The Quest for Value: Clinical and Financial Leadership in Healthcare

Katie Gilfillan, MSW, CHFP
Director, Healthcare Finance Policy, Physician and Clinical Practice
Healthcare Financial Management Association
HFMA represents 41,000 + leaders in healthcare finance, clinical medicine, and health plans.

We bring together professionals across the healthcare continuum to collaborate and deliver value.

OUR MISSION
Leading the financial management of health care

OUR VISION
HFMA will bring value to the industry as the leading organization for healthcare finance
Agenda

- Shift to Value
- 5 Areas of Need for Clinical Leadership
- HFMA Resources
The Shift to Value
Prices for healthcare are growing faster than prices in the general economy.

National Health Expenditures: 2018-2027 national health spending is projected to grow at an average rate of 5.5 percent per year for 2018-27 to reach nearly $6.0 trillion by 2027.

Source: Altarum analysis of monthly BLS price data and monthly GDP data published by Macroeconomic Adviser. Get the data.
Cost of healthcare continues to rise for patients

**Premiums and Deductibles Rise Faster than Worker’s Wages Over Past Decade**

- **Workers’ Earnings**: 2009=100
- **Overall Inflation**: 2009=100
- **Family Premiums**: 2009=100
- **Deductibles**: 2009=100

<table>
<thead>
<tr>
<th>Year</th>
<th>Workers’ Earnings</th>
<th>Overall Inflation</th>
<th>Family Premiums</th>
<th>Deductibles</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>2010</td>
<td>110</td>
<td>105</td>
<td>105</td>
<td>110</td>
</tr>
<tr>
<td>2011</td>
<td>120</td>
<td>110</td>
<td>110</td>
<td>120</td>
</tr>
<tr>
<td>2012</td>
<td>130</td>
<td>115</td>
<td>115</td>
<td>130</td>
</tr>
<tr>
<td>2013</td>
<td>140</td>
<td>120</td>
<td>120</td>
<td>140</td>
</tr>
<tr>
<td>2014</td>
<td>150</td>
<td>125</td>
<td>125</td>
<td>150</td>
</tr>
<tr>
<td>2015</td>
<td>160</td>
<td>130</td>
<td>130</td>
<td>160</td>
</tr>
<tr>
<td>2016</td>
<td>170</td>
<td>135</td>
<td>135</td>
<td>170</td>
</tr>
<tr>
<td>2017</td>
<td>180</td>
<td>140</td>
<td>140</td>
<td>180</td>
</tr>
<tr>
<td>2018</td>
<td>190</td>
<td>145</td>
<td>145</td>
<td>190</td>
</tr>
<tr>
<td>2019</td>
<td>200</td>
<td>150</td>
<td>150</td>
<td>200</td>
</tr>
</tbody>
</table>

Primary care physicians spend on average $50,468 annually per year dealing with external quality measures.
Medical Group Management Association Cumulative % Change Since 2001 for Physician Owned Multispecialty with Primary Care Only Groups for Operating Cost, the Consumer Price Index, and Medicare Physician Payments

Practice Expenses are Rising

Medicare Payment Growth Will Not Keep Up with Practice Expenses

Reduction avoided by passage of the MACRA which abolished the SGR

- Source for change in operating cost: MGMA DataDive for Revenue and Expense
- Operating cost values for 2015 to 2020 are moving average projections of previous years’ data
- CPI is the actual annual value 2001 through 2015, then increased by 2% (the "official" inflation target used by the U.S. Federal Reserve

- Medicare Conversion Factor
- CPI
- Total Operating Cost per FTE Physician
- Medicare Conversion Factor
Costs of Waste and Potential for Savings

$760 billion to $935 billion annual cost of waste

Failure of Care Delivery $102.4 billion to $165.7 billion
Failure of Care Coordination $27.2 billion to $78.2 billion
Overtreatment/Low-Value Services $75.7 billion to $101.2 billion
Pricing Failures $230.7 billion to $240.5 billion
Fraud and Abuse $58.5 billion to $83.9 billion
Administrative Complexity $265.6 billion

JAMA. Published online October 7, 2019. doi:10.1001/jama.2019.13978
The Value Equation

\[ \text{VALUE} = \frac{\text{Quality}^{(1)}}{\text{Payment}^{(2)}} \]

\{1\} Composite of patient outcomes, safety, and experiences

\{2\} Cost to all purchasers of purchasing care
Value-based care models
ACO Growth

Growth in Covered Lives

Contract Growth by Payer

Number of ACOs

# of ACOs

# of Covered Lives

© 2018 LEAVITT PARTNERS
ACOs perform better with experience

Percent ACOs that Generate/Earn Savings Over Time

<table>
<thead>
<tr>
<th></th>
<th>% ACOs that generated savings</th>
<th>% ACOs that earned savings bonus</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-2013</td>
<td>54%</td>
<td>24%</td>
</tr>
<tr>
<td>2014</td>
<td>54%</td>
<td>52%</td>
</tr>
<tr>
<td>2015</td>
<td>52%</td>
<td>56%</td>
</tr>
<tr>
<td>2016</td>
<td>56%</td>
<td>60%</td>
</tr>
<tr>
<td>2017</td>
<td>60%</td>
<td>34%</td>
</tr>
</tbody>
</table>

Update: 2018 ACOs
- 66% Generated Savings
- 37% Earned Shared Savings

Net Program Savings/Losses Over Time

<table>
<thead>
<tr>
<th>PY</th>
<th>Net Loss/Gain to CMS (millions)</th>
<th>Net Savings Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>-$82.3</td>
<td>-0.19%</td>
</tr>
<tr>
<td>2014</td>
<td>-$49.8</td>
<td>-0.09%</td>
</tr>
<tr>
<td>2015</td>
<td>-$216</td>
<td>-0.30%</td>
</tr>
<tr>
<td>2016</td>
<td>-$39.3</td>
<td>-0.05%</td>
</tr>
<tr>
<td>2017</td>
<td>$313.7</td>
<td>0.33%</td>
</tr>
</tbody>
</table>

Update: 2018 $739M in savings to CMS

ACO Earnings by start date

<table>
<thead>
<tr>
<th>Start Date</th>
<th>% ACOs that generated savings</th>
<th>% ACOs that earned savings bonus</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/1/2012</td>
<td>53%</td>
<td></td>
</tr>
<tr>
<td>7/1/2012</td>
<td>48%</td>
<td></td>
</tr>
<tr>
<td>1/1/2013</td>
<td>42%</td>
<td></td>
</tr>
<tr>
<td>1/1/2014</td>
<td>43%</td>
<td></td>
</tr>
<tr>
<td>1/1/2015</td>
<td>28%</td>
<td></td>
</tr>
<tr>
<td>1/1/2016</td>
<td>28%</td>
<td></td>
</tr>
<tr>
<td>1/1/2017</td>
<td>21%</td>
<td></td>
</tr>
</tbody>
</table>
Next Gen ACO strategies and results

- Investments in care management
- Focus on care transitions, care management, end-of-life care and beneficiary engagement around self-management
- Expanded HIT and data analytics capacity
- SNF Benefit enhancement
- Focus on Annual Wellness Visit
- More in-network care
  - Decrease in spending in post-acute (SNF) setting
  - Decrease in inpatient hospital days
  - Decrease in non-hospital E/M visits
  - Increase in Annual Wellness Visits

CMS Findings at a Glance, NGACO Report Evaluation Performance Year 1
Bundled/Episodic Payments

**Bundled Payment for Care Improvement**

- MJRLE-NF: -$1,105**
- MJRLE-F: -$1,924**

Reductions in Total and SNF Episode Spending for Fracture and Non-Fracture Cases

*BPCI Hospital Compared to Control Hospital*

**Comprehensive Care for Joint Replacement (CJR) Model**

Average Total Episode Payments Decreased by 3.3% more for CJR than Control LEJR Episodes
Quality Payment Program

MIPS performance weights 2019

<table>
<thead>
<tr>
<th>Year</th>
<th>Quality</th>
<th>Cost</th>
<th>Improvement Activities</th>
<th>Promoting Interoperability</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>40%</td>
<td>20%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>35%</td>
<td>25%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2022</td>
<td>30%</td>
<td>30%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Advanced APMs 2019

- Bundled Payments for Care Improvement (BPCI) Advanced
- Comprehensive ESRD Care (CEC) – Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Medicare Accountable Care Organization (ACO) Track 1+ Model
- Medicare Shared Savings Program – Track 2, Track3, Level E of the BASIC track, the ENHANCED track
- Next Generation ACO Model
- Oncology Care Model (OCM) – Two-Sided Risk
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1-CEHRT)
- Vermont Medicare ACO Initiative
- Comprehensive ESRD Care (CEC) Model
- Maryland All-Payer Model (Care Redesign Program)
- Maryland Total Cost of Care Model (Maryland Primary Care Program)
- Maryland Total Cost of Care Model (Care Redesign Program)
New CMMI Models

Direct Contracting

Direct Contracting offers new forms of capitated population-based payments (PBPs), enhanced payment options, and flexibilities to increase the tools available for providers to meet beneficiaries’ medical and non-medical needs.

<table>
<thead>
<tr>
<th>Option</th>
<th>Risk Arrangement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional PBP</td>
<td>50% Savings/Losses</td>
</tr>
<tr>
<td>Global PBP</td>
<td>100% Savings/Losses</td>
</tr>
<tr>
<td>Geographic PBP (proposed)</td>
<td>100% Savings/Losses</td>
</tr>
</tbody>
</table>

Primary Care First

Primary Care First includes two payment model options for practices ready to accept increased financial risk in exchange for flexibility and potential rewards based on performance, including support for practices serving high-needs populations.
Cost Variation

Risk-Adjusted Standardized Per Capita Costs for Medicare Beneficiaries
### Overview of Three Studies

**Growth of Population Based Payments Is Not Associated with a Decrease in Market-Level Cost Growth, Yet**
- Examines whether the growth of value-based payment models is associated with decreased spending and increased quality at the market level.
- Prior studies do not assess VBP penetration at the market level; they look at outcomes/cost savings within each VBP model.

**Market Factors Associated with Medicare Costs and Cost Growth**
- Examines why markets vary in their Medicare costs and why some markets have higher Medicare cost growth than others.
- Prior research examines individual-level factors that explain Medicare cost variation; our study examines market-level factors.
- Multiple data sources for the years 2007-2015.

**What Is Driving Total Cost of Care? Analysis of Factors Influencing Total Cost of Care in U.S. Health Care Markets**
- Provides insights into the findings of the quantitative analyses and into how health care organizations and community stakeholders are responding to specific combinations of factors within their markets.
- Interviews conducted in 9 markets: Baton Rouge, LA; Billings MT; Grand Rapids, MI; Huntsville AL; Los Angeles, CA; St. Paul/Minneapolis, MN; Oklahoma City, Ok; Portland, ME; Portland, OR.

Together, the studies provide a snapshot of how markets are evolving, and what the implications are for policy markers, health systems, clinicians, health plans, and other community leaders.
Which of the following factors do you think has the most significant impact on baseline Medicare costs in your market (choose one)?

1. Hospital readmission rates
2. Socioeconomic status of the patient population
3. Prevalence of chronic disease
4. Provider concentration in the market
5. Health plan concentration in the market
6. Other
Impact of Market Factors on Medicare Baseline Costs

Legend:
- CBBSA = Core-based statistical area
- HHI = Herfindahl-Hirschman Index
- PCP = Primary care physicians
- MA = Medicare Advantage
- SES = Socioeconomic status
Medicare & Commercial Costs Across Qualitative Study Markets

Actual Medicare & Commercial Costs Across Nine Qualitative Study Markets*

Standardized Medicare & Commercial Costs Across Nine Qualitative Study Markets*

HFMA Total Cost of Care Report
Characteristics of Market Clusters

**Lower Cost Markets**
- Significant presence of one or more integrated delivery system
- Competition among a few well-organized health systems with geographic coverage
- High physician employment or alignment
- Information-sharing mechanisms for care purchasers & others

**Mid-Range Markets**
- The Portland, ME market had many of the same features as the lower-cost markets
  - The Huntsville market had:
    - Dominant presence of a single commercial payer, which depressed hospital rates
    - Little utilization management of healthcare services

**Higher Cost Markets**
- Highly fragmented (e.g., many players competing but relatively little integration of care delivery)
- Indications of higher than average utilization rates
- Tendency to segment patients and providers by socioeconomic status
5 Areas of Need for Clinical Leadership in Healthcare Finance

- Engaging and aligning physicians
- Development of data metrics and analytics
- Developing meaningful incentives
- Redesigning care pathways
- Patient financial communications
Engaging and aligning physicians
Physician Groups are Consolidating

Percentage of Physicians by Group Size, 2Q2013-4Q2017

- 0-2
- 3-9
- 10-24
- 25-49
- 50-99
- 100-499
- 500+

Jun-13 Jan-14 Jul-14 Feb-15 Sep-15 Mar-16 Oct-16 Apr-17 Nov-17

+18.1%
+46.2%
-20.9%
-18.2%
-9.8%
+2.2%
-5.3%

Source: Leavitt Partners Analysis of Medicare Physician Compare Data
Trend towards Vertical Integration

Percentages of practices that were independent in 2007 and had integrated with either a hospital or a health system by 2017
The relationship with the hospital/health system is increasingly important for measuring quality and outcomes, lowering operating costs, and contracting in risk-based arrangements.

2.5 3 3.5 4 4.5 5

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Today</th>
<th>In 2-3 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessing data about outcomes and quality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lowering operating costs for the group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contracting with Medicare and private plans in risk-based arrangements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identifying and training physician leaders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attracting and keeping physicians</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stabilizing physician compensation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increasing market share</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accessing capital for needed technology and facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accessing patients through payer contracts &amp; local reputation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being affiliated (branded) with a well-known institution</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How do you view the importance of your relationship with the hospital?
(1. Not important 5. Very important)

HFMA Survey of Physician Practice Executives
Physician – Health System Alignment Options

Integration

Level of alignment

Physician-led integrated system
Multi-specialty employed group clinic
Employment of PCPs & specialists

Clinically integrated network
Network service co-management
Common EHR
Bundled payments contract

Physician lease
Management services
Practice management
Hospital service co-management

Hospital-based specialty contracting
Independent MDs with hospital privileges

Autonomy

Degree of change

Accountability
## Need for Physician Engagement

“Once you talk to the physicians themselves, not very many of them can articulate what the [VBP process] changes are; that is why they don’t see it as positive.”

— David Muhlestein, Chief Research Officer, Leavitt Partners

### Physician Beliefs on the Impact of Payment and Delivery Models on Patient Health Outcomes

<table>
<thead>
<tr>
<th>Payment and Delivery Models</th>
<th>Very or somewhat positive</th>
<th>Not sure yet</th>
<th>Somewhat or very negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paying physicians for performance (P4P), or outcomes</td>
<td>25%</td>
<td>14%</td>
<td>34%</td>
</tr>
<tr>
<td>Patient Centered Medical Homes (PCMHs)</td>
<td>46%</td>
<td>46%</td>
<td>40%</td>
</tr>
<tr>
<td>Integrated Delivery Networks (IDNs)</td>
<td>56%</td>
<td>29%</td>
<td>30%</td>
</tr>
<tr>
<td>Accountable Care Organizations (ACOs)</td>
<td>46%</td>
<td>29%</td>
<td>40%</td>
</tr>
<tr>
<td>Episode-based payments</td>
<td>55%</td>
<td>16%</td>
<td>25%</td>
</tr>
<tr>
<td>Managed Care Organizations (MCOs)</td>
<td>45%</td>
<td>32%</td>
<td>13%</td>
</tr>
<tr>
<td>Bundled payments</td>
<td>48%</td>
<td>33%</td>
<td>14%</td>
</tr>
<tr>
<td>Global payments</td>
<td>58%</td>
<td>32%</td>
<td>16%</td>
</tr>
<tr>
<td>Capitated payments</td>
<td>45%</td>
<td>33%</td>
<td>25%</td>
</tr>
</tbody>
</table>


Development of Data Metrics and Analytics
Physician Engagement

Which of the following statements do you agree.

- 38% My organization makes effective use of clinical pathways, protocols, and guidelines to develop a common approach to patient care.
- 22% My organization has a trusted single source of truth for the data and reports we share with our clinicians.
- 14% Our clinicians would say that they have access to actionable information that helps them address unwarranted clinical variations and other cost-related quality concerns.
- 45% None of the above

Clinical leadership is necessary for trust in data

Defining cohorts of patients
Define and refine quality metrics
Risk stratifying patients
Patient attribution
Understanding data sources
Collecting and displaying meaningful data

Ask “Do you give a darn?”

Ari Robesicek, MD,
Chief Medical Analytics Officer, St. Joseph Health System
Developing Meaningful Incentives
Finance executives are transitioning physician compensation models to align with alternative payment models.

CFOs are redesigning physician compensation plans to support value-based contracts.

What is the split in your compensation plan today for the majority of physician in your group?

- 84% Base
- 16% Bonus

Considering the environment for the next 2-3 years in your market:
For physicians in your group: To achieve optimal performance, how would you split compensation?

- 70% Compensation
- 30% Bonus

Source: HFMA Survey of Finance Executives 2017
Finance executives must maintain a focus on volume and productivity while also shifting to rewards based on better outcomes and patient satisfaction.

What factors would you include in your bonus payment and how would you weight the importance of each?

**Large variability in how CFOs will weight clinical productivity.**

Others listed:
- Peer working relationships
- Citizenship
- Quality measures (quality, safety and resource measures)
- Financial performance of the group as a whole

Source: HFMA Survey of Finance Executives 2017
Compensation Challenges & Opportunities:

Compensation should align with health system goals and payment models.

Quality and efficiency metrics will be increasingly important with decreasing emphasis on productivity.

Defining metrics sufficiently valid to support decisions affecting physician incomes.

Financial incentives are insufficient to ensure physician commitment to change practice patterns and care delivery.

Developing physician champion positions within the organization.

Physician participation in annual budget and strategic planning.

“Practice of the Future” or “Clinical Leadership” Councils/Committees.
Redesigning Care
Pathways
Where do you see the greatest opportunities for cost savings in healthcare?

- High performing or narrow networks
- Improvements in productivity management
- Clinical process/workflow redesign
- Centralizing administrative functions
- Partnerships to achieve economies of scale
Greatest Opportunities for Savings in Clinical Process Redesign

What have you identified as the greatest opportunity to achieve savings over the next three years?

- Clinical process/workflow redesign/greater use of clinical pathways and evidence-based medicine: 61%
- Improvements in productivity management: 41%
- Establishing a high-performing network of physicians to ensure best quality/low cost choice for payers and consumers: 29%
- Centralization of administrative/operational functions (e.g., shared physician office functions, shared IT): 27%
- New partnerships/affiliation/merger to achieve economies of scale: 24%
- Service rationalization (e.g., fewer heart surgery programs): 7%
- Asset rationalization (e.g., fewer or smaller facilities): 5%
“All health care is local. Differences in market structure, local culture and politics, and geography and demography are real, and suggest that different markets will evolve at different rates, using different approaches, and potentially with different end goals in sight.”

Source: Impact of Value-Based Payment on Total Cost of Care Healthcare Financial Management Association. 2018 (in press)
Impact of Social Risk Factors

- Healthcare accounts for 20% of factors contributing to health. Social, environmental, and behavioral factors account for 60%.
- Yet, healthcare represents 90% of national health expenditures. Behavioral issues are just 9%.

Leveraging Healthcare Dollars to Address Health-Related Social Determinants

- Healthcare: 20%
- Genetics: 20%
- Social, Environment, and Behavioral Factors: 60%
- Healthcare: 90%
- Behavioral: 9%
- Other: 1%

Adapted from James Rubin MD, TAV Health; * $3.2 Trillion in 2015 (CMS.gov Accessed 5/22/17)
Redesigning Care Pathways

Start with what matters to the patient
  • Begin with quality

Identifying and caring for high-risk patients
  • Designing care models for high touch care
  • Focus on care coordination and care transitions

Rethinking care delivery and care pathways
  • Looking for gaps and variations in care
  • Use of evidence-based protocols
  • Appropriate settings
  • Understanding SDOH risks
Patient Financial Communications
When topic of healthcare spending arose during clinical encounters, physicians discuss strategies to reduce expenses 44% of the time.
Patients Delay or Avoid Care Because of Copayments or Coinsurance

Insured adults ages 19–64 who pay a copayment or coinsurance

Note: FPL refers to federal poverty level.
Out of pocket costs as side-effects

- “Discussing out-of-pocket costs enables patients to choose lower-cost treatments when there are viable alternatives”

- “Such discussions could assist patients who are willing to trade off some chance of medical benefit for less financial distress.”

- “Discussing out-of-pocket costs could benefit patients by enabling them to seek financial assistance early enough in their care to avoid financial distress.”

- “A growing body of evidence suggests that including consideration of costs in clinical decision making might reduce costs for patients and society in the long term.”

Clinician Role

Recognize the needs of price-sensitive patients
Be alert to risk factors associated with burden from out of pocket costs (advanced age, multiple comorbidities, low income, self pay, HDHP)
Invite patients to raise their concerns

Help patients make informed decisions about treatment plans
Physicians can consider less expensive alternatives and long-term solutions
When financial concerns are raised by patients, explore further

Help patients identify providers that offer the best value
Minimize expenses by using generic and lower cost brand names

healthcare financial management association
“One easy thing for a provider to do is to ask very simply,

‘Are you able to afford this treatment?’

For patients who say no, we can refer them to financial counselors, or social workers or pharmacists to get them resources in a timely fashion.”

Yousuf Zafar, M.D., M.H.S.
Duke University Medical Center
HFMA Resources
HFMA's Business of Health Care

Recommended for clinical leaders

Online course on business fundamentals designed for physicians, nurses and other clinical leaders

13.5 AMA PRA Category 1 Credits;
Continuing Medical Education Credit

hfma.org/boh
Regulatory Resources: Perspective on the Policymaking Process

hfma.org/policy
Total Cost of Care Report

Available for download at hfma.org/tcoc
Educate Consumers, Improve Transparency

hfma.org/transparency
The Value Project:

hfma.org/valueproject
E-Newsletter for Physician Leaders

hfma.org/leadership/physician
News, Strategies, Insights

_hfm_ magazine

The #1 publication for healthcare CFOs

**Newsletters**

- Leadership
- Revenue Cycle Strategist
- Healthcare Cost Containment
- Strategic Financial Planning
- Physician Business Adviser
HFMA’s Podcast Series

Insights from leading experts on a range of topics in healthcare finance

hfma.org/podcast
Do More than Keep Up.

Get actionable solutions for today and the insights you need to prepare for tomorrow. Join us for the premier healthcare finance conference.

June 28–July 1
San Antonio

SAVE THE DATE