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CLINIC

The Fourteenth National Value-Based Payment and Pay for Performance Summit

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Los Angeles, California

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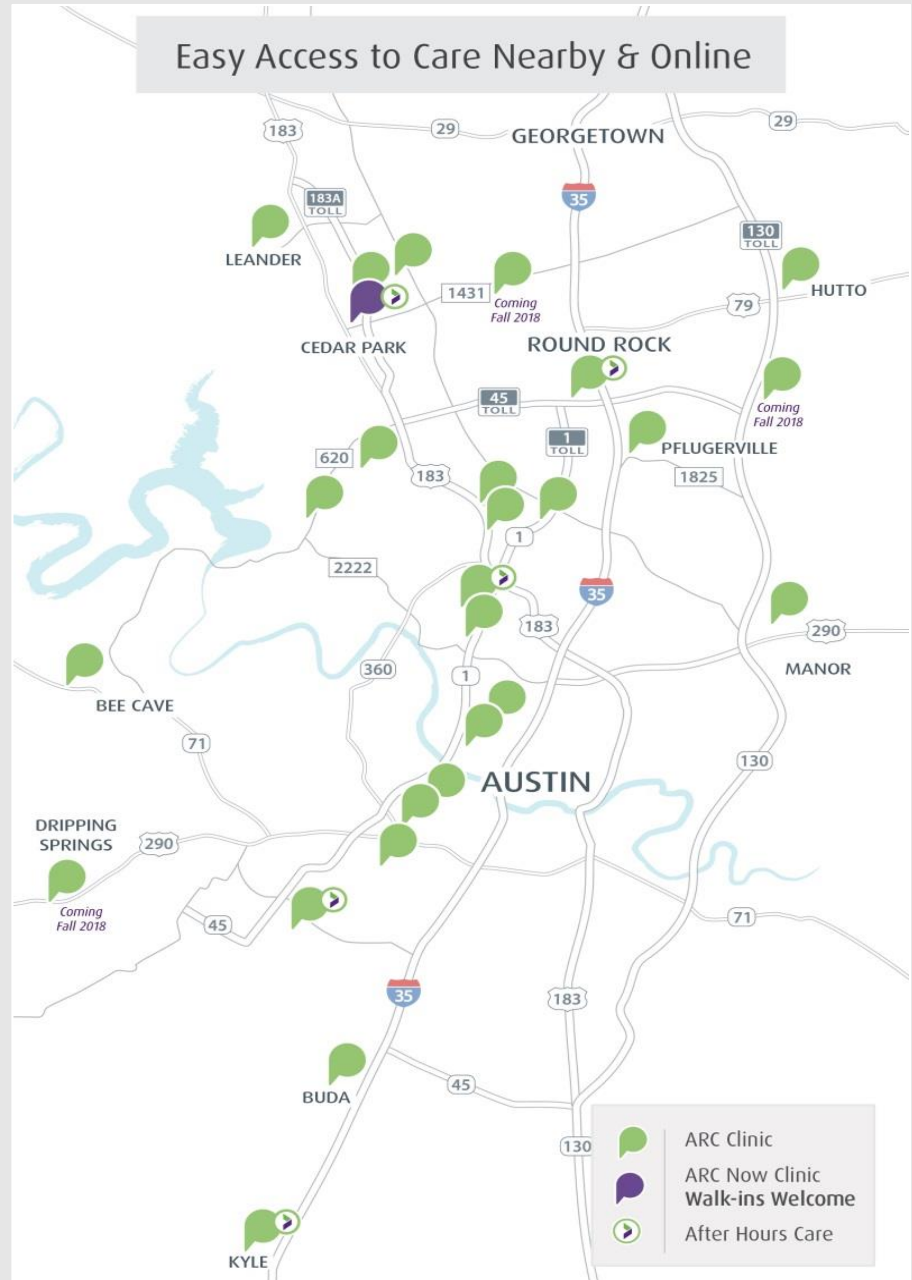
President and CEO

Austin Regional Clinic - Profile



- **$300,000,000 topline revenue**
- **1,300,000+ patient visits**
- **500,000+ active patients**
- **2000+ employees**
- **340 physicians**
- **26 locations** ***(and counting)***
- **19 specialties**
- **10 cities**
- **3 counties**
- **1 multispecialty medical group**

ARC
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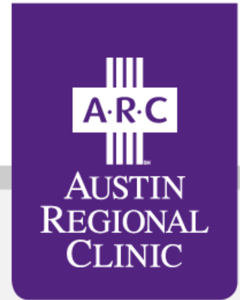
Austin Regional Clinic (ARC) brought managed care to the Austin metro area in 1980. ARC spent it's first two decades focused on delivering high quality, capitated care. Multiple environmental factors dictated a retreat from capitation in 2000.

2000-2010, was a decade of pure FFS.

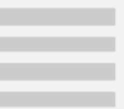
Changing conditions in 2011, permitted a return to value based care.

On 1/1/19, ARC began a fully delegated Medicare Advantage Program – thus returning to it's initial business model.

ARC History 1980-2018



	Fully delegated capitated risk		FFS	FFS + Medical Home Shared Savings
Year	1980	2001	2001-2010	2018
ARC Doctors	3	99	200+	340
Lives Managed	0	80,000 (global risk)	0	240,000 (shared savings)



What makes re-engagement a possibility?

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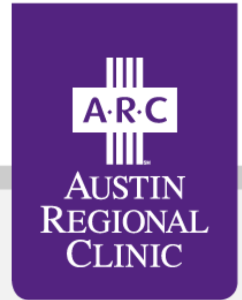
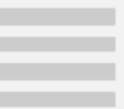
- Passage of the Affordable Care Act has ignited enthusiasm nationally for the ACO model.
- Commercial plans have embraced the concept of population management.
- Large employers have pushed commercial health plans to pilot the PCMH model.
- A Technology promise to allows better stratification of risk and targeted interventions.
- Access to Capital (various forms and stings attached).
- Pricing distortions
- Consumerism
- No clear plan B

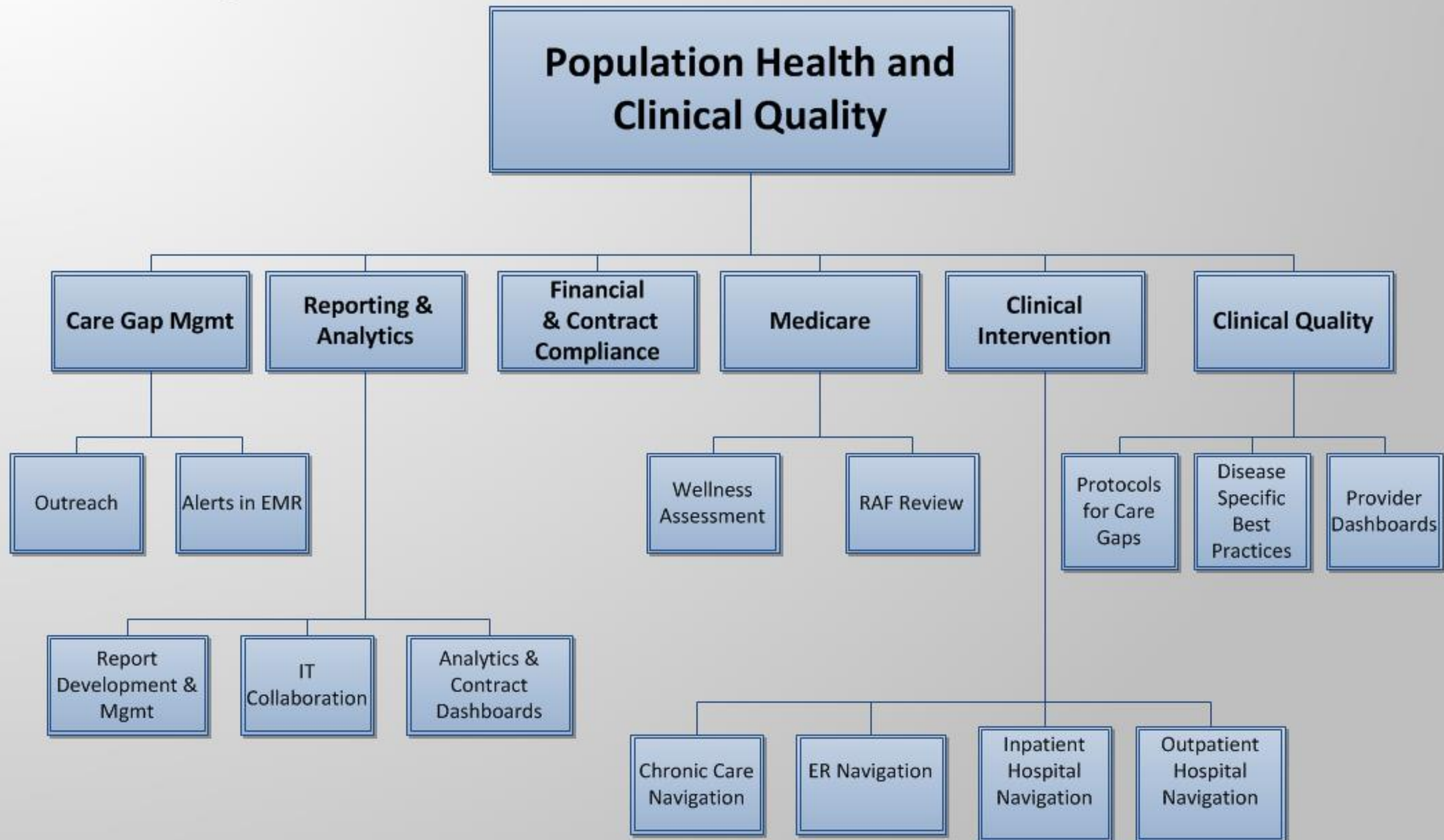
The Journey Continues!



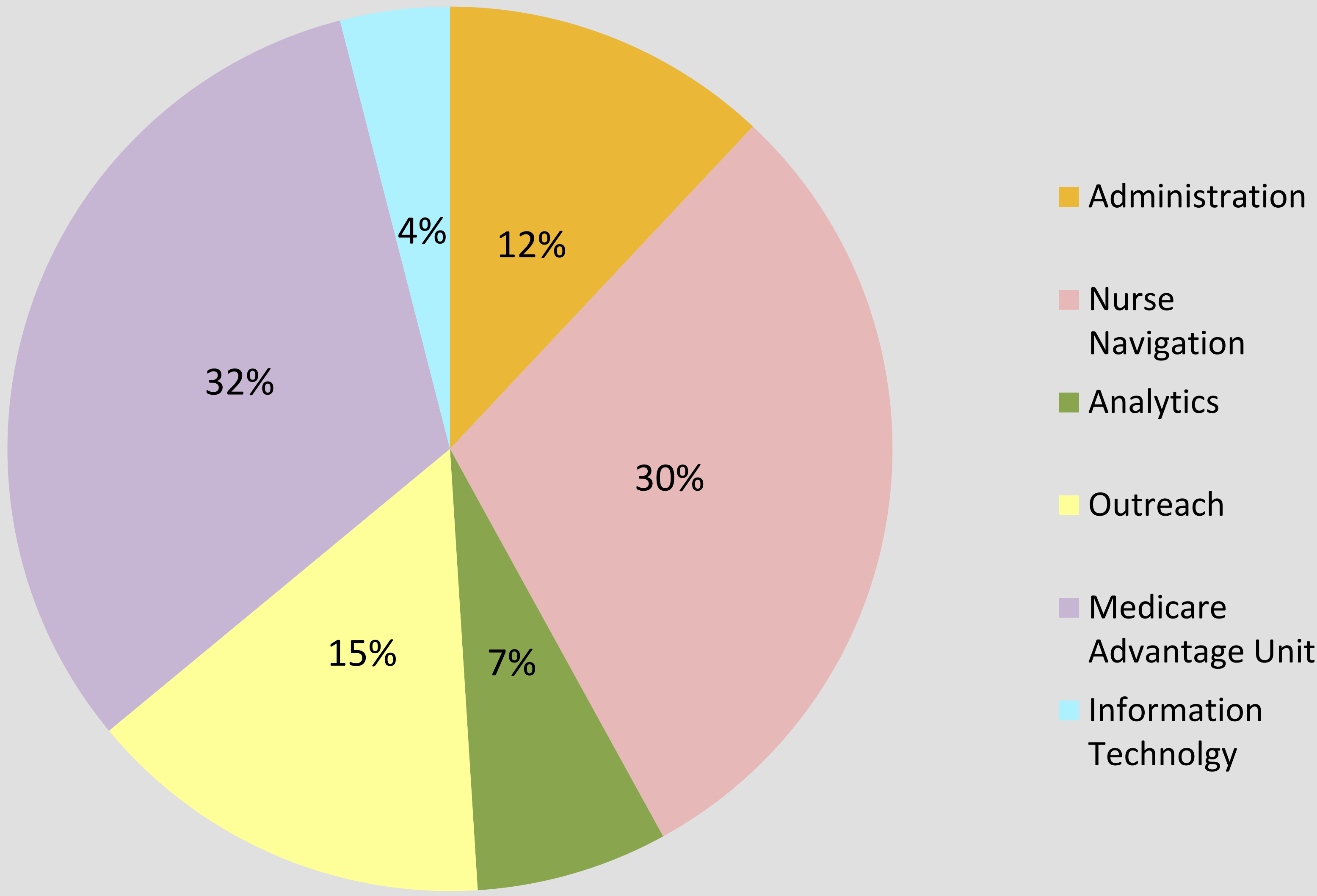
Evolution of ARC's Medical Home Division								
	2011	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Contracts	1	3	5	7	10	12	13	22
Patients	45,000	60,000	80,000	81,000	150,000	200,000	200,000	240,000
Clinical staff/providers*	4	10	17	17	24	22	23	25
Non-clinical staff*	10	17	12	13	16	25	18	18
Medicare Wellness staff/providers*	n/a	3	7	7	14	17	15	15
Medicare Wellness visits by AMH mid-levels	n/a	698	2,922	4,320	6,000+	7,000+	8,000+	8,000+



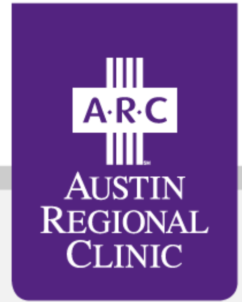
Organizational Structure



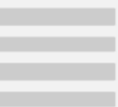
Allocation of Resources by FTE



What's needed for success?



- Committed and sophisticated physician leadership.
- Adequate funding for currently un-and under-reimbursed professional services (Hospitalists, Extensivists, Behavioral Health, Post-Acute Services, etc.).
- Comprehensive, accurate, convenient, real time clinical data.
- Actuarially financial reward for predefined quality & cost goals.
- Robust and committed infrastructure to manage post-acute patient care efficiently.



7 years into our ACO/PCMH Journey

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- $50,000,000 in shared savings but…
- Financial models, policies, direction continue to evolve with limited long term visibility.
- Expensive cost of Care management is certain but cost of care savings aren't.
- Attribution models and patients have no skin in the game.
- IT & analytics are still complex , expensive and frequently providing "noise but not a signal".
- Fragmentation and misalignments are still deeply rooted
- Need to balance competing business models (FFS vs. Risk).

What's next for us?

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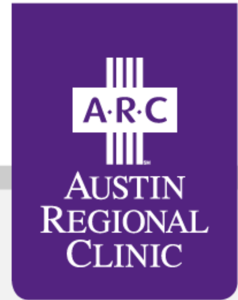
- Mounting challenges to remain in a pure FFS model.
- Questionable sustainability of the current ACOs models: Cost is guaranteed, rewards are optional.
- Difficulty in sustaining a dual model (now triple).

“Back to the Future” “Back to Global Risk”



- Access to smart and appropriately constrained and aligned capital.
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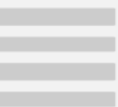
- “Longer” term runway.
- Access to risk expertise.
- Ability to access and build strong national multi-payers relationship and contracts.



Capital $ $ $ $
Contracts Expertise
Analytics/Services

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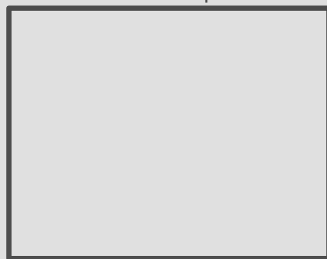
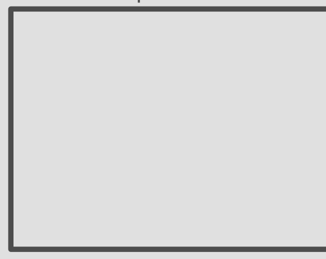
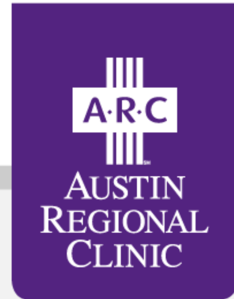
ARC (& other like minded community partners)

Organized multi-specialty platform
MA contracts/lives
Employer-Payer-community-Knowledge

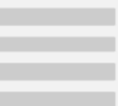
Local
Risk Base
MSO for MA
Global cap

“Next Steps ”



- Building a network of high value parterres
- Specific focus on post-acute: Home health collaboration, imbedded hospital “care managers”, geriatric and palliative care consults, home visits
- Placing “filters” between PCP and Specialty in Cardiology and Spine
- Advancing PCP comp models
- Drug cost (onsite pharmacists)
- Telemedicine and Tele-monitoring



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