Financial Landscape of Healthcare

Kaleidoscope 2016

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History of Healthcare Reimbursement – before 1920

- Before 1920, the amount of lost wages due to illness were 4 times the expenses to treat it
- Many physicians billed families a fixed amount per year to take care of all the family's medical needs
- The Flexner Report (1910) redefined the paradigm of North American medical education
  - Recommendations for stricter entrance requirements, tougher standards, more rigorous medical training and physician licensure resulted in closure of medical schools and a sharp drop in number of physicians
  - The law of supply and demand
    - Fewer physicians = increased cost of physician services
    - Advances in medical technology also led to increased costs

History of Healthcare Reimbursement – 1930's – 1960's

- Early insurance plans were prepaid hospital plans
  - Blue Cross (hospitalization)
  - Blue Shield (physician services)
- The rise of employer-based insurance plans
  - If people were healthy enough to work, they were a healthier group overall and a better actuarial risk
  - Tax benefits
- LBJ Administration's passage of Medicare Parts A & B (1965)

History of Healthcare Reimbursement – 1970's - 1990's

- Managed Care
  - Passage of the Health Maintenance Organization (HMO) Act of 1973
  - The collaborative relationship between physicians, hospitals, and patients was transformed into a competitive marketplace
  - The goal was to contain costs and increase quality, reducing the unsustainable fee for service model
  - Pay to keep patients well, not pay to treat them when they're sick
  - Those that tried to improve outcomes found their incomes dropping
  - Short-range focus was to save money – HMOs remained solvent by allegedly denying care
- Failure of the Clinton Plan was due largely to a rushed approach and poor political strategy

History of Healthcare Reimbursement – 2000's

- Health Reform lay dormant until Obama was elected in 2008
- Passage of the Patient Protection and Affordable Care Act in 2010
  - Medicaid Expansion (optional based on Supreme Court decision in 2012)
  - State-based exchanges or "marketplaces"
  - Tax credits and subsidies for smaller employers to offer coverage
  - Extension of dependent coverage until age 26

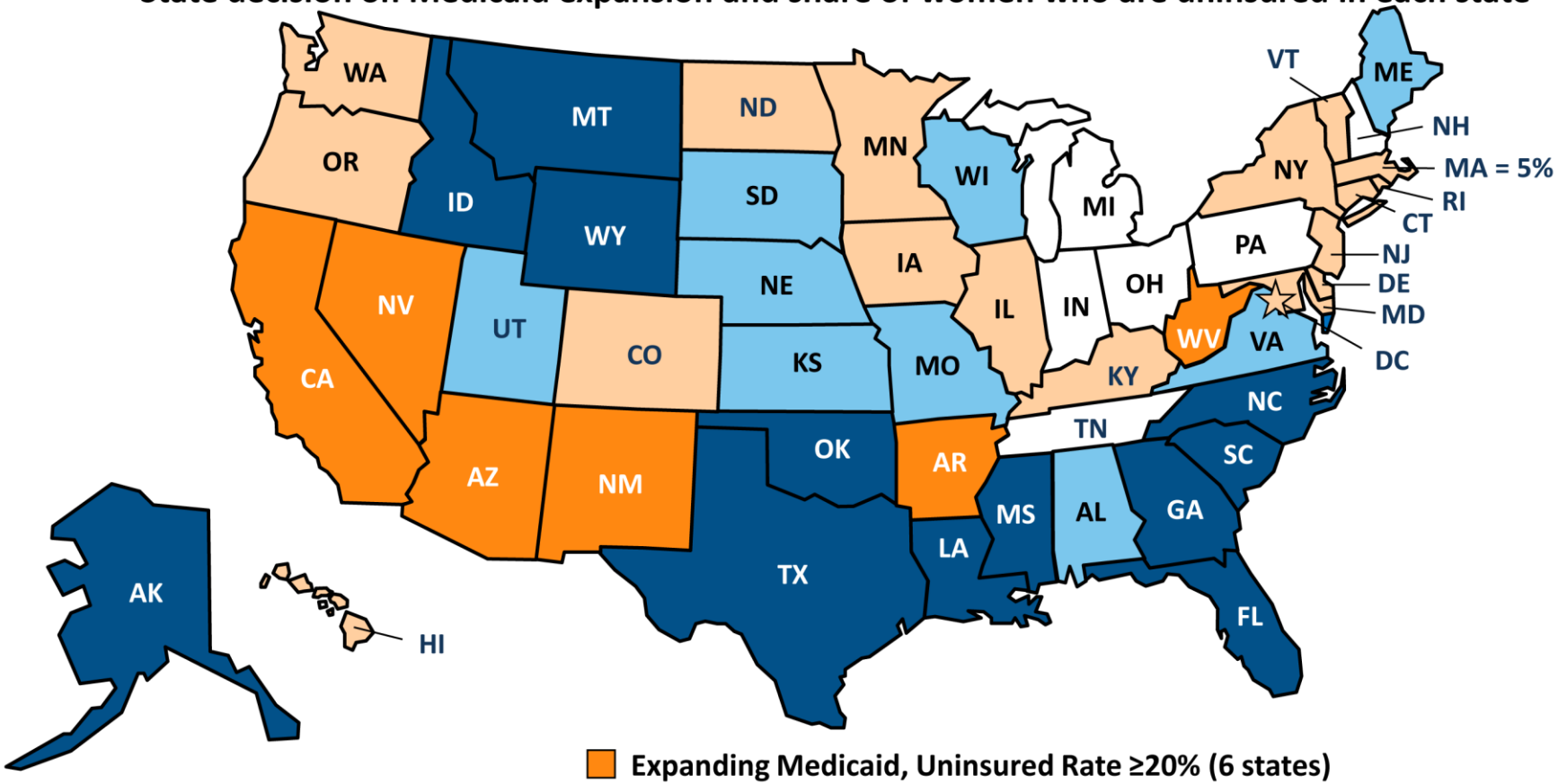
PPACA & Women's Health

- Maternity & newborn care
- STI & gestational diabetes screenings
- Breastfeeding support
- Mental health screening and treatment, postpartum depression education and support
- Well woman exams
- Annual mammograms at age 40
- HPV vaccine & testing
- FDA approved prescription contraceptives & family planning (with certain religious exemptions)
- Domestic violence screening
- Sex education programs
- Mental health screening and treatment, postpartum depression education and support

Figure 3

More than half of states not expanding Medicaid have higher than average rates of uninsured women

State decision on Medicaid expansion and share of women who are uninsured in each state



NOTE: Uninsured rates of women ages 18 to 64.

SOURCE: Kaiser Family Foundation, StateHealthFacts. KFF/Urban Institute tabulations of 2011 and 2012 ASEC Supplement to the CPS.

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Financial Management: Operating Statement Review

What Tools do you need to be ready for Value Based Payment?

- Understand your operating statement; look at it every month
- Understand your variances and explain them thoughtfully; minimize them when you can
- Understand flex budgeting
- Understand how your documentation affects coding and reimbursement; consistently improve
- Pay attention to the line-item detail; errors are more common than you think

What Tools do you need to be ready for Value Based Payment?

- Create a healthy mindset toward standardization
- Teach your staff to look for non-standardized products, overstocking
- Create a culture of relentlessly eliminating waste
- Monitor compliance with care protocols

What Tools do you need to be ready for Value Based Payment?

- Understand your data; if you need it portrayed differently, ask
- If you discover ideas to contain costs, speak up
- Never lose sight that the patient comes first
  - Patient satisfaction leads to healthy financial performance
  - Even more so under patient cost sharing (e.g., higher deductibles) and value based payments

Future of Healthcare Reimbursement

- Value-Based Reimbursement
- What is value?

$$\frac{\text{Quality}}{\text{Cost}}$$

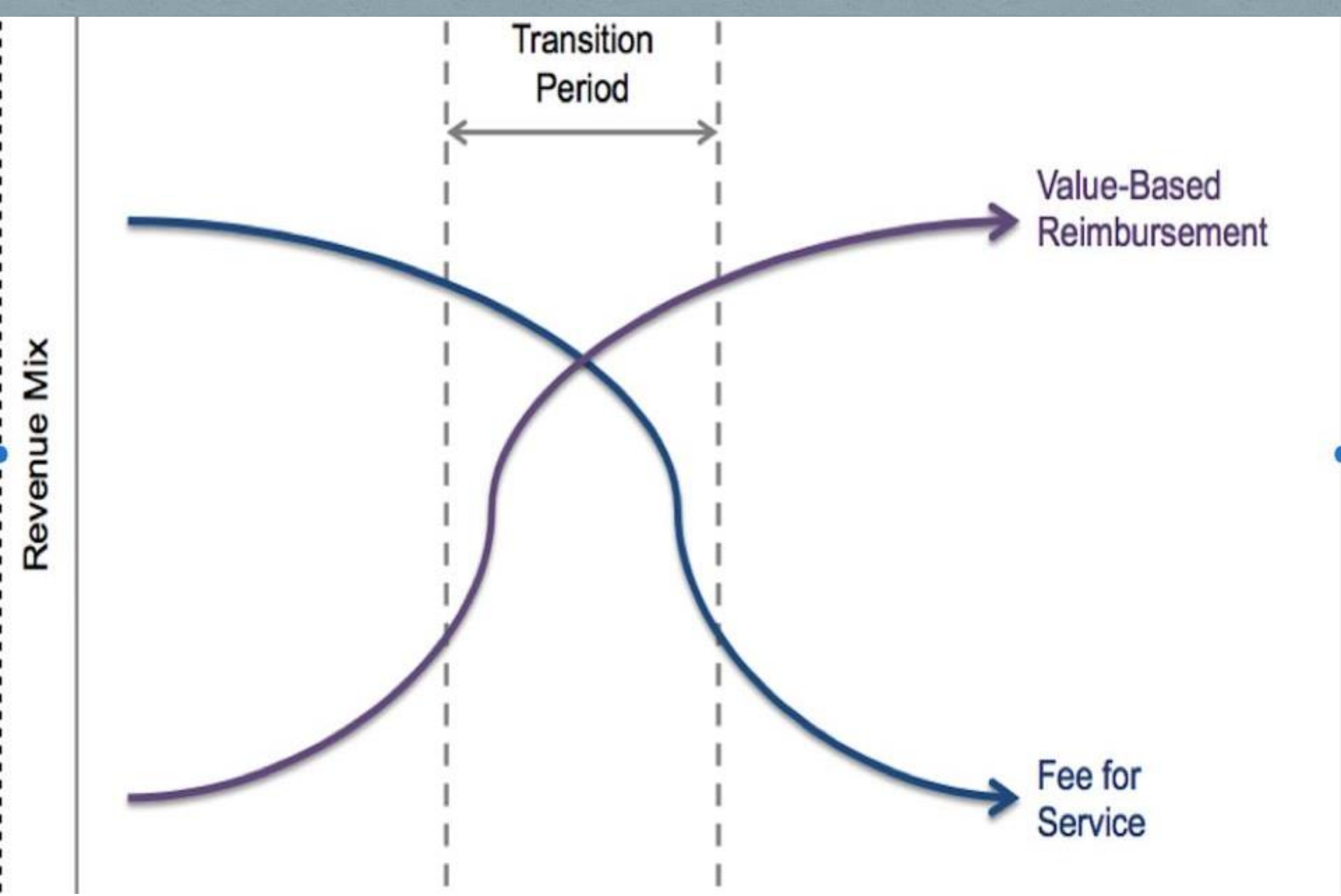
- How is this different than managed care?
  - Incentivizing providers to reduce spending for a defined patient population through receipt of net savings
  - Alternative Payment Models: Shared Savings, Bonus Pools, Care Management Incentives, Merit Based Incentives

The Scoring Trend

- HRRP
- HAC Reduction Program
- IQR
- OQR
- PQRS
- HCAHPS
- CGCAHPS
- Medicare Star Ratings for Nursing Homes and Home Health
- Meaningful Use – rolling up as a component of "MIPS"

Other Trends

- Shifting Revenue Mix
  - A higher % of patients are covered by public insurance; reimbursements are traditionally lower than commercial payers
  - Baby boomers are aging into Medicare
- Employers designing and managing their own health plans
- Benchmarking / Transparency
  - (Hospital Compare, Physician Compare, Star Ratings, HealthGrades, RateMDs)



Brown, B. & Crapo, J. (2014). The Key to Transitioning from Fee-for-Service to Value-Based Reimbursement. Accessed February 3, 2016, healthcatalyst.com.

Questions?