How Transparency Efforts Helped One System's Financial Turnaround

Stephen A. Purves, FACHE

SUMMARY

Healthcare consumerism, costs, and price transparency are garnering unprecedented attention from hospitals and health systems in the United States. To many observers of the US healthcare delivery system, the inability to provide accurate pricing information and the variability in prices for comparable services are utter failures of the administrative infrastructure that supports patient care processes.

Price transparency and the affordability of healthcare have also become top concerns for professional and trade organizations, which are devoting significant resources to assist member institutions in facing these issues. In many states, elected officials have passed legislation requiring pricing support for consumers. When the value equation (cost divided by quality) is considered, comparisons of healthcare providers can become even more confusing.

Price transparency and demonstration of cost-effective, high-quality service to patients have become strategic imperatives at Maricopa Integrated Health System (MIHS). A safety-net system and one of Arizona's largest providers of graduate medical education and other teaching programs, MIHS faced an operating deficit of more than $74 million in fiscal year 2014. In 2015, financial concerns prompted the CEO and board to hold weekly meetings to appraise cash availability and management interventions. Over the next four years, MIHS achieved a cumulative improvement in net income of more than $150 million. Today, MIHS is reinventing itself through a major capital campaign made possible in part by a $935 million public bond referendum passed by the voters of Maricopa County. Ultimately, our ability to better serve the community involves connecting with our patients and addressing their need for price transparency.

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Maricopa Integrated Health System (MIHS) has a 140-year tradition of being both the community's safety-net healthcare system and Arizona's only public teaching hospital. MIHS comprises 325 acute care and 241 behavioral health beds, a Level I trauma center, a burn center that serves the entire southwestern United States, a large HIV primary care center, a refugee women's health clinic, a children's center, two behavioral health centers, and 13 federally qualified health centers (FQHCs). Sixty percent of MIHS's patient population is Hispanic, and almost 75 percent is a racial or ethnic minority.

Transparency and stewardship of resources are key accountabilities in MIHS's role as a public teaching hospital and safety-net system of care for more than 4.4 million people in Phoenix and Maricopa County. In addition, our network of FQHCs requires that pricing determinations for patients qualifying for discounted sliding fee schedules be consistent and easily understandable from the beginning to the end of the patient's relationship with our system. Web-based tools and other technologies, such as the patient portal in our electronic health record and our information technology platform, are growing in importance as consumers increasingly rely on these forms of communication.

In terms of payer mix, 45 percent of MIHS patients are served through Medicaid (administered through the Arizona Health Care Cost Containment System, AHCCCS), 17 percent through Medicare, 13 percent through commercial insurance, and 14 percent through other government insurance; 11 percent are uninsured (Exhibit 1).

Medical education has been at the core of MIHS's mission since it began Arizona's first graduate medical education (GME) program in 1952. The only public teaching hospital and health system in Arizona today, MIHS has 778 medical student rotations per year through 16 programs and more than 400 medical residents on campus continuously. MIHS is the primary center for clinical rotations for the University of Arizona College of Medicine in Phoenix and is a founding member of a new Arizona healthcare partnership with Creighton University in Omaha, Nebraska, called the Creighton University Arizona Health Education Alliance. This alliance combines the MIHS and Dignity Health St. Joseph's Hospital GME programs with the Creighton University School of Medicine and District Medical Group, which provide the medical faculty practice for MIHS.

Financial Stewardship and the Burning Platform

Regardless of ownership status, hospitals and health systems are struggling with cost increases and the ability to generate enough revenues to adequately fund capital and cover operational expenses. Public safety-net hospitals have long faced financial challenges given their high levels of uncompensated care and teaching costs, as well as their lack of economies of scale and access to the sort of capital that is available to multihospital systems. As an independent special healthcare district and safety-net system with a robust teaching mission, MIHS faces these challenges. However, this does not diminish its governing board's fiduciary responsibility to ensure a fiscally viable future or to demonstrate sound financial stewardship to the public it serves.

Mounting operating losses, coupled with the loss of a vital $50 million supplemental funding source, created an operating deficit of more than $74 million in fiscal year 2014. Further, MIHS was in danger of exhausting its cash reserves by the summer of 2015 unless significant changes occurred

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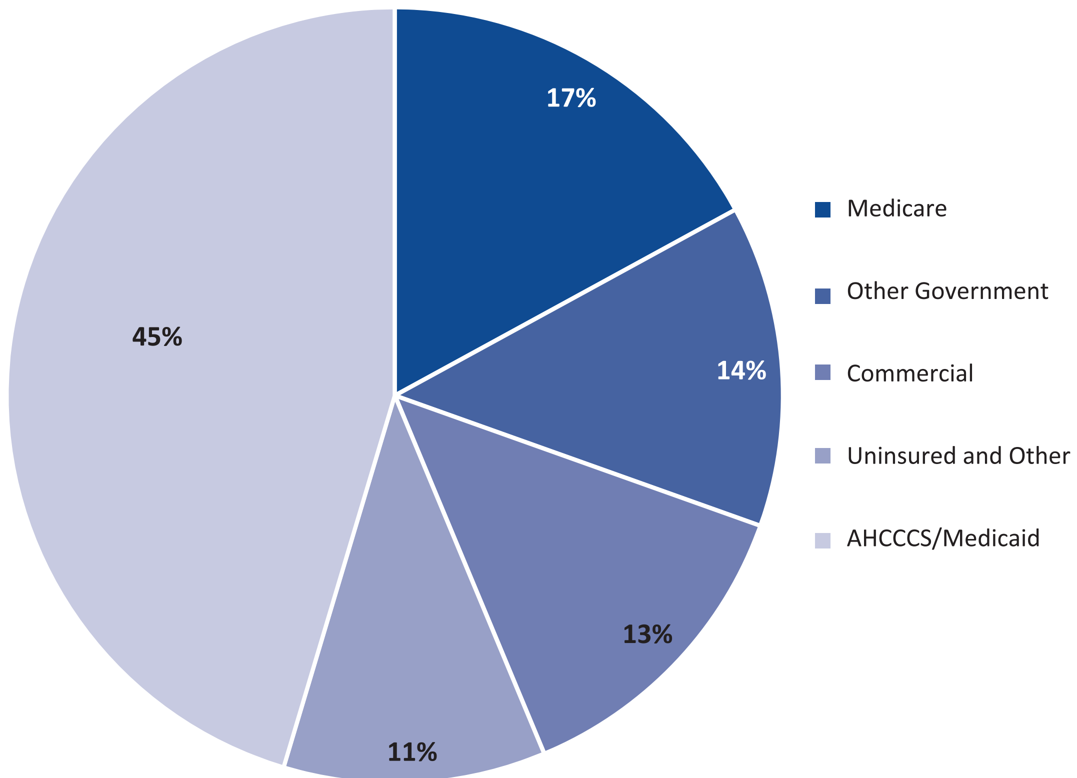
EXHIBIT 1
MIHS Payer Mix as of June 30, 2018



Note: AHCCCS = Arizona Health Care Cost Containment System.

very quickly (see the darker line in Exhibit 2). Although MIHS secured $935 million in capital support in November 2014 through a ballot referendum, this money could not be used to fund operations.

Knowing there was no appetite in the state legislature or governor's office for a bailout, MIHS decided that a financial turnaround would have to be accomplished through operations—by significantly improving the revenue cycle, supply chain, productivity management, referral and patient throughput, efficiency and waste reduction, and—perhaps most important—leadership development to enable all these initiatives to succeed.

To understand its costs, MIHS used a cost-accounting product to rank-order the contribution margin of each service line so that informed decisions could be made in the event some services would need to be eliminated. We measured the direct variable, indirect, and fixed costs at the patient level by service line. We used industry-accepted methods for allocation of fixed costs to determine total costs so that both the contribution margin and the total margin could be calculated for each service line. This process, although painful, was necessary to understand resource consumption so that decisions could be made after factoring in community benefit. Fortunately, it was not necessary to eliminate services or service lines.

MIHS began its margin improvement efforts in earnest at the beginning of calendar year 2015. The process emphasized leadership development, readiness for change, collaboration, speed to implementation, and idea generation. MIHS leadership attitudes

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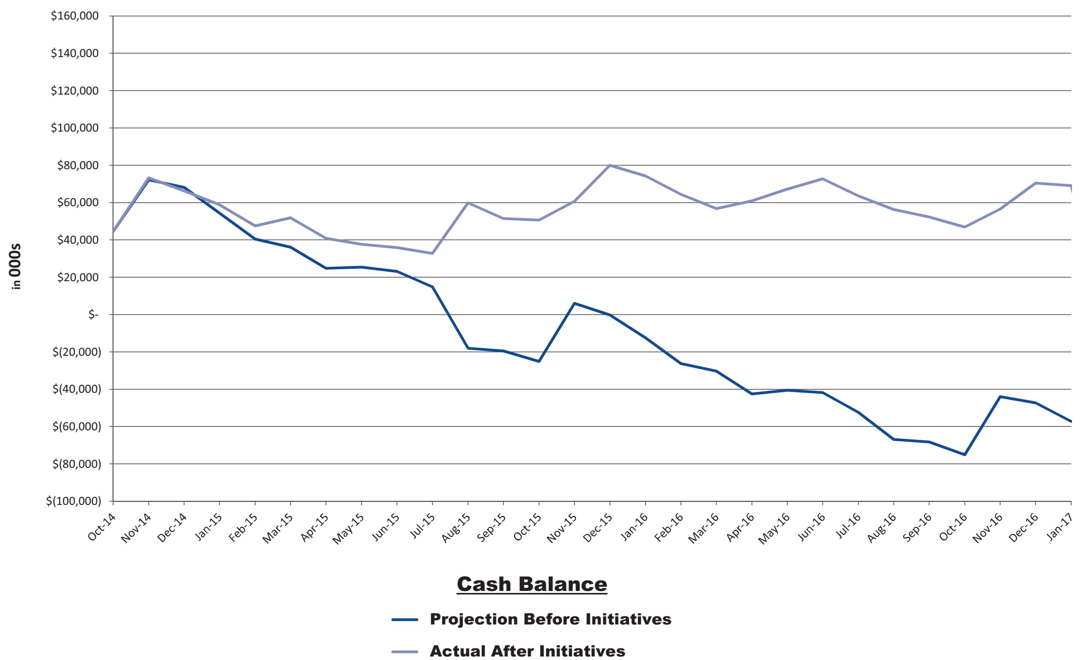
EXHIBIT 2

Unsustainable Financial Trajectory/Turnaround



and perceptions were measured against those of leaders of top-performing, margin-producing hospitals and health systems in the nation. The results showed that we had a long way to go in our capabilities to produce the kind of results necessary to ensure solvency and long-term viability (Exhibit 3). One manager noted, "MIHS continues to operate in distinct silos in relation to business operations and support operations . . . a cultural problem." Another said, "Leaders want to move forward and effect positive changes; however, there are frequent barriers and pushback."

When this information was shared with MIHS leaders, the message became clear: Our major financial problems were not going to be solved through supplemental funding. Further, the inability to quickly identify costs and revenue opportunities was contributing to the problem.

Although the problems faced by MIHS in 2014 and 2015 were sobering, the feedback provided to senior leadership and the analysis of opportunities created a readiness for change that resulted in significant improvements at MIHS over the next three years.

Adopting a leader development approach to margin improvement and 100-day cycles tied to institutional priorities, MIHS began to quickly turn around its financial situation. Embedded in this approach was an emphasis on value and patient experience, as well as swift implementation of the tools that supported these priorities. By the end of fiscal year 2018, MIHS's net income was more than $34 million, which brought the system's total financial turnaround since fiscal year 2014, as measured by cumulative net income, to more than $150 million (Exhibit 4). These gains were accomplished without eliminating community services and with a reduction in workforce of less than 1 percent.

The stabilization of MIHS's finances enabled the board, medical staff, and leadership team to look toward the future and address

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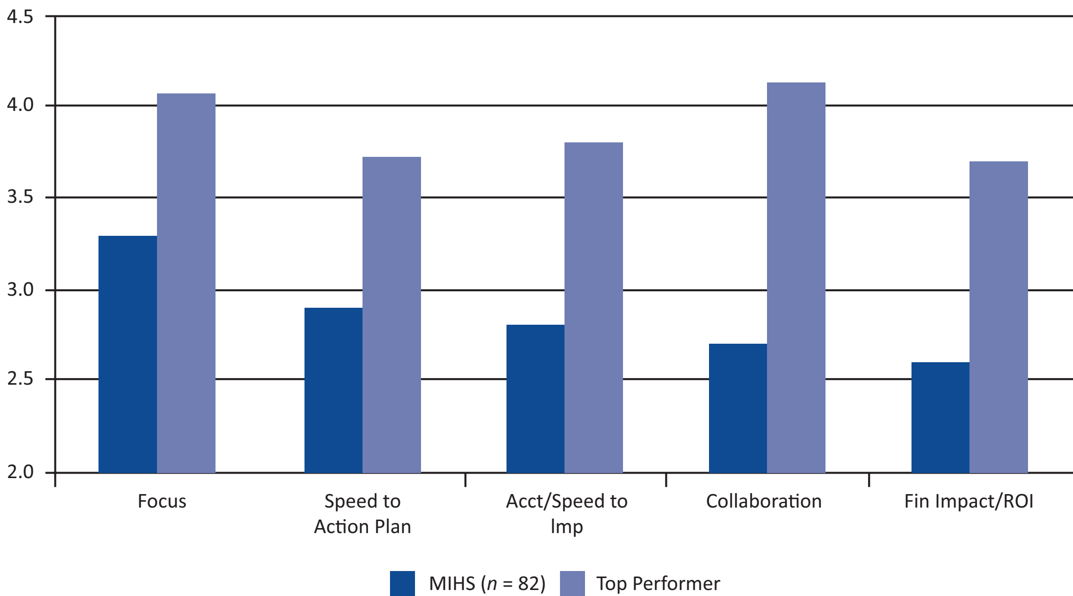
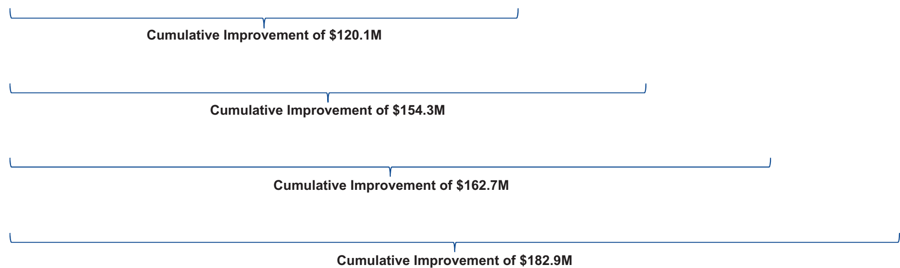
EXHIBIT 3
Survey of Leadership Readiness for Change



Notes: The vertical axis shows responses to a 33-question survey using a 5-point Likert scale (1 = disagree, 2 = somewhat disagree, 3 = neutral, 4 = somewhat agree, 5 = agree). The horizontal axis terms refer to the categories being measured for leaders at MIHS (n = 82) compared to leaders at top-performing hospitals: Acct/Speed to Impl = accountability/speed to implementation, Fin Impact/ROI = financial impact/return on investment.

EXHIBIT 4
Margin Improvement Journey

	Audited					Budget	Forecast
	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Net Income	$ (23,336,822)	$ (41,167,409)	$ (15,332,177)	$ 45,939,467	$ 34,201,486	$ 8,391,694	$ 20,164,265
Less: SNCP Revenue	(52,786,667)	(2,317,701)	-	-	-	-	-
Add: KidsCare Expense	1,950,490	-	-	-	-	-	-
Adjusted Net Income	$ (74,172,999)	$ (43,485,110)	$ (15,332,177)	$ 45,939,467	$ 34,201,486	$ 8,391,694	$ 20,164,265



Notes: Excludes Maricopa Health Plan, Maricopa Care Advantage, and health plan sale. Bond revenues and state pension accounting, all years adjusted. Safety-net care pool (SNCP) funds the unreimbursed costs incurred by eligible providers in caring for the uninsured and Arizona Health Care Cost Containment System (AHCCCS) populations. KidsCare is Arizona's children's health insurance program (CHIP). AHCCCS offers health insurance through KidsCare for eligible children (under age 19) who are not eligible for other AHCCCS health insurance. M = million.

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the question of how best to manage the $935 million capital makeover of the health system. In early 2016, we established the integrated program management office, which brought together internationally recognized talent in the areas of program management, model-of-care redesign, strategic planning, real estate, communication, and branding to reinvent the teaching hospital and healthcare system. The term *Care Reimagined* was adopted to reinforce the fact that this endeavor involved more than just bricks and mortar; it entailed a total redesign of care delivery, as well as the business processes and other activities that support it. The goal was to lower the per capita cost of care, improve the patient experience and clinical outcomes, and enhance caregiver job satisfaction.

State Legislative and Policy Actions

In 2013, House Bill 2045 was signed into law, requiring a healthcare facility with more than 50 inpatient beds to make available on request or online its price for the 50 most-used diagnosis-related group codes and the 50 most-used outpatient service codes. A facility with 50 or fewer inpatient beds must make available at least 35 of the outlined codes.

The legislation also requires healthcare providers and facilities to make available the direct-pay price for their most common services or codes, as well as to delineate details related to additional costs and complications. The legislation defines direct-pay price as

> *the entire price that will be charged by a healthcare provider (or facility) for a lawful healthcare service, regardless of the health insurance status of the person, if the entire fee for the service is paid in full directly to a healthcare provider (or facility) by the person, including the person's health savings account, or by the person's employer and that does not prohibit a provider (or facility) from establishing a payment plan with the person. (Arizona State Senate 2013)*

Both the AHCCCS and the Arizona Department of Health Services maintained comparative cost data on hospitals online from 2010 through 2013.

Affordable Care Act Open Enrollment

To bring more information about cost and price transparency to the community, MIHS undertook significant efforts to assist individuals enrolling in Medicaid or Affordable Care Act (marketplace) plans. We understood that this process could be confusing and complicated, especially with respect to the impact of high-deductible plans and premium costs on total out-of-pocket expenses. In the first year of open enrollment (OE1), we set a goal of assisting 10,000 individuals in submitting applications. These efforts were guided by careful planning and implementation, as well as by sponsorship and support at the highest level of the organization.

Results from OE1 included the following:

- A total of 10,347 individual applications were submitted to Medicaid and the marketplace.
- The call center's volume of calls exceeded 420,000 outbound, with 3,188 successful contacts (74 percent Medicaid and 26 percent marketplace). The call center received 2,619 inbound calls, with 832 successful dispositions (46 percent Medicaid and 54 percent marketplace).
- The application counselor organization submitted 5,231 applications

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(89 percent Medicaid and 11 percent marketplace).
- A total of 150 individuals attended events targeted to the Hispanic population, and 41 were registered by MIHS enrollment specialists.
- A total of 129 refugees representing 21 nationalities attended two outreach events; 54 of these individuals were directed to the Medicaid agency, and 43 were directed to the marketplace.

Concurrent with these activities, MIHS's marketing team developed a focused approach to engaging the community about the enrollment opportunities available through our dedicated URLs. The strategy included both traditional (direct mail marketing, fliers, and ads) and online tactics to deliver important information and drive the audience to the in-depth content on the support websites. The marketing campaign was hugely successful, generating more than 11,625 webpage views, with an average of more than two minutes spent on each page. A total of 883 leads were generated, with a conversion rate of 7.5 percent that far exceeded the industry standard of 2.35 percent. Nearly half of these leads were for marketplace enrollees, and the rest were for Medicaid enrollees. MIHS ultimately brought coverage to almost 38,000 lives in OE2, and we continue to educate and encourage enrollment.

The Call for Price Transparency

According to a nationwide Gallup poll of 1,041 adults, 55 percent of those surveyed consider healthcare availability and affordability to be their top concern, ranked ahead of federal spending, gun availability, drug use, and hunger and homelessness (Jones 2018). Now more than ever, patients want financial transparency regarding their healthcare needs.

As mentioned, MIHS has a challenging payer mix. With a disproportionate share of uninsured, underinsured, and Medicaid patients, we must provide affordable services to our community while remaining financially viable.

Financial Programs and Initiatives

To improve access to care and address the financial needs of the community in a transparent manner, MIHS developed several comprehensive financial programs. Our programs align closely with the price transparency guidelines and recommendations of the American Hospital Association (2014) and the Healthcare Financial Management Association (2015). The MIHS financial programs aimed at price transparency are outlined in the following sections.

Financial Counseling

MIHS developed a robust financial counseling program to help patients determine their out-of-pocket costs. For the uninsured, financial counselors assist families in applying for government programs such as Medicaid, Medicare, disability, emergency Medicaid, and other federal or state programs. MIHS employs 21 full-time financial counselors who are stationed throughout 13 family health centers, a comprehensive health center, a medical center, an emergency department, and behavioral health facilities. In addition to these employed financial counselors, MIHS also uses an outside service to help with applications for financial counseling, including home visits when necessary, and with follow-ups on pending government program applications. Patients who do not qualify for any state or federal programs are screened for eligibility under our sliding-fee discount program for uninsured patients. Our financial

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counselors, appointment schedulers, and registration staff also give insured patients estimates of their out-of-pocket expenses, either before service is provided or at the point of service.

Sliding Fees for the Uninsured

MIHS has a sliding-fee discount program for uninsured patients who do not qualify for any state or federal programs. There are two schedules: one for the FQHC Look-Alike clinics (which serve the same population as the FQHCs and receive enhanced Medicaid payments but do not receive federal Health Resources and Services Administration grants or sovereign immunity) and one for non-FQHC services. The financial counselors work with families to complete a financial screening that includes family income and size, as well as supporting documents to verify income. The program is based on a discount schedule that correlates to a patient's ranking (category 1 to 5) on the federal poverty level scale. MIHS uses the Medicare rate as the baseline for calculating the discount. This program is reviewed and revised periodically to meet the needs of the community. (Our sliding-fee discount schedule for uninsured patients for the non-FQHCs is provided as Appendix A to this article, published online as Supplemental Digital Content at http://links.lww.com/FRONTIERS/A1.) In 2017, we provided discounted services to 27,295 patients under this program.

Price Estimates

Technology can be a powerful enabler of price transparency. MIHS registration, scheduling, and financial counseling staff use several computer-assisted tools to provide patients with price estimates. The web-based nThrive care price tool, for example, ties together chargemaster pricing data with the terms of MIHS's insurance contracts to estimate the average price for each service according to payer. The MIHS registration system is aligned with the payer databases to allow real-time verification of insurance benefits for each patient, including out-of-pocket expenses such as deductibles, copays, and coinsurance. This information is used in conjunction with the pricing tool to arrive at accurate price estimates that can be printed and provided to the consumer. On average, we provide 900 price estimates per month, valued at $2.3 million.

MIHS also publishes the discount schedule for uninsured patients and prices for the most common inpatient and outpatient procedures on our website. A link to the MIHS chargemaster is also provided in a machine-readable format to further promote price transparency, although the chargemaster listing is not what consumers pay. The website also explains the financial programs and how to connect with a financial counselor; information about insurance contracts and registration and billing procedures is provided as well.

Hospital Cost Shifting

MIHS is working to provide price transparency for patients while also understanding the difference between a patient's costs and the hospital's costs. Internal MIHS data from July 2015 through March 2018 show that Medicaid paid, on average, only 80 percent of the actual cost of hospital care for MIHS Medicaid patients. Almost 60 percent of MIHS patients are covered by Medicaid or are uninsured, so these patients' costs must be absorbed in other ways. Such cost shifting occurs when a healthcare provider requires a greater payment from an insured patient than from governmental payers or uninsured patients for the same procedure or service. Individuals with health insurance—and, in the case of MIHS, our community via local

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tax support—pay for the financial shortfall incurred when care is provided to uninsured patients or those covered by Medicaid. During 2017, payments to MIHS for the care of privately insured people were equal to about 136 percent of their actual costs of care. Thus, private payers are making up for the deficits incurred by providing care to Medicaid patients and the uninsured. A portion of the amount paid by individuals with private insurance (through premiums and out-of-pocket costs) is attributable to the need for hospitals to fund uncompensated costs.

Patient Assistance Center and Financial Clearance

In 2018, MIHS created a centralized appointment and referral center, the Patient Assistance Center (PAC). The PAC gives patients easy access to MIHS services through a centralized call center. Before PAC, scheduling staff were spread across 23 locations, and the services and processes lacked standardization. In addition to appointment scheduling, the transition to a centralized model has allowed for standardization of processes in preregistering patients, verifying insurance benefits, informing patients of their out-of-pocket expenses, and connecting uninsured patients with a financial counselor before service is provided. A true financial clearance model such as MIHS's provides the patient with a clear understanding of price prior to service, improving the overall experience.

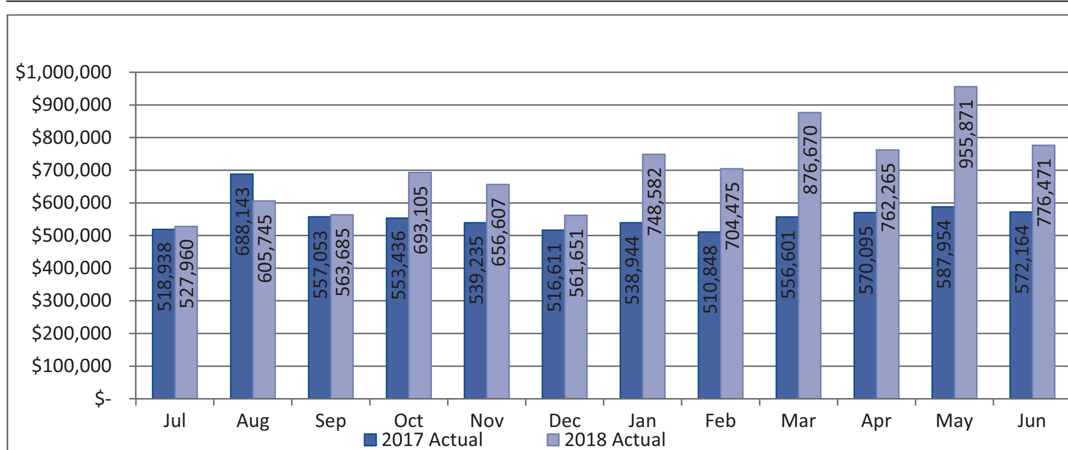
Point-of-Service Cash Collections

Pricing transparency at MIHS has had a positive effect on the preservice and point-of-service cash collections. Patients are more likely to pay if they are informed of the costs beforehand. Sharing this information at the start also creates a better patient experience by allowing patients to make informed decisions about their healthcare. Exhibit 5 shows the positive trend in MIHS point-of-service collections over two years. The implementation of MIHS's financial clearance model in 2018 resulted in increased collections as compared to 2017. We expect further improvement in the months ahead as preregistration and financial clearance processes are refined.

Rate Setting

MIHS uses nThrive annually to perform comparative modeling of our rates against

EXHIBIT 5
MIHS Point-of-Service Cash Collections, 2017–2018



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those of similar hospitals in the market. Comparative rate modeling provides an assessment of competitive position, on aggregate and individual charge code levels, using comparative benchmarks from similar health systems. The assessment allows for a realignment of the existing chargemaster to better position prices in relation to benchmark prices, while considering the gross and net revenue impact of these changes and the organization's long-term strategic pricing goals. The most recent rate change at MIHS, on July 1, 2018, was 0.03 percent.

MyChart

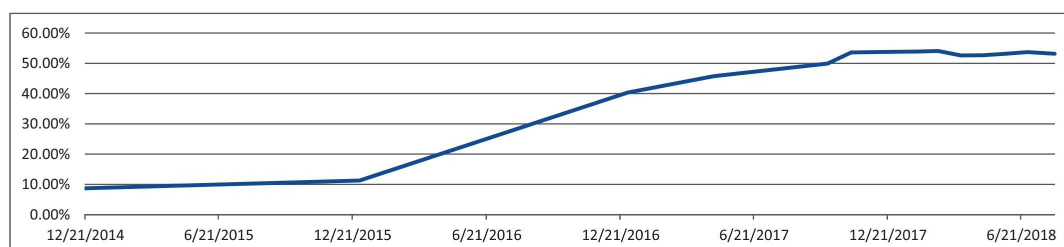
MIHS provides a secure online health connection through Epic's MyChart. MyChart allows patients to communicate with their providers, request prescription refills, make a payment on their health account, access test results, ask billing questions, and manage appointments. Providing this convenient and efficient online tool became a priority for MIHS in 2015. Despite being on Epic for more than five years, our overall activation rate was very low (8.7 percent in December 2014). We identified several barriers to activation, including a complex sign-up process involving a long code that patients had to enter on a website, lack of reliable personal computer or smartphone access to complete the setup, confusion regarding MyChart's functionality, and inconsistent promotion. MIHS created an acceleration plan in December 2015 with the goals of increasing sign-up, enhancing functionality, and promoting MyChart consistently across the organization. We facilitated a meeting between the MIHS executives responsible for ambulatory care and the leadership at each clinic site, with the primary goal to demonstrate the in-person sign-up process and develop a plan to sign up patients in the clinic. The group unanimously decided that this process would be completed by the medical assistant in the treatment room. Clinic site leaders became the owners of the plan, accountable for achieving targeted benchmarks for each clinic. The plan was a success: Activation rates jumped and continue to climb steadily (Exhibit 6). MIHS collects an average of $30,000 per month through 320 payment transactions via online bill pay with MyChart.

Looking Ahead

With price transparency a major healthcare initiative, the Centers for Medicare & Medicaid Services is developing guidelines for hospital compliance with transparency requirements—for example, posting a list of standard charges on hospital websites in 2019. Although this governmental dictate may improve access to accurate and timely price estimates, what matters most to patients is the amount of money they will actually pay

EXHIBIT 6

Patients Who Activated MyChart Accounts During Clinic Visits



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out-of-pocket. According to the *Trends in Healthcare Payments Eighth Annual Report: 2017* (InstaMed 2018), the role of consumers in healthcare has grown in direct proportion to their increasing financial responsibility. A major contributor to this trend is the increasing number of consumers enrolled in high-deductible health plans. Many patients do not understand their medical bills or their payment responsibility, and healthcare terms are often confusing. Only 9 percent of consumers could successfully define the basic healthcare insurance concepts of plan premiums, deductible, coinsurance, and out-of-pocket maximums. Consumer out-of-pocket healthcare spending is expected to grow from $416 billion in 2014 to $608 billion in 2019 (InstaMed 2018). Consequently, we believe that consumerism will be the catalyst for changes in price transparency.

Moving forward, MIHS is committed, as part of its reinvention, to becoming a more patient-centered, consumer-friendly organization. This commitment includes providing better tools for patients—and their insurers and employers—to understand their out-of-pocket costs for services. The challenging regulatory environment for chargemaster maintenance, balance billing, and covered services (which vary from payer to payer) makes it imperative that hospitals and health systems get this right, and that starts with a better understanding of consumer needs. MIHS has begun this effort in earnest with the establishment of our patient and family advisory council, which provides valuable input on how we can better address customer service, including price transparency. Staff training is critical to support all the work being done in this area. These workflows are tested as part of the overall Care Reimagined model. We will constantly test the services provided by vendors to ensure that the important work they are doing is tailored to the consumer and linked to insurance plans and that it ultimately provides accurate estimates of out-of-pocket costs, regardless of insurance status.

Understanding cost and pricing information in our service area is essential. A growing number of alternative sites of care, such as ambulatory surgery centers, urgent care centers, imaging centers, and walk-in clinics, are being developed at a rapid pace. Often, these competing sites of care are operated by nontraditional enterprises that will deploy the latest technology to support consumer satisfaction.

Conclusion

At the end of the day, MIHS is a publicly owned healthcare system that is responsible to the community for stewardship of scarce resources. The tools described here, and others to be developed in the future, are all about fulfilling our obligations to the community and providing better service to a diverse population, including many who are among the most vulnerable in our society.

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