Practice Economics: Mission, Money, Midas and Magic

David A. Piccoli, MD
Chief, Division of GI, Hepatology and Nutrition
The Children's Hospital of Philadelphia
Perelman School of Medicine at the Univ. of Pennsylvania

Conflict of Interest Statement

- I have
  - No conflicts related to any portion of this talk
  - No speaker's bureaus
  - No industry supported grants

Conflicts

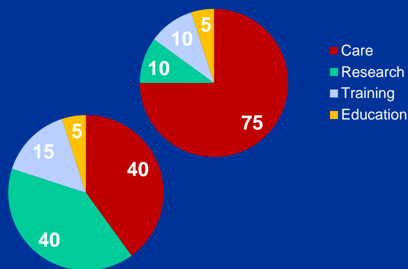
- By its very nature, the art of "practice economics" is predominantly managing the conflicts …
  - Limited resources
  - Infinite requests
  - Practic(e)al realities, ….
- Not always fully appreciated by
  - Administrators
  - Bosses
  - Colleagues
  - Staff
  - Patients

Objectives

- To review the sources of revenue in an academic practice
- To review the expenses and expenditures
- To review changes in the structure of pediatric gastroenterology and reimbursement that will affect practice economics and the academic mission in the future.

Portfolio: GI Division Missions

- Clinical care
- Research
  - Basic
  - Clinical
  - Translational
- Training
- Education
- Advocacy
- IP and Technical



Mission and Margin – Clinical, Research, Training

- There is a margin or a deficit on each component of the mission
- Net revenues are different from region to region, and center to center:
  - Patient payer mix,
  - Local and national competition
  - Contracts and charges
  - Research funding
  - Size and scale of programs
  - Cost of “doing business”

GI Division Balance Sheet

- Assets and liabilities (income and expenses)

- Charge (to the payer)
- Cost (to the payer = reimbursement, collections)
- Expenses (cost to the Institution, Division)
- Profit (net) -- Loss

Resources / Assets

- Clinical activity and revenue
- Hospital, Department, Medical School support
- NIH funding, foundation funding, pharma/industry
- Endowment
- Philanthropic support

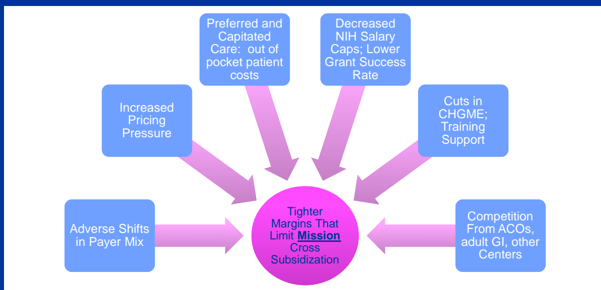
Liabilities / Expenses

- Salary and benefits
  - Faculty
  - Fellows and Nurses
  - Support, administrative and research staff
- Hospital, Department, Medical School charges (tax, rent)
  - Required margin contribution
- Research costs – un- and under-funded research
- Equipment, supplies, malpractice, professional expenses
- Mission costs
- “Non-value” added costs

St. Elsewhere GI Division Balance Sheet

	$M	
• Assets (Income)		
– Clinical collections	12.0	(Charges 24, 30, 36 $M)
– Research income	2.0	
– Transfers (in)	1.0	
– Endowment	0.5	
– Philanthropy	1.0	
• Liabilities (expenses)		
– Charges on net revenue	2.4	(Tax, rent, malpractice)
– Staff salaries	8.6	
– Research costs	3.0	
– Unfunded other research	1.0	
– Other costs	1.0	(supplies, equipment)

Factors Affecting GI Division Revenue

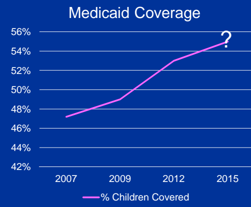


Current Risks to Income

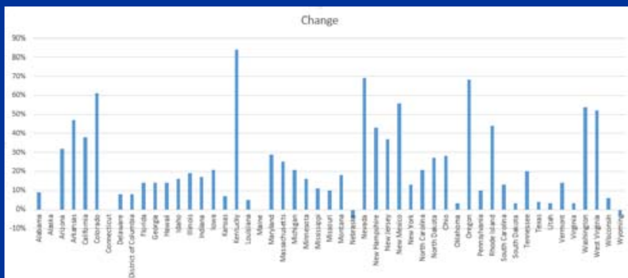
- Payer contracts, negotiations, consolidation of payers
  - Exclusion from some networks
  - Patients shift to lower reimbursement payer
- Escalation of deductibles, co-pays
  - Preferential co-pay for in-network venues (!)
- Un-reimbursed services, studies
- Loss of faculty (illness, departure)

Medicaid Coverage – Pre ACA (ICH Data)

- 2007 47.2%
- 2009 49.0%
- 2012 53.0%
- Medicaid: the predominant payer for children's services nationally

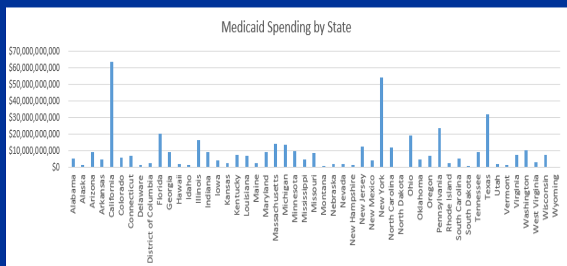


Medicaid and CHIP: Pre-ACA and 6/2015 - % Change



State Health Facts: The Kaiser Family Foundation

Current Medicaid Spending by State



State Health Facts: The Kaiser Family Foundation

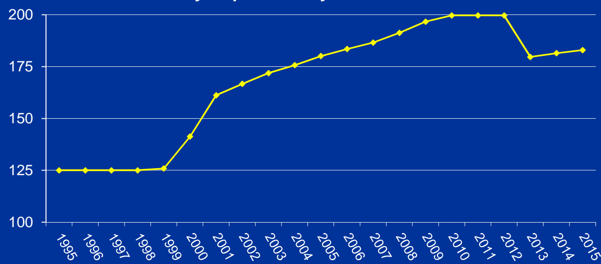
Minute Changes – Mission Critical

- For $30 M in charges
  - Every 1% decrease in collection rate = -$300 K
- For an operating margin of $0.5 M (to support the Mission)
  - A decrease in 2% wipes out Mission support
- Salaries, the major expense, move upward yearly at >>1%
  - Every 1% increase (8.6 M salary) is 86 k expense

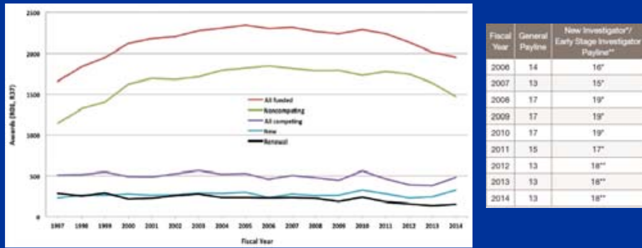
Research

- Essential for the field of Pediatric GI
- Optional for any one Division of Pediatric GI
- Never revenue neutral, to varying degrees
  - Bench – start up, recruitment
  - Translational / clinical
  - Unfunded
- Protected time expense
- Salary gap
- Funding gaps – "bridge funding"
- Long-term ROI
- IP, Innovation, Tech Transfer, Start-up opportunities (!*!)

NIH Salary Cap



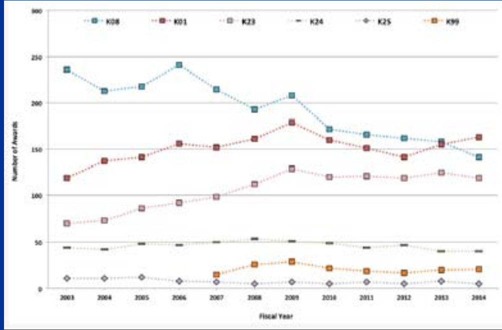
NIDDK R01 Awards by Year



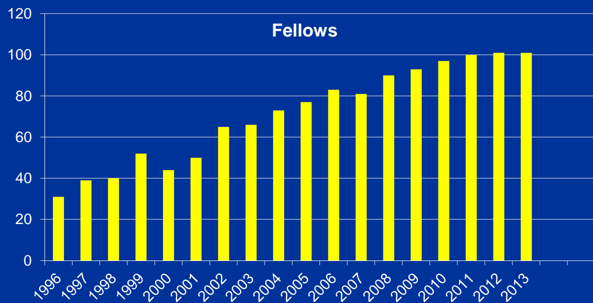
Fiscal Year	General Payline	New Investigator*/ Early Stage Investigator Payline**
2006	14	16*
2007	13	15*
2008	17	19*
2009	17	19*
2010	17	19*
2011	15	17*
2012	13	18**
2013	13	18**
2014	13	18**

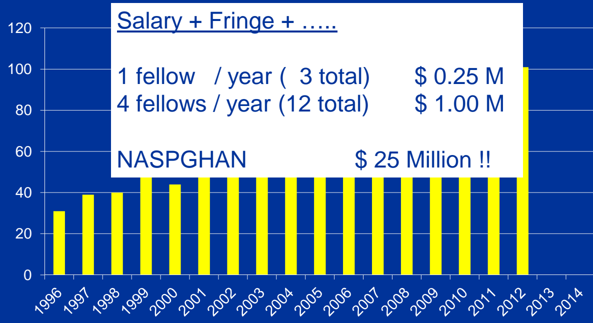
- NIH Website, 2015

NIDDK Career Development K Awards by Year



Training Mission: Pediatric Gastroenterology New Fellows





Training Costs – CHOP

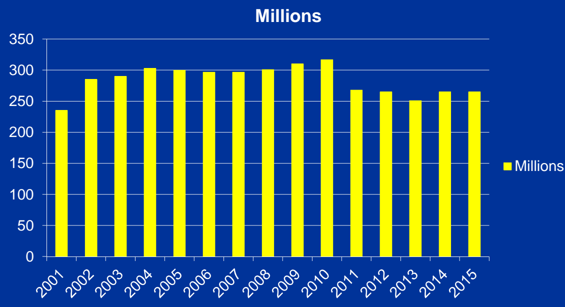
- Money:
  - GI, Nutrition, Hepatology, Research (MD and/or PhD), Other
  - CHOP mean 14; range 13-18,
  - Cost S&F: 88k/fellow = 1.3 million $ /d year
  - Degree programs - tuition
    - MSCE, MTR, MPH, MEd
  - Training directors “protected time”
  - Associated costs
- Mission:
  - Efficiency, effectiveness, clinical care, research
  - Joy and satisfaction – mission of training the next generation!
- Midas:
  - Creative ways to pay for it!

Training Costs

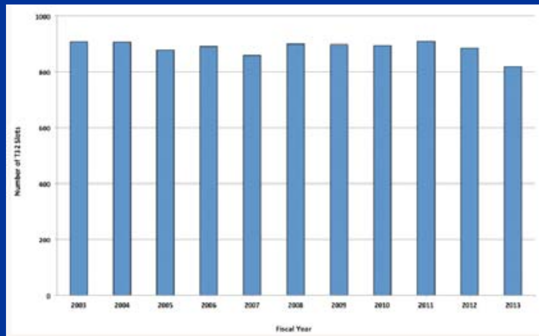
- Money:
  - GI, Nutrition, Hepatology, Research (MD and/or PhD), other
  - MSCE, MTR, MPH, MEd
  - CHOP mean 14; range 13-18,
  - Cost S&F: 88k/fellow = 1.32 million $ per year
  - Training d
  - Associate
- Mission:
  - Efficiency,
  - Joy and s neration!
- Midas:
  - Creative ways to pay for it!

$1,500,000 from …..
Hospital CH GME, Dept. of Pediatrics
NIH (T32, F32, other)
Foundations
Philanthropy (!*!)
Clinical Operational Revenue ****

CHGME Funding



NIDDK Training T32 Awards by Year



Challenges for the Future

- Clinical care and reimbursement
- Research support
- Training and Education funding

- "No Money, No Mission"
- (attributed to many CEOs, Chairs, Chiefs)

Predicting the Future ?

- "Predictions are always difficult, ….
  - especially about the future!"
  - Not actually said by Yogi Berra
  - Formally attributed to Niels Bohr
- Applies to many things:
  - Path of a knuckleball to the catcher's mitt
  - Path of an electron through a slit
  - Path of healthcare reform in America over the next decade

"Schizophrenic" Inflection Point for Pedi GI

Fee for service (now)
- Charge generator
  - Hospital
    - Inpatient
    - Outpatient
  - GI
    - Visits
    - Procedures
  - Associated specialties

High "margin"

Risk and cost sharing (soon)
- Cost generator
  - Hospital
    - Inpatient
    - Outpatient
  - GI
    - Visits
    - Procedures
  - Associated specialties

Loss leader ??

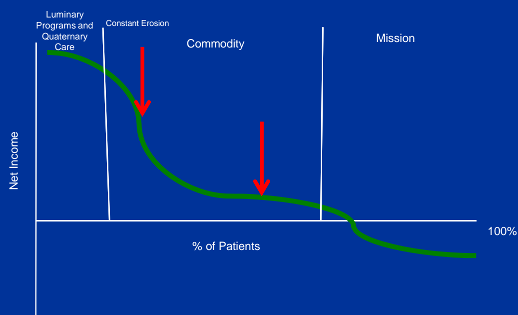
Evolution from Service to Value to Risk

Offer service	FFS
Reimbursed for quality	Quality incentives
Contracted for quality	
Pay for performance	Quality and cost incentives
Bundled payments	
Shared savings	Shared financial incentives
Shared risk	
Capitation / full risk	Financial risk

Venue and Value

- Right....
  - Care — GI value (do you really need to …?)
  - Place — Hospital, satellite, home …
  - Provider — GI, PMD, PA, NP, internet …
  - Time…. — If at all ......

Programmatic "P & L"



Individual P & L Statements ??

- RVUs
- Dollars
- Profits ……

- Quality?
- Value?
- Metrics
- Patient satisfaction?

Value and Cost

- Value = Quality/Cost
- Cost to external payers is what they reimburse for care
- Cost to Division/Hospital is what it costs to provide care
- Internal cost reduction will be essential to be competitive
- Cannot be the highest cost provider in your marketplace.

Proving our "Value"

- How do we create, measure and demonstrate value?
- We (NASPGHAN) need to take the lead in defining value
  - How to measure it?
  - How to improve it?
- Need data and outcomes
- High value/high quality may not mean high volume !!
- Right provider right care,
- Compensation for "managing and treating" rather than "doing".
  - How do we split the pie?

The Future of the Training and Education Mission

- Fellowship funding is decreasing
- Fellowship numbers will decrease
- Clinical fellow roles will be assumed by:
  - Non-physicians / extenders
  - Attending physicians
  - General pediatricians / hospitalists

The Future of Pediatric GI Research Mission

- Funding will likely decrease
- Competition will increase
- Less “start-up” money
- Fewer academic faculty will maintain research initiatives
- Fewer fellows will choose research
- There will be a shift from research to clinical efforts

- Need for prioritization, collaboration, lobbying NIH

So What – So What Can We Do?

Increasing Revenue

- Increase:
  - Workload
  - Programs and services
  - Market share
  - Payer mix
  - Contracts
  - Efficiency
  - Charge
  - Billing / Collections
  - Physician extenders
  - Research funding
  - Philanthropy (!*!)

Increasing Revenue !!

- Improve value, quality and outcomes

Value-able Steps

- Components will likely include
  - Evidence-based guidelines and pathways
  - Demonstration of improved outcomes
  - Design and implementation of new care models across the patient care and health system continuum.
  - Partnerships around care and cost

Philanthropy = 100% Mission

- Grateful families
- Events / fundraisers
- Corporate support / partnerships
- Naming opportunities
- Major gifts / endowed chairs and funds

- Families want to participate / give back / take action
- Children's Hospitals raise $50-150 M / year
- Philanthropy can fund the Mission when everything else dries up
- Identifying grateful families is a learned and valuable skill !!
- It cannot happen if you do not make an effort !!

IP / IPO / Patents / Labs / Partnership

- The New Frontier – Leveraging academic center research and innovation
- Rotavirus vaccine – CHOP / Merck - 2008
- Spark Therapeutics – CHOP IPO 1/2015
- RegenxBio – U Penn IPO 9/2015
- Boutique Labs …..

Decreasing Division Costs – Limited Options

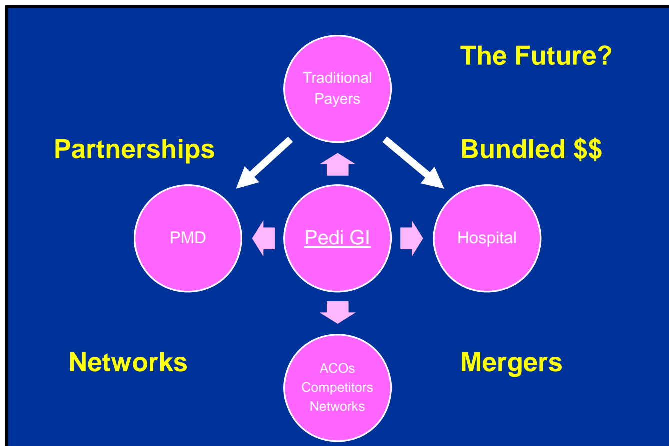
- Faculty
  - Decrease faculty salary or salary at risk ??
  - Decrease faculty number
  - Decrease ratio of faculty to non-MD providers
  - Decrease research faculty number?
- Decrease support staff
- Decrease fellow number
- Decrease research support?
- Sharing expenses across programs, divisions, silos
- Cut programs that lose money?

Meteoric What ifs ……?

- A major shift in our disease population
  - Cure for Hepatitis C (adults)
  - Cure for IBD
  - Effective therapy for IBS
- A major change in our diagnostic paradigm
  - Biomarker for EoE activity
  - Advances in “capsule technology”
    - Video
    - Microbiome

Bundled Payment - Assuming Risk?

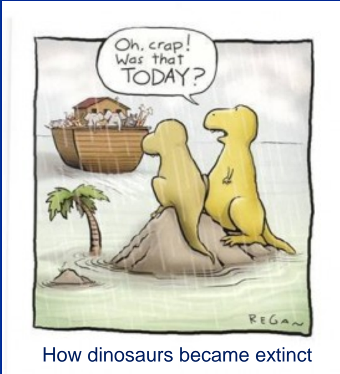
- How much would you take to provide all GI-related care for all labs, studies, medications, hospitalizations and your professional fees for ....
  - Crohn disease
  - EoE
  - ! FAP
- What if you shared the risk for a net loss of revenue?
- Would the “value” and “cost” of care change, and how?



Il Buono, Il Brutto, Il Cattivo

- HealthCare is rapidly changing
- GI practices will have to change, in advance of a crisis
- Provide excellent care and value at Medicaid rates
- Must maintain focus on Mission
- Consider alternative care models – be creative
- Must invest in the future with research, education and training
- Develop novel means of funding the Mission
  - Philanthropy
  - Intellectual property, technology
- Keep the faith! We will be able to do this!

Get On The Boat !!! (before it's too late)



How dinosaurs became extinct

Creating a Value-Based GI Division

- Organize care into specialized disease centers
  - Organize primary and preventive care when possible
  - Pathways for care when possible
- Measure outcomes and cost for every patient
- Prepare for bundled prices for care cycles
- Integrate care delivery across system facilities
- Expand areas of excellence
- Build an enabling information technology platform for analysis, documentation, research, outcomes

Adapted from Professor Michael Porter-HBS

Money and Scale are Essential Ingredients