State of the Industry
A Network-Driven Marketplace

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The Advisory Board is Uniquely Positioned

Research and Relationships at the Intersection of a Dynamic Industry

Physician Groups

Hospitals

Post-Acute and Long-Term Care Providers

Suppliers

Nursing Leaders

Insurers

The Advisory Board Difference

We are …
- Willing to challenge conventional wisdom
- Devoted to exceeding member expectations at every turn

And we offer …
- Unique visibility into provider CXOs’ world – challenges, priorities, vendor perceptions
- Direct access to over 500 in-house health care experts

3,000+ Hospitals and Health Systems
200+ Independent Physician Practices
1,500+ Post-Acute Care Facilities and Agencies
200+ Health Care Product and Service Companies
5,000+ CXO Relationships Across the Care Continuum
1. A Network-Driven Marketplace

2. The Focus on Cost-Efficient Behavior

3. Meeting a New Set of Mandates
Returning to Our Mission

“Triple Aim” to Improve Health Care

1. Improve the patient experience of care (including quality and satisfaction)

2. Improve the health of populations

3. Reduce the per-capita cost of health care

Entitlement Reform Necessary—But Which Direction?

Unable to Remain Stuck in the Middle

Medicare Benefits Spectrum
Possible Future Scenarios

“Embracing Defined Contribution”
“Optimizing Defined Benefit”

Potential Medicare Spending

Fee-for-Service

Medicare Advantage

Means Testing

Rate Cuts

Prior Authorization

Global Spending Caps

Accountable Payment Models

Pure Voucher System

Hybrid Voucher System

Medicare Advantage

Medicare Involvement in Financing Care Delivery

Source: Advisory Board interviews and analysis.
ACA Brings Changes in Coverage, Reimbursement

Three Major Components of ACA

**Changes in Coverage**

- **Health Insurance Exchanges**
  
  Create online marketplace where individuals and small businesses can buy insurance

- **Medicaid Expansion**
  
  Expand Medicaid eligibility to include individuals and families with incomes up to 133% of the FPL

**Change in Reimbursement**

- **Risk-Based Payments**
  
  Introduce payment and care delivery models that ties reimbursement to cost and quality outcomes

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1) Affordable Care Act
2) Federal poverty level

Source: Advisory Board interviews and analysis.

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Networks A Popular Solution for Today’s Problems

Formation Motivated by a Range of Issues

Variety of Questions Facing Providers, Payers

- How do I improve patient access?
- What steps can I take to reduce costs?
- How do I ensure cross-provider collaboration?
- What can I do to enhance downstream quality?

One Common Answer: Network Formation

Source: Post-Acute Care Collaborative interviews and analysis.
Network Emergence a Widespread Trend

Networks Forming Across the Nation

**Accountable Care Alliance**
Provider-led ACO, including Methodist Health System and the Nebraska Medical Center

Massachusetts GIC¹
Employer-sponsored insurance network for state employees

**Anthem Blue Cross Vivity**
HMO composed of Anthem Blue Cross with 7 California health systems

**AARP Medicare Complete Focus**
Medicare Advantage plan organized by United with St. Elizabeth and Trihealth as preferred providers

The Ideal Network

“The best narrow plans would avoid high-cost, low-quality providers, while still offering customers the services they need...”

New York Times


¹ Group Insurance Commission.
Public Exchange Plans Mainly Narrow Network

Payers Responding to Anticipated Premium Sensitivity

Majority of Public Exchange Plans Exclude >30% of Largest Hospitals

20 Urban Markets, December 2013

- **Broad**
  - 30%
- **Narrow**
  - 32%
- **Ultra-Narrow**
  - 38%

Excludes 30% of 20 largest hospitals
Excludes 70% of 20 largest hospitals

Employer Shifting Risk by Increasing Cost-Sharing

Particularly Severe for Out-of-Network Care

Percent of Covered Workers Enrolled in a Plan with a $1,000+ Deductible by Firm Size

Single Coverage

<table>
<thead>
<tr>
<th>Year</th>
<th>Small Firms (3-199 Workers)</th>
<th>Large Firms (200+ Workers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>40%</td>
<td>13%</td>
</tr>
<tr>
<td>2010</td>
<td>46%</td>
<td>17%</td>
</tr>
<tr>
<td>2011</td>
<td>50%</td>
<td>22%</td>
</tr>
<tr>
<td>2012</td>
<td>49%</td>
<td>26%</td>
</tr>
<tr>
<td>2013</td>
<td>58%</td>
<td>28%</td>
</tr>
</tbody>
</table>

Average In- and Out-of-Network Deductibles for Group Plans

\( n = 1,100 \) employers

<table>
<thead>
<tr>
<th>Year</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
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<tbody>
<tr>
<td>2009</td>
<td>$1,000</td>
<td>$680</td>
</tr>
<tr>
<td>2010</td>
<td>$1,380</td>
<td>$760</td>
</tr>
<tr>
<td>2011</td>
<td>$1,750</td>
<td>$1,010</td>
</tr>
<tr>
<td>2012</td>
<td>$1,570</td>
<td>$940</td>
</tr>
<tr>
<td>2013</td>
<td>$2,110</td>
<td>$1,230</td>
</tr>
</tbody>
</table>

Medicare Advantage Continues Record Growth

MA Enrollment to Nearly Double by 2025

**Total Enrollment and Percentage of Total Medicare Population**

- **2005**: 10.4M (13%)
- **2015**: 17.3M (30%)
- **2025**: 30.0M (40%)

8.0% MA enrollment growth since 2010

MA Penetration Varies by State

**Total MA Enrollment as a Percent of Total Medicare Population**

- **0%-13%**
- **14%-25%**
- **26%-38%**
- **39%-51%**

The Emerging Medicaid Managed Care Environment

Policy Evolution of Medicaid Long-Term Care

I

Home and Community-Based Service Expansion

- New federal funds increase spending for HCBS
- States shift balance of LTSS services toward non-institutional care

Combined Impact: Intensified HCBS demand, LTC rate and utilization risk

II

Medicaid Managed LTSS

- States adopt managed long-term services and supports programs
- MCOs assume state’s role in managing LTSS

III

Dual Eligibles Integration

- States partner with CMS to integrate Medicare/Medicaid for dual eligible beneficiaries
- MCOs manage Medicare and Medicaid benefits

Combined Impact: “Medicalization” of LTC, primary care provider as LTSS coordinator

Source: Post-Acute Care Collaborative interviews and analysis.

1) Home and Community-Based Services.
# Overview of Accountable Payment Models

<table>
<thead>
<tr>
<th>Key Attributes</th>
<th>Value-Based Purchasing</th>
<th>Bundled Payments</th>
<th>Accountable Care Organizations (ACOs)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>Pay-for-performance program differentially rewards or punishes hospitals (and likely ASCs, physicians, PAC providers in coming years) based on performance against predefined process and outcomes performance measures</td>
<td>Purchaser disburses single payment to cover certain combination of hospital, physician, post-acute, or other services performed during an inpatient stay or across an episode of care; providers propose discounts, can gain share on any money saved</td>
<td>Network of providers collectively accountable for the total cost and quality of care for a population of patients; ACOs are reimbursed through total cost payment structures, such as the shared savings model or capitation</td>
</tr>
<tr>
<td><strong>Purpose</strong></td>
<td>Create material link between reimbursement and clinical quality, patient satisfaction scores</td>
<td>Incent multiple types of providers to coordinate care, reduce expenses associated with care episodes</td>
<td>Reward providers for reducing total cost of care for patients through prevention, disease management, coordination</td>
</tr>
<tr>
<td><strong>Advisory Board Assessment</strong></td>
<td>Withhold-earn back model will put significant dollars at risk for all providers, force immediate focus on quality and experience metrics</td>
<td>Increases accountability for cost and quality within episodes of care without removing FFS volume incentive; new lever for financial alignment between independent specialists and hospitals</td>
<td>Long-range goal of CMS to migrate to risk contracting; will spark industry-wide investment in primary care infrastructure to establish narrower networks</td>
</tr>
<tr>
<td><strong>Role of CMMI</strong></td>
<td>Dedicated $500M to Partnership for Patients, targeting hospital-acquired infections, readmissions</td>
<td>Accepting providers’ proposals to test four different bundled payment models, including one without inpatient care</td>
<td>Accepting providers’ proposals to test various payment systems, including both shared savings and partial capitation</td>
</tr>
</tbody>
</table>

1) Center for Medicare and Medicaid Innovation.

Source: Marketing and Planning Leadership Council interviews and analysis.
Importance of Clinical Process Weight Continues to Decline

CMS Focused on Efficiency, Outcomes

Medicare Hospital VBP\(^1\) Program Domain Weights

<table>
<thead>
<tr>
<th>FY 2013</th>
<th>FY 2014</th>
<th>FY 2015</th>
<th>FY 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Process</strong>&lt;br&gt;70%&lt;br&gt;45%&lt;br&gt;30%&lt;br&gt;25%&lt;br&gt;20%&lt;br&gt;10%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Experience</strong>&lt;br&gt;30%&lt;br&gt;30%&lt;br&gt;30%&lt;br&gt;25%&lt;br&gt;25%&lt;br&gt;25%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outcomes of Care</strong>&lt;br&gt;30%&lt;br&gt;30%&lt;br&gt;30%&lt;br&gt;40%&lt;br&gt;40%&lt;br&gt;40%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Efficiency</strong>&lt;br&gt;30%&lt;br&gt;25%&lt;br&gt;20%&lt;br&gt;25%&lt;br&gt;25%&lt;br&gt;25%</td>
<td></td>
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</tr>
</tbody>
</table>

Incenting an Efficient Episode of Care

Introducing CMS’s First Mandatory Bundle

Comprehensive Care for Joint Replacement (CJR) Model in Brief

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>Accountability</th>
<th>Financial Risk</th>
<th>Waivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>All traditional Medicare, lower extremity joint replacement patients in 67 selected markets are included in the bundle</td>
<td>Acute care hospitals will bear financial risk; hospitals participating in BPCI Models 1, 2, or 4 are excluded</td>
<td>Providers’ episodic costs will be compared to a target price; providers would gain added reimbursement or owe CMS based on cost, quality performance</td>
<td>Program includes provisions for gainsharing with PAC partners, waivers for 3-day stay rule, home visit and telehealth reimbursement</td>
</tr>
</tbody>
</table>

The CJR Model in Numbers

- **2**: MS-DRGs subject to bundled payment: 469 and 470 (lower extremity joint replacement)
- **67**: Number of markets in which CMS plans to implement mandatory bundling
- **$343M**: Net savings expected by CMS from the program between 2016 and 2020


1) Not already counted in a BPCI model 1, 2, or 4.
Continued Growth in ACO Model

Early Financial Results a Mixed Bag, Indicate Improvement Opportunity

ACOs Continue to Grow

23.5M

Americans enrolled in or attributed to Medicare, Medicaid, or commercial ACOs

744

ACOs of all types nationwide

ACO Performance in Medicare Shared Savings Program

Performance Year 2014

- 45% Did not hold spending below benchmark
- 28% Held spending below benchmark, earned shared savings payment
- 27% Held spending below benchmark, but did not earn shared savings

50%

HHS seeks to tie half of all Medicare payments to provider quality via ACOs or bundled payment arrangements by 2018

1. A Network-Driven Marketplace

2. The Focus on Cost-Efficient Behavior

3. Meeting a New Set of Mandates
Market Demands Dictate Utilization Changes

Four Key Actions Necessary for Success Under New Payment Models

Factors Driving Additional Demands Providers

Legislative Forces
- Additional regulatory requirements
- Emerging payment models focused on outcomes and cost

Commercial Forces
- Increasing overlap in payer/provider capabilities
- Rise of consumerism among beneficiaries

Demographic Forces
- Rising complexity, acuity of patient profile
- Rapid growth in elderly population

Suite of Emerging Patient Management Expectations for Providers

1. Proper Care Setting, Patient Access
2. Complex Patient Management
3. Elevated Provision of Cost-Saving Services
4. Enhanced Downstream Coordination

Source: Post-Acute Care Collaborative interviews and analysis.
A Growing Network of Immediate Access Choices

Emerging Set of Access Points Prioritize Primary Care

Consumer-Oriented Service Delivery Sites Filling the Gap

Driving Provider Questions:

- Should we partner to establish retail clinics?
- Should we build or expand our urgent care footprint?
- Is virtual care something that we should provide?
- When should we enter into partnerships to meet patient demands?

Source: Mehrota A et al, “Visits To Retail Clinics Grew Fourfold From 2007 To 2009, Although Their Share Of Overall Outpatient Visits Remains Low,” Health Affairs, August 2012; Health Care Advisory Board interviews and analysis.
Encouraging Appropriate Post-Acute Utilization

IMPACT Act of 2014 in Brief

Standardizing Data Reporting…

Required Domains and Sample Metrics

**Patient Assessment**
- Special services required
- Cognitive function

**Quality Measures**
- Changes in skin integrity
- Medication reconciliation

**Resource Use Measures**
- Medicare spending per beneficiary
- Rate of discharge to community

…To Guide Patient Placement

**Three Stated Purposes**

1. Compare quality across PAC settings
2. Inform hospital discharge planning
3. Create foundation for future PAC payment reform (likely via site-neutral or bundled payments)

New Discharge Planning Requirements

To meet CMS conditions of participation, hospitals and PAC providers must incorporate PAC quality and resource use data into discharge planning procedures by January 1, 2016


1) Acute care and critical access.
Health Plans Trading Control for Collaboration When Strategic

Anthem Signaling Shift from Vertical Integration

Vertically Integrated Model
- Anthem employs physicians to operate CareMore model
- Difficult to implement nationally

Provider-Contracted, Customized Model
- Partners with capable providers, to operate “CareMore-like” model
- Increases scale, coordination, impact

naviHealth Waiting for PAC to Become the Quarterback

“Post-acute care managers are put in place because current payment models do not incentivize the quarterbacking of a post-acute episode—guiding a patient from hospital back to the community.

So we’re putting decision support technology and care coordination in place out of necessity.”

SVP Business Development, naviHealth

Skeptical of Vertical Integration’s Potential

“I don’t believe any insurer, health system, or provider group can acquire or consolidate their way to sustainable success.”

CEO, Wellpoint

**Incenting Cohesive Services for Complex Patients**

**Medicare Offers Payment for Clinician-led Care Coordination**

**New Medicare Billing Option**

- Medicare covers clinician-led\(^1\) care coordination services
- Targets beneficiaries with two or more chronic conditions
- Requires 24/7 clinician availability for urgent chronic care needs

**Care Coordinator Responsibilities**

- Arrange smooth transitions from hospital to home or nursing home
- Assess patients’ medical, psychological and social needs
- Draft and execute care management plan
- Monitor care provision from other providers
- Improve medication adherence

**Payment for Coordination**

- **$42** Approximate monthly payment, per patient
- **20%** Approximate patient portion of fee

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1) Care Coordinator role can be filled by physician, nurse practitioner, PA, or other health professional.


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Service Demands Driven by Demographics

Patients, Residents Older and Sicker

Chronic Disease Prevalence
Residential Care Facilities, 2010

- 50% with 4-10 conditions
- 26% with 2-3 conditions
- 18% with 1 condition
- 6% with 0 conditions

Seniors as a Portion of the US Population

- Actual
- Projected

Key Reasons for Higher Patient Acuity and Complexity in Post-Acute Care Settings

Aging Population
Population growing older, with more chronic conditions

New Payment Models
Reimbursement changes incent shorter LOS, favor lower-cost settings

Professional and Family Support in Short Supply

Projected Increase in Supply and Demand of Professional Caregivers by 2022

Demand for Direct Caregivers

48%

Direct Caregivers Available

1%

Ratio of Family Caregivers to Every Person Over Age 80

7:1 in 2010

4:1 in 2030

Massive Growth in Caregiver Demand

1.3M Necessary number of new paid caregivers to satisfy demand over the next decade

Establish Infrastructure to Fill Niche Service Gaps

Training to Address Medically Complex Behavioral Health Patients

HealthEast – Cerenity Senior Care Partnership

Collaborative Hospital-SNF Training

Protocols Around Patient Mental Capacity

**Problem:** SNF inexperienced assessing capacity for patient decision-making and determining decision-maker

**Solution:** Hospital shares ethical principles for substituted judgment and beneficence

Clinical Training for Medication Management

**Problem:** Mandated dose reduction in SNF raises concerns about return of symptoms

**Solution:** Hospital and SNF physicians discuss procedures for safely tapering medications

Guidance for Addressing Population Needs

**Problem:** Younger population requires activities atypical of average SNF patient

**Solution:** Hospital provides input on patient stimulation and socialization

Real-Time Clinical Support

Outpatient Clinic

Patient seen at hospital physician clinic to avoid unnecessary readmission

Physician Support Line

Hospital team available over the phone for on-demand consults

Source: Advisory Board interviews and analysis.
Expectation #3: Elevated Provision of Cost-Saving Services

Acknowledging the Value of End-of-Life Care

Increased Hospice Utilization Generates Significant Savings for Medicare

$2,309
Average Medicare savings per beneficiary if hospice used in last year of life

47%
Lower Medicare spending during last 14 days of life for patients using hospice

4
Average fewer hospital days during last 30 days of life for beneficiaries using hospice

Available Hospice Coverage During Patient Care Trajectory

Traditional Medicare Hospice Benefit

<table>
<thead>
<tr>
<th>Time</th>
<th>Curative Care</th>
<th>Hospice Care</th>
</tr>
</thead>
</table>

Medicare Care Choices Program

<table>
<thead>
<tr>
<th>Time</th>
<th>Curative Care</th>
<th>Hospice Care</th>
</tr>
</thead>
</table>

Remote Solutions Address Access Challenges

Telephonic End-of-Life Care Counseling

Vital Decisions

Nationwide Access to Palliative Care Experts...

"For the first time during the course of my illness, someone took a genuine interest in explaining the delicate topic of possible scenarios that may happen and the choices that are available."

Vital Decisions Patient

...When Patients Need an External Confidant

"I can’t talk that way with my son in the room."

Vital Decisions Patient

An Extender for Plan Case Managers

Plan case manager refers patient to counselor

Counselor (e.g. LCSW) reaches out, facilitates ongoing conversations as appropriate

If requested, counselor helps communicate decisions with providers, family

Senior Living Key to Supporting the Elderly

Adult Day Oversight a Physician ACO Solution

Populations Excluded from Senior Housing Market Driving Physician Challenges

- Low-income seniors
  - More likely to be high-utilizers and non-compliant with medications

- Seniors with dementia choosing to age in the community
  - Disrupt physician office dynamics, physician workflow

Adult Day Care Solutions

**Low-Cost Care**
- Inexpensive relative to senior living or long-term care
- Does not count toward ACO Medicare distribution

**High-Touch Oversight**
- Contact up to 60 hours a week
- Nutrition and hydration
- Skilled oversight and health status monitoring

Source: Post-Acute Care Collaborative interviews and analysis.
Expectation #4: Enhanced Downstream Coordination

Hospitals Providing Increased Support Post-Discharge

Reliant PACS’ Clinically Enhanced Network Management Model

Traditional SNFist Model

- SNFists round in facilities to support appropriate utilization

Reliant PACS Expanded Model

- Overlay additional services to manage care across continuum

Care Coordination

- Hospital-based NP manages transitions, reducing hospital LOS and facilitating in-network placement

Evidence-Based Utilization Management

- Build DRG-specific care protocols into EMR to promote cost-effective care

On-Site Clinical Support

- Embed therapy and nurse practitioner teams in SNFs to reinforce and enhance care protocols

Source: Reliant Post-Acute Care Solutions; Post-Acute Care Collaborative Interviews and analysis.
The Return of House Calls?

Home Health, Hospice Spending Support Lower Total Costs

Financial Impact of Medstar’s Medicare Home-Based Primary Care Demonstration

*Mean 2-year spending per patient*

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Intervention</th>
<th>Control</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice</td>
<td>$3,144</td>
<td>$1,505</td>
<td>109%</td>
</tr>
<tr>
<td>Home Health</td>
<td>$6,579</td>
<td>$4,170</td>
<td>58%</td>
</tr>
<tr>
<td>Physician</td>
<td>$4,143</td>
<td>$5,718</td>
<td>(28%)</td>
</tr>
<tr>
<td>Skilled nursing</td>
<td>$4,821</td>
<td>$6,098</td>
<td>(20%)</td>
</tr>
<tr>
<td>Other¹</td>
<td>$7,962</td>
<td>$11,392</td>
<td>(30%)</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>$17,805</td>
<td>$22,096</td>
<td>(19%)</td>
</tr>
<tr>
<td><strong>Total Medicare</strong></td>
<td><strong>$44,455</strong></td>
<td><strong>$50,978</strong></td>
<td>(13%)</td>
</tr>
</tbody>
</table>

*HBPC Model*

- Primary care team of geriatricians, NPs, social workers, LPNs, office coordinators
- Physicians visit every 3-4 months and provide 24/7 call, NPs visit regularly as needed
- Team conducts weekly care conferences with home health, mental health, pharmacy

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1) Diagnostic testing, transportation, Medicare Part B drugs, nonphysician practitioners, durable medical equipment, outpatient facility.

### Medicare Spending for Home-Based Primary Care by Patient Frailty

<table>
<thead>
<tr>
<th>Frailty Category (JEN Index)</th>
<th>Proportion of Sample</th>
<th>Intervention</th>
<th>Control</th>
<th>Change</th>
<th>Statistically Significant?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low (0-3)</td>
<td>20%</td>
<td>$22,611</td>
<td>$19,146</td>
<td>18%</td>
<td>No</td>
</tr>
<tr>
<td>Medium (4-6)</td>
<td>43%</td>
<td>$42,223</td>
<td>$43,383</td>
<td>-3%</td>
<td>No</td>
</tr>
<tr>
<td>High (7+)</td>
<td>37%</td>
<td>$58,689</td>
<td>$76,827</td>
<td>-24%</td>
<td>Yes (p &lt; 0.001)</td>
</tr>
</tbody>
</table>

With Proper Risk Stratification, Less Can Be More

Patients included in the intervention cohort who could have been served with routine care to achieve similar spend reduction results at a lower program cost

63%
1. A Network-Driven Marketplace

2. The Focus on Cost-Efficient Behavior

3. Meeting a New Set of Mandates
Market Changes Prompt New Approach

New Realities Require Evolution in Provider Alignment, Service Offerings

**Network-Driven Marketplace**

**Focus on Cost-Efficiency**

**New Mandates for Success**

1. **Curate the Right Set of Assets**
   - Bring together necessary services, sectors to address network concerns and extend organizational reach

2. **Offer a Differentiated Product**
   - Develop services that rise above the status quo to appeal to network consumers, secure future role

**Key Underlying Organizational Commitments**

- Demonstrate Cost-Conscious Behavior
- Provide Coordinated, Patient-Centered Care

Source: Post-Acute Care Collaborative interviews and analysis.
New Partnerships Aim at Integration Without M&A

Partnerships and Affiliations On the Rise

- Large academic medical center signs preliminary partnership agreement with six rival hospitals to better compete with bigger systems
- Allina and HealthPartners affiliate to create a “testing lab” for accountable care
- Medium-sized academic medical center partners with smaller rival to fill cath lab service deficiencies
- New Hanover Regional Medical Center, Wilmington Health, BCBSNC agree to accountable care alliance
- Baylor College of Medicine, CHI form community hospital joint venture to explore joint affiliation options
- Large medical center agrees to sell CON-approved open-heart surgery suite to competitor

Growth Goals for Partnerships

- Ambulatory footprint
- Access to new regions
- New clinical program
- Brand equity

Independent Post-Acute Networks Improve Quality, Achieve Noticeability

Too Small
Unable to command payer attention

Too Big
Risks antitrust violations; unable to control for quality

Just Right
25%-35%

“It’s a balancing act between making sure we have enough capacity to get noticed and we are not so big that we lose control over our quality.”

Director, Health Care Strategic Initiatives, Cincinnati PACN Member Organization

Delivering on Network Quality Assurance

Interventions Target Underperforming Members

Covenant Health Network’s “SWAT Teams”

- Team composed of 3 RNs and 2 administrators
- Dispatched to members underperforming relative to state and national benchmarks

SWAT Team Intervention Process

1. Perform facility review
2. Create report and remedial plan
3. Ensure member implementation of plan
4. Remove member from network if no improvement seen

Network Quality Brings Shared Savings, Premiums on Rates

- 4.2 Average Medicare five-star quality rating
- 15-30% Average premium on Medicaid contract rates
- $1M Annual marginal revenue from shared savings

Source: Covenant Health Network; Post-Acute Care Collaborative interviews and analysis.
Offer a Differentiated Product

Defining True Specialization

What Is Specialization?

Specialization is a business philosophy wherein the organization makes conscious, principled decisions to focus on **specific patient groups** and creates **dedicated, distinct clinical programs** to serve those patients.

Key Components of a Specialty

**Organizational Commitment**
- Executives, leadership, and clinicians visibly support specialty
- Specialty program is a key organizational strategic priority

**Dedicated Resources**
- Distinct staff, leadership, and/or equipment dedicated to the specialty
- Additional investments in staffing, training and technology made as necessary

**Differentiated Offerings**
- Specialty stands out, is sufficiently different from competitors’ offerings
- Specialty performance is demonstrably superior to competitors, or is unique in the market

**Clinical Excellence**
- Staff and leaders committed to delivering excellent clinical outcomes
- Ongoing staff education and protocol development supports quality

Source: Post-Acute Care Collaborative interviews and analysis.
A Dual Approach to an Enhanced Value Proposition

Evolution to Strengthen Core, Expand Business Opportunities

Reinventing the Health Care Identity

Mastering Your Core Identity
- Enhance clinical capabilities
- Deliver value-focused, efficient care
- Offer full set of patient solutions

Pursuing New System Roles
- Expand valuable specialty offerings
- Engage patients across multiple care sites
- Elevate primary care, long-term patient management

Distance from Traditional Core Offerings

Diversity of Offerings

Recognizing the Potential of Targeted Services

“Solution” Sales on the Rise for Non-Providers

Case in Brief: Walgreen Co.

- Largest drug retail chain in the United States, with 372 Take Care Clinics and over 700 locations throughout the country
- In 2012, created WellTransitions™ program to help health systems reduce readmissions by offering transitional support for at-risk patients
- Strong initial results include 5 point lower readmission rate over 6 months for patients enrolled in the program versus eligible patients who did not enroll
- Received American Hospital Association endorsement for medication adherence portion of WellTransitions™

WellTransitions™ Program Components

- Medication Reconciliation
- Prescription Delivery
- Appointment Reminders
- Follow-Up Phone Calls

An Analogous Market Imperative

Disruptive Innovation Swings Share, Shrinks Market

Company in Brief: Proctor & Gamble Co.

- 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

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

58%

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

$0.25

Change in total U.S. sales of detergent, 2012-2013

(2.1%)