

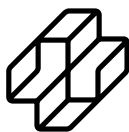


HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

HEALTHCARE PAYMENT REFORM

ACCELERATING SUCCESS

The pace of payment reform is accelerating, requiring new structures, tools, and processes to deliver enhanced quality while managing cost and revenue. Learn the competencies hospitals need to succeed, based on findings from HFMA's 3rd-Annual Thought Leadership Retreat.



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healthcare financial management association

MESSAGE FROM HFMA PRESIDENT AND CEO

Dear Colleagues:

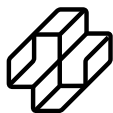
Payment reform is changing health care, bringing with it the need for new competencies for success. Healthcare leaders need innovative strategies to integrate with physicians, manage risk, reduce cost and price bundled services, and enhance quality while lowering cost. Business as usual is not an option. The pace of payment reform is accelerating, accompanied by a tough economy, rising costs, and universal demand for improved quality. Now is the time for healthcare providers to build the organizational skills they need for the new reality.

In September 2009, HFMA invited healthcare leaders from across the country to share their thoughts on the competencies essential to success under healthcare payment reform, and the ways in which mastery of these competencies could be accelerated. The findings are presented in this report.

HFMA would like to thank the 115 healthcare thought leaders and major stakeholders who participated in HFMA's 3rd-Annual Thought Leadership Retreat and who contributed their insights on how providers can best prepare for the challenges of payment reform. The action steps in this report will help pave the way for healthcare organizations to continue to meet the healthcare needs of the communities they serve, now and in the future.



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



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EXECUTIVE SUMMARY

The Healthcare Financial Management Association (HFMA) recognizes that changing the current health-care payment system is key to achieving the nation's overall health goals of wellness, high-quality care, access to care and other societal benefit, and financial stability.

HFMA's most recent healthcare payment reform retreat, "Payment Reform: Leading the Way to Change," held in September 2009, brought together 115 healthcare executives from key provider organizations across the country to review HFMA's findings on payment reform and develop a consensus on general assumptions about the future of healthcare reform. At a 2008 HFMA thought leadership conference on payment reform, major stakeholders identified three key competencies for provider success under reform. However, during the September 2009 conference, participants indicated that there are, in fact, four competencies that providers should build upon to succeed under healthcare payment reform.

Integration: Collaboration among stakeholders across the care continuum, especially between physicians and hospitals, will be critical.

Risk management: As payment reform shifts a greater portion of the financial risks of providing care to healthcare providers, providers should become adept at managing these risks as well as the risks associated with quality of care (the risks that errors, poor quality of care, or poor outcomes will not be paid for or will result in a financial penalty) and efficiency (related to a facility's ability to provide cost-effective care at an acceptable level of quality).

Pricing: Under payment reform, providers will need to establish prices and negotiate payments at levels that allow them to recoup costs (both direct and indirect), include some measure of the risk involved in providing the service, and incorporate a margin that allows the provider to make necessary capital reinvestments and fund programs central to the mission of the organization.

Competencies related to quality, cost, and value: As the course of healthcare reform gains momentum, the ability to drive higher quality, lower cost, and ultimately, greater value is needed. "Clinical excellence and accountability for outcomes" was considered the most important factor for success under healthcare reform by participants in HFMA's 2009 payment reform retreat. That factor was

followed by "clinical and financial integration among providers" and "process improvement and cost control."

Actions that will enable providers to build these competencies include the following:

- To establish an effective integration strategy, organizations should conduct a market analysis and set realistic goals based on this analysis as well as organizational capabilities; develop physician leaders who have high credibility; heighten physician engagement through cultural blending; and work toward establishing effective incentives that help meet the organization's goals.
- Managing risk begins with data collection and knowledge building, participants agreed. Healthcare organizations should build their understanding of financial risk, execution risk, and population health risk to begin to comprehend the myriad impacts that these risks can have on their organizations.
- Providers should work toward building their costing and pricing competencies as they move toward clinical process reengineering and as payment systems evolve.
- To further develop competencies related to quality, cost, and value, healthcare CFOs should ensure that their organizations' capital allocation processes reflect the organization's strategic and tactical goals, are data based, and adequately account for the various pools of capital expenditures. They should apply the same rigor to auditing quality and efficiency measures and comparison data as is applied to auditing financial data.

Healthcare CFOs will play a critical role in the transformation of their organizations. For example, CFOs can work to break down silos between senior leaders, physicians, and clinicians; engage the CEO in a partnership for change throughout the organization; hold the organization accountable for results in quality-of-care and efficiency initiatives; and increase value in healthcare delivery.

Going forward, HFMA will draw on the lessons learned from leading organizations to identify better practices related to the competencies of integration, pricing, risk management, and achieving value. HFMA will pay particular attention to the need to bridge the gap between finance and clinicians with business intelligence that allows healthcare clinical and administrative leaders to make decisions about quality improvement with knowledge of the effect on an organization's revenue and cost.

1. INTRODUCTION: POSITIONING HEALTHCARE PROVIDERS FOR PAYMENT REFORM

Payment reform is coming. Although the current iterations of healthcare reform legislation stop short of mandating specific, widespread payment reform, they do begin to plant the seeds of payment reform through a series of minor adjustments and demonstration projects that continue the march toward payment that is based on quality and that requires integration across disparate sites. In addition to the great leverage that Medicare has to stimulate payment reform, commercial payers are making their own changes to promote quality and integration through payment innovation. The fact that the current trends in healthcare coverage, quality, and costs are not sustainable makes it highly likely that payment reform efforts will accelerate across all of these fronts.

HFMA's payment reform project has been at the forefront of payment reform, starting with the identification of the principles that reform should follow: *quality, alignment, fairness/sustainability, simplification, and societal benefit*. HFMA's project also has examined how specific payment techniques—such as condition-specific capitation and episode-of-care payment—would fulfill these principles and would be viewed by various stakeholders, including

hospitals, physicians, payers, and employers. These principles and techniques continue to be at the heart of payment reform initiatives.

HFMA's most recent payment report, *Healthcare Payment Reform: A Call to Action*, showed how leading providers were changing their structures, processes, and technologies to embrace reform. That report identified three competencies considered key to success under payment reform.

Integration: Collaboration among stakeholders across the care continuum, especially between physicians and hospitals, will be critical.

Risk management: As payment reform shifts a greater portion of the financial risks of providing care to healthcare providers, providers should become adept at managing these risks as well as the risks associated with quality of care (the risks that errors, poor quality of care, or poor outcomes will not be paid for or will result in a financial penalty) and efficiency (related to a facility's ability to provide cost-effective care at an acceptable level of quality).

HFMA'S PAYMENT REFORM PROJECT

HFMA recognizes that changing the current healthcare payment system is key to achieving the nation's overall health goals of wellness, high-quality care, access to care and other societal benefit, and financial stability. In September 2007, HFMA held a retreat titled "Building a Better Payment System" to get input from a cross section of payment system stakeholders and identify principles that should guide changes to the current system. Arising from that retreat was the paper *Healthcare Payment Reform: From Principles to Action*. The paper identified the guiding principles of quality, alignment of incentives, fairness/sustainability, simplification, and societal benefit. The paper further identified a number of payment techniques that could support the principles and included feedback from industry stakeholder groups about how these techniques might be received in the industry.

In September 2008, HFMA brought together a group of healthcare executives to examine the actions that providers would need to take to support various approaches to payment reform and followed up that retreat with research to see how

leading provider organizations are preparing for reform. The result was the paper *Healthcare Payment Reform: A Call to Action*, which shows the key competencies that provider organizations will need to succeed under payment reform that is emerging from the federal government and throughout the country.

HFMA's most recent healthcare payment reform retreat, "Payment Reform: Leading the Way to Change," held in September 2009, brought together healthcare executives from key provider organizations across the country to review HFMA's findings on payment reform and develop a consensus on general assumptions about the future of healthcare reform. This paper is the product of discussions from that conference.

HFMA will continue to help its members and others involved in healthcare finance to succeed given the nation's efforts to build a sustainable and effective health system.

Get project news, insights, and strategies at www.hfma.org/paymentreform.

Pricing: Under payment reform, providers will need to establish prices and negotiate payments at levels that allow them to recoup costs (both direct and indirect), include some measure of the risk involved in providing the service, and incorporate a margin that allows the provider to make necessary capital reinvestments and fund programs central to the mission of the organization.

In September 2009, HFMA held its third-annual thought leadership retreat related to payment reform, “Payment Reform: Leading the Way to Change.” The retreat was attended by 115 healthcare executives from organizations across the country, and featured keynote presentations from industry leaders. It was sponsored by 3M Health Information Systems, McKesson, RelayHealth, and Kaufman, Hall & Associates, Inc.

Based on the findings from this retreat and other HFMA thought leadership retreats on this topic, HFMA has identified strategies for accelerating mastery of the competencies needed for success under payment reform. This report:

- Clarifies the trajectory and momentum of payment reform
- Introduces an additional competency related to driving value by improving quality and lowering cost
- Explains the key success factors related to each competency
- Identifies the role of healthcare finance leaders in achieving needed change

Actions taken by providers to accelerate mastery of the key competencies identified in this report will position healthcare organizations for success on the cusp of major payment change.

2. THE COURSE OF HEALTHCARE REFORM— AND WHAT IT WILL MEAN FOR PROVIDERS

During HFMA's September 2009 thought leadership retreat, "Payment Reform: Leading the Way to Change," participants were polled regarding their views on the path the nation is taking toward healthcare reform and providers' efforts to better develop the key competencies needed to succeed under reform.

- Attendees were optimistic about the course of reform: 73 percent of participants believed that major federal reform enacted in 2009 or 2010 will impact cost and quality by 2015.
- Sixty-seven percent of attendees believe the percentage of uninsured people will decrease somewhat by 2015, and that federal reform without a public plan option will be the strategy to provide the additional coverage.
- Sixty-one percent expected that by 2015, 10 to 24 percent of their organizations' total payments will be at risk based on performance, and 40 percent of attendees believed that an episode-based, bundled reimbursement will be included in their revenues by 2015.
- Sixty-two percent anticipated that by 2015, the majority of hospitals and physician groups will have demonstrated meaningful use of electronic health records (EHRs), and that the investment will exceed the cost savings associated with EHRs.

Recognizing the course of health reform in general and payment reform in particular, the unsustainable cost of care, and the imperative of improved quality, retreat participants embraced the need for a rapid yet deliberative approach to implementing best practice solutions for improvement.

This message was reinforced by Robert Galvin, MD, executive director of health services and chief medical officer, General Electric Company. Healthcare reform is a critical issue for stakeholders in the private sector who must compete in the global market place. Galvin shared his views on the course of payment reform from the perspective of a major purchaser of healthcare services and as a founding participant in the Leapfrog Group, Bridges to Excellence, PROMETHEUS Payment®, and the Center for Payment Reform.

In presenting the views of major providers of employer-supplied insurance, Galvin recommended a cautious, thoughtful approach to healthcare reform that would not immediately discard fee-for-service structures, but rather, would provide strengthened incentives to produce high-quality and low-cost care. Employers will increasingly seek the highest quality of care at the lowest price, and this will place heightened demands for transparency of data related to quality and cost on providers, Galvin says. The inability to supply this data and/or poor performance on quality and cost metrics will be a growing liability for provider organizations in the future.

3. THE KEY COMPETENCIES: TAKING A CLOSER LOOK

HFMA's most recent thought leadership retreat on payment reform provided a rich set of insights into the difficult issues that providers will face as we move forward toward payment reform, as well as the strategies that will need to be deployed by healthcare providers to succeed in a reform environment. The key competencies for success under healthcare reform were explored in depth.

INTEGRATION

Physician integration—which involves changes in care practices to produce better coordination and overall outcomes—requires a closer relationship among providers than does physician alignment—which involves contractual relationships, limited employment of needed specialties, joint ventures, and similar relationships.

Currently, there is no one dominant integration structure being deployed in the market, and most thought leaders on this issue do not believe that a dominant structure will emerge. The structures used are a function of regional market and regulatory frameworks that differ so widely, a “one-size-fits-all” strategy will be nearly impossible to find.

Information regarding one alternate structure for integration—that of a “regional superpower”—was presented by Mark Grube, partner, Kaufman, Hall & Associates. During HFMA's 2009 thought leadership retreat on payment reform, Grube noted that, although there has been a steady trend toward consolidation by hospital providers, the market remains relatively fragmented as compared with other industry segments, such as retail pharmacies. However, the following changes in healthcare market dynamics are providing additional impetus for consolidation of providers, leading to regional superpower integration models, according to Grube:

- Insurance market consolidation
- Staggering new financial and intellectual capital requirements
- Changes in facilities and equipment:
 - IT
 - Care management infrastructure
- The transition from an independent to an integrated physician community
- The need for a rationalized service distribution system
- Increasing transparency of quality of care and outcomes
- Dominance of regional and national brands
- More difficult capital access for many organizations
- Increasing evidence of a correlation between size, performance, and capital reinvestment

A *regional superpower* was defined as a system that “serves a large geographic region with multiple operations in largely contiguous markets” and has strong financial performance (net revenue of \$1 billion to \$5 billion and an ‘A’ or ‘AA’ credit rating). Although regional superpowers appear to be functioning quite well in the current environment, such that it is easy to anticipate additional development of regional superpowers as the macro trends intensify, there also exists the potential for the rise of smaller, more nimble systems that perform well and could potentially gain favor from capital investors. There could also be pushback from federal and state regulators that would object to the consolidation of market power inherent in these models.

Discussion at the retreat also pointed toward younger physicians seeking different employment/practice models than previous generations of physicians, a factor that may accelerate the integration process. Participants in the retreat stressed that the way in which “softer issues,” such as leadership and cultural issues, are dealt with is vital to the success of integrated organizations. This is not surprising when viewed in the context of the industry's track record on integration in the 1990s, when many fledgling integrated systems abandoned their integration efforts due to an inability to reconcile conflicting cultural norms. Finally, participants agreed that integration structures should be built with an intense focus on patients and the high-quality and efficient care processes that both patients and employers will demand.

Integration subcompetencies. There is little debate about whether closer integration between providers is necessary. For integration to be successful, incentives should be clearly aligned, and providers should enhance efficiency through efforts to reduce redundancy and waste. The key question is how to achieve the goals of integration.

Based on the discussions that took place at HFMA's 2009 retreat on payment reform, HFMA has identified subcompetencies that should be addressed in executing an effective integration strategy, including the following.

Market analysis: A clear view of the market position of each of the component organizations involved in the integration process will be essential.

Key questions include the following:

- What are the primary and secondary markets of each organization?
- How do customers view each component, and how are they likely to view the combined entity?

- What competitive response, if any, is the integration likely to elicit in the market?

Goal setting: One key to success as an integrated organization is setting realistic goals based on organizational capabilities and an assessment of market and customer base.

Key questions include the following:

- What are the most effective techniques for assessing the capabilities of newly integrated organizations?
- What key areas should goal setting cover?
- What is the role of the financial executive in shaping goals for an integrated organization?

Physician leaders/champions: Developing key physician leaders/champions who have a high level of credibility with physicians and other providers will be critical to producing the changes necessary to create a sustainable healthcare industry.

Key questions include the following:

- What makes a “credible leader” credible?
- Are there optimal structures with which physician leaders may engage?
- Are there recommended structures for physician leaders to engage with employed clinical professionals and community staff?
- What methods should be employed to compensate physician leaders/champions?

Data sharing: The development and sharing of credible data on utilization, cost, and quality will be essential to making informed decisions on system composition, process and incentives.

Key questions include the following:

- What data should be shared to build an effective integrated relationship?
- What are the barriers to obtaining and sharing this information?
- What strategies should be employed to foster effective discussions and transform data into knowledge useful to the integrated entity?

Compensation/incentives: Compensation policies and economic incentives are powerful tools that can be employed to align incentives and foster change.

Key questions include the following:

- How do you establish integrated goals amenable to compensation/economic incentives?

- How do you identify stakeholders who are key to achieving goals?
- How do you tailor compensation/economic incentives to stakeholders and ensure that major goals are accomplished?

Engagement/cultural blending: One definition describes engagement as a heightened level of ownership wherein each employee does whatever he or she can for the benefit of internal and external customers and for the success of the organization as a whole. The complexity of integrated organizations and the importance of efficiency and cost effectiveness make it essential that the organization develop sound processes to heighten stakeholder engagement.

Cultural differences between the various component organizations proved to be a significant factor behind the failure of many organizations that attempted to integrate in the 1990s. Examples of these cultural differences are rural versus urban cultures, religious versus secular views, or simply the demographic differences among the customers an organization serves.

Key questions include the following:

- Are engagement/cultural blending planning, analyses, and processes owned by human resources departments? What can finance professionals do to influence these competencies?
- Can engagement/cultural blending be measured? What are reasonable goals for success in these subcompetencies?
- Are there change management or other specific strategies that have proven effective in smoothing the transition into a truly integrated organization?

BARRIERS TO INTEGRATION IN HEALTHCARE ORGANIZATIONS

Collaboration among stakeholders across the care continuum, especially between physicians and hospitals, will be critical as the nation’s healthcare payment system is reformed. Participants in HFMA’s payment reform retreat identified several barriers to integration:

- Difference in cultures/lack of trust
- Different perspectives (physicians versus administrators)
- Technologies that are not interoperable
- Cost of implementing effective technologies to integrate decisions and care information
- Lack of capital
- Low community support/board support

Technology: Shared IT can serve as an important, unifying backbone to support an integrated organization by providing a common syntax and shared data that can be used to build knowledge of system performance.

Key questions include the following:

- How can the disparate needs of stakeholders be accommodated while still implementing standardized platforms?
- What organizational structures and processes have proven effective in planning, implementing, and maintaining enterprisewide IT systems?
- What can finance professionals do to foster effective investment and processes around technology?

Process improvement: Given the enormous challenges facing healthcare organizations, those that engage in continuous process improvement are likely to be more successful. This competency requires a well-trained staff, sound tools to measure processes, and a culture that encourages “outside-the-box” thinking and communication.

Key questions include the following:

- What strategies can be employed to engage stakeholders in continuously thinking about process improvement in both clinical and administrative processes?
- What role do finance professionals play in process improvement?
- How does an organization make sound decisions on the portfolio of process improvement initiatives it undertakes (balancing between those with positive ROI and those that are mission related)?

STRATEGIES FOR MANAGING RISK

Participants in HFMA’s 2009 thought leadership retreat on payment reform identified a number of strategies healthcare organizations can use to manage risk, including the following:

- Tracking clinical data for both cost and quality (“You Are What You Measure and Incent”)
- Shifting attitudes around quality (“It’s No Longer Acceptable to be Average”)
- Implementation of interoperable IT systems
- Using a health risk assessment tool to identify problem patients and aggressively manage their care

RISK MANAGEMENT

Payment reform may shift portions or all of the financial risks embedded in the payment system for patient care among industry stakeholders, making the ability to manage these risks essential for success under payment reform. For providers, the two primary risks are the high financial risk of managing a population’s health and taking on the technical risk associated with adapting to systems based on quality and efficiency.

The risk management competency proved to be a difficult concept to discuss from an enterprisewide standpoint during HFMA’s 2009 thought leadership retreat on payment reform, “Payment Reform: Leading the Way to Change.” Most providers tend to see the risks inherent in their businesses on the basis of one or two key issues for their organizations. In reality, providers face a complex mélange of current and future risks that intersect in complex ways. Managing these risks begins with data collection and knowledge building, participants agreed. Only through building an understanding of financial risk, execution risk, and population health risk can providers begin to understand the myriad impacts that these risks can have on their organizations.

As with many of the other competencies, the importance of effective leadership came to the forefront in the discussion of the risk competency. Having strong clinical and administrative leadership is essential in developing trust in the sound data sets needed to understand these complex issues and develop effective strategies to manage the risks that organization has taken on. With risks related to quality performance growing, and risk from population health expected to arise in the future, leaders from across the organization will need to come together to plan, teach, coach, and execute the innovative strategies that will be needed to succeed.

One of the early tests of an organization’s ability to manage the risks related to quality and payment reform will come as the Centers for Medicare & Medicaid Services (CMS) transitions its payment systems to the ICD-10 coding system, an implementation that is scheduled for October 2013. During HFMA’s 2009 retreat on payment reform, Caroline R. Piselli, RN, MBA, FACHE, program manager, ICD-10 and pay for performance, 3M Health Information Systems, explained why this new coding system is an integral part of healthcare reform.

The current coding system used by U.S. healthcare systems is more than 27 years old and has a relatively limited number of codes for diagnosis (13,000) and procedures (3,000). ICD-10 coding has 68,000 diagnosis codes and 72,000 procedure codes. The increased specificity that ICD-10 will provide will be essential as billing and other data are mined to support comparative effectiveness research and further knowledge of which services and procedures drive optimal clinical outcomes, Piselli says. But, Piselli noted, managing the transition process from ICD-9 to ICD-10 will be daunting: For example, one current angioplasty procedure code will be expanded to 1,170 potential procedure codes under the ICD-10 coding scheme.

Clearly, managers from across provider organizations will need to be involved in a transition of this magnitude, and finance leaders in particular should pay attention to this implementation, as failure to be actively engaged in this process could have significant impacts on an organization's cash flow. Piselli shared the following quote from the coding services manager of a Canadian hospital (Canada has already implemented ICD-10): "I wish I had taken the transition more seriously. In retrospect, I could have positively impacted my organization if we had paid attention to ICD-10 opportunities rather than be consumed with day-to-day operations."

Clearly, this is a call to early action for healthcare finance leaders.

PRICING

Under payment reform, providers will need to establish prices and negotiate payments at levels that allow them to recoup costs (both direct and indirect), include some measure of the risk involved in providing the service, and incorporate a margin that allows the provider to make necessary capital reinvestments and fund programs central to the mission of the organization.

Payment systems that could potentially foster more substantial alignment of hospital and physician interests include creating bundled payments across providers over time through such means as episode-based payments for hospitalized patients, episode-based payments for chronic care patients to accountable health entities, and outcomes-based payments.

The costing and pricing competencies of healthcare organizations is increasingly coming to the forefront as providers move toward clinical process reengineering and as payment systems evolve. On this issue, finance leaders who attended HFMA's 2009 thought leadership retreat on payment reform appear to be firmly rooted in the "here and now," expressing the view that current costing and pricing techniques are adequate for today's market conditions. But those organizations that are in the "early adopter" phase of clinical reengineering and preparations for payment reform are expressing extreme dissatisfaction with current capabilities in costing, pricing, and other financial management tools needed to support the transformation of clinical processes.

ASSESSING YOUR ORGANIZATION'S COSTING AND PRICING METHODOLOGIES

Pricing is clearly an area where demonstrating a concrete ROI in the current market may not be possible. But healthcare finance leaders should ask themselves the following questions:

- Will I be able to explain to my CEO and board why our costs have not decreased in spite of the "successful" conclusion of a major process improvement project that achieved all of its stated goals?
- Will I know what the costs are for a bundled payment contract with quality triggers, make a sound decision to accept a price for that bundle, and effectively manage the financial impacts of that contract?

- Will I be able to rapidly educate and help manage my organization on the revenue and expense impact of quality and process improvement projects and work together with leadership and peers to mitigate any adverse impacts?

If the answer to any of these questions is "No," the costing and pricing methodologies that are currently employed in the organization are unlikely to be adequate in the near future. Investments in developing competencies in costing and pricing are well placed as our nation rapidly moves toward healthcare reform, particularly at a time when every investment decision could carry enormous consequences for the organization.

Other challenges cited by participants at HFMA’s “Payment Reform: Leading the Way to Change” retreat in relation to costing and pricing include:

- Regional variations in government payment, which participants say are increasing
- Payer differentials in payment methodology and contracting, which vary by market
- Lack of a consistent costing strategy (although improvements were noted)
- Lack of a consistent pricing strategy (although improvements are being seen in this area)
- Lack of good financial information (although participants acknowledge that their access to such information is improving)

Galvin, of General Electric Company, cautions that any efforts aimed at payment reform will need to consider such risks as a precipitous rise in costs, new models that won’t work or take a lot of time to properly implement, and substantial burdens on already strained provider systems.

Galvin notes that there is limited evidence of integration or bundling in other countries. And although bundling has had some selected successes in demonstration projects, clinical care processes are very complex, and the efforts needed to transform them shouldn’t be underestimated.

COMPETENCIES RELATED TO QUALITY, COST, AND VALUE

As the course of healthcare reform gains momentum, it has become clear that a fourth competency is needed: driving higher quality, lower cost, and ultimately, greater value. “Clinical excellence and accountability for outcomes” was considered the most important factor for success under healthcare reform by participants in HFMA’s 2009 thought leadership retreat on payment reform. That factor was followed by “clinical and financial integration among providers” and “process improvement and cost control.”

This recognition by key healthcare executives—and healthcare finance executives in particular—that clinical excellence will be the major determinant of future success for healthcare organizations under healthcare reform represents a critical sea of change in the healthcare industry. Today, entire leadership teams of leading provider organizations are mobilizing to redesign care processes.

Whatever shape healthcare reform ultimately takes, alignment of payment for hospitals and physicians around care coordination and high-quality clinical care will be key.

Efforts focused on restructuring payment to reduce fragmentation and counter volume-driven incentives of the current fee-for-service program can both improve quality of care and reduce costs, according to Janet Corrigan, PhD, president and CEO of the National Quality Forum. Such efforts include increasing dollars at risk under current pay-for-performance programs, developing chronic condition coordination payments, and providing payment for patients to receive educational decision aides.

During HFMA’s “Payment Reform: Leading the Way to Change” retreat, Corrigan provided insights into issues surrounding quality and outcomes.

Corrigan highlighted the slow rate of improvements in the quality of care delivered by our nation’s current healthcare system, noting that the Institute of Medicine’s “wake-up calls” on quality—the landmark reports *To Err is Human* and *Crossing the Quality Chasm*—were published 10 years ago. Yet the 2007 AHRQ National Healthcare Quality Report on measures of quality and safety showed an average rate of healthcare quality improvement of less than 2 percent per year.

Although some of the pay-for-performance programs that are currently in place are making some progress in supporting improvements in quality at healthcare organizations, Corrigan stressed that fundamental payment reform must take place before incentives for achieving high-quality and efficient healthcare can be fully aligned. Further, healthcare delivery systems will have to change to meet the new incentives inherent in the payment system and deliver the high value of care needed.

Corrigan also cited recommendations from the Institute of Medicine’s *Crossing the Quality Chasm* report to outline several of the key attributes of the new organizational models that will be needed in the future. These attributes are:

- Investment in and use of IT
- Redesign of care processes based on “best practices”
- Knowledge and skill management
- Deployment of multidisciplinary teams
- Coordination of care across patient conditions, services, and settings
- Performance measurement and improvement

These are clearly areas in which healthcare finance executives can and should be playing a vital role within their organizations. If, as Corrigan indicates, payment reform is one of the key vehicles for providing alignment around the proper incentives, healthcare CFOs will be vital to efforts to increase value in healthcare delivery. Healthcare finance executives should develop and demonstrate their competencies as follows to address the attributes outlined here.

Sound capital allocation processes: In an environment where capital is more scarce and expensive, healthcare CFOs should ensure that their organizations' capital allocation processes reflect the organization's strategic and tactical goals, are data based, and adequately account for the various pools of capital expenditures.

For example, healthcare finance leaders have indicated that investments in IT are one of the most difficult types of capital equipment to allocate properly. Large-scale information systems are expensive, and timing of the purchase of an IT system also can be an issue, as the implementation of many of these systems significantly draws on an organization's manpower. The complexities behind timing this human capital investment against the need to implement the technology can be daunting. Additionally, it's frequently difficult to determine the financial benefit of a large-scale system replacement or implementation, since the benefits often come through enabling higher-quality care or better coordination of clinical processes. Some CFOs go as far as to carve out separate "buckets" of capital dollars to fund IT investments. This separate bucket can then be allocated based on criteria specific to IT, rather than competing on the general criteria used for other purchases.

Leaders and working members of multidisciplinary teams: It's likely that much of the care redesign and the development of systems and structures to coordinate care will be accomplished through the work of multidisciplinary

teams. Healthcare finance leaders will be able to bring their understanding of the reimbursement ramifications of any potential change to such initiatives and will be able to guide the teams in their management of any revenue or expense impact related to these initiatives. Finance professionals should readily embrace the quantitative tools used in typical process improvement efforts and perform as valued members of quality teams. In addition to their role within these teams, finance executives should leverage their overarching views of their organizations' operations—specifically, the financial performance of the organization—to suggest process improvement projects that can increase efficiency in care delivery.

Comparison data and audit/assurance of data integrity: Healthcare finance professionals are used to dealing with massive amounts of numerical data and have developed systems for auditing these data. The same rigor that is applied to financial reporting should be extended to auditing quality and efficiency measures and comparison data. Leaders of healthcare organizations will need to know which measures result from objective processes and which are produced by subjective processes, and will require data that are fundamentally sound to make such analyses.

Clearly, healthcare finance leaders bring valuable tools and expertise to the table that can support quality and process improvement initiatives. Finance department involvement in such initiatives should be viewed as an operational imperative. With pay for performance and value-based purchasing efforts affecting ever larger portions of a provider's revenues, and with the potential for margin impacts from clinical process improvement, healthcare finance executives should have extensive knowledge of and involvement in the quality and process improvement efforts within their organization to ensure and protect the organization's financial success.

4. TRANSFORMING OUR NATION'S HEALTHCARE SYSTEM: THE ROLE OF FINANCE LEADERS

What is the role of healthcare CFOs and other finance leaders in accelerating their organizations' competencies for success under healthcare reform and healthcare payment reform? Participants in HFMA's 2009 thought leadership retreat on payment reform, who divided into five breakout sessions to discuss this issue, shared their thoughts on how healthcare CFOs can lead their organizations through changes that will be prompted by healthcare reform and healthcare payment reform.

According to participants, healthcare CFOs' role in the transformation of their organizations to meet the challenges of reform could include the following:

- Breaking down silos between senior leaders and physicians and clinicians
- Engaging the CEO in a partnership for change throughout the organization
- Holding the organization accountable for results in quality-of-care and efficiency initiatives
- Taking on the role of educator to physicians, clinicians, staff, and the community regarding the financial ramifications of everything the organization does
- Helping physicians understand the financial side of hospital operations while learning the clinical side (analytics)
- Serving as the architect of operational strategies and execution of such strategies, and bridging such strategies
- Becoming a leader in change management (making change "stick")
- Playing a larger role on both sides of the balance sheet
- Influencing reform by telling the story of how reform will affect healthcare organizations (i.e., of Medicare not covering cost of care)

5. MOVING AHEAD

Going forward, HFMA will draw on the lessons learned from leading organizations to identify better practices related to the competencies of integration, pricing, risk management, and achieving value. Although this report uses the context of payment reform to present these competencies, their importance is even broader. The forces of payment reform, a challenging economy, rapidly increasing costs, reduced access to capital, intense competition, and a demand for quality all require that provider leaders master these competencies.

A common thread among these competencies is a need to close the gap between clinicians and finance. Closing this gap holds the potential for simultaneously increasing quality and reducing cost—key to success for any healthcare organization. However, clinical and administrative leaders in hospitals lack the business intelligence tools they need to make decisions that consider the effect of quality

improvement on cost and revenue. Further, in many organizations, there are few operating or strategic links between financial and clinical leaders that would foster strong joint decision making on issues related to cost and quality. HFMA plans to fill this gap by helping finance leaders to:

- Identify and provide financial information that clinical and administrative leaders need to make effective decisions to enhance the value of the care provided
- Define costing systems that provide current and accurate costing of clinical and administrative processes
- Develop metrics and analytics that allow executives to understand the impact of improvement efforts on the financial performance of the enterprise

In short, HFMA will continue to be a uniting force in helping finance leaders work effectively with other leaders within and outside their organizations to build a sustainable and effective healthcare delivery system.

ABOUT HFMA



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healthcare financial management association

The Healthcare Financial Management Association (HFMA) provides the resources healthcare organizations need to achieve sound fiscal health in order to provide excellent patient care. With more than 35,000 members, HFMA is the nation's leading membership organization of healthcare finance executives and leaders. We provide education, analysis, and guidance; we lead change and innovative thinking; and we create practical tools and solutions that help our members get results. Addressing capital access to improved patient care to technology advancement, HFMA is an indispensable resource on healthcare finance issues.

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