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

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OFA LEADERSHIP SERIES: HEALTHCARE FINANCE 101

October 2023

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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.

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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

slido

Where do you work?

ⓘ Start presenting to display the poll results on this slide.

slido

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)

ⓘ Start presenting to display the poll results on this slide.

CURRENT STATE OF MEDICAL ECONOMICS IN THE US

slido

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.

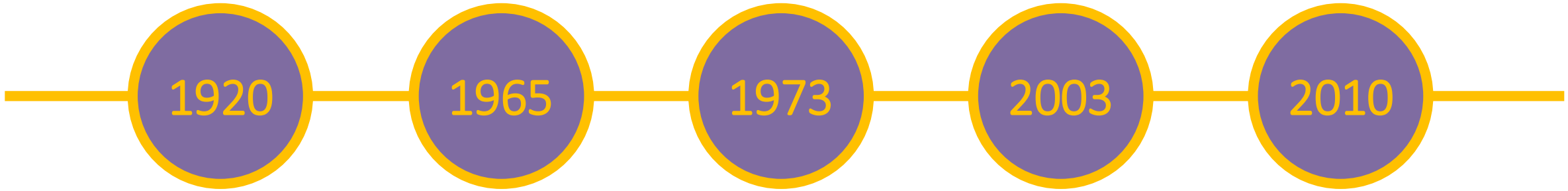
Slido Answer

Rank & Country	GDP (USD billion)	GDP Per Capita (USD thousand)
#1 United States Of America (U.S.A)	26,954	80.41
#2 China	17,786	12.54
#3 Japan	4,231	33.95
#4 Germany	4,430	52.82
US HEALTHCARE SPEND	4,300	Of US Fed Budget 19%
#5 India	3,730	2.61
#6 United Kingdom (U.K.)	3,332	48.91
#7 France	3,052	46.32
#8 Italy	2,190	37.15
#9 Brazil	2,132	10.41
#10 Canada	2,122	53.25

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



Employer sponsored insurance

Pre covid 55% of population covered this way

Medicare

Medicaid enacted

Part A hospital insurance. Part B medical insurance.

Medicare Advantage Programs

AKA Part C. Today approaching 50% of

Medicare Part D

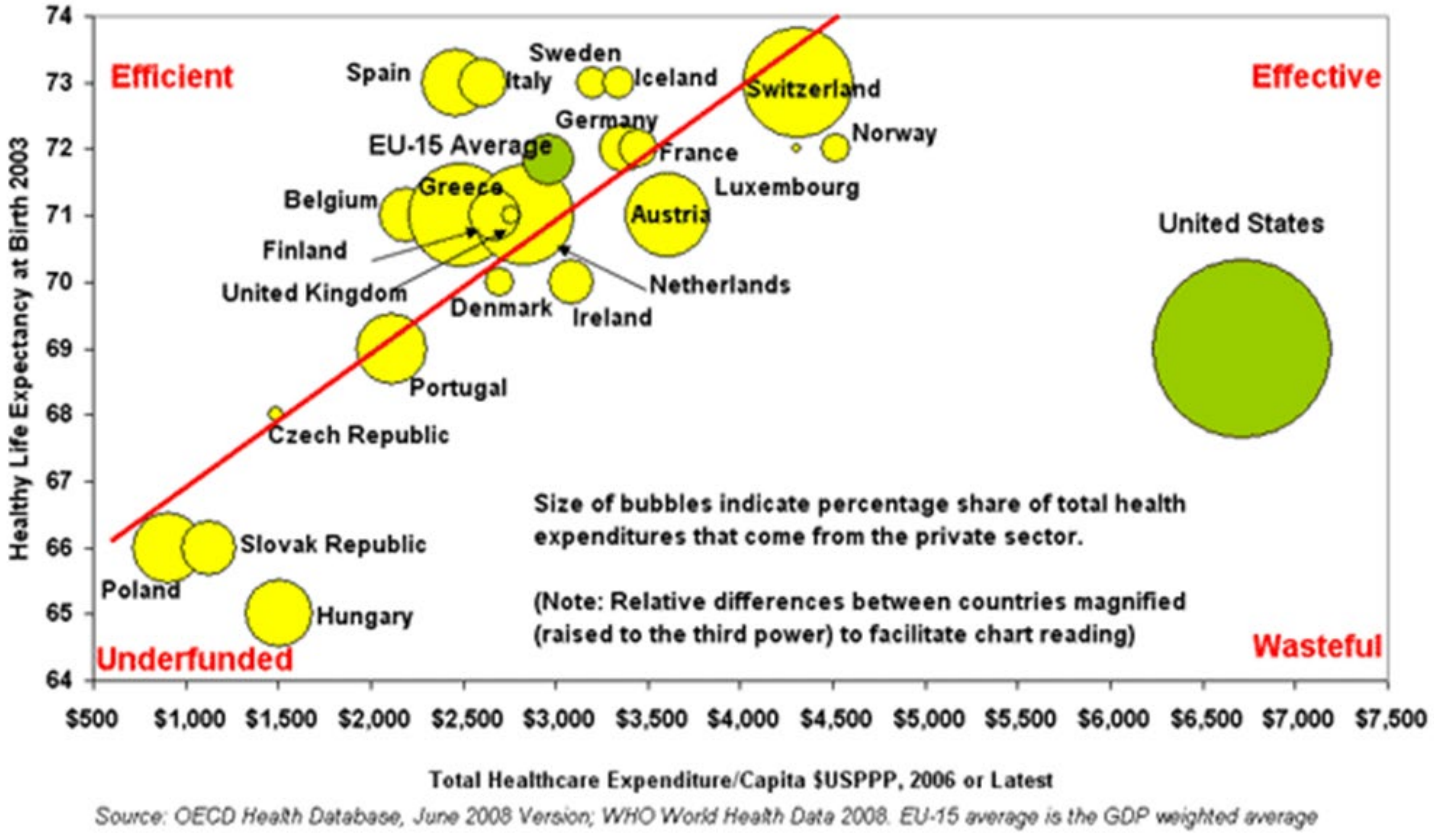
Drug benefits for Medicare Programs

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

Figure 1: Healthy Life Expectancy Total Population and Total Healthcare Expenditure/capita, 2003/2006



Source: OECD Health Database, June 2008 Version; WHO World Health Data 2008. EU-15 average is the GDP weighted average

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.

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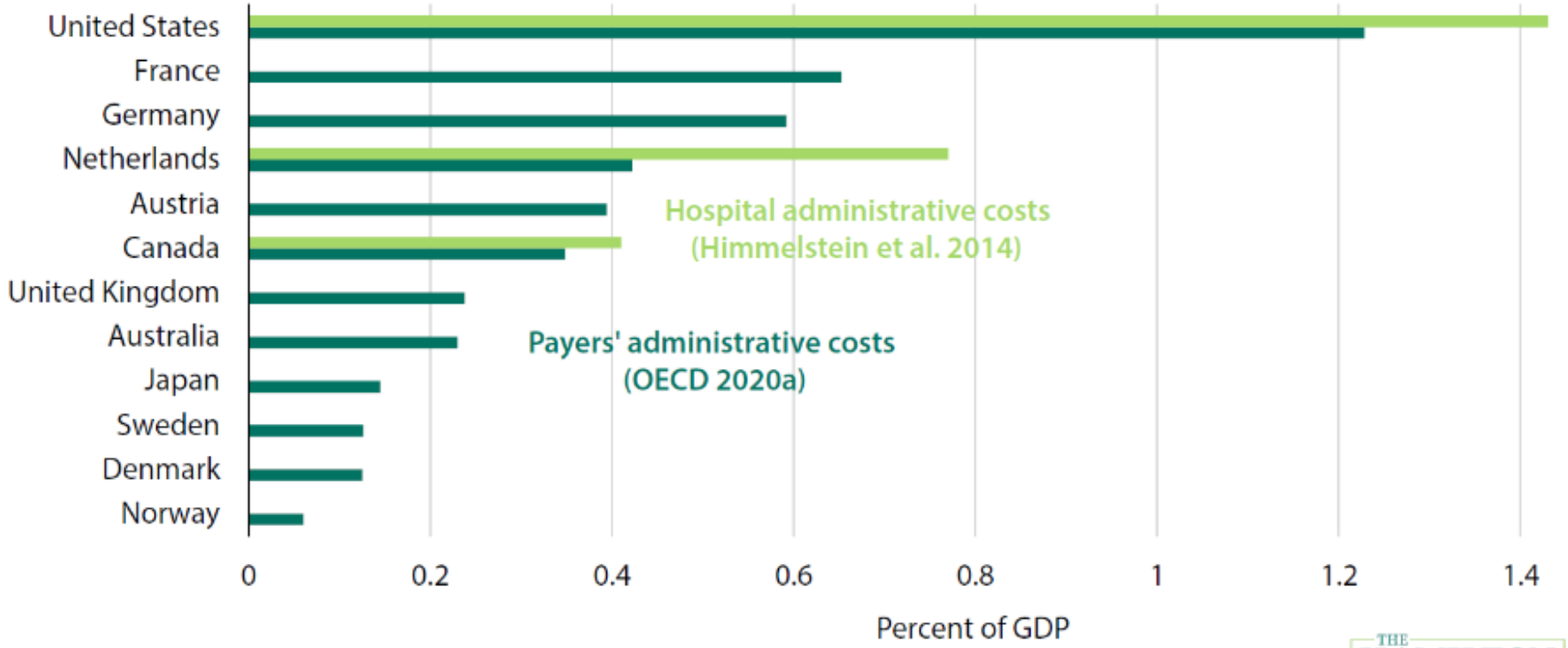
Administrative costs are high in the US in large part due to complexity of our payment systems

FIGURE 10.

Selected Administrative Costs as a Share of GDP, by Country



Source: Himmelstein et al. 2014; OECD 2020a.

Note: Data for the United Kingdom are for 2013. All other data are for 2010. See Himmelstein et al. 2014 and OECD 2020a for details.

THE HAMILTON PROJECT
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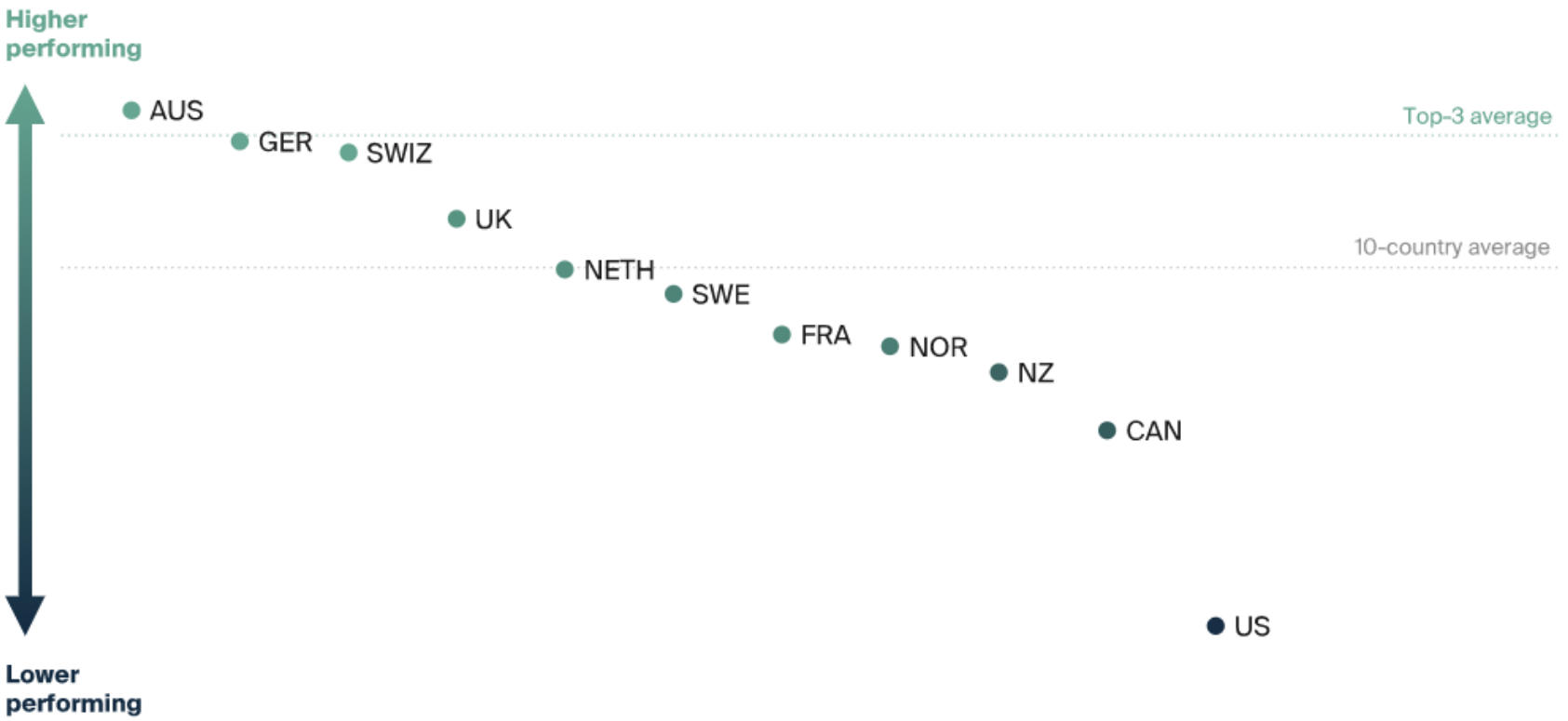
US healthcare is inequitable compared with other OECD countries

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.

Source: Eric C. Schneider et al., *Mirror, Mirror 2021 — Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries* (Commonwealth Fund, Aug. 2021).

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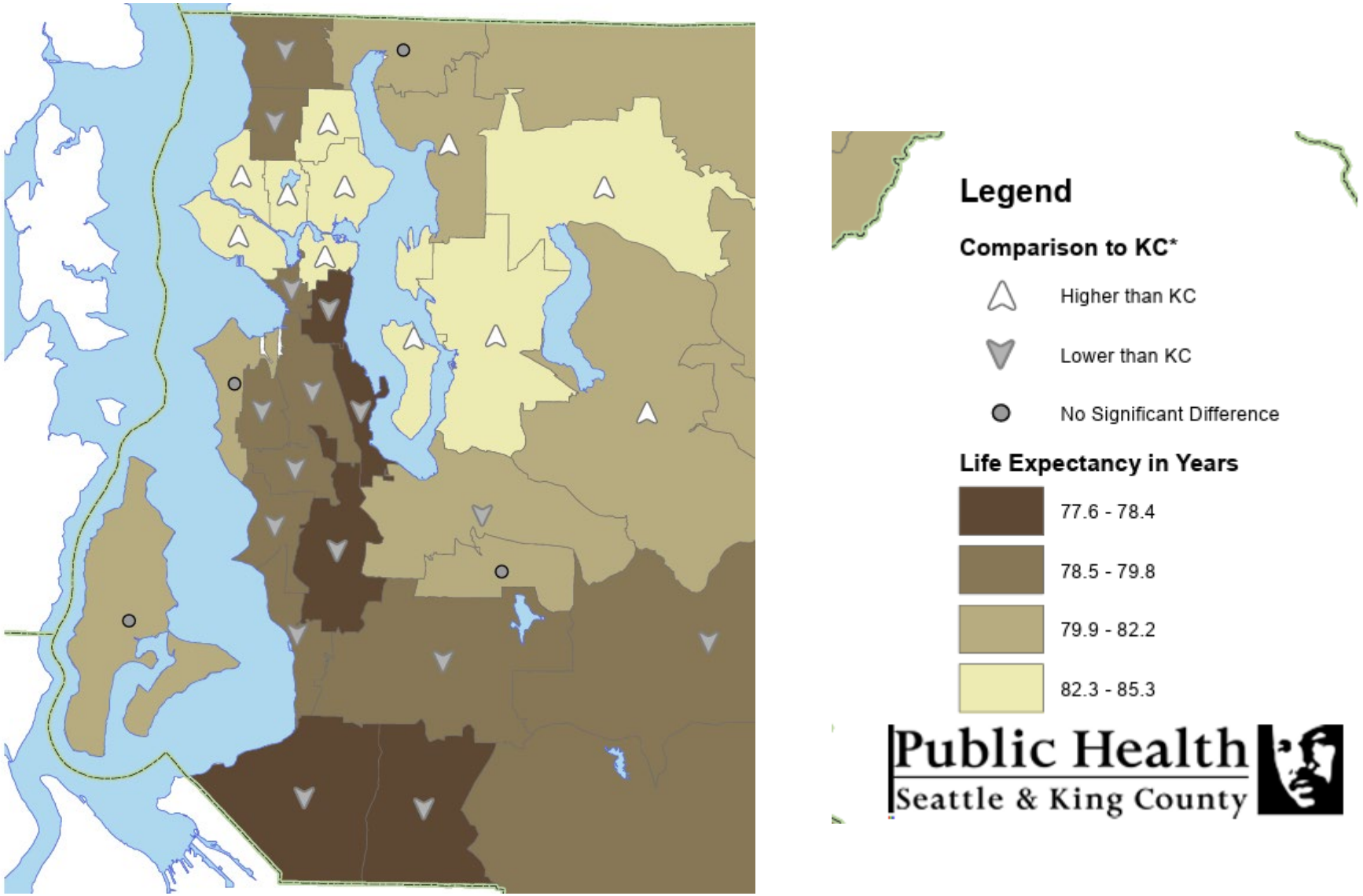
Local differences in life expectancy 2003-2007



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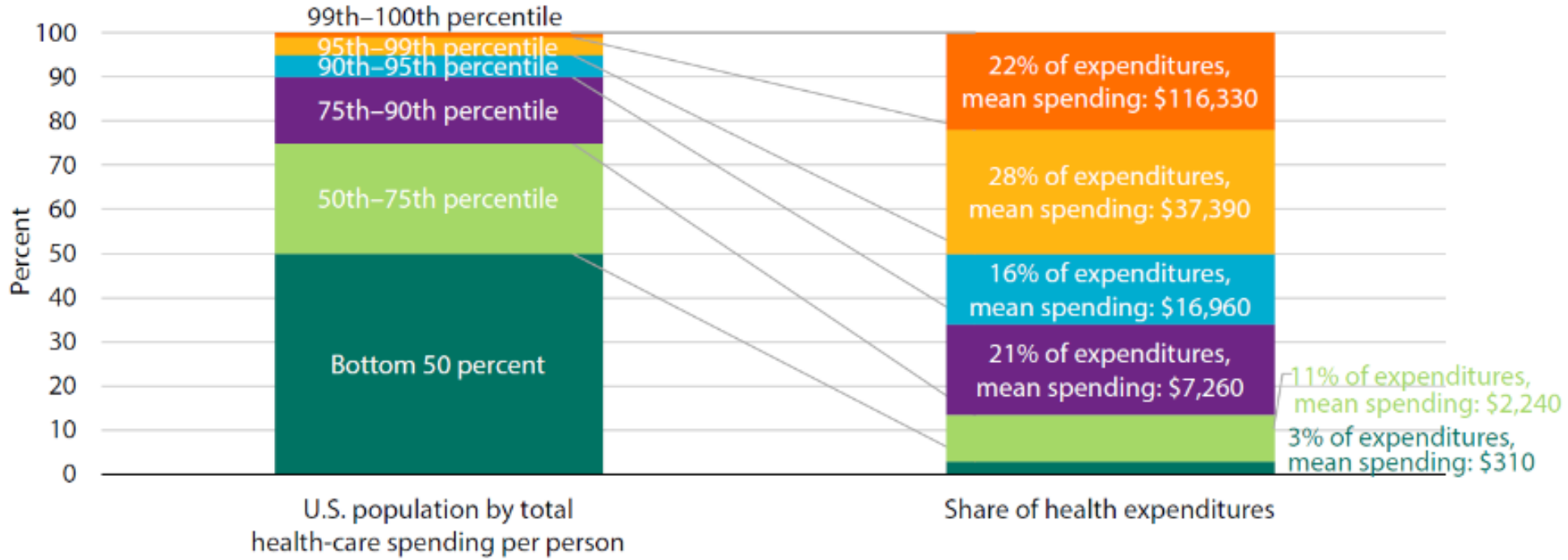
Small populations drive large costs

FIGURE 4.

Distribution of Health Expenditures for the U.S. Population



Source: MEPS 2017; authors' calculations.

Note: Data are for 2017. Sample includes people of all ages. Mean expenditures are rounded to the nearest 10.

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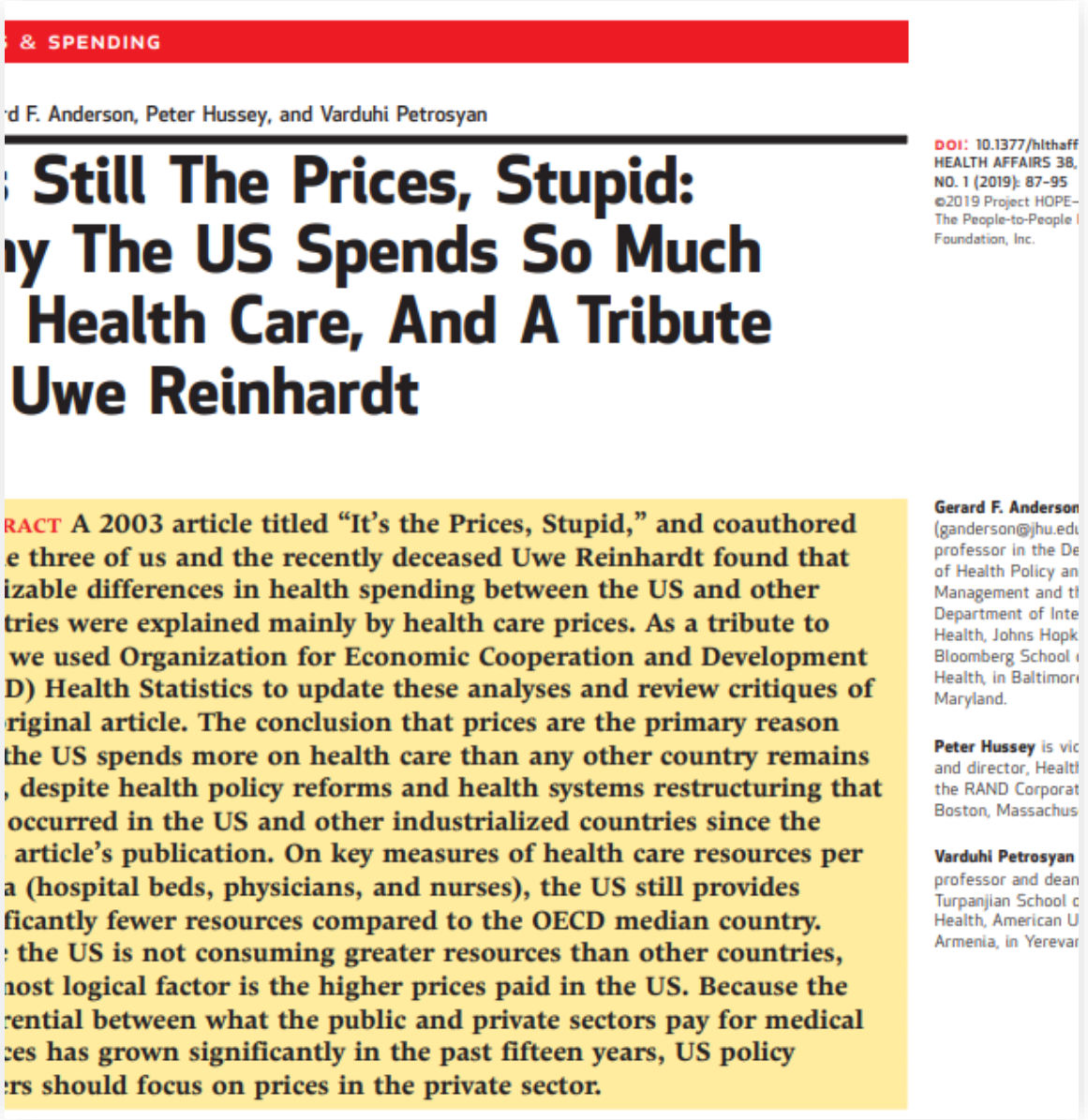
It’s the prices, stupid.

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



& SPENDING

d F. Anderson, Peter Hussey, and Varduhi Petrosyan

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Still The Prices, Stupid:
ny The US Spends So Much
Health Care, And A Tribute
Uwe Reinhardt

RACT A 2003 article titled “It’s the Prices, Stupid,” and coauthored
e three of us and the recently deceased Uwe Reinhardt found that
izable differences in health spending between the US and other
tries were explained mainly by health care prices. As a tribute to
we used Organization for Economic Cooperation and Development
D) Health Statistics to update these analyses and review critiques of
riginal article. The conclusion that prices are the primary reason
the US spends more on health care than any other country remains
, despite health policy reforms and health systems restructuring that
occurred in the US and other industrialized countries since the
article’s publication. On key measures of health care resources per
a (hospital beds, physicians, and nurses), the US still provides
ficantly fewer resources compared to the OECD median country.
the US is not consuming greater resources than other countries,
nost logical factor is the higher prices paid in the US. Because the
rential between what the public and private sectors pay for medical
ces has grown significantly in the past fifteen years, US policy
rs should focus on prices in the private sector.

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Peter Hussey is vic and director, Healt the RAND Corporat Boston, Massachus

Varduhi Petrosyan professor and dean Turpanjian School Health, American U Armenia, in Yerevar

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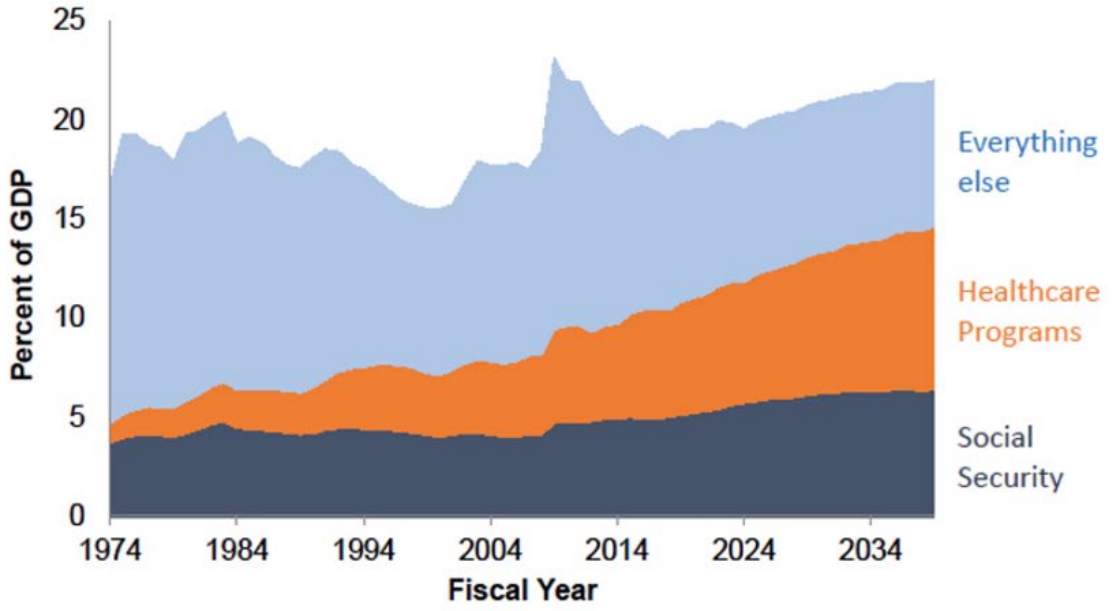
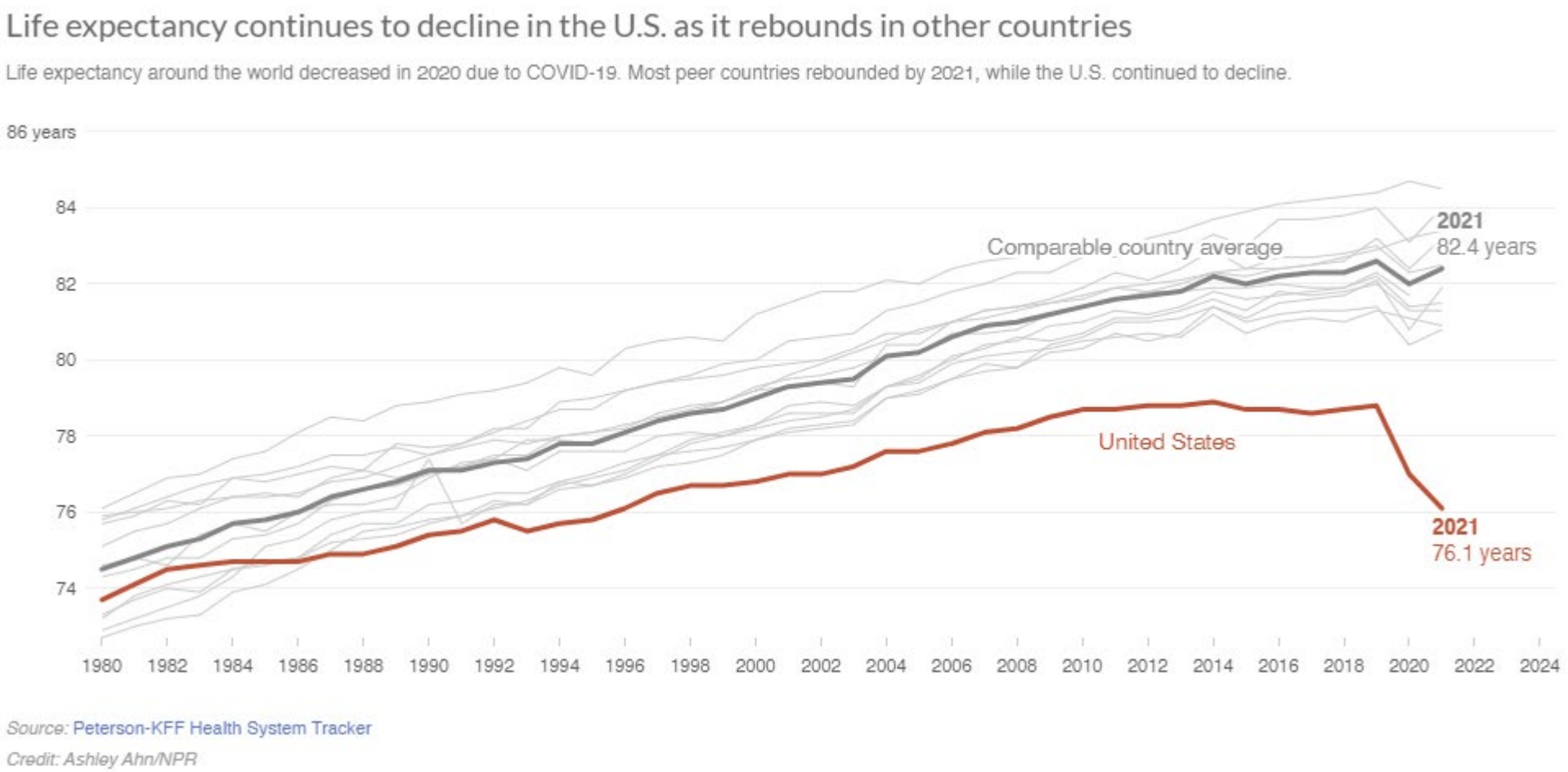
And Healthcare expenditures are taking more of the US budget at a non-sustainable rate.

Health Care & the Federal Budget



Source: Congressional Budget Office, 2016 Long-Term Budget Outlook.

Paradox of US Healthcare



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Market Forces in US Healthcare

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

Standard Economic Theory

- Healthcare is not a 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

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Overview

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

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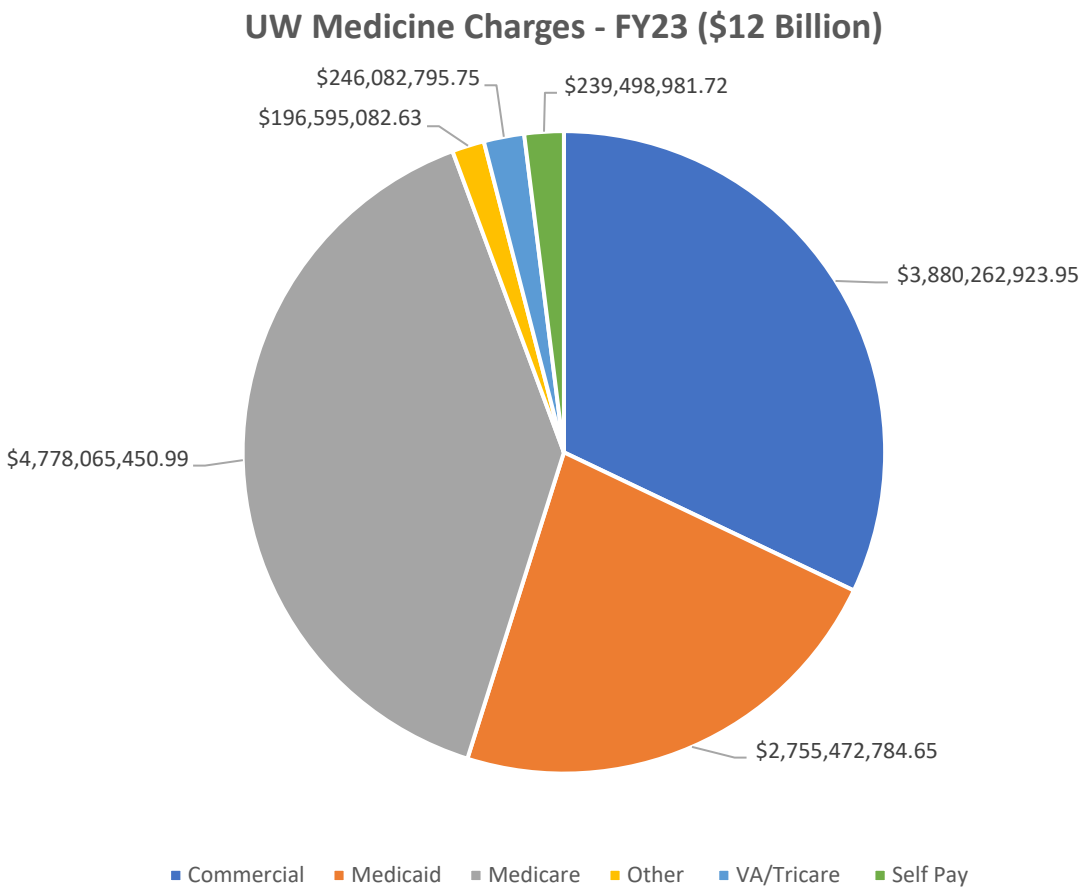
UW Medicine Payer Mix – Gross Charges (~$12B)



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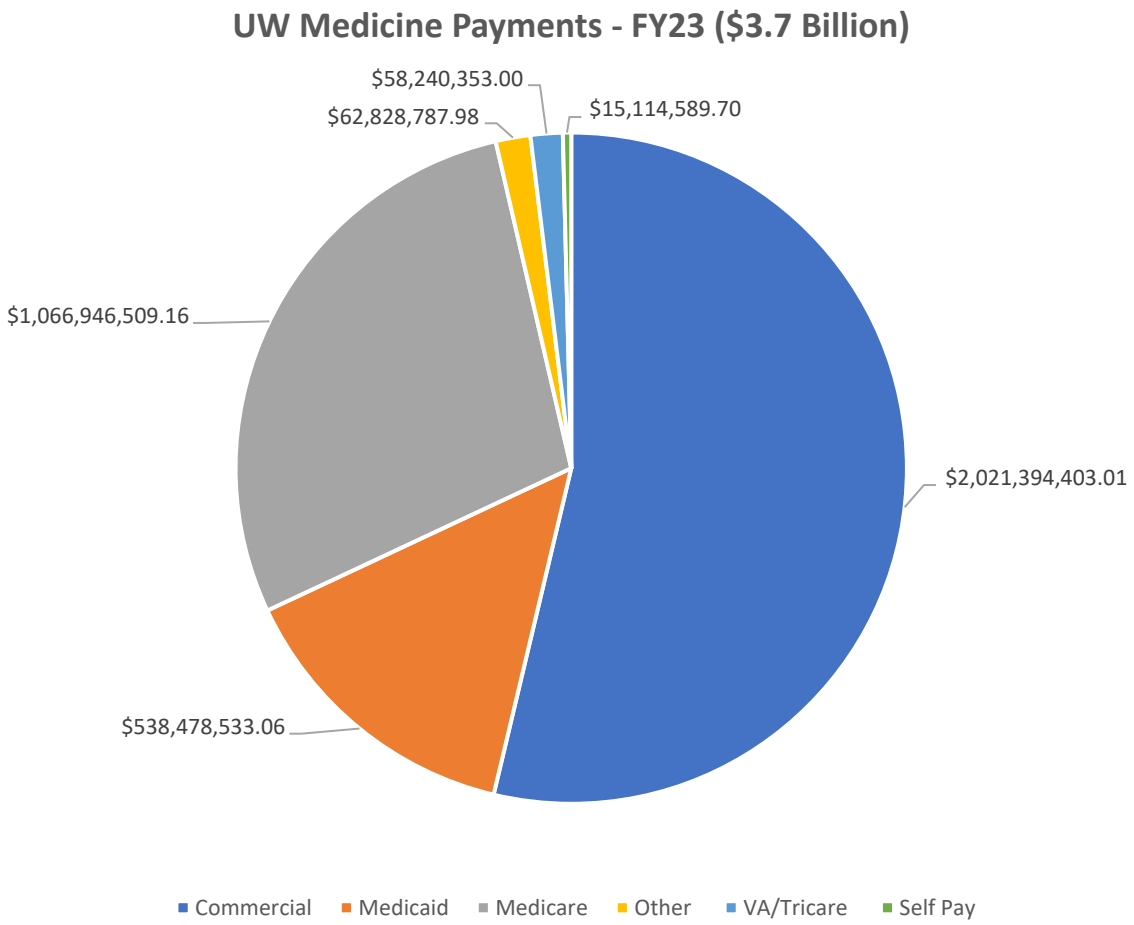
UW Medicine Payer Mix – Net Payments (~$3.7 B)



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How we are paid: Typical Payment Methods

Reimbursement is rooted in Medicare methodology:

DRG/MS-DRG	• Diagnosis Related Grouper • For Inpatient/Hospital Services
APC	• Ambulatory Payment Classification • For Outpatient Hospital Services
RBRVS	• Resource Based Relativity Value Scale • For Professional Services
Other payment methods	• Percent of charge, per diem, bundled payment, case rate, P4P, capitation, etc.
Lump sum payments	• Less than our charges

"Understand Medicare, Understand All"

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Typical Payment Methods…

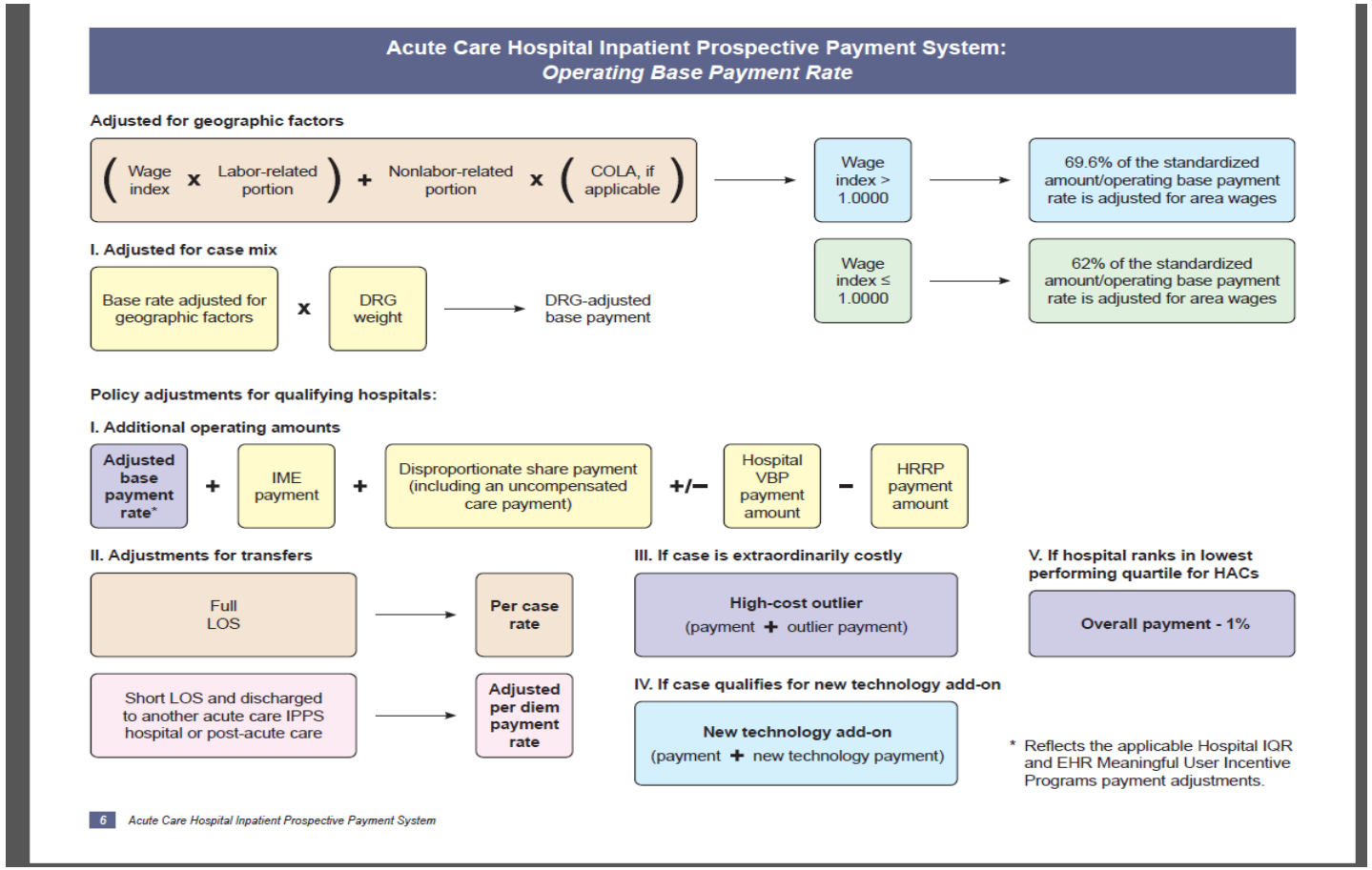
Focus:

- 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



Acute Care Hospital Inpatient Prospective Payment System:
Operating Base Payment Rate

Adjusted for geographic factors

(Wage index x Labor-related portion) + Nonlabor-related portion x (COLA, if applicable) → Wage index > 1.0000 → 69.6% of the standardized amount/operating base payment rate is adjusted for area wages

Wage index ≤ 1.0000 → 62% of the standardized amount/operating base payment rate is adjusted for area wages

I. Adjusted for case mix

Base rate adjusted for geographic factors x DRG weight → DRG-adjusted base payment

Policy adjustments for qualifying hospitals:

I. Additional operating amounts

Adjusted base payment rate* + IME payment + Disproportionate share payment (including an uncompensated care payment) +/− Hospital VBP payment amount − HRRP payment amount

II. Adjustments for transfers

Full LOS → **Per case rate**

Short LOS and discharged to another acute care IPPS hospital or post-acute care → **Adjusted per diem payment rate**

III. If case is extraordinarily costly

High-cost outlier (payment + outlier payment)

IV. If case qualifies for new technology add-on

New technology add-on (payment + new technology payment)

V. If hospital ranks in lowest performing quartile for HACs

Overall payment - 1%

* Reflects the applicable Hospital IQR and EHR Meaningful User Incentive Programs payment adjustments.

- Base x Weight

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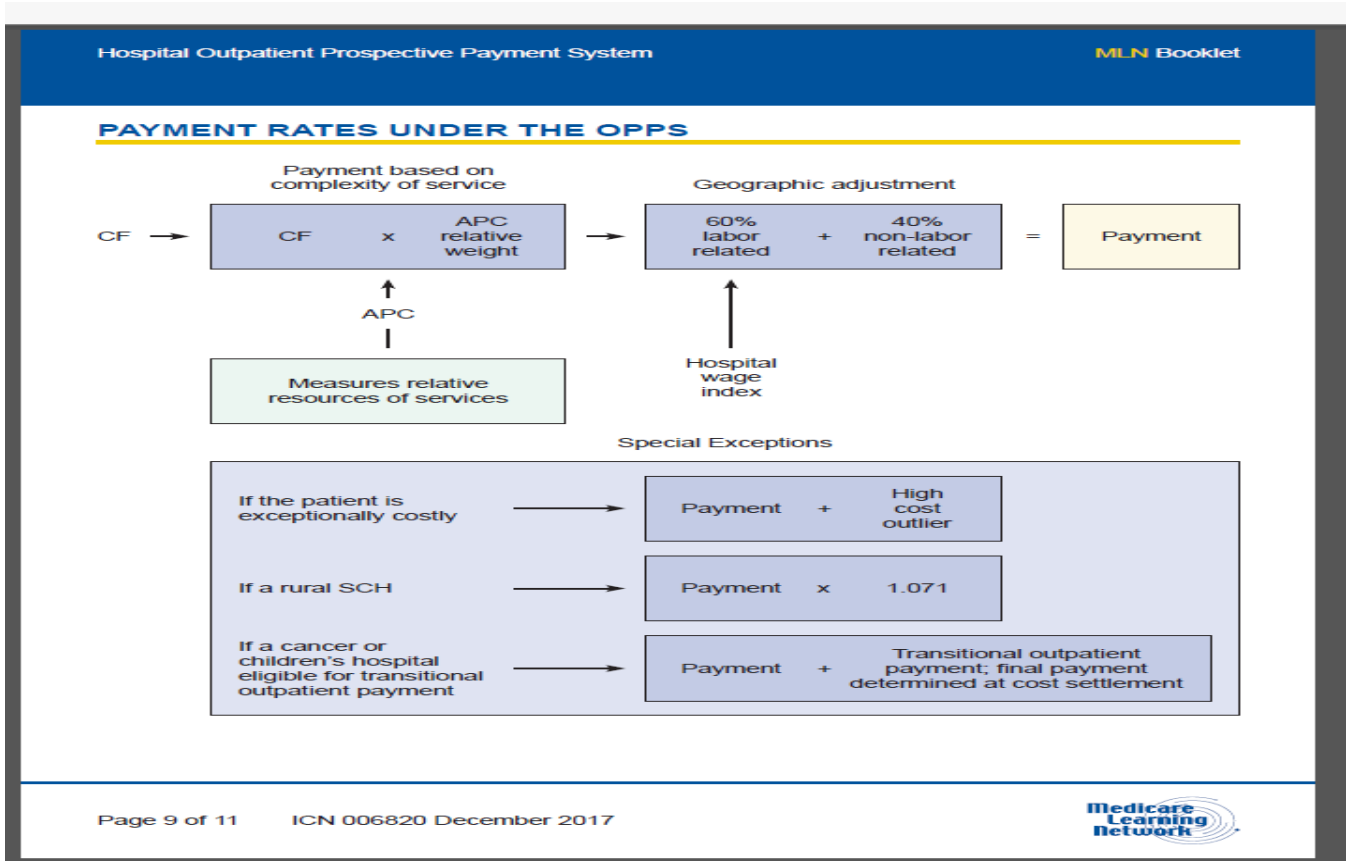
APC - “Ambulatory Payment Classification”

- 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

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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

RBRVS

Medicare Physician Fee Schedule MLN Fact Sheet

MEDICARE PFS PAYMENT RATES

The Medicare PFS payment rates formula shows how a payment rate for an individual service is determined, and we provide a description for each component below the formula.

Medicare PFS Payment Rates Formula

Payment = [Work RVU x Work GPCI + PE RVU x PE GPCI + MP RVU x MP GPCI] x CF

1) Relative Value Units (RVUs)

Three separate RVUs are associated with calculating a payment under the Medicare PFS:

- **The Work RVU** reflects the relative time and intensity associated with furnishing a Medicare PFS service
- **The Practice Expense (PE) RVU** reflects the costs of maintaining a practice (such as renting office space, buying supplies and equipment, and staff costs)
- **The Malpractice (MP) RVU** reflects the costs of malpractice insurance

2) Geographic Practice Cost Indices (GPCIs)

Each of the three RVUs are adjusted to account for geographic variations in the costs of practicing medicine in different areas within the country. These adjustments are called GPCIs, and each kind of RVU component has a corresponding GPCI adjustment.

3) Conversion Factor (CF)

To determine the payment rate for a particular service, the sum of the geographically adjusted RVUs is multiplied by a CF in dollars. The statute specifies the formula by which the CF is updated on an annual basis.

You can use the Physician Fee Schedule Search Tool to obtain national and local payment rates. For information on how to use the Physician Fee Schedule Search Tool, refer to How to Use the Searchable Medicare Physician Fee Schedule.

Page 2 of 4 ICN 006814 February 2017 CMS

- Conversion Factor x RVU Value

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Commercial Reimbursement

- Generally, mirrors Medicare in methodologies:
- "Know Medicare, Know All"
- Base/CF x Weight
- 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 *attribution* of patients to specific health systems (CINs)/PCPs/medical homes
  - Quality and Cost/Utilization measures

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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 then 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

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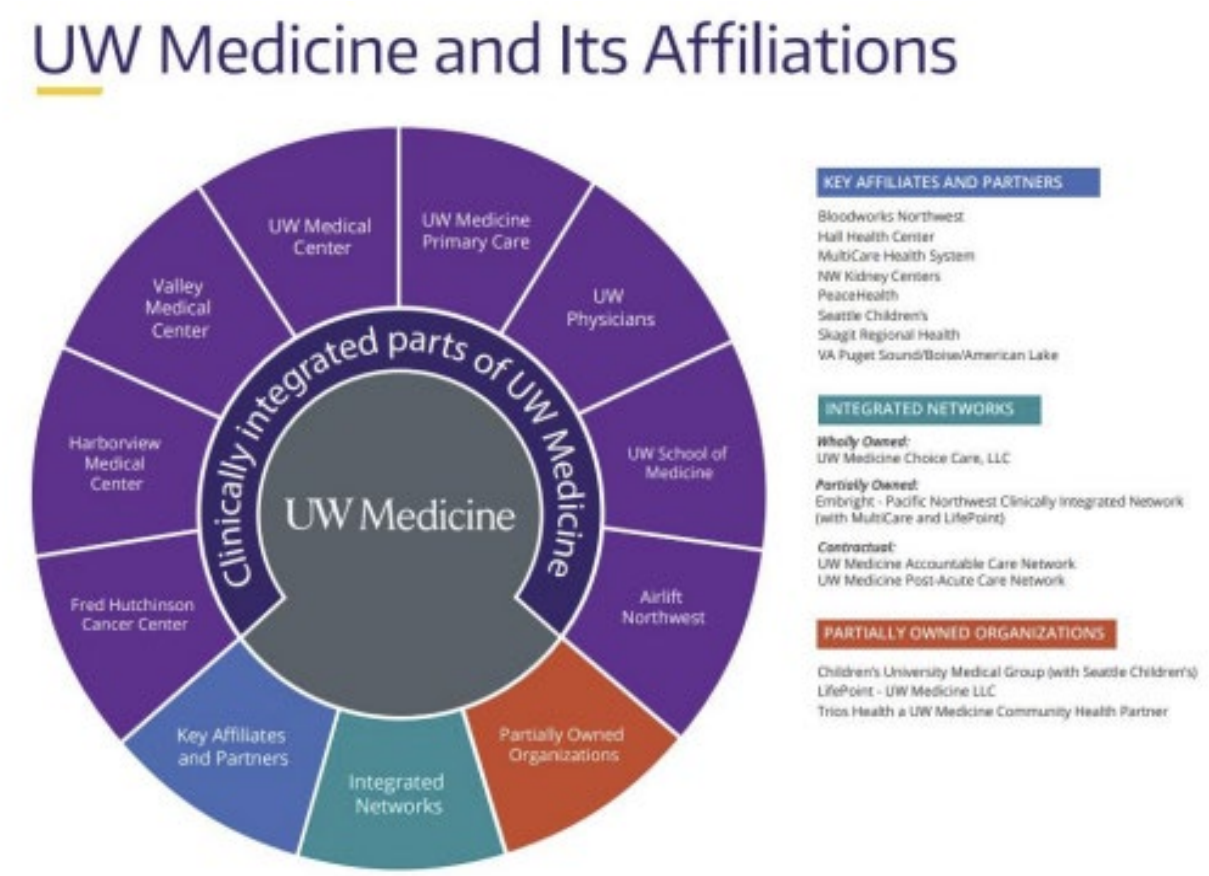
UW Medicine is a family of organizations



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

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UW Medicine – A History Timeline of Value Based Activities by Performance Year

PY 2014

UW Medicine Accountable Care Network

UW Medicine
MultiCare
Skagit
Seattle Children's
SCCA*
Capital*
Overlake**
Island**
PeaceHealth**

PY 2015

Jan 1, 2015 – UW Medicine Accountable Care Network launches a commercial, first, direct to employer, two-sided contract with Boeing

BOEING

Jan 1, 2015 - UW Medicine launches the new Office of the Chief Medical Officer with Dr. Carlos Pellegrini, first CMO for UW Medicine

Oct 31, 2015 - CMMI care transformation 4-year grant begins
Medicine

PY 2016

Jan 1, 2016 – UW Medicine ACN launches its second two sided commercial direct to employer contract with WA Health Care Authority for PEBB lives

UMP Plus+

Mar 2016, UW Medicine Central Population Health Management team formed

May - Aug 2016- Summer of empanelment

PY 2017

Stop loss triggered in Boeing contract. Contract renegotiations begin

Strong focus on MA contracts with significant gains in AWV rates (AWV rates 5%->65%,
care gaps 65%->80%,
risk adjustment 45%->65%)

Central care managers and panel navigators outreaching on gaps and AWVs

Improvements seen in ACN quality metrics also due to PATH program efforts

UW Medicine HealthCare Equity Blueprint launched

PY 2018

Dr. Tim Dellit begins as UW Medicine's new CMO

Boeing 2.0 contract begins

HCA PEBB achieves shared savings for first time

PY 2019

Sep 2019 Embright LLC announced as CIN, founded by UW Medicine, MultiCare and Life Point

Embright

UW Medicine wins the AMGA Acclaim Award for population health achievements

Medicine wins back Regence MA PPO contract based on 2017 performance results

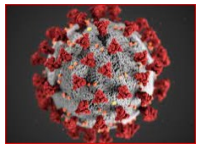
CMMI grant ends in Dec 2019

HCA PEBB achieves shared savings

PY 2020

SEBB product launches in HCA ACN contract to become PEBB/SEBB contract

Northwest Hospital merges with UWMC as second campus. NWH TIN no longer in use



Feb 2020, UW Medicine begins its COVID 19 response, launches EOC structure.

COVID response continues, multiple surges, State mandates, crisis standards of care, staff furloughs

No financial settlement in Boeing contract due to COVID

HCA PEBB and SEBB achieves shared savings

PY 2021

- COVID response continues
- Dec 31, 2021 - Boeing contract with UW Medicine ACN ends
- Dec 31, 2021- Final year UW Medicine ACN is the convenor for the HCA contract

Innovation articles show pandemic accelerated VB payment model design (Telehealth, PCMH PMPM, Bundled, capitation)

PY 2022

Embright network launches its own two-sided Boeing 3.0 contract

Embright is contracted to manage the HCA contract on behalf of UW Medicine ACN, we still own the HCA contract.

UW Medicine Accountable Care Network managed by Embright
UMP Plus+

PEBB and SEBB current contracts extended to Dec 31, 2025, both two-sided VBAs

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES | MEDICARE SHARED SAVINGS PROGRAM

UW Medicine Choice Care launches MSSP in Level A

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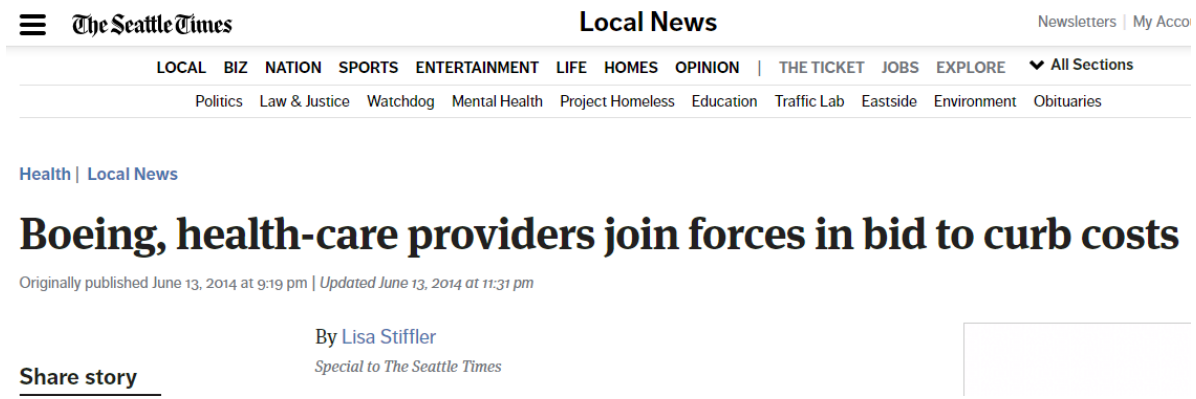
UW Medicine was a leader in value-based care



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Boeing, health-care providers join forces in bid to curb costs

Originally published June 13, 2014 at 9:19 pm | *Updated June 13, 2014 at 11:31 pm*

By Lisa Stiffler

Special to The Seattle Times

Share story

- 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

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Medicare plans to move all payments to Value-Based Care Models

GOAL STATEMENT

Accelerate the percentage of US health care payments tied to quality and value in each market segment through the adoption of **two-sided risk APMs.**

	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2020	15%	15%	30%	30%
2022	25%	25%	50%	50%
2025	50%	50%	100%	100%

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

[Health Care Payment Learning and Action Network | CMS Innovation Center]

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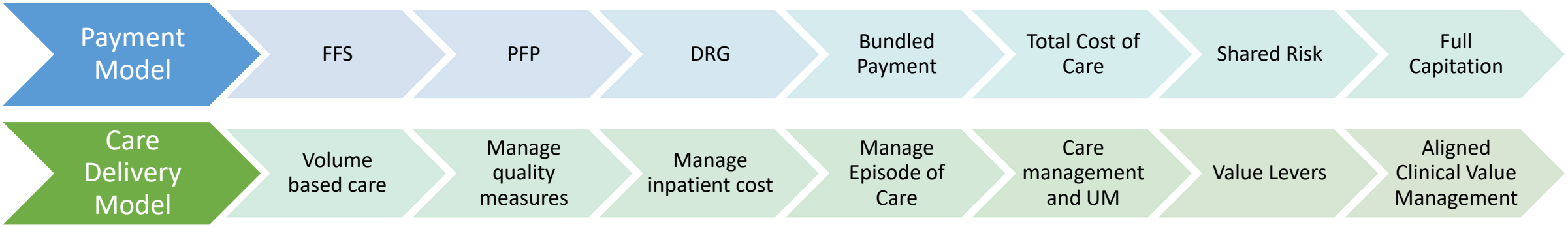
Different payment and care delivery models



- 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.

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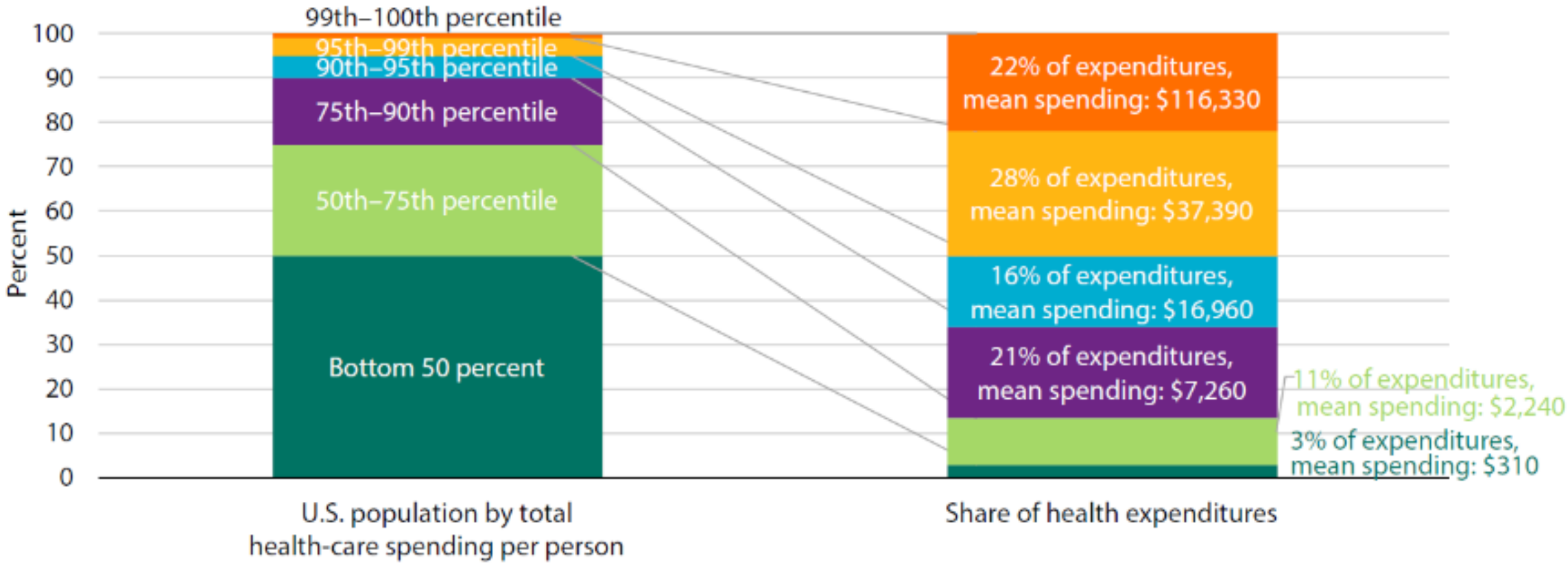
FIGURE 4.

Distribution of Health Expenditures for the U.S. Population



Source: MEPS 2017; authors' calculations.

Note: Data are for 2017. Sample includes people of all ages. Mean expenditures are rounded to the nearest 10.

THE HAMILTON PROJECT

BROOKINGS

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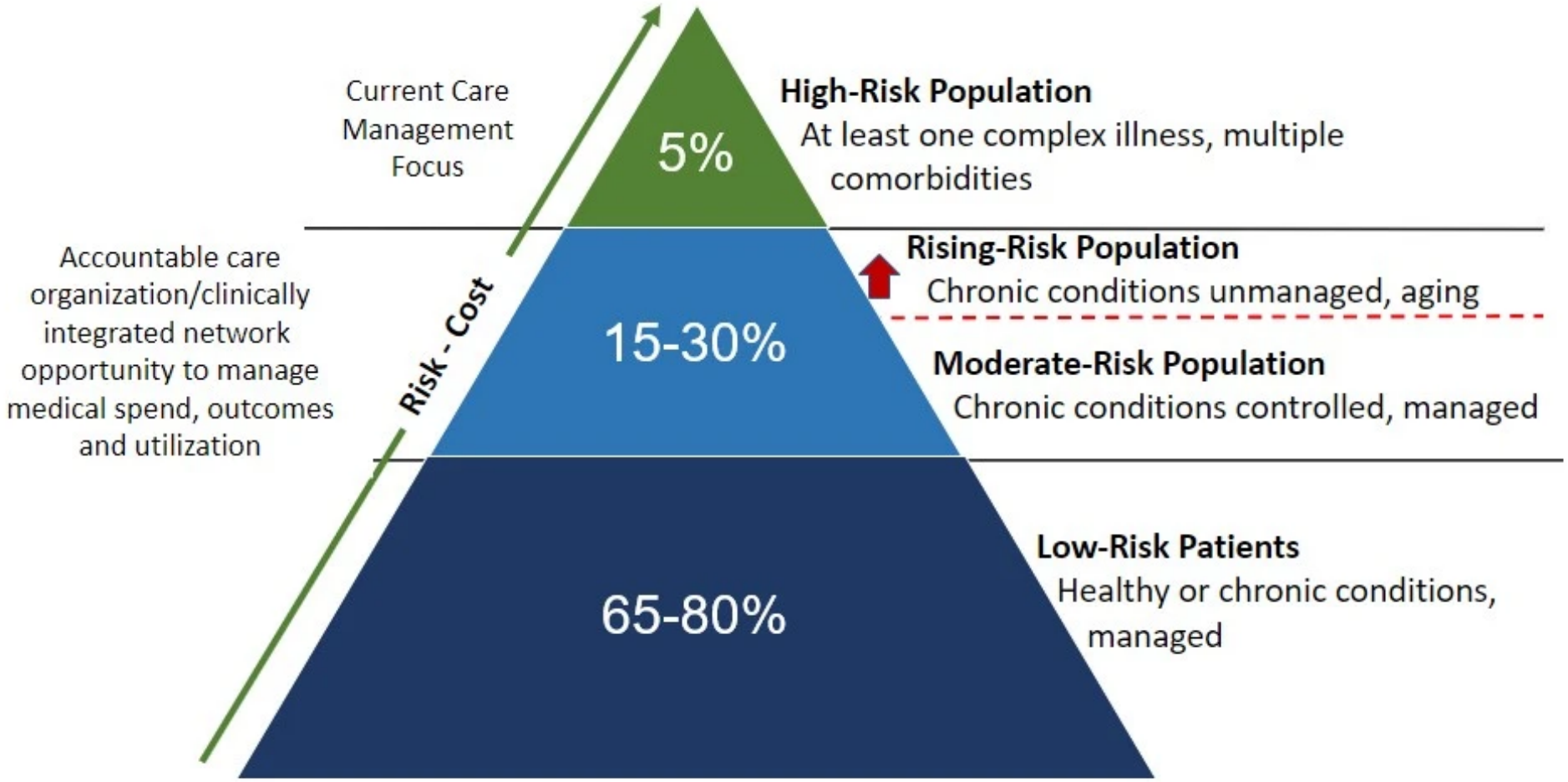
How to address population health



[A Blueprint for Building a 'Risk Ready' Healthcare Organization (hfma.org)]

DISRUPTORS

- 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

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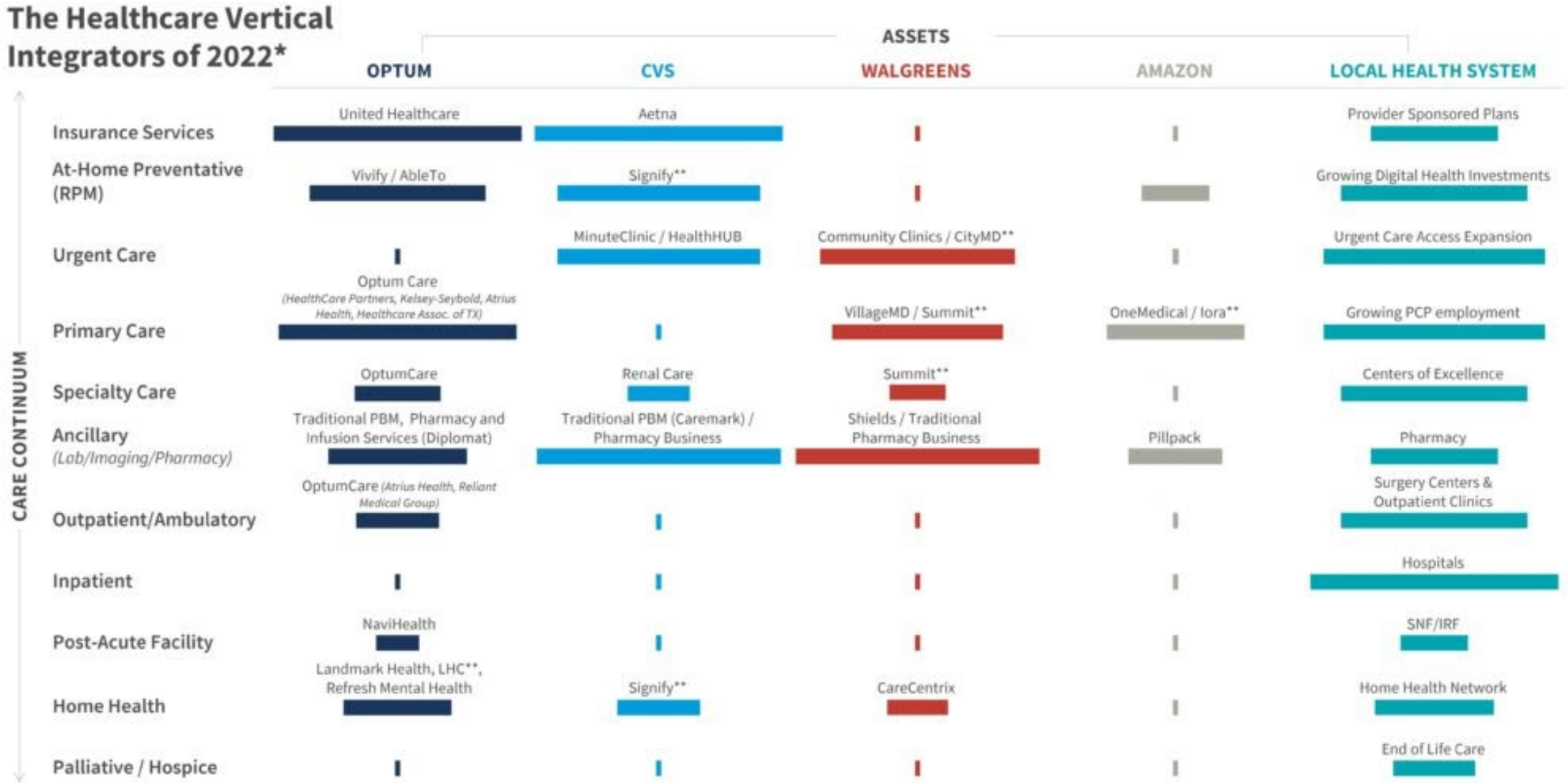
What company employs the largest number of physicians in the US?

ⓘ Start presenting to display the poll results on this slide.

Vertical Integration in the Marketplace



*Scale based on relative market impact as of 11/2022. | **Pending transactions |

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.

PAST

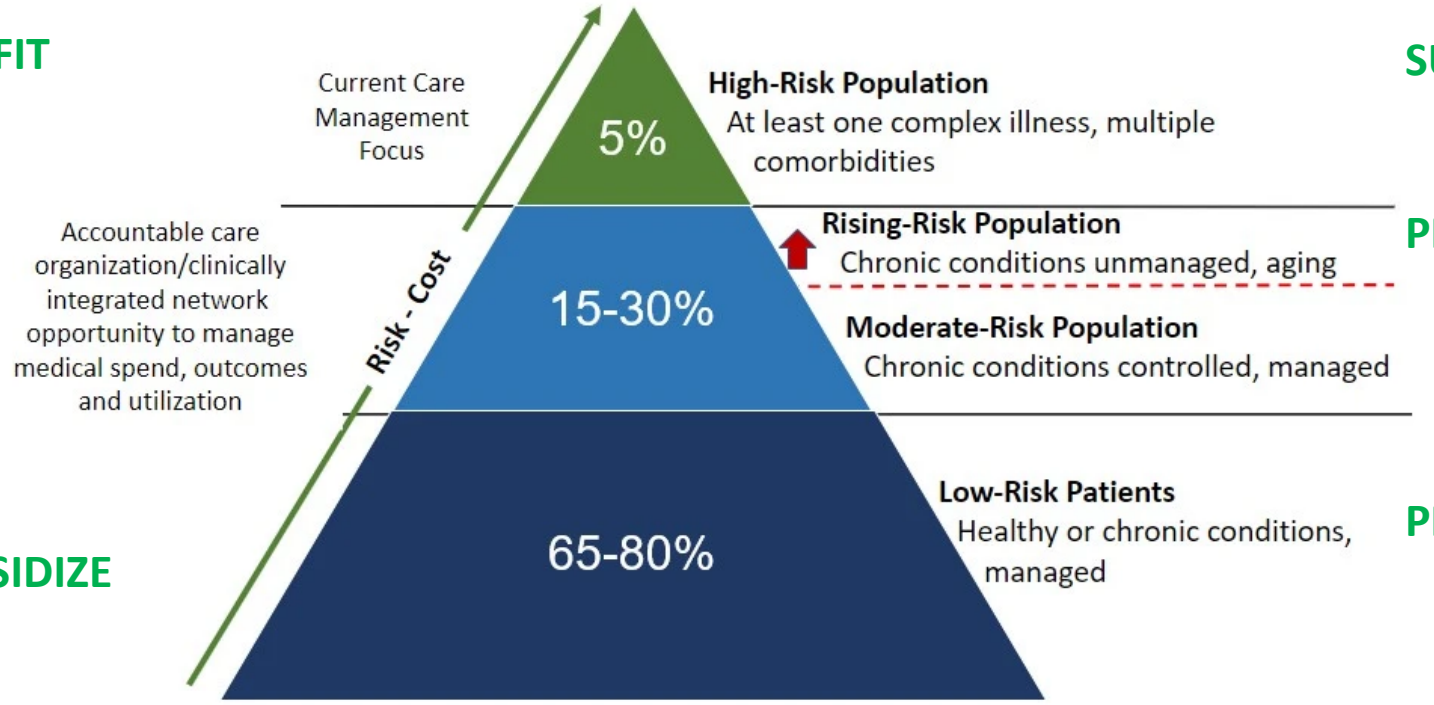
PRESENT

FUTURE

UW Medicine

PROFIT

SUBSIDIZE



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Optum

PROFIT

Oak St. Health

iorahealth

PROFIT

CVS Health

one medical

Carbon Health

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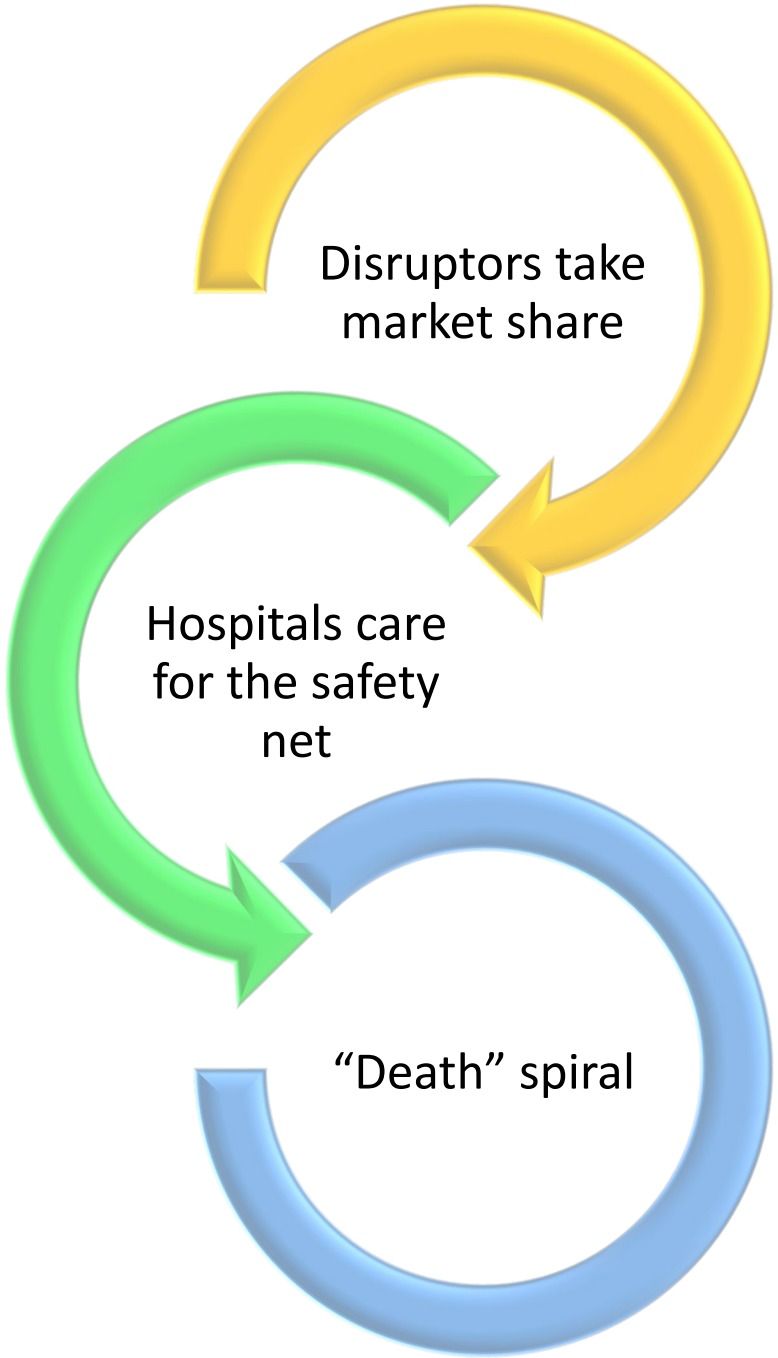


Risky financial foundations

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.

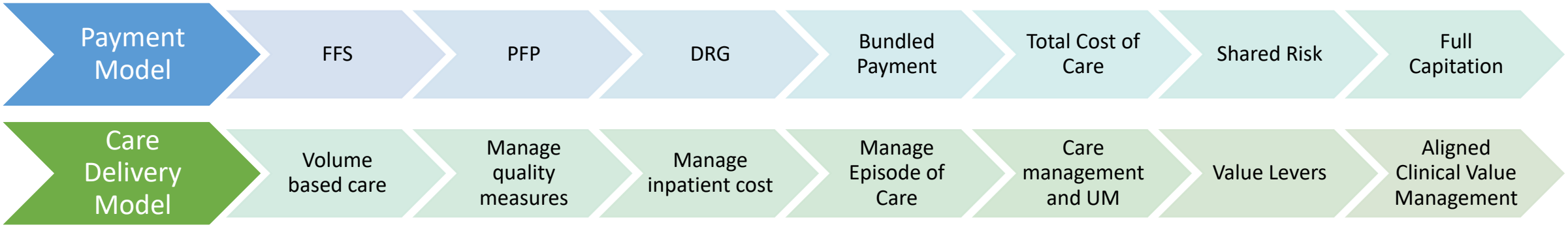
UW Medicine and adverse selection

- 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

Different payment and care delivery models



- 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.

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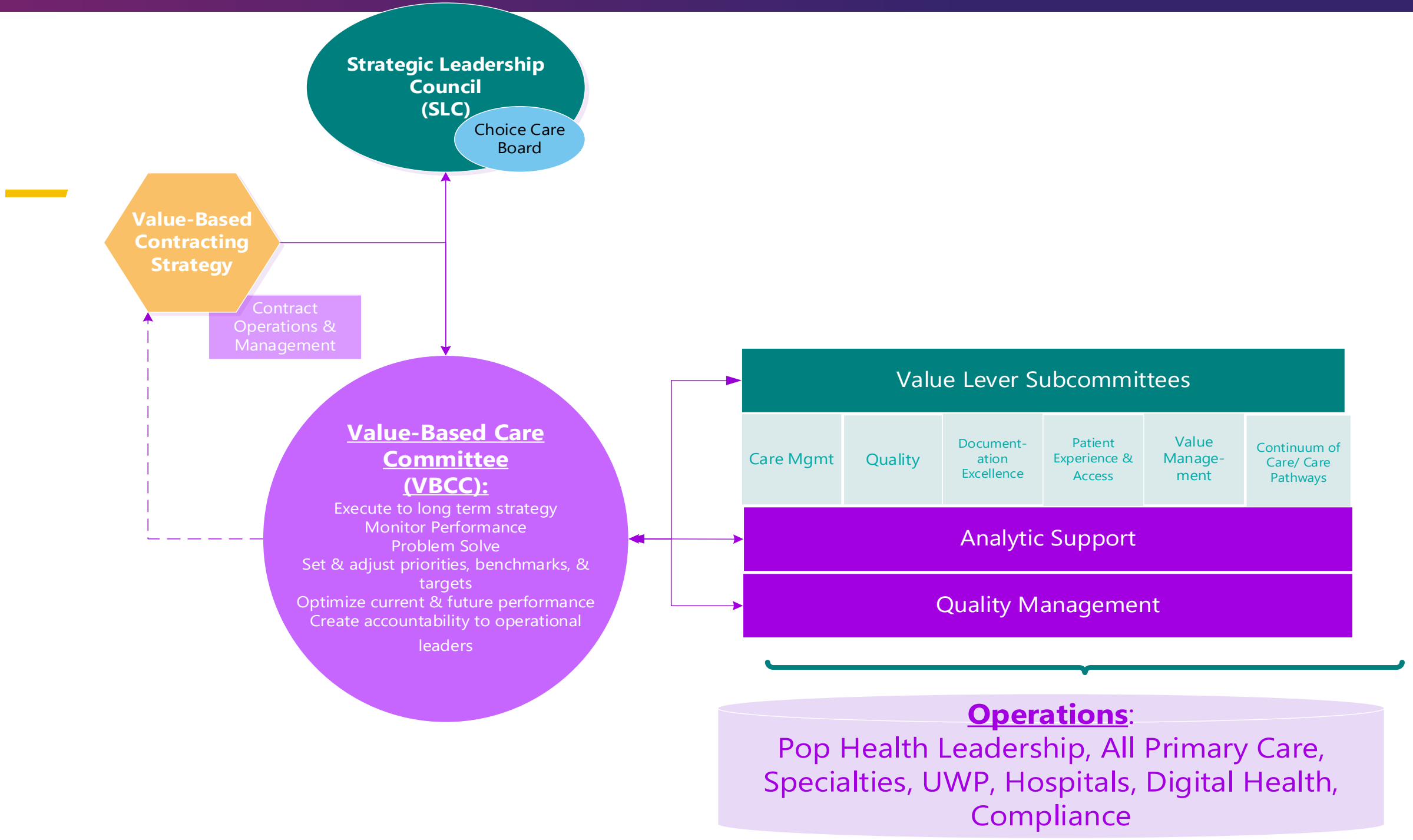
Value Levers Alignment to Maximizing Value

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

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

Highest Quality	Patient Experience	Total Cost of Care
• Patient centered medical home (PCMH) and neighborhood • Management of chronic conditions and diseases	• Access – in person, digital, virtual touch • Network Adequacy • Care Management – timely system care navigation	• Risk adjustment • Site of Care Optimization • Keep-age/ Steerage in network • Utilization Management

Communication and education
Sharing best practices


Strategic Leadership Council (SLC)
Choice Care Board
Value-Based Contracting Strategy
Contract Operations & Management
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
Document-ation Excellence
Patient Experience & Access
Value Manage-ment
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.
- Understand changes in the marketplace and strategies integrated healthcare systems such as UW Medicine have in place to thrive in an uncertain healthcare environment.

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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)

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QUESTIONS?

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