care. Those under age 65 who were not covered by health insurance were nearly twice as

likely as the non-elderly insured to report these types of access problems (75 percent compared with 40 percent). Of the uninsured, six in 10 said they postponed getting health care they needed because of the cost, and nearly half reported skipping a recommended test or treatment and not filling a prescription.⁸

The payment system creates barriers to other societal benefits as well. Other than the terms of some government payers, payment for the cost of training future physicians is not explicitly defined. Thus, hospitals and health systems that provide graduate medical education often build the cost of that service into the rates they negotiate with private payers. This system unnecessarily complicates the overall payment for health services and distorts the pricing system. Similarly, the facilities, technology, and innovation that are needed to sustain healthcare delivery in the future require providers to generate a margin on revenues, which is difficult when some payers do not pay the full cost of care.

Barriers to Stability

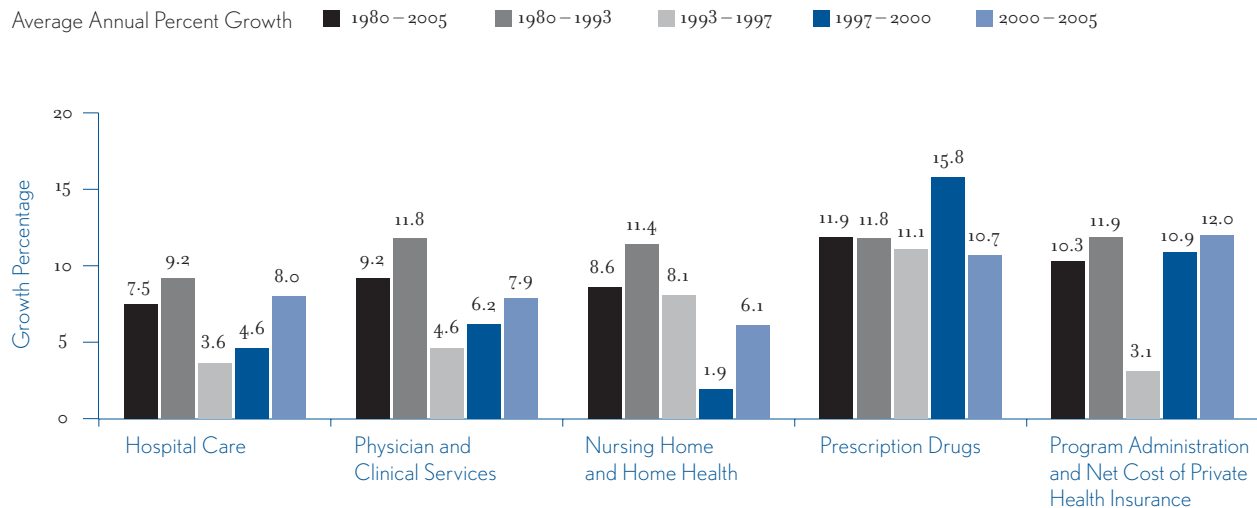
Complying with our payment system’s complex requirements is a great burden for provider, consumer, and payer alike. A variety of factors undermine fiscal stability.

Researchers estimate 31 percent of healthcare expenditures in the United States are administrative in nature.⁹ Administrative costs in the United States are six times higher on a per capita basis than those of a peer group of Western European nations.¹⁰ As shown in Exhibit 3, program administration and net cost of private health insurance were the highest category of health expenditure growth in the years 2000 through 2005.¹¹

One reason for this high administrative cost is the variety of payment methods used (diagnosis-related groups, per diem, pay-for-performance, capitation, fee-for-service) and the complexity and cost these diverse methods add to the billing and collection process.

Exhibit 3.

HEALTH EXPENDITURE GROWTH 1980–2005 FOR SELECTED CATEGORIES OF EXPENDITURES



SOURCE: A. Catlin et al., “National Health Spending in 2005: The Slowdown Continues,” *Health Affairs*, Jan./Feb. 2007 26(1):42-53.

Reprinted from Davis K et al. “Slowing Growth of U.S. Health Care Expenditures: What Are the Options?” The Commonwealth Fund, Jan. 2007. Used with permission.

Most recently, program administration has become the highest growing category of health expenditure.

Another way that the payment system challenges fiscal stability is by systematically encouraging providers to create cross-subsidies (which some refer to as a “hidden tax”) on some payers as a way of offsetting the losses stemming from other payers—including federal and state governments—and uninsured or underinsured individuals who are unable or unwilling to cover the full cost of services provided. These cross-subsidies, which are essential to the financial viability of providers, are so pervasive in current processes of list pricing that the prices that result often appear irrational to all concerned—including providers of care. Further, the high margins that come from some services, because of this cross-subsidy pattern, create incentives for providers to add service capacity beyond what is needed.

Solving these problems systematically may seem to be a daunting task given the market-driven nature of health care in the United States. However, the lack of sustainability of the current payment system makes systemic change imperative: Medicare’s hospital insurance trust fund is projected to be exhausted by 2019, the percentage of those covered by employer-sponsored health insurance is falling, healthcare bad debt is increasing, and providers’ margins often are insufficient to cover the investments needed to transform care processes. The need to create a payment system that will be stable, predictable, and sustainable into the foreseeable future is essential.

Also, the current payment system makes it difficult to predict the amount of funding that will be flowing into the healthcare system. Funding uncertainty can be introduced too easily through today’s complicated interactions of regulatory policy, insurance underwriting cycles, philanthropic giving patterns, and other macro-economic factors. As an example, provider payment reductions from the Balanced Budget Act of 1997 shrunk hospital margins dramatically, bankrupted most of the publicly traded nursing home chains, and reduced the number of home agencies by nearly half. The likelihood for such instabilities makes it difficult for all entities to access the capital markets and other sources of investment and to chart the future of their organizations with a high level of confidence.

HFMA INITIATIVE

Changing the payment system is a multifaceted problem. Any change to solve one aspect of the system holds the potential to make some other worse. To cite just one example, improving quality and reducing cost are two generally agreed upon payment system goals. However, creating payment incentives to reward high-quality outcomes may add cost unintentionally if the incentives are structured in such a way as to encourage overutilization in pursuit of those outcomes.

In the face of this situation, an overall framework is crucial to ensure that payment system change thoughtfully considers the multitude of trade-offs necessary to accommodate the unique and appropriate desires of key stakeholder groups: providers, payers, employers, and consumers. (The term “providers” includes a healthcare professional, a group of healthcare professionals, a hospital, or some other facility that provides direct care to patients, as well as entities such as disease management organizations.)

HFMA proposes that this framework be built on principles of a new payment system that have broad consensus among all of these groups. Only through shared perspectives will it be possible to develop a system that respects the stakeholders’ needs, provides appropriate incentives, and minimizes level of risk. With this in mind, HFMA has sought input and advice on healthcare payment reform from a diverse cross section of these stakeholders through a variety of means, including HFMA’s Building a New Payment System retreat in September 2007.

This paper reflects these contributions and seeks to:

- Reach broad consensus on principles of a new payment system
- Identify areas of consensus among possible design elements to enact the principles
- Identify key elements of system design that need discussion, research, definition, or resolution

HFMA will lead efforts to focus stakeholder discussion around these key areas needing resolution. Ensuring that these efforts are within the context of shared principles for reform and shared goals for the nation’s health should foster the collaboration necessary for meaningful change.



Principles of a New Payment System

What might this ideal payment system look like? The following discussion explores this idea by presenting several principles of a new payment system, noting the strongest areas of consensus for them and listing potential challenges in their implementation.

Payment system reform can be considered in relation to five principles.

PRINCIPLE 1: QUALITY

Payments should encourage and reward high-quality care and discourage medical errors and ineffective care. Wherever possible, payments should reward positive outcomes, rather than adherence to processes. In the absence of outcome measures, payment systems should reward the use of accepted practice and evidence-based processes and protocols that meet or exceed standards of quality and safety to promote optimal outcomes. Payers should not be responsible for payment to cover costs directly related to serious preventable medical errors.

This principle supports the goal of creating a health system that provides high-quality care that is based on the systematic use of accepted practice and evidence-based processes. Not all health procedures currently have rigorous evidence-based protocols, of course, so stakeholders will need to establish interim minimum standards for identifying generally accepted good practice in these areas. Providers should have meaningful incentives to adopt—or, where needed,

develop—these evidence-based good practices to achieve better outcomes. With this in mind, incentives should reward interim progress toward improved quality and outcomes as well as meeting or exceeding quality standards. This principle also embraces the concept that payers should not pay for the services resulting from preventable medical errors.

Preventive care is an inherent component of providing comprehensive, high-quality care. Therefore, this principle supports the goal of improved health by creating incentives for a wellness system rather than primarily a sickness-care system. Also, this principle encourages the creation of an efficient, sustainable, and fiscally responsible healthcare system that minimizes need for intensive and expensive care and enables continuous improvement through a reliable future workforce, new discoveries, and innovation.

Leading providers already have supported the tenets of this principle by collaborating with payers in pilots and demonstration projects, such as the Hospital Quality Incentive Demonstration sponsored by the Centers for Medicare and Medicaid Services and Premier Inc., in which hospitals earned bonuses for complying with evidence-based guidelines or risked loss of payment

for failure to do so. Similarly, many providers agreed to an employer-led initiative—the Leapfrog Never Events policy—in which they waive all costs directly related to a serious preventable medical event. Such activities signal the readiness of providers, payers, and employers to collaborate on new approaches to quality incentives.

All stakeholder representatives consulted strongly supported quality as a payment system principle. However, implementation of a payment system that embodies this principle will face some key hurdles: identifying, accepting, and using evidence-based practices; determining a system of accountability for outcomes; overcoming consumer tolerance for an environment where emotional or purely business-driven decisions fuel healthcare underuse, overuse, and misuse; and ensuring that healthcare consumers do their part to help accomplish desirable health outcomes.

PRINCIPLE 2: ALIGNMENT

Payments should align incentives among all stakeholders to maximize the efficiency and coordination of health services based on accepted practice and evidence-based delivery models and protocols. Payment systems should stimulate and reward healthful behavioral choices and selection of value-based services by consumers related to prevention, primary care, acute care, and chronic disease management. Care decisions should be made through a shared decision-making process in which patients' values and preferences are identified and respected.

This principle supports the national health goals of wellness, high-quality care, and system stability through alignment and coordination of appropriate and efficient services. Payment systems should align the incentives of providers to coordinate services and care in these various settings to eliminate duplication and waste. And payment systems should provide incentives for consumers and patients to make decisions that result in a healthier lifestyle while respecting their unique values and preferences.

This principle also supports the goal that payment systems should recognize accepted and evidence-based care processes as the basis for effective care delivery. Care delivery and health services should be based on the best evidence available that the services result in achieving the desired health outcome.

All of those consulted representing the stakeholder groups—providers, payers, employers, and consumers—strongly supported this principle. However, they also pointed out a number of implementation challenges:

- Because stakeholders are sensitive to shifts in revenue, fostering cooperation among stakeholders to realize this principle may be difficult.
- The principle requires broad concurrence on quality measures. Although defining and measuring desired outcomes may not be too difficult, some agreement would be needed on the degree of flexibility a provider would have in determining which processes would best achieve these outcomes.
- Current societal acceptance of underuse, overuse, and misuse of healthcare services will be difficult to change.
- Current health delivery structures are fragmented. Alignment would require substantial redesign of organizations and delivery patterns.

PRINCIPLE 3: FAIRNESS/SUSTAINABILITY

Payment systems should sufficiently balance the needs and concerns of all stakeholders. Payments should recognize appropriate total costs for the efficient delivery of healthcare services that are necessary and consistent with evidence-based care, high-quality/low-cost provider benchmarks, and the advancement of medical science. Payment systems should accommodate payers' and purchasers' needs to allocate funds in a predictable, manageable fashion. In addition, consumers should have financial incentive to select high-quality, efficient care without being discouraged from seeking necessary and appropriate services. Finally, the payment system should be sustainable, providing a stable funding stream in the face of competing claims on public and private capital.

This principle supports the goal of a financially stable healthcare system that holds all stakeholders accountable for ensuring appropriate levels of payment for the value of services rendered. Consistent with this principle, payment shortfalls should be eliminated so that payment levels cover the financial requirements of efficient providers, including appropriate operating and capital reserves. Similarly, excessive payments—payment levels

that exceed these fair-market-value costs—should also be eliminated to provide the funding needed to address shortfalls in other areas. Within this principle is the concept of investment and innovation in services and care delivery that are critical to the evolution of medical science and health goal attainment.

This principle recognizes the role that consumers play in the selection of high-quality and effective health services, including preventive services. Payment systems that involve consumer portions should discourage pursuit of unnecessary or inefficient services, and at the same time eliminate disincentives for seeking needed services, including evidence-based prevention and wellness services. In addition, consumer payment portions should be set in relation to the individual's ability to pay.

All providers are responsible for delivering high-quality services in an efficient manner; payment systems should ensure that incentives among doctors and hospitals are aligned in such a way that each party is held accountable for elements of service delivery, quality, outcomes, and cost that are within its control.

The sustainability of any future payment system goes hand in hand with the fairness principles discussed. Recognition of the value and costs of healthcare services should not change suddenly and dramatically simply because public and private funding systems can no longer afford the care rendered. Although this concept obligates payers to develop a clear view of the value of a particular healthcare service, it also obligates providers to develop stable prices commensurate with cost and to utilize services as indicated solely by clinical need.

Stakeholder representatives generally supported this principle. However, they also identified the critical challenge of defining appropriate costs according to benchmarks for high-quality and efficient care so that payers are not supporting costs of inefficient providers. Also, some stakeholders indicated that methods for determining the consumer's payment portion would need to allow for ease of implementation.

PRINCIPLE 4: SIMPLIFICATION

Payment processes should be simplified, standard, and transparent. Payment and billing systems should reduce the volume and complexity of communications sent to healthcare consumers and the cost of billing, adjudication, and payment for providers of care and payers. All parties should use payment methodologies, standardized at the national level, to reduce complexity. The payment methodologies should be transparent to those affected by them, and comply with privacy, security, and antitrust laws and regulations.

This principle supports the goal of a stable healthcare system by addressing the pressing need to reduce the administrative burden associated with today's fragmented healthcare delivery and payment systems.

The complexity of the current payment system reflects two pricing methods—administered pricing from Medicare and Medicaid programs and some private payers, and market pricing from other payers—neither of which is based on a provider's costs and both of which only indirectly reflect a provider's charges. Meanwhile, each payer's contract with a provider has unique elements. The relative leverage of commercial payers and providers in managed care contracting depends on individual market, payer, and provider circumstances. Accommodating this complexity adds tremendous administrative costs to the healthcare system and makes price "transparency" to healthcare consumers difficult; transparency without simplification only sheds light on the problems inherent in the system.¹²

A simplified, standardized system of payment methods (not to be confused with a single-payer system or a national price system) has great potential for reducing the workforce needed to make that system work and to provide the transparency that payers, employers purchasing health plans, and consumers need to evaluate the value of the healthcare services being delivered. Such a system most likely would be tested at a regional level, but consistency at a national level is an important goal if multi-state providers, employers, and health plans are to share in the benefits of standardization.

It is an exceedingly delicate balance that must be struck when developing payment standards that will not only support the widespread consistency needed to achieve efficient care and funding stability but also allow for innovations in financing or data sharing.

All stakeholder representatives consulted supported this principle, with many identifying it as among their top priorities.

However, stakeholders identified several implementation challenges:

- A point of contention may be whether the standards are established on a national or regional level.
- The method of implementing this principle will need to adhere to antitrust law, maintaining vigorous competition in the marketplace.
- Transparency of provider prices, particularly when prices are bundled in such a way as to match those of competitors, could lead to price increases that hurt consumers according to some stakeholders, although other experts believed that this transparency may lower prices.

PRINCIPLE 5: SOCIETAL BENEFIT

The resources needed to support broad societal benefits such as medical and public education, medical research, and care for disenfranchised or uninsured persons should be identified and paid for explicitly. Similarly, payment systems should reward innovators who develop technologies, services, processes, and procedures that enhance safe, high-quality, and efficient care.

This principle supports the health goal of access to care and other societal benefit, as well as the goal of a stable healthcare system. The intent of this principle is that the costs that healthcare organizations incur to address the specific needs of their communities and society, including those incurred for training and research, should be articulated, recognized, and paid for in a sustainable way.

Tax-exempt healthcare providers are becoming more skilled at articulating these benefits and will continue to improve in this area as the revised IRS Form 990 is implemented. Healthcare activities that are of a broad benefit to society include provision of essential healthcare services that lose money because of high costs combined with low volume or inadequate payment rather



than inefficient operations. Common examples include burn units, neonatal units, community mental health centers, medical and public education, and provision of other unmet human needs, such as senior citizen outreach programs and care for “boarder” babies. This principle also incorporates support for a sustainable system that enables new discoveries and innovation for reliable and continuous improvement in high-quality and efficient care.

Most stakeholders supported Principle 5; one stakeholder said transparency about the built-in costs of, for example, medical education would be welcomed so stakeholders and consumers can determine what societal benefits they wish to support and at what level that support should be offered.

A significant challenge in implementing this principle is achieving broad-based support for the method used to define and quantify “societal benefit” and the fair share of those costs to be borne by each stakeholder group.

An additional belief expressed by most stakeholders consulted for this report is that achieving insurance coverage for every individual will improve the health system’s efficiency, increase the health system’s capacity to serve more patients, and create a sustainable healthcare infrastructure.

SUMMARY OF CONSENSUS AND CONCERNS RELATED TO PAYMENT SYSTEM PRINCIPLES

America’s key healthcare stakeholders share the same values and are ready to move forward together to create a better way to pay for healthcare services. This conclusion was evident from discussions with representatives of providers, payers, employers, and consumers.

The principles with the broadest support pertained to *quality*, *aligning incentives*, and *simplification*. Clear consensus exists for these key concepts of payment-system reform: accountability, efficiency, shared responsibility, and the use of evidence-based care. And all stakeholders support incentives that encourage providers to deliver effective, efficient care and consumers to have healthful behaviors and follow care regimens.

The experts consulted also identified implementation challenges for a system based on these principles. In some cases, the challenges would require stakeholders to resolve conflicting interests:

- Agreement on quality measures will be challenging, especially in the matter of measuring outcomes or processes. While outcome measures generally are seen as ideal, some outcomes can be measured only after a long period of time and require risk adjustment.
- Financially penalizing providers that fail to meet quality and efficiency standards may have the unintended effect of restricting their subsequent abilities to improve care due to the reduction in resources available to them.
- All stakeholders expressed concern about the cost of transitioning from the current payment system to a future system. Although most stakeholders believe that an appropriately designed payment system could save money in the long term, the emphasis on much wider use of preventive services in the short term presents a financial hurdle.
- A critical challenge of implementing these principles is creating an environment in which all stakeholders share the sense of urgency that will foster expeditious change.
- The stakeholders who need to make investments and take action to implement a new payment system are not necessarily those who will benefit the most.
- Determining and rewarding appropriate levels of care will be contentious. For example, rewarding desirable outcomes should not mean rewarding an excessive volume of services to achieve those outcomes. Also, some stakeholders voiced concern over whether the malpractice environment would need to be addressed to make such a system actionable.
- Any effort to establish financial incentives related to changing the utilization of expensive life-saving or life-extending care in situations where death is imminent will incite great debate.
- Defining and determining how to apportion responsibility for societal benefits such as medical education and care for the uninsured will be significant challenges.
- Implementing these principles will require widespread behavior changes in how consumers and providers view and practice health care.

3

Elements of a New Payment System

With these principles in mind, the next step is to consider whether they could be put into practice. If they are put into practice, what benefits would providers, payers, employers, and consumers realize? What trade-offs might these stakeholders have to make?

Designing a payment system that will achieve the nation's health goals and support the identified payment principles requires an examination of specific elements of how the payment system could be designed. While payment system principles are important to set the context for change, the real challenge is actually working through design options that require operational detail and resolution of legitimate concerns among the health system stakeholders.

When considering elements of a new payment system, it is helpful to first recognize that healthcare payment methods can be categorized into six basic types.¹³

- *Fee-for-service*, where payment to the healthcare provider is based on each service provided to a patient
- *Per diem*, where payment of a pre-established amount is given to a provider based on each day of a patient's treatment for a particular condition
- *Episode of care — individual providers*, where a global payment is given to a single provider for delivering a related group of services
- *Episode of care — multiple providers*, where a global payment is given to a group of providers for delivering a related group of services
- *Condition-specific capitation*, where a provider receives a single payment for delivering a group of services designed to meet the care needs for a specific health condition
- *Full capitation*, where a provider receives a single global payment for delivering a group of services designed to meet the nonacute health needs of a covered group of individuals

As illustrated in Exhibit 4, risk for stakeholders will vary for each payment type primarily by the incentives to control costs related to steps in the treatment process (efficiency) and the number of episodes of care.

Fee-for-service payment carries no incentive to reduce the number of episodes of care. For healthcare consumers, this means a risk of overtreatment. Employers risk high costs of inefficiencies.

Per diem payment carries some additional incentive for provider efficiency in the treatment process, but not for reducing episodes of care.

Episode-of-care payment places significant financial risk on providers for the efficiency and coordination of

the treatment process, which in turn creates a risk that consumers will receive fewer services than appropriate.

Condition-specific capitation also places financial risk on the provider to control the efficiency of care and the number of episodes of care, thereby increasing risk to consumers of fewer services delivered than appropriate.

Full capitation creates the incentive for providers to reduce the number of episodes of care by keeping the covered population healthy, but also brings significant financial risk for the provider if a population is sicker than average. Consumers risk undertreatment under full capitation, and employers will risk long-term high costs if sicker individuals do not receive adequate care.

Given the significant risk inherent in either end of the range of payment types, payment system change efforts tend to focus in the middle of this continuum—on episode-of-care payment and condition-specific capitation. Although narrowing the potential payment types in this way is helpful, it is far from the specific design elements necessary to achieve the nation’s health

goals, fulfill the payment system principles, and gain the support of the stakeholder groups.

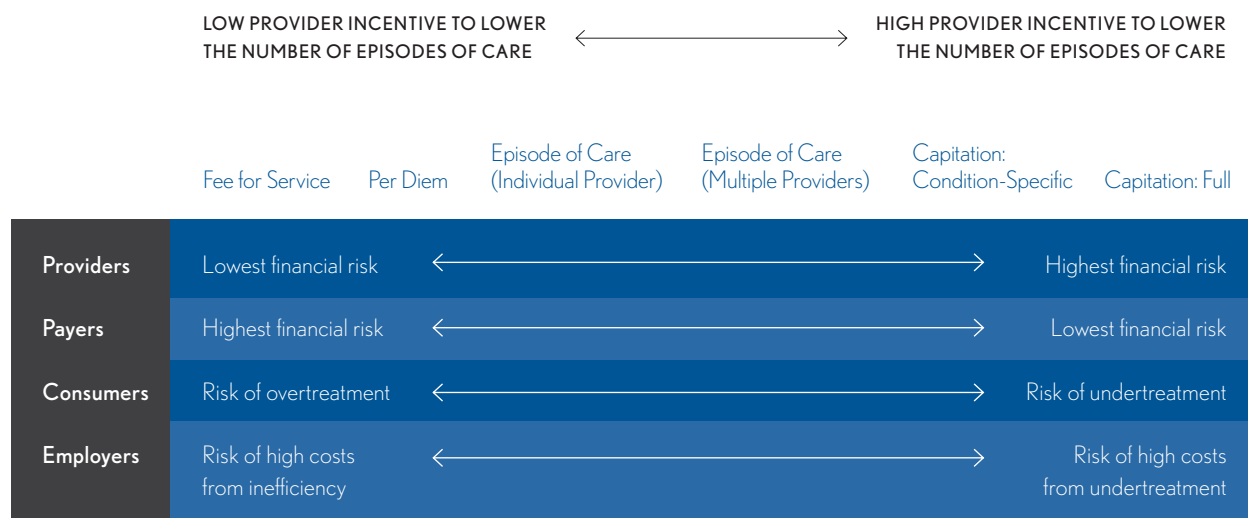
Just some of the considerations that should be given when developing effective design elements: Incentives of various kinds are needed to motivate achievement of goals such as preventive care, adherence to evidence-based practices, and collaboration among providers. Definitions of desired clinical processes and outcomes are needed. And risk-adjustment methods need to be implemented to mitigate the financial risk of sicker patients.

To engage in a realistic assessment of which design elements hold the greatest promise of success, HFMA organized a number of these design elements into three categories: condition-specific capitation, episode-of-care payment, and payment for societal benefit.

The selected elements are intended to embody the payment system principles. For each category, the elements seek to align incentives, reward high-quality care, fairly distribute payment, standardize and simplify payment processes, and foster an explicit payment

Exhibit 4.

OVERVIEW OF STAKEHOLDER RISK BY PAYMENT TYPES



Risks for stakeholders by payment type will largely depend on the incentive for providers to be efficient in the treatment process and lower the number of episodes of care.

structure for societal benefits. The elements also are intended to support achieving the nation’s health goals of longer life, better quality of life, improved access to care, high-quality care, and a financially sound system. HFMA does not specifically endorse any of these elements. Rather, they are a basis for study intended to move the industry toward consensus on true payment reform.

As with the principles, HFMA shared the design elements with representatives of the stakeholder groups: providers, payers, employers, and consumers. HFMA asked for responses with the goals of:

- Identifying which design elements or types of elements had the greatest potential for consensus among stakeholders; and
- Identifying questions, concerns, and challenges in implementing the various design elements or types of elements.

With this information in hand, it should be possible to focus subsequent payment system reform efforts on:

- Resolving concerns about various design elements;
- Building on payment system elements with the broadest consensus;
- Creating operational details to help resolve challenges; and
- Testing different payment system elements and designs.

Because these design elements will take place within the context of the nation’s health goals and the payment system principles, they will be coherent in focus and reflect an understanding of stakeholder relationships and values.

Note that the design elements HFMA selected are based on *Incentives for Excellence: Rebuilding the Healthcare Payment System from the Ground Up*, a report stemming from the Network for Regional Healthcare Improvement’s 2007 Summit on Creating Payment Systems to Accelerate Value-Driven Health Care. See the appendix to this report for descriptions of a number of demonstration projects that have tested payment methods.

In the next section of this report, each category of design elements that HFMA selected is followed by the health goals they support, the payment principles they support, areas of consensus, potential challenges to implementation, and details that need to be defined.

CONDITION-SPECIFIC CAPITATION FOR PREVENTIVE SERVICES AND CHRONIC CARE

A sample of payment design elements grouped to reflect a condition-specific capitation arrangement might look like the following.

Preventive Services

- Healthcare providers receive a periodic payment to cover the management of preventive care services for a patient, with the amount of the payment adjusted for the age and risk of the patient, in addition to separate fees for specific preventive services, such as immunizations and routine screening tests and procedures.
- Providers receive financial rewards from payers for identifying and encouraging use of preventive services (for example, those prescribed by the U.S. Preventive Services Task Force); providers’ payments are reduced if they fail to provide such services.
- Consumers receive financial incentives for following provider-recommended processes for preventive care.
- The healthcare provider receives financial rewards for defined patient outcomes (adjusted for patient risk) related to the served population’s compliance with preventive measures, ranging from smoking cessation and weight management to reduced hospitalization and reduced mortality. These bonuses offset some or all of the reductions in service-specific fees that the provider would experience due to improved health of the patient population.

Chronic Care Services

- Healthcare consumers with the chronic illness(es) select a primary healthcare network (sometimes called a medical home) that is able to deliver the recurring care needed to treat the condition(s). A primary provider either delivers care directly, or helps the consumer access other providers and coordinates that care.
- The payer gives the primary provider a global, risk-adjusted periodic payment that covers all of the patient’s care management, preventive care, and minor acute care services associated with the chronic condition as defined by accepted practice, evidence-based approaches, and protocols. The payment varies based on patient characteristics—both the specific

chronic illness(es) experienced and other factors affecting the level of healthcare services needed.

- Within accepted practice, evidence-based case management, and protocols, if a healthcare provider other than the patient's primary care provider is needed to deliver specific services as part of caring for the patient's chronic condition, then the primary provider would be responsible for paying for those services out of the global payment.
- Typically, global payment for chronic care would not include hospital and specialty care for major acute episodes or long-term care.
- Providers are paid bonuses (or payment penalties) based on chronic-care consumers' outcomes and satisfaction.
- Providers are not required to provide specific types of services to consumers in order to receive payment.

Both Preventive and Chronic Care Services

- For a provider to be eligible to receive capitated payment for preventive and chronic-care services, it needs to demonstrate that it has the structure and systems, including healthcare IT systems, in place to provide the elements of care needed by consumers for successful treatment and good outcomes.

Health System Goals Supported

- Wellness
- High-quality care
- Access to care
- Financially sound system

Payment Principles Supported

- Quality
- Alignment
- Fairness/Sustainability
- Simplification

Areas of Consensus

- All stakeholder representatives were adamant about the importance of creating a functional preventive care payment system.

- All stakeholder representatives supported the concept of consumers' incentives to use preventive services and healthful behavior guidelines being aligned with those of providers and payers.
- Most stakeholders are enthusiastic about linking provider payment to following evidence-based care processes and achieving desirable outcomes.
- Most stakeholders indicated primary care physicians would eagerly embrace global payment to providers for preventive care.

Potential Challenges

- All stakeholders consulted are concerned about the costs and resource consumption of providing more preventive services.
- Revenue shifts may create resistance if demand for certain physician and hospital services are reduced.
- Assigning responsibility for preventive care will be a challenge, as will coordination of care. The movement toward payers contracting with groups of providers—"accountable health systems"—rather than individual physician practices may help ease this concern, as well as create the ability to track outcomes for a larger group of patients associated with the system, as opposed to each individual physician.
- Tying financial incentives to outcomes may prompt some providers to avoid difficult cases. That makes effective risk and complexity adjustment imperative.
- It will be challenging to set the payment at a level that covers all costs incurred by all associated providers.
- Reaching consensus on the various matters requiring definition—especially care processes and outcomes—will be challenging.
- The requirement for a certain level of infrastructure to participate may leave out many providers and create gaps in service in areas of the country.
- Even if consumers receive financial incentives for compliance, it is likely that those who are noncompliant will undermine a good outcome even when a physician follows accepted care protocols. This makes it important to have appropriate incentives for both healthcare consumers and physicians.

Details Needing Definition

- A significant number of definitions are required, such as services included under preventive care and chronic care, providers eligible to coordinate care, accepted evidence-based care processes, and desirable outcomes.
- A risk-adjustment method will be critical to success.
- A mechanism would need to be developed to determine payment rates. For example, the payment rates may be standard rates determined within geographic areas or determined through negotiations.
- Mechanisms to smooth out the impact of revenue swings and to recognize short-term cost and long-term benefit must be developed to gain buy-in from various stakeholders. (For example, such a mechanism might involve up-front funding from government, commercial payers, and/or provider coalitions with a claim on the future benefits as they accrue.)
- Special efforts would be needed to make these elements work for providers with small numbers of patients.
- Pilot tests would be required to confirm potential benefits and identify pitfalls.

EPISODE-OF-CARE PAYMENT

A sample of payment design elements grouped to reflect an episode-of-care payment arrangement might look like the following.

- A healthcare network that provides all services needed by a patient for an accident or illness event receives a global (all inclusive) payment—or multiple payments are made to multiple providers with appropriate withholds to ensure that all providers are aligned in their efforts. Members of the healthcare network would be encouraged to create joint arrangements among themselves for accepting and dividing the payment and ensuring alignment. (In the long run, groups of providers would be expected to define a single accountable payee for receiving and allocating a payment among themselves.) The amount of the payment will be based on an individual-based, algorithmic risk-adjustment methodology.¹⁴

- Adjustments in the payment are made for cases requiring unusually high levels of service as long as defined outcomes are achieved and as long as additional service is not because of preventable adverse events or complications resulting from such events.
- Providers (which are paid based on the episode of care) would receive bonuses or payment penalties based on acute-care patients' outcomes and satisfaction.
- All of those providing necessary care for the episode of illness or injury, including hospitals and home healthcare agencies, would be eligible for payment.

Health System Goals Supported

- Wellness
- High-quality care
- Financially sound system

Payment Principles Supported

- Quality
- Alignment
- Fairness/Sustainability
- Simplification

Areas of Consensus

- All stakeholders' representatives expressed enthusiasm about aligning physician and hospital incentives.
- Physician-hospital collaboration could have a significant payoff in enhancing efficiency, quality of care, and consumer satisfaction.

Potential Challenges

- Significant organizational and care delivery changes would be needed to align incentives among independent providers. In some cases, state law may restrict certain delivery models (e.g. corporate practice of medicine).
- Payment determinations will need to be flexible and nimble enough to keep pace with changes in accepted medical practice and evidence-based care knowledge.

- Agreement on evidence-based care processes, expected outcomes, and especially appropriate use of high-cost procedures will be a significant challenge.
- The payment design will need protections to avoid exclusion of consumers with complex, costly conditions, including effective application of risk adjustment.

Details Needing Definition

- A significant number of definitions are required, including services included, accepted evidence-based care processes, and desirable outcomes.
- The methods used to determine payment allocation based on noncovered services within a covered episode of care would need to be developed.
- The methods used to determine payment rates would need further development. For example, negotiations between each payer and each provider might determine rates for certain types of episodes, or perhaps standard rates could be determined within geographic areas.

PAYMENT TO SUPPORT SOCIETAL BENEFIT

A sample of design elements intended to support a payment system for societal benefit might look like the following.

- All the payers in a region make separate payments to teaching and research hospitals to cover their additional costs related to medical education/training and research. This revenue comes from a uniform surcharge on all payments in the region to ensure that the prices for the same types of care are comparable for teaching and nonteaching hospitals.
- All the payers in a region make separate payments to providers to cover their costs of providing uncompensated care and other recognized community benefit and community-building activities. This revenue comes from a uniform surcharge on all payments in the region.

Health System Goals Supported

- Access to care
- High-quality care

Payment Principles Supported

- Societal benefit

Areas of Consensus

- Medical education and research are recognized as providing broad-based benefit for the healthcare system.
- Uncompensated care is recognized as a significant challenge to society as a whole and to providers attempting to maintain financial viability.

Potential Challenges

- Broad-based support for the method used to define and quantify “societal benefit” will need to be achieved.
- Determining the “fair share” of costs that must be borne by each health system stakeholder and the obligations potentially associated with being a recipient are likely to create contention. As just one example, tax-exempt status for recipient hospitals might fall into question.

Details Needing Definition

- A significant number of definitions are required, including services included as societal benefit, though work by HFMA, the Catholic Health Association, VHA, and others have improved definitions as identified by the IRS Form 990, Schedule H.
- A system of support will need to be developed that would enable new discoveries and innovation for reliable and continuous improvement in high-quality and efficient care.



Agenda for Action

Achieving meaningful transformation of the healthcare payment system is a vastly complex endeavor, requiring collaboration among providers, payers, employers, and consumers. Given the complexity of the current payment system, progress toward a more rational system may not be as rapid as some stakeholders would wish. That said, collaborative efforts to shape payment have the greatest potential for solving many of today's healthcare challenges.

HFMA identifies the following actions as necessary for meaningful payment reform:

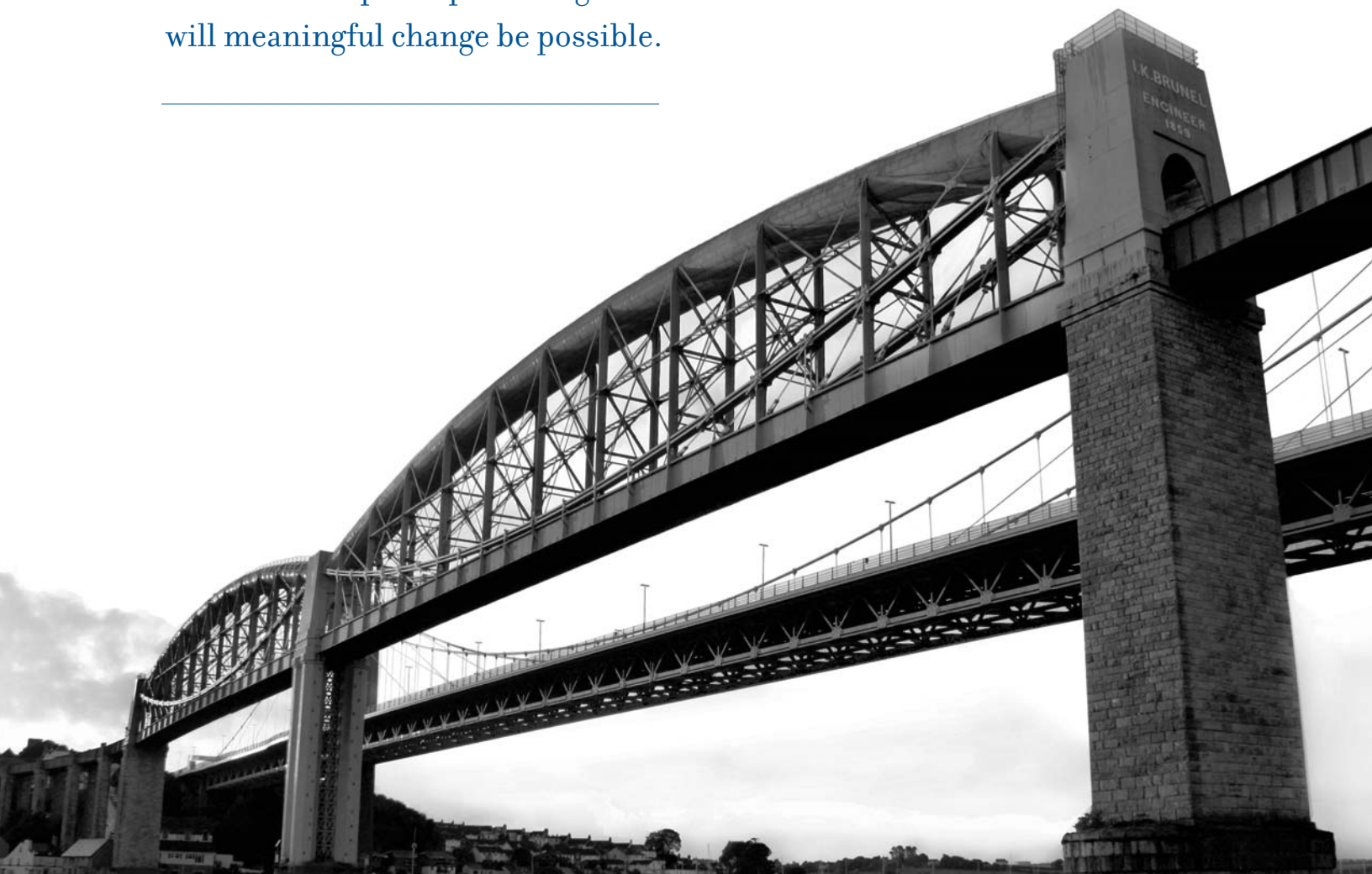
- Payment system changes should be planned within a conceptual framework that defines principles of a payment system that are shared by key stakeholders and that supports the nation's health goals, such as the principles defined in this report. The public and private sector will need to come together to achieve the goals. The proper incentives will need to be aligned among all constituents to balance the interests of all parties, including shareholders of public companies, payers, and federal and state governments.
- Payment reform should be undertaken in a spirit of trust, not only among but within the key stakeholder groups, including between hospitals and physicians. While recognizing that the current system creates conflicting motivations, stakeholders also should appreciate that they often share both a desire for reform and many ideas of how that reform can be carried out. The areas of consensus identified in this report represent a foundation for enhancing trust among stakeholders.
- Payment reform efforts need to have a sense of urgency, a belief that the status quo is not an option and that the current payment system is not sustainable. However, the pace of reform must match the ability of stakeholders to adjust organizational, delivery, resource allocation, funding, and other systems.
- Payment reform may create significant revenue shifts, including increased initial costs with potentially reduced costs in the future. Mechanisms to smooth out the effects of such revenue shifts and to recognize short-term cost and long-term benefit must be developed to gain buy-in from various stakeholders.
- Key building blocks for payment reform require study, definition, and consensus, including:
 - Developing agreed upon evidence-based processes, and determining whether a separate entity is necessary to administer these quality protocols
 - Developing robust modeling to evaluate the different payment methodologies and payment rate-setting processes

- Creating multistakeholder gainsharing arrangements so that payers, providers, and consumers share equally in the long-term benefits of aligned, efficient, high-quality care
- Developing a transition path that minimizes cost of creating the financial incentives for preventive care
- Defining and determining how to apportion responsibility for societal benefits

Achieving these principles will require an unprecedented level of cooperation and trust among all the parties. This shared outlook will be difficult to achieve because of the ramifications of the redistribution of the healthcare dollar, which potentially could fuel increasing levels of contention among the very groups that must cooperate.

Creating that cooperation—and the outcome of meaningful payment system reform—requires gathering key stakeholders to address the specific areas of concern listed above and elsewhere in this report, within the context of consensus about the principles of an ideal payment system and many basic elements that could make up that system. Only by operating within a shared framework of principles and goals will meaningful change be possible.

Only by operating within a shared framework of principles and goals will meaningful change be possible.



End Notes

- ¹ HFMA defines the payment system as the mechanism by which money moves from payers of health services (government, insurance companies, and individuals) to the providers of health and wellness services, which influences the methods by which these services are offered and delivered. The payment principles and models in this document assume that changes can be made within the current pluralistic system of public/private financing and care provision.
- ² Many such studies are cited in “Prevention’s Potential for Slowing the Growth of Medical Spending,” National Coalition of Health Care, Oct. 2007.
- ³ Schoen, C. et al., “Insured but Not Protected: How Many Adults Are Underinsured?” *Health Affairs* web exclusive, June 13, 2005.
- ⁴ “Medical Expenditure Panel Survey,” Center for Financing, Access, and Cost Trends, Agency for Healthcare Research and Quality, 2005.
- ⁵ Asch, SM, et al., “Who Is at Greatest Risk for Receiving Poor-Quality Health Care?” *New England Journal of Medicine*, March 16, 2006, pp.1147-1156
- ⁶ “Effective Care: A Dartmouth Atlas Project Topic Brief,” Center for the Evaluative Clinical Sciences, Jan. 2007.
- ⁷ Miller, H.D., analysis prepared for the Network for Regional Health Care Improvement, Pittsburgh Regional Health Initiative.
- ⁸ “Economic Problems Facing Families,” Kaiser Family Foundation, April 2008.
- ⁹ Woolhandler, S., Campbell, T., and Himmelstein, D.U., “Costs of Health Care Administration in the United States and Canada,” *New England Journal of Medicine*, August 21, 2003, pp. 768-775.
- ¹⁰ “Accounting for the Cost of Health Care in the United States,” McKinsey Global Institute, Jan. 2007.
- ¹¹ “Slowing Growth of U.S. Health Care Expenditures: What Are the Options?” The Commonwealth Fund, Jan. 2007.
- ¹² Taken in part from Ginsburg, P., “Principles of a New Payment System” (lecture, HFMA Building a New Payment System retreat, Washington, D.C., Oct. 11, 2007).
- ¹³ The descriptions of payment types that follow are adapted with permission from Miller, H.D., “Creating Payment Systems to Accelerate Value-Driven Health Care,” Network for Regional Healthcare Improvement, March 2007, sections IIB and IIC; “Types of Payment Methods,” with acknowledgement of additional authors, particularly Robinson, J. C., “Theory and Practice in the Design of Physician Incentives,” *Millbank Quarterly*, June 2001, pp. 149-177.
- ¹⁴ The episode-of-care elements are similar to ones proposed in “PROMETHEUS: Provider Payment for High Quality Care; A White Paper,” PROMETHEUS Payment®, Inc., May 2006.

Appendix: Payment Reform Pilots and Proposals

A number of healthcare payment reform pilots and proposals have been developed and tested. These embody many of the principles and design elements discussed elsewhere in this paper.

This appendix summarizes a number of these efforts, including standardized payment structure, bundled or consolidated payments, evidence-informed case rates, capitated payment for care management, pay for performance, and state reform.

STANDARDIZED PAYMENT STRUCTURE

One approach to simplifying the healthcare payment system is for a single entity to set standard rates that all payers pay. In 1977, Maryland became just such a system, establishing hospital rates that must be charged to all patients regardless of their insurance status. All payers, including Medicare and Medicaid, must reimburse hospitals based on these rates.

Since its inception, Maryland's Health Services Cost Review Commission (HSCRC) estimates it has saved Marylanders about \$1.3 billion in hospital costs by keeping the growth in cost per admission below the national rate. Setting its own fees for healthcare services also enables Maryland to cover reasonable costs of uncompensated care. In 2000, \$469 million was included in rates for uncompensated care. As a result, the HSCRC says Maryland has no need for public hospitals.

Physician reimbursement rates do not fall under the all-payer system. For several years, the Maryland legislature has debated establishing minimum reimbursement levels for specific groups of physicians who are obligated to provide care to all patients, including physicians working in emergency rooms and trauma centers. However, effective rate regulation relies heavily on the collection of audited, detailed, and timely financial and patient acuity data to determine standards of reasonableness for rate setting. It also requires the participation of all physicians. In the past, the physician community has been reluctant to provide such data and to participate universally in a statewide system.

BUNDLED OR CONSOLIDATED PAYMENTS

There has been renewed interest in bundled, consolidated, or global payment rates as a means of aligning physician and hospital financial incentives to provide optimal care to patients.

On May 16, 2008, CMS announced a new demonstration to test the use of global (or bundled) payments for Part A and Part B Medicare services furnished during an inpatient stay for certain cardiac and orthopedic

services. The goal of the Acute Care Episode (ACE) demonstration is to better align hospitals' and physicians' incentives to collaborate on care delivery efficiencies through increasing market share, quality improvement in clinical pathways, improved coordination of care among specialists, and gainsharing. "CMS expects to demonstrate how to not only better coordinate inpatient care, but also achieve savings in the delivery of that care that can ultimately be shared between providers, beneficiaries, and Medicare," said CMS Acting Administrator Kerry Weems.

CMS plans to competitively award one ACE demonstration site per market area during the first year of the demonstration. Dubbed "Value-Based Care Centers," these sites will be actively marketed by CMS to both beneficiaries and referring physicians. The ACE demonstration is open to applicants from Texas, Oklahoma, New Mexico, and Colorado.

The Medicare Payment Advisory Commission (MedPAC) had recently recommended that CMS pursue such policies to foster joint accountability across an episode care involving a hospitalization.

Medicare has experimented with bundled payments before. A notable test of this concept was the 1991–96 demonstration project in which Medicare negotiated global payment rates for all Part A and Part B services associated with coronary artery bypass graft surgery. The participating hospitals and physicians were free to divide up the single payment any way they chose, and physicians were not permitted to balance bill patients. In addition to the inpatient hospital and physician services, the rates incorporated prorated hospital pass-throughs (e.g., capital and direct medical education), readmissions, and an estimated outlier amount based on the each hospital's previous experience.

The demonstration results were mixed. CMS found that hospitals were able to work jointly with their medical staffs to develop a single bid that resulted in savings to both the Medicare program and to beneficiaries. Quality of care was improved on several measures, although in many cases the improvements were mirrored in overall industry trends. Patients were pleased with a single copay amount, supplemental insurers liked the flat actuarial payments, and physicians were pleased to be relieved of the responsibility for collecting copayments.

On the other hand, the fact that consulting physicians could not bill Medicare directly proved contentious in several sites. Surgeons cut back on their use of consultants, which aggravated some physicians even more. And, hospitals experienced the brunt of the administrative burden in billing and collection work.

EVIDENCE-INFORMED CASE RATES

Several groups are working to develop case rate or bundled payment models. One group that is currently piloting "evidence-informed case rates" is the not-for-profit PROMETHEUS Payment[®], supported by a grant from the Robert Wood Johnson Foundation. These rates are single, risk-adjusted payments given to providers across healthcare settings who care for a patient diagnosed with a specific condition, such as colon cancer, or for a specific procedure, such as knee replacement. Payment amounts are based on the resources required to provide care as recommended according to the best available clinical guidelines. To further promote quality care, the PROMETHEUS Payment model calls for a portion of the payment to be withheld and distributed according to various performance measures. Tenets of the payment model include:

- Providers have the opportunity to negotiate meaningfully their payment amounts in accordance with evidence-based case rates constructed from clinical practice guidelines.
- No one receives a provider's payment unless the provider bargained to be paid through another party.
- Mechanisms of payment and the systems for reporting payment are transparent and public.
- Providers have the option to configure themselves in whatever aggregations they choose.
- The implementation of the PROMETHEUS Payment model explicitly seeks to lower administrative burden wherever possible.
- Providers measured for efficiency will have information about other providers in order to facilitate effective referral choices.
- Providers have the opportunity to speak to scorecard issues (e.g., data, findings) before they are made public.

This approach is being implemented at pilot sites across the country. Implementation starts with participating entities adopting the PROMETHEUS Payment model engine, which is a combination claims tracking and financial accounting system, along with a scorecard that uses both claims and other data, including medical record data, to measure the quality of care that is being delivered to patients. The engine allows for sharable data without requiring payers and providers to modify their existing claims systems. Instead, the engine will work through the tracking of the evidence-based case rates in the background and inform payers and providers.

CAPITATED PAYMENT FOR WELLNESS AND CARE MANAGEMENT

Despite the painful capitation experiences of the 1990s, many policy experts believe that the approach still has a role in improving the payment system, especially for preventive services and chronic care management.

In “Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care” (*Journal of General Internal Medicine*, March 2007), a team of physicians led by Alan Goroll, MD, of Massachusetts General Hospital, propose a model in which primary care practices would receive monthly payments for each patient under their care, with adjustments made according to the patient’s needs and risks. Over two-thirds of the payments would be designated to pay for multidisciplinary care teams and for information systems to monitor safety and quality, including interoperable electronic health records. Fifteen to 25 percent of payments would be linked to performance in meeting benchmarks of cost-effectiveness, efficiency, health outcomes, and patient-centered care. Payments for hospital and specialist services, laboratory tests, imaging studies, and other ancillary services would remain unchanged.

The authors emphasize that three features of this model would serve to avoid the pitfalls of earlier capitation systems, which erected barriers to necessary care and encouraged providers to avoid complex patients. First, the payments would be adjusted according to patients’ levels of risk and need. Second, outcome and patient satisfaction measures would ensure that health services would not be underused. And finally, funds would be provided to support healthcare teams and infrastructure.

Several healthcare finance experts have noted that there are significant opportunities in combining capitation for chronic disease management and fee-for-service payments for the usual services.

This concept, referred to by some as “advanced medical homes,” is to be tested in January of 2009, when CMS plans to launch a demonstration project examining how a medical home could provide Medicare beneficiaries better health care at lower cost. The demonstration was authorized by the Tax Relief and Health Care Act in 2006, for rural, urban, and underserved areas in up to eight states. Under this demonstration project, a board-certified physician will provide comprehensive and coordinated care as the “personal physician” to beneficiaries with multiple chronic illnesses. The doctors selected will receive a care management fee, in addition to whatever Medicare-covered services they may provide. Payment would be based on Medicare’s physician relative value scale.

This approach is also elaborated in a model for chronic care management proposed in *Incentives for Excellence: Rebuilding the Healthcare Payment System from the Ground Up*, a report stemming from the Network for Regional Healthcare Improvement’s 2007 Summit on Creating Payment Systems to Accelerate Value-Driven Health Care.

When a healthcare provider other than the patient’s primary care provider is needed to deliver specific services as part of caring for the patient’s chronic condition, then the primary provider would be responsible for paying for those services out of a chronic care payment (CCP). (For example, an ophthalmologist giving an eye exam to someone with diabetes would be paid by the primary physician that is receiving a CCP for managing the individual’s diabetes care.) The CCP could be used for any appropriate service delivered by an individual trained or licensed to provide that service, not just a physician.

Not covered by the CCP would be hospital and specialty care for major acute episodes associated with the chronic illness, such as an amputation necessitated by poor diabetes control; costs of care unrelated to the chronic illness, such as injuries suffered in an automobile accident; and costs of long-term care (the CCP would cover the primary care physician’s *management* of the patient’s care in long-term care facilities). These services would be paid for separately. Given time, or where

integrated systems of hospitals, physicians, and long-term care providers exist, a more comprehensively bundled payment structure might be feasible.

In addition to CCP payments, providers would receive bonuses or penalties based on the outcomes they achieve and patient satisfaction with services.

PAY FOR PERFORMANCE

Value-based purchasing (VBP) is CMS's pay for performance initiative to reward Medicare providers for delivering high-quality, efficient clinical care. The Deficit Reduction Act of 2005 requires CMS to implement a VBP for Medicare hospital services starting in FY09.

The Premier Hospital Quality Incentive Demonstration is the most well-known of the Medicare pilot projects to test whether performance incentives and quality data reporting requirements would actually result in significant improvement in the quality of inpatient care. Under the demonstration, participating hospitals in the not-for-profit Premier, Inc. group get composite scores for each of five clinical conditions (acute myocardial infarction, heart failure, community acquired pneumonia, coronary artery bypass graft, and hip and knee replacement), and the hospitals are ranked in order of their scores. Hospitals with scores in the top 10 percent get a 2 percent bonus of their payments for Medicare fee-for-service patients, while hospitals with scores in the second 10 percent get a 1 percent bonus.

CMS reports that the average composite quality scores improved significantly between the inception of the program and the end of Year 2 in all five clinical focus areas. In addition, CMS notes, the range of variance among participating hospitals also is smaller, as those hospitals in the lower quality range continue to improve their quality scores and close the gap between themselves and top performers.

The private sector is also actively exploring the use of financial rewards to deliver better, safer, more efficient care. Currently, pay for performance programs number approximately 148 nationwide, up from 39 in 2003, according to survey findings from The Leapfrog Group, a coalition of public and private organizations created to reduce medical errors and improve quality and safety in hospitals, and Med-Vantage®.

Private sector pay-for-performance leaders include The Leapfrog Group. The Leapfrog Hospital Rewards Program, which ties financial incentives to hospital performance on measures collected and reported by the Joint Commission on the Accreditation of Hospitals, is the first nationally standardized pay for performance program that can be licensed and implemented by employers, healthcare coalitions, and health plans.

Another leader is Bridges to Excellence, a not-for-profit organization made up of physicians, employers, health plans, and patients. Pay for performance programs currently under way are the Physician Office Link, the Diabetes Care Link, Spine Care Link, and the Cardiac Care Link (a program for internal medicine is currently under development). Under the programs, providers who demonstrate they are top performers in one of those areas of care can earn a set amount (up to \$200 per year for cardiac care) for each patient covered by a participating employer. Participating employers fund these incentives from the savings they achieve through lower healthcare costs and the increased employee productivity that results from the delivery of higher quality care.

In January, Bridges to Excellence integrated its program standards into a medical home program, in which doctors can receive an annual bonus payment of \$125 for each patient covered by a participating employer, with a suggested maximum yearly incentive of \$100,000. Physicians will earn the bonuses by demonstrating they have adopted and are effectively using advanced systems of care to produce good results for their patients.

COMPREHENSIVE STATE REFORM

Minnesota is on the forefront of state-level payment reform initiatives. In 2007, the state legislature required the governor to convene a Health Care Transformation Task Force to develop an action plan for transforming the healthcare system in Minnesota. Gov. Tim Pawlenty signed this legislation into law on May 29, 2008.

Phased-in payment reform, with a target date of 2012, is a key component of the plan. Under the task force's proposal (which is currently before the legislature), during the first level of the transition, payments for all services would be tied to achieving specific quality standards. At the second level, explicit care management

payments would be established for providers that demonstrate they have the ability to function as an effective medical or healthcare home.

At Level 3, transparent prices for “baskets” of services would be established to help consumers make better choices based on cost. Communitywide definitions of the “baskets” would enable apples-to-apples comparisons. Provider groups would submit bids on the total cost of care for a given population, and patients would choose provider groups based on cost and quality, and payments to providers would be risk-adjusted based on the health of the population they manage. Because providers would share in any savings they achieve, providers would have incentives to innovate and compete on ways to better manage population health. The new payment system would be implemented and administered by a new, not-for-profit organization.

The plan would establish financial incentives for consumers to choose and use a medical or healthcare home that coordinates their care. It would also simplify pricing to make it easier for consumers to understand and use cost information. For people with private insurance, providers would no longer receive different prices for services depending on what health insurance plan a patient has. Health plans and providers would no longer negotiate over price discounts, and health plans would structure benefits so that consumers would pay more out of pocket for using higher-cost providers.

To achieve the critical mass necessary for payment reform to succeed, a range of options for increasing the number of people who purchase health care would be considered. For example, participation in the new system might be a condition of receiving payment for any person whose health care is paid for with state funds, or who receives health insurance through a local government or school district.

In its final recommendations to the Minnesota governor and state legislature, the Health Care Transformation Task Force noted that the proposed approach to payment

reform is not untested. For example, the Buyers Health Care Action Group (BHCAG) implemented a similar model in the 1990s; while initially very successful in attracting the participation of healthcare providers and large employer groups, the BHCAG experience also demonstrates the importance of achieving and sustaining a critical mass of people who purchase health care and developing long-term incentives for providers to redesign the way they deliver care.

Despite the painful capitation experiences of the 1990s, many policy experts believe that the approach still has a role in improving the payment system,

With the initiative, the role of health plans will also change fundamentally: instead of competing on which plan can negotiate the biggest discounts from provider fees, plans will compete based on how well they can help consumers effectively navigate the system and on how well they help consumers to stay healthy. Even though providers will be accountable for the total cost of care that they promise to the market, they will not be held responsible for catastrophic costs of unexpected high claims – health plans will continue to bear that risk just as they do now.

The payment reform efforts would be complemented by some strategic e-health initiatives: first, starting in 2009, all providers and group purchasers must electronically exchange eligibility verification, claims, and payment and remittance advice, using a single standard for content and format. Second, all hospitals and healthcare providers must have an interoperable electronic health records system by Jan. 1, 2015. The Commissioner shall develop a statewide plan to meet the mandate, including uniform standards for sharing patient data. Minnesota would provide \$7,000,000 in grants and \$6,300,000 in interest-free loans to help providers in rural and underserved urban areas comply.

About the Experts Consulted

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EXPERTS CONSULTED

Helen Darling
President
National Business Group on Health
Washington, DC

Paul B. Ginsburg, PhD
President
Center for Studying
Health System Change
Washington, DC

Karen Ignagni
President & CEO
America's Health Insurance Plans
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William F. Jesse, MD, FACMPE
President & CEO
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Management Association
Englewood, CO

Harold D. Miller, M.S.
President
Future Strategies, LLC
Pittsburgh, PA
*Adjunct Professor of
Public Policy & Management*
Carnegie Mellon University's
Heinz School of Public Policy
and Management

Tracey Moorhead
President & CEO
DMAA: The Care
Continuum Alliance
Washington, DC

John Rother
*Director of Legislation
and Public Policy*
AARP
Washington, DC

Steven A. Schroeder, MD
*Distinguished Professor
of Health and Health Care*
Department of Medicine,
University of California
San Francisco, CA

Jeff Stensland
Senior Analyst
Medicare Payment
Advisory Committee
Washington, DC

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Monterey, CA

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SSM Health Care System
Saint Louis, MO

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Ascension Health
Saint Louis, MO

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