Healthcare Finance 101

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Series of discussions about Healthcare Finance

Healthcare Finance and Medical Economics

101 – The basics of healthcare finance.

201 – Advanced topics in UW Medicine's Portfolio of contracts.

301 – IN PERSON. Case studies for UW Medicine and Healthcare for the next decade.

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Agenda Healthcare 101

- Introduction to contracting and population health

- Why care about healthcare finance?

- How we get paid

  - Understand Medicare
  - Evolution and current reimbursement systems/methodologies
  - Key takeaways from current payment models

- Break

- Value-based payment models

- UW Medicine's Value-based portfolio

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On a scale of 1 to 10, with 1 = completely unaware, and 10 = expert understanding - how well do you think you understand how healthcare services are reimbursed?

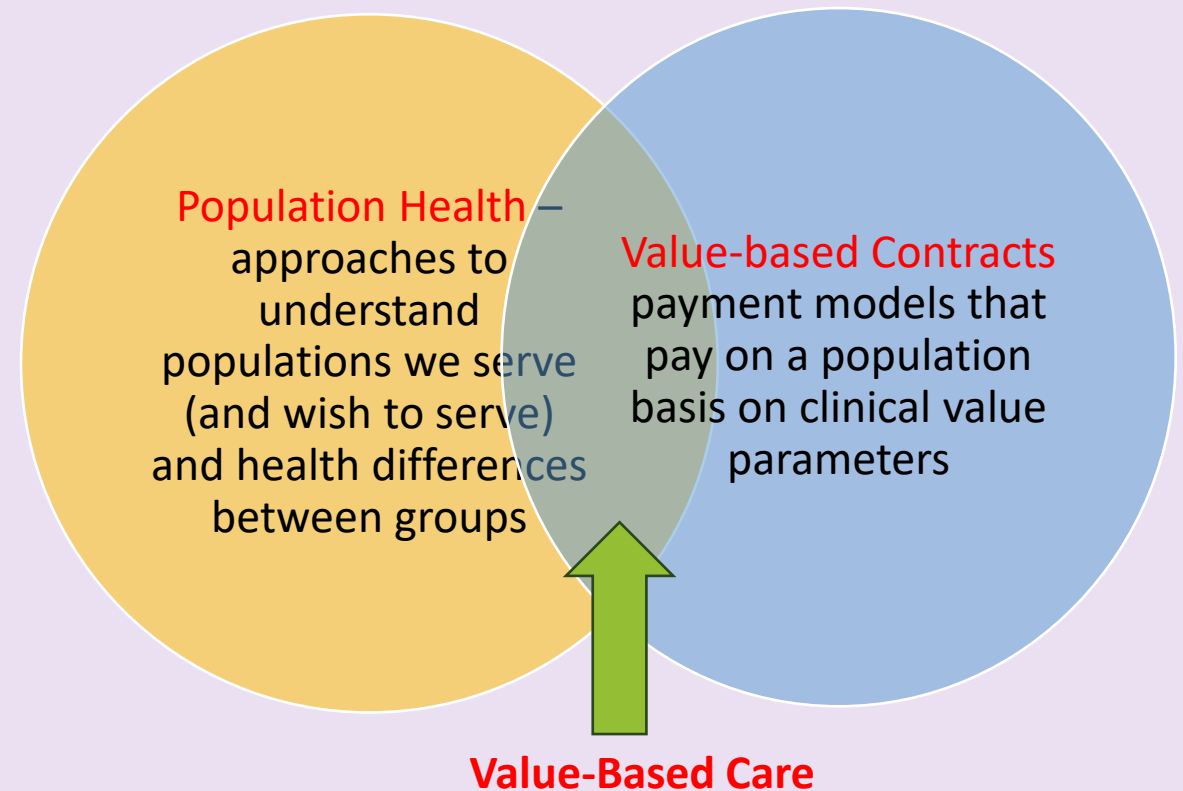ⓘ Start presenting to display the poll results on this slide.

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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Population Health at UW Medicine

- Organized by our CPHO team out of the CMO's office. Working with many stakeholders throughout UW Medicine.

- Works between contracting, strategy, and care delivery, coordinating work in all areas of UW Medicine

- Main committee structures are based on the Value-based Care Committee and Value-lever structures

- Works to optimize UW Medicine's current and long-term success in value-based arrangements.

Population Health – approaches to understand populations we serve (and wish to serve) and health differences between groups

Value-based Contracts payment models that pay on a population basis on clinical value parameters

Value-Based Care

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UW Medicine Mission/Vision

UW Medicine has a single mission:

To improve the health of the public.

Vision: UW Medicine will provide:

A care experience for patients and their families that helps them achieve their personal goals for wellness and disease management; an educational environment for health professionals, students and trainees that prepares them for leadership in their professional careers; and a research enterprise for scientists that enables them to advance medical knowledge and clinical innovations with groundbreaking discoveries.

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Why care about healthcare finance?

- How much should UW Medicine care about the costs of healthcare?
  - Money and Mission
  - Should clinical decisions be affected by revenue and costs?
  - Costs to whom? Government, insurance, employers, communities, or patients?
  - UW Medicine's role in understanding clinical value

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If US Healthcare was a country…

Rank	Country/Region	GDP in billion $	GDP in $ per capita
1	United States	27,360.9	81,695
2	China	17,794.8	12,614
	US Healthcare Expenditure in 2023	4,800	Health 14,500
3	Germany	4,456.1	52,746
4	Japan	4,212.9	33,834
5	India	3,549.9	2,485
6	United Kingdom	3,340.0	48,867
7	France	3,030.9	44,461
8	Italy	2,254.9	38,373
9	Brazil	2,173.7	10,044
10	Canada	2,140.1	53,372

The 50 largest economies in the world (worlddata.info)

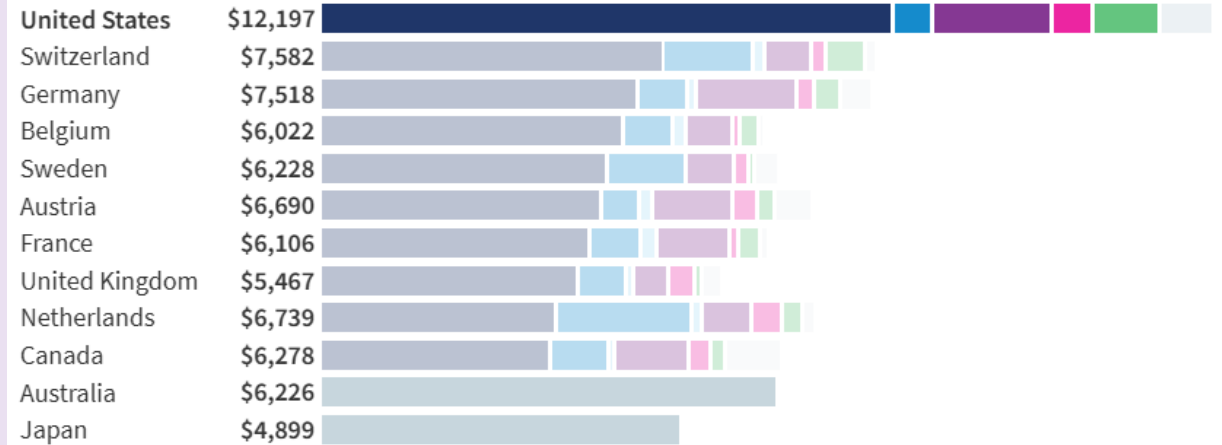UW Medicine

General Statements on US Healthcare

- Complex

- Costs are not transparent

- Employer-driven healthcare insurance creates inequities

- All healthcare payment models have pro/con

- Despite high per-capita healthcare expenditures, US health outcomes lag behind most economically comparable countries.

- Outcomes are inequitable across many cross populations.

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Healthcare in the US

GDP Per Capita and Health Consumption Spending Per Capita, 2021 (U.S. Dollars, PPP Adjusted)
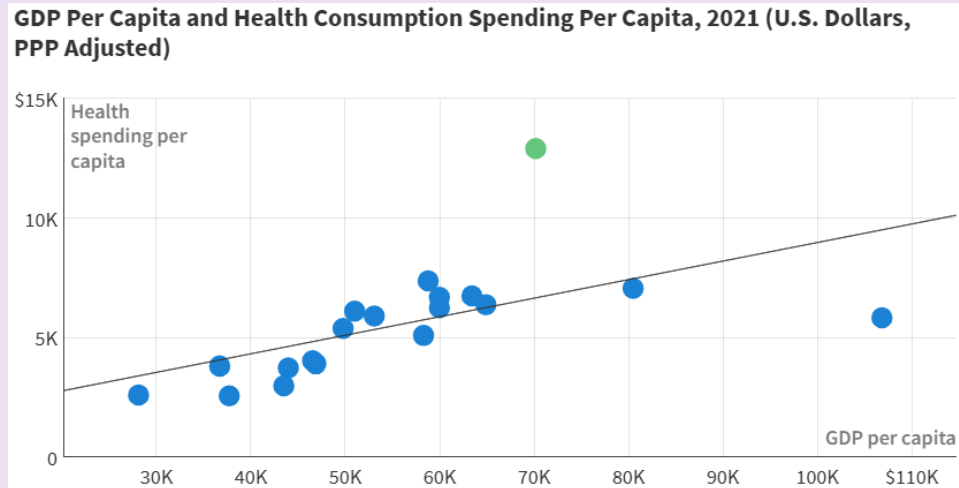
Health Spending Per Capita, U.S. Dollars, 2021

- Very complex payment models lead to high administrative burden
  - Admin costs in the US $1,055 per capita (Germany #2 at $306)
  - US physicians devote 13% of working hours vs 8% in Canada
  - At least half of Administrative expenditures are considered wasteful.

The Role Of Administrative Waste In Excess US Health Spending | Health Affairs
How Does Quality of Care in the U.S. Compare to Other Countries? - International Comparison of Health Systems | KFF

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US life expectancy changes over time

Life expectancy at birth, in years, 1980-2022

Comparable Country Average

United States

The U.S. has lost nearly **two decades** of progress in life expectancy
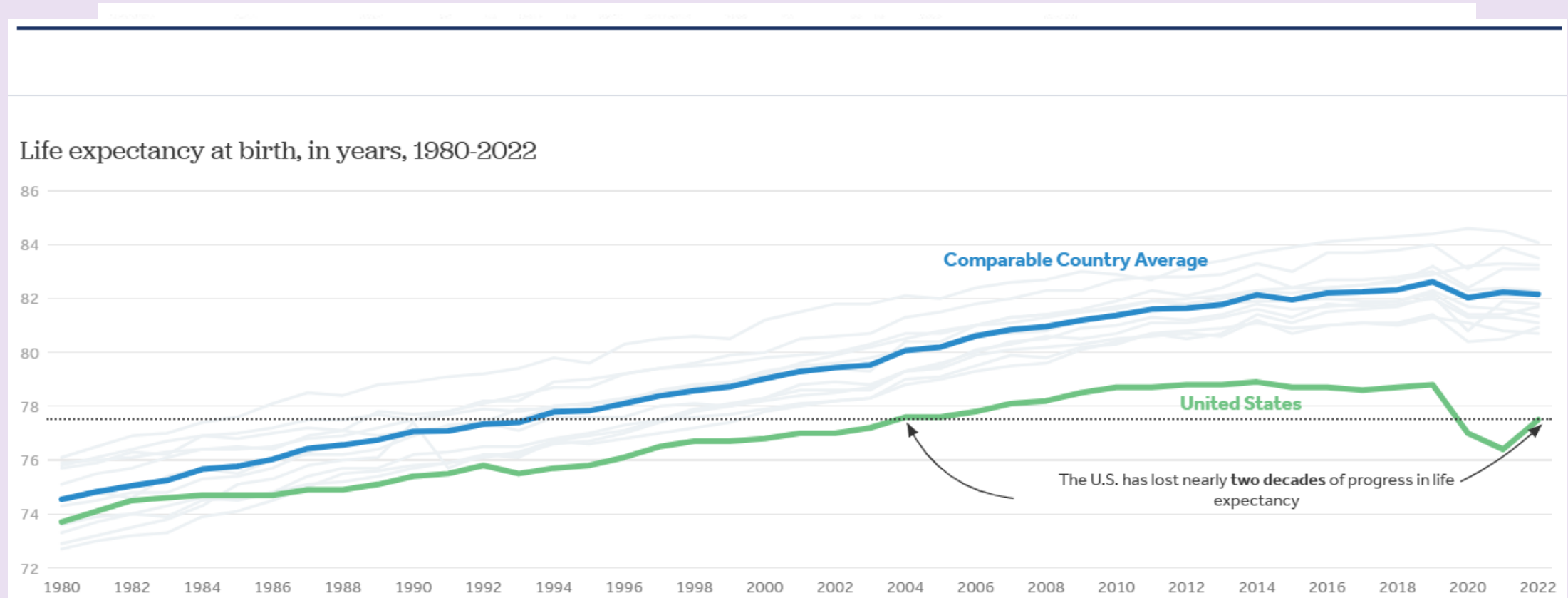
Notes: Comparable countries include Australia, Austria, Belgium, Canada, France, Germany, Japan, the Netherlands, Sweden, Switzerland, and the U.K. See Methods section of "How does U.S. life expectancy compare to other countries?"

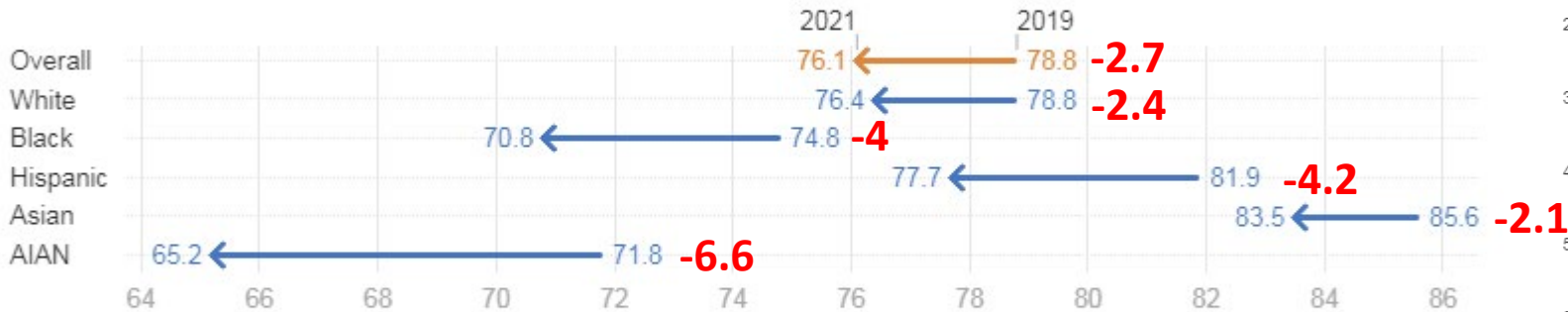Source: KFF analysis of CDC, OECD, Australian Bureau of Statistics, Japanese Ministry of Health, Labour, and Welfare, Statistics Canada, and U.K. Office for National Statistics data • Get the data • PNG

Peterson-KFF
Health System Tracker

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Large decreases in life expectancy were not equal amongst Race/Ethnic groups

Figure 2

Life Expectancy in Years by Race/Ethnicity, 2019-2021

	2021	2019	
Overall	76.1	78.8	**-2.7**
White	76.4	78.8	**-2.4**
Black	70.8	74.8	**-4**
Hispanic	77.7	81.9	**-4.2**
Asian	83.5	85.6	**-2.1**
AIAN	65.2	71.8	**-6.6**

NOTE: Estimates based on provisional data for 2021 and final data for 2019 life expectancy at birth. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic.
SOURCE: Arias E, Tejada-Vera B, Kochanek KD, Ahmad FB. Provisional life expectancy estimates for 2021. Vital Statistics Rapid Release; no 23. Hyattsville, MD: National Center for Health Statistics. August 2022. DOI: https://dx.doi.org/ 10.15620/cdc:118999. • PNG
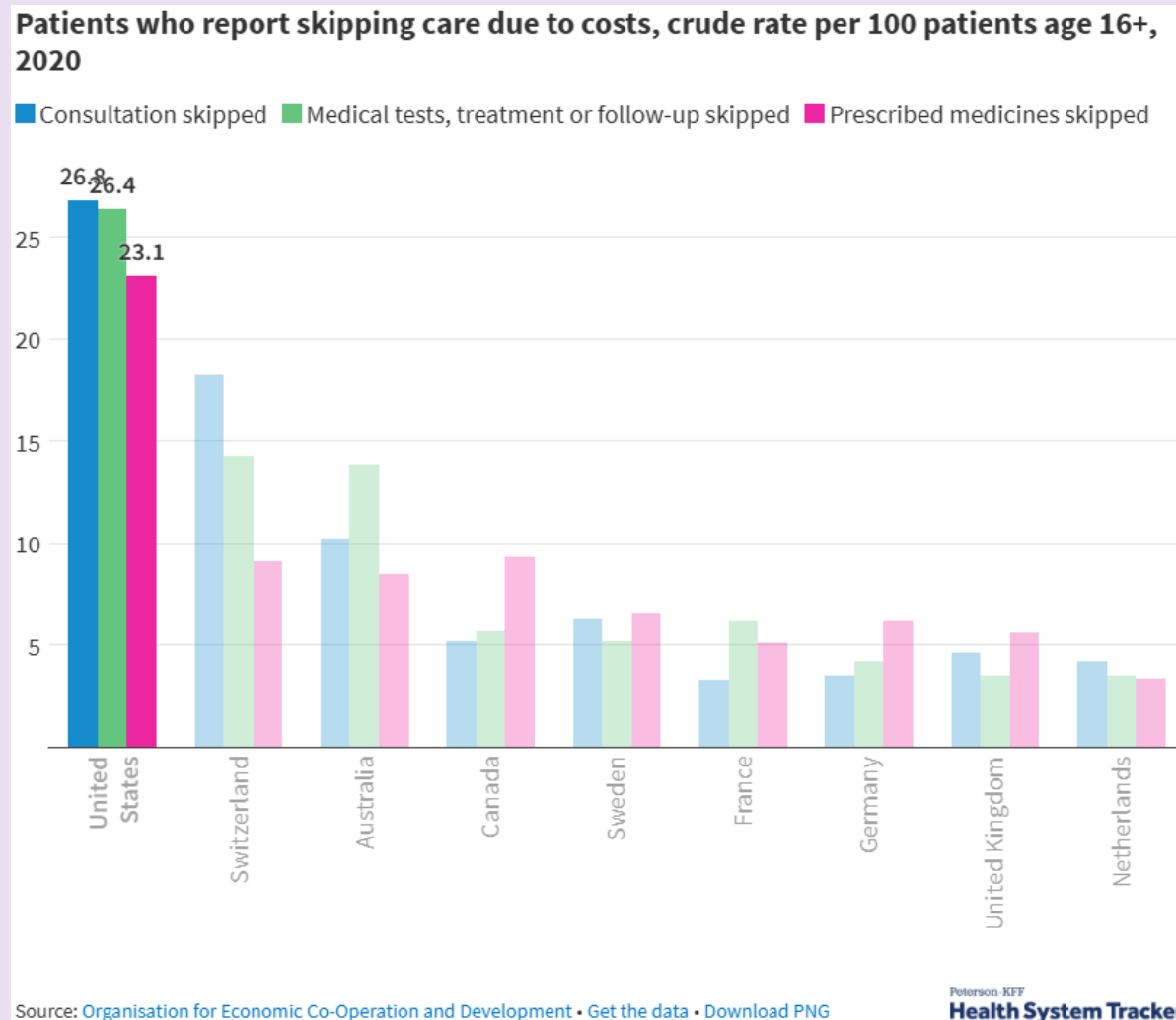
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Figure 3

Top 10 Leading Causes of Death in the U.S. (Age-Adjusted Death Rates), by Race/Ethnicity, 2019 and 2021

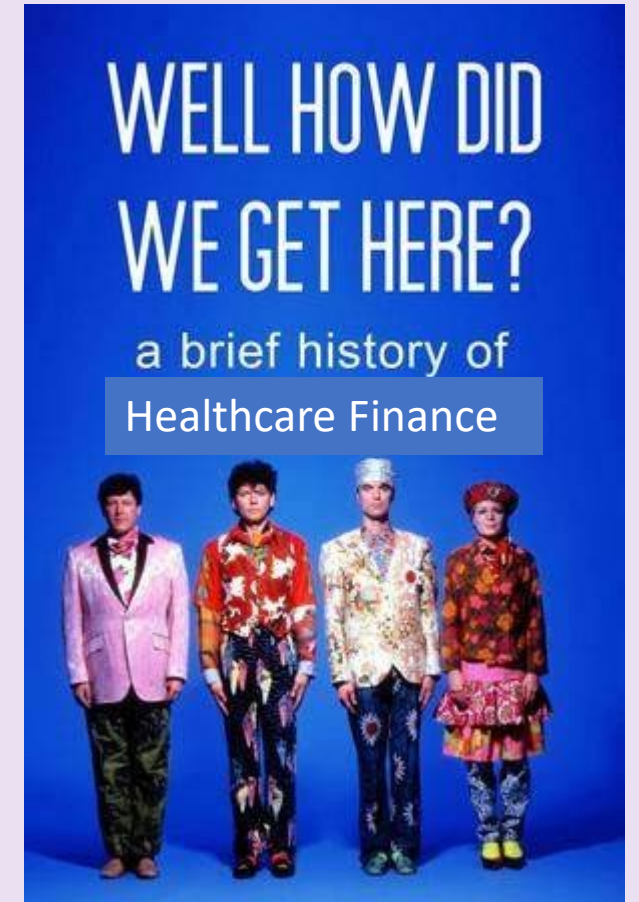| Rank	White		Black		Hispanic		
	2019	2021	2019	2021	2019	2021	
1	Heart disease (166.4)	Heart disease (179.8)	Heart disease (208.6)	Heart disease (226.2)	Cancer (105.6)	COVID-19 (151.8)	
2	Cancer (152.0)	Cancer (153.7)	Cancer (173.1)	Cancer (167.4)	Heart disease (111.3)	Heart disease (119.0)	
3	Chronic respiratory (43.7)	COVID-19 (93.5)	Accidents (52.2)	COVID-19 (136.4)	Accidents (35.1)	Cancer (105.1)	Stro
4	Accidents (55.0)	Accidents (70.0)	Stroke (53.1)	Accidents (79.6)	Stroke (32.8)	Accidents (47.3)	A
5	Stroke (35.7)	Chronic respiratory (39.9)	Diabetes (38.8)	Stroke (59.6)	Diabetes (25.6)	Stroke (36.1)	D
6	Alzheimer's disease (31.5)	Stroke (39.8)	Chronic respiratory (29.2)	Diabetes (46.3)	Alzheimer's disease (25.3)	Diabetes (29.4)	Alz
7	Diabetes (19.1)	Alzheimer's disease (32.6)	Homicide (23.7)	Homicide (33.7)	Liver disease (14.6)	Alzheimer's disease (27.7)	re
8	Flu and Pneumonia (12.5)	Diabetes (22.4)	Nephritis (25.4)	Chronic respiratory (27.9)	Chronic respiratory (16.1)	Liver disease (17.3)	P
9	Suicide (17.7)	Liver disease (15.2)	Alzheimer's disease (27.7)	Nephritis (26.5)	Nephritis (11.8)	Chronic respiratory (14.7)	
10	Nephritis (11.4)	Suicide (17.4)	Hypertension and related (17.3)	Alzheimer's disease (29.4)	Suicide (7.3)	Nephritis (12.3)	Hyp an

NOTE: Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. AIAN refers to American Indian or Alaska Native.
SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2021 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 2018-2021, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. • Download PDF

KF

More than 1 in 4 Americans skip healthcare due to costs

Patients who report skipping care due to costs, crude rate per 100 patients age 16+, 2020

■ Consultation skipped ■ Medical tests, treatment or follow-up skipped ■ Prescribed medicines skipped

26.8 26.4

23.1

Source: Organisation for Economic Co-Operation and Development • Get the data • Download PNG

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History is prolog
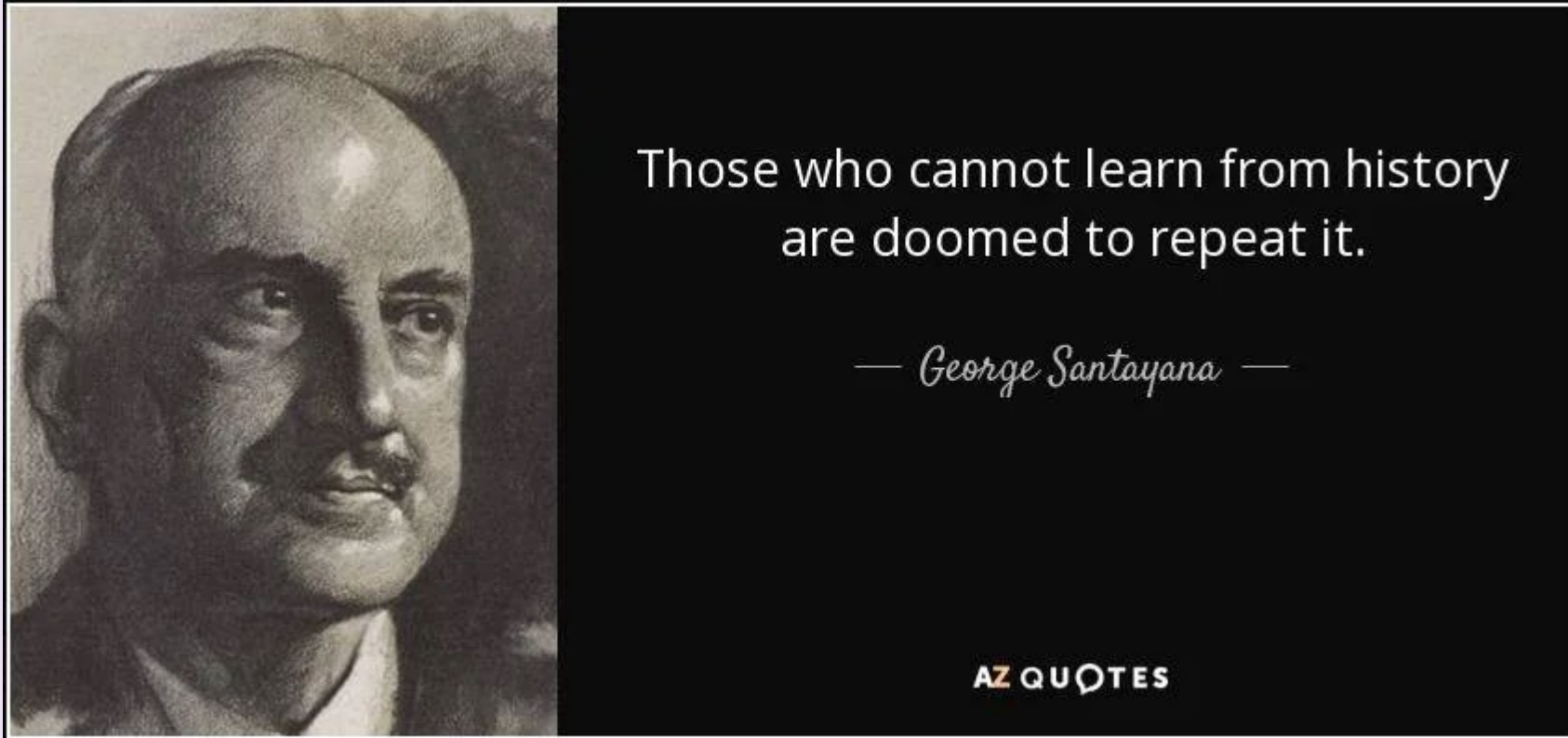
Those who cannot learn from history are doomed to repeat it.

— George Santayana —

AZ QUOTES

WELL HOW DID WE GET HERE?
a brief history of
Healthcare Finance

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Medicare History

Table 1. Legislative Milestones in the Evolution of Medicare Coverage, Payment, and Quality Improvement.

Year	Milestone
1965	The Social Security Amendments of 1965 (Public Law 89-97) created Medicare and Medicaid. Medicare coverage for hospital (Part A) and physician (Part B) services began on July 1, 1966.
1972	The Social Security Amendments of 1972 (Public Law 92-603) extended Medicare eligibility to persons under the age of 65 years with long-term disabilities and those with end-stage renal disease (beginning in 1973) and established the Professional Standards Review Organizations (PSROs) to review appropriateness of care.
1982	The Tax Equity and Fiscal Responsibility Act (Public Law 97-248) added a Medicare hospice benefit for terminally ill beneficiaries, established a risk-contracting program for private plans (beginning in 1985), set limits on Medicare hospital payments per case and required the development of a prospective payment system for inpatient hospital services, and replaced the PSROs with Peer Review Organizations.
1983	The Social Security Amendments of 1983 established a Medicare prospective payment system for inpatient hospital services.
1987	The Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) established quality standards for Medicare- and Medicaid-certified nursing homes.
1988	The Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) established an outpatient prescription-drug benefit and a cap on beneficiaries' out-of-pocket costs. The major provisions of the law were repealed in 1989.
1989	The Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239) established the Resource-Based Relative Value Scale (RBRVS) for physician services, which was used to set Medicare physician fees beginning in 1992.
1997	The Balanced Budget Act of 1997 (Public Law 105-33) implemented prospective payment systems for hospital outpatient services and post–acute care and established the Medicare+Choice program (Part C), which expanded the types of private plans available to Medicare beneficiaries.
2003	The Medicare Modernization Act (Public Law 108-173) established a prescription-drug benefit (Part D), which was available to all Medicare beneficiaries beginning in 2006, and replaced the Medicare+Choice program with the Medicare Advantage program, making additional types of private plans available to beneficiaries and substantially increasing payments.
2010	The Affordable Care Act (Public Law 111-148) strengthened Medicare coverage of preventive care, reduced beneficiary liability for prescription-drug costs, instituted reforms of many payment and delivery systems, and created the Center for Medicare and Medicaid Innovation.

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How Do We Get Paid?
A Brief Discussion of Healthcare Reimbursement (and Other Things)

Matt Lund

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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 Hospital Reimbursement
  - DRG/IPPS

- Outpatient Hospital Reimbursement
  - APC/OPPS

- Professional Fee Reimbursement
  - RVU/RBRVS

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INPATIENT REIMBURSEMENT

- Brief history

- DRG

- IPPS

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1983 Medicare Prospective Payment System

- In 1962 48% of seniors lacked health insurance compared with 2% today.

- Medicare has grown from 0.7% of the GDP to 3.6% today.

- In the 1960's Medicare mimicked local "usual and customary charges" and reimbursing hospitals for "reasonable costs."

- Since 1967 Congress authorized demonstration projects as alternatives retrospective cost reimbursement

- 1963 Medicare Prospective Payment System paying by Diagnosis-related groupers (DRGs)

- Medicare's most successful cost-saving measure to date.

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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

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IPPS – Inpatient Prospective Payment System

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

- Base x Weight
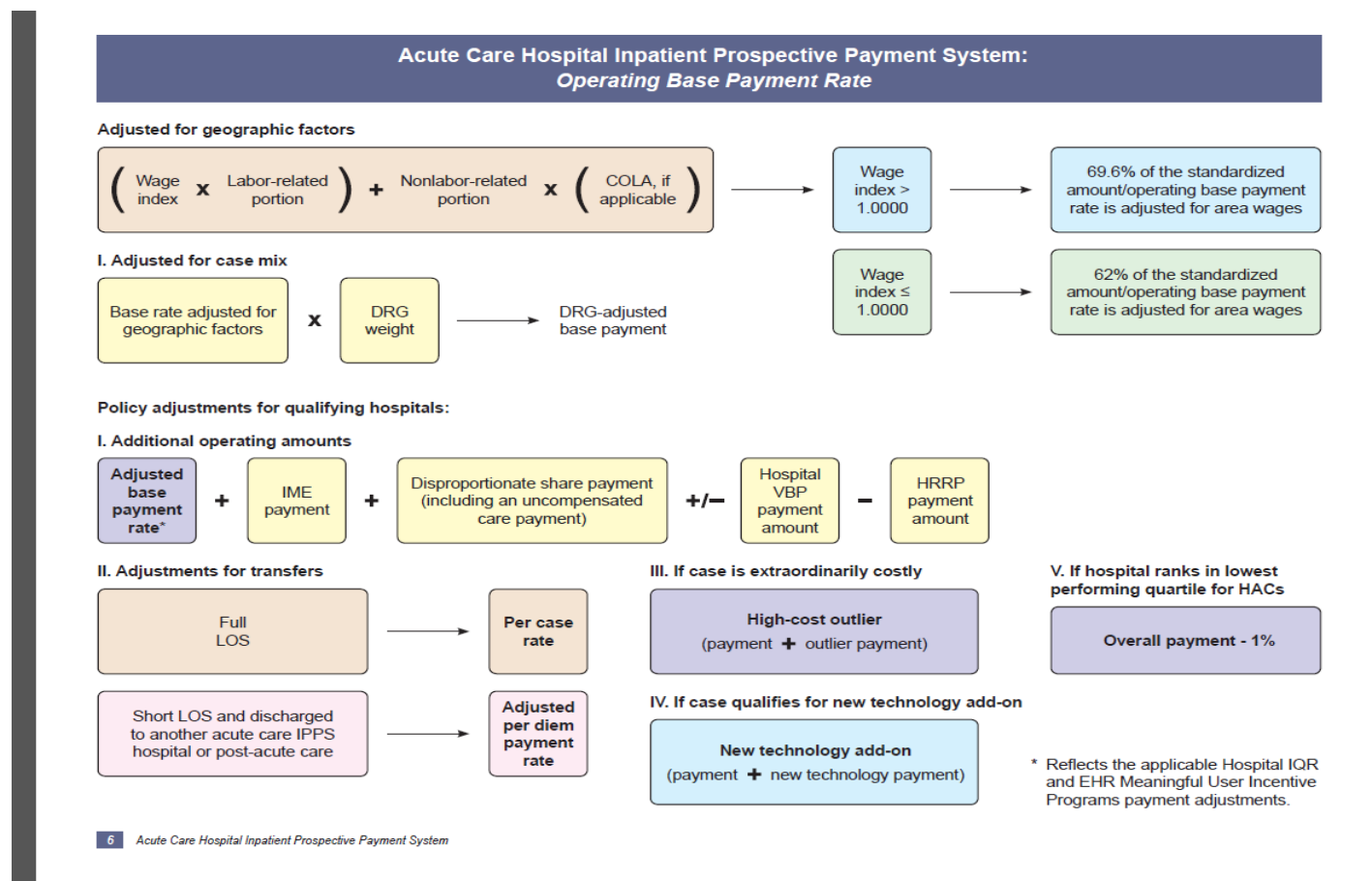
APC - "Ambulatory Payment Classification"

- 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

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OPPS – Outpatient Prospective Payment System
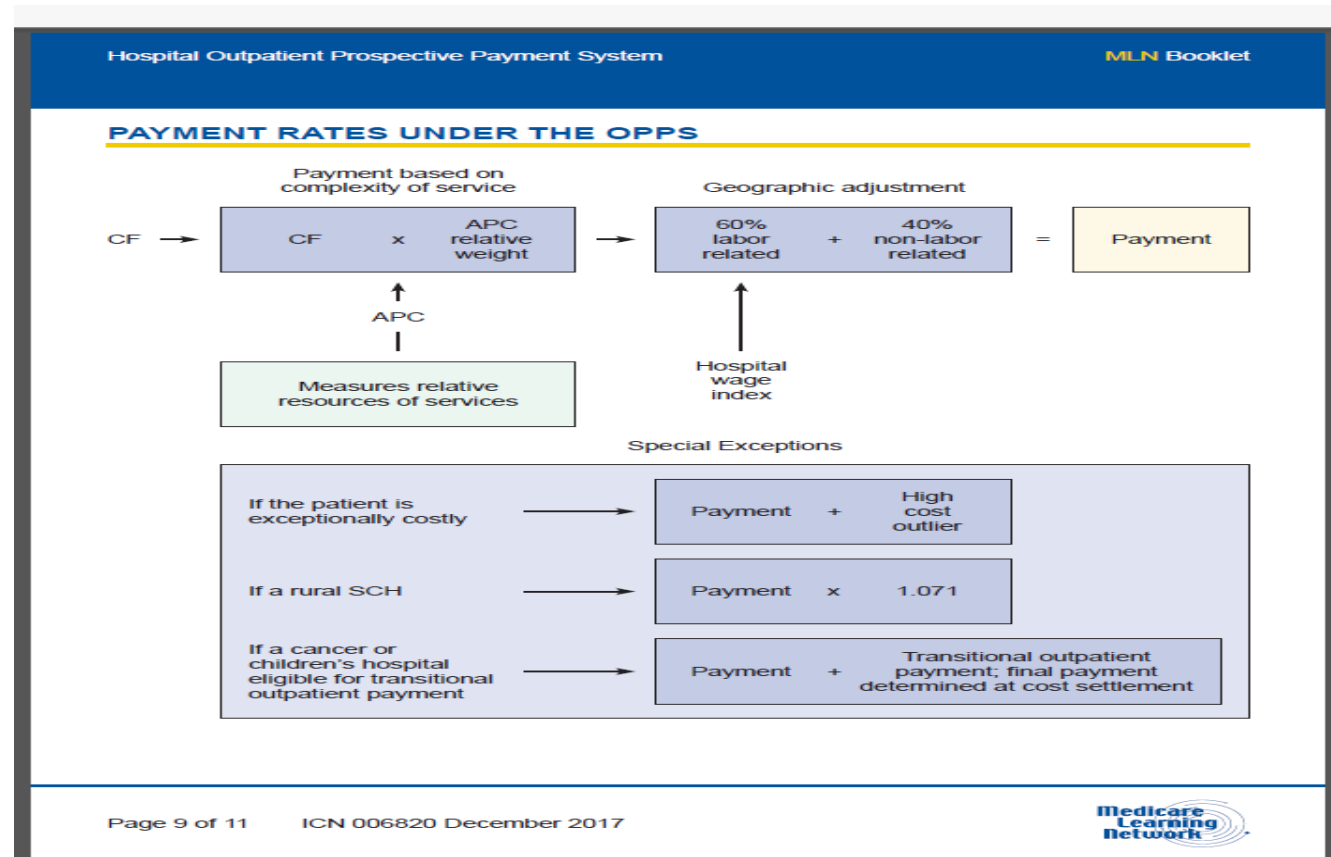
- Conversion Factor x Weight

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

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RBRVS

- Conversion Factor x RVU Value

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Commercial Reimbursement

- Generally, mirrors Medicare in methodologies:

- "Know Medicare, Know All"

- Base/CF x Weight

- <u>Base/CF is negotiable</u>; <u>Weight is typically not</u>

- *Some* percent of charge contracts at UW Medicine

- (Commercial contracts almost always have a P4P/value-based component)

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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); upcoming RFP will change lineup of MCOs soon

- Managed Medicaid is more restrictive then FFS Medicaid, as patients are managed by plans at full risk for spend

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How are the vast majority of healthcare services in the US reimbursed?

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Key Takeaways

- Know Medicare, know all:

  - Majority of reimbursements made pursuant to a Medicare-like (lump sum) method for all lines of business

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

  - Bases/CFs vary by **facility** (<u>not</u> 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"

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Break

Incorporating Value Measures to payment

Sept 2024

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Different perspectives on healthcare cost

1. Cost to produce – regardless of model of payment FFS or FFV, reducing costs to produce a "unit" of healthcare is beneficial to health systems.

2. Cost of care to payor –

    1. Financial risk-taking entity is paid a per-member per-month (PMPM) and then is accountable for the ultimate health care payments
    2. Often called total cost of care this lens is important for the risk-taking entity.

Potential misalignment of these costs/profits. Example.

- A highly efficient Emergency Room visit might be profitable for a healthcare system, but if that visit was avoidable with better primary care, it may drive costs up despite being profitable for the healthcare system.

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Market relevancy

- What do the entities that pay for health care require, want, and need?

- Important to think of who pays for healthcare

  - Patients – premiums, co-pays, balance billing, self-pay, etc
  - Employers – direct ACO contracting Boeing, PEBB and SEBB act as payors.
  - Insurers – note their customers are employers or Governmental programs such as Medicare Advantage or Medicaid.

Healthcare Consumed 17.5% of GDP in 2023

$4.8 billion dollars spend on direct health expenditures 2023

$27.36 actual 2023 GDP of the US in 2023

Estimated $7.7 Trillion dollars in healthcare expenditures by 2032

Down from over 19% during the Covid-19 pandemic

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Fee-for-service payment models incentivizes and disincentivizes critical components of healthcare

Incentivize

- Increase utilization

- Increase billable Encounters

- Intensity of care (billing levels)

- Raise prices/Cut Costs

- Commercial payor mix

Dis-incentivizes

- Wellness

- Most cost-effective modalities of care

- Cost-effective sites and workflows of care

- Improved Patient experience

- Innovation for access

- Equity

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High-risk sub-populations drive much of US Healthcare expenditures

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

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

Share of health expenditures

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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"Where Medicare goes, so goes the market" – Matt Lund (Chief Contracting Officer UW Medicine)

Medicare is leading the movement to Value Based Payment models

Bipartisan support continues to exist for Medicare to offload management of clinical value to other entities which could include insurers, venture-capital backed integrated systems, or traditional healthcare systems.

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%
2030	50%	50%	100%	100%

Different payment and care delivery models

Payment Model	FFS	PFP	DRG	Bundled Payment	Total Cost of Care	Shared Risk	Full Capitation
Care Delivery Model	Volume based care	Manage quality measures	Manage inpatient cost	Manage Episode of Care	Care management and UM	Value Levers	Aligned Clinical Value Management
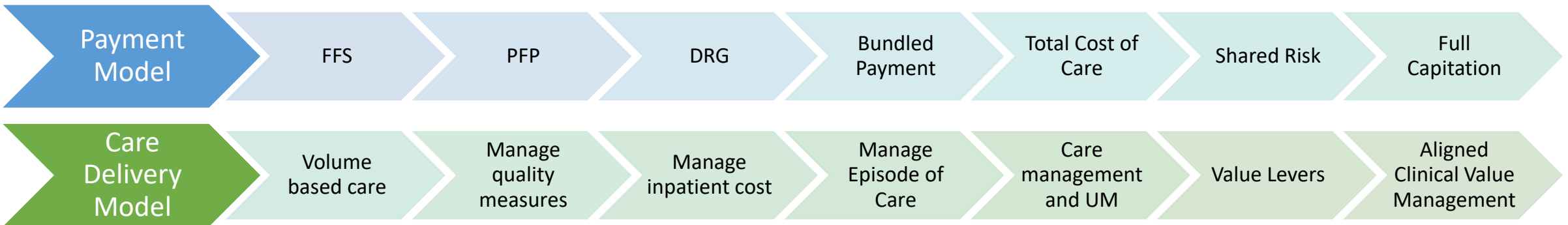
- Currently we have contracts in nearly all of these categories, but UW is biased toward the FFS compared with other systems and disruptors in our market.
- In a blended FFS and FFV model, healthcare systems are challenged to evolve two systems of payment
  - But there are areas that "win" in both FFS 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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2024 UW Medicine Lives in Value Based Arrangements (updated March 2024)

UW Medicine System has ~215,814 VB lives

UWP ~ 130,757 lives					Valley ~ 85,057 lives			
Medicaid* 35,975	Medicare Advantage* 17,093	MSSP* 19552	Commercial Payer* 23,097	Commercial Direct to Employer** 14,563 designated 16,509 attributed	Medicaid* 31,830	Medicare Advantage 9,098 MSSP 8,700	Commercial Payer* 15,216	Commercial Employer** 6,087 designated 9,512 attributed

*Payers are United, Aetna, Premera, Regence, Cigna, Molina, Coordinated Care of WA, Amerigroup
** Employers are Boeing, PEBB and SEBB
Numbers will vary slightly month to month
Note – 88% of these lives are in a combined VBA with Valley and UWP. Only MSSP and Premera MA are contracted separately.

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Types of value-based payment models

- Pay for performance
  - Usually specific payments for quality, utilization, or experience goals

- Episode of care
  - DRG
  - Bundled Payment methodologies

- Shared Savings Models
  - Examples – MSSP, Boeing, PEBB and SEBB ACO Models
  - Cost is often a gateway to savings

- Capitation
  - Primary Care – e.g. Making Care Primary
  - Total Capitation – insurance companies are typically the "risk entity" in commercial insurance.

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Value-based payment model Challenges

- Reconciliation and Payment Latency
  - Hard to predict performance
  - Hard to invest
- Reductionist measures on Quality
  - Over 70 quality measures across our Value-based contracts
- Multiple models create operational complexity

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Latent reconciliation and payments make investments in value-based care challenging example of PY2022

Claims need to be all received and calculations evaluated and negotiated
UW Medicine's fiscal year budget is particularly challenging for performance

BY 2021   PY2022 #1   PY2023 #2   PY2024 #3   Perform Year

FY2022   FY2023   FY2024   FY2025   Fiscal Year

6/24 First Budget after first year reconcilation

9/23 Reconciliation for the first performance year finalized

7/23 Budgeting for PY3

7/22Budgeting for PY2

1/22 Start of the first performance year

7/21 Budget planning for the start of the program

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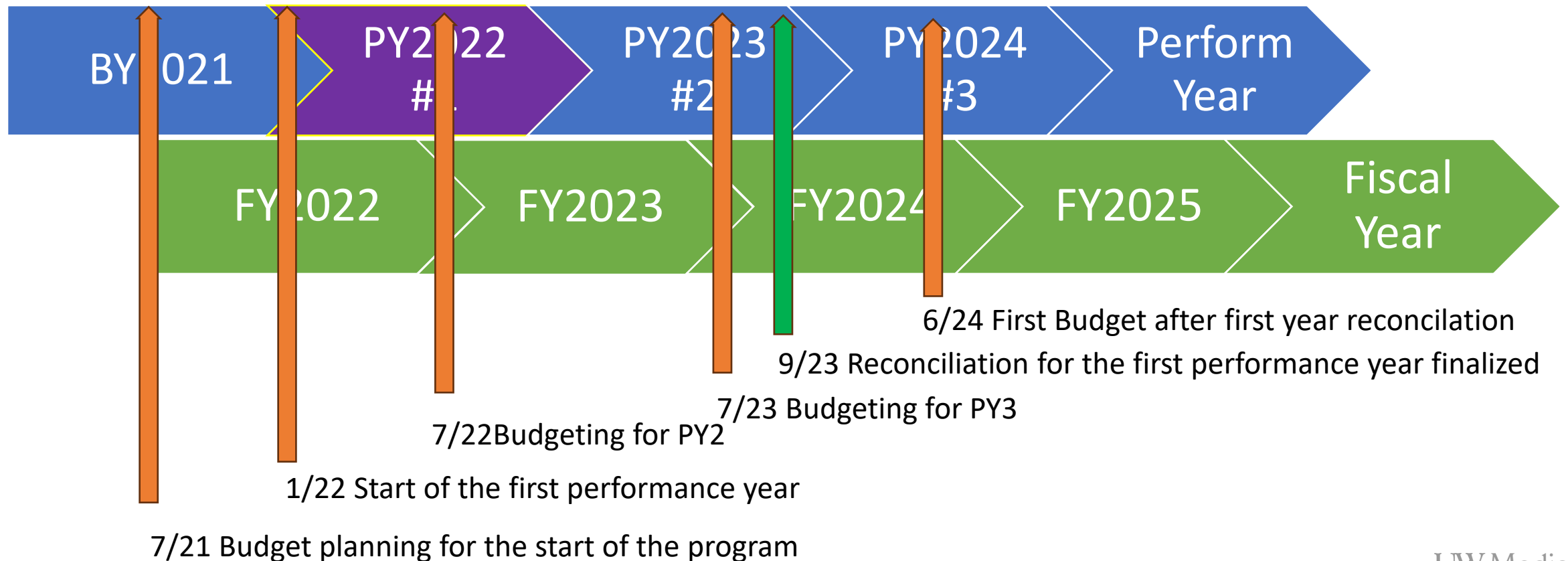
Reductionist measures

- For inpatient value-based payment models

  - Catheter Associated Bloodstream infections and other (now) rare measures – how does this reflect overall quality of care?

- For ambulatory value-based payment models

  - Diabetes A1C control
  - Retinal Eye exams
  - Breast Cancer Screening

- For cost measures

  - "Avoidable" ED utilization

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2023 Medicare ACO (MA-APCPi) | Final Estimated Earnings

Source: April 2024 (Final 2023 Runout) | Data represents claims processed as of Mar. 31, 2024.

2023 Financial Incentive Opportunity	Potential Earnings	Estimated Earnings YTD
① ACO MA-APCPi Average Star Rating Bonus (Table A)	**$1,287,150** (assumes 4.75 * Mbrs)	$0 (Final 3.96)
② ACO ACV HP Bonus (Table B)	**$560,875** (assumes all 4,487 HP Mbrs with ACV)	$349,000 (2,792 completed – 62%)
③ ACO ACV Superior Bonus (Table C)	**$1,072,625** (assumes average 4 ASR on PX, 90% ACV)	$0 (Final ACV = 69% PX 3.60)
Total	**$2,920,650**	**$349,000**

A.) MA-AdvancedPCPi Average Star Rating Bonus: Your practice can earn our Average Star Rating Bonus when you achieve an average Star Rating of 4.00 or higher.

ACO Average Star Rating	Average Star Rating Bonus (PMPY: Per member per year)	Estimated Current Membership 8,581
4.75 and above	$150 PMPY	$1,287,150
4.74-4.50	$125 PMPY	$1,072,625
4.49-4.25	$50 PMPY	$429,050
4.24-4.00	$25 PMPY	$214,525
3.99 and below	$0	$0

B.) ACV Bonus: You're eligible to receive **$125** for each qualifying ACV you conduct with a high priority MA-APCPi member. Paid Quarterly.

ACV Bonus Opportunity	Incentive Amount	Total Opportunities	Estimated Bonus
High Priority Mbrs	$125	4,487	$349,000 = 62% seen

C.) ACV Superior Bonus: You can earn an additional bonus if you achieve a Star Rating average of 4 or higher on the Patient Experience Measures AND achieve an ACV completion rate of 70 percent or greater. Paid at the end of the program year.

ACO ACV Completion Rate	ACV Superior Bonus (PMPY: Per member per year)	Estimated Current Membership 8,581
90-100%	$125 PMPY	$1,072,625
80-89%	$100 PMPY	$858,100
70-79%	$75 PMPY	$643,575
Less than 70%	$0	$0

2023 Medicare MA-PCPi Incentive Opportunity

Source: April 2024 (Final 2023 Runout) | Data represents claims processed as of Mar. 31, 2024.

Non-ACO

2023 Financial Incentive Opportunity	Potential Earnings	Estimated Earnings YTD
1 MA-PCPi Average Star Rating Bonus (Table A)	**$773,500** (assumes 4.75 * Mbrs)	*$123,760* (Current 3.93 ASR)
2 MA-PCPi ACV & High Priority ACV (Table B)	**$663,600** (assumes all 4,424 HP mbrs complete in Q1/Q2)	$273,450+ (1,823 completed – 41%)
3 ACV Quality Bonus (Table C)	**$154,700** ($25) **$464,100** ($75) (assumes ASR 4.00+ & all members seen)	$76,625 (3,065 ACVs * $25) $229,875 (3,060 * $75)
Total	**$2,055,900**	**$473,835**

A.) MA-PCPi Average Star Rating Bonus: Your practice can earn our Average Star Rating Bonus when you achieve an average Star Rating of 3.75 or higher.

Average Star Rating	Average Star Rating Bonus (PMPY: Per member per year)	Estimated Current Membership 6,188
4.75 and above	$125 PMPY	$773,500
4.74-4.50	$80 PMPY	$495,040
4.49-4.00	$40 PMPY	$247,520
3.99-3.75	**$20 PMPY**	**$123,760**
3.74 and below	$0	$0

B.) High Priority ACV Bonus: You practice can earn $150 in Q1 and Q2 and $100 in Q3 and $150 Q4 for each ACV you conduct for a high-priority MA-PCPi customer..

ACV Bonus Opportunity	Incentive Amount	Total Opportunities	Estimated Bonus
High Priority Mbrs	**$150 or $100**	**4,424**	**$273,450**

C.) ACV Quality Bonus: ACV Bonus: You're eligible to receive **$25** for each qualifying ACV you conduct.
You're eligible to receive an additional **$75** bonus if you achieve a year-end Average Star Rating of 4.00 or higher. This bonus will be paid annually

MA-PCPi Star Rating	ACV Quality Bonus (PMPY: Per member per year)	Estimated Current Membership 6,188
	$25 per ACV	3,065 x $25
4.00 or higher	$75	3,065 x $75
3.99 and below	$0	$TBD

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United Performance over time

UNITED MA NON-ACO QUALITY INCENTIVE PROGRAM PERFORMANCE YEARS
(PY 2023 INCOMPLETE)

PY2016: $0
PY2017: $500,025
PY2018: $422,000
PY2019: $879,550
PY2020: $230,880
PY2021: $264,205
PY2022: $520,565
PY2023: $473,835

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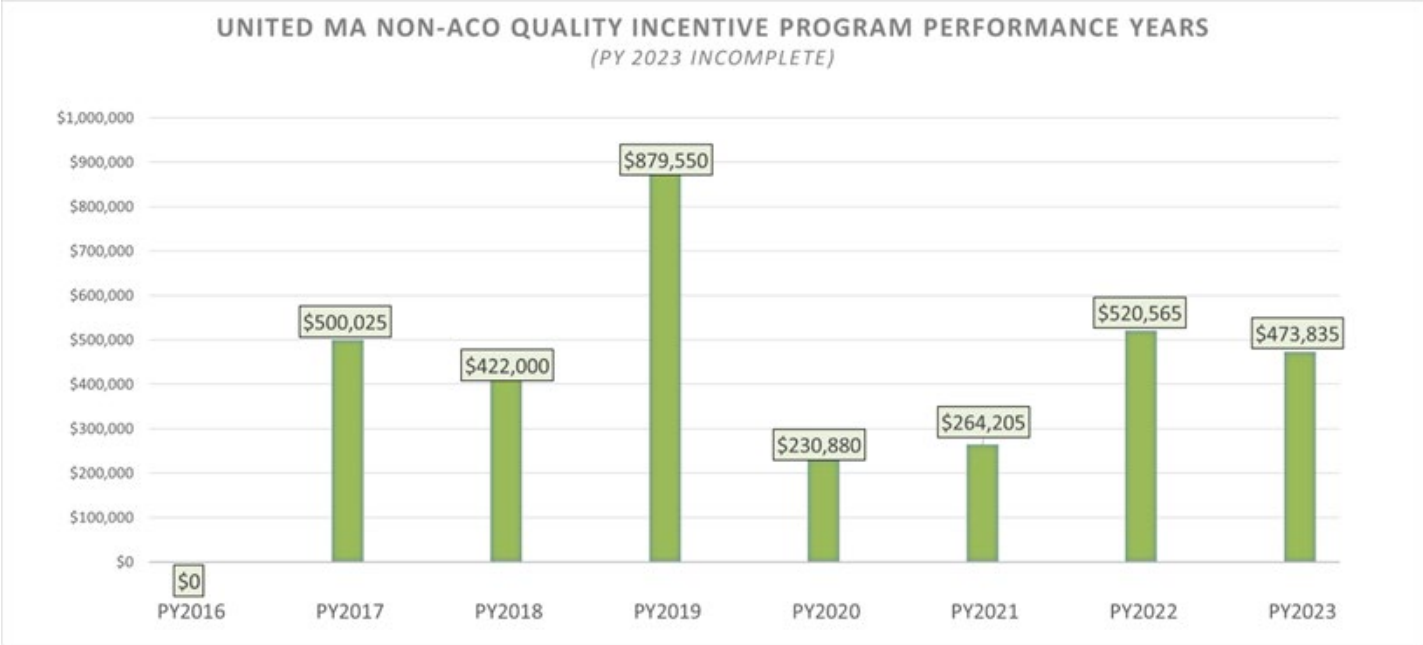
Shared Savings Programs – MSSP, Boeing, PEBB and SEBB

- Shared Savings gate – we need to meet certain financial measures to achieve any savings

- Savings are mitigated by quality scores – renegotiated yearly

- Documentation and Coding appropriate medical complexity (aka Risk Adjustment) affects calculated predicted costs significantly.

- Many have multi-year progressive risk – MSSP and United Medicare Advantage

Performance in PEBB – covering many UW Medicine employees

PEBB Performance Actual and 2023 Estimated

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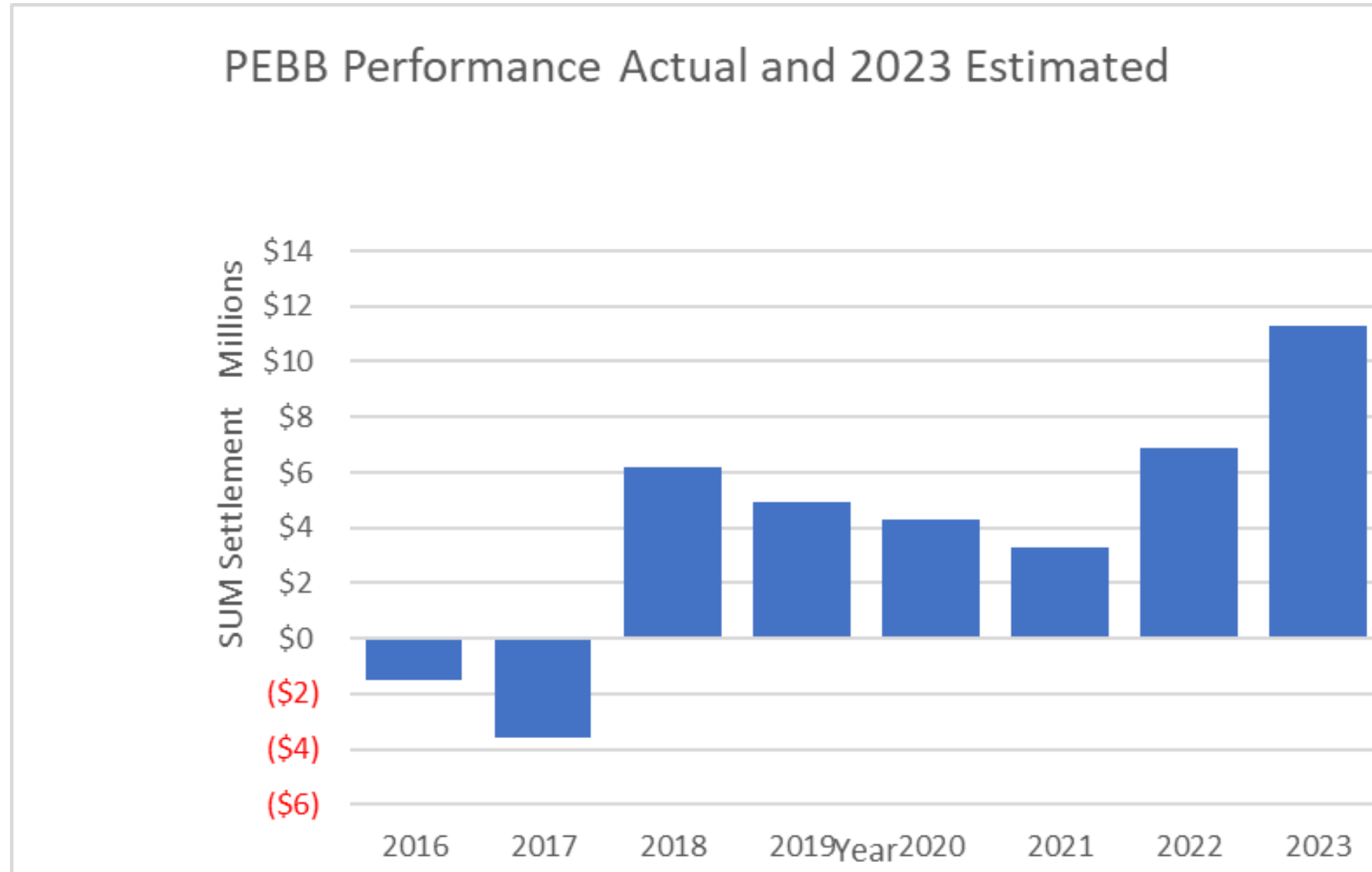
Capitation – taking on financial risk?

- Contrast limited capitation vs. full capitation

- Nearly all of our inpatient payment is paid by an "episode" capitation (DRG)

- Bundle payments are similarly fixed on an episode usually including a hospitalization (or surgical center) plus 30 or 90 days cost with quality measures.

- Full capitation makes the healthcare entity essentially the insurer and responsible for managing total cost of care for a defined population. UW Medicine does not have any of these arrangements at this time.

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MAKING CARE PRIMARY

- Washington is one of 8 states offered this program through Center for Medicare and Medicaid Innovation (CMMI)
- UW entered in 2024

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Participation Track Options Overview

MCP includes three (3) tracks that health care organizations can select from when applying to the model. The three tracks provide opportunities for organizations with differing levels of care delivery and value-based payment experience to enter the model at a point that matches their capabilities at the start of MCP.

	Track 1 Building Infrastructure	Track 2 Implementing Advanced Primary Care	Track 3 Optimizing Care and Partnerships
Focus Area	Building capacity to offer advanced services, such as risk stratification, data review, identification of staff for, or HRSN screening and referral	Transitioning between FFS and prospective, population-based payment	Optimizing advanced primary care services and specialty care integration enabled by prospective, population-based payment
	Level of VBC Experience ➔		
Duration	Participants who enter* in Track 1 can remain up to 2.5 years before progressing to Track 2	Participants who enter* in Track 2 can remain in Track 2 up to 2.5 years before moving to Track 3	Participants who enter* in Track 3 can remain for the entirety of the MCP

*Organizations that start in Track 1, 2, or 3 will have an additional 6 months (or half of a year) in that track, given the mid-year start date for the model. A participant's length of time in a track depends on which track they started in.

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MCP Payment Types

Prospective Primary Care Payment (PPCP)

Track 1	**Track 2**	**Track 3**

Quarterly per-beneficiary-per-month (PBPM) payment (calculated based on historical billing) to support a gradual progression from fee-for-service (FFS) payment to a population-based payment structure.

Enhanced Services Payment (ESP)

Track 1	**Track 2**	**Track 3**

Non-visit-based per-beneficiary-per-month (PBPM) payment that is adjusted to reflect the attributed population's level of clinical (CMS-HCC) and social (ADI) risk to provide proportionally more resources to organizations that serve high-needs patients.

Performance Incentive Payment (PIP)

Track 1	**Track 2**	**Track 3**

Upside-only performance incentive payment designed to reward MCP participants for improvements in patient outcomes and quality measures. Structured to maximize revenue stability (half of estimated PIP will be paid in the first quarter of performance year).

Upfront Infrastructure Payment (UIP)

Track 1	Track 2	Track 3

Lump-sum payment for select Track 1 participants to support organizations with fewer resources to invest in staffing, SDOH strategies, and HIT infrastructure.

MCP E-Consult (MEC)

Track 1	**Track 2**	**Track 3**

Ambulatory Co-Management (ACM)

Track 1	Track 2	**Track 3**

Payments to support specialty integration strategy to support communication and collaboration for longitudinal primary care and short-term specialized care for chronic conditions. MEC code billable by MCP primary care clinicians while ACM is billable by Specialty Care Partners and in-house MCP Specialists at multispecialty participants.

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Track 1: MCP Payments for Primary Care

- For Pre-MCP/FFS: Revenue also includes $86K for care management services
- Upfront Infrastructure Payments (UIP) – Track 1 only: $145,000
- Specialty Care FFS untouched

Performance Measurement and Reporting

Focus	Measure	Type	Track 1	Track 2	Track 3
Chronic Conditions	Controlling High Blood Pressure*	eCQM	X	X	X
	Diabetes Hba1C Poor Control (>9%)*	eCQM	X	X	X
Wellness and Prevention	Colorectal Cancer Screening*	eCQM	X	X	X
Person-Centered Care	Person-Centered Primary Care Measure (PCPCM)	Survey	X	X	X
Behavioral Health	Screening for Depression with Follow Up*	eCQM		X	X
	Depression Remission at 12 months	eCQM		X	X
Equity	Screening for Social Drivers of Health*	CQM		X	X
Cost/ Utilization	Total Per Capita Cost (TPCC)	Claims		X	X
	Emergency Department Utilization (EDU)	Claims		X	X
	TPCC Continuous Improvement (CI) *(Non-health centers and Non-Indian Health Programs (IHPs))*	Claims		X	X
	EDU CI *(Health Centers and IHPs)*	Claims		X	X

- NOTE: MCP measures are aligned with other CMS quality programs, including the Universal Foundation Measure Set (as indicated above with an asterisk "*")

- NOTE: All "non-claims" measures are assessed on ***all-payer*** basis for primary care patients

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Key considerations about value-based payment models

- Payment transformation has to go hand-in-hand with care transformation, but hence a "chicken and egg" situation dependent on % of lives cared forand revenue.

- CMS and other insurers will continue to push value-based models in future payment

- Highly funded corporations and Venture capital are trying to disrupt the US historic care model and are betting profit in the future will be outside of hospitals.

- The US will have a complex and blended payment model for the foreseeable future

- There are huge opportunities for organizations who can deliver and demonstrate high value care to patients, populations, and payors.

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Questions?

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QUESTIONS?

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Big money wants to eat our lunch

The Healthcare Vertical Integrators of 2022*

ASSETS

CARE CONTINUUM	OPTUM	CVS	WALGREENS	AMAZON	LOCAL HEALTH SYSTEM
Insurance Services	United Healthcare	Aetna			Provider Sponsored Plans
At-Home Preventative (RPM)	Vivify / AbleTo	Signify**			Growing Digital Health Investments
Urgent Care		MinuteClinic / HealthHUB	Community Clinics / CityMD**		Urgent Care Access Expansion
Primary Care	Optum Care (HealthCare Partners, Kelsey-Seybold, Atrius Health, Healthcare Assoc. of TX)	Oak Street Health/Carbon	VillageMD / Summit**	OneMedical / Iora**	Growing PCP employment
Specialty Care	OptumCare	Renal Care	Summit**		Centers of Excellence
Ancillary (Lab/Imaging/Pharmacy)	Traditional PBM, Pharmacy and Infusion Services (Diplomat)	Traditional PBM (Caremark) / Pharmacy Business	Shields / Traditional Pharmacy Business	Pillpack	Pharmacy
Outpatient/Ambulatory	OptumCare (Atrius Health, Reliant Medical Group)				Surgery Centers & Outpatient Clinics
Inpatient					Hospitals
Post-Acute Facility	NaviHealth				SNF/IRF
Home Health	Landmark Health, LHC**, Refresh Mental Health	Signify**	CareCentrix		Home Health Network
Palliative / Hospice					End of Life Care

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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 medical neighborhood • Management of chronic conditions and diseases • HEDIS measures	• 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, coordination, and education
Sharing best practices

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