Healthcare Finance 101
FFS, FFV, and how we get paid

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OFA LEADERSHIP SERIES: HEALTHCARE FINANCE 101

October 2023
Learning objectives

• Understand the ways that UW Medicine is currently paid in fee-for-service and in fee-for-value models.

• Understand key terms and how they are derived including wRVU, DRG, Evaluation and Management (E and E) coding, and concepts around risk-adjustment.

• Understand changes in the marketplace and strategies integrated healthcare systems such as UW Medicine have in place to thrive in an uncertain healthcare environment.
Agenda

• Mission, Vision, and Values - MM
• Overview of US medical finances and pressures on healthcare systems - MM
• Contracting and how we get paid - ML
• BREAK
• UW Medicine and evolving payment models
• Disruptors in Healthcare
• UW Strategies
Mission and Vision

- UW Mission –
  - To improve the health of the Public
- Pop Health Vision –
  - UW Medicine and partners will coordinate and demonstrate the highest clinical value of care for patients and communities we serve.
  - Create sustainable financial models through blended fee-for-service and value-based arrangements.
  - We will seamlessly integrate clinical, equity, research and educational goals.
  - Focus on simplifying health for our patients, communities, and care teams.
UW Medicine Values

- We treat people with respect and compassion.
- We embrace diversity, equity and inclusion.
- We encourage collaboration and teamwork.
- We promote innovation.
- We expect excellence
Where do you work?

Start presenting to display the poll results on this slide.
What is your level of confidence on how we get paid and changes in the healthcare market? Scale of 1-10 (10 being very confident)
CURRENT STATE OF MEDICAL ECONOMICS IN THE US
If the US healthcare budget was a country, what would that country rank amongst the world's largest Gross Domestic Products? Enter number (#1 is the US $26 trillion), #2 is China, etc.)

Start presenting to display the poll results on this slide.
<table>
<thead>
<tr>
<th>Rank &amp; Country</th>
<th>GDP (USD billion)</th>
<th>GDP Per Capita (USD thousand)</th>
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</thead>
<tbody>
<tr>
<td>#1 United States Of America (U.S.A)</td>
<td>26,954</td>
<td>80.41</td>
</tr>
<tr>
<td>#2 China</td>
<td>17,786</td>
<td>12.54</td>
</tr>
<tr>
<td>#3 Japan</td>
<td>4,231</td>
<td>33.95</td>
</tr>
<tr>
<td>#4 Germany</td>
<td>4,430</td>
<td>52.82</td>
</tr>
<tr>
<td><strong>US HEALTHCARE SPEND</strong></td>
<td><strong>4,300</strong></td>
<td>Of US Fed Budget 19%</td>
</tr>
<tr>
<td>#5 India</td>
<td>3,730</td>
<td>2.61</td>
</tr>
<tr>
<td>#6 United Kingdom (U.K.)</td>
<td>3,332</td>
<td>48.91</td>
</tr>
<tr>
<td>#7 France</td>
<td>3,052</td>
<td>46.32</td>
</tr>
<tr>
<td>#8 Italy</td>
<td>2,190</td>
<td>37.15</td>
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<tr>
<td>#9 Brazil</td>
<td>2,132</td>
<td>10.41</td>
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<tr>
<td>#10 Canada</td>
<td>2,122</td>
<td>53.25</td>
</tr>
</tbody>
</table>

https://www.forbesindia.com/article/explainers/top-10-largest-economies-in-the-world/86159/1
US Healthcare Major changes

Key dates in pre-pandemic US insurance markets

1920
Employer sponsored insurance
Pre covid 55% of population covered this way

1965
Medicare
Medicaid enacted
Part A hospital insurance. Part B medical insurance.

1973
Medicare Advantage Programs
AKA Part C. Today approaching 50% of

2003
Medicare Part D
Drug benefits for Medicare Programs

2010
Affordable Care Act
Uninsured adults decreased from 20% to 12% pre-pandemic
US Spends more on healthcare per capita than any OECD country but health outcomes lag

If you include public health and prevention, then the GDP spend by the US is more in line with European countries but with worse outcomes.
Administrative costs are high in the US in large part due to complexity of our payment systems.
US healthcare is inequitable compared with other OECD countries

EXHIBIT 6
Health Care System Performance Scores: Equity

Note: To normalize performance scores across countries, each score is the calculated standard deviation from a 10-country average that excludes the US. See How We Conducted This Study for more detail.

Data: Commonwealth Fund analysis.

Local differences in life expectancy 2003-2007

Legend

Comparison to KC
- ▲ Higher than KC
- ▼ Lower than KC
- ☃ No Significant Difference

Life Expectancy in Years
- ☮ 77.6 - 78.4
- ✔ 78.5 - 79.8
- ☎ 79.9 - 82.2
- ☳ 82.3 - 85.3

Public Health
Seattle & King County

UW Medicine
PATIENTS ARE FIRST
Small populations drive large costs

**Figure 4.**
Distribution of Health Expenditures for the U.S. Population

- **99th–100th percentile**: 22% of expenditures, mean spending: $116,330
- **95th–99th percentile**: 28% of expenditures, mean spending: $37,390
- **90th–95th percentile**: 16% of expenditures, mean spending: $16,960
- **75th–90th percentile**: 21% of expenditures, mean spending: $7,260
- **50th–75th percentile**: 11% of expenditures, mean spending: $2,240
- **Bottom 50 percent**: 3% of expenditures, mean spending: $310

Source: MEPS 2017, authors’ calculations.
Note: Data are for 2017. Sample includes people of all ages. Mean expenditures are rounded to the nearest 10.
It’s the prices, stupid.

Is it price or volume that drives US costs?

• The US growth in pharma spending was 3x OECD countries
• In 2015 the US had 19% fewer practicing physician per 1,000 population than the median OECD country
• The US had 7.5 medical school graduates per 100,000 compared with the OECD median of 12.1
• US nurse population is 20% below OECD median but we train more nurses than the OECD median
• The US has 26% fewer inpatient acute hospital beds per 1,000 population than the median OECD country
And Healthcare expenditures are taking more of the US budget at a non-sustainable rate.
Paradox of US Healthcare

Life expectancy continues to decline in the U.S. as it rebounds in other countries

Life expectancy around the world decreased in 2020 due to COVID-19. Most peer countries rebounded by 2021, while the U.S. continued to decline.

Source: Peterson-KFF Health System Tracker
Credit: Ashley Ahn/NPR
Market Forces in US Healthcare

US Healthcare markets have not been a “free market” by economic definitions

Standard Economic Theory
• Healthcare is not an exchangeable good
• There is not free competition for many aspects of care
• There is not enough information to value elements of healthcare

Modern Economic
• For-profit organizations have increasingly entered healthcare in the last decade (Amazon, CVS/Aetna, Walgreens, Walmart, etc)
• Venture Capital has also entered healthcare and has $1 Trillion dollars more to invest this next Decade.
The future of healthcare

“Every system is perfectly designed to get the results it gets” – Attributed to Paul Batalden (IHI)
How Do We Get Paid?
A Brief Discussion of Healthcare Reimbursement

Matt Lund
UW Medicine
Today we will discuss...

• Managed Care Contracting at UW Medicine
• *How are we paid?* - Reimbursement Systems/Methodologies
• How Medicare Impacts All Reimbursement
• Key Takeaways
• Common Myths/Misunderstandings
• Reimbursement Trends and Challenges in Era of Healthcare Reform
• Q&A
Contracting at UW Medicine

- All reimbursements for medical services negotiated by UW Medicine Contracting & Payer Relations Department ("Contracting")
- Three hospitals, UWP and other professionals, Airlift Northwest
- Commercial and Government/Managed Government payers (Medicare, Medicaid, Tricare, etc.)
- Negotiations focus on total annual dollar reimbursement by UW Medicine entity and UW Medicine system
- $3.7 Billion in annual reimbursement
- Key factors in contracting process: payer mix, acuity mix, market trends, institutional mission, language, access, law/regulations
UW Medicine Payer Mix – Gross Charges (~$12B)
UW Medicine Payer Mix – Net Payments (~$3.7 B)
How we are paid: Typical Payment Methods

Reimbursement is rooted in Medicare methodology:

<table>
<thead>
<tr>
<th>Method</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRG/MS-DRG</td>
<td>Diagnosis Related Grouper for Inpatient/Hospital Services</td>
</tr>
<tr>
<td>APC</td>
<td>Ambulatory Payment Classification for Outpatient Hospital Services</td>
</tr>
<tr>
<td>RBRVS</td>
<td>Resource Based Relativity Value Scale for Professional Services</td>
</tr>
<tr>
<td>Other payment</td>
<td>Percent of charge, per diem, bundled payment, case rate, P4P, capitation, etc.</td>
</tr>
<tr>
<td>Lump sum</td>
<td>Less than our charges</td>
</tr>
</tbody>
</table>

“Understand Medicare, Understand All”
Typical Payment Methods...

Focus:

• Inpatient Reimbursement
  • DRG/IPPS
• Outpatient Hospital Reimbursement
  • APC/OPPS
• Professional Fee Reimbursement
  • RVU/RBRVS
DRG – “Diagnosis-Related Grouper”

- CMS/Medicare Concept
- Inpatient services
- Lump sum payment
- **Facility Specific Base**
- Service Specific Weight
- Base and Weights set by CMS (annual rule)
- Base x Weight = Payment
- Outlier
- DRG Versions
- See CMS Inpatient Prospective Payment System (“IPPS”)
- MS-DRG, APR-DRG, DRG
IPPS – Inpatient Prospective Payment System

- Base x Weight
APC - “Ambulatory Payment Classification”

- CMS/Medicare Concept
- Outpatient Hospital Services
- Lump sum payment
- **Facility Specific Conversion Factor**
- Service Specific Weight
- CF and Weights set by CMS (in annual rule)
- Conversion Factor x Weight = Payment
- Outlier
- APC Versions
- **See CMS Outpatient Prospective Payment System (OPPS)**
- APC, EAPG
OPPS – Outpatient Prospective Payment System

- Conversion Factor x Weight
RBRVS - “Resource-Based Relative Value Scale”

- CMS/Medicare Concept
- Professional Services
- Lump Sum Payment
- Geographic-Specific Conversion Factor (GPSI)
- Service-/CPT-Specific RVU value
- Conversion Factor x RVU value = payment
- RVU year
- See CMS Physician Fee Schedule
• Conversion Factor x RVU Value
Commercial Reimbursement

- Generally, mirrors Medicare in methodologies:

- “Know Medicare, Know All”

- Base/CF \times Weight

- \textit{Base/CF is negotiable; Weight is not}

- Some percent of charge contracts at UW Medicine

- Commercial contracts almost always have a P4P/value-based component:
  - Rely heavily on \textit{attribution} of patients to specific health systems (CINs)/PCPs/medical homes
  - Quality and Cost/Utilization measures
Medicaid Reimbursement

- Similar to Medicare reimbursement with some differences
- Conversion Factor x Weight
- APR-DRG and EAPG
- FFS Medicaid administered by the HCA; most Medicaid is administered by MCOs
- HCA currently has 5 MCO’s (Amerigroup, Coordinated Care, CHPW, Molina, United)
- Managed Medicaid is more restrictive than FFS Medicaid, as patients are managed by plans at full risk for spend
- Medicaid P4P/VB Programs are mandated by HCA
Key Takeaways

• Majority of reimbursements made pursuant to a Medicare-like (lump sum) method

• CMS Weights Set by CMS/HCA (not negotiable)

• Bases/CFs vary by **facility** (not by provider or specialty) – are negotiable

• CMS Professional Conversion Factors based upon geographic region

• UW Medicine reimbursement strategy focused on total yearly revenue of system

• Efficiency in utilization (cost management) is key to success in current business environment – “Cost is King”
Myths, Misconceptions, Challenges, and Trends

- Carve-Outs are Rare
- We “Deserve” More
- Data-Driven Negotiations
- EMR – Unification and Payer Access
- Purchasers desire value for their dollars, not just services
- Cost and Quality – Must Be Demonstrated
- Accurate Coding of HCCs is expected by the market and necessary to optimize reimbursement and value-based success
- Optimizing Site of Service, Care Management, Mastering Quality Measures, Ideal Prescribing Patterns, Population Health Management, etc.
Questions?

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BREAK
UW Medicine is a family of organizations

UW Medicine (UWM) is a complex set of entities

- What does clinical integration mean?
- UWM does not meet criteria as a Clinically Integrated Network by FTC criteria
UW Medicine was a leader in value-based care

- Boeing led UW’s journey to Value but rapidly revealed difficulties in running this type of relationship
- PEBB/SEBB have been advanced models with overall better results
- MSSP has also had mixed results to date
- UW is evaluating new models of payment including Making Care Primary
Medicare plans to move all payments to Value-Based Care Models

Medicare will move 100% of it’s contracts to two-sided Advanced Payment Models
• In effect, CMS is de-risking and putting the risk of managing total cost of care to other entities
• Non-traditional healthcare organizations are willing to take risk in these governmental programs such as Medicare Advantage.
• Where Medicare goes, the rest of insurers follow
Currently we have contracts in nearly all of these categories, but UW is biased toward the FFS compared with other systems and disruptors in our market.

In a blended FFS and FFV model, healthcare systems are challenged to evolve two systems of payment:

- But there are areas that “win” in both FFS and FFV models:
  - Managing Cost of care
  - Manage clinical outcomes
  - Manage quality
  - Complex care management
  - LOS
- And with high demand and full capacity, there isn’t traditional tradeoff of value for volume.
FIGURE 4.
Distribution of Health Expenditures for the U.S. Population

U.S. population by total health-care spending per person

- Bottom 50 percent
- 50th-75th percentile
- 75th-90th percentile
- 90th-95th percentile
- 95th-100th percentile

Share of health expenditures

- 3% of expenditures, mean spending: $310
- 21% of expenditures, mean spending: $7,260
- 16% of expenditures, mean spending: $16,960
- 28% of expenditures, mean spending: $37,390
- 22% of expenditures, mean spending: $116,330

Source: MEPS 2017; authors’ calculations.
Note: Data are for 2017. Sample includes people of all ages. Mean expenditures are rounded to the nearest 10.
How to address population health

High-Risk Population
At least one complex illness, multiple comorbidities

Rising-Risk Population
Chronic conditions unmanaged, aging

Moderate-Risk Population
Chronic conditions controlled, managed

Low-Risk Patients
Healthy or chronic conditions, managed

Accountable care organization/clinically integrated network opportunity to manage medical spend, outcomes and utilization

Current Care Management Focus

Risk - Cost

5%
15-30%
65-80%
• There is wide realization that the 4 trillion dollars spent on healthcare is not resulting in better health for our country
• Outside forces are now “disrupting” healthcare in significant and accelerating ways
What company employs the largest number of physicians in the US?
Vertical Integration in the Marketplace

The Healthcare Vertical Integrators of 2022*

<table>
<thead>
<tr>
<th>CARE CONTINUUM</th>
<th>OPTUM</th>
<th>CVS</th>
<th>ASSETS</th>
<th>AMAZON</th>
<th>LOCAL HEALTH SYSTEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Services</td>
<td>United Healthcare</td>
<td>Aetna</td>
<td></td>
<td></td>
<td>Provider Sponsored Plans</td>
</tr>
<tr>
<td>At-Home Preventative (RPM)</td>
<td>Vivify / AbleTo</td>
<td>Signify**</td>
<td></td>
<td></td>
<td>Growing Digital Health Investments</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Optum Care (HealthCare Partners, Kelanay, Atrius Health, Healthwise Assoc. of TS)</td>
<td>MinuteClinic / HealthHUB</td>
<td>Community Clinics / CityMD**</td>
<td></td>
<td>Urgent Care Access Expansion</td>
</tr>
<tr>
<td>Primary Care</td>
<td>OptumCare</td>
<td>Renal Care</td>
<td></td>
<td></td>
<td>Growing PCP employment</td>
</tr>
<tr>
<td>Specialty Care</td>
<td>Traditional PBM, Pharmacy and Infusion Services (Diplomat)</td>
<td>Traditional PBM (Caremark) / Pharmacy Business</td>
<td>Shields / Traditional Pharmacy Business</td>
<td></td>
<td>Centers of Excellence</td>
</tr>
<tr>
<td>Ancillary (Lab/Imaging/Pharmacy)</td>
<td>OptumCare / Atrius Health, Reliant Medical Group</td>
<td></td>
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<td></td>
<td>Pharmacy</td>
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<tr>
<td>Outpatient/Ambulatory</td>
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<td>Surgery Centers &amp; Outpatient Clinics</td>
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<td>Inpatient</td>
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<td></td>
<td>Communities</td>
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<tr>
<td>Post-Acute Facility</td>
<td>Navicare</td>
<td></td>
<td></td>
<td></td>
<td>Home Health Network</td>
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<tr>
<td>Home Health</td>
<td>Landmark Health, LHC**, Refresh Mental Health</td>
<td>Signify**</td>
<td>CareCentrix</td>
<td></td>
<td>End of Life Care</td>
</tr>
<tr>
<td>Palliative / Hospice</td>
<td></td>
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</tbody>
</table>

*Scale based on relative market impact as of 11/2022. **Pending transactions. ©2022 Lumeris | Proprietary & Confidential
Local Disruption – “Payvider” models and for profit

- Owned by Premera – Kinwell Clinics – 17 clinics through Washington State – “Kinwell is a startup, determined to change the primary care experience.”

- Optum – by far the largest medical group in the nation, over 70,000 providers, Kaiser Permanente has 24,000 by comparison. Locally they own The Everett Clinic, the Polyclinic, Sound Physicians amongst other groups.

- Amazon – owns One Medical and offers primary care for just $144 dollars for the first year. Promises “Hassle-free primary care” Also owns Iora – a large practice specializing in Medicare Advantage patients.
UW Medicine can learn from other disrupted industries

• The story of many industries are that the incumbents did not recognize external threats early enough to respond

• All “disrupted” industries have similar stories
  • Computers IBM to Microsoft
  • Steel – Big Steel to Nucor
  • Entertainment – Blockbuster to Netflix
Blockbuster Video

• The Blockbuster story is particularly relevant to healthcare
  • Blockbuster did not understand what its product was – entertainment delivery, it focused on video rental (and late fees) and the customers moved on
  • Blockbuster also became anchored to brick-and-mortar business model and killed a successful mail/streaming service to compete with Netflix.
Risky financial foundations

Non-Virtuous Cycle

- Disruptors take manageable patient populations from healthcare systems
- Healthcare systems continue to care for high cost and/or difficult to manage patient populations (e.g., mission aligned patients with social determinants)
- Continued commercial cost pressures decrease margins.
- Existential threat to high-expense healthcare systems.
UW Medicine and adverse selection

- UW Medicine is the specialty referral center for WWAMI states.
- UW Medicine mission is aligned around being the safety net system for those most vulnerable in our communities.
  - [Harborview’s] primary mission is to provide healthcare for the most vulnerable residents of King County.
- Current risk models have difficulty fully risk-adjusting patients who have failed prior therapeutic interventions.
- Example from FHCC.
UW STRATEGIES

• What is UW Medicine Doing to organize health care transformation to high-value healthcare
Currently we have contracts in nearly all of these categories, but UW is biased toward the FFS compared with other systems and disruptors in our market.

In a blended FFS and FFV model, healthcare systems are challenged to evolve two systems of payment

- But there are areas that “win” in both FFS and FFV models
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  - Complex care management
  - LOS
- And with high demand and full capacity, there isn’t traditional tradeoff of value for volume.
Value Levers Alignment to Maximizing Value

The value levers are revised to align with maximizing clinical value.

Maximize Clinical Value = \[
\frac{\text{Highest Quality Care and Patient Experience}}{\text{Net Cost to Deliver}} \]

**Highest Quality**
- Patient centered medical home (PCMH) and neighborhood
- Management of chronic conditions and diseases

**Patient Experience**
- Access – in person, digital, virtual touch
- Network Adequacy
- Care Management – timely system care navigation

**Total Cost of Care**
- Risk adjustment
- Site of Care Optimization
- Keep-age/ Steering in network
- Utilization Management

Communication and education
Sharing best practices
Strategic Leadership Council (SLC)

Choice Care Board

Value-Based Care Committee (VBCC):
- Execute to long term strategy
- Monitor Performance
- Problem Solve
- Set & adjust priorities, benchmarks, & targets
- Optimize current & future performance
- Create accountability to operational leaders

Value Lever Subcommittees
- Care Mgmt
- Quality
- Documentation Excellence
- Patient Experience & Access
- Value Management
- Continuum of Care/Care Pathways

Analytic Support

Quality Management

Operations:
- Pop Health Leadership, All Primary Care, Specialties, UWP, Hospitals, Digital Health, Compliance
What business is UW Medicine in?

- Sick care – tertiary, quaternary, regional referral
- Wellness, cost of care at population levels and value management
- Consumer/Retail/Industry/Disruptors
- What do our patients need? How can we do this equitably?
- What does the market need?
- FUTURE – WHAT IS THE ROLE OF UW MEDICINE?
Learning objectives

- Understand the ways that UW Medicine is currently paid in fee-for-service and in fee-for-value models.
- Understand key terms and how they are derived including wRVU, DRG, Evaluation and Management (E and E) coding, and concepts around risk-adjustment.
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QUESTIONS?