Healthcare Finance Trends and Perspectives

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Chuck Alsdurf, MAcc, CPA
Director, Healthcare Finance Policy, Operational Initiatives
Healthcare Financial Management Association (HFMA)
Discussion Topics

- Environmental Update & Transition to Value
- Bundled Payment Overview
- Other Current Issues
- Challenges Ahead
- Key Takeaways
Uninsured rates are decreasing...

Figure 2
Quarterly Uninsured Rate for the Nonelderly Population by Age, Q4 2013-Q1 2015

...out-of-pocket costs remaining high for exchange plans....

### 2014 Average Benefits by Plan Type

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Bronze</th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avg. Ind. Deduct.</td>
<td>$5,081</td>
<td>$2,907</td>
<td>$1,277</td>
<td>$347</td>
</tr>
<tr>
<td>Avg. Fam. Deduct.</td>
<td>$10,386</td>
<td>$6,078</td>
<td>$2,846</td>
<td>$698</td>
</tr>
<tr>
<td>% Covered Expenses</td>
<td>60%</td>
<td>70%</td>
<td>80%</td>
<td>90%</td>
</tr>
<tr>
<td>OOP Max Ind.</td>
<td>$6,267</td>
<td>$5,370</td>
<td>$4,081</td>
<td>$1,855</td>
</tr>
<tr>
<td>OOP Max. Fam.</td>
<td>$12,569</td>
<td>$11,495</td>
<td>$8,649</td>
<td>$3,710</td>
</tr>
</tbody>
</table>

### 2015 Enrollment on Exchanges

- Bronze
- Silver
- Gold
- Platinum

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1Source: Dept. of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, ASPE Issue Brief: Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report (March 10, 2015)

2Source: HealthPocket.com; averages across 34 states
...and employer plan premiums continue to climb...
…and even those insured are challenged to pay bills…

Figure 8
Problems Paying Medical Bills Among Low- and Middle-Income Nonelderly Adults, by Insurance Coverage in Fall 2014

NOTE: Includes adults ages 19-64. “Previously Insured” includes people who were insured as of interview date and have been insured since before January 2014. “Newly Insured” include people who were insured as of interview date and gained coverage since January 2014. “Uninsured” includes people who lacked coverage as of the interview date.

* Significantly different from Newly Insured at the p<0.05 level.

…with varying levels of knowledge…

Very or Somewhat Confident in Understanding of the Term: “Deductible”

Nongroup: Nonelderly adults currently purchasing individual coverage and not eligible to buy health insurance through an employer or other group.  
Source: Urban Institute Health Policy Center - Health Reform Monitoring Survey, 2013
…pushing significant and necessary change in the patient financial experience…

Historical Model

Gather basic info before & at the time of service.

Billing process is post-service. Amount due is based on data gathered after service, calculated retrospectively.

Patients told of financial obligations after insurance is billed & paid.

The Near Future

Gather detailed info before & at time of service. Estimate out-of-pocket costs.

Bill at or right after service. Many patients know in advance what they owe & agree on terms.

Insurance bill verifies what patient already expects.
...and increasing competition from retail healthcare...

- Retail healthcare gaining momentum
  - Walgreens, CVS and Walmart providing non-urgent care for affordable rates
  - As High Deductible Health Plans (HDHP) increase across the country, these retail clinics are less costly than a visit to an urgent care or primary care physician
  - Full payment is handled at time of service

- Private companies opening increasing number of Urgent Care centers
  - Similar to retail clinics, these are more convenient than scheduling an appointment
…driving value-based payment models

- Medicare Shared Savings & Pioneer ACO
  - At-risk portion of Medicare payments with quality metrics impacting financial outcome
- Bundled Payment Models
  - Governmental and commercial models combining different aspects of care episode
- Pay for Performance (MACRA/MIPS)
  - Physician and professional payment system using comparative data to incentivize quality and financial performance
Bundled Payment Overview
Definition and Purpose of Bundled Payments

• Single payment for all services provided during the defined episode of care
  – Typically less than the sum of the individual services

• Creates a package for patient and payer simplifying billing and cost for these parties

• Incent reduction in provider cost by shifting risk
  – Should result in lower patient cost as well

• Increase collaboration across hospitals, physicians, and post-acute providers

• Improve patient outcomes and experience
Shifting Risk

Payment System Reforms Will Require Providers to Bear Greater Population-Based Financial Risk

<table>
<thead>
<tr>
<th>Degree of Population Risk Transferred to Provider by Payment System</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low</strong></td>
</tr>
<tr>
<td>Fee for Service</td>
</tr>
<tr>
<td>Paid for each unit of service w/o constraint on spending</td>
</tr>
</tbody>
</table>
Current Models

• Reconciliation Model
  – Billing practices remain the same
  – Total savings or overages are determined after ‘performance period’
  – If savings target achieved, payer sends payment to provider(s)
  – If target not achieved, provider(s) send payment to payer
    ▪ Example: Comprehensive Joint Replacement (CJR) model

• Global Payment Model
  – Consolidated claim/bill submitted
  – Single episodic payment received by primary provider or ACO and then distributed amongst all providers for that episode
    ▪ Would require agreement with other providers in advance of care being provided
    ▪ System mechanics would need to be revised
  – Example: Medicare Acute Care Episode (ACE) model
Current Models

• Per Member Per Month (PMPM) Model
  – Similar to Periodic Interim Payment structure (PIP)
  – If performance targets achieved, payer sends payment to ACO, if not, ACO owes payer
  – May or may not follow financial structure of Global Payment model in that the ACO will adjudicate claims/bills from care providers
  – Example: Medicare Oncology Care Model (OCM)

• Direct Employer and Commercial Payer Models
  – Employers are beginning to work directly with providers in an effort to deliver affordable, high quality care to their employees
  – Commercial payers utilizing various models depending on region, providers and patient population
Bundled Payment System:

1: Current Payment Methodology:

- MS-DRG Pmt
- Physician Fee Schedule (PFS)
- Home Health PPS Episode
- Readmission: MS-DRG Pmt

Sample Inpatient Stay:

- 3 Days Admit
- 7 Days Discharge
- 14 Days +
- 19 Days +
- 27 Days +
- 30 Days +

30 Day Episode of Care

2: Bundled Payment System:

- MAC: Payment
- NORIDIAN
- MS-DRG + PFS + Avg. PAC Cost - “Efficiencies” - Readmissions
- Medicare Provider
- Negotiated Pmts

Illustration of Bundled Concept
Collaboration

• All providers involved in episode of care must work together to increase coordination and efficiency

• Relationships and agreements will need to be established for compliant and efficient operational and financial structures

• Need for infrastructure investments to support operational model
Volume Remains an Important Factor

Not Surprisingly, the Bundled Payments for Care Improvement (BPCI) Episodes Including the Most Common MS-DRGs Are the Most Prevalent

**Most Prevalent BPCI Clinical Episodes in Models 2–4**

<table>
<thead>
<tr>
<th>Clinical Episode</th>
<th>Number of Episodes</th>
<th>Percentage of Total Episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major joint replacement of the lower extremity</td>
<td>360</td>
<td>7.2%</td>
</tr>
<tr>
<td>Simple pneumonia and respiratory infections</td>
<td>247</td>
<td>4.9%</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>239</td>
<td>4.7%</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease, bronchitis, asthma</td>
<td>229</td>
<td>4.5%</td>
</tr>
<tr>
<td>Sepsis</td>
<td>179</td>
<td>3.6%</td>
</tr>
</tbody>
</table>

The five most prevalent Clinical Episodes account for 1,254 episodes, 24.9% of the Clinical Episodes currently being tested in BPCI.

Source: CMS Innovation and Health Care Delivery System Reform, Amy Bassano, Director Patient Care Models Group, CMMI, Presentation to HFMA’s BPCI Council, June 22, 2015
Direct Contracting with Centers of Excellence

Walmart → Baylor Scott & White → Cleveland Clinic

Sources:
1) http://thehealthcareblog.com/blog/2012/10/18/walmart-moves-health-care-forward-again/
2) http://my.clevelandclinic.org/about-cleveland-clinic/newsroom/releases-videos-newsletters/lowes_expands_heart_healthcare_benefits
Other Current Issues

- Mergers and Acquisitions continue across the country in provider and health plan segments

- Cost of new IT systems adding to expense base of many health systems and physician practices

- Not-for-profit status of some providers could be challenged

- Presidential election will likely create another round of change to ACA
Challenges Ahead

• **Aligning goals** amongst providers delivering services

• Measuring **current cost** of delivering services

• Delivering care at a **lower cost**

• Changes in **risk pool** of patients receiving bundled services

• Accuracy and timeliness of **performance data**
Core Capabilities

Capabilities Necessary to Improve Value Are Mutually Reinforcing…

Collaboration, accountability, and communication
People and Culture

Measurement, assessment, and mitigation of risk
Contract and Risk Management

…and Require Clinicians and Finance Staff to Collaborate

Elimination of variation, unsafe practices, and waste
Performance Improvement

Data and metrics
Business Intelligence

Value

hfma healthcare financial management association
## Successful Organizations Emphasize Project Management and Execution

### Project Selection

**Criteria:**
- Quality/safety
- Patient satisfaction
- Cost reduction

**Enablers:**
- Understand constraints
- Existing best practice

### Project Management

**Keys to Success:**
- Specific goals and measurements
- Formal review meetings
- Assigned responsibility for results
- Build savings into budget

### Project Execution

**Keys to Success:**
- Cross-functional teams
- Allow flexibility for local differentiation
- Allow freedom for experimentation
- Provide platform for knowledge transfer
Flying Blind

Few Organizations Are Measuring, Let Alone Managing the Impact of Value Reducing Events

<table>
<thead>
<tr>
<th>MEASUREMENT AND USE OF BUSINESS INTELLIGENCE</th>
<th>Not</th>
<th>Measure</th>
<th>Manage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costs of Adverse Events</td>
<td>43%</td>
<td>37%</td>
<td>20%</td>
</tr>
<tr>
<td>Margin Impact of Readmissions</td>
<td>38%</td>
<td>42%</td>
<td>20%</td>
</tr>
<tr>
<td>Cost of Waste in Care Processes (i.e. duplicative/unnecessary tests/procedures)</td>
<td>50%</td>
<td>29%</td>
<td>21%</td>
</tr>
</tbody>
</table>

**Source:** HFMA Value Project Survey, January 2011.
Providers Must Develop A Consistent Knowledge Strategy

Knowledge Strategy

Data  Timely

Analysis  Definition

Knowledge
Inaccurate

Providers Must Work to Improve the Accuracy of Their Base Costing Data

“To put it bluntly, there is an almost complete lack of understanding of how much it costs to deliver patient care, much less how those costs compare with the outcomes achieved.”

While Providers Believe Costing Accuracy Will Improve in the Future…

Percentage of Respondents Stating “At the Patient Level, My Organization Can…at A High Level:”

- Costing
- Clinical Data Mart
- Coding

Future Planning

…Investments in Costing Systems Aren’t Prioritized

Percentage Respondents Indicating Category Is “Bottom Priority”

- Costing: 39%
- Data Mart: 47%
- Clinical: 10%
- Coding: 4%
Key Takeaways

• Healthcare reform has impacted uninsured rates as well as out-of-pocket costs for consumers

• Education and communication are critical for both providers and patients

• The payment models will evolve and vary depending on payer, providers and type of service

• Managing the efficient delivery, cost, and quality of care will be key to success as additional risk shifts to providers