Practice Economics: Mission, Money, Midas and Magic

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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

- Assets (Income) $M
  - 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

- Tighter Margins That Limit Mission Cross Subsidization
- Adverse Shifts in Payer Mix
- Increased Pricing Pressure
- Decreased NIH Salary Caps; Lower Grant Success Rate
- Cuts in CHGME; Training Support
- Competition From ACOs, adult GI, other Centers

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

Salary Cap Summary FY 1995 - 2015
NIDDK R01 Awards by Year

NIDDK Career Development K Awards by Year

Training Mission: Pediatric Gastroenterology New Fellows

* NIH Website, 2015
Training Costs – CHOP

- Money:
  - GI, Nutrition, Hepatology, Research (MD and/or PhD), Other
  - CHOP mean 14; range 13-18,
  - Cost S&F: 98k/fellow = 1.32 million $ per year
  - Degree programs - tuition
  - MSCE, MTR, MPH, MEU
  - 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!

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

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**“Schizophrenic” Inflection Point for Pedi GI**

<table>
<thead>
<tr>
<th>Fee for service (now)</th>
<th>Risk and cost sharing (soon)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Charge generator</strong></td>
<td><strong>Cost generator</strong></td>
</tr>
<tr>
<td>– Hospital</td>
<td>– Hospital</td>
</tr>
<tr>
<td>– Inpatient</td>
<td>– Inpatient</td>
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<tr>
<td>– Outpatient</td>
<td>– Outpatient</td>
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<tr>
<td>– GI</td>
<td>– GI</td>
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<tr>
<td>– Visits</td>
<td>– Visits</td>
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<tr>
<td>– Procedures</td>
<td>– Procedures</td>
</tr>
<tr>
<td>– Associated specialties</td>
<td>– Associated specialties</td>
</tr>
<tr>
<td>High “margin”</td>
<td>Loss leader ??</td>
</tr>
</tbody>
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**Evolution from Service to Value to Risk**

- Offer service
- Reimbursed for quality
- Contracted for quality
- Pay for performance
- Bundled payments
- Shared savings
- Shared risk
- Capitation / full risk

- FFS
- Quality incentives
- Quality and cost incentives
- Shared financial incentives
- 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 ......

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**Programmatic “P & L”**

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**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?

The Future?

Partnerships
- Traditional Payers
- PMD
- Pedi GI
- Networks
- ACOs
- Competitors
- Mergers
- Bundled $$
- Hospital

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