Building the Collaborative Care Enterprise

Neal C. Hogan, PhD

Charting Course

- Preface: Basic Point of View
- The Pressure Cooker
- Toward the Collaborative Care Enterprise
Charting Course

- Preface: Basic Point of View
  - Cost/Quality=Value
  - Who will drive this?
    - Government
    - Business
    - Consumers
- The Pressure Cooker
- Toward the Collaborative Care Enterprise

A Brief History of Bubbles

- The Paradigmatic Bubble
  - The South Sea Bubble - 1720
- The First Bubble
  - Dot Com Bubble - 2000
- The Second Bubble
  - Housing Bubble - 2008
- The Third Bubble
  - Healthcare Bubble – 2011?
**Bubble Dynamics: “Unsustainable trends will not be sustained.”**

**South Sea Stock Bubble**

**Dot-Com Bubble**

**Health Care Bubble?**

**History does repeat itself**

<table>
<thead>
<tr>
<th>Necessary Fallacy</th>
<th>South Sea Bubble</th>
<th>Dot-Com Bubble</th>
<th>Housing Bubble</th>
<th>Health Care Bubble</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customers Ignore</td>
<td>Just recapitalizing of debt with equity.</td>
<td>Dawn of the “New Economics”</td>
<td>Home Prices Always Increase</td>
<td>Prices Never Fall</td>
</tr>
<tr>
<td>Government Blinder</td>
<td>There is no “company” with revenues you are just buying debt.</td>
<td>P/E Ratios</td>
<td>Falling Hurdles to Obtaining Mortgages (NINJA)</td>
<td>Triple Cross Solvency</td>
</tr>
<tr>
<td>Security Rationalization</td>
<td>This is a great way to downsize our debt!</td>
<td>DotComs creating enormous wealth (New Revenues for Treasury!)</td>
<td>Housing: Our Reliable Economic Engine</td>
<td>Deficits Don’t Matter</td>
</tr>
<tr>
<td></td>
<td>Enormous new market (New World) creates security.</td>
<td>Enormous New Market (Internet) creates security.</td>
<td>Hedging creates Security.</td>
<td>Scale creates security.</td>
</tr>
</tbody>
</table>
Quotes from The Third Bubble - 2008

- “Some type of reform will pass, which may lead to more people being insured, but in a product (or products) that may have rates closer to Medicare than to commercial insurance.”

- “Between 2011 and 2013
  ➞ The Federal Government will cut Medicare spending.
  ➞ Vast budget deficits created by stimulus packages will lead the government to finally decide that “deficits matter.” In 2013 a New Balanced Budget Act will be passed.”

- “Hospitals will need to “design to cost” meaning that patients need to be housed in accordance with the price being paid. Analyses of readmission rates and the ability to curb them, along with pulling physicians along down that curve, are a must. New reviews of ED use, treatment of chronic patients, and mix must be undertaken. Systems need to determine ways to care for patients using non-hospital assets (preventing admissions). “

- “Once the “real assessment” of physician readiness is complete, it is time to turn to the next effort: working with the physicians to move the entire system toward “the possible.” The possible is the strategy that the physicians and the hospital choose together to move forward in the market. “

BIG FACT 1: There simply is not enough money

- “If costs per enrollee in Medicare and Medicaid grow at the same rate over the next four decades as they have over the past four, those two programs will increase from 5% of GDP today to 20% by 2050.

- Despite the attention often paid to Social Security, spending on that program rises much more modestly -- from 5% to 6% of GDP -- over the same time period.

- Over the long run, the deficit impact of every other fiscal policy variable is swamped by the impact of health-care costs.” Peter Orzag

This is not just a government problem – it is a market problem.
“Herbert Stein’s Law”

“If something cannot go on forever, it will stop.”

Projected Federal Spending on Medicare and Medicaid (% GDP)

- It is the rate of spending per individual that will have the most impact, rather than the growth in demographics of an aging population.
- “Effect of excess cost growth” refers to the extent to which the increase in health care spending for an average individual exceeds the growth in per capita GDP.
- “Interaction” refers to effects of excess cost growth and the aging of the population, which result in greater growth in spending than would result from either factor separately.
- “Aging of population” refers to demographic factors, such as an increasing average population age and life expectancy.

Source: Congressional Budget Office

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Our National Budget: (Enormous Price Pressure)

Most of Budget Goes Toward Defense, Social Security, and Major Health Programs

- Defense and Security: 21%
- Safety Net Programs: 11%
- Interest on Debt: 8%
- Medicare, Medicaid, and CHIP: 20%
- Social Security: 21%

Expenses: $3.518B
Revenues: $2.105B
Deficit: $1.423B

Equals $630M

Program Areas in the Remaining Fifth of the Budget

- Benefits for Federal Retirees and Veterans: 6%
- Scientific and Medical Research: 3%
- Transportation Infrastructure: 3%
- Education: 2%
- Non-security International: 1%
- All Other: 5%

Source: Congressional Budget Office
Note: Percentages may not total 100% due to rounding.

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Cost Performance: A Mixed Bag

Health care cost increases appear to have settled in at about 6.5% and yet, we are increasingly unaffordable.


Employee Share Flat, But Amount Up 40% Across 5 Years

Total Employee/Employer Health Care Costs

2006 Total Cost = $8,079

23% $1,834
77% $6,245

2011 Total Cost = $11,176

24% $2,660
76% $8,516

We need to change the cost structure

- Business as usual is
  - Bankrupting the United States government – Medicare.
  - Bankrupting the States – Medicaid and pension plans
  - Bankrupting companies – double digit health plan inflation
  - Bankrupting American Families – taking more of their paychecks.

BIG FACT 2: Quality is Being Measured

Quality is already being measured and reported – on someone else’s terms.
What Gets Measured – Gets Managed (sort of)

Data Demonstrates It is Easier To Improve “Managed” Care

2009 National Health Care Quality Report

- Measures of hospital care improve more quickly than measures of outpatient care.

- Measures of acute treatment improve more quickly than measures of preventive care and chronic disease management.

Not in good company

Number 34 in the 2010 World Infant Mortality Ranking
More than a bit fragmented

The percentage of Chronically Ill patients seeing 10 or more doctors in their last 6 months of life increased 20% from 2003 to 2007.
We need to change the quality performance

- Business as usual is
  - Pushing us further down the world health rankings
  - Failing to improve the health of our sickest patients
  - Increasing our fragmented care model
  - Damaging our communities

How it all adds up….

Less Money + Quality Reporting = Value Based Payments

There will be a shift in payment – away from fee-for-service toward some sort of “value based payment”

- Payment Reform
- Consumer Pressure
- Bundled Payment
- Capitated Payment
- ACOs
# Payment Reform Models

## Models Overview

1. Global Payment
2. ACO Shared Savings
3. Medical Home
4. Bundled (Episode) Payment
5. Hospital-Physician Gainsharing
6. Payment for Coordination
7. Hospital P4P
8. Readmissions
9. Hospital-acquired conditions
10. Physician P4P
11. Shared Decision Making

### Performance Goals Addressed by Payment

- Broadly-defined
- Narrowly-defined

### Degree of Provider Aggregation

- More aggregated
- Less aggregated

### Type of Payment

- Population-based
- Fee-for-service

## Charting Course

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  - Cost/Quality=Value
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    - Business
    - Consumers

- **The Pressure Cooker**

- **Toward the Collaborative Care Enterprise**

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**Source:** NQF

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US Health Reform 2010 Was A Response To Market Forces

Two-Pronged approach to Redesign of the US Health Care System. The nation has somehow focused on only 1 Prong....

- PCMH = Patient Centered Medical Home
- ACO = Accountable Care Organization

The State of the ACO: November 2012

Following the New Release of Regulations

The Bottom Line On CMS Estimates:

- The aggregate cost associated with the start-up investment of ACOs participating in the Shared Savings Program will range from $29 million to $157 million
- The aggregate on-going annual operating costs for the participating ACOs will range from $63 million to $342 million
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Health Reform - Beyond Washington D.C.

*Businesses looking to improve their value*

"We can no longer accept 8-12% increases in our health care costs. My objective is to negotiate decreases in our contracts."

Chief Purchasing Officer, CBS Corporation
Lowe's and GE Already on the Move

GE chief seeks local co-op to cut health costs

By James Phelan - jphelan@cincinnati.com -
February 28, 2010

LOVELAND - Cincinnati's major businesses should band together to create the kind of health-care plan that could lower costs, improve service and possibly be a national model for health reform. General Electric's top executive of area business leaders.

Saying "government can't fix the problem, business has to," GE's Jeffrey Immelt outlined a plan that would include combined insurance coverage shared among the region's largest companies. The plan would include a wellness program and education campaigns.

Alternative Quality Contract (ACQ)

BCBS of Massachusetts
Alternative Quality Contract (AQC)

Blue Cross Blue Shield of Massachusetts VB Contract

Contract Overview:
- A "Value-Based" Contract offered to Provider Groups (Voluntary)
- Introduced in January 2009
- Modified Global Payment Model
- Annual Payments to Medical Groups Linked to a "PMPM Budget"
- Quality Performance "Bonus" Opportunity
- 1600 PCPs participating (25% of BCBS Mass network PCPs)
- Twelve (12) major groups in contract

Philosophy
Global Payment allows the Purchaser to control both Price and Quantity (Volume) simultaneously.

Capitation “failure” in the ‘1996-2008’

AQC attempts to avoid the capitation mistakes of the ‘90s…

Physicians refusing to participate in capitated contracts:

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>36.2%</td>
</tr>
<tr>
<td>2008</td>
<td>60.7%</td>
</tr>
</tbody>
</table>

What was different then…?
- Providers unprepared to manage risk
- Quality metrics in infancy
- No broad clinical IT infrastructure
- Importance of registry not understood
- Capitation pitted providers against each other
- Hospitalist movement in its infancy
- No concept of a medical home
- Little understanding of Chronic Care Model
- Just developing process improvement capability
- Adversarial relationship between plans/ providers
**Alternative Quality Contract**

<table>
<thead>
<tr>
<th>Contract Type</th>
<th>Eligible Provider Organizations</th>
<th>Size</th>
<th>Contract Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACQ</td>
<td>MSGs, IPAs or PHOs</td>
<td>PCPs with &gt; 5000 members*</td>
<td>5 years</td>
</tr>
</tbody>
</table>

**Key AQC Features:**

- Global Budget with annual spending growth limits
- Incentive Payments to Improve Quality
- Technical Support for the Groups

**What is different now...?**

- Provider Risk Mitigation Strategies Proposed
- Robust Quality Metrics
- EMR / IT infrastructure in rapid adoption phase
- Real-time Registry Systems available
- Group sharing of Cost/Quality Accountability
- Hospitalists widely deployed
- Medical Home adoption in progress
- Chronic Care Model under adoption
- Process Improvement Capability strong (Hospital)
- Payer – Provider Collaboration in consideration

* MSG = Multispecialty Group  
* IPA = Independent Practice Association  
* PHO = Physician-Hospital Organization

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**BCBS Alternative Quality Contract**

**Contract Terms:**

- Alternative Quality Contract groups agree to accept a global budget to cover all health care services delivered to Blue Cross HMO and POS patients, whether or not the care is provided by the provider group’s physicians and hospitals.....
- Blue Cross negotiates a base year’s budget with each participating group!
- Starting point for the negotiation is the past year’s medical spending for Blue Cross HMO and PPO members who are on the panel or patient roster of the group’s primary care physicians
- BC does not seek to reduce the initial spending budget, but rather targets controlling increases going forward
- Setting the future annual growth rates is a critical aspect of the negotiation
- Over the five year term, the annual budget increases are reduced by 50%
- Groups with higher baseline budgets are generally given lower budget increases than groups with lower baseline budgets
- Budget trajectories are intended to reduce payment disparities related to market power
BCBS Provider Reports

Blue Cross Reporting:
• Data reporting system
• Regular data and performance reports
• Consultative reports
• Organized sessions with providers
• Focus on “unexplained practice pattern variation”
  * Robert Greene and Colleagues methodology

Clinical Focus

- Avoidable Admissions (Asthma, etc.)
- 30-day Readmissions
- Non-urgent Emergency Department Use

Mitigating Financial Risk

5 ways BCBS will “help” providers manage the financial risk…?

- Budgets are adjusted annually for changes in patients' health care status (measured concurrently using DxCG*)
- Groups can choose to participate in the AQC on a “risk sharing” basis rather than a “full risk” arrangement
- All groups required to purchase reinsurance (pays 70-90% of expenses above a high-cost threshold)
  ➔ Offered by Blue Cross
- Alternative Contract includes a “unit cost corridor” — increasing or decreasing the global budget based on provider rate negotiations above or below projected
- A fall-back “overall cost corridor” based on all BC HMO patients cost experience that can be used to adjust budgets if needed

* Diagnostic Cost Groups Risk Adjustment Model
AQC: Quality Incentive Payments

Program offers a significant potential to earn additional dollars based on Quality Performance

- Payments up to 10% of the total PMPM monthly payments
  - 5% bonus on performance of 32 care measures for ambulatory or office-based care
  - 5% bonus on performance of 32 measures of hospital care
- Incentive payments must be “earned” annually (not incorporated in the budgets)
- Quality bonus is:
  - Based on “absolute” rather than “relative” performance
  - Measures are the same for all groups and constant for the 5 years
- Payouts occur after each 12-month cycle

AQC Quality Incentive Plan

**Ambulatory Measures (32) – the Domain of Primary Care**

<table>
<thead>
<tr>
<th>Process</th>
<th>Clinical Conditions (32 measures)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Acute-Phase Rx</td>
</tr>
<tr>
<td></td>
<td>Continual Phase</td>
</tr>
<tr>
<td>• Depression</td>
<td></td>
</tr>
<tr>
<td>• Diabetes</td>
<td>High (12)</td>
</tr>
<tr>
<td></td>
<td>Eye exams</td>
</tr>
<tr>
<td>• Cholesterol Mgmt</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diabetes U/L C</td>
</tr>
<tr>
<td></td>
<td>Screening</td>
</tr>
<tr>
<td></td>
<td>Visual Cloning</td>
</tr>
<tr>
<td>• Preventive Screening/ Rx</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Breast cancer screening</td>
</tr>
<tr>
<td></td>
<td>Cervical cancer screening</td>
</tr>
<tr>
<td>• Chlamydia Screening</td>
<td></td>
</tr>
<tr>
<td>• Adult Respiratory Testing</td>
<td></td>
</tr>
<tr>
<td>• Medication Adherence</td>
<td></td>
</tr>
<tr>
<td>• Pediatric testing/treatment</td>
<td></td>
</tr>
<tr>
<td>• Pediatric well-care visits</td>
<td></td>
</tr>
<tr>
<td>• Adolescent well-care visits</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>HbA1c Control (≤ 6.0)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diabetes</td>
<td></td>
</tr>
<tr>
<td>• Hypertension</td>
<td></td>
</tr>
<tr>
<td>• Cardiovascular Disease</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Experience</th>
<th>Quality of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patient Experience – Adult</td>
<td>Communication Quality, Knowledge of Patients, Integration of Care, Access to Care</td>
</tr>
<tr>
<td>• Patient Experience - Pediatric</td>
<td>Communication Quality, Knowledge of Patients, Integration of Care, Access to Care</td>
</tr>
</tbody>
</table>
AQC Quality Incentive Plan

**Hospital Measures (32)**

<table>
<thead>
<tr>
<th>Process</th>
<th>Hospital Measures (32)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Myocardial Infarction</td>
<td>AQC/MIN for LVF, ASA on Arrival, Smoking Cessation, LVF at Discharge</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>Blood Pressure Evaluation at Baseline, Instructions, Smoking Cessation, LVF at Discharge</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>Flu Vaccine, Antibiotic within six hours, Smoking Cessation, Antibiotic Selection, Blood Culture</td>
</tr>
<tr>
<td>Surgical Infection</td>
<td>Antibiotic Administered, Antibiotics Received, LVF at Discharge, Smoking Cessation</td>
</tr>
</tbody>
</table>

**Outcomes**

- In-hospital Mortality (overall)
- Wound Infection
- Select Infections due to Care
- Pneumonia after Major Surgery
- Post-Operative DVT/PE
- Birth Trauma, Injury to Neonate
- Obstetric Trauma, Vaginal

**Patient Experience**

- Communication with Nurses
- Communication with Doctors
- Responsiveness of Staff
- Discharge Information

---

**AQC - Quality Score Calculation**

*Cumulative Scores on all Measures determine the Incentive Payout…*

<table>
<thead>
<tr>
<th>Process Score</th>
<th>Experience Score</th>
<th>Outcomes Score (3X)</th>
<th>Payout potential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gate 1 Network Median</td>
<td>Gate 2</td>
<td>Gate 3</td>
<td>Gate 4</td>
</tr>
<tr>
<td>0%</td>
<td>25%</td>
<td>50%</td>
<td>75%</td>
</tr>
<tr>
<td>Breast Cancer Screening (%)</td>
<td>77.1</td>
<td>Linear</td>
<td>90.0</td>
</tr>
<tr>
<td>HbA1c Poor Control (%)</td>
<td>45.0</td>
<td>Linear</td>
<td>4.7</td>
</tr>
<tr>
<td>Access to Care</td>
<td>70.0</td>
<td>Linear</td>
<td>90.0</td>
</tr>
<tr>
<td>Flu Vaccine</td>
<td>77.8</td>
<td>Linear</td>
<td>98.6</td>
</tr>
</tbody>
</table>

Payout potential

- Ambulatory = 5% of total pmpm (all claims)
- Hospital = 5% of total pmpm (all claims)
Groups Enrolled in the BCBS AQC (through 2009)

<table>
<thead>
<tr>
<th>Group Name</th>
<th>Description</th>
<th>#PCPs</th>
<th># Spec</th>
<th>Type Phys Group</th>
<th>Hospitals</th>
<th>Prior Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atrius Health</td>
<td>MSG</td>
<td>400</td>
<td>444</td>
<td>Large</td>
<td>0</td>
<td>Yes</td>
</tr>
<tr>
<td>Caritas Christi Network</td>
<td>PHO</td>
<td>276</td>
<td>843</td>
<td>Small</td>
<td>6</td>
<td>No</td>
</tr>
<tr>
<td>Hamden County IPA</td>
<td>IPA</td>
<td>72</td>
<td>0</td>
<td>Small</td>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>Lowell General PHO</td>
<td>PHO</td>
<td>80</td>
<td>200</td>
<td>Small</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>Mt. Auburn Cambridge IPA</td>
<td>IPA with Hosp</td>
<td>112</td>
<td>399</td>
<td>Small</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>New England Quality Care Alliance</td>
<td>Hospital-owned IPA</td>
<td>369</td>
<td>982</td>
<td>Mixed</td>
<td>0</td>
<td>Some</td>
</tr>
<tr>
<td>Signature Health</td>
<td>Integrated System</td>
<td>50</td>
<td>109</td>
<td>Large</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>South Shore PHO</td>
<td>PHO</td>
<td>98</td>
<td>281</td>
<td>Small</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>Beth Israel Deaconess</td>
<td>Starts 2011</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Smallest contract = 72 physicians
Largest contract = 1,300 physicians

Note: 12% of physicians are in one or two-member practices (able to participate because of membership in an IPA). Approximately 16% of BC Network are in small practices without a supporting structure (would need to join a group to participate).

Early Reports of Success

- In 2009, the AQC covered 1,600 physicians (25% of BC network PCPs)
- Group’s all achieved budget
- Quality incentive payments distributed to some providers
- 1/3 of care delivered “outside” of the contracting network’s providers
### AQC vs. Medicare Shared Savings

#### Significant Differences in AQC from the Proposed Medicare Shared-Savings Program

<table>
<thead>
<tr>
<th>Issue</th>
<th>AQC</th>
<th>Medicare Shared Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget Risk</td>
<td>Groups bear budget risk</td>
<td>No risk initially?</td>
</tr>
<tr>
<td>Patient Participation</td>
<td>HMO or PPO products only – Members must choose PCP</td>
<td>No PCP selection requirement</td>
</tr>
<tr>
<td>Payment Rates and Budgets</td>
<td>Based on group’s historical differences in care patterns, severity of patients' medical conditions, and negotiated rates</td>
<td>Likely based on Medicare Targets (congressional decisions)</td>
</tr>
<tr>
<td>Contract Term</td>
<td>5-Year Term</td>
<td>Annual re-negotiation?</td>
</tr>
</tbody>
</table>

#### Model Considerations

**BCBS Massachusetts**
- Negotiates Budgets with each Group
- Selects Measures
- Sets Targets (?)
- Creates Data/Reports
- Distributes Incentives
- Determines Members

**BCBS North Carolina**
- Funds Pool
- Shares Claims Data
- Negotiates Contract
- Selects Measures
- Sets Targets
- Creates Data/Reports
- Distributes Incentives
- Determines Members

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A side bet on consumerism

Medica’s new iPhone app provides Minneapolis-St. Paul consumers with access to comparative pricing on a comprehensive range of health services.

Two “Clicks”
Who would have thought....

From the New York Times

A lot of balls in play....

Employers with >50 employees can pay a (small) penalty for not ensuring the work force

Employers with <50 employees not required to purchase insurance for work force

Individuals will be mandated to buy insurance

Insurance will become a direct to consumer market
**What do you think consumers will buy?**

Admittedly incomplete…

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Cost per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concierge</td>
<td>20,000</td>
</tr>
<tr>
<td>Everything</td>
<td>15,000</td>
</tr>
<tr>
<td>Everything</td>
<td>10,000</td>
</tr>
<tr>
<td>Everything</td>
<td>7500</td>
</tr>
<tr>
<td>Only our</td>
<td>5000</td>
</tr>
<tr>
<td>Everything is covered —</td>
<td></td>
</tr>
<tr>
<td>prescriptions, docs visits,</td>
<td></td>
</tr>
<tr>
<td>hospitalizations</td>
<td></td>
</tr>
<tr>
<td>Everything is covered —</td>
<td></td>
</tr>
<tr>
<td>but only in these locations,</td>
<td></td>
</tr>
<tr>
<td>by these docs</td>
<td></td>
</tr>
<tr>
<td>Only our locations, a limited</td>
<td></td>
</tr>
<tr>
<td>number of MD and ED visits,</td>
<td></td>
</tr>
<tr>
<td>10000 deductible after</td>
<td></td>
</tr>
<tr>
<td>that.</td>
<td></td>
</tr>
<tr>
<td>Catastrophic Coverage</td>
<td></td>
</tr>
<tr>
<td>Negotiated prices at our</td>
<td></td>
</tr>
<tr>
<td>providers</td>
<td></td>
</tr>
</tbody>
</table>

- Will care come in
  - Bundles
  - Full service ACO
  - Catastrophic Care
  - Donut Policies
- What would the price point be?
  - Lots of price points – from Hyundais to Maybachs
- Who will they buy from?

- Consumers think locally – not globally
- Consumers like “low low prices”
- What would a patient with a chronic condition want to buy?
- Will any of this match up with where Medicare is trying to go?

**What happens when a market “goes consumer”?**

**Hint – “You think insurance companies are tough on price?”**

- Airline Deregulation in 1978
- Southwest Airlines seeks to attract “bus passengers” as “the low cost carrier”
  - No frills
    - No seat assignments
    - No food
    - Luggage restrictions
    - Limited routes
  - Fast Turnaround Times
- What happens to all the legacy carriers?
  - Delta
  - American
  - USAirways
  - United
- Who do the new carriers emulate?
Charting Course

- Preface: Basic Point of View
- The Pressure Cooker
  - Decreasing Admissions
  - Hammers Look for Nails
  - The Need to Think Like a Plan
- Toward the Collaborative Care Enterprise

Market Changes Are Real

New forms of commercial contracts focused on total medical cost growth are proliferating

Total Cost of Care / Shared Savings Contracts
- Massachusetts
- Minneapolis
- Chicago
- Louisville

Private Label Payer-Provider Partnerships
- San Francisco
- Los Angeles
- Phoenix
- New Jersey

Payer-Sponsored Primary Care Initiatives
- New Jersey
- Maryland
This is the Greatest Challenge in Health Care

Crossing the Crevasse

FEE FOR SERVICE
- Build physician base
- More primaries
- Build IT ability
- Clinical Effectiveness
- Cost Accounting
- Build systems
- Not incented to do more

VALUE BASED PAYMENT
- Profits from Higher Quality Care in Home Setting
- Longitudinal Payments for Chronic Care
- Bundled Payment for Implantables
- Joint Contracts with Payers
- Focus on Data

Accountable Care: A Radical Shift in Thinking

Is an Emergency Hospital Admission a...

Good Thing!?......
- Fill a bed, take x-rays, do a procedure

OR

...an Ambulatory Sentinel Event?

- Missed appointment?
- Unable to get into clinic?
- Failed to fill prescription?
- Unable to get Rx refill?
- PC / specialty miscommunication?
- Patient misunderstanding
- Failure to listen to patient?
- Missed lab or x-ray report?
“Did you say a 22% Decline in Discharges?”

An analysis at one large Midwest health system

A Serious Problem with Capital Costs

Ripe for a Disruptive Technology

- Room Cost Per Day: $27
- Room Cost Per Day: $1200
Borders and the Kindle

Remember when people worried about the local bookstore....

- 2008 – 1000+ stores
- 2010 Revenue - $2 Billion
- Stock Price High - $40 per share
- Today’s value – 15 Cents

On the Verge of a Disruption?

As the number of older adults with acute health needs grows, hospitals need more innovative and cost effective ways to treat these patients. Hospital at Home provides safe, high-quality, hospital-level care to older adults in the comfort of their own homes. Developed by the Johns Hopkins School of Medicine and tested at medical centers across the country, this innovative care model reduces complications, is highly valued by patients and caregivers, diminishes caregiver stress, and lowers health care costs by nearly one-third.

If you are looking for innovative care solutions to solve your hospital’s growing business challenges, we can help you implement the program and bring quality care to your patients. Contact us to learn more about Hospital at Home.
Charting Course

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The Race to “Buy Up Cardiology Practices”

- Cardiovascular services represent a significant portion of overall volume
- Demand is expected to increase over time
- CV services contribute a disproportionate share of overall profitability
- Profitability from CV services is usually tied to selected cardiology practices
- Tremendous Fear that the competition will steal “our” cardiologists
**Case System: Growth Rates are High within Cardiovascular Services**

*Source: Solucient Data, BDC Advisors Analysis*

**Case System: CV Services Contribute a High Proportion of Net Income**

*Source: System data for 2008 calendar year discharges*
Case System: Finances Actually Balanced on a Pin

Profitability Depends on a few DRGs within Cardiology

Not only is the case system dependent on cardiology, it is hyper-dependent on 8 "Super-DRGs".

<table>
<thead>
<tr>
<th>Service Line</th>
<th>Sum of Contribution Margin - SIW Adjusted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perc cardiovasc proc w drug-eluting stent w/o MCC</td>
<td>$11,548,768</td>
</tr>
<tr>
<td>Perc cardiovasc proc w drug-eluting stent w MCC or 4+ vessels/stents</td>
<td>$4,671,285</td>
</tr>
<tr>
<td>Circulatory disorders except AMI, w card cath w/o MCC</td>
<td>$2,841,237</td>
</tr>
<tr>
<td>Heart failure &amp; shock w MCC</td>
<td>$2,811,348</td>
</tr>
<tr>
<td>Perc cardiovasc proc w non-drug-eluting stent w/o MCC</td>
<td>$2,075,752</td>
</tr>
<tr>
<td>Major cardiovasc procedures w MCC or thoracic aortic aneurysm repair</td>
<td>$2,017,827</td>
</tr>
<tr>
<td>Major cardiovascular procedures w/o MCC</td>
<td>$1,037,490</td>
</tr>
<tr>
<td>Perc cardiovasc proc w coronary artery stent or AMI w MCC</td>
<td>$665,697</td>
</tr>
<tr>
<td>Grand Total</td>
<td>$27,669,404</td>
</tr>
</tbody>
</table>

Source: Case Study Hospital, BDC Advisors Analytics

But Grave Risks

- Buying Practices at the Top of the Market
- Practices Demanding Income at 2009 Rates
- How long is the income guarantee?
- What will occur with a shift to value based payment (capitation) (Nevada in the 1990s)?
- Will today's big winners be tomorrow's big losers?
Charting Course

- Preface: Basic Point of View
- The Pressure Cooker
  - Decreasing Admissions
  - Hammers Look for Nails
  - The Need to Think Like a Plan
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Key to the Hospital Business

Same Beds, Fewer Days – Need More and More Admissions

Hospitals make money by remaining full.
Hospitals have stayed full by increasing admissions.
Value based payment will reward systems for managing the health of populations.

Hospitals now need to
- Expand Reach
- Radically Reduce Operating Costs
- Excel at managing populations
**Hospital System – Narrow Focus**

_Hospital Systems’ leadership/business model not prepared to function in a value based world_

---

**Primary Care**

- Staying Healthy
- Living with Chronic Disease
- Getting Better (Acute Care)
- End of Life Care

**Value Based Care**

- Healthy Lifestyle Model
- Chronic Care Model* (Wagner – IHI)
- Evidence-Based Medicine
- Palliative Care Model

---

**A Need to Think About the Pot of Money**

_The driver of change in healthcare exemplified by reform is to lower the cost of care – i.e., reduce revenues to providers and intermediaries_

If we want to preserve our revenues, we have two options:

1. Capture more market share from other health systems
2. Capture more of the health care dollar from payers, other providers

---

* Medical Home

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Your New Best Friend: The Medical Loss Ratio Floor

Health Reform requires 80 – 85% of premium to be spent on health care

- Insurers will be required to spend a minimum of 80 to 85% of premium on health care costs
- If they under-spend, the balance must be refunded to individual members
- Provides strong incentive to pay more $$ and delegate case management
- Change will create room for contracting for quality bonus pools and efficiency incentives

It also incent insurers to get into the direct care business

The ‘Deep Throat’ Business Philosophy . . . . . “Follow the Money Trail”

- Easiest way for insurers to maintain revenue stream is to follow the $$ and get into care delivery
- Insurers target primary care practices to control the flow of patients

“Humana Buys Concera Clinics”

“United Buys Monarch Health”

“WellPoint completes CareMore acquisition”
This will blur the lines between Payer & Provider

Payers who manage Medical Homes or ACOs

Payers who purchase physician groups

Providers organized as CINS or ACOs who take financial risk

Joint Ventures Between Payers & Providers

Traditional Boundaries Breaking Down

Health plans are acquiring or “partnering with” providers in a variety of ways.

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Provider Partner</th>
<th>Type</th>
</tr>
</thead>
</table>
| United HealthCare – Optum Collaborative Care | • Applecare Medical Group (Orange Cty)  
• Memorial Healthcare IPA (Long Beach)  
• WellMed Medical Management (Texas, Florida)  
• LifePrint – UHC network (Phoenix)  
• Sierra Health Services (Las Vegas)  
• Monarch IPA (Los Angeles) | Acq     |
| Humana                            | • Concentra  
• CMMI (Florida medical group)  
• Norton Healthcare | Acq, ACO-SS |
| Horizon Blue Cross / Blue Shield  | • [various medical groups]  | Acq    |
| Wellpoint                         | • CareMore  
• HealthCare Partners (Los Angeles) | Acq    |
| Highmark Blue Cross / Blue Shield | • West Penn – Allegheny Health System | Inv    |
| Aetna                             | • Carilion Clinic  | ACO-SS  |
| BCBS Illinois                     | • Advocate Health System | ACO-SS  |

Acq = Acquisition  
ACO-SS = Shared savings contract  
Inv = Investment

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Health Plan Product Evolution

Old managed care labels and concepts are blurring. New frameworks are needed to design accountable care organizations and virtual health systems.

Product Design Variables

- How is risk shared between plans, providers?
  - Type of risk
  - Magnitude of risk
  - Payment "bundles"
  - Incentive structures
  - Funding formulas

- How are members incentivized?
  - Magnitude, structure of deductibles ("doughnuts")
  - Variable deductibles
  - Co-pays (in-network, out-of-network, prevention, etc.)
  - Other incentives (e.g., allowances, free services)

- Who owns what?
  - Insured vs. ASO
  - Service agreements

- HMOs increasing co-pays and deductibles
- "Open-access HMOs" limiting "gatekeeper" controls
- PPOs adding P4P and other risk-sharing features
- Narrow-network PPOs (EPOs) strengthening incentives for members to stay "in-network"

This is the Greatest Challenge in Health Care

Crossing the Crevasse

FEE FOR SERVICE

VALUE BASED PAYMENT

Unit Management

Population Management
Population management requires insurance company viewpoint

Payer Contracting Strategy
Managing relationships between a health system and its payers to enhance outcomes for the health system

Population Risk Management
Targeting a population for management of the financial resources, health risk and cost of care risk

Population Management Model
Premise:
The sick can’t afford the full cost of their care. The healthy need to subsidize the sick.

Distribution of Health Risk

Cost per person
Population Management Model

Population Management seeks healthy populations, take full risk and uses the excess premium to cover cost of care to the sick

- Emphasis on Segmentation
  - Importance of benefit design and pricing to attract a healthier than average population
- Requires taking full risk or close to full risk to capture the premium revenue from healthy who don’t need care.
- Initial success is not dependent on an integrated, efficient delivery system, but longer term cost position requires efficient care.
- MLR floor established in health reform supports reinvesting in care.

Customer Segmentation

In a "Population Management" model, understanding customer segmentation becomes critical.

- Costs < Premium Revenue
- Costs > Premium Revenue
- Gray area

- Uninsured
- Government Insured
- Commercial Insured
- Young & healthy
- Growing family
- Genetic anomalies
- Chronic Conditions
- Complex/Frail Elderly / End-of-Life

- Children 0-17
- Adults 18-64
- Seniors 65+
### Customer Segments Have Different Needs

<table>
<thead>
<tr>
<th>Segments</th>
<th>Description</th>
<th>Core Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Non-Patient</td>
<td>• No regular PCP</td>
<td>• No cost or Low out-of-pocket price for insurance</td>
</tr>
<tr>
<td></td>
<td>• No chronic conditions</td>
<td>• Convenient access to basic care (e.g., flu shots)</td>
</tr>
<tr>
<td></td>
<td>• Usually young to middle age</td>
<td>• Want 24/7 electronic communication</td>
</tr>
<tr>
<td>Healthy Patient</td>
<td>• Regular PCP</td>
<td>• Convenient access to high quality primary care</td>
</tr>
<tr>
<td></td>
<td>• No major chronic conditions</td>
<td>• Low → moderate out-of-pocket price</td>
</tr>
<tr>
<td></td>
<td>• Often young families w/ kids</td>
<td>• Assurance of high quality care when needed</td>
</tr>
<tr>
<td>Emergency or Immediate</td>
<td>• Acute episode of care</td>
<td>• Immediate access</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• High-quality acute care / pain relief / great outcomes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Great service / convenience</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Manageable out-of-pocket price (unexpected costs)</td>
</tr>
<tr>
<td>Chronic Conditions</td>
<td>• Already diagnosed as having a chronic condition</td>
<td>• High quality care over time – minimize life impact</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Education about disease, self-care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Coordinated care (e.g., care manager)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Low → moderate out-of-pocket price</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Convenience, good service</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Assurance of high-quality acute care when needed</td>
</tr>
<tr>
<td>Complex/Frail Elderly / End-of-Life</td>
<td>• Life threatening illness</td>
<td>• Assistance with ADLs / social environment</td>
</tr>
<tr>
<td></td>
<td>• Multiple chronic conditions</td>
<td>• Pain management</td>
</tr>
<tr>
<td></td>
<td>• Family involved in care decisions</td>
<td>• Care coordination</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Life planning</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Cost management support</td>
</tr>
</tbody>
</table>

**Current Model** Target

**Population Health Target**

**Hospital Ads Target**

- *Best Cardiac Rehab*
- *Best Cancer Center*

<table>
<thead>
<tr>
<th>Segments</th>
<th>Description</th>
<th>Core Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Non-Patient</td>
<td>• No regular PCP</td>
<td>• Convenient access to basic care</td>
</tr>
<tr>
<td></td>
<td>• No chronic conditions</td>
<td>• Low out-of-pocket price</td>
</tr>
<tr>
<td></td>
<td>• Not frail elderly or end-of-life</td>
<td>• Assurance of high-quality care</td>
</tr>
<tr>
<td>Healthy Patient</td>
<td>• Regular PCP</td>
<td>• Convenient access to high quality primary care</td>
</tr>
<tr>
<td></td>
<td>• No chronic conditions</td>
<td>• Low → moderate out-of-pocket price</td>
</tr>
<tr>
<td></td>
<td>• Not frail elderly or end-of-life</td>
<td>• Assurance of high-quality care when needed</td>
</tr>
<tr>
<td>Intense Immediate</td>
<td>• Acute episode of care</td>
<td>• Immediate access</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• High-quality acute care / great outcomes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Great service</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Moderate out-of-pocket price</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Convenience</td>
</tr>
<tr>
<td>Chronic Conditions</td>
<td>• Identified as having a chronic condition</td>
<td>• High quality care over time</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Education about disease, self-care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Connection to care-giver (e.g., care manager)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Low → moderate out-of-pocket price</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Convenience, good service</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Assurance of high-quality care when needed</td>
</tr>
<tr>
<td>Complex/Frail Elderly / End-of-Life</td>
<td>• Life-threatening illness</td>
<td>• Assistance with ADLs</td>
</tr>
<tr>
<td></td>
<td>• Multiple chronic conditions</td>
<td>• Healthy social environment</td>
</tr>
<tr>
<td></td>
<td>• Treatment requires intensive technology and drugs</td>
<td>• Pain management</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Care coordination</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Life planning</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Low out-of-pocket price</td>
</tr>
</tbody>
</table>
Population Management II: Melds Value Based w/ Segmentation

As health reform takes effect MLR floor will force improvements in care and sharing of savings

- In phase II model addresses cost of care and seeks to reduce costs of population by limiting the network to narrow set of efficient providers
- Absent a shared savings strategy, lower premiums may benefit payer / employer more than delivery network

Payer Strategy Issues

Old Definition

- How can a health system maximize revenues from payers?
  - Create competitive advantage vis-à-vis peers and payers
  - Influence market structure to advantage providers over payers

- Key variables:
  - Product demand
  - Market structure (à la Porter)
  - Contract payment structure
    - FFS, bundled payments, carve outs, capitation, terms / timing
  - Relative pricing
- Should we pursue direct contracting and eliminate the middle man?

New Definition

- How can health system form mutually profitable relationships?
  - Partner with health plans on quality, cost and utilization
  - Move up the revenue chain and share financial risk / return

- Key Variables:
  - Care Management Capability
    - Integrated physician & hospital structure, EMRs, Outcome Report,
  - Financial Risk Tolerance / Ability
    - Low Cost position or excess capacity
  - Ability to Move Market Share
- How do we leverage the expertise of both providers and payers?
### Value Based vs. Population Risk Selection Models

#### Pay for Performance

- **Key to Success:**
  
  Develop full-spectrum clinical delivery network capable of providing efficient, high quality care

- **Financial Reward:**
  
  Share in savings generated by reducing unnecessary medical services and improving efficiency in care delivered to the sick

#### Population Management

**Phase I**

- **Key to Success:**
  
  Develop network of lowest cost providers capable of providing efficient care but with high service OB/Peds

- **Financial Reward:**
  
  Market to Healthy Population

**Phase II**

- **Key to Success:**
  
  By investing healthy people’s premium in care efficiency improvements, maintain low-cost position in market

### Payer Strategy Issues with Population Management

- **[All the old issues]**

- **New segments**
  
  - The Non-Patient is your best source of revenue. Requires access to premium revenue.

- **New products**
  
  - Narrow-network, limited benefit plans
  - Tiered benefit structure
  - Consumer-Directed Health Plans (CDHP)
  - P4P products layered over all of these

- **Provider-partnership issues**
  
  - Payer flexibility, transparency, willingness to work with health system
  - Willingness to co-own premium revenue, share MLR with providers
  - Willingness to participate in cost-engineered product development
  - Book of business (How price-elastic?)
  - Brand not as important as price

- **Should we own / start a health plan?**
  
  - Which plan?
  - What do we do with the others?
How are companies managing health care costs?

**Median Trends for High, Average and Low Performers**

<table>
<thead>
<tr>
<th>Calendar Years</th>
<th>High Performers</th>
<th>Average Performers</th>
<th>Low Performers</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003/04</td>
<td>15.0</td>
<td>10.0</td>
<td>5.0</td>
</tr>
<tr>
<td>2004/05</td>
<td>11.6</td>
<td>8.0</td>
<td>3.0</td>
</tr>
<tr>
<td>2005/06</td>
<td>11.0</td>
<td>8.0</td>
<td>2.5</td>
</tr>
<tr>
<td>2006/07</td>
<td>10.0</td>
<td>6.2</td>
<td>1.0</td>
</tr>
<tr>
<td>2007/08</td>
<td>10.5</td>
<td>5.8</td>
<td>.5</td>
</tr>
<tr>
<td>2008/09</td>
<td>10.5</td>
<td>6.5</td>
<td>.3</td>
</tr>
<tr>
<td>2009/10</td>
<td>10.0</td>
<td>6.0</td>
<td>1.0</td>
</tr>
</tbody>
</table>

### Focusing on More Active Management of Care/Lifestyle

#### The Top Tactics Implemented by the Consistent Performers

<table>
<thead>
<tr>
<th>Percentage of Consistent Performers Implementing the Tactic in 2011</th>
<th>Percentage of Consistent Performers Implementing the Tactic in 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reregulate financial arrangements with current pharmacy benefit manager (PBM)</td>
<td>1. Differentiate cost sharing for use of high-performance networks or centers of excellence</td>
</tr>
<tr>
<td>2. Repeal unsustainable enrollment in specialty care services</td>
<td>2. Reward (or penalize) based on biometric outcomes other than smoking, tobacco use status</td>
</tr>
<tr>
<td>3. Change plan options</td>
<td>3. Change plan options</td>
</tr>
<tr>
<td>4. Provide a total compensation or total benefit statement that includes the value of health benefits</td>
<td>4. Use wellness-based benefit designs</td>
</tr>
<tr>
<td>5. Participate in a community-based pilot program (e.g., patient-centered medical home, accountable care organizations)</td>
<td>5. Reward (or penalize) based on smoking, tobacco use status</td>
</tr>
<tr>
<td>6. Use hard-dollar return-on-investment calculations to support future decisions</td>
<td>6. Audit of medical claim payments</td>
</tr>
<tr>
<td>7. Reward (or penalize) only those who complete requirements of a healthy lifestyle activity</td>
<td>7. Provide employer with information on provider and/or hospital quality</td>
</tr>
<tr>
<td>8. Require employees to complete the health risk appraisal and/or biometric screening to be eligible for other financial incentives for treating conditions</td>
<td>8. Use incentives of excellence for treatments other than transplants</td>
</tr>
<tr>
<td>9. Provide employee with information on provider and/or hospital quality</td>
<td>9. Reward (or penalize) only those who complete requirements of a healthy lifestyle activity</td>
</tr>
<tr>
<td>10. Use incentives of excellence for treatments other than transplants (e.g., specialty treatment networks)</td>
<td>10. Require employers to complete the health risk appraisal and/or biometric screening to be eligible for other financial incentives for healthy activities</td>
</tr>
<tr>
<td>11. Reward (or penalize) based on smoking, tobacco use status</td>
<td>11. Reward (or penalize) enrollment in health plan that offers health care services</td>
</tr>
<tr>
<td>12. Invest in enhancements to case management for serious conditions</td>
<td>12. Use hard-dollar return-on-investment calculations to support future decisions</td>
</tr>
</tbody>
</table>

#### Not Just the Top Performers

**What are your top three health care strategies for 2012**

- Stay up to date and comply with the PPACA
- Develop/expand healthy lifestyle activities
- Adopt/expand the use of financial incentives to encourage healthy behaviors

**Employee Focused**

- Rethink Benefits
- Increase Quality, and Management of Care

**Payer/Provider Focus**

- Focus on:
  - Increase Quality, and Management of Care
**A win-win-win: Adventists PCMH Program**

A way for hospitals to radically reduce employee health benefits costs

- Focused on high-risk members (121 polyusers – 15 providers, 9 prescribing MDs) improve their health.
- Increased efficiency of the healthcare delivery for these members. Targeted support to PCPs treating these members.
- **Adventist HealthCare reduced its per-member-per-month costs by 35 percent and reduced the high-risk patient population by 48 percent.**
- Based on a total pilot cost of $31,204, and annual PMPM cost reduction of $381,630, which represents an ROI of 12.
- **By the end of 2011, HealthNet hopes to have approximately 450 high-risk members linked in the process and all PCPs in its network participating in the PCMH. Potential Savings – $17,100,000**

---

**Shifting Doctors Thinking**

From “The patient in my office” to “My patients who need to be managed”
Developing Patient-Centered Medical Homes (PCMH)

A Second Structure to Strengthen Care Coordination across the Continuum

- PCMH: Joint Principles of the AAFP, AAP, ACP, AOA:

<table>
<thead>
<tr>
<th>Principles (2007)</th>
<th>PCMH</th>
<th>PCP*</th>
<th>Urg Care</th>
<th>ED**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Physician</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Physician-Directed Medical Practice</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Whole Person Orientation</td>
<td>Yes</td>
<td>+/-</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Care is Coordinated and/or Integrated</td>
<td>Yes</td>
<td>+/-</td>
<td>+/-</td>
<td>+/-</td>
</tr>
<tr>
<td>Quality and Safety</td>
<td>Yes</td>
<td>?</td>
<td>?</td>
<td>+/-</td>
</tr>
<tr>
<td>Enhanced Access to Care</td>
<td>Yes</td>
<td>+/-</td>
<td>Yes</td>
<td>Yes ++</td>
</tr>
<tr>
<td>Payment Reform (to Recognize Services Provided)</td>
<td>Proposed</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

• PCP = Current Model under FFS
• ED = Offers Access to Specialists and Diagnostics not Available to other Models

Patient-Centered Medical Home (PCMH)

A Variety of PCMH Models and Criteria for Accreditation (NCQA, BTE, etc.)

NCQA Medical Home Certification:

- 500 Practices with 4,600 Physicians have received certification
- Current Criteria:
  - Access and communication
  - Patient tracking and registry functions
  - Care management
  - Patient self-management support
  - Electronic prescribing
  - Test tracking
  - Referral tracking
  - Performance reporting and improvement
  - Advanced electronic communications

<table>
<thead>
<tr>
<th>Gatekeeper</th>
<th>PCMH</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP Assignment</td>
<td>PCP of Choice</td>
</tr>
<tr>
<td>Specialist by Referral Only</td>
<td>Open Access to Specialists</td>
</tr>
<tr>
<td>PCP at Financial Risk for Cost</td>
<td>PCP Paid for Quality Outcomes</td>
</tr>
</tbody>
</table>
### Other Approaches Failed to Address all PCMH Principles

<table>
<thead>
<tr>
<th>Factor/Principle</th>
<th>PCMH</th>
<th>Non-integrated managed care*</th>
<th>Pay for performance</th>
<th>Disease management</th>
<th>Chronic care model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose/focus</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facilitate partnership between PCP and patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient centered/ personal/PCP</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Maybe, often led by actors independent of primary care</td>
<td>Yes, for chronic illness</td>
</tr>
<tr>
<td>PCP directed medical &quot;team&quot;</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Whole person orientation</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Care is coordinated and/ or integrated</td>
<td>Yes</td>
<td>No incentive for coordination</td>
<td>No incentive for coordination</td>
<td>Maybe</td>
<td>Yes</td>
</tr>
<tr>
<td>Emphasis on quality and safety</td>
<td>Yes, evidence-based and best practice; improved outcomes rewarded</td>
<td>No, reduced utilization rewarded</td>
<td>Indirectly, process targets rather than outcome ones</td>
<td>Yes, particularly for diseases</td>
<td>Yes, for chronic illnesses</td>
</tr>
<tr>
<td>Enhanced access</td>
<td>Yes</td>
<td>No, reduced access</td>
<td>No</td>
<td>Maybe</td>
<td>No</td>
</tr>
<tr>
<td>Appropriate reimbursement</td>
<td>Yes for PCPs, unclear for others</td>
<td>Potential conflict in motivation</td>
<td>No, still volume driven</td>
<td>Partially, if evidence-based used</td>
<td>No</td>
</tr>
</tbody>
</table>

### How PCMH Improves Quality and Lowers Costs

- **Outcomes**
  - Accelerate ability to improve health outcomes and reduce cost for defined populations
  - Reduce cost per capita 15% +
  - Improve quality: example set
    - Lower mortality rates
    - Lower morbidity rates
    - Increase access to care
    - Increase use of hospice (EOL)
    - Earlier cancer intervention
    - Improve population experience for members and patients
    - Improve provider experience
What’s your “Primary Care IQ” in the C-Suite?

How prepared is your team to lead across the full continuum?

- What are the elements of your current primary care strategic plan?
- What primary care clinical quality metrics are you measuring and reporting?
- What PC non-clinical performance metrics (KPIs) do you track? How do they compare to benchmarks?
- How do your PC practices perform? Are they NCQA credentialed? Do you know the NCQA criteria for credentialing?
- Do you know your customer experience metrics? Access statistics?
- Do you claim your primary care practices? Or are they a “stealth” practice?
- Do they have a name? Are they branded? Are they identified with the system?
- Are you tracking and reporting ambulatory sentinel events?
- Are your PCPs paid at market rates? Do they have payment tied to quality or service performance?
- Does your primary care group have a leader? A leadership council?
- Are there primary care physicians on your Board? Is there a system primary care medical director?
- Does each practice have a lead physician?
- Are you preparing for or piloting a PCMH?

PCMH is Not Enough - Historical Relationships

Historically, most hospitals and physicians have contracted independently, and behaved in a “dis-integrated” way

- Loose “medical staff” relationship – No Economic Alignment
- Many independent practices – little influence in contracts
- Multiple contracts, all with different terms
- Health Plan

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Clinically Integrated Network

Key Elements

- **Clinical management infrastructure**
  - Evidence based clinical protocols to reduce variation in care
  - Clinical IT system to sharing information across entire network
  - CIN staff coaches practices
- **Joint contracting** for hospital and physicians (employed and private) to enable sharing value for improved performance
- **Rewards and penalties** for joint agreed on attainable goals (Payer-blind – System administers)
- **New physician governance construct** to support hospital physician decision making, flow of information, quality initiatives

CINs Create a Framework for More Rationale Market Relationships

A clinically integrated network can engage all providers and payers in community health improvement and cost containment

- **New “Pluralistic” entity**
- **Clinically Integrated Network**
  - Health System Trustees
  - Aligned goals and incentives – Speaks with one voice
  - Consistent contract terms
- **Hospital**
  - Medical Group
  - HHC
- **SNF**
  - Incorporate full continuum
- **Joint Contracting**
  - BC/BS
  - Aetna
  - United Health
  - Humana

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Integration Issues Are Mirrored in All American Industry

A decade ago, a sense of the “entropy of workers”

2002

Legions of Americans, and increasingly citizens of other countries as well, are abandoning one of the Industrial Revolution’s most enduring legacies—the “job”—and forging new ways to work. They’re becoming self-employed knowledge workers, proprietors of home-based businesses, temps and permatemps, freelancers and c-lancers, independent contractors and independent professionals, micropreneurs and infopreneurs, part-time consultants, interim executives, on-call troubleshooters, and full-time soloists.

The New Normal Changes How We View Work

How Do We Marry Free Agents and Institutions?

2011

- The third norm is that loyalty matters. A few years ago there was a celebration of Free Agent Nation. But now most people, even most young people, would rather work long-term for one company than move around in search of freedom and opportunity.

David Brooks
New York Time
October 18, 2011
### A Call to Higher Purpose, Drives Performance

**A New Model for Organizations**

#### The Collaborative Organization

“Collaborative communities encourage people to continually apply their unique talents to group projects—and to become motivated by a collective mission, not just personal gain or the intrinsic pleasures of autonomous creativity. By marrying a sense of common purpose to a supportive structure, these organizations are mobilizing knowledge workers' talents and expertise in flexible, highly manageable group-work efforts. The approach fosters not only innovation and agility but also efficiency and scalability.”

#### Three Models of Corporate Community

<table>
<thead>
<tr>
<th>Traditional Industrial Model</th>
<th>Free-Agent Model</th>
<th>Collaborative Community Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>GE, Proctor and Gamble</td>
<td>App Companies, Programmers, Reporters</td>
<td>CSC, IBM,</td>
</tr>
<tr>
<td>These Organizations:</td>
<td>These organizations:</td>
<td>These communities are:</td>
</tr>
<tr>
<td>• Hold strongly shared values and traditions</td>
<td>• Are innovative and flexible</td>
<td>• Organized around a Shared Purpose</td>
</tr>
<tr>
<td>• Mandate clear roles</td>
<td>• Forgo rules, procedures, and deferential relations</td>
<td>• Collaboratively Developed Procedures</td>
</tr>
<tr>
<td>• Offer consistent opportunity for advancement</td>
<td>• Focus on reward for individual effort and reward.</td>
<td>• Documented Procedures</td>
</tr>
<tr>
<td>• Offer job security, and benefits.</td>
<td>• Loyalties are based on affection for leaders or colleagues.</td>
<td>• Belief in the Diversity of Capability</td>
</tr>
</tbody>
</table>

The combination of loyalty and bureaucratic structure allows such organizations to reach unprecedented scale, but makes them inflexible and slow to innovate. This model is effective for modular projects, but weak organizational ties make it difficult to build the extensive team structure that is needed for knowledge-based work. Such organizations excel in interdependent knowledge-based work.
Perhaps This is Our World?

<table>
<thead>
<tr>
<th>Traditional Industrial Model</th>
<th>Free-Agent Model</th>
<th>Collaborative Community Model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Traditional Hospital?</strong></td>
<td><strong>Traditional Medical Staff?</strong></td>
<td><strong>Clinically Integrated Organization?</strong></td>
</tr>
<tr>
<td>These Organizations:</td>
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Such organizations excel in interdependent knowledge-based work.

The Best of Two Different Cultures

Strengthen the Identities of each Group and Recognize the Contributions of both Cultures

<table>
<thead>
<tr>
<th>The Physician Professional Culture………</th>
<th>The Hospital Administration Culture……….</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>“Expert Culture”</strong></td>
<td><strong>“Collective Culture”</strong></td>
</tr>
<tr>
<td>• Autonomy</td>
<td>• Embraces organizational mission, values, vision</td>
</tr>
<tr>
<td>• Need for rapid decision-making</td>
<td>• Avoids conflict</td>
</tr>
<tr>
<td>• Individualistic behavior</td>
<td>• Unlikely to take risk</td>
</tr>
<tr>
<td>• Flat structures (resists hierarchy)</td>
<td>• Respects hierarchy</td>
</tr>
<tr>
<td>• Consensus in group decisions</td>
<td>• Training: Social and Management Science</td>
</tr>
<tr>
<td>• Training: Biomedical Science</td>
<td>• Trained to delegate and work in groups</td>
</tr>
<tr>
<td>• Trained to work independently</td>
<td></td>
</tr>
</tbody>
</table>
Why Focus on a “Shared Purpose”?

“A shared purpose is not the verbiage on a poster or in a document, and it doesn’t come via charismatic leaders’ pronouncements. It is multidimensional, practical, and constantly enriched in debates about concrete problems.” Paul Adler

Max Weber “Four Types of Social Relations”

Shared Purpose is the basis for trust and organizational cohesion:
- More robust than self-interest
- More flexible than tradition
- Less ephemeral than emotional, charismatic appeals

Strong Charismatic Leader
- GE
- Microsoft
- Apple
- Virgin
- Bose

Tradition
- Money
- Hedge Funds
- Most Work

Self-interest
- Tried and True
  - Stickley
  - Harvard

Affection

To build such communities, companies must master a new set of skills:

- Define and build a shared purpose
- Cultivate an ethic of contribution
- Develop scalable processes for coordinating people’s efforts
- Create an infrastructure in which collaboration is valued and rewarded

“We have learned from practically a century of experience with the traditional model that it is quite possible for everyone to work hard as an individual without producing a good collective result. An ethic of contribution means going beyond one’s formal responsibilities to solve broader problems, not just applying greater effort. It also rejects the strong individualism of the market model and instead emphasizes working within the group (rather than trying to gain individual control or responsibility) and eliciting the best contributions from each member for the common good.”
Clinical Integration Leads to Collaborative Care

The Idea is to Work Together to Improve Quality and Lower Costs

Insurers
Collaborating with the network to provide money for incentive pools and the costs of developing care coordination

Individuals
Collaborating to improve their own health status

Physicians
Collaborating to develop systems to improve care coordination and reduce variations in care

Communities
Collaborating to improve the health status of the population

Hospital Employees
Collaborating to ensure informed handoffs of patients

The Collaborative Care Enterprise (CCE)

Transforming Hospitals and Medical Practices into a New Organization

Called to the higher purpose of improving health and lowering health care costs for our community

- Need new metrics for quality
- Not quality of unit of service, but quality in health improvement
- What percentage many chronic patients are getting right tests and treatments
- How many are being counseled, so that expensive care is prevented
- How many are staying healthier
- New Metrics for Financial Performance
- Are we decreasing the costs of health care for the local community
- Are commercial rates flattening for our businesses
- Have we stopped an increase in Medicare and Medicaid Costs

Incented for Collaborative Effort, Not just personal effort

- Bonuses tied to performance of the whole, and to effective care coordination efforts
- Focus on developing effective policies and procedures that can guide individuals toward working as a team effectively
- Collective Process Mapping

Focused on How My Effort Moves Our Organization to the Higher Ground?

- Does this effort that is difficult for me (working an EMR, collecting data, fixing a process), result in moving our organization to the higher ground
Three Eras of Payment

Era of Experimentation

Era of Open Access

Era of Bundling

Physician-Hospital Alignment

Experiments in Integration

Size Matters

Collaboration Matters

1990 1999 2009 2015

For more information
Please Contact
Neal Hogan, PhD
Managing Director
207-442-7025