Healthcare Finance 101

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September 9, 2025

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Where do you work? (type in location)

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What type of work do you do? (can pick multiple)

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Series of discussions about Healthcare Finance

Healthcare Finance and Medical Economics

101 – The basics of healthcare finance focus on how healthcare systems are paid

201 – Advanced topics in payment models, including value-based care payment and care models, and advanced contracting topics.

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

Agenda Healthcare 101

- Introduction to contracting and value-based care/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 - basics

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On a scale of 1 to 5 stars, with 1 = completely unaware, and 5 = expert understanding - how well do you think you understand how healthcare services are reimbursed?

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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.

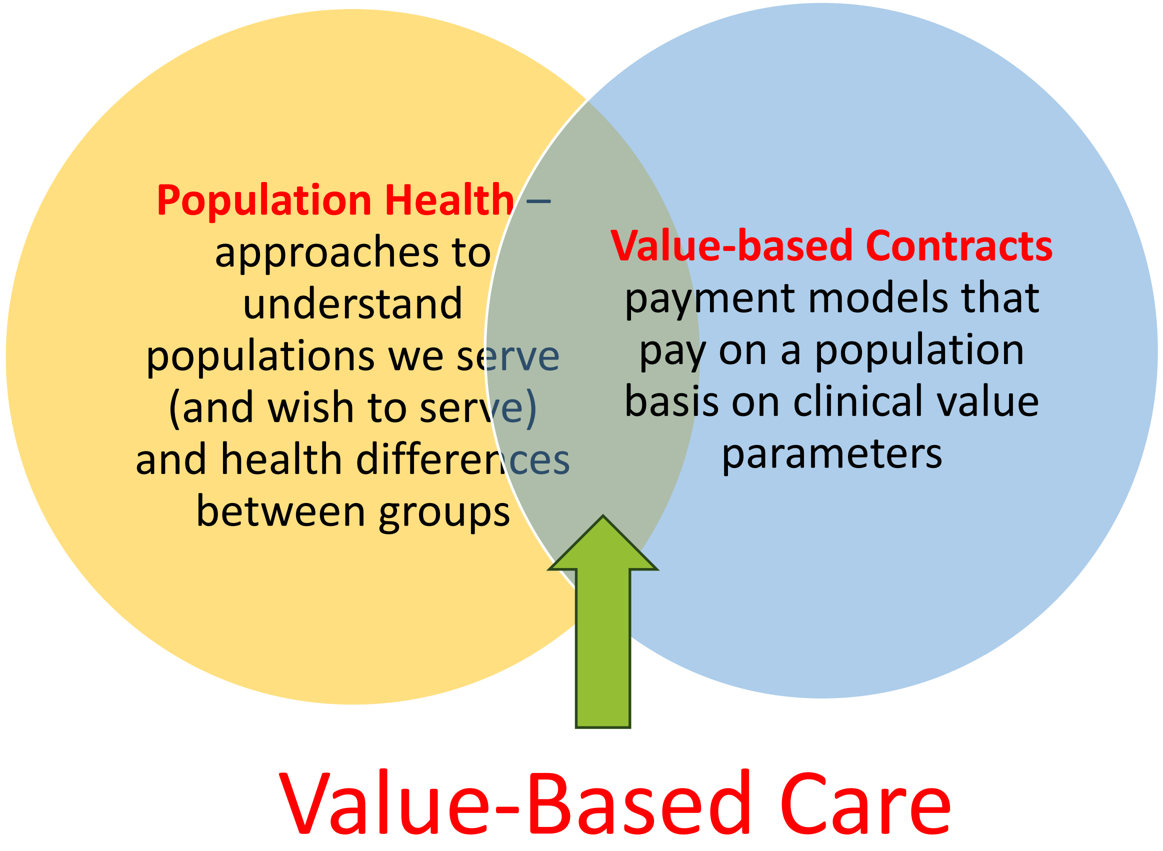
Glossary

- Finance – the management of money by companies. Monetary support for an enterprise. In this case UW Medicine and related entities.
- Economics – the branch of knowledge concerned with the production, consumption, and transfer of wealth. In this case we will focus on the US.
- Opportunity cost – "the loss of potential gain from other alternatives when one alternative is chosen" in the setting of scarcity.
- Use of acronyms – can't be avoided in discussion of US healthcare, but we will explain the terms and a glossary is linked [VB Glossary Sep 2024 revisions CPHO office.docx].

Wikipedia August 2025

UW Medicine – Population Health

- Organized by the Chief Population Health Office's (CPHO) team out of the Chief Medical Officer's (CMO) office. Coordinates population and value-based work across UW Medicine and partners.
- Works between contracting, strategy, and care delivery, coordinating financial performance with care model optimization
- 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.



Why care about healthcare finance?

- How does UW fund our mission?
- Any revenue for healthcare systems is a cost to some other entity
- Costs to whom? Government, insurance, employers, communities, or patients?
- Fee for service (FFS) incentivizes volume/intensity of care
- What is the role of fee-for-value (FFV) payment models that attempt to pay for outcomes?
- To optimize any change in financial models, care models also need to change

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If US healthcare expenditures were compared with the GDP of other countries, where would it rank among world economies?

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If US Healthcare was a country…

Rank	Country/Region	GDP in billion $	GDP in $ per capita
1	United States	29,185	85,810
2	China	18,744	12,330
	US Healthcare Expenditure in 2024*	5,263	Health 16,630
3	Germany	4,660	55,800
4	Japan	4,026	32,476
5	India	3,913	2,697
6	United Kingdom	3,644	52,637
7	France	3,162	46,150
8	Italy	2,373	40,226
9	Canada	2,241	54,283
10	Brazil	2,179	10,280

The 50 largest economies in the world (worlddata.info)
Downloaded 9/5/2025

https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.00545

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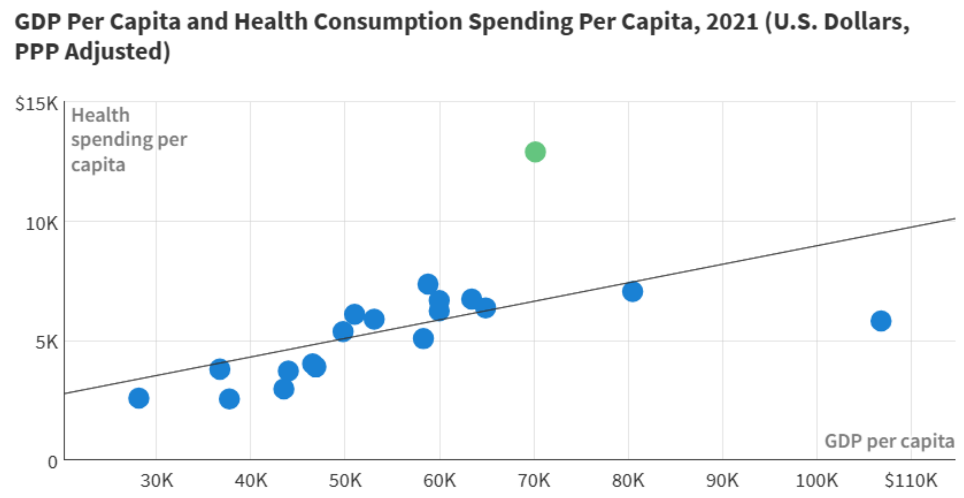
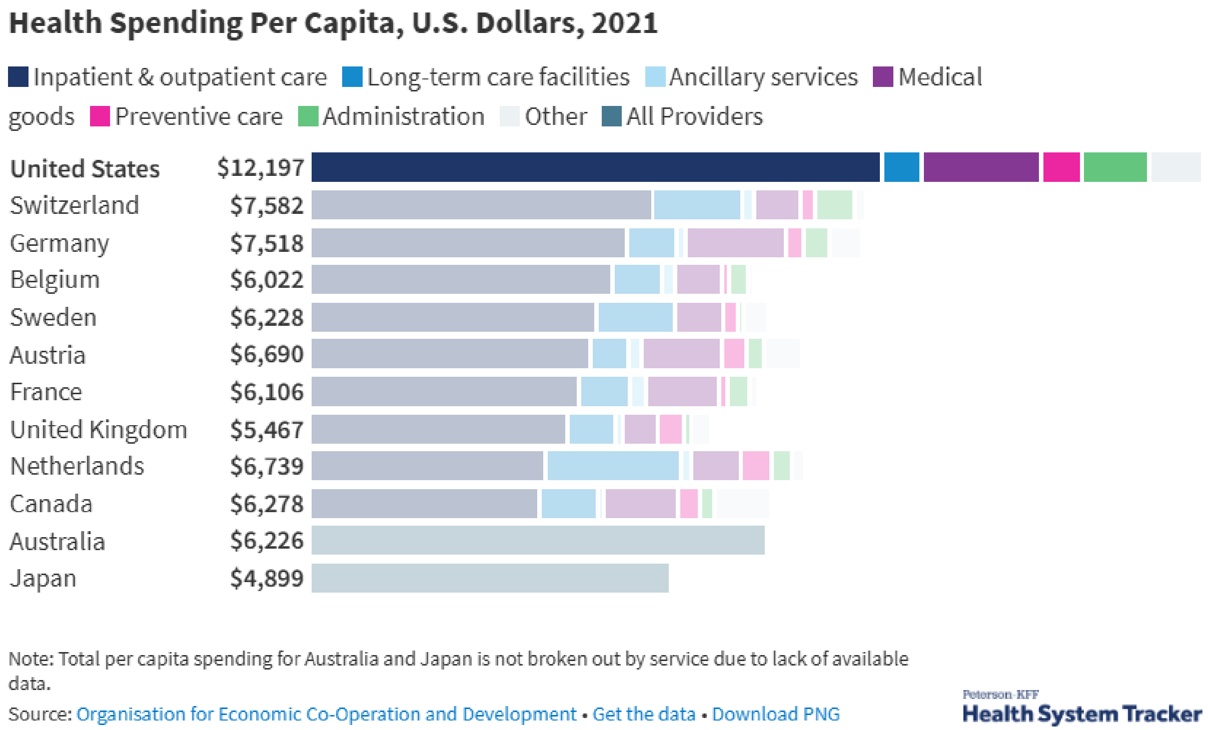
Healthcare in the US



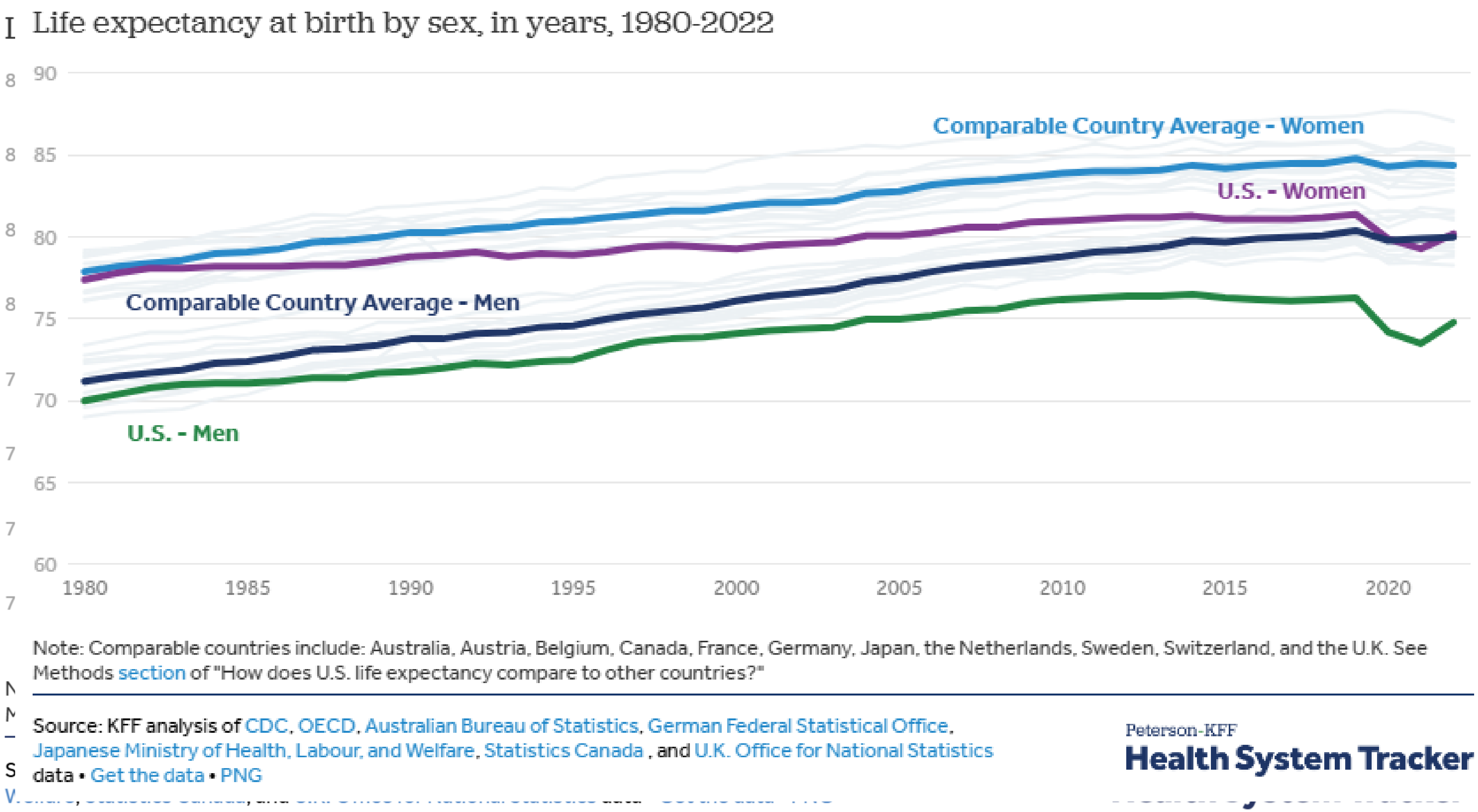


- Very complex payment models lead to a high administrative burden
  - Admin costs in the US $1,055 per capita (Germany #2 at $306)
  - US physicians devote 13% of working hours vs 8% in Canada
  - At least half of administrative expenditures are considered wasteful.

[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]

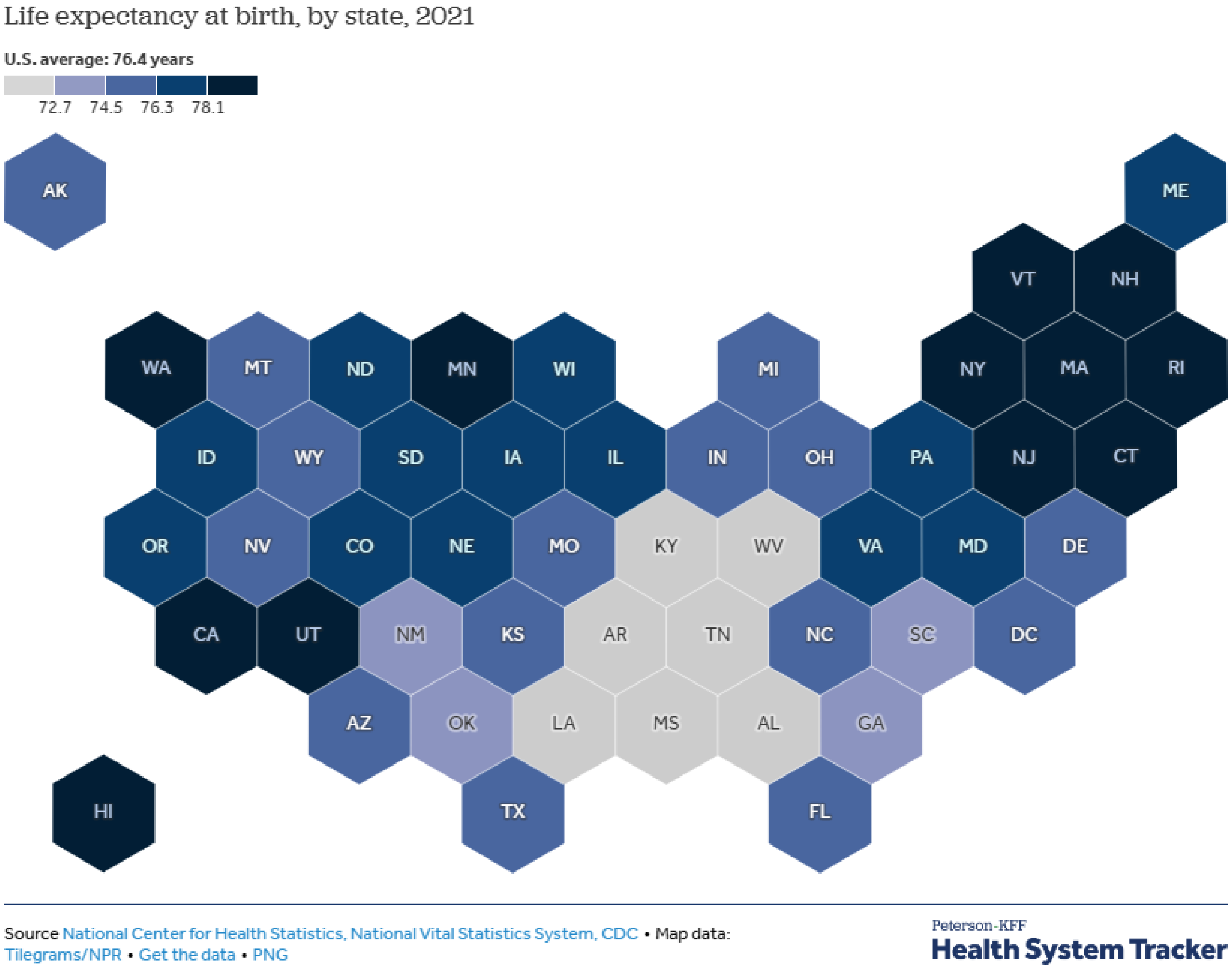
Do we get the clinical value we are paying for?

US life expectancy changes over time



[Life expectancy - Peterson-KFF Health System Tracker]()

Geography Is health Destiny



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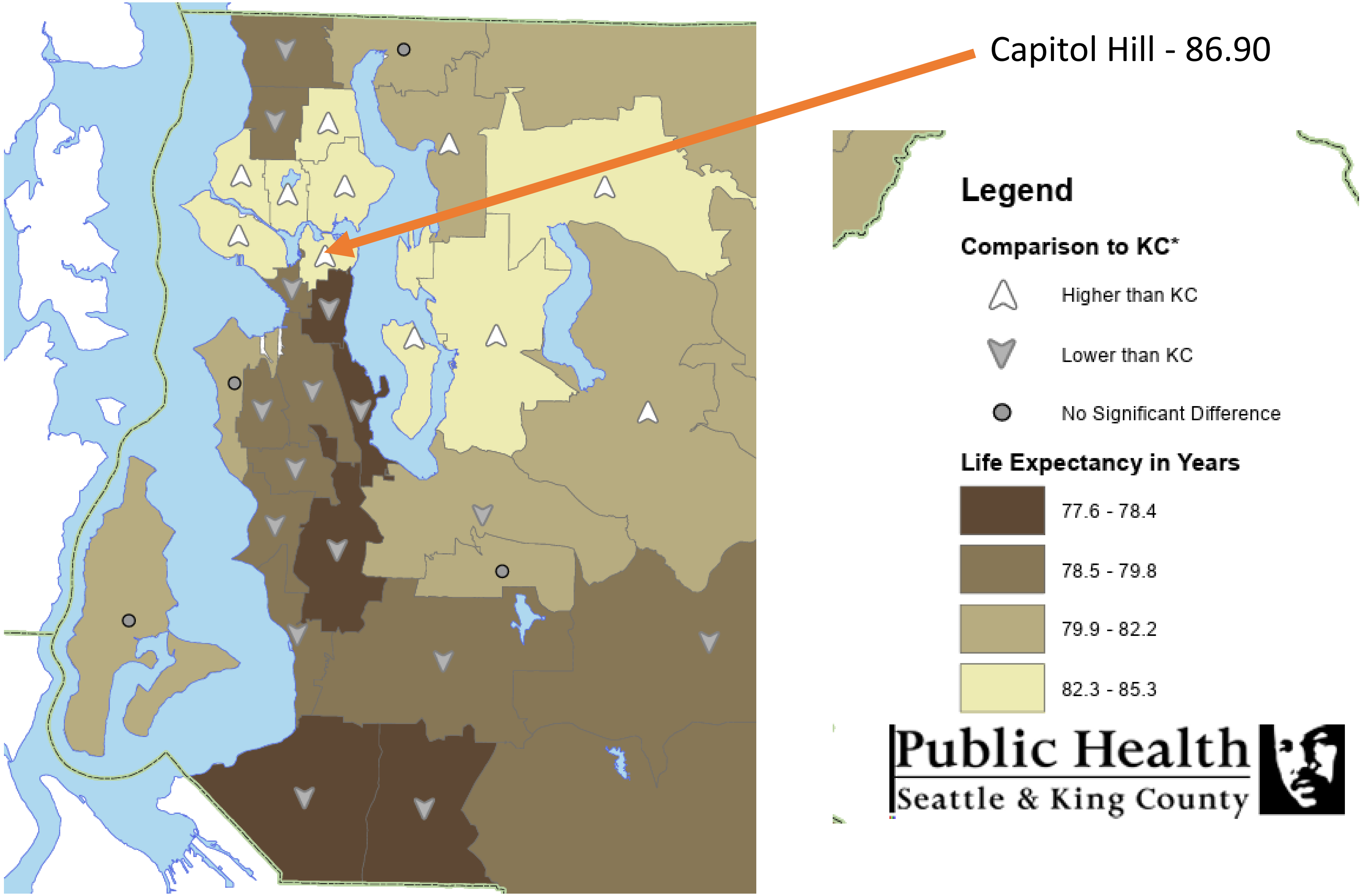
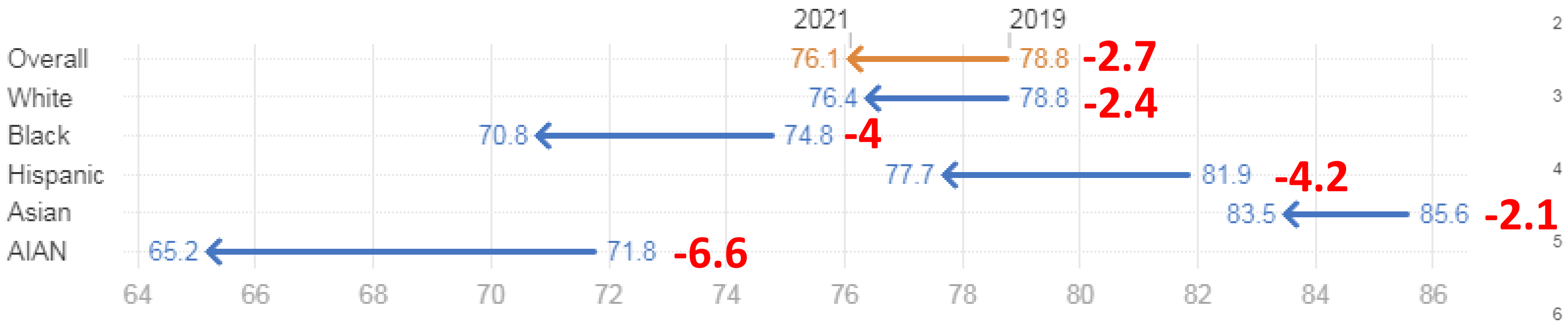
Local differences in life expectancy 2003-2007



Covid related decreases in life expectancy were not equal among Race/Ethnic groups

Figure 2

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



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

KFF

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)
4	Accidents (55.0)	Accidents (70.0)	Stroke (53.1)	Accidents (79.6)	Stroke (32.8)	Accidents (47.3)
5	Stroke (35.7)	Chronic respiratory (39.9)	Diabetes (38.8)	Stroke (59.6)	Diabetes (25.6)	Stroke (36.1)
6	Alzheimer's disease (31.5)	Stroke (39.8)	Chronic respiratory (29.2)	Diabetes (46.3)	Alzheimer's disease (25.3)	Diabetes (29.4)
7	Diabetes (19.1)	Alzheimer's disease (32.6)	Homicide (23.7)	Homicide (33.7)	Liver disease (14.6)	Alzheimer's disease (27.7)
8	Flu and Pneumonia (12.5)	Diabetes (22.4)	Nephritis (25.4)	Chronic respiratory (27.9)	Chronic respiratory (16.1)	Liver disease (17.3)
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)

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

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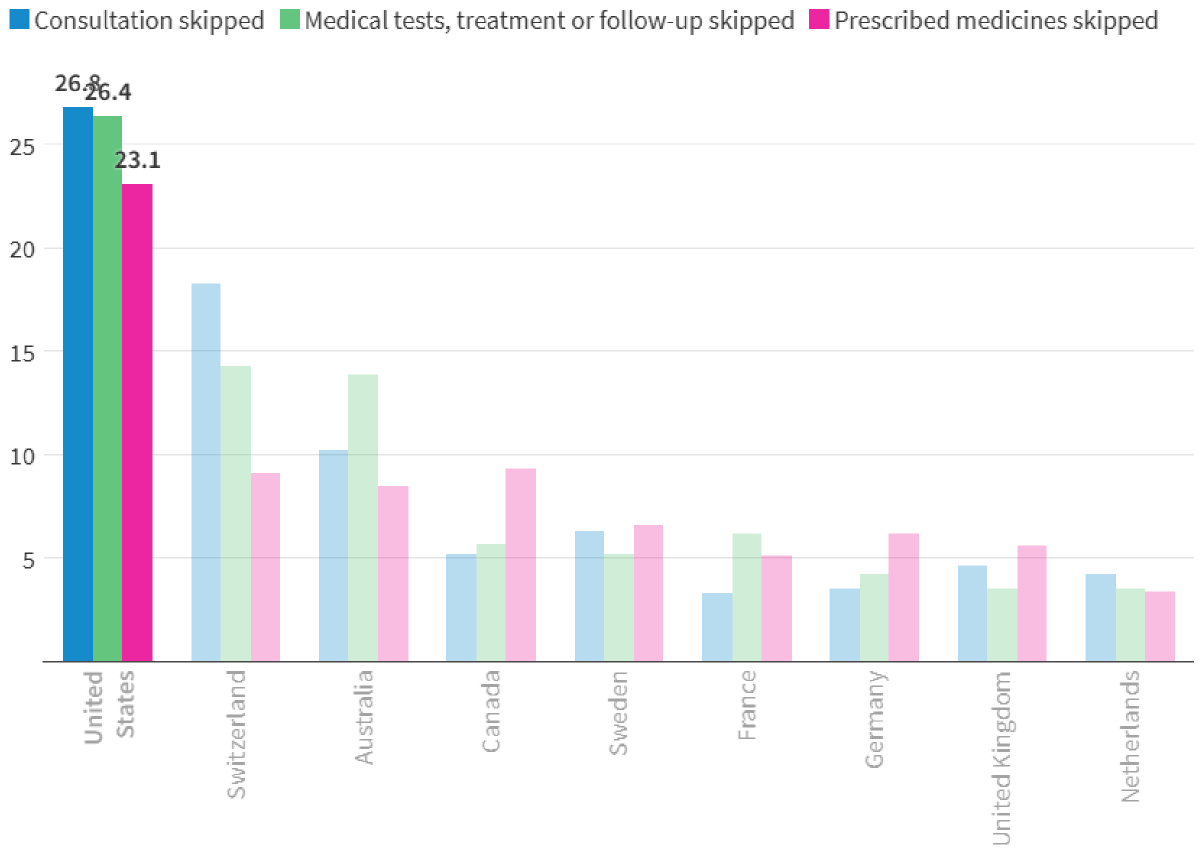
More than 1 in 4 Americans skip healthcare due to costs

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



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

Peterson-KFF Health System Tracker

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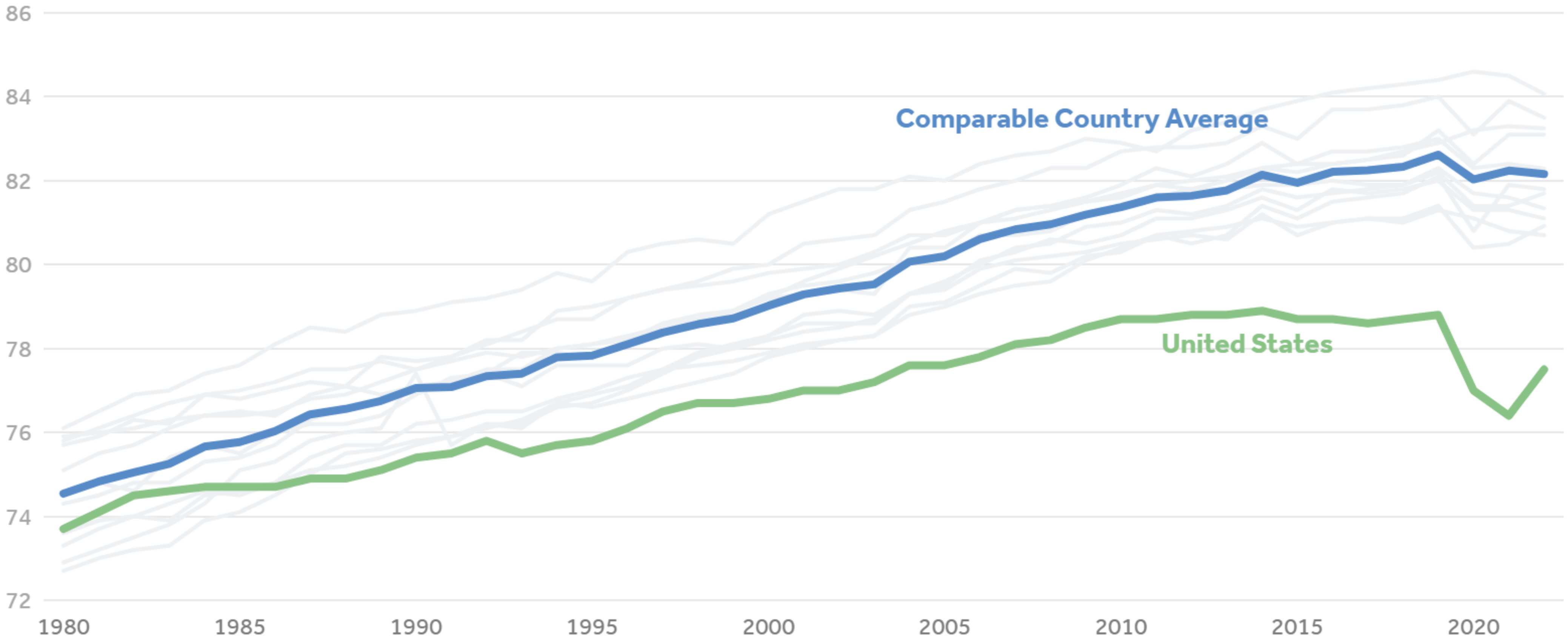
General Statements on US Healthcare

- Complex
- Costs are not transparent
- Employer-driven healthcare insurance contributes to inequities, and recent legislation decreasing Medicaid payments creates a “payor mix” dilemma.
- There are no easy answers to improve US healthcare (Law of unintended consequences)
- Despite high per-capita healthcare expenditures, US health outcomes are worse and declining compared to most economically comparable countries.
- Outcomes are inequitable across many sub-populations.

Life expectancy at birth, in years, 1980-2022



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

Matt Lund

UW Medicine

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In terms of DOLLARS CHARGED for services annually by business line at UW Medicine, which is the correct order of magnitude?

A. Commercial, Medicare, Medicaid
B. Medicare, Commercial, Medicaid
C. Medicaid, Medicare, Commercial
D. Medicaid, Commercial, Medicare
E. Commercial, Medicaid, Medicare

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In terms of DOLLARS REIMBURSED for services annually by business line at UW Medicine, which is the correct order of magnitude?

A. Commercial, Medicare, Medicaid
B. Medicare, Commercial, Medicaid
C. Medicaid, Medicare, Commercial
D. Medicaid, Commercial, Medicare
E. Commercial, Medicaid, Medicare

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Overview

Today we will discuss...

- Managed Care Contracting at UW Medicine
- *How are we paid?* – FFS Reimbursement Systems/Methodologies
- How Medicare Impacts All Reimbursement
- Value-Based Payment Models
- Key Takeaways
- Q&A

Contracting at UW Medicine

- All reimbursements for medical services negotiated by UW Medicine Contracting & Payer Relations Department ("Contracting")
- UWMC, HMC, UWP and Airlift Northwest
- Commercial and Government/Managed Government payers (Medicare, Medicaid, Tricare, VA, etc.)
- Negotiations focus on total annual dollar reimbursement by UW Medicine entity and UW Medicine system
- $ 3.3 Billion in annual reimbursement
- Key factors in contracting: payer mix, acuity mix, market trends, institutional mission, language, access, law/regulations

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"

Typical Payment Methods…

Focus:

- Inpatient Hospital Reimbursement
  - DRG/IPPS
- Outpatient Hospital Reimbursement
  - APC/OPPS
- Professional Fee Reimbursement
  - RVU/RBRVS

1983 Medicare Prospective Payment System

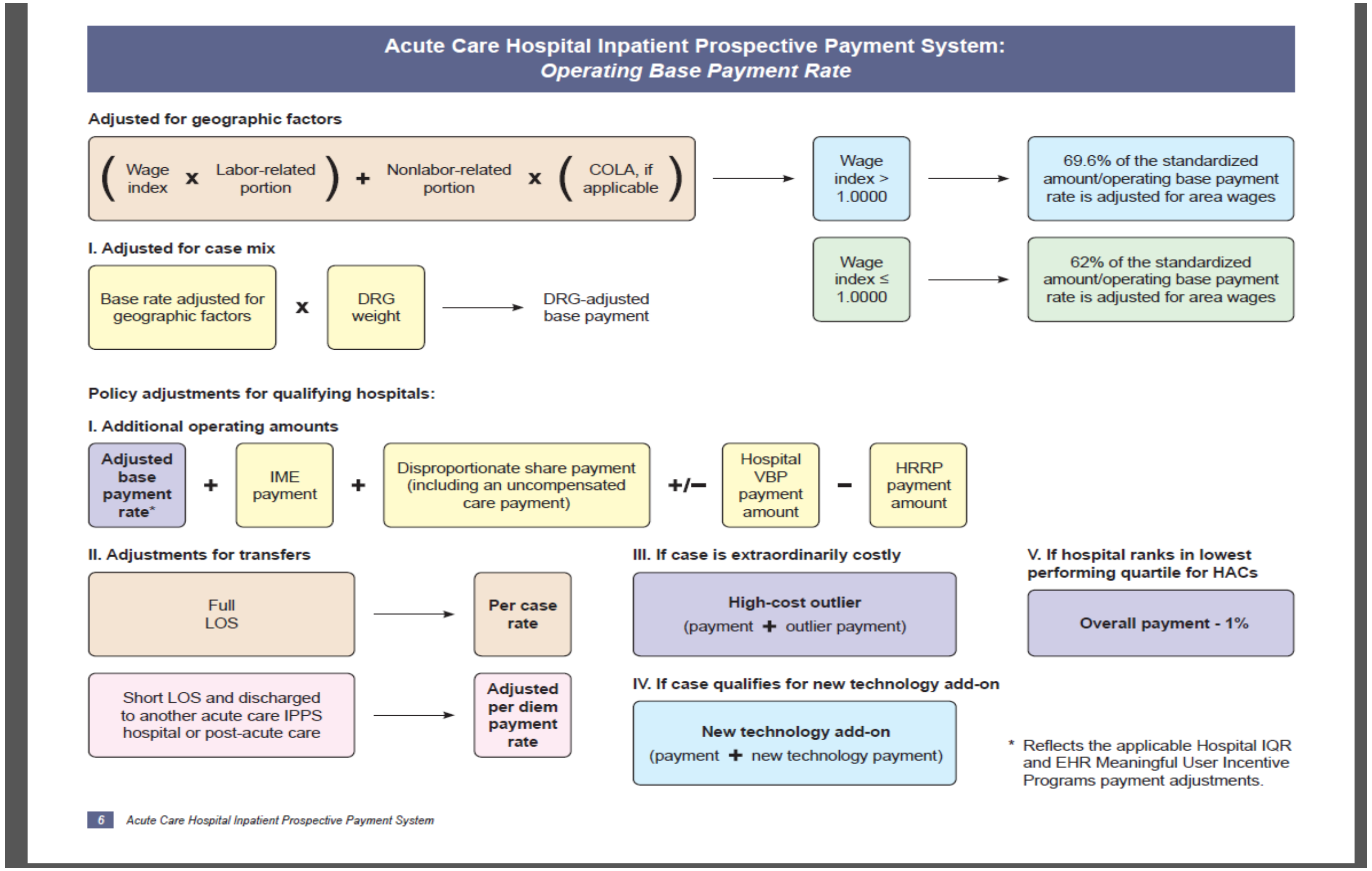
- In 1962 48% of seniors lacked health insurance compared with 2% today.
- Medicare has grown from 0.7% of the GDP to 3.6% today.
- In the 1960's Medicare mimicked local "usual and customary charges" and reimbursing hospitals for "reasonable costs."
- Since 1967 Congress authorized demonstration projects 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.

Blumenthal D, avis K, Guterman S, NEJM 372;5. Medicare at 50

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

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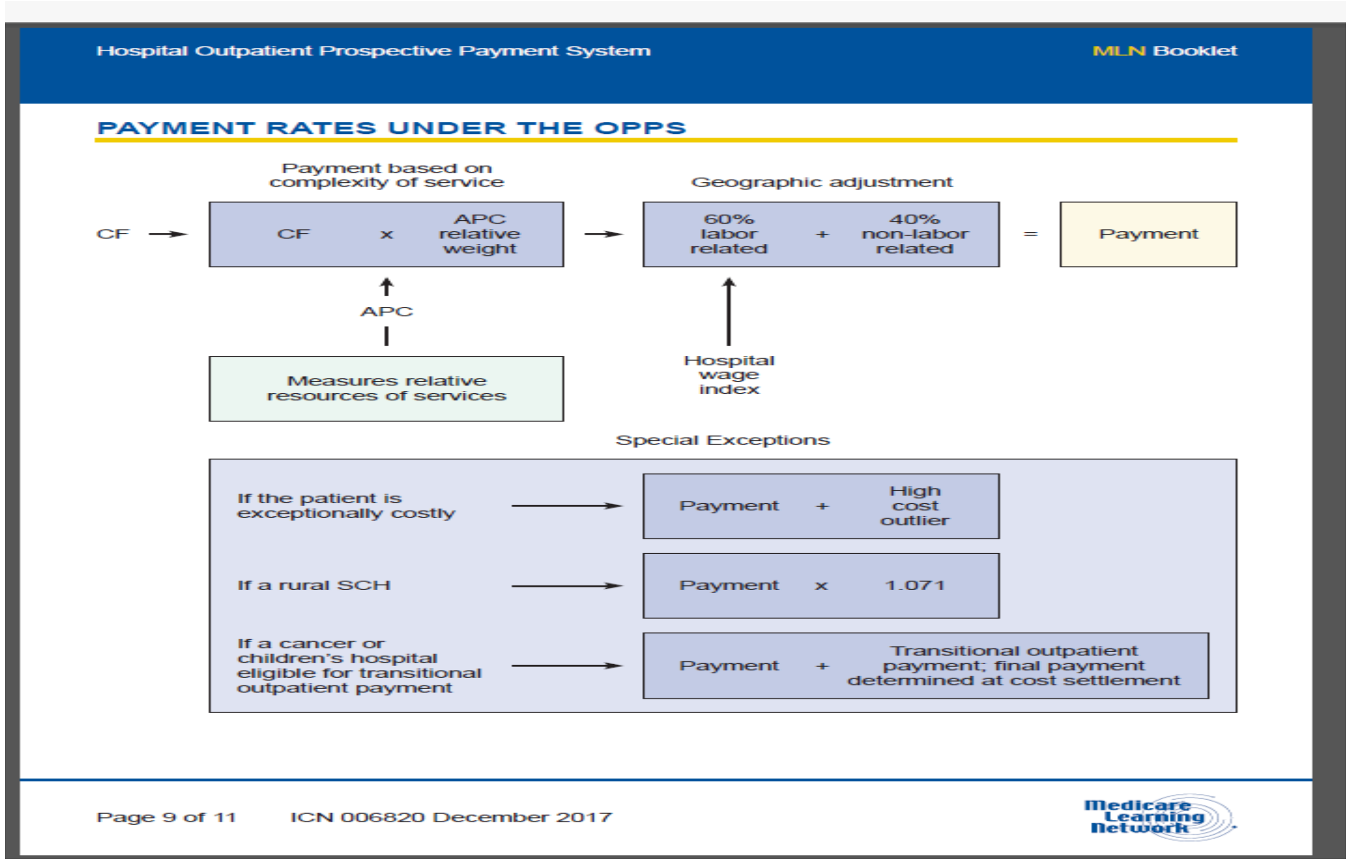
APC - “Ambulatory Payment Classification”

- 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

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 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.

- Conversion Factor x RVU Value

Commercial Reimbursement

- Generally, mirrors Medicare in methodologies:
- “Know Medicare, Know All”
- Base/CF x Weight
- Base/CF is negotiable; Weight is typically not
- *Some* percent of charge contracts at UW Medicine
- (Commercial contracts almost always have a P4P/value-based component)

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 (typically 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”

Break

Incorporating Value Measures to payment

Sept 2024

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What if UW Medicine had its own health plan?

- Often, our CPHO team is approached with this potential solution to the challenges of working with third-party insurance companies
- Key challenges to healthcare organizations
  - Financial models for FFS healthcare are fundamentally misaligned with Financial models for insurance.
  - What is a margin-generating business for healthcare is a cost to insurance.
  - What is administrative cost control from the insurance is considered unnecessary bureaucracy from the standpoint of healthcare systems.
  - Who pays in the end? Government, corporations, and patients.

Different perspectives on healthcare costs

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 to purchase –
   1. Financial risk-taking entity is paid a per-member per-month (PMPM) and then is accountable for the ultimate health care payments
   2. The risk bearing entity cares about per member and total cost of care.

Potential misalignment of these costs/profits. Example.

- A highly efficient Emergency Room visit with a commercially insured patient 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.

Market relevancy

- Unlike many industries, the customers don't always know or want what they may need from evidence-based practices.
- 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.

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

<u>Incentivize</u>

- Increase utilization
- Increase billable Encounters
- Intensity of care (billing levels)
- Raise prices/Cut Costs
- Commercial payor mix

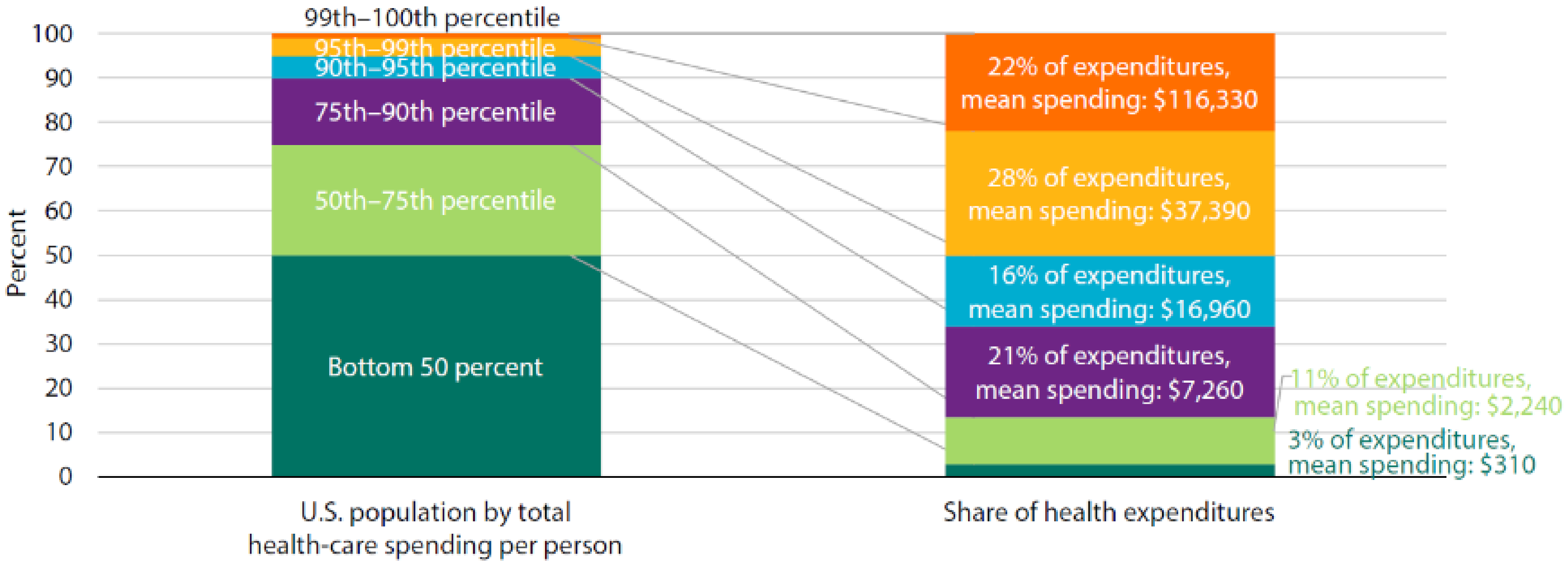
<u>Dis-incentivizes</u>

- Wellness
- Most cost-effective modalities of care
- Cost-effective sites and workflows of care
- Improved Patient experience
- Innovation for access
- Equity

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

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.

“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	Fee for service	Pay for Performance	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, UW Medicine has 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
- post-COVID high demand and full capacity is an opportunity where some areas don’t have a traditional tradeoff of value for volume.

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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When do we see our performance (reconciliation) and payment for performance in 2024?

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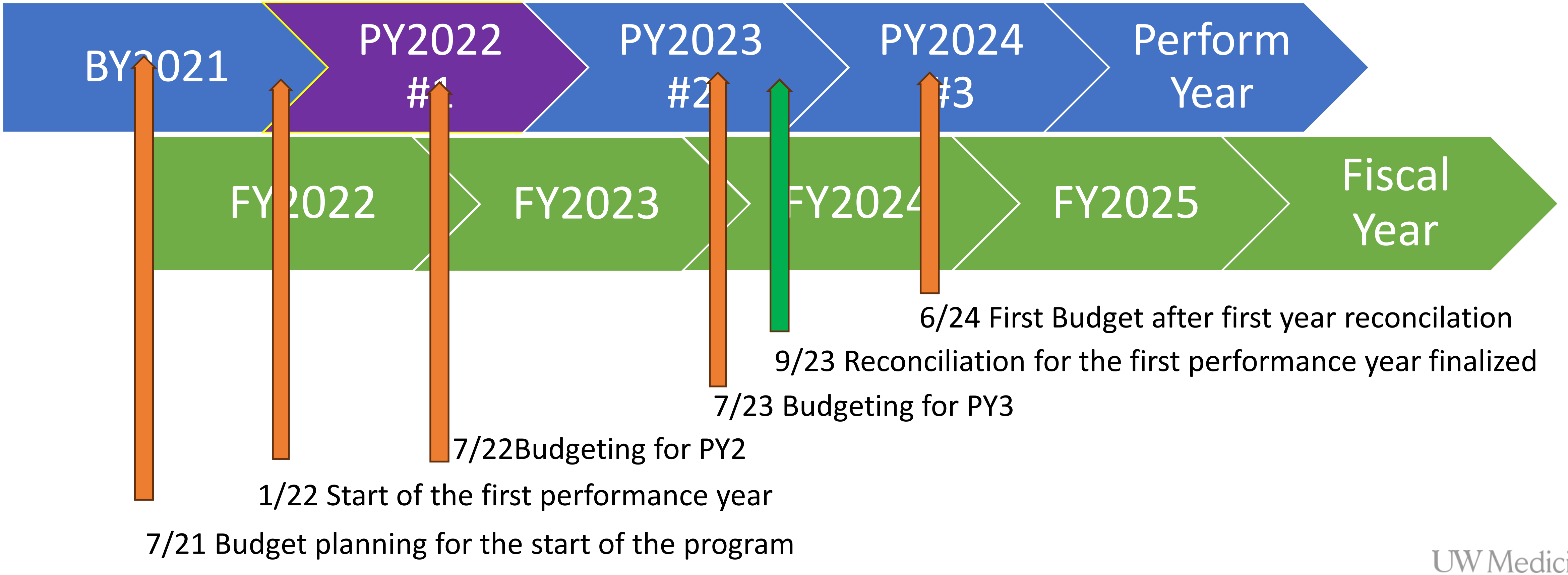
Value-based payment model Challenges

- Reconciliation and Payment Latency
  - Difficult to predict performance
  - Difficult to invest with unclear Return on Investments
- Reductionist and diverse measures on Quality
  - Over 70 quality measures across our Value-based contracts
- Multiple models create clinical operational complexity

Latent reconciliation and payments make investments in value-based care a 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



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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

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

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

ACO

	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)	Current Estimated 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

Shared Savings Programs – MSSP, Boeing, PEBB and SEBB

- Shared Savings gate – To succeed organizations 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

Bundles and Capitation – taking on financial risk?

- Nearly all of our inpatient payment is paid by an "episode" payment (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.
- Contrast limited capitation vs. full capitation
- 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.

Summary

- Health outcomes in the US lag behind other economically developed countries despite high spending per capita.
- Payments in the US are complicated and predominantly Fee-for-service
- Inpatient, hospital ambulatory, ambulatory payments, professional payments tend to follow Medicare methodologies.
- Value-based payments are complicated, but some like the DRG payments for hospital-based services are well-established.
- In the 201 talk we will discuss current issues including cost transparency, site-neutrality, the sustainable growth rate (SGR), and ways value-based care is evolving at UW Medicine and across the country.

slido

On a scale of 1 to 5 stars, with 1 = completely unaware, and 5 = expert understanding - how well do you think you understand how healthcare services are reimbursed?

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

Questions?

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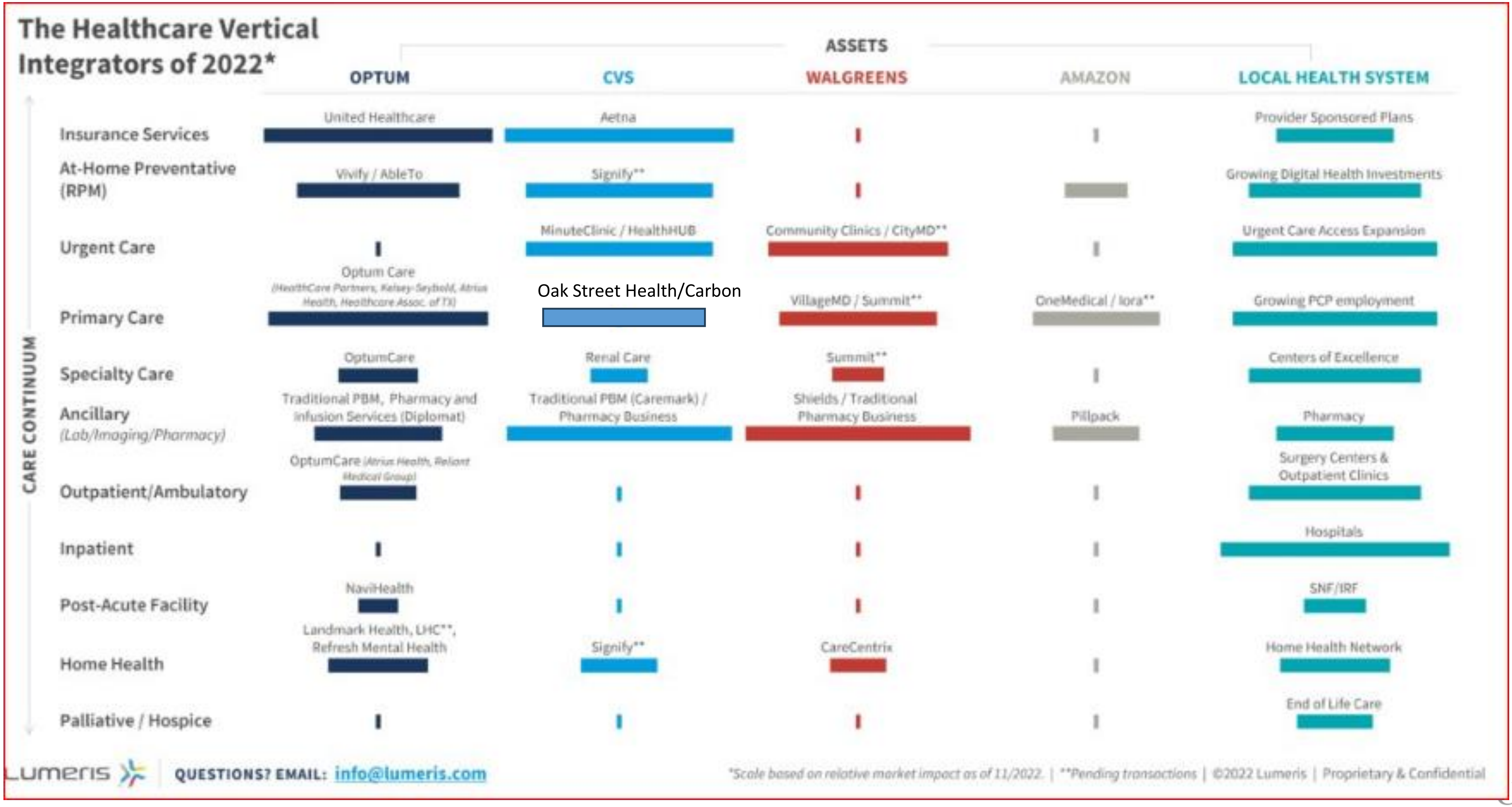
QUESTIONS?

Big money wants to eat our lunch



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 centered medical home (PCMH) and medical neighborhood
- Management of chronic conditions and diseases
- HEDIS measures

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/ Steerage in network
- Utilization Management

Communication, coordination, and education

Sharing best practices