

Healthcare Finance 101



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Attendance

CODE: 18158

1. Send a text message to **833-394-7078**
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(UW faculty and staff should use their UW email address).
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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 CPHO update MM August 2026.docx](#)

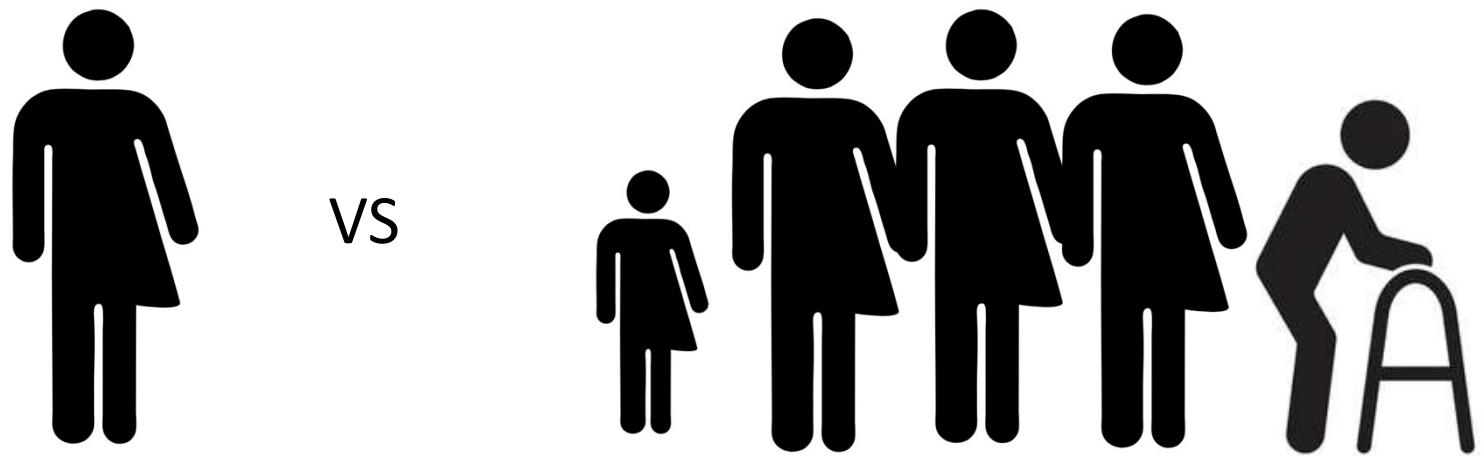
Why care about healthcare finance?

- How does UW fund our mission?
- Any revenue for UW Medicine is a cost to some other entities
- We will review how the revenues flow between employers, insurance companies, the government, communities, and patients.
- Fee-for-service (FFS) payment models pay by volume and intensity.
- What is the role of value-based payment models that attempt to pay for outcomes?
- To optimize improving the health of the public, financial and clinical models require purposeful alignment.



Patient vs. Population approaches

- Public Health, Population Health, Value-based care, patient centered care are all a continuum



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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...

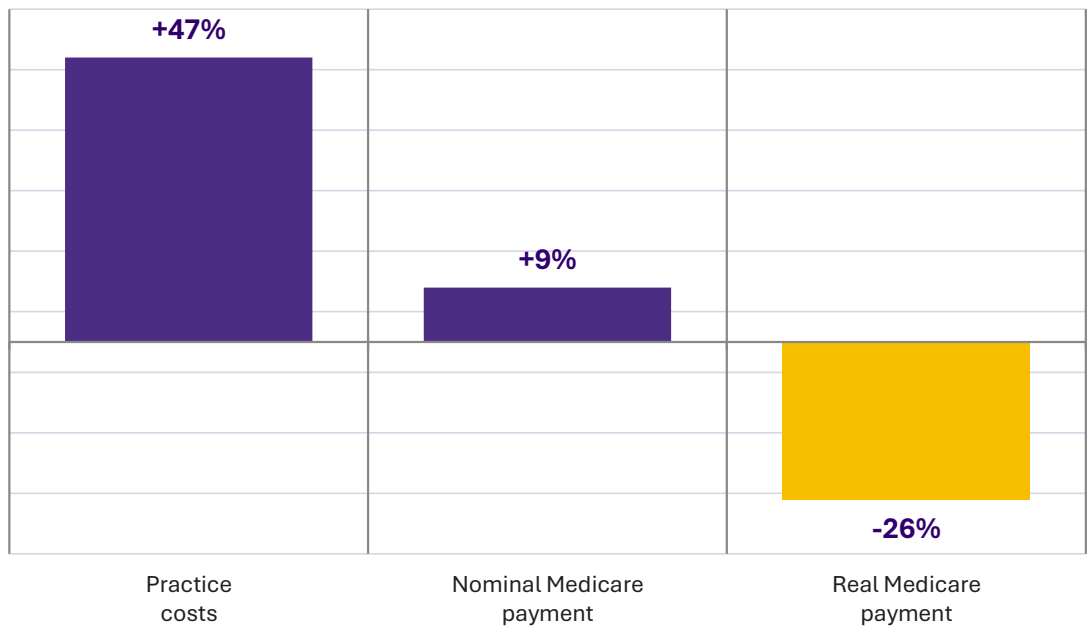
Rank	Country/Region	GDP in billion \$	GDP in \$ per capita
1	United States	29,185	85,810
2	China	18,744	12,330
	US Healthcare Expenditure in 2024*	5,263	Health 16,630
3	Germany	4,660	55,800
4	Japan	4,026	32,476
5	India	3,913	2,697
6	United Kingdom	3,644	52,637
7	France	3,162	46,150
8	Italy	2,373	40,226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

Do we get the clinical value we are paying for?



Physician Pay: Nominal Gains, Real Erosion

Cumulative % change, 2001–2023 · Medicare Physician Fee Schedule vs. cost of running a practice



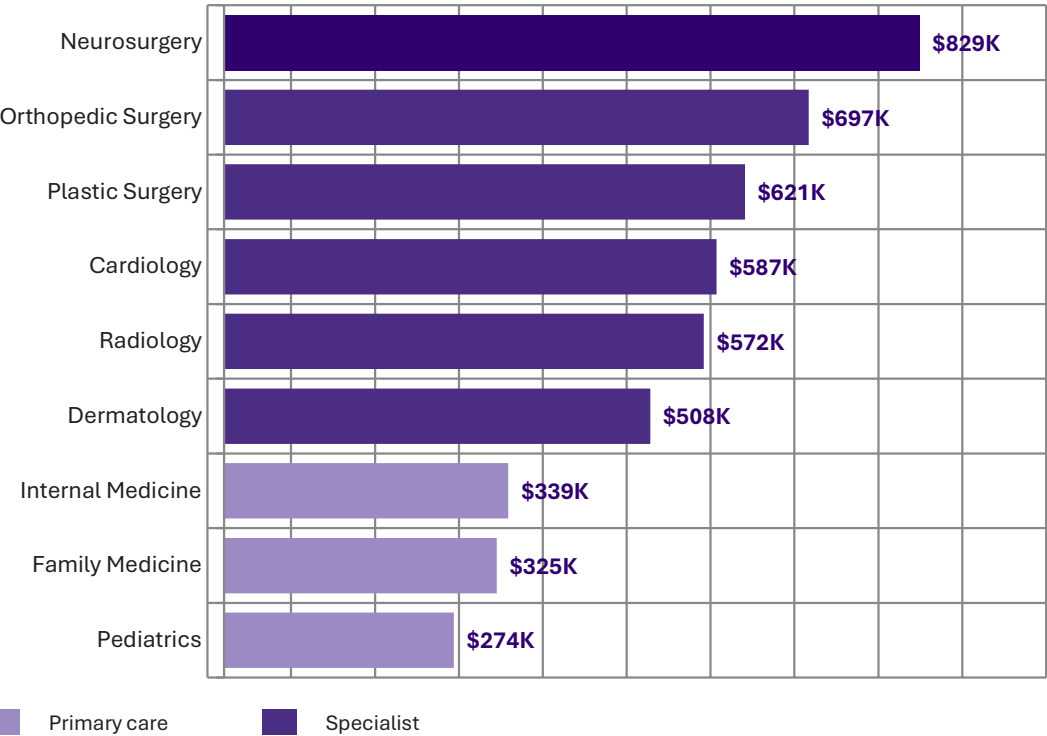
- Medicare's physician fee schedule has fallen ~26–29% in inflation-adjusted terms since 2001, even as practice overhead rose ~47%.
- Doximity: real (inflation-adjusted) physician compensation fell 3.1% from 2017–2023 despite nominal pay rising every year.
- MGMA: physician/APP pay rose ~16% cumulatively over the last 5 years vs. ~20.6% cumulative inflation — a real-dollar loss.
- Longer view (JAMA, 1987–2010): physician real earnings grew just 9.6% cumulatively over 23 years, with ~0% real growth from 1996–2010.

-26%
Real Medicare physician payment, 2001–2023

Sources: American Medical Association; KFF; Doximity 2024–2026 Physician Compensation Reports; MGMA 2025 Provider Compensation & Productivity Report; JAMA 2012 (Seabury et al., earnings 1987–2010).

The Primary Care–Specialist Gap Has Widened

2026 average compensation by specialty (\$000s) · primary care (light) vs. specialty care (dark)



+90%

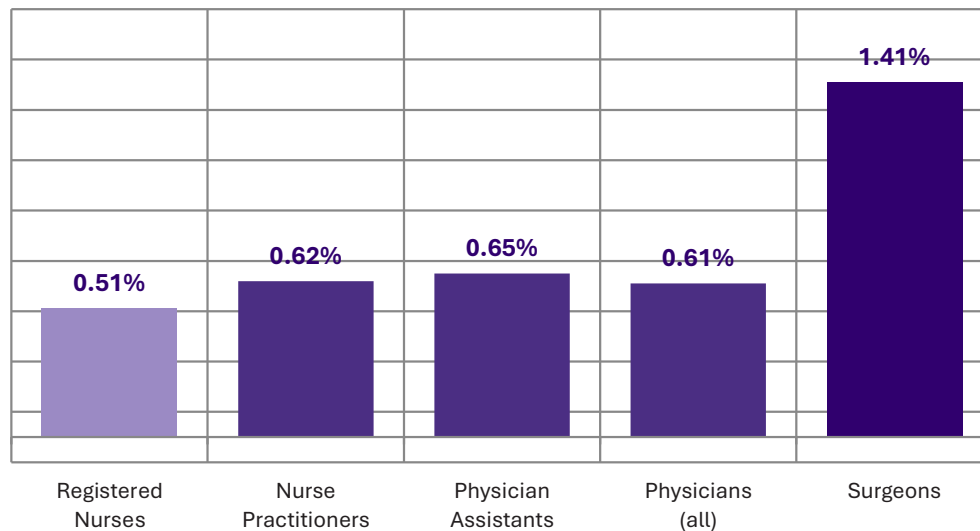
Surgical specialists vs. primary care, 2025 — up from +87% in 2024, reversing 3 years of narrowing

- Non-surgical specialists now earn 38.8% more than primary care physicians on average (Doximity, 2026).
- 2017–2023 in real terms: non-surgical specialists –7%, primary care –4%, surgical specialists –3.6%.
- Exception: plastic surgery real compensation rose 5.2% over the same span — cash-pay, cosmetic work is insulated from insurance reimbursement pressure.
- The pattern is consistent with RBRVS/RUC valuation, which prices procedural work above cognitive and preventive care.

Sources: Doximity 2026 Physician Compensation Report; Medscape Physician Compensation Report 2026.

Other Health Professionals: Mostly Flat, One Sharp Split

Real (inflation-adjusted) annualized wage growth, 2012–2023



RNs posted the slowest real wage growth of any clinical role measured; NPs/PAs — the lowest-cost substitute for both physicians and RNs — grew fastest after surgeons.

- Pharmacists (long view): real earnings rose 44% from 1987–2010 — nearly 5x physicians' 9.6% — but the wage premium over the average health worker has eroded from ~54% a decade ago to ~30% today.
- Retail pharmacy is contracting sharply — employment at its lowest since 2010, down another 8,200 jobs in 2025 — while hospital-based pharmacist pay holds up (~\$151K).
- Physical/occupational therapists: median salaries grew just ~2.6%/yr over 15 years — barely above inflation — while PT program tuition more than tripled over the same span, producing the sharpest pay-to-debt mismatch of any group reviewed.

General Observations on US Healthcare

- Complex
- Costs are not transparent to patients or care teams
- Current US healthcare models rely on employer-driven health insurance.
- 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.
- Understanding how we get paid is critical to understand the unique challenges of US healthcare and help us find better solutions to improve the health of the public

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...

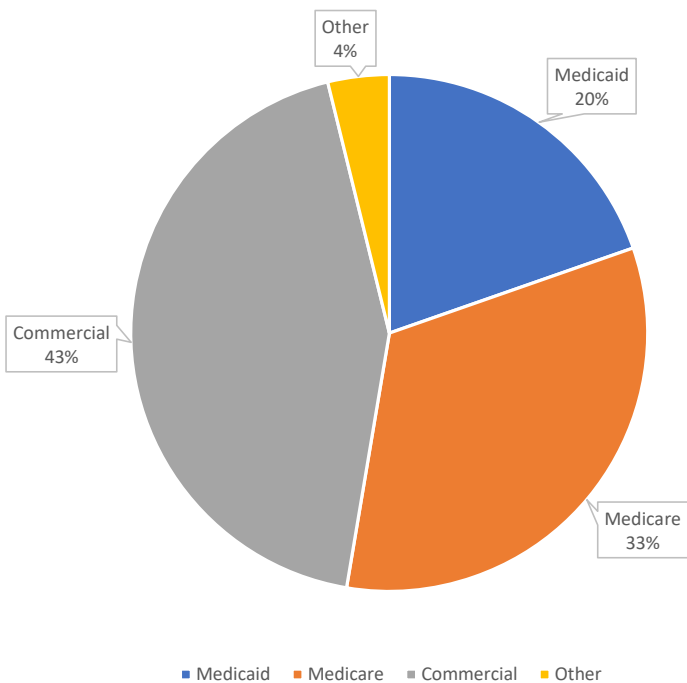
- Managed Care Contracting at UW Medicine
- *How are we paid?* – FFS Reimbursement Systems/Methodologies
- How Medicare Impacts All Reimbursement
- Key Takeaways
- Q&A

Contracting at UW Medicine

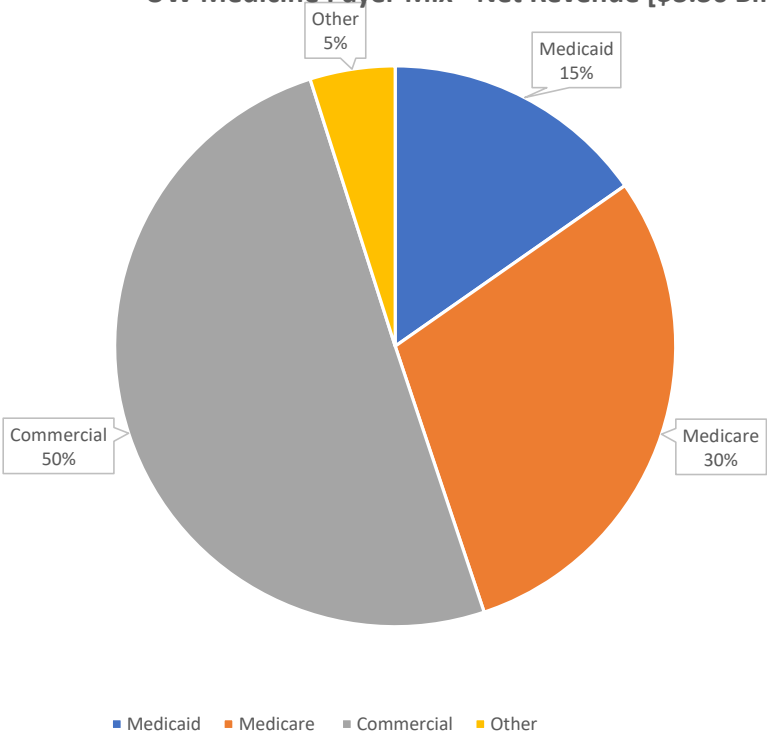
- All reimbursements for medical services negotiated by UW Medicine Contracting & Payer Relations Department (“Contracting”)
- Hospitals, UWP, and Airlift Northwest
- Commercial and Government/Managed Government payers (Medicare, Medicaid, Tricare, VA, etc.)
- Negotiations focus on total annual dollar reimbursement by UW Medicine entity and UW Medicine system
- \$ 3.4 Billion in annual reimbursement
- Key factors in contracting: payer mix, acuity mix, market trends, institutional mission, language, access, law/regulations

UW Medicine Payer Mix

UW Medicine Payer Mix - Gross Charges [\$10.5 Billion]



UW Medicine Payer Mix - Net Revenue [\$3.36 Billion]



CDM

- “Gross Charge”
- CDM = Charge Description Master (Charge Master)
- Hospital’s comprehensive list of charges for billable services and items, including:
 - Medical procedures and therapies
 - Lab tests
 - Imaging
 - Room and board
- Legally required to be publicly available (on UW Medicine website)
- Professional service fees – “Fee Schedule”
- Is payer reimbursement ever greater than the amounts we charge?
- Concept of “Lesser-Of”

How we are paid: Typical Payment Methods

Reimbursement is rooted in Medicare methodology:

DRG/MS-DRG

- Diagnosis Related Group
- 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.

“Understand Medicare, Understand All”

Typical Payment Methods...

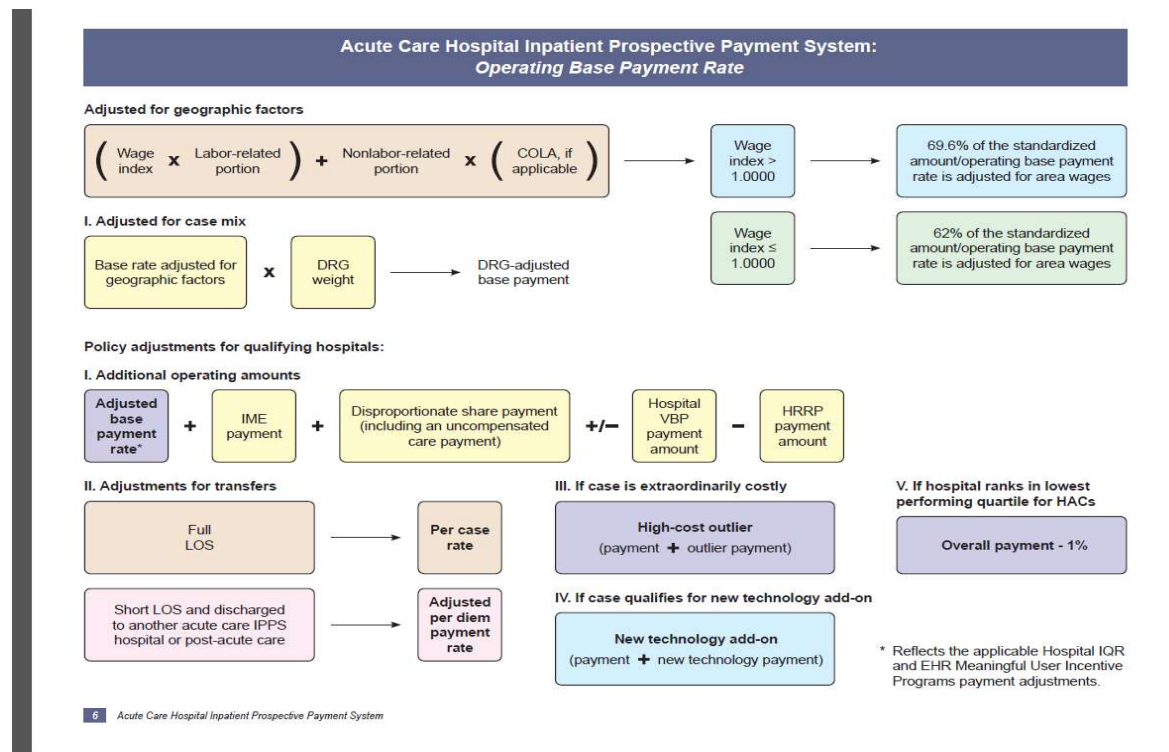
Today we will focus on the following CMS reimbursement systems:

- Inpatient Hospital Reimbursement
 - DRG/IPPS
- Outpatient Hospital Reimbursement
 - APC/OPPS
- Professional Fee Reimbursement
 - RVU/RBRVS
- Question: how do billed/gross charges influence how we are paid?

DRG – “Diagnosis-Related Grouper”

- CMS/Medicare Concept
- Inpatient services
- Lump sum
- Facility Specific Base (e.g., \$7744)
- Service Specific Weight (e.g., 5.2054)
- $\text{Base} \times \text{Weight} = \text{Payment}$
- Base and Weights set by CMS (annual rule)
- *IME, GME, DSH, Capital, Uncompensated Care; Outlier*
- DRG Versions
- See CMS Inpatient Prospective Payment System (“IPPS”)
- MS-DRG, APR-DRG, DRG

IPPS – Inpatient Prospective Payment System



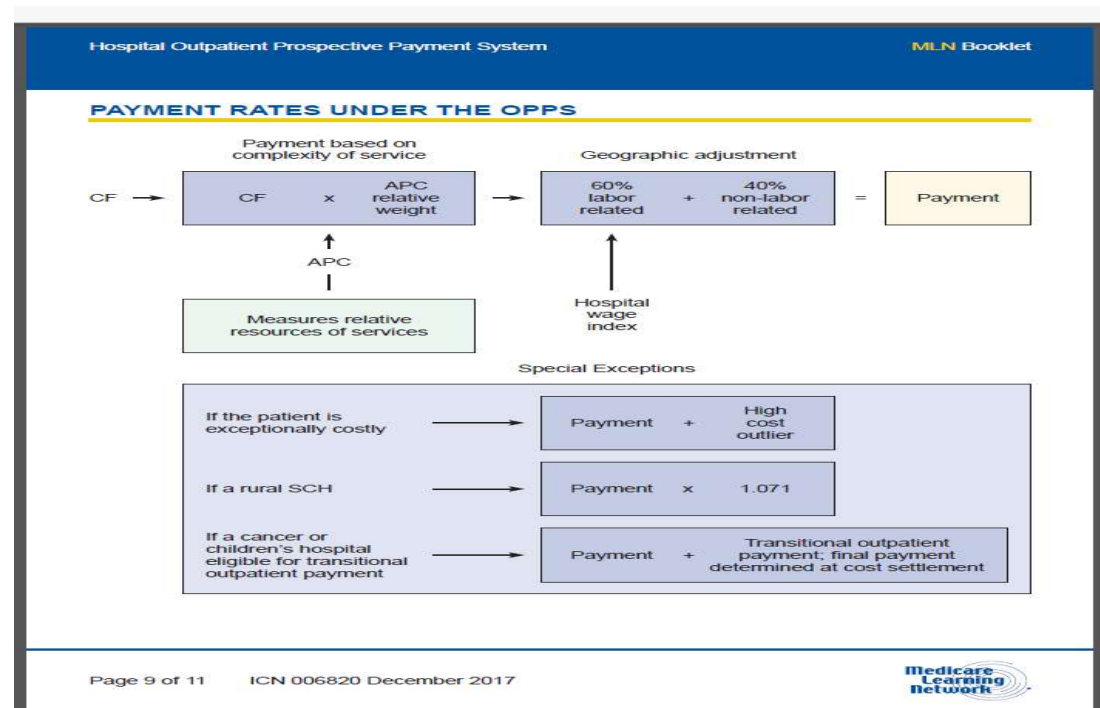
- Base x Weight

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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)
- $\text{Conversion Factor} \times \text{Weight} = \text{Payment}$
- *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
- $\text{Conversion Factor} \times \text{RVU value} = \text{Payment}$
- 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

×

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](#).

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ICN 006814 February 2017



- Conversion Factor x RVU Value

Medicare's Influence on Commercial Reimbursement

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

CMS Influence on 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 than 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 for all business lines are made pursuant to a Medicare-like method
 - CMS Bases/CFs and Weights Set by CMS/HCA
 - Bases/CFs vary by **facility** (not by provider or specialty)
 - CMS Professional Conversion Factors based upon geographic region
- FFS does not incentive cost efficiency or wellness/prevention like VB models can
- Efficiency in utilization (**cost management**) is key to success in current business environment – “Cost is King”

Break



The evolving role of value-based payment models



MICHAEL MYINT, MD MBA

Sept 2026

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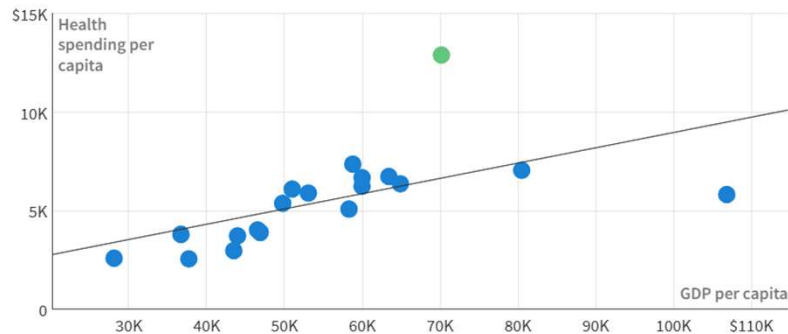
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Do we get the clinical value we are paying for?

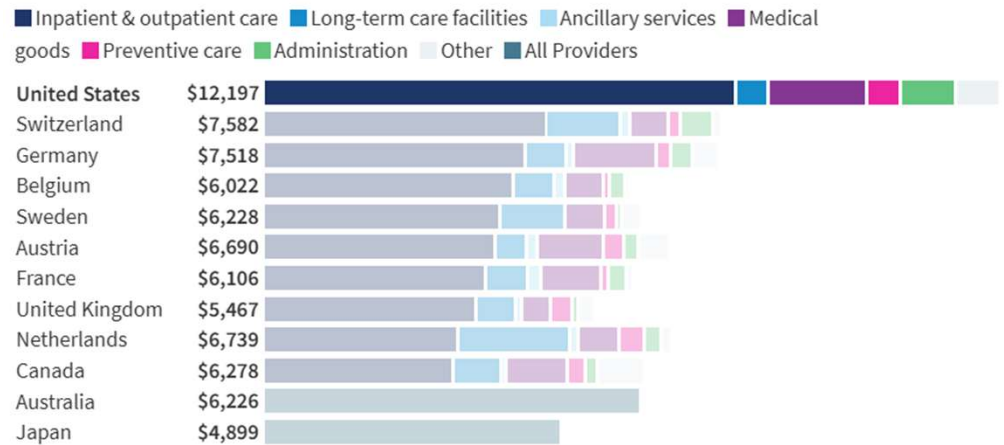


Healthcare in the US

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



Health Spending Per Capita, U.S. Dollars, 2021



Note: Total per capita spending for Australia and Japan is not broken out by service due to lack of available data.

Source: Organisation for Economic Co-Operation and Development • [Get the data](#) • [Download PNG](#)

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Health System Tracker

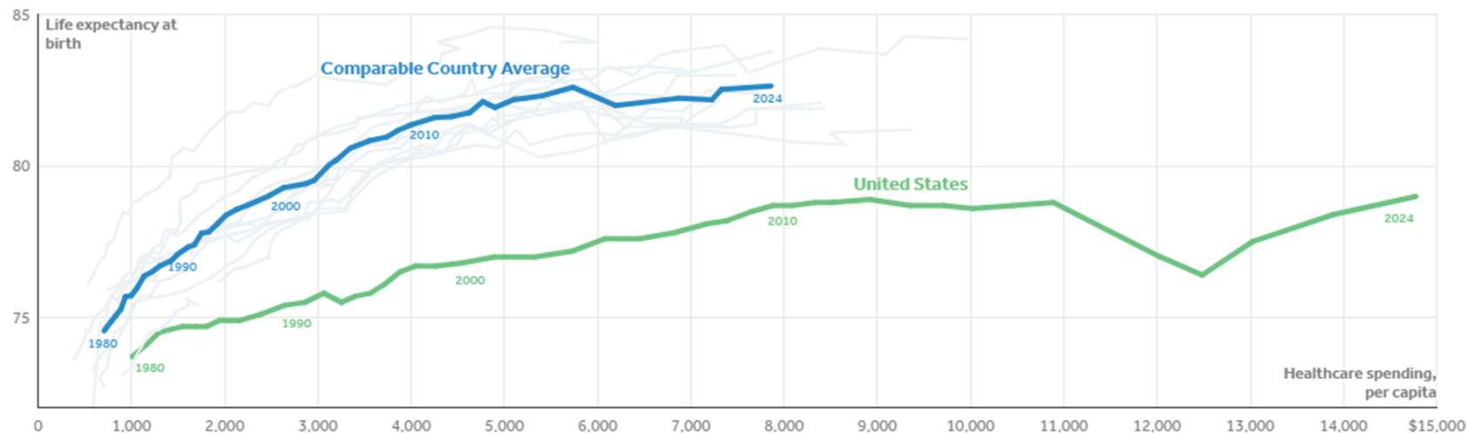
- Very complex payment models lead to a high administrative burden
 - Admin costs in the US \$1,055 per capita (Germany #2 at \$306)
 - US physicians devote 13% of working hours vs 8% in Canada
 - At least half of administrative expenditures are considered wasteful.

[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](#)

Since the 1980s, the US has spent more with less population-based success

Life expectancy and healthcare spending per capita, 1980-2024



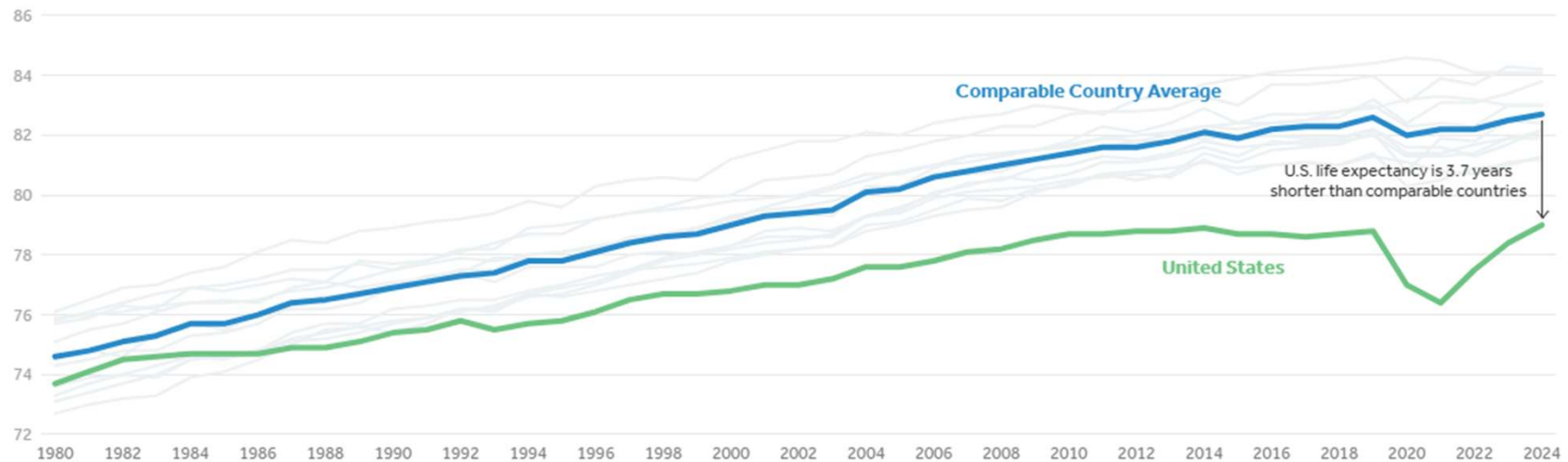
Notes: Health spending per capita data represent health consumption spending per capita. Comparable countries include: Australia, Austria, Belgium, Canada, France, Germany, Japan, the Netherlands, Sweden, Switzerland, and the U.K. See Methods [section](#) of "How does U.S. life expectancy compare to other countries?"

Source: KFF analysis of life expectancy data from the [OECD](#) and official health and statistics department websites and health expenditure data from the [OECD](#) and [National Health Expenditure \(NHE\)](#) • [Get the data](#) • [PNG](#)

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Among peer countries, the U.S. had the lowest life expectancy at birth for both women and men

Life expectancy at birth, in years, 1980-2024



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?"

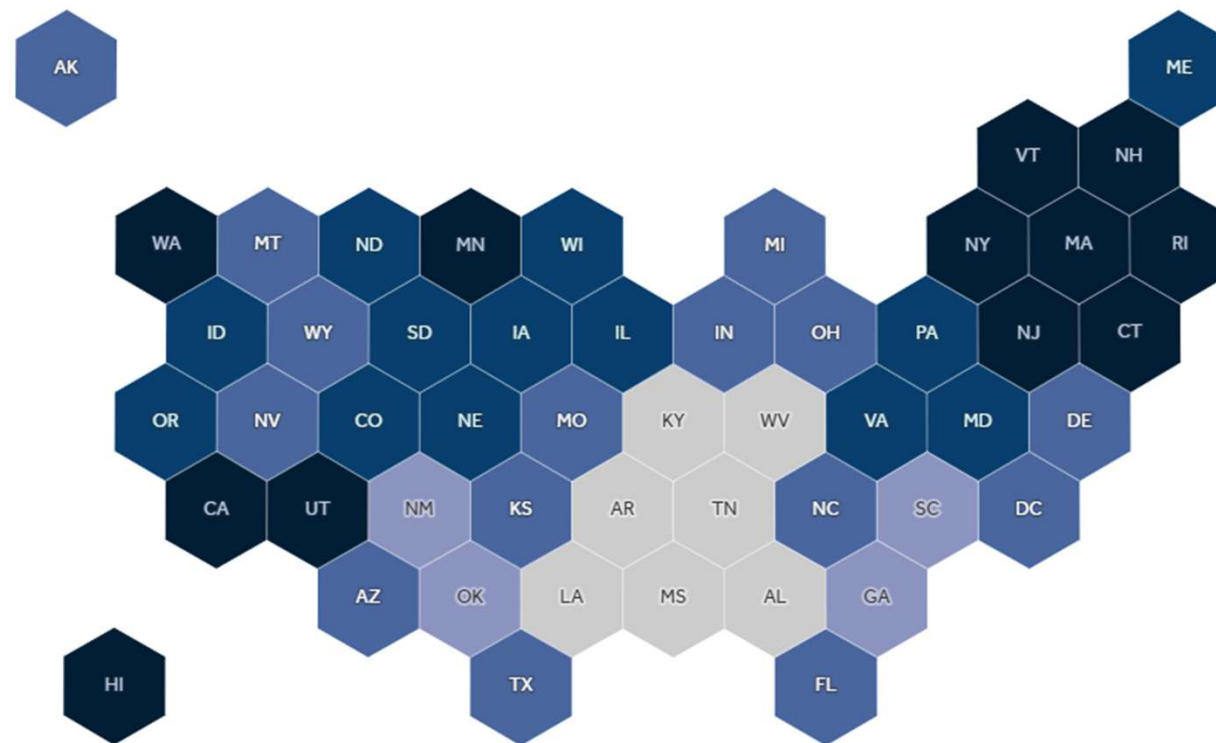
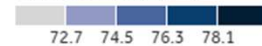
Source: KFF analysis of life expectancy data from the [OECD](#) and official health and statistics department websites. • [Get the data](#) • [PNG](#)

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Geography Is health Destiny

Life expectancy at birth, by state, 2021

U.S. average: 76.4 years

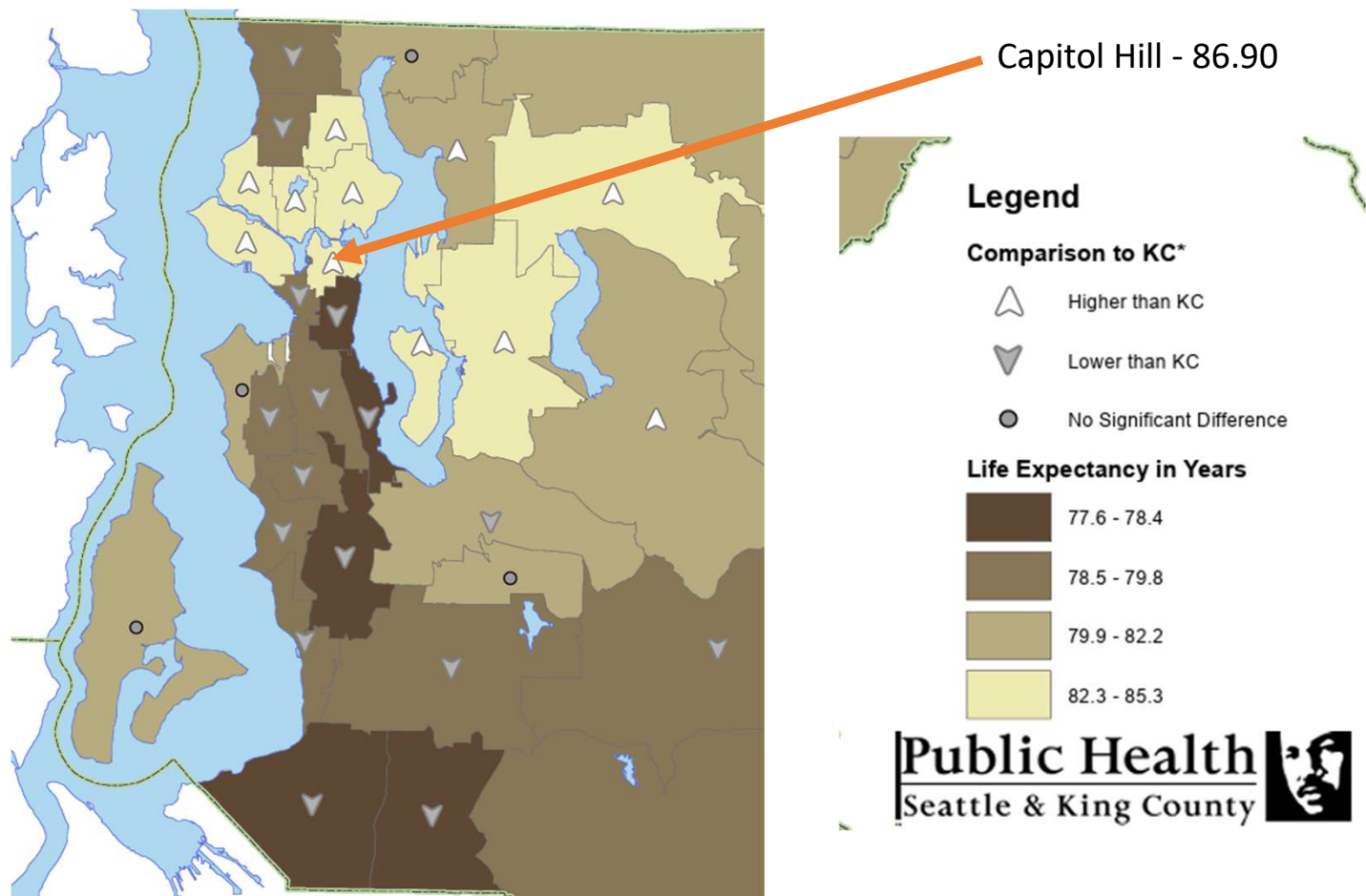


Source [National Center for Health Statistics, National Vital Statistics System, CDC](#) • Map data: [Tilegrams/NPR](#) • [Get the data](#) • [PNG](#)

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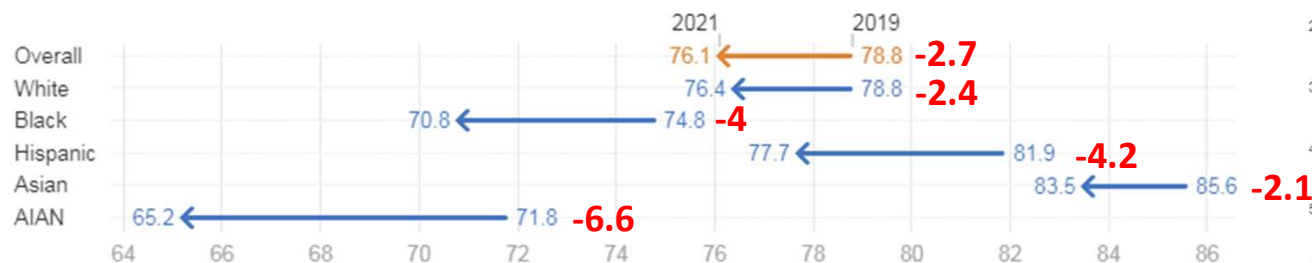
Local differences in life expectancy 2003-2007



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

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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

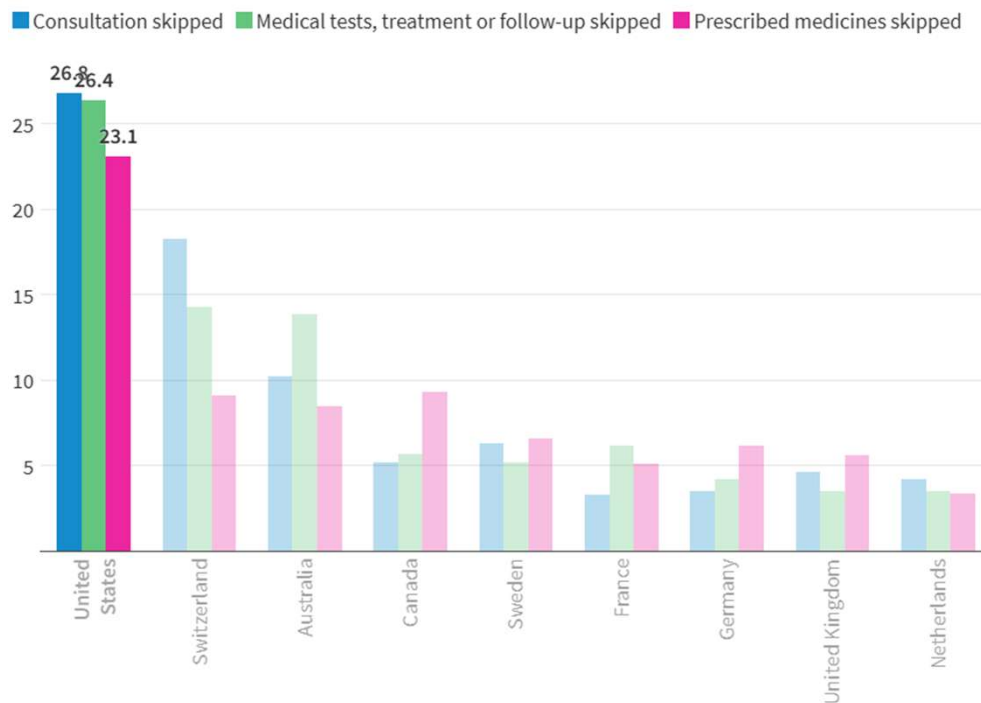
Rank	White		Black		Hispanic	
	2019	2021	2019	2021	2019	2021
1	Heart disease (166.4)	Heart disease (179.8)	Heart disease (208.6)	Heart disease (226.2)	Cancer (105.6)	COVID-19 (151.8)
2	Cancer (152.0)	Cancer (153.7)	Cancer (173.1)	Cancer (167.4)	Heart disease (111.3)	Heart disease (119.0)
3	Chronic respiratory (43.7)	COVID-19 (93.5)	Accidents (52.2)	COVID-19 (136.4)	Accidents (35.1)	Cancer (105.1)
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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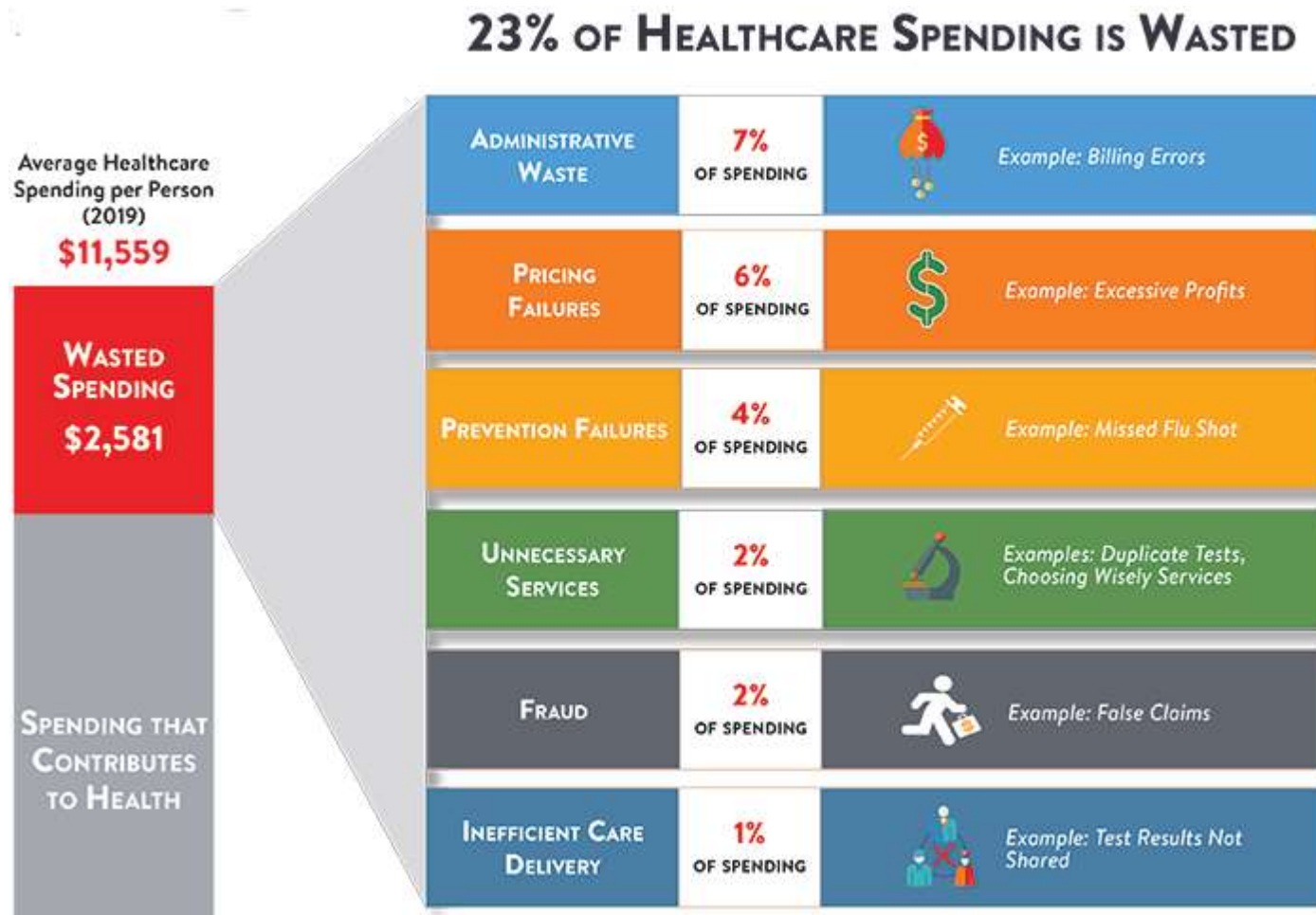
More than 1 in 4 Americans skip healthcare due to costs

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](#)

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<https://jamanetwork.com/journals/jama/article-abstract/2752664>

What if UW Medicine ran 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.

“Every system is perfectly designed to get the results it gets” W. Edwards Deming

Healthcare and
Population Health
Management

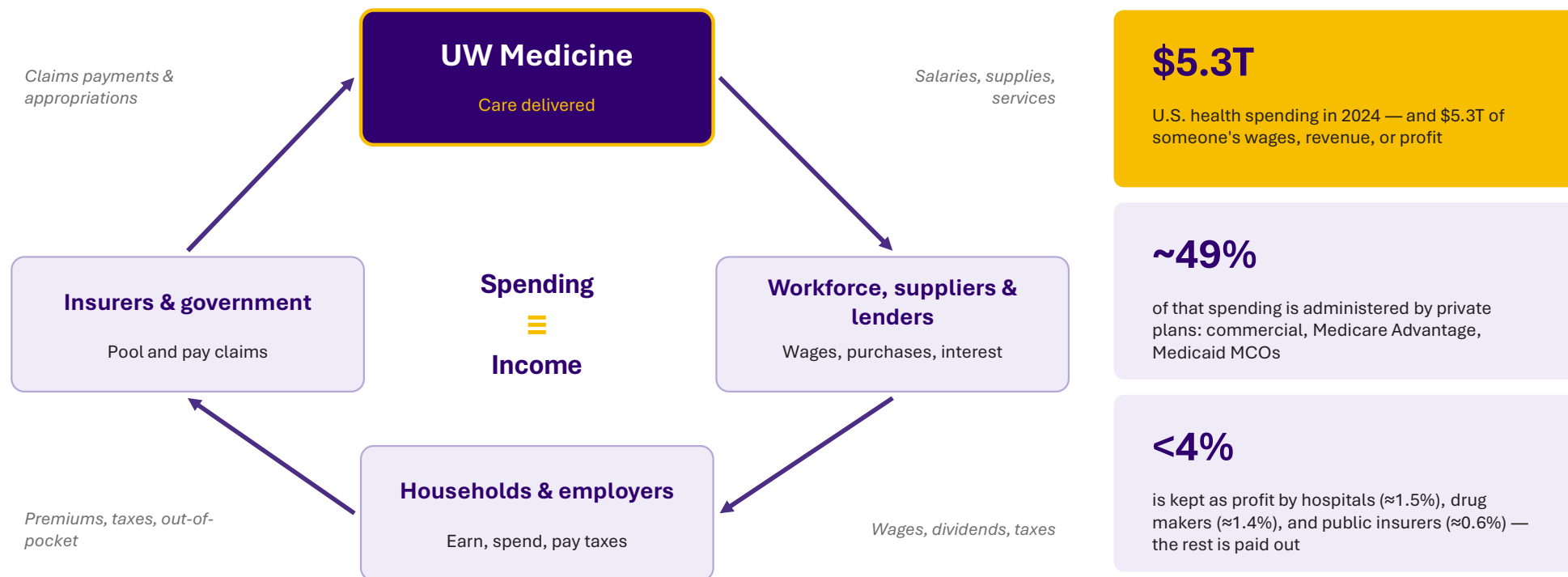


Healthcare Finance

- Payment models
- incentives

VARIATION D · THE CLOSED LOOP

Health Care Spending Is Health Care Income



Example – Commercially insured patient with an avoidable ED visit.

Sources: CMS National Health Expenditures 2024 (\$5.28T). Profit estimates: Kaufman Hall 2024 hospital margin; IQVIA 2024 net manufacturer revenue × ~15% margin; Becker's 2024 net income of seven public payers.

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

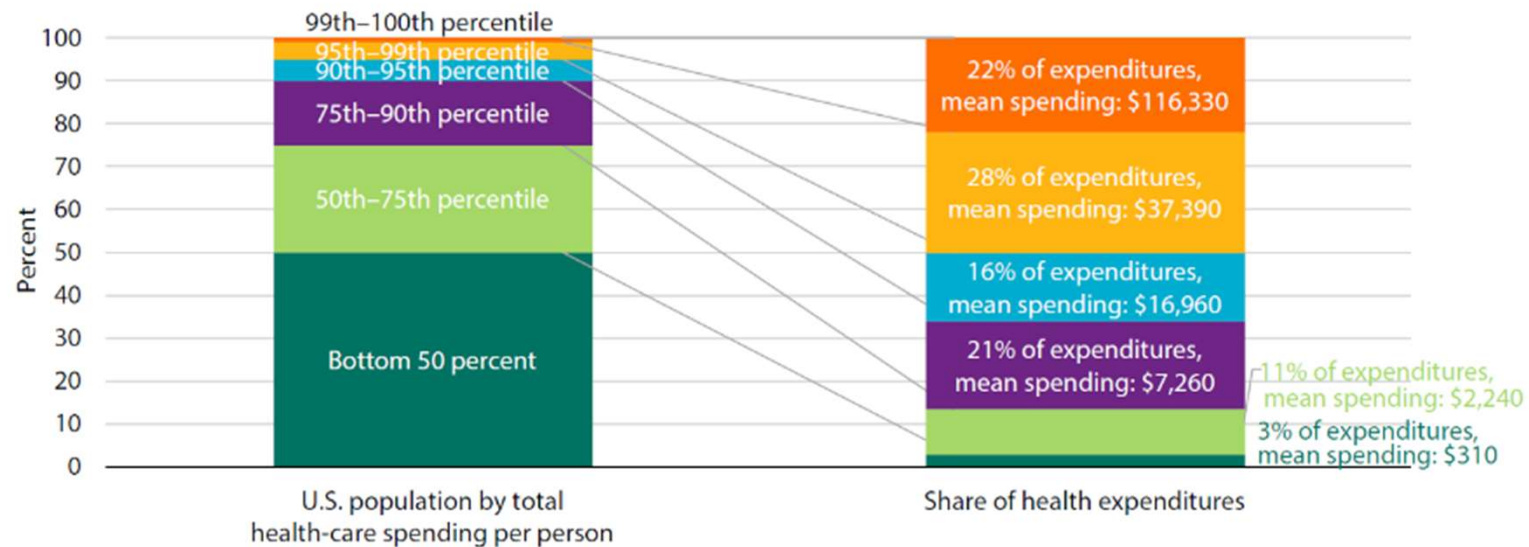
- Wellness
- Most cost-effective modalities of care
- Cost-effective sites and workflows of care
- Improved Patient experience
- Innovation for access
- Equity



Intensity of care drives much of US healthcare spend

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

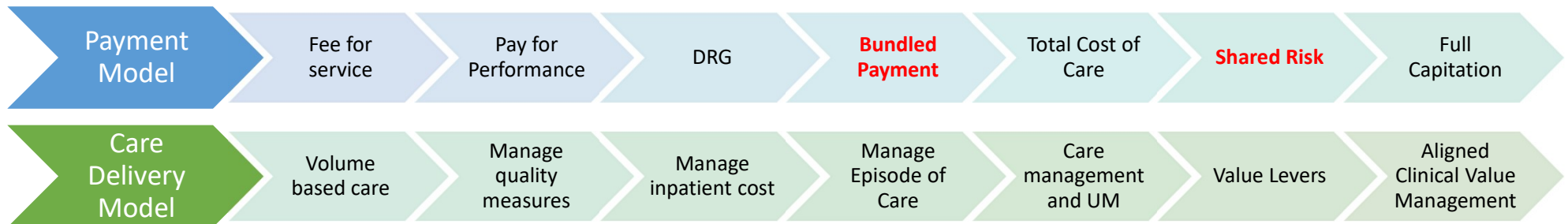
Bipartisan support continues to exist for Medicare to offload management of clinical value to other entities which could include insurers, venture-capital backed integrated systems, or traditional healthcare systems.

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



- 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.

Value-based payment model Challenges

- Contradicts the care/finance model in an integrated healthcare system
- 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
- Funds Flow

AMBULATORY ECONOMICS

Same Primary Care Visit, Two Business Models

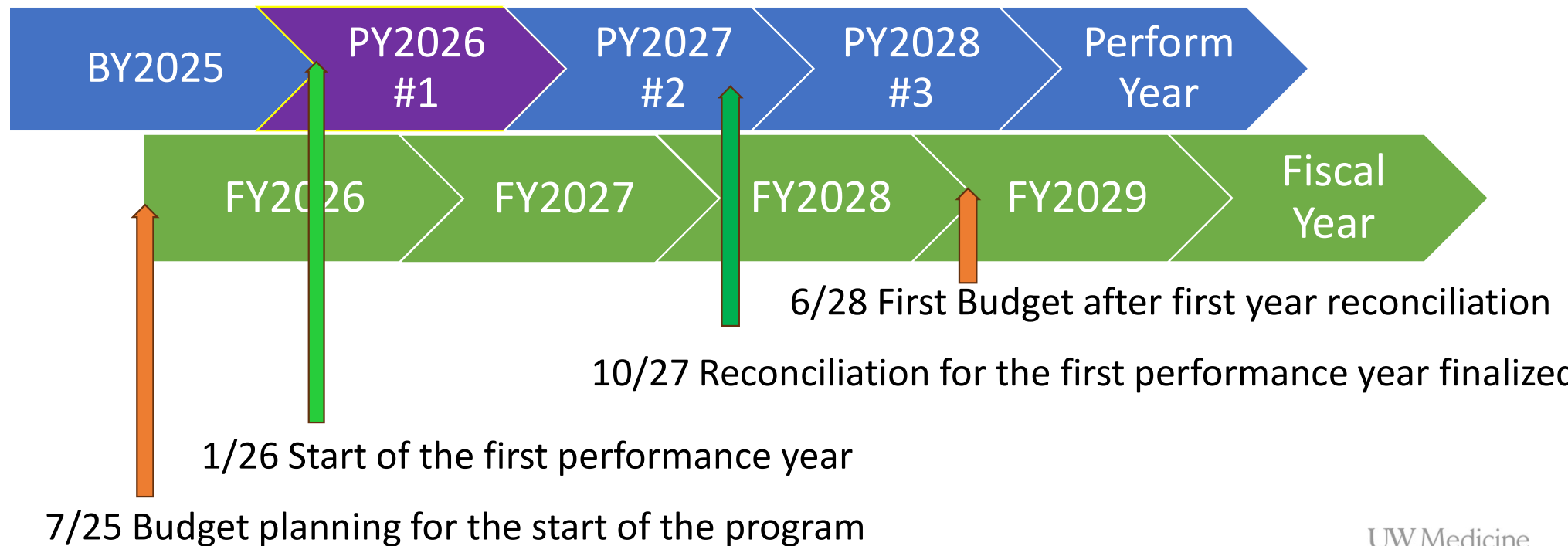
	PRIMARY-CARE-ANCHORED GROUP e.g., Vancouver Clinic — physician-owned, 500+ clinicians, ~20 sites, no hospital	HOSPITAL-CENTERED HEALTH SYSTEM Employed primary care feeding hospital-based services
How the money flows	<pre> graph LR A[Primary care the front door] --> B[In-house lab In-house imaging Group-owned ASC] B --> C[Group keeps the margin] </pre>	<pre> graph LR A[Primary care run at a loss] --> B[Hospital outpatient lab & imaging Admissions Hospital OR] B --> C[Hospital keeps the margin] </pre>
Role of primary care	The front door and the core business; physician-owners share in the whole enterprise's margin	A loss leader: health systems lose a median ~\$307K per employed physician FTE, justified by downstream referrals
Lab & imaging	In-house clinical lab plus X-ray, CT, MRI, 3D mammography, ultrasound and nuclear imaging at office rates	Hospital outpatient lab and imaging at facility rates (commercial chest X-ray priced 238% higher than in an office)
Surgery & procedures	Group-owned ASC across 9 service lines (GI, ortho, ENT, urology, ophthalmology...); Medicare pays ASCs ~54% of HOPD rates	Hospital ORs and HOPDs; each family physician drives ~\$2.1M/yr (internist ~\$2.7M) in hospital revenue
Fit with value-based care	Aligned: lower-cost sites keep savings inside the group; actively growing Medicare Advantage risk	Conflicted: moving care out of the hospital shrinks the revenue that subsidizes primary care

Independent groups make primary care pay by owning the lab, the scanner, and the ASC. Health systems make it pay through the hospital, which is why value-based care challenges the loss-leader model.

Sources: Vancouver Clinic (tvc.org; PracticeLink); Kaufman Hall/Vizient May 2025 (loss per employed physician FTE, all specialties); Merritt Hawkins 2019 revenue survey; MedPAC Mar 2025; KFF (BCBS 2022 commercial prices).

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



Reductionist and multiple 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
- Over 50 measures across nearly 20 value-based programs

Bundled payment models

NEW – CJR-X now mandated for lower extremity joint replacements starting Jan 2028

- 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 procedure) plus 30 or 90 days of costs.
 - Two “live” programs Regence EOC
 - CJR-X now mandated starting January 2028



LEAD (Long-term Enhanced ACO Design) Model

DRAFT 09-03-26

PROGRAM FEATURES

Designed to support a broader range of health systems and clinical practices in succeeding in Accountable Care Organization (ACO) models

10-year Medicare Innovation Center Model, only assured entry point is Jan 2027

Total cost of care (Medicare Parts A and B) accountability, shared savings/losses, quality-adjustment

Upfront \$ with no repayment for high spend organizations -
-> from Medicare's standpoint, a spend-now-to-save-later model

Prospective primary care capitation

Positive financial modeling for UWM over 5 years



LEAD (Long-term Enhanced ACO Design) Model

DRAFT 09-03-26

Program Evaluation

Adds resources for the Original Medicare patient population while enabling us to invest, build capacity, and enhance care across all populations

- Investments and operational innovation both in primary care and across the care continuum needed for success – standardized care management models are mission-critical
- Systematic value-based accounting and funds flow needed to support investment and re-investment where it is needed – multiple specific accounting streams needed
- Learning Health System-ready opportunity – integrate with QI and scholarly work
- Built for integrated health systems without historic focus on Medicare Shared Savings



LEAD

NOTES:

- For the claims-based and CAHPS measures, the denominator is LEAD patients
- For the diabetes and blood pressure measures, the denominator is *all* patients, *all* payers for UWM

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LEAD Performance Measures

Table 17: Summary of LEAD Quality Measures

Measure	Source	Method of Data Submission	Domain	Pay for Performance/ Pay for Reporting
Risk-Standardized All-Condition Readmission	ACO REACH	Claims	Care Coordination/ Patient Safety	Pay for Performance
All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	ACO REACH	Claims	Care Coordination/ Patient Safety	Pay for Performance
Days at Home for Patients with Complex, Chronic Conditions	ACO REACH	Claims	Care Coordination/ Patient Safety	Pay for Performance
Timely Follow-Up After Acute Exacerbations of Chronic Conditions	ACO REACH	Claims	Care Coordination/ Patient Safety	Pay for Performance
CAHPS Survey	ACO REACH	Patient-Reported	Patient/Caregiver Experience	Pay for Performance
Diabetes: Glycemic Status Assessment Greater Than 9%	New	eCQM	Prevention and Management of Chronic Diseases	PY 1-2 Optional PY 3-4 Pay for Reporting PY 5-10 Pay for Performance
Controlling High Blood Pressure	New	eCQM	Prevention and Management of Chronic Diseases	PY 1-2 Optional PY 3-4 Pay for Reporting PY 5-10 Pay for Performance

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?

① Start presenting to display the poll results on this slide.

Evaluation



Questions and feedback?



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QUESTIONS?

