

Physician Practice Group Executive Council Meeting Takeaways

Presented by:



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Overcoming the Challenges of Providing Physicians Actionable Clinical and Financial Data

Sharing Data with Physicians

Physician Scorecards include: collections, days in A/R, coding details, RVU production and other data points. Display as graphically as possible and offer from practice level to individual physician level.

Department Liaisons communicate revenue cycle outcomes to physicians, office staff and central business office. Liaisons serve as a single point of contact for all revenue cycle issues.

Physician Chart Reviews: Practices are spending more resources on coding and documentation, through implementation of CDI programs. Practices are developing open chart policies with financial penalties to physicians if charts are not closed within 21 days,

What are people doing with claims/clinical data?

Merging clinical data with claims data: Many organizations are using vendor technologies to merge data for actionable conversation. Health information exchanges do not yet provide enough data. Difficulty in incorporating psychiatric data as its often carved out, pharmacy data is often a source.

Physician to Physician conversations using data sometimes have more traction than the finance team speaking directly to physicians.

Other discussion items

Limiting/reducing Physician Support and Leakage are focused initiatives. Financial data and understanding downstream revenue is critical, as is improving quality, care coordination and patient satisfaction.

Determining physician compensation through establishment of targets and a compensation gap on a 5-year cycle. Can not look at one point in time as there are fluctuations in specialty care, and it may not be accurate if you look at today's pay.

Managing Bundled/Episodic Payments

Derek Wildman, Executive Finance Director, UNC Physicians

Bundled Payments for Care Improvement (BPCI) Initiative

The CMS Innovation Center set out to align hospitals, post-acute care providers, doctors and other practitioners through common payment. Research suggests that bundled payments can align providers across the continuum of care which can enhance the patient's overall care delivery.

The 4 Payment Models

	Episode	What's in the bundle?	Payment
Model 4	Selected DRGs, hospital plus readmissions	All non-hospice Part A & B services (including the hospital and physician) during initial inpatient stay & readmissions	Prospective
Model 3	Select DRGs, post-acute period only	All non-hospice Part A & B services during the post-acute period & readmissions	Retrospective
Model 2	Select DRGs, hospital + post-acute period	All non-hospice Part A & B services during the initial inpatient stay, post-acute period & readmissions	Retrospective
Model 1	All acute patients, all DRGs	All Part A services paid as part of the MS-DRG payment	Retrospective



Bundled Payments for Care Improvement (BPCI) Initiative: General Information. CMS.gov. <http://www.cms.gov/090909main/Bundled-PaymentInitiative.html>. Accessed on 10/22/14.

3

UNC Physicians Weigh the Risk

Derek walked the group through how the UNC Physician Network determined their participation in different bundles, which arrangements were worth taking on, and how to split the risk.

Do the dollars outweigh the risk?

Examine the data for your System's performance

- Historical claim information, you can quickly understand the financial risk for each episode group; selecting the ones with the most upside.

Understand the offering from CMS

- This is based on DRG, not ICD-9 codes or any other classification.

Know your physicians' interest level

- In order for this to work, the entity taking risk needs alignment/buy-in from physicians and other caregivers.

Readmission rates

- Readmission costs are a critical part in the patient care cost continuum.
- Having a solid understanding and execution of post-acute care is paramount in these type of arrangements.



4 Considerations for Hospital Bundled Payment Programs. Heather Linder, May 13, 2013. <http://www.hospitalbundledpayment.com/files/considerations-for-hospital-bundled-payment-programs.html>. Accessed on 10/22/14.

6



Building Predictive Models to Understand Opportunities to Improve Care Management

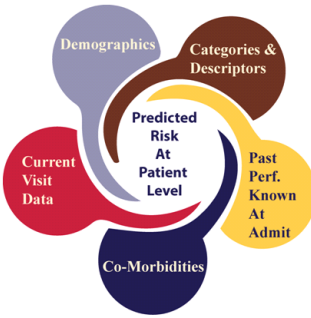
Stephen Hippler, MD, Senior Vice-President of Clinical Excellence, OSF Healthcare System
 Ralph Velazquez, MD, Senior VP, Care Management, OSF Healthcare System

Building Predictive Models

OSF Healthcare built and implemented a predictive tool to identify and eliminate unnecessary utilization through better care management. They eventually used the tool to devise a health management program that addressed high risk patients through a myriad of avenues, and provided flexibility to address patient specific issues.

OSF Healthcare 30 Day Readmission Predictive Model

Model Description



- Built for the One OSF population
- Explored more than 140 potential independent variables
- 70 variables included in final model
- Not reliant on vendor supplied risk scores
- Uses data currently in the EDW
- Can be deployed via SQL based reporting

OSF HEALTHCARE 10

Using Data to Support High Risk Patients

OSF identified patients for their care management program with the help of a data scientist, using over 70 variables to identify their target population. Their health management program covers 100-200 patients at a time. Patients are in the program for 2 years --until they can manage their conditions with less oversight.

OSF Healthcare Cost of Care Predictive Model

Commercial models	Our model
Based on previously coded encounters	Built from the problem list
Typically validated on standard population	Can be validated on individuals
Limited to coded data	Includes non-coded data from our EHR
No social data	Insight into social determinants
Data lag	Contemporaneous data
Limited to data from payers	Potential to risk adjust entire panel
Includes pharmacy	No insight into pharmacy costs
Includes data external to our EHR	Limited to internal EHR data
Easy	Difficult

OSF HEALTHCARE 17

The Impact of Employed Physicians on a Health System's Bond Rating

Emily E. Wadhvani, FACHE, Director - Public Finance Healthcare Group, FitchRatings

Changes in Median Ratios

Emily provided an overview of how Fitch determines their ratings, as well as recent trends in ratings. In the last few years, the median ratios have decreased as operating volatility means less revenue. When determining how organizations can absorb cash flow uncertainty it comes down to balance sheet strength.

Fitch 2014 Median Ratios

	Median	'AA'	'A'	'BBB'	'BIG'
Sample Size	243	60	99	69	15
Total Operating Revenue (\$ Mil.)	575.7	1,866.7	572.4	414.6	141.7
Days Cash on Hand	193.9	277.1	199.2	145.0	74.8
Days in Accounts Receivable	49.3	49.3	49.8	48.8	48.3
Cushion Ratio (x)	16.4	26.5	17.0	10.5	5.3
Days in Current Liabilities	64.8	67.9	61.5	67.3	63.4
Cash to Debt (%)	127.7	178.5	131.2	93.6	55.7
Operating Margin (%)	2.2	3.9	2.5	1.1	(1.4)
Op EBITDA Margin (%)	9.2	11.0	9.5	7.9	7.3
Excess Margin (%)	3.7	7.3	4.1	2.4	(0.5)
EBITDA Margin (%)	10.9	13.1	11.0	9.2	7.6
Personnel Costs as % of Total Operating Revenue	55.0	52.8	55.0	57.4	60.9
Bad Debt as % of Patient Revenue	5.8	5.5	6.1	6.4	5.8
EBITDA Debt Service Coverage (x)	3.5	5.4	3.8	2.6	1.8
Op EBITDA Debt Service Coverage (x)	3.0	4.4	3.1	2.3	1.6
Maximum Annual Debt Service as % of Revenues	3.1	2.6	3.1	3.6	4.0
Debt to EBITDA (x)	3.6	2.9	3.6	3.9	4.6
Debt to Capitalization (%)	37.8	31.1	36.3	44.9	52.7
Average Age of Plant (Years)	10.6	9.9	10.5	11.1	11.4
Capital Expenditures as % of Depreciation Expense	115.7	149.5	119.9	99.4	68.1

EBITDA - Earnings before interest, taxes, depreciation, and amortization. BIG - Below Investment Grade.
Source: Fitch Internal Data

FitchRatings

www.fitchratings.com

10/8/14

4

Prediction for the Future

Emily predicts increasing consolidation as organizations find it necessary to grow scale to continue to operate. Small and rural providers will find it increasingly difficult to scale to take risks.

Significant Headwinds: A Sector in Transition

- Greater volatility in year over year financial performance.
- Growing consumerism due to an increasing shift to high deductible health plans.
- Continued pressure on reimbursement from managed care and Medicare payors.
- Providers in Medicaid expansion states seeing early benefit from expanded coverage with reductions in bad debt expense.
- The impact from non-Medicaid enrollees through the health insurance exchanges on volumes and profitability is uncertain at this time.
- Increasing consolidation and widening credit gap

FitchRatings

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10/8/14

20