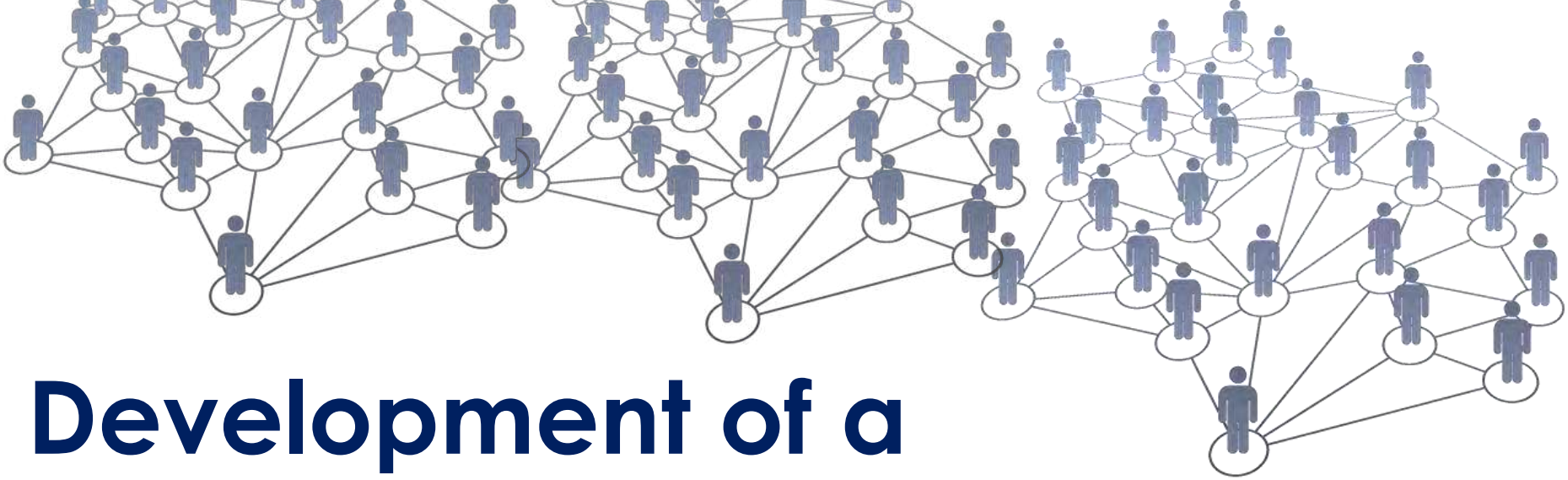


Development of a Clinically Integrated Network

for 2014 HFMA Summer Institute Conference

Patrick Hammond
Chief Executive Officer, Emory Healthcare Network
July 17, 2014

Do You Believe Fee-For-Service Medicine (i.e. World A) is Sustainable?

AGENDA

- Why World A is Not Sustainable
- Why An Organization May Want to Form a Clinically Integrated Network in World B
- Q &A Mid-Session
- What It Requires to Develop a Clinically Integrated Network
  - Governance & Legal Structure
  - Provider Network Development
  - Payer Contracts & Negotiations
  - Population Management Strategies & Infrastructure
  - Funding Requirements
- Q &A Wrap-Up

"WORLD A" NO LONGER SUSTAINABLE

Fee-for-service Medicine (i.e. World A) is no longer sustainable

Global Economy

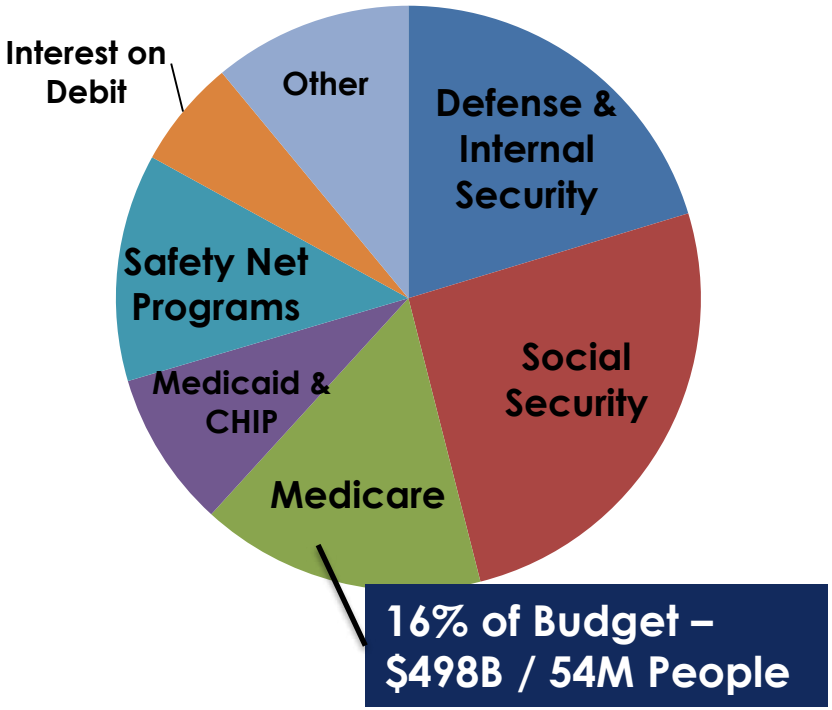
Baby Boomers Retiring and Moving to Medicare

Consumerism

EMORY HEALTHCARE NETWORK

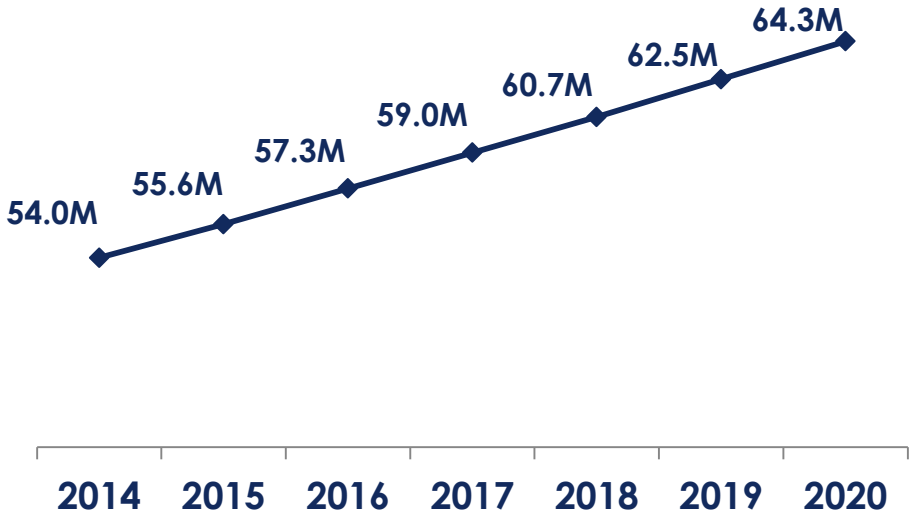
BABY BOOMERS DRIVE MEDICARE GROWTH

2013 FEDERAL BUDGET



PROJECTED NUMBER OF MEDICARE BENEFICIARIES

(Millions of Beneficiaries)



Source: 2013 Figures from Office of Management and Budget 2015 Historical Tables
Source: The Advisory Board Company – CMS, "2013 Annual Report of the Board of Trustees Of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," May 31, 2013.

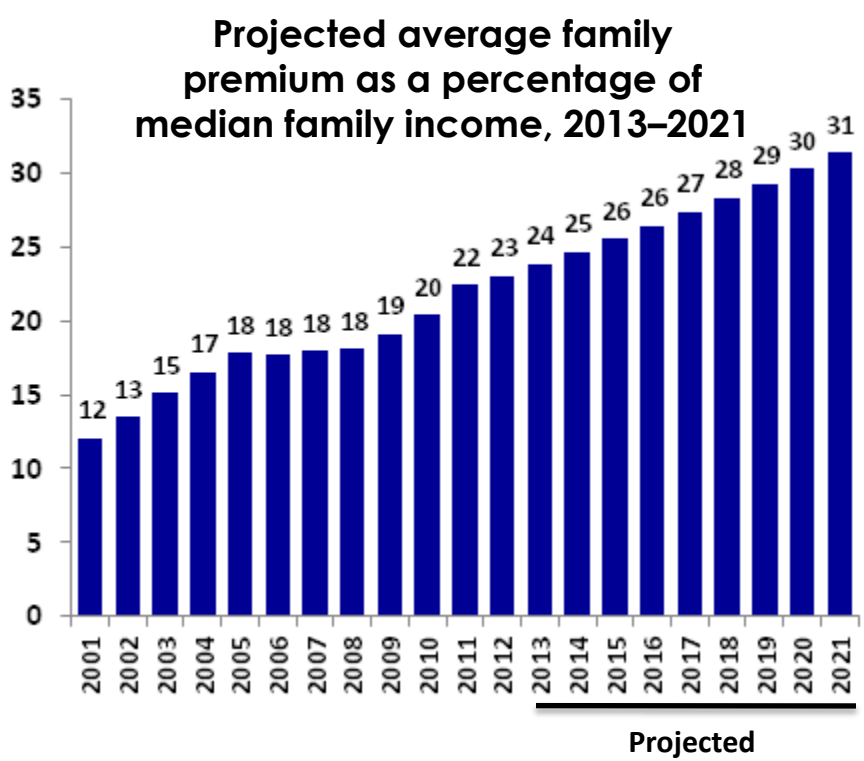
CONSUMERISM DRIVING FORCE OF CHANGE

Meet Mary Jo & Family
Mary Jo has Multiple Chronic Conditions

Mary Jo's Percentage of Household Income Spent on Healthcare:

2008: 7%
2013: 18%

Mary Jo & Her Family's Situation is Becoming Common - Even For Families Without Chronic Conditions



Source: (right)Based on CPS ASEC 2001 – 12, Kaiser/HRET 2001-12, CMS OACT 2012-21

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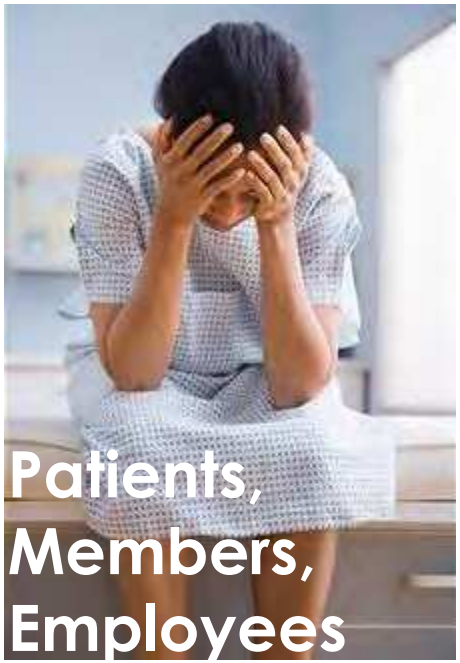
WHY DO HEALTHCARE INFLATION TRENDS CONSISTENTLY EXCEED GENERAL INFLATION TRENDS?

No Silver Bullet, However:
There is a Misalignment of the Financing of Healthcare with Desired Outcomes

- **Healthcare Providers:**
  - Reimbursed to Care for Isolated Acute Episodes
- **Underlying Healthcare Financing Structure:**
  - Helps Create the Cross-Subsidized $5 Aspirin
  - Tip of Iceberg: Impact of Baby Boomers Retiring
- **Consumer Actions & Demands:**
  - Lifestyle Choices
  - Demand for Latest with Little Connection to Cost/Benefit

DISSATISFACTION AMONG ALL

Payers



Patients, Members, Employees

Hospitals

Physicians

Government

Employers

EMORY HEALTHCARE NETWORK

"**Insanity:** Doing the same thing over and over again and expecting different results."

–Albert Einstein

Why An Organization May Want to Form a Clinically Integrated Network in Value-based Reimbursement (i.e. World B)

Note: Clinically Integrated Network = Population Health Manager

CLINICALLY INTEGRATED NETWORK

What It Is Not And What It Will Not Do

- Is not the new name for a physician-hospital organization (PHO), independent practice association (IPA), etc.
- It is not a short-term strategy
- It will not return a $1 for $1 exchange for utilization reductions

VALUE & POPULATION MANAGEMENT

How We Can Bend the Cost Curve Trend by Focusing on Value Through Population Management

Value = Quality/Cost

Quality = outcomes
+ ↑ intended care
+ ↓ unintended care
+ experience of care

EMORY HEALTHCARE NETWORK

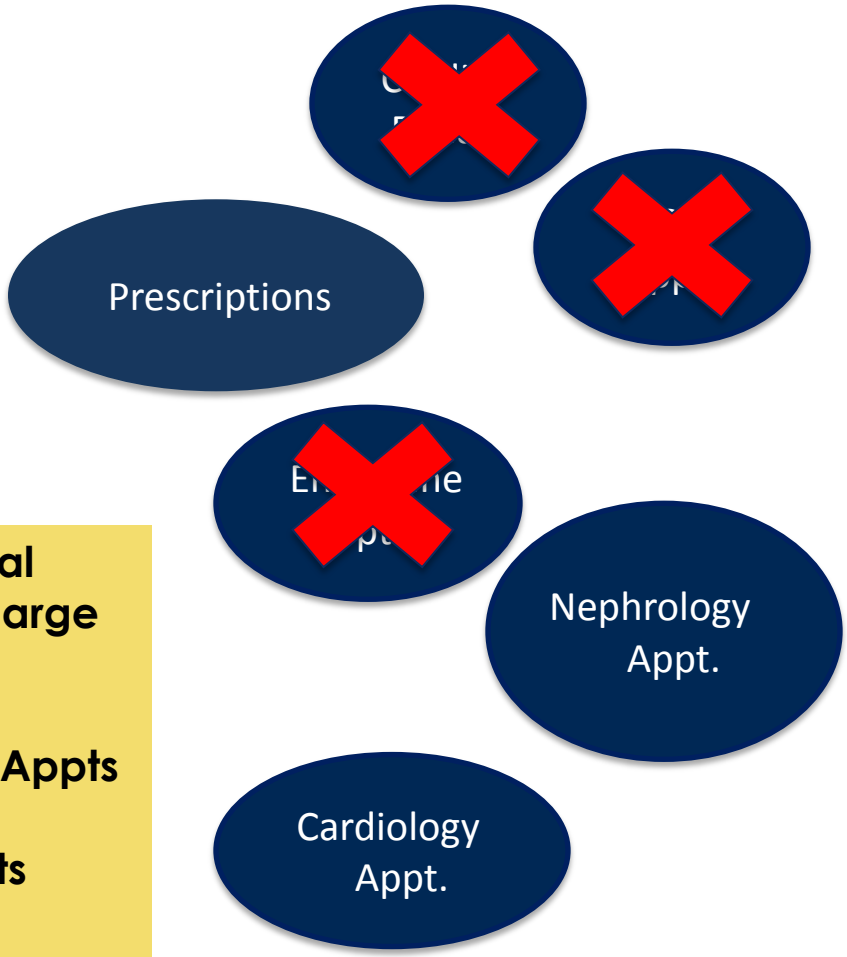
COMPARISON: WORLD A - THE CURRENT STATE

Mary Jo & Family

Mary Jo has Multiple Chronic Conditions

Admission to Hospital Instructions at Discharge

- 8 Prescriptions
- Cardiac Rehab
- Make Follow-up Appts
  - PCP
  - Endocrinologists
  - Cardiologists
  - Nephrologist



- Only fills 6 of 8 prescriptions
- Son's band camp expenses
- None of her providers know

- Her nephrologists and cardiologists not clinically integrated
- Order duplicative tests; unaware of each other's care plan

Mary Jo:
Another Acute Episode Readmitted to Hospital

EMORY HEALTHCARE

COMPARISON: WORLD B – WHAT'S TO COME

Hospital Admission at Discharge
- 8 Medications – Initial Supply Provided
- Follow-up Appt PCP – Scheduled
- 1st Cardiac Rehab Visit - Scheduled

PCP Follow-Up Visit:
- Reviews Care Plan
- Orders Consultative Visits:
  - Cardiologist – Scheduled
  - Endocrinologists Scheduled
  - No Nephrology Necessary
  - Coordinates Care Plan
  - Necessary Labs Once

Embedded Care Coordinator with PCP
- Notes Mary Jo Didn't Refill 2 Prescriptions
- Working w/PCP Replaces with Affordable Generic

Results for Mary Jo:
- Conditions Successfully Managed in Ambulatory Setting through Better Care Coordination
- Total Cost Reduced
- Higher Quality Outcome

Mary Jo & Family

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WORLD A REIMBURSEMENT INCENTIVES

HEALTHCARE PROVIDERS CURRENTLY REIMBURSED TO CARE FOR ISOLATED ACUTE EPISODES IN WORLD A

Price (i.e. Cost) Per Unit X Number of Units = Per Member Per Month (PMPM) or Per Employee Per Year (PEPY)

	Avg. Price Per Unit	Total Units
Hospital Admissions	$13,991	2,630
ER Visits	$713	8,624
Physician Office Visits	$160	266,402
Prescriptions	$99	411,016
Sub-Total:		

Provider View

Membership	**43,121**
Total Cost	PMPM
$36,796,330	$71.11
$6,148,912	$11.88
$42,624,320	$82.37
$40,690,584	$78.64
$126,260,146	$244.00

Payer View

EMORY HEALTHCARE

REIMBURSEMENT & VALUE MANAGEMENT

Reimbursement model must align with value management strategies to see gains

- Midwest Example*
  - Health system – **pursued clinical integration efforts**
  - Prior to value improvement efforts, utilization was **2% higher** than Midwest average
  - 4 years into efforts – **6% lower** than Midwest average
  - Estimated **annual savings of $500 million**
  - **None of savings maintained by health systems**
    - Still in fee-for-service reimbursement contracts
    - Direct impact on system's profits

**Source: Milliman/Mercer Study of a Midwest Health System Market*

POPULATION HEALTH MANAGERS

The population managers in World B may come in many forms

Walmart

Stratus HEALTHCARE

PROMED ALLIANCE
TECHNOLOGY AND INNOVATION SOLUTIONS FOR THE PRACTICE PUZZLE

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MAYO CLINIC Network

DaVita. | HealthCare Partners.

WELLSTAR

take care clinic is now healthcare clinic

Piedmont

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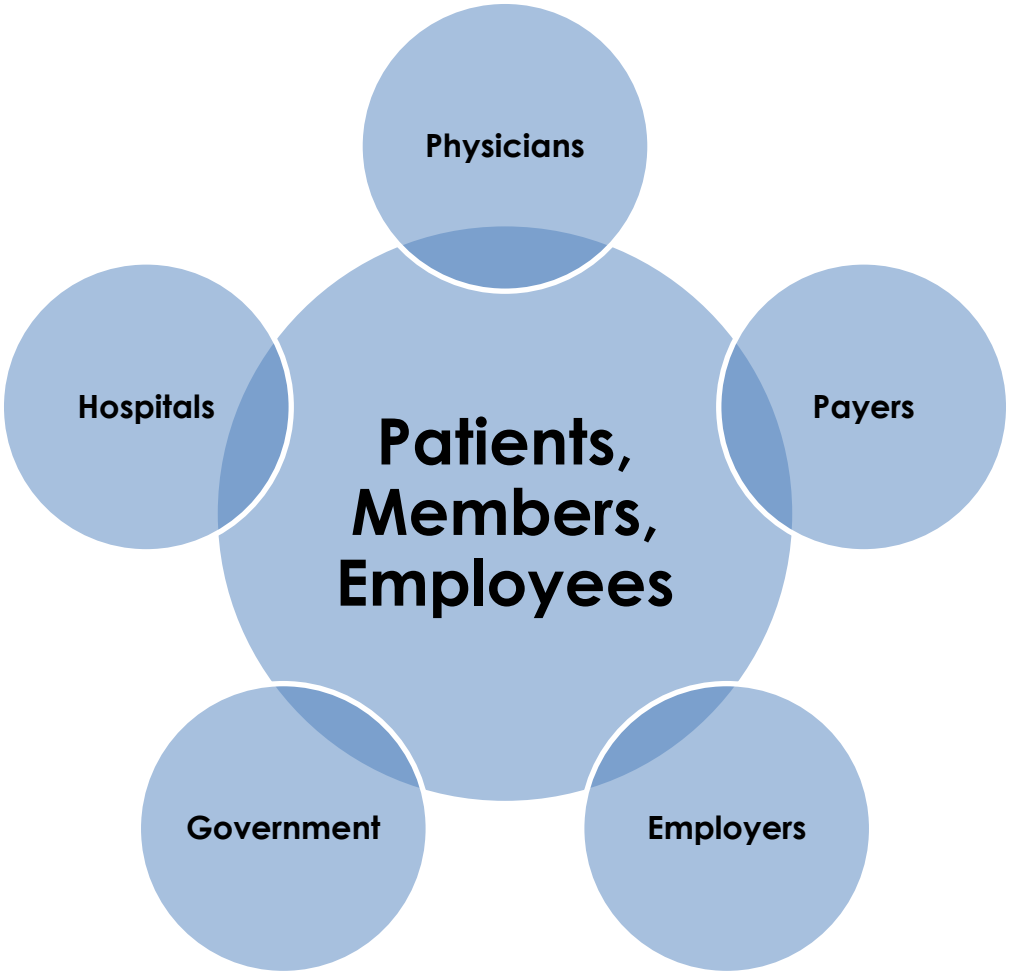
Midpoint Questions

SUCCESSFUL CLINICALLY INTEGRATED NETWORKS CREATE VALUE FOR ALL CONSTITUENTS

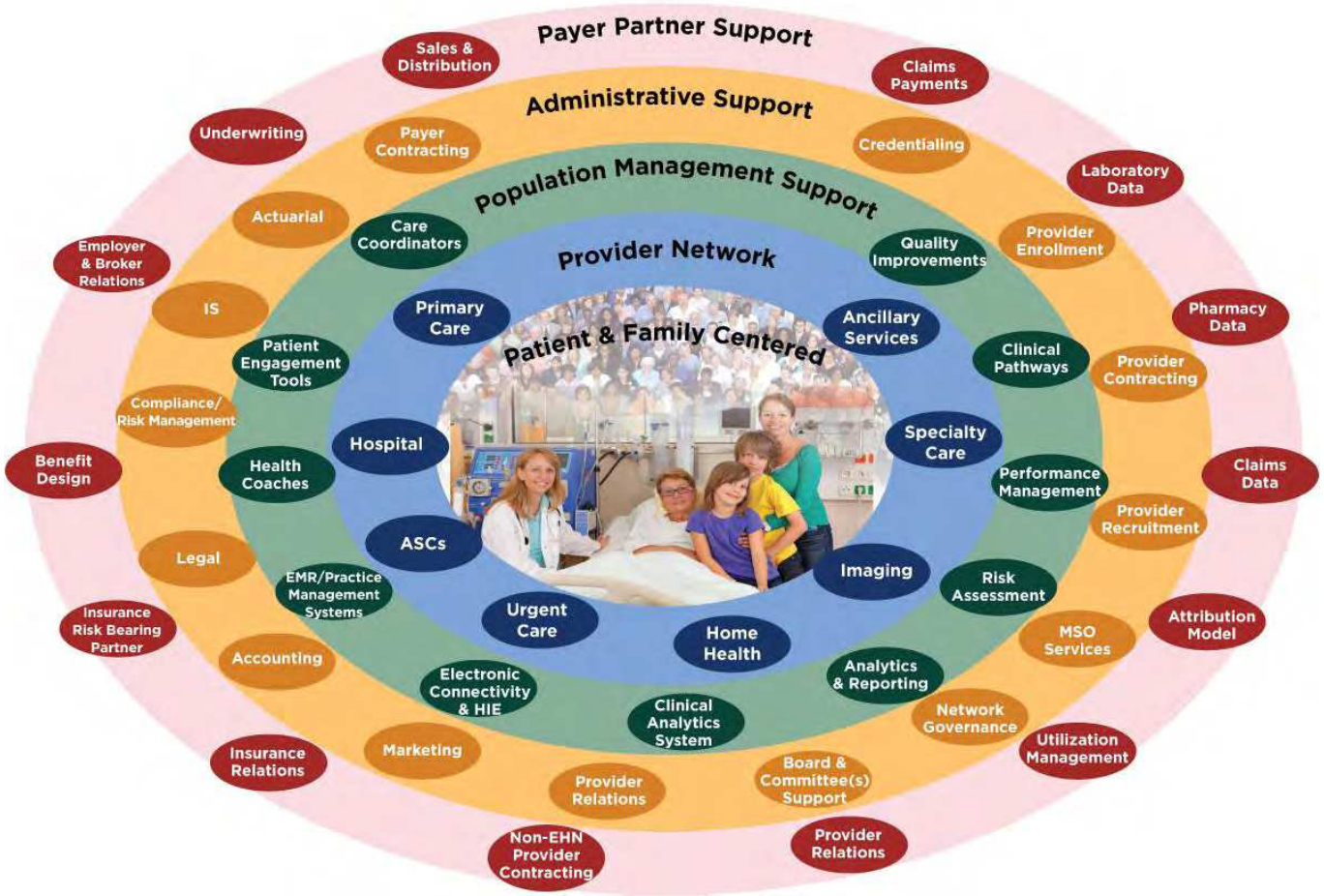


WHAT IS A POPULATION HEALTH MANAGER?

An organization that manages health outcomes, including *quality* and *total cost,* for a defined population

EMORY HEALTHCARE NETWORK

POPULATION HEALTH MANAGEMENT



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GOVERNANCE & LEGAL STRUCTURE

- More About What Are You Trying to Accomplish Than Who Controls
- Trust & Empower Physicians
- Address Any Control Issues Through Reserve Powers
- Engage Strong Expert Counsel to Formalize Legal Structure

  {Note: Anti-Trust Not Only Legal Issue}

PROVIDER NETWORK DEVELOPMENT

- Composition of Provider Network
- Provider Participation Criteria:
  - Inclusive or Exclusive Initially
  - Ability to Invoke Tougher Exclusive Criteria Than Medical Staff Bylaws
  - Participation Criteria Aligns What Organization Trying to Accomplish
- Credentialing & Re-Credentialing:
  - Standards to Obtain Delegated Credentialing (i.e. NCQA, URAC, etc.)
  - Support Review Committee
  - Separate Review Committee from Medical Staff Credentialing Committees
  - Peer Review Protection – Both Ways (i.e. *another reason for expert counsel)*

PROVIDER NETWORK DEVELOPMENT

- Physician & Other Provider Enrollment with Payers:
  - **Labor Intensive!!!!**
    - Initial & On-Going
    - Tracking & Distributing Billing Numbers & Effective Dates
  - By Tax I.D. or NPI
  - Direct Impact on Attribution Models
  - Impact on Physician Satisfaction

- Provider Reimbursement:
  - Fee-for-service Methodology & Rates
  - Incentive Plan
  - Alignment With Expected Payer Contracts (i.e. Market Competitive)
  - Reimbursement Aligns What Organization Trying to Accomplish

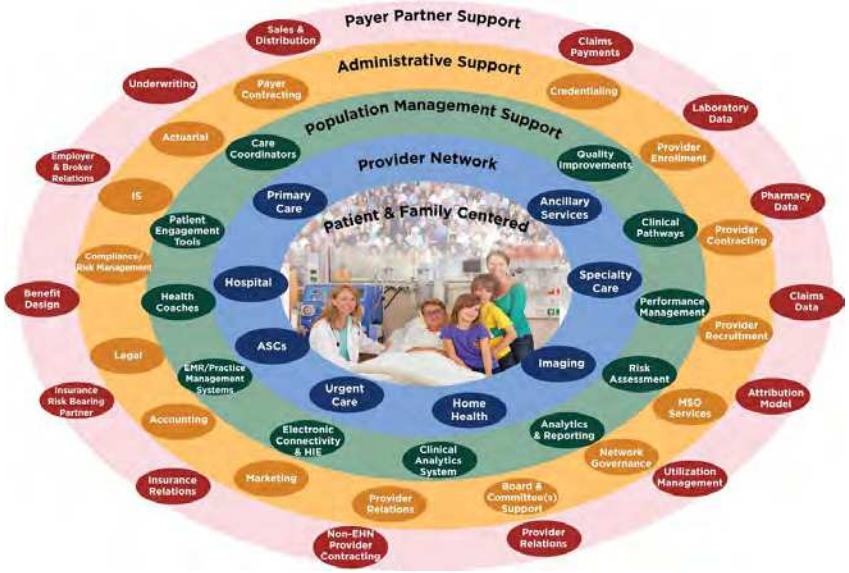
PROVIDER NETWORK DEVELOPMENT

- Provider Contracts:
  - Alignment With Expected Payer Contract Terms
  - Alignment with All Legal Requirements
  - Opt-In and Opt-Out Provisions
  - Tracking & On-Going Amendments
  - Efficient Communication Vehicles to Provider Network on Terms

- Provider Recruitment & Relations:
  - Identification & Recruitment of Individual Providers
  - On-Going Support of Providers - **Another Labor Intensive Activity!!!**

PAYER CONTRACTS & NEGOTIATIONS

Need Collaborative Payer Partners for Success



Payer Partner Support
Claims Payments
Laboratory Data
Pharmacy Data
Claims Data
Attribution Model & Determination
Utilization Management
Provider Relations
Non-EHN Provider Contracting
Insurance Relations
Insurance Risk-Bearing Partner
Benefit Design
Employer & Broker Relations
Underwriting
Sales & Distribution

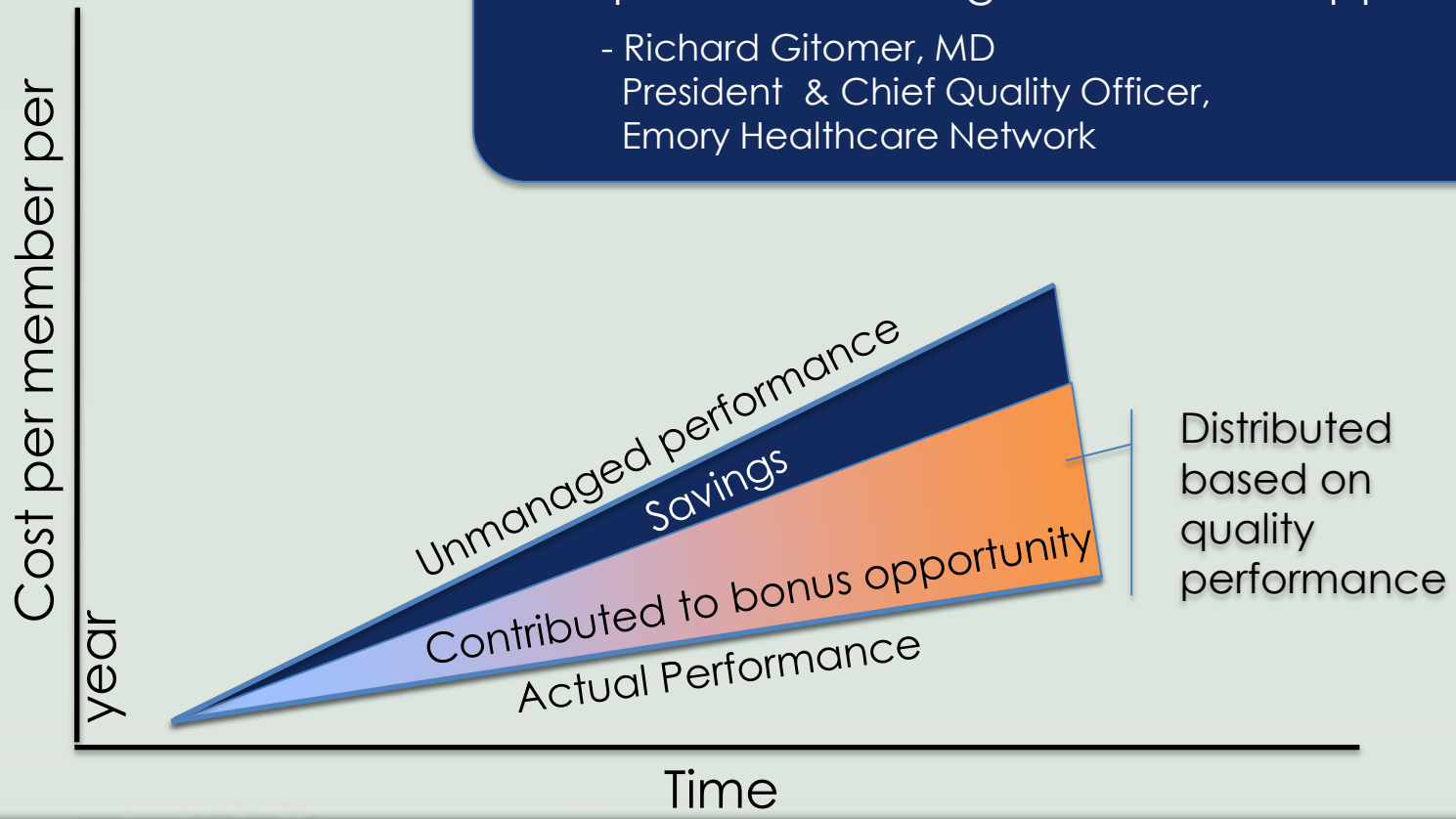
EMORY HEALTHCARE NETWORK

Payer Contracts & Negotiations

CONCEPTUAL VIEW OF SHARED SAVINGS

"Risk contracts are conceptually simple, but complex - 50% savings isn't what it appears."

- Richard Gitomer, MD
  President & Chief Quality Officer,
  Emory Healthcare Network



EMORY HEALTHCARE

PAYER CONTRACTS & NEGOTIATIONS

WOULD YOU SIGN THIS SHARED SAVINGS DEAL?

Proposed Terms:

- 5-year agreement
- First 2 years – no downside risk; only upside opportunity
  - 45% of shared savings
- Years 3 through 5 – downside risk and upside opportunity
  - 55% of shared savings = upside opportunity
  - 50% of downside risk

Would Have Retained 13% of Total Savings for 5 Years

PAYER CONTRACTS & NEGOTIATIONS

A GOOD ACTUARY IS YOUR FRIEND

- Risk contracts – conceptually simple, but complex
- 50% savings isn't what it appears

Partial List of Shared Savings Terms:

- Minimum Risk Corridor; Length of Contract; Rebasing/Smoothing; Upside Shared Savings %; Downside Shared Savings %; Up-Side/Downside Caps; Actuarial Trending; Risk Adjusters; Attribution Model; Outliers; Termination Provisions; Quality Metrics, Quality Metrics Calculations; Quality Metrics Weighting; Quality Percentile Rankings; Quality Levels; Quality Aggregate Scorer Tables; Normalization, etc.

Key Network Infrastructure Support:
Strong Actuarial Support – Day 1

PAYER CONTRACTS & NEGOTIATIONS

Extra Important Key Terms!!!

- Attribution Model
- Minimum Risk Corridor (MRC)
- Rebasing/Smoothing Period
- Quality Metrics & Terms
- Actuarial Trending Methodology (i.e. "Black Box Important")

POPULATION MANAGEMENT STRATEGIES & INFRASTRUCTURE

Effectively managing a population is ***not the same*** as efficiently managing acute episodes. It requires different skill sets, infrastructure and processes.

POPULATION MANAGEMENT STRATEGIES & INFRASTRUCTURE

Population Management Support
Care Coordinators
Patient Engagement Tools
Health Coaches
EMR/Practice Management System
Electronic Connectivity & HIE
Clinical Analytics System
Analytics & Reporting
Risk Assessment
Performance Management
Clinical Pathways
Quality Improvement

Population Management Support Infrastructure is The Engine

EMORY HEALTHCARE NETWORK

POPULATION MANAGEMENT STRATEGIES & INFRASTRUCTURE

Common Key Population Management Strategies

- Reduce Gaps In Care
- Improve Generic Prescription Utilization
- Through Better Care Coordination Reduce Utilization In:
  - Outpatient Imaging
  - Emergency Room Visits
  - Hospital Admissions

Are You Still With Me That World A is Not Sustainable?

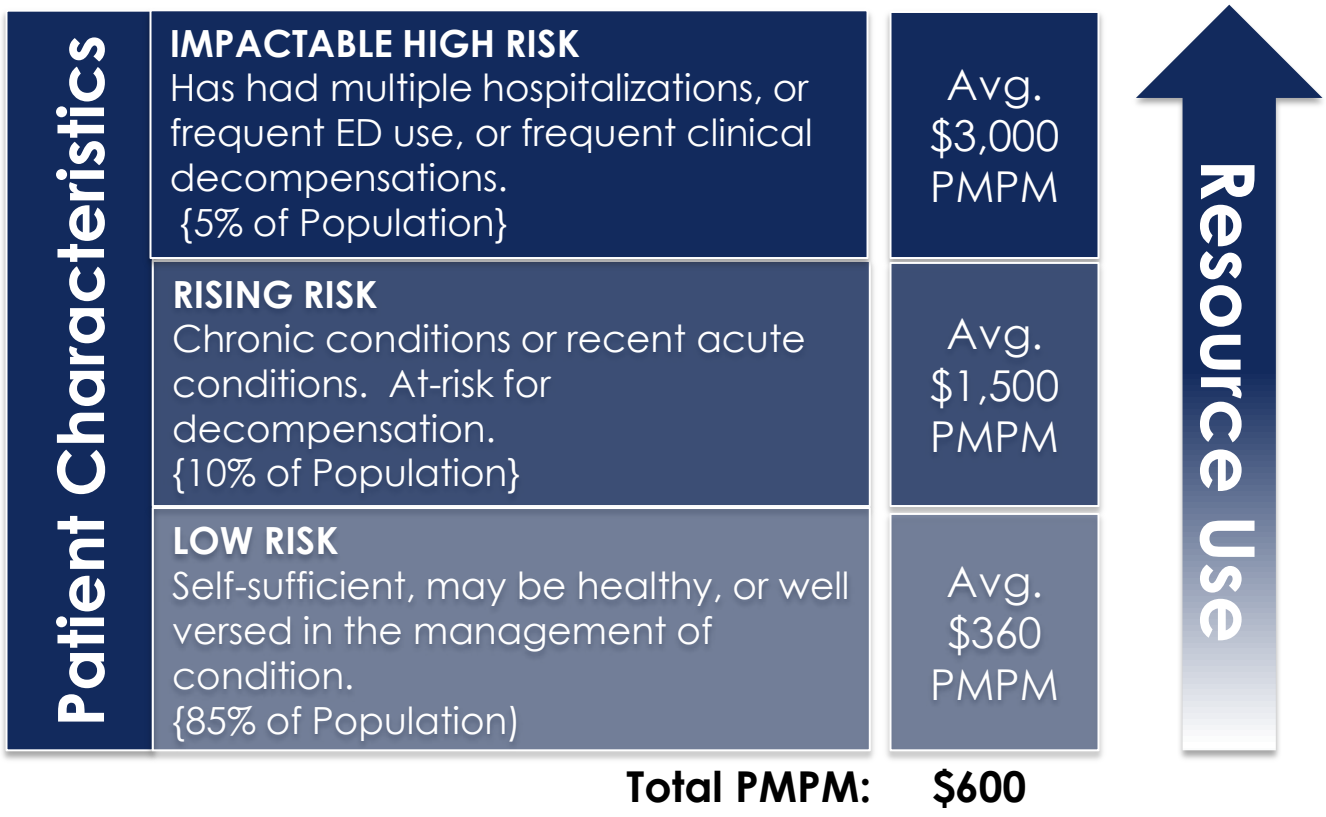
POPULATION MANAGEMENT STRATEGIES & INFRASTRUCTURE

Foundational Element – Information Technology Platform to Manage Population

- Track & Manage Network Financial & Quality Performance
- Track & Provide Regular Feedback on Performance to Individual Providers
- Segment Population into Risk Categories for Patient Population Management
- Enabler of Providers for Improved Value-Based Care
- Data Normalization of Multiple Data Sources

POPULATION MANAGEMENT STRATEGIES & INFRASTRUCTURE

RISK STRATIFICATION OF POPULATION



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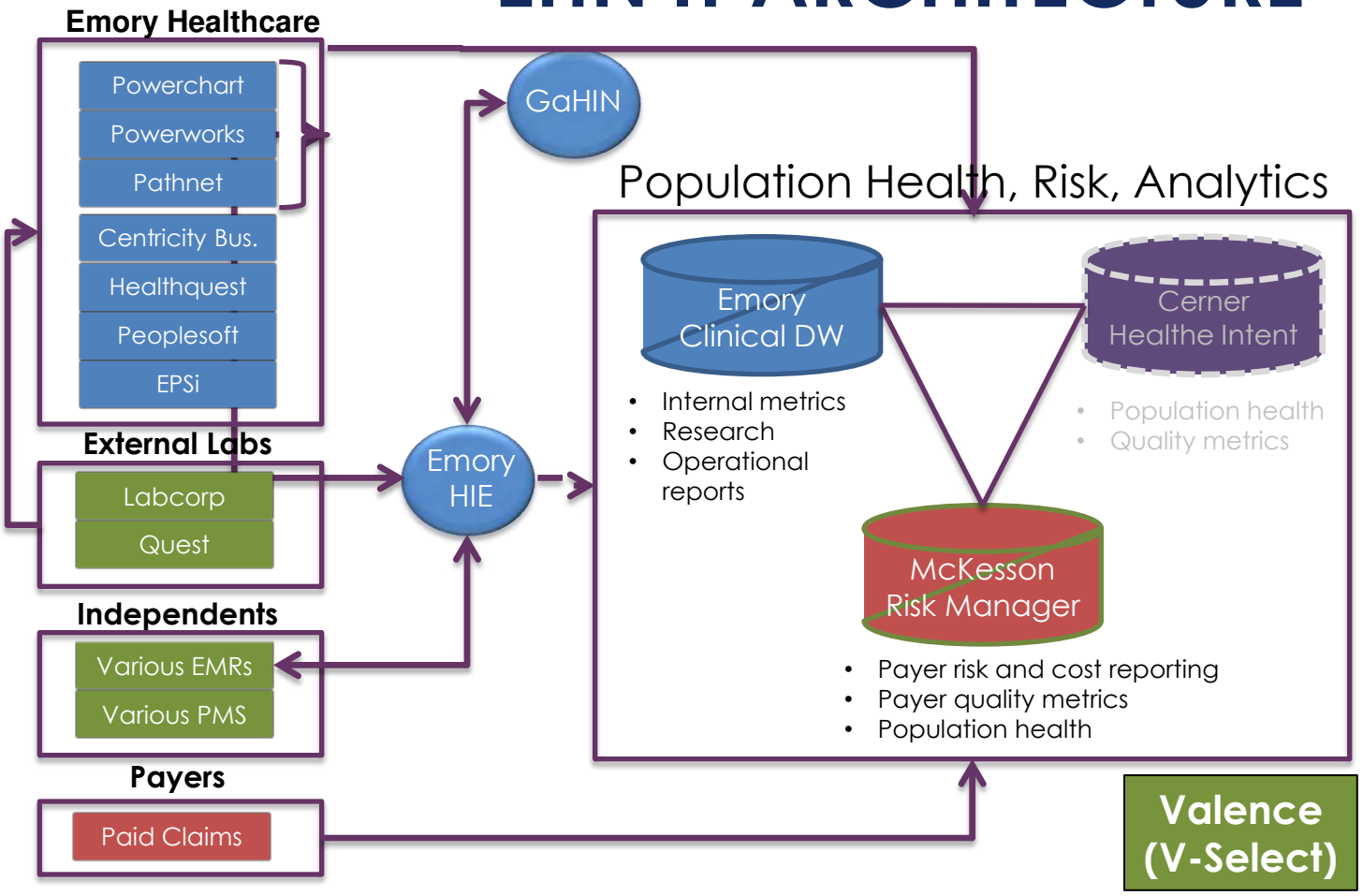
EHN IT ARCHITECTURE



Emory EHN and IT Goals

- Support management of patient care across the continuum
- Improve the quality of health care services
- Control costs
- Engage the patient
- Make information available at the time of care
- Efficient and effective reporting of quality data and metrics

Providers	Care Coordinators	Partners (minute clinics)	Network Administration	Hospitals
• EMRs • PMSs • CDW • Risk Manager • Healthe Intent	• Powerchart • Risk Manager • Healthe Intent	• EMRs • PMSs	• Peoplesoft • Risk Manager • Healthe Intent	• Powerchart • Healthquest • Peoplesoft • EPSi • EDW

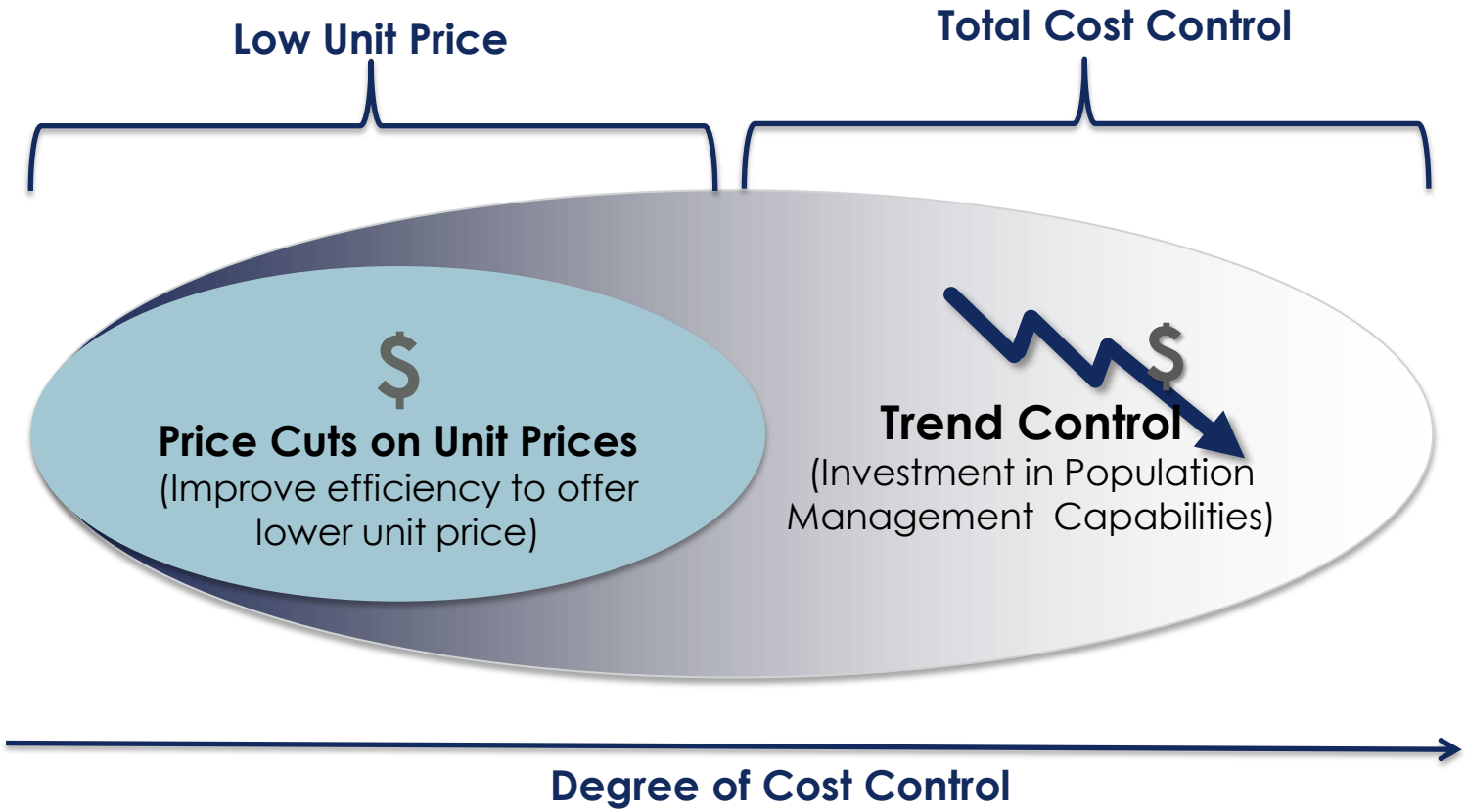
POPULATION MANAGEMENT STRATEGIES & INFRASTRUCTURE

Next Steps of Population Management Are Differentiation Steps That Determine Successful Execution verses Failure:

- Wide Variation in Strategies
- Understanding Healthcare Local
- Proprietary

FUNDING REQUIREMENTS

The Tension Between Unit Price and Total Cost



Source: Adapted from Healthcare Advisory Board Company Presentation, June 2014

FUNDING REQUIREMENTS

$12 Million

AHA's estimate of ACO start-up costs for a 5-hospital system

$14.1 Million

AHA's estimate of ongoing ACO Annual ACO costs for a 5-hospital system

Source: Adapted from Healthcare Advisory Board Company Presentation, June 2014 American Hospital Association, "Activities and Costs to Develop an Accountable Care Organization, May 5, 2014

TENSION BETWEEN UNIT PRICE AND TOTAL COST

SHORT-TERM INVESTMENTS

- IT infrastructure
- Care management staff
- Care coordination programs
- New access points

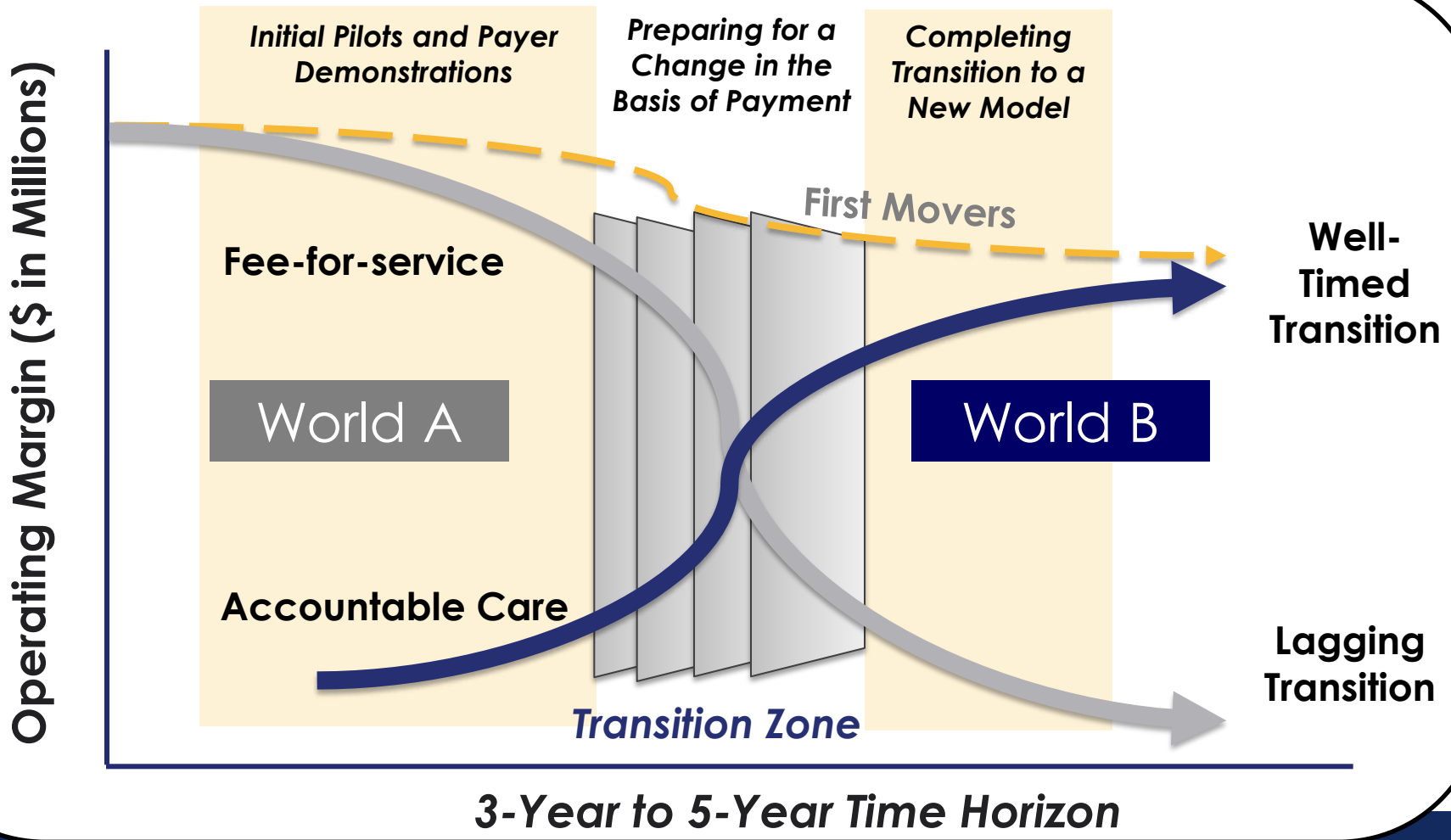
LONG-TERM PAYOFF

- Cost trend control
- Improved health outcomes
- Improved patient satisfaction

EMORY HEALTHCARE NETWORK

TRANSITIONING TO WORLD B

Managing Transition Economics



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Questions?