Strategies for Successful Value-Based Partnerships

A REPORT FROM HFMA'S ANI 2017 EXECUTIVE EXPERIENCE SESSION

SEPTEMBER 30, 2017

EXECUTIVE SUMMARY

More than ever, collaboration among healthcare stakeholder groups is essential for the industry to achieve sustainability. To increase the value that patients get from health care, providers and health plans will need to collaborate in novel ways to help improve quality while reducing overall costs.

In that spirit, the inaugural ANI 2017 Executive Experience, sponsored by EY, brought together finance leaders, clinical leaders, and health plan executives to share their stories and insight related to building value-based partnerships. The event included more than four hours of strategic dialogue and brainstorming.

As described in detail in this report, numerous key points arose from the discussions, which were guided by leaders with GE Healthcare Camden Group: Daniel J. Marino, MBA, MHA, executive vice president; David DiLoreto, MD, MBA, senior vice president of population health; and Carlos Bohorquez, MHA, vice president.

SUMMARIZING THE EXECUTIVE EXPERIENCE, THIS REPORT COVERS:

- Key financial trends facing the healthcare industry
- Strategies for successful value-based partnerships
- Three case studies relating to the negotiation of value-based contracts

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INSIGHTS AND THEMES THAT EMERGED FROM THE MEETING INCLUDED:

- Providers and health plans must be willing to share data transparently and ensure that incentives are aligned. Without appropriate alignment, care model transformation cannot be achieved.
- A phased approach to taking on risk is advisable. Organizations first should focus on agreements that allow them to develop the necessary infrastructure. They then can move on to establishing viable partnerships before taking on full risk management.
- Despite the industry-wide pressure to move to two-way risk, organizations should be methodical in their preparations. Moving too fast can be as detrimental to an organization as moving too slowly or not at all. A sound approach is to build a roadmap with budgets and benchmarks that ensure the organization remains on sound footing every step of the way.
- Value-based contract negotiations between providers and health plans should address care coordination and management, including ways to ensure that care management activities are duly compensated. Metrics should address patient engagement by care transition teams and should link clinical performance goals to financial rewards. Incorporating the Division of Financial Responsibility tool during negotiations can be beneficial for both sides.
- Among the potential obstacles to building value-based partnerships are built-in silos within organizations, technical challenges in sharing information, financial pressures, and regulatory uncertainty. These and other issues should be addressed during negotiations to ensure that none becomes a deal-breaker.
- Organizations can overcome these obstacles and position themselves for success if they establish common goals, establish trust through data transparency, redefine traditional roles as needed, define the infrastructure and dedicated resources from the perspectives of both providers—including physicians—and health plans, and use shared accountability to structure the relationship.

The healthcare industry continues to undergo major change in 2017. Amid issues involving legislative policy uncertainty, competition, innovation, technology, consumerism, and changing payment models, health care's future will be shaped by today's leaders.

In June, HFMA's inaugural ANI Executive Experience, sponsored by EY, created a kind of workshop laboratory to help facilitate problem-solving dialogue among a diverse cross-section of thought leaders in finance, clinical medicine, and health plans. This year's theme was "Strategies for Successful Value-Based Partnerships."

The program was facilitated by leaders with GE Healthcare Camden Group: Daniel J. Marino, MBA, MHA, executive vice president; David DiLoreto, MD, MBA, senior vice president of population health; and Carlos Bohorquez, MHA, vice president.

PRESSURE TO REDUCE COSTS, IMPROVE VALUE

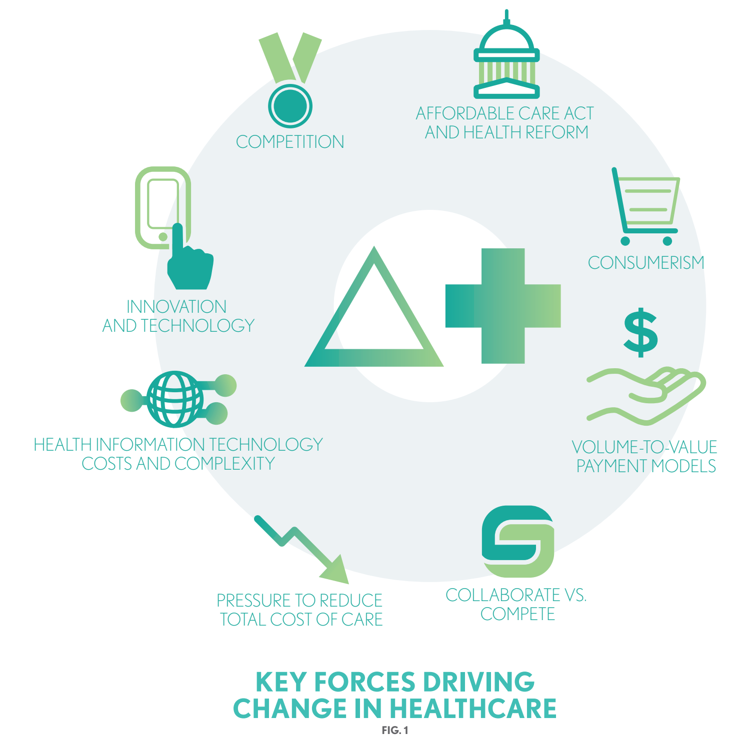
Some of the most vexing challenges facing health care today, Marino said, are largely due to a convergence of trends, including pressure to reduce the total cost of care while improving quality. The industry, Marino said, is conflicted between short-term and long-term strategies, creating uncertainty about how to approach risk contracting while fee-for-service remains in place.

"The government is unclear in terms of what direction to go in," Marino said. "Health plans are struggling with how to make themselves financially sound while moving into value-based care. Hospitals and health systems are struggling to bring down costs" because of the need to maintain a certain level of payment.

This uncertainty is driving the need for better collaboration between healthcare stakeholders.

"Never in health care has collaboration been so important as it is now," Marino said. "If we are truly going to reduce the costs of care, we have to be transparent in the information we share. We have to collaborate on the care that we're delivering, and we have to be open to the result of providing high-quality care while reducing cost."

Innovation means transforming the care model, and payment and contracting will have to support transformation. "If we don't have the right incentives, and we are not all aligned to those incentives, then we are not going to achieve all of those goals," Marino said.



KEY FORCES DRIVING CHANGE IN HEALTHCARE
FIG. 1

Strategies for Successful Partnerships

In breakout discussion groups, attendees were asked to offer input on key issues to address when developing value-based partnerships.

Here are four vital questions and the respective attendee answers.

What do health plans, hospitals, physicians, and employers collectively need to do to form a successful value-based relationship?

- Understand the goals and vision of each entity at the start of discussions.
- Learn about the culture of each organization when coming together. No one organization can have authority over other entities in the relationship; the relationship must be collaborative.
- Establish common goals for care coordination and efficiency of care to achieve quality.
- Establish trust and transparency with all stakeholders.
- Share common data.
- Remain open-minded, but agree to disagree.
- Redefine roles up front; traditional roles should shift. Communicate often and effectively. Dedicated resources will be needed to ensure that communications between stakeholders are timely.
- Offer education for all parties to help structure the new culture of collaboration. Define the infrastructure and dedicated resources from both a provider and a health plan perspective. A medical group and chief medical officer should be part of conversation.
- Plan and structure the relationship using shared accountability.

What obstacles could potentially impede success?

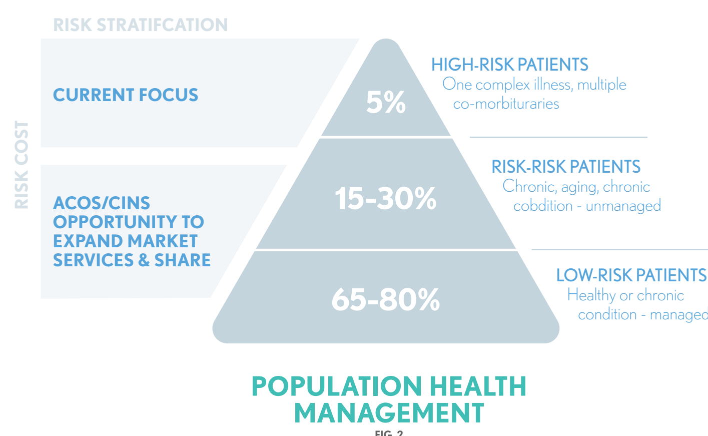
- Built-in silos within organizations
- Inconsistent communication
- Governance limitations or technical challenges in sharing information
- Poorly defined strategy or plan design (resulting in a lack of focus on the patient)
- Lack of technology (or an inability to utilize it effectively)
- Lack of engagement among partners (are the right people at the table?)
- Ineffective care management
- Financial challenges (given that "the pie is not getting any bigger" and getting additional cost out of the system may be a formidable challenge)
- Potential risks to previous capital investments
- Regulatory, regional, state, and national uncertainty related to the impact of the Affordable Care Act, the Medicare Access and CHIP Reauthorization Act (MACRA), etc.
- Cultural issues in implementing changes to move to value
- Cost pressures, particularly for small community hospitals
- Clinical variation
- Narrow-network characteristics that may create access issues and perception problems for employers

What characteristics or capabilities are necessary for success?

- Data: integrity, timeliness, ability to interpret and use
- Acceptance of data
- Transparency. Early wins to build trust and momentum
- Champions/leaders to drive the effort
- A patient-centered approach by all stakeholders

What are the limiting factors that each partner must overcome within its organization to build success in a value-based partnership?

- Fear of change among organizations and people
- Difficulty with the sharing and integration of data
- Not having a defined set of quality metrics
- Lack of access to an adequate volume of live data as opposed to claims data
- A short-term focus as opposed to a long-term strategic perspective
- Limited workforce supply (are there enough physicians?)



POPULATION HEALTH MANAGEMENT
FIG. 2

GETTING INTO RISK MANAGEMENT

In an effort to address cost and improve outcomes, many organizations are focused on high-risk populations.

But the real opportunity is to focus on the rising-risk population so that people and providers better understand how to manage chronic conditions to save costs for the long term.

Organizations should consider entering risk arrangements in a phased approach, Marino explains.

EY Leader: Executive Experience Session Showcases Potential for Collaboration

Attendees of the Executive Experience at HFMA's ANI 2017 found the format highly conducive to networking and exchanging information regarding how to establish value-based partnerships. Jacques Mulder, U.S. Health Sector Leader at EY, which sponsored the event, described the engagement from the senior healthcare leaders in attendance as energizing.

> *"It was really rich in content and reinforced the point that we're all focused on this as a common goal," he said. "We know that we need to move the agenda forward, and it was really encouraging to see that much senior-level support and passion behind the cause of delivering better health care and a healthier working world."*

Conversations focused on putting the patient at the center of the healthcare continuum and delivering high-quality care that will affect health at the population level. "We took a look at the whole patient experience and the way that providers and insurers will become competitive, with patients exercising choice in the type of health care that they receive and the manner in which they receive it," Mulder recalled. "The patient experience and the quality of that experience will be a huge determinant of competition in the future, but I believe it's also the fueling power behind the energy that will drive our healthcare costs down and our healthcare quality up. So, the patient experience is a big one."

Another topic of discussion that stood out to Mulder was the digitization of the enterprise amid the need to find innovative ways to engage with consumers. "We have to find different ways of outreach while embracing the growth and development in technology—not only to give us more contact with the patient and the consumer, but also to enhance their ability to interact with the healthcare system overall," Mulder said.

> *"Very closely tied to that, we are on a relentless focus to bring operational efficiency and performance optimization into the delivery of health care. What that may mean is a dramatic shift as we move from volume into a selection of those things that deliver the most value and the highest-quality outcomes, and, very specifically, keep patients healthy in their day-to-day lives in the population."*

This approach requires expansive views about health care and payment for services. "Suddenly, things like clean water, access to good meals, or maybe access to a microwave oven to prepare those meals are as important in some ways as the next drug or the next diagnostic test that the patient may get," Mulder said.

Another focus of discussion was the risk of cyber attacks. "Cyber risk becomes a greater concern for everyone, and, therefore, we have to be ever-diligent in the way that we treat, protect, de-identify, and really embrace the personal privacy of patients and consumers as far as their personal health information," Mulder said.

"There's a whole line of work around the ownership of health information. Setting up health care in the home and outside of a large institution like a hospital, or at least a minimizing the stay, is a trend that I don't believe is going to change in the near future." Healthcare entities thus need to focus on ways to minimize breaches in outside environments.

He added that getting healthcare stakeholders to embrace new models of care delivery and payment, with a real focus on the patient and on health and wellness at the population level, is an aspirational goal. "It's something that I believe we will achieve," he said. "I felt very confident leaving the meeting that there's enough energy and focus around this that we will solve this problem over time."

"We all share the responsibility for wellness, and that's one of the themes that came out," Mulder added. "I saw the number of 'aha' moments and light bulbs going off, saying, 'If we could do this together, that would be great.' I walked away with a very good experience and being really encouraged about the future."

"There is a maturity that we have to go through to prepare for this level of risk-based contracting and this level of value-based care," Marino said. "It's a culture of transition. It's making sure we have the right infrastructure in place."

So, while the industry faces pressure to move into two-way risk, a tremendous amount of organizational planning and execution are necessary to be successful in that model.

The chief concern for health system and hospital CFOs is moving too fast into value-based care without having existing payments keep up with the change. Understanding economic drivers, including the details of value-based contracts and partnerships, and attaining clinical and operational alignment are critical success factors, Marino said.

CONTRACT NEGOTIATIONS

Negotiations between hospitals and health plans traditionally are considered adversarial, DiLoreto said. Each side may fight to gain a little bit of ground one year, only to lose that ground during the next contracting period.

"Contracts are not all about rates and utilization anymore," he said. Quality metrics are becoming increasingly important, especially as they relate to improved performance.

"The reality is that a sustainable contracting process in the future will truly require greater collaboration between financial and clinical leaders because they can impact outcomes in significant ways," DiLoreto said.

Another common issue is a lack of care coordination and management. These elements should be addressed during the contracting phase.

Key considerations include whether the organization can create value for care management activities, and how that value is captured in terms of payment. And how is the value determined?

Another factor is the extent to which care transition teams are truly engaging patients, and the methodology for gauging their effectiveness. Readmissions is among several metrics that are currently used to determine the effectiveness of such programs in a population health management framework. Other metrics will be needed and can be developed by considering the following questions:

- What's the role of the population health management program in improving outcomes and reducing expenses?
- How do we know that the care managers understand their role in positively influencing these metrics?
- Are we educating the workforce about the strategic importance of these efforts?
- What are the redundancies or inefficiencies in the current system?
- Are we adding allied health professionals simply to do more clerical work? Are they operating at the top of their licenses? Similarly, are physicians spending too much time on administrative tasks?
- Are our clinical performance goals linked to financial performance?

DANIEL J. MARINO, MBA, MHA | DAVID DILORETO, MD, MBA | CARLOS BOHORQUEZ, MHA

KEY DRIVERS

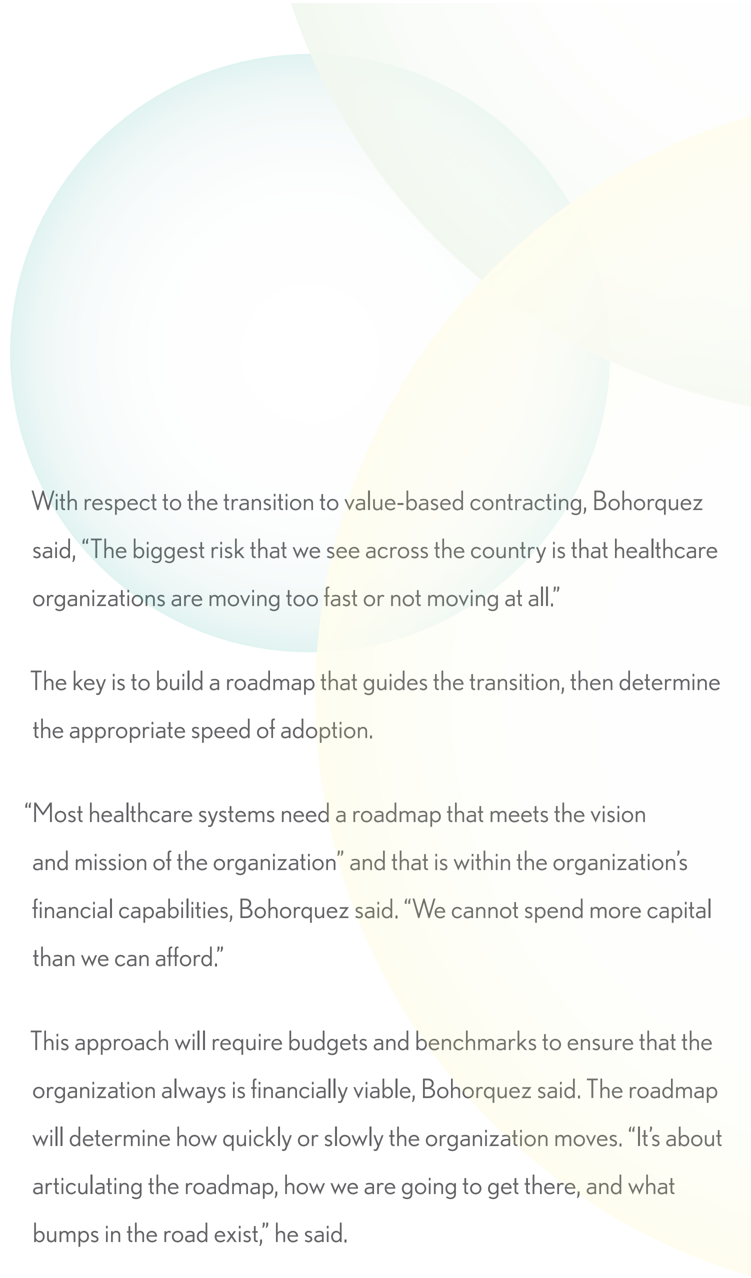
- REIMBURSEMENT (FFS VS. CAPITALIZATION)
- COST -OF-CARE (PMPM)
- PROVIDER/MEMBER ATTRIBUTION
- CARE MANAGEMENT AND QUALITY INDICATORS
- RECONCILIATION PERIOD
- PATIENT ACCESS

KEY DRIVERS OF A VALUE-BASED CONTRACT
FIG. 3

THE FINANCIAL VISION

For hospitals and health systems, the financial administration of health care has been an extremely difficult environment, Bohorquez said. "There has been significant pressure on revenue," he said. "Ten to 15 years ago, organizations were focused on building revenue and new programs. Today, when you're building new programs, and you're increasing revenue on a year-over-year basis, it hides a lot of operational sins.

"We are seeing a shift in the way capital is deployed. There is more capital being deployed for IT integration as opposed to bricks-and-mortar projects. We are having to get that back from new operations."



With respect to the transition to value-based contracting, Bohorquez said, "The biggest risk that we see across the country is that healthcare organizations are moving too fast or not moving at all."

The key is to build a roadmap that guides the transition, then determine the appropriate speed of adoption.

"Most healthcare systems need a roadmap that meets the vision and mission of the organization" and that is within the organization's financial capabilities, Bohorquez said. "We cannot spend more capital than we can afford."

This approach will require budgets and benchmarks to ensure that the organization always is financially viable, Bohorquez said. The roadmap will determine how quickly or slowly the organization moves. "It's about articulating the roadmap, how we are going to get there, and what bumps in the road exist," he said.

Creating balance between meeting the vision/mission of the organization while funding the capital needs and ensuring long-term financial stability.

- Developing a financial Roadmap for the organization by setting sufficient and realistic financial performance targets.
- Maintaining or improving the financial position of the organization within an appropriate risk context.
- Remaining creditworthy to have access to capital
- Managing the operating and capital budgeting process
- Creating and distributing financial analyses and reports
- Understanding the financial impacts/risks of new government mandates and regulations
- The evolving responsibilities of financial executives:
  - Educate different levels of the organization on the imperative of meeting budgets/targets
  - Ensure the organization develops financial plans/budgets which include achievable assumptions
  - Develop partnerships with operations, strategy, contracting, clinical, and IT teams to enact change
  - Disseminate accurate, timely, and actionable data across the organization

HOW ARE ORGANIZATIONS RESPONDING TO FINANCIAL CHALLENGES
FIG. 4

CASE STUDY 1:

Contracting with a Commercial Health Plan

Attendees also provided insights on three case studies involving value-based contracting. The first scenario involved a newly formed clinically integrated network (CIN) that was seeking to engage in a value-based contract with a commercial health plan.

The health plan proposed a three-year contract term, which attendees agreed was the minimum needed to obtain sufficient data on performance effectiveness. Some attendees also said the contract should add downside risk in the third year.

Other attendees urged a longer contract period, noting that the providers should ensure in advance that they understand the population and are capable of managing the high-risk portion

KEY PROVISIONS

Among the needed contract provisions are performance guarantees on the part of the health plan partner. For example, the contract should specify penalties for the plan if data is not given to the provider partner as agreed upon. The contract also should include financial penalties for provider organizations that fail to meet requirements.

One key point for provider organizations in such arrangements is to understand that health plans will drive volume to them in exchange for a lower per-unit cost. Financial incentives and accountability in the contract thus should aim to ensure that the expected volume increase materializes. Provider organizations should be willing to accept lower payments if the health plan enrolls more young and healthy lives to diversify the risk.

Contracts also need to address how patient attribution will be defined. For example, would patients be attributed to a provider organization based on geography or on demographics? Provider organizations need to understand the methodology in advance, and the contract needs to clearly spell it out.

Another key point of negotiation is the performance benchmark that will be used and whether the provider's performance will be compared to the local market or on a national scale. The preferred approach probably will depend on the type of patient population. For instance, Medicare managed care plans might have different opportunities than commercial plans.

Contracts also need to define quality, almost as a proof of concept, and describe the data that will be tracked to measure quality. The case study contract includes a care coordination payment (CCP) at an established per member per month (PMPM) rate for attributed members, with an opportunity for the provider to receive bonus payments based on performance in seven measures tied to HEDIS standards.

It's a mutual investment and it shows goodwill, and that we're all working towards that same goal. I think that is an important element... You have to do the work ahead of time to ensure each party's understanding about what we're working toward here.

Daniel J. Marino, MBA, MHA

In the second year of the contract, the CCP and bonus payments would be replaced with a shared savings structure that establishes a PMPM based on an annual medical-expenditure budget for all attributed members.

Attendees agreed that such contracts should include some type of case management or care management fee—especially when the agreements involve accountable care organizations or CINs, which are able to circumvent some antitrust barriers to such payments.

Under the proposed contract, the CIN would be responsible for half of any surplus or deficit in the shared savings pool. The health plan would withhold 10 percent of its fee-for-service payments to the CIN to fund a potential deficit.

Another key provision would provide up-front capital to help the provider organization create the needed infrastructure, instead of requiring the provider to wait 18 months into the contract term for incentive payments.

"It's a mutual investment and it shows goodwill, and that we're all working towards that same goal," Marino said. "So I think that is an important element."

POTENTIAL PITFALLS

Top pitfalls or concerns include the viability of the health plan from which the provider organization is counting on ongoing payments under the contract.

To avoid the risk of being locked into a partnership with a deteriorating health plan, some providers include language stipulating that the contract will be terminated if the plan's financial health deteriorates to the extent that ratings agencies place the plan at a specified level of risk. Likewise, some contracts require that the provider make its quarterly financial statements available to the plan.

Another pitfall is a failure to engage physicians in the contracting process and the negotiation of metrics, which could impact the extent to which they buy in to the agreement.

"You have to do the work ahead of time to ensure each party's understanding about what we're working toward here," Marino said.

Another risk is that provider organizations will enter into a contract without understanding what they are accountable for because they did not delve into the contract to understand the goals each party was working toward.

CASE STUDY 2:

Entering Into a Risk-Bearing Relationship

A second case study focused on a hypothetical CIN consisting of approximately 1,200 providers. The CIN participated in various upside-only contracts that covered approximately 250,000 lives.

A commercial health plan then approached the CIN about moving into a two-way risk contract that would eventually transition to a full-risk (i.e., capitation) model. For 2017, the plan proposed using the current fee schedule with a 2 percent cost-of-living adjustment. Ten percent of payment would be held in reserve, with a semiannual reconciliation period. The plan hoped to move to full capitation within a few years.

Attendees first discussed the ideal duration of the risk-bearing contract. One discussion group suggested a three-year contract, with the first year limited to shared savings and the second year transitioning to shared risk as long as the number of covered lives reached an agreed-upon minimum.

Another group settled on five years as a viable duration, with shared savings and shared risk in effect the whole time. After three years, either party could renegotiate or opt out of the contract. If both sides thought the partnership was working as envisioned at that time, they could move to a capitated model.

Both sides should easily be able to initiate discussions and negotiations around any issues that arise in the partnership, with monthly joint-operating committee meetings proposed as one way to make sure each side is getting what it expected out of the relationship.

KEY PROVISIONS

Points that should be addressed in a shared-risk contract include data sharing and patient attribution. Regarding data, one suggestion was to ask the health plan to provide three years of past-performance data on the patient population up front.

Ensuring that a certain number of attributed lives are in place is critical when a provider accepts downside risk, Marino said. "The last thing we want to do, even if [the CIN is] performing well, is having 500 lives go from shared savings to downside risk in Year 2," he said.

Once the full-risk portion of the contract begins, the health plan should also agree to set benefit levels in a way that deters members from going out-of-network. In-network referral guidelines should be negotiated as well.

A target medical-loss ratio could be another point of negotiation. And given that the target could shift every year based on characteristics of the attributed patient population, it should probably be up for renegotiation annually.

A possible solution would be to negotiate separate PMPM fees based on risk stratification, in the same manner as many arrangements specify for care management. Then you're thinking about the population cohort slightly differently, with incentives wrapped around that.

Daniel J. Marino, MBA, MHA

Another idea was to include contract language that establishes a shared data warehouse using claims data and electronic health record data, with a lag time of no more than 90 days.

A tool called Division of Financial Responsibility (DOFR), used in shared-risk contracts to define which side is financially responsible for which services, also was mentioned as a focus of negotiations. The provider might be responsible for inpatient and outpatient services but not for transplants, for example. These details are crucial to lay out in the contract, whether via DOFR or another approach.

Most of the points came back to ensuring that goals and incentives are aligned among all parties. For example, one way to get physicians on board would be to assure them that the relationship will lead to improvements in protocols such as preauthorization, thereby allowing them to spend more time with patients.

POTENTIAL PITFALLS

The parties in any type of risk arrangement should be aware of what may be carved in and out of member benefits by employers, discussion participants noted. For example, care for mental illness or substance abuse may not be covered for certain members.

In a tumultuous political environment, the CIN and health plan also would need to keep apprised of regulatory developments that could affect some provisions—even in the case of a commercial contract.

Smaller providers, especially, may not be equipped to participate in an arrangement with full cost allocation. Depending on certain diagnoses or comorbidities that may occur in the patient population, a provider's cost risk may go up considerably in the second year. Providers may have a hard time gauging the actuarial value of the risk they are taking on.

A possible solution, Marino said, would be to negotiate separate PMPM fees based on risk stratification, in the same manner as many arrangements specify for care management. "Then you're thinking about the population cohort slightly differently, with incentives wrapped around that," he said.

CASE STUDY 3:

Cobranding a Product for a Large Regional Market

The key is to have that collaborative relationship, so you're supporting the HCCs, supporting the infrastructure, supporting the care management, and having sort of a clear, defined idea as to how those roles need to be combined and work together.

Daniel J. Marino, MBA, MHA

In this scenario, a large regional Medicare Advantage (MA) plan with 60,000 members and $550 million in annual revenue approached a CIN with an offer to create a cobranded MA product. The MA plan would need approval from the Centers for Medicare & Medicaid Services to expand its services into the new market.

The plan offered exclusive provider-network rights and was willing to create two cobranded primary care clinics that would cater to senior care.

KEY PROVISIONS

Network adequacy, access, and the ability to deliver the continuum of care would be critical elements in this sort of an arrangement especially.

On the financial side, one key would be to provide contractual detail about finances with regard not only to premiums but also to healthcare services, including how primary care physicians, specialists, and other components of the CIN would be compensated in alignment with the payment model

The ability to capture hierarchical condition categories (HCCs) is critical because HCCs allow providers and health plans to identify high-cost, high-risk patients who would benefit from care management. Capturing HCCs also allows the parties to quantify the actuarial value of the risk pool and, in turn, to appropriately set premium rates.

Based on patient relationships, the provider should be the side that is responsible for capturing HCCs. The MA plan should contribute its expertise, perhaps by training physicians on coding and HCCs and on aligning those tasks with their work flows. The plan has access to claims data that, with the right analytics, providers can use to drill down into population health trends.

"The key is to have that collaborative relationship," Marino said, "so you're supporting the HCCs, supporting the infrastructure, supporting the care management, and having sort of a clear, defined idea as to how those roles need to be combined and work together."

Shared risk—both upside and downside, and as described in a DFOR—is critical. Clearly defined care management responsibility is a bedrock as well, and the details should be established in a way that is actionable and that makes clear who's doing what and when.

Infrastructure with respect to both data and care management also is vital, as are provisions that ensure high-quality actuarial work to understand what's occurring within the MA population, given the likelihood of significant variation. Deciding on the stop-loss threshold is another important step.

POTENTIAL PITFALLS

Lack of experience in population health management would be a hindrance in any type of shared-risk arrangement, but especially in one this advanced. "This is a high-level type of product, solution, and capability," Marino said. "You have to have that experience."

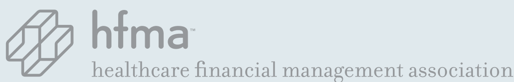
Given that the regulatory overhead associated with MA is significant, a cobranded product in which one of the parties does not perform optimally in pro forma requirements could lead to a breakdown of the partnership.

Finally, any semblance of financial instability on either side could doom the partnership, given the likelihood in such an arrangement of having to "weather storms," in the words of one attendee.

IN CONCLUSION

HFMA thanks attendees for their contributions to the Executive Experience session at ANI 2017. Although transforming health care to improve value is a thoroughly complex challenge, ideas such as those generated during the Executive Experience can give stakeholders a blueprint with which to move forward. As well, the spirit of partnership that was evident during the session bodes well for the ability of different groups of stakeholders to come together in this endeavor.

Collaboration in the effort to improve health care will remain vital going forward. With that in mind, HFMA is already planning similar activities for ANI 2018 in Las Vegas. Much more information will be forthcoming.



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With more than 38,000 members, the Healthcare Financial Management Association (HFMA) is the nation's premier membership organization for healthcare finance leaders. HFMA builds and supports coalitions with other healthcare associations and industry groups to achieve consensus on solutions for the challenges the U.S. healthcare system faces today. Working with a broad cross-section of stakeholders, HFMA identifies gaps throughout the healthcare delivery system and bridges them through the establishment and sharing of knowledge and best practices. It helps healthcare stakeholders achieve optimal results by creating and providing education, analysis, and practical tools and solutions. HFMA's mission is to lead the financial management of health care.

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PUBLISHED BY:
Healthcare Financial Management Association
3 Westbrook Corporate Center, Suite 600
Westchester, Illinois 60154-5700

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