From Fee-for-Service to Value-Based Healthcare

Managing The Pace of Change in Clinical Transformation

A Panel Discussion
The Fourth Annual Accountable Care Organization Summit
June 12-14, 2013
Hyatt Regency on Capitol Hill, Washington, DC
Never Assume Anything
ASSUMPTION
It makes an ass out of you and me
500 Beds * 1 Billion Gross Revenue * $400 Million Medicare Revenue * 3% Profit Margin (All Payers) * $30 Million Profit per Year (All Payers) * $12 Million Dollar Profit on Medicare Patients

Anytown Hospital
Anytown, USA 08057
2013: VBP, Bundled Payments, Readmission Reduction, Penalties
MSSP ACO

2014

2015

2016

2017

2018

2019

2020: Full Risk IHDS
Global Payment for Defined Population

2013: Value Based Purchasing
Organization Accountable Care
Medical Home Care

HRRP Penalty Cap
1% 2% 3%

2013 2014 2015
Value Based Purchasing

$400 Million in Medicare Revenue

2013: $4 Million
2014: $8 Million
2015: $12 Million
Hospital Readmission Reduction Penalty (HRRP)

$400 Million in Medicare Revenue
- 2013: $4 Million
- 2014: $8 Million
- 2015: $12 Million
Bundled Payments
EARN BACK YOUR MONEY

$12 Million Dollars

Value Based Purchasing

ENHANCE REVENUE OPPORTUNITIES

$11 Million Dollars on Joints

$50 - $150 Million Dollars
Figure 1. Total Knee Replacement Average Costs
Average costs for a total knee replacement episode in a Medicare fee-for-service population, split between typical and potentially avoidable complications.
**Bundled Payments Revenue Opportunity Calculations**

Total Joint Surgery: Assume - $28,500 for Episode of Care

$7000 Hospital * $1500 Surgeon
$2000 other Medical Expenses (Consults, Labs, Etc)
$7000 SNF * $7000 Home Care * $4000 Implant

**Total: $28,500**

**Plan:**
Reduce SNF Spend to Zero if Possible: Send patient home with home PT
If SNF needed, keep LOS optimized (7 days rather than 30 days)
Reduce cost of implant.

**Savings:**
$2000 in implant and $5000 in SNF: $7000 per case profit
$7000/$28,500 = 25% Profit

Assume 1600 Total Joint Cases per Year. (1600 cases) x ($7000 profit/case)
= $11.2 Million Dollar Profit

Can we keep 100% of Savings
How does SNF replace lost Revenue?
Figure 1. Total Knee Replacement Average Costs
Average costs for a total knee replacement episode in a Medicare fee-for-service population, split between typical and potentially avoidable complications.

Average Knee Replacement Episode Cost
- Average PAC Cost
- Average Typical Cost

Costs:
- $16,826
- $5,785

Cost Labels:
- $25,000
- $20,000
- $15,000
- $10,000
- $5,000
ACO Revenue and Profit Opportunity

ACO and Commercial Contracting
IHDS with Contracting
MSSP ACO which is 50% Shared Savings with No Downside

50,000 in population
Current cost is $10,000 per member per year
Total Yearly Spend on Population: $50,000 x 10,000 which is $500 Million per Year
Reduce cost of care to $9000 per member per year
Savings is ($10,000 PMPY x 50,000) – ($9000 PMPY x 50,000) which is $50 Million per Year

$50 Million per year on $500 Million per Year Gross Revenue is 10% margin

For Baseline of $10,000 per member per year on population of 50,000 members:
$9000 PMPY  $50 Million Net Revenue
$8000 PMPY  $100 million Net Revenue
$7000 PMPY  $150 million Net Revenue

Significant Dollar Opportunity in ACO program if we get to keep 100% of Savings
ASSUMPTIONS

NEVER ASSUME WHAT YOU’RE TRYING TO PROVE,
UNLESS YOU’RE TRYING TO PROVE YOU’RE A BONEHEAD.
Conclusions

2013: “Value Based Care” = $8 Million at Risk
1% of Gross Revenue and 27% of Profit

$8 Million/$1 Billion in Revenue = 0.8%
$8 Million/$30 in Profit = 27% of Profit at Risk

2020: “Full Capitation and Full Risk”

$50 Million Dollar Opportunity for each 50,000
member population over 65 years of age
98% Fee For Service
1% Value Based Purchasing
1% Readmission Reduction

Staged Quality Improvement Per Year
Staging Populations to bring into Value Based System


Full Risk, Global Capitation
Payer/Provider Merge as One
Population Health & Complex Case Management
Incentives Aligned
High Quality, High Value, High Patient Satisfaction
Physician Designed
Cost and Quality Data Feedback, Process Improvement
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<td>10% Uncompensated Care</td>
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<td>Fee for Service</td>
<td>98%</td>
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<td>Risk Sharing</td>
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<td>Fee For Service</td>
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<td>FFS plus Shared Savings (MMSP ACO)</td>
<td>10%</td>
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<td>Value Based Purchasing</td>
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<td>Readmission Reduction</td>
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<td>Bundled Payments</td>
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<td>Gainsharing</td>
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<td>$9 per month Capitation (not much money)</td>
<td>Physician Led with Robust Physician Engagement</td>
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<td>$2 Co-pay for Visit (Different Incentives for Provider and Patient)</td>
<td>Robust Support Structures and Processes to assist Primary Care</td>
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<td>Incentive NOT to see Patient</td>
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<td>Data not complete, reliable or believable</td>
<td>Electronic Medicare Records</td>
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<td>No Electronic Medical Records</td>
<td>Fully-Informed Care</td>
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<td>Payer and Provider at Odds</td>
<td>Robust Communication and Information Sharing</td>
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<td>Physician Engagement Poor</td>
<td>Payer and Provider are Tight Partners</td>
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<td>Patient Engagement Poor</td>
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<td>Patient Education - Poor</td>
<td>Performance Improvement Systems</td>
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<td>Rules made by Managed Care Companies and Actuaries not Physicians</td>
<td>Care Teams: Physician, Nurse Practitioner/Physician Assistant, Office Staff, Social Workers, Case Managers Community Health</td>
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<td>Not many physicians in management in 1992</td>
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Evolent Health:

Seth Frazier, Chief Transformation Officer
June 13th, 2013
Evolent’s Comprehensive Population Health and Health Plan Infrastructure

Providing the people, process, and technology to assist Health Systems in the Movement to Value-Based Care
(UPMC and Advisory Board Launched Company)

Offerings

I. Strategic “Blueprint”
   (i.e., integrated value-based business plan)

II. MSO
   Population Management & Network
   Health Plan
   Analytics & Workflow Engine

Payer-Neutral Population Platform

- Health System Employees
- Medicare Advantage/ACO
- Commercial Payers
- Managed Medicaid
- Commercial Health Plan

21
UPMC Case Study: Population Health Outcomes

Demonstrated Mastery of Population Health

Superior patient engagement...
2010 - Indexed to 1.0

...leads to lower trend
Employee 2011 trend

Compounding Effect of Lowering Trend
PMPM Trend: UPMC vs. Industry

Achieving outcomes at scale...
Admin Costs as % of Revenue

International Customer Mgmt Institute
NCQA
JD Powers
National Business Group on Health

...and earning top marks for health plan quality

$65,732,231 5-year savings

Savings by Year
2007 $4.5M
2008 $6.9M
2009 $3.3M
2010 $15.4M
2011 $35.6M

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Technology Overview
Identifi Platform Supports an Ecosystem of Care

Integrated Reporting and Dashboarding Layer

Rules Engine and Workflow Layer

Evolent employs a locally staffed model to embed professionals to complement a system-wide care team.

HIE
Care Team Inputs
Labs
Biometrics
PBM Rx
Core Principles of the Evolent Population Health Model

- Transforming data into action
- Engaging patients with a proactive team
- Aligning physicians with a value-based payment model
- Partnering with payers to align incentives
- Reconstructing the care model
- Providing quality-driven clinical programs
- Managing total cost of care
The Future in Focus

Leading Your Health System to Success in the Affordability Economy

Tom Cassels, Executive Director for Research & Insights
The Advisory Board Company

<email address>
Washing Away Market Flaws

Future Strategy and Ambition—P&G or C&W?

Company in Brief: Proctor & Gamble

• In February 2012, launched Tide Pods capsules
• Fixed-dose product prevents over-utilization, increases customer convenience

Pod is killing the laundry detergent category...Now, what kind of a new product is good when it’s hurting the total category?

CEO, Church & Dwight
Maker of Arm & Hammer

58%
P&G’s share of the North American laundry market

$0.25
Unit price of Tide Pods, compared to $0.20 for traditional detergent

(2.1%)
Change in total U.S. sales of detergent, 2012-2013

Nearing the Limits of Extractive Growth Strategies

Legacy Growth Levers Increasingly Time-Limited

Traditional Hospital Growth Strategies

**Consolidate Market Position**

*Emerging Limitations:*
• High degree of existing consolidation in major markets
• Heightened scrutiny of hospital mergers
• Limited capital available for acquisitions

**Lock Up Referral Streams**

*Emerging Limitations:*
• Fewer physicians remain unaffiliated
• Increased scrutiny of practice acquisitions
• Elevated competition from other health systems, physician aggregators

**Demand Price Increases**

*Emerging Limitations:*
• Shrinking population of commercially insured patients
• Rise of stealth and contingent rate cuts
• Activist purchasers refusing price increases

Source: Health Care Advisory Board interviews and analysis.
A Transformative Strategy of Productive Growth

Adapting to New Rules of Competition

<table>
<thead>
<tr>
<th>Description</th>
<th>Health System Strategy, c. 2003</th>
<th>Health System Strategy, 2013-2023</th>
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<tr>
<td><strong>Grow by being bigger</strong>: Leverage market dominance to secure prime pricing, network status</td>
<td><strong>Grow by being better</strong>: Leverage cost, quality, service advantage to attract key decision makers</td>
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**Key Success Factors**
- Expand market share
- Strengthen service lines
- Exert pricing leverage
- Solidify referrals
- Secure physicians
- Increase utilization

**Target of Strategy**
- Commercial payers
- Government purchasers
- Physicians
- Employers
- Individuals
- Population health managers

**Performance Metrics**
- Discharges
- Service line share
- Fee-for-service revenue
- Pricing growth
- Occupancy rate
- Process quality
- Share of lives
- Geographic reach
- Risk-based revenue
- Share of wallet
- Outcomes quality
- Total cost of care

**Competitive Dynamics**
- Service line competition
- Centers of excellence
- Referral channels
- Physician loyalty
- Comprehensive care
- Patient engagement
- Clinical quality
- Service quality

**Critical Infrastructure**
- Inpatient capacity
- Outpatient imaging centers
- Clinical technology
- Ambulatory surgery centers
- Primary care capacity
- Care management staff and systems
- IT analytics
- Post-acute care network

**Key Leaders**
- CEO
- CFO
- COO
- CMO
- CNO
- Board

1) Chief physician executive.
2) Chief transformation officer.
3) Chief integration officer.

Source: Health Care Advisory Board interviews and analysis.
Succeeding as a Population Health Manager

Positioning For Long-Term Growth

Three Key Imperatives for Providers

1. Market Share of Lives
   - Key Imperative: Assemble Reliable Service Network

2. Value-Based Reimbursement
   - Key Imperative: Develop Primarily Risk-Based Payment Model

3. Utilization Management
   - Key Imperative: Operate Effective Population Health Infrastructure

Source: Health Care Advisory Board interviews and analysis.
Assembling a Reliable Service Network

Ensuring Timely Care for a Diverse Array of Conditions

Comprehensiveness Not Contingent Upon Ownership

Source: Health Care Advisory Board interviews and analysis.
Developing Appropriate Risk Based Payment

Full Risk—or Close To It—Required for Success

Financial Outlook Under Various Payment Models

Margin Impact of 10-Percent Reduction in Inpatient Utilization

- If per-capita utilization declines, hospital profits decline under fee-for-service and shared savings models, though shared savings defray some losses.
- Only full-risk models provide positive incentive to reduce demand.

Source: Health Care Advisory Board interviews and analysis.
Operating Effectively as a Population Manager

Building Three Complementary Care Delivery Models

Five Essential Elements of Care Management

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<th>High-Cost</th>
<th>Rising-Risk</th>
<th>Low-Cost</th>
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<tr>
<td><strong>Care Model</strong></td>
<td>Single point of contact with high-risk care manager</td>
<td>Medical home</td>
<td>Online patient portal and access to low-cost sites of care</td>
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<tr>
<td><strong>Support Services</strong></td>
<td>Home care, pharmacist</td>
<td>Group visits, online health community</td>
<td>Mobile apps</td>
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<tr>
<td><strong>Technology</strong></td>
<td>EMR tracking module</td>
<td>Risk segmentation analytics</td>
<td>Online portal</td>
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<tr>
<td><strong>Labor</strong></td>
<td>High-risk care manager</td>
<td>Health coach</td>
<td>Health coach, when needed</td>
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<td><strong>Network</strong></td>
<td>Comprehensive network of aligned post-acute providers</td>
<td>Primary care practice</td>
<td>Retail clinics, urgent care</td>
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Source: Health Care Advisory Board interviews and analysis.
Heaviest Lift Remains Culture Change

Key Determinants of Health Management Success

Clear Organizational Priorities

- Direct relationships with purchasers
- Reducing the Total Cost of Care for lives under care
- “Good growth” derives from enrollment and retention of individuals, groups to the network

Strategic Pivot in Resource Allocation

- Physician-led coordinated care network
- Sophisticated tools for risk stratification and targeting interventions
- Investments in a diverse set of physical and virtual access points

Processes for Operating a Coordinated Care Enterprise

- “Best Care” guidelines that follow patients across the continuum
- Role definition and simplification of patient engagement
- Becoming a “lighter” enterprise through smart capacity management

Source: Advisory Board interviews and analysis.
Transforming our Focus, Not our DNA

Core of the Mission

I was recently reminded that our founders didn’t come to our community to fill hospital beds, they came to serve people in need. And I want to know that decades from now, even hundreds of years now ... people [will] look back and say "the [leaders] who were running these Catholic ministries at the turn of the century made the right decisions to put us on a path moving forward.”

Kevin Lofton
CEO
Catholic Health Initiatives

Source: Health Care Advisory Board interviews and analysis.
Summit Medical Group
Pace of $\Delta$

Kimberly Kauffman
Vice President, Value-Based Care
Summit Medical Group

- Physician owned, physician-only Board
- 150 PCPs + 70 specialists + 80 extenders
- 320,000 active patients
- 55 practice sites, 12 county market
- Ancillaries – lab, imaging, sleep, PT / OT, urgent care & wellness
- 100% primary care sites recognized by NCQA as Patient Centered Medical Home
- AllScripts EMR in all sites
Summit Health Solutions

• MSSP ACO w/ July 1, 2012 start date
• Wholly owned by Summit Medical Group
• Two hospital systems as participant providers
• 23 RN CCs, 5 LCSWs, 2 LPNs, 1 Med’l Dir
• 36,000 attributed beneficiaries
• 44,000 pts in Med Adv or Mcare FFS
• Optum Care Suite live 5/1/13
What Keeps You Up @ Night?

- Goal
  Outcome = Income

- Process
  Ready → Shoot → Aim
Changes initiated in 2006

Infrastructure
Compliance
Scope of service
Quality
Informatics
Contracting
A Work In Process

Culture Eats Strategy for Breakfast
2013 – 2020 To Do List

• Get really good at coordinating care
• Increased transparency
• Enhanced customer engagement
Contact info:
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Summit Health Solutions
Kkauffman@SummitHealthcare.com
(865) 212-0116