Who We Are – DHG Healthcare Consulting

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Insights from the Front Lines of Change...
1. Key Challenges of the Reform Era
2. Hospital and Physician Alignment Drivers
3. New Models of Care Delivery
4. Co-Management – A Transitional Model
Key Challenges of the Reform Era
THE MOMENT IT ALL CHANGED

Every sector of the industry starts sifting through hundreds of pages of legislation to assess the law’s financial and regulatory impact.

March 2010
PPACA Made Law
Special report: Most integrated systems lay foundation for future / Page 28

Modern Healthcare
THE ONLY HEALTHCARE BUSINESS NEWS WEEKLY
JANUARY 24, 2011
$5.50

HOUSE VOTES TO REPEAL PATIENT PROTECTION AND AFFORDABLE CARE ACT

REFORM ON THE RUN
Awash in political rhetoric and conflicting statistics, providers weigh practical effect of repeal vote / Page 6

Members hustle to the U.S. House chamber to vote on the repeal of the Patient Protection and Affordable Care Act.

High court taking on Medicaid / Page 8
What’s on the minds of CEOs / Page 10
FEDERAL JUDGE SAYS PATIENT PROTECTION AND AFFORDABLE CARE ACT UNCONSTITUTIONAL

SEPARATION ANXIETY

Providers follow spirit of the reform law and move forward while many states use ruling to pull back from mandates / Page 6
A NEW DAWN?

The healthcare industry mulls whether new regulations hold financial promise or unacceptable risks for providers

Page 6
Future of Medicare’s accountable care organization plan jeopardized...

...by providers unwilling to take on what they say is big risk for little reward
Modern Healthcare
THE ONLY HEALTHCARE BUSINESS NEWS WEEKLY
JUNE 14, 2010
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FEDS BUILDING FIRST CENTER FOR MEDICARE AND MEDICAID INNOVATION

THE GOVERNMENT’S $10 BILLION HEALTHCARE INCUBATOR

What hatches will affect how providers deliver and get paid for care in the future
Page 6

CEO IT Achievement Awards
Special section profiles two new honorees
Spending Not Related to Quality or Value

Source: OECD Health Data 2009
“would reduce Medicaid spending by $771B over 10 years and $30B from Medicare” p6
US National Debt at $15.9 Trillion

- Unless the U.S. government fixes the budget, US National debt (credit card bill) will topple $16 trillion this fall and rise to $22.1 Trillion within 4 years.
- US national debt passes 20% of the entire world’s combined GDP.

Each pallet equals $100 million dollars, full of $100 dollar bills.
A New Dialog

**Annual Increase**
Total Spend: 7.0%
Medicare Spend: 6.8%
Private Insurance Spend: 7.1%
November 16, 2010

Source: “U.S. Healthcare Costs” KaiserEDU.org
HHS RELEASES LONG-AWAITED FINAL REGS ON ACCOUNTABLE CARE ORGANIZATIONS

AFTER FURTHER REVIEW

Conferring over provider complaints, Medicare officials ease up on ACO rules to encourage participation / Page 6
DEFICIT-REDUCTION SUPERCOMMITTEE FAILS TO REACH AN AGREEMENT

SUPERFAILURE

Healthcare providers left wondering what comes next as lawmakers leave fiscal issues unresolved / Page 6

Special report: Guarding against diagnostic radiation overdoses / Page 28

Modern Healthcare
THE ONLY HEALTHCARE BUSINESS NEWS WEEKLY
NOVEMBER 28, 2011
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Sen. Max Baucus (D-Mont.), a supercommittee member, talks with reporters the day negotiations collapsed.

NEWS MAGAZINE

First insurer called on rate hikes / Page 8
SOUNDS LIKE A PLAN

Insurers want their own physician practices to ensure that enrollees have access to services

Page 6
WASTING AWAY

Experts call on providers to develop more effective and efficient strategies to care for common maladies

Page 6
STARTING A NEW LINE

In what’s viewed as a bellwether transaction, DaVita diversifies into primary care and becomes part of ACO program.

Page 6
Special report: The changing world of the nation’s hospitalists / Page 28

Modern Healthcare
THE ONLY HEALTHCARE BUSINESS NEWS WEEKLY
APRIL 2, 2012
$5.50

SUPREME COURT HEARS ORAL ARGUMENTS ON HEALTHCARE REFORM LAW

BIG DECISION
Future of Affordable Care Act looks uncertain after justices debate legal challenges to healthcare overhaul / Page 6
Physicians take the lead in the next phase of Medicare accountable-care organization contracting program / Page 6
That was close

Narrow 5-4 decision gives providers vindication and critics ammunition / Page 2
FEELING THE HEAT

With the number of Medicare ACOs more than doubling, the pressure is mounting on providers and the CMS to perform / Page 6
Where the ACOs Are

32 Pioneer and 116 Shared Savings Program ACOs¹ as of July 2012

Source: The Advisory Board Company
Early On, Revenue Implications….

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Revision of Certain Market Basket Updates

Medicare Advantage Payments

Hospital Readmissions Reduction Program

Medicaid Disproportionate Share (DSH)

Medicare Disproportionate Share (DSH)

Payment Adjustment for Conditions Acquired in Hospitals

Program in place
Then, Delivery Implications

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Program in place: Blue
Pilot or Demonstration Period: Gray
Integrating Across the Care Continuum

#1 Cost Reduction/Payer Leverage

#2 Physician Alignment and Clinical Integration

#3 Geographic Coverage, Access, and OP

#4 Service Line Optimization

#5 Developing Networks and Integration Across the Continuum

#6 New Payment Models and Trials
Integration Accelerating Across the Continuum

Acuity

Community-Based Care
- Home
- Wellness and Fitness Center
- Retail Pharmacy
- Physician Clinics
- Diagnostic/Imaging Center
- Ambulatory Procedure Center

Urgent Care Center

Recovery & Rehab Care
- Hospital
- Acute Care
- IP Rehab
- SNF
- OP Rehab
- Home Care

Source: Sg2
Hospital and Physician Alignment Drivers
Caregiver Supply Not Meeting Demand

PCP Supply vs. Demand (in thousands)


2020 Deficits … PCP = 66,000
Specialist = 79,000

Source: SHP/VHA 2009 | Merritt Hawkins 2007
Caregiver Supply Not Meeting Demand

National Supply and Demand Projections for FTE Registered Nurses (2000 – 2020)

Source: Bureau of Health Professions, RN Supply & Demand Projections
Volume Growth Widening the Gap

Projected Ten Year Volume Growth With and Without Reform

**INPATIENT DISCHARGES**
- With Reform: 8.5%
- Without Reform: 8.1%

**OUTPATIENT VISITS**
- With Reform: 23.1%
- Without Reform: 19.1%

**MEDICAL ADMISSIONS**
- With Reform: 7.4%
- Without Reform: 7.3%

**SURGERIES**
- With Reform: 11.2%
- Without Reform: 10.2%

Source: Sg2
Physician "Real Income" Declining

Source: Health Leaders 2011

60% Gap Increase

Practice Cost Increase (MEI Estimates)

SGR Medicare Physician Payment Updates


Source: Health Leaders 2011
Hospital Margins At Risk

Reimbursement At Risk


Value-Based Purchasing
- 1% (2010)

30-Day Readmissions
- 1% (2010)

Hospital Acquired Conditions

TOTAL
- 2% (2010)
- 3% (2011, 2012, 2013)

Source: Sg2
Hospital-Physician Concerns

Physician Concerns
- Medicare Professional Reimbursement Changes: 78%
- Private Payor Professional Reimbursement Changes: 74%
- Overhead / Expense Management: 71%
- Practice Growth: 32%
- Malpractice Costs: 28%
- Pay for Call: 27%
- Hospital Relations: 22%
- Regulation: 17%
- Quality: 15%
- Workload: 14%

Hospital CEO Concerns
- Financial Challenges: 43%
- Patient Safety and Quality: 41%
- Care for the Uninsured: 32%
- Physician Alignment: 32%
- Personnel Changes: 30%
- Healthcare Reform: 26%
- Patient Satisfaction: 22%
- Capacity: 16%
- Technology: 9%
- Malpractice: 2%

Source: Sg2 2009 | ACHE 2009
Hospital Drivers for Alignment

Lower Costs
“The biggest potential income streams for both hospitals and physicians may reside in sharing savings from providers. To do that, hospitals and physicians must manage care together.” – PwC

“Physician orders are directly responsible for 80% of U.S. healthcare spending.” – Deloitte Center for Health Solutions

Better Quality
“Better quality will finally pay off for hospitals but they need physicians to deliver it.” – PwC

New Payment Systems
“Hospitals need to partner with physicians as a means of participating in ACO’s and other new payment arrangements.” – PwC

Expand Base, Increase Volume, Grow Market Share
“High end expensive procedures are at risk unless we can expand the referral base.” – Michael Sachs, Sg2

Source: PricewaterhouseCoopers | Deloitte | Sg2
Physician Drivers for Alignment

- Professional Fees
- Ancillary Revenue
- Leverage with Payors
- Profitability & Personal Income

- Operating Expense
- Administrative Burden
- Assessment / Audit Risk
- Alignment with Hospitals
Physician Distribution by Practice Setting

1998/1999 vs. 2008

N=4,700

- Solo/2-Physician Practices: 37.4% (1998-99) vs. 32.0% (2008)
- 50+ Physician Practices: 3.5% (1998-99) vs. 6.1% (2008)

Source: PwC 2010
Practice Trends

Percentages of U.S. Physician Practices Owned by Physicians and by Hospitals, 2002-2010

Some ‘New’ Models Not So New

Employment Trends

- Hospital and health systems acquire primary care practices.
- Growing interest in alignment and willingness to partner with physicians.
- Many hospitals divest of primary care practices, refocus on core business.
- • Expansion of hospitalist model
  • Refocus on primary care strategy and referring physician relationships
  • Employment of Specialists

Source: Sg2 2008
Payment Reform Models Emerging

High Scope of Risk vs. High Degree of Complexity

- **Fee for service**
- **Inpatient case rates (DRGs)**
- **Bundled episodes (inpatient only)**
- **P4P/value-based purchasing**
- **Disease-specific capitation**
- **Clinical integration program**
- **ACO**
- **Global capitation**
- **Insurance product**

Source: Sg2
New Models of Care Delivery
The Old Model
The New Model
Market Dynamics Accelerating New Models

More Care (32M uninsured, Baby Boomers, Chronic Disease)

Higher Quality (P4P, Shared Savings, Core Measures)

Less Money ($240B Cuts, $90B Penalties)

“Bottom line, if you attempt to use the same care delivery model moving forward, faced with the magnitude of reductions in forecasted revenue, you will go out of business.” Michael Sachs, Sg2
Reform Initiatives

- PPACA / HCERA
- Center for Medicare/Medicaid Innovation (CMI)
- CMS Payment Cuts & Penalties
- CMS Triple Aim
- Pilots and Demonstrations
- Legislative Battles and Reform Funding
Reform: Impact on Providers

- Insured: +32M
- Inpatient: +5%
- Outpatient: +4%

- $90B in penalties
- P4P/Bundling
- Shared Savings
- Communication
- Performance Tracking
- CMS Reporting

- Medicare Cuts
- $240B
- Hospital Consolidations
- Physician Owned Hospitals and ancillaries
Shifting Risk

Consumers
Employers
Health Plans
Government Payors

FFS Reimbursement Cuts
Pay-for-Performance
Value-Based Purchasing
Bundled Payments
Shared Savings
Global Payments / Capitation

Risk Shift

Physicians
Medical Groups
Hospitals
Other Providers

Source: PricewaterhouseCoopers | DHG
Payment Reform Accelerating New Models

Source: PricewaterhouseCoopers
Variety of Alignment Options

% of Medical Staff Involved
- Small (<10% of the medical staff)
- ~25% of the medical staff
- ~50% of the medical staff
- ~75% or more of the medical staff

Level of Integration
- Co-management
- Joint Ventures
- Gainsharing
- IT subsidy
- Next-generation PSA
- IPA
- MSO
- Traditional PHO
- Voluntary model
- Medical directorships
- Call coverage agreements
- Traditional Employment
- Foundation Models
- Full Integration
- Clinic Model
- Clinic Model
- ~75% or more of the medical staff
- ~50% of the medical staff
- ~25% of the medical staff
- Small (<10% of the medical staff)

Source: Sg2 2012
Clinically Integrated Models

Patient Centered Medical Home (PCMH):
Primary care approach that supports comprehensive, team based care, improved patient access and engagement; serves as “hub” of care coordination; focuses on chronic disease management

Clinical Integration Network (CIN):
Acute care hospital, multispecialty physician network and other providers committed to quality and cost improvement, with support from joint negotiated commercial contracts

Accountable Care Organization (ACO):
Model to promote accountability for a patient population by improving care coordination, encouraging investment in infrastructure, and redesigning the care continuum around quality

Co-Management: Model to align physician incentives around quality, cost and satisfaction with fair market compensation

Source: The Advisory Board
Clinically Integrated Network (CIN or IPN)

CIN is commonly defined as an integrated health network using proven protocols and measures to improve patient care, decrease cost, and demonstrate value to the market. After demonstrating value, the CIN negotiates with payers and large employers to support the network with incentives based on demonstrated value and achieved results.
CIN Components

Clinically Integrated Network

- Payer and Employer Contracting
- Communication and Education
- Information Technology
- Physician Leadership
- Legal Structures
- Performance Objectives
- IPN Infrastructure

DIXON HUGHES GOODMAN
South Carolina Hospital Association
The CIN is a Separate Business Entity with …

- Distinct leadership structure and staff
- Independent budget and financial statements
- Participating agreements with providers
- Sustainable source of revenue

![Diagram showing fund flow for Clinically Integrated Network (CIN) with inputs from Health System Investment/Dues, Physician Investment/Dues, and Market Sources (Payers, Employers) leading to Clinically Integrated Network]
CIN Legal Structures

PHO

- Health System
- Participating Physicians
- PHO
- Payers / Employers

50% 50%

IPA

- Health System
- Participating Physicians
- IPA
- Payers / Employers

100%

Health System Subsidiary

- Health System
- Participating Physicians
- Subsidiary
- Payers / Employers

100%
Hospital Efficiency Program (HEP)

Health System

Physician Org. (PHO, IPA, Sub)

services

HEP Agreement

Validate Savings from HEP Performance
- Clinical Supply and Pharmacy
- Medical Claims per Employee
- Throughput and Average LOS

Define Fair Market Value Compensation for HEP Initiatives
- Base Fee (administration)
- Incentive Component (performance)

Design Compensation Methodology for Participating Physicians
CIN / HEP Benefits

**Health System**
- Transformational Care Redesign
- Demonstrated Quality
- Reduction in Operating Costs (Waste)
- Co-leadership with Physicians
- Enhanced Reimbursement for Demonstrated Quality

**Patients & Communities**
- Improved coordination of care, resulting in higher patient satisfaction and demonstrated quality of care that is cost efficient

**Physicians**
- Transformational Care Redesign
- Enhanced Patient Care and Satisfaction
- Improved Network Coordination
- Co-Leadership with Hospitals
- Long-term Viability of Private Practice
- Enhanced Reimbursement for Demonstrated Quality
• Defined in pilot programs in 44 states
• Built on 7 fundamental principles
• Focuses on comprehensive patient management
• Focuses on treatment and management of chronic conditions
• Manages expense of high cost, perpetual patients (Diabetes, COPD, Hypertension, Asthma)
• Increases access by leveraging physician extenders
• Qualifies for additional incentive based payments
## PCMH Care Redesign

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<td>Patients make appointments</td>
<td>Patients are registered in the medical home</td>
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<td>Patients’ chief symptoms or reasons for visit determine care</td>
<td>PCMH systematically assesses all patient health needs to plan care</td>
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<tr>
<td>Care is determined by today’s problem and time available today</td>
<td>Care is determined by a proactive plan to meet patient’s needs (with our without an office visit)</td>
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<td>Care varies by provider</td>
<td>Care is consistent with evidence-based guidelines</td>
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<td>Patients are responsible for coordinating their own care</td>
<td>A prepared team of professionals coordinates all patient care</td>
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<td>Acute care is delivered during the next available appointment and to walk-ins</td>
<td>Acute care is delivered by open-access and non-visit contacts</td>
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<td>Patient must tell caregiver what happened</td>
<td>PCMH tracks tests, consultations, ED visits, hospital visits and follow-up care</td>
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<td>Operations center on physician’s schedule</td>
<td>A multidisciplinary team works to serve patients</td>
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Source: Central Ohio PCMH Project
The PCMH is a health care approach that facilitates partnerships between patients, their families and personal physicians (and/or extenders). The PCMH follows a set of standards around care coordination and data monitoring that leads to demonstrated quality outcomes at reduced costs.

**Benefits**

- Increases quality and reduces cost of chronic patient care
- Enhances access and continuity of care
- Aligns PCP physicians around care delivery
- Focuses on integrated care management
- Patient survey results help drive quality improvement
- Presents opportunity for enhanced reimbursement
- Creates possible competitive advantage

**Risks**

- ROI uncertain and difficult to measure
- Demands increased administrative support
- Requires (significant) IT investment
- Creates significant change in culture and practice patterns
- Requires progressive use of technology and other models of patient interaction

Source: NCQA, 2011
Accountable Care Organization (ACO)

Specialists: Increased level of integration with PCPs, increased efficiency, focus on reducing re-admissions

Primary Care Provider: Increased focus on patient health, greater access to information, increased use of quality metrics, better reimbursement,

Patient: Less costly, more convenient care; coordinated services, productive long-term relationship with all physicians

Hospital: Lower admissions and re-admissions; more appropriate use of ED; integration with physicians; enhanced reimbursement(?)

Payer: Improved member satisfaction, lower costs, opportunity for new business models

Government: Lower healthcare costs, healthier population

Employer: Lower costs, more productive workforce, improved employee satisfaction
## ACO Structure

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<th>Component</th>
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<td><strong>Legal Structure</strong></td>
<td>• Legal entity under state and federal law</td>
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<td></td>
<td>• Capable of receiving / repaying shared savings / losses</td>
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<td>• Separate legal entity if 2 or more independent participants</td>
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<td><strong>Governance</strong></td>
<td>• Defined governance structure in ACO application</td>
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<td>• ACO participants must control 75% of board</td>
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<td>• Beneficiaries must be included in governance</td>
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<td><strong>Leadership and Management</strong></td>
<td>• ACO must have operations manager under control of board</td>
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<td>• ACO clinical management by of one of ACO physicians</td>
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<td>• QA / PI initiatives and protocols must be defined</td>
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<td><strong>Mid-Cycle Structural Changes</strong></td>
<td>• New participants may be added to ACO during period</td>
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<td>• Must notify CMS of any changes within 30 days</td>
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<td><strong>IT Initiatives</strong></td>
<td>• Percent of PCPs qualifying for EHR incentive program weighted</td>
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<td>heavily in scoring of quality measures</td>
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<td>• ACO required to promote evidence based medicine, report internally</td>
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<td>on quality and cost metrics and coordinate care</td>
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Source: CMS
ACO Participants

What is an ACO Professional?

- MD or DO
- Practitioner (PA, nurse practitioner, clinical nurse specialist)

Who Can Participate in an ACO?

- ACO professionals in group practice arrangement
- Networks of individual practices of ACO professionals
- Partnerships between hospitals and ACO professionals
- Hospitals employing ACO professionals
- Critical Access Hospitals (CAHs) that bill under Method II*
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)

*Under Method II a CAH bills for both facility and professional services, which provides CMS with the data needed to perform various programmatic functions

Source: CMS
## ACO Mechanics

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### Assignment

- > 5,000 Beneficiaries
- Preliminary Prospective Assignment
- Retrospective Reconciliation
- Unrestricted Provider Choice

### Billing

- Providers Bill Normally
- Receive FFS

### Comparison

- Total Cost Incurred Compared to Target Expenditures
- Compare to Defined Targets

### Bonus

- Dependent on Savings and Quality Metrics
- Size Determined by Selected Model

### Distribution

- Determined by ACO Participants
- Defined Governance Structure

Source: CMS
Key Imperatives for Success

Manage Utilization Risk
• Develop and utilize ambulatory network
• Appropriately utilize pre and post acute care providers
• Reduce preventable acute care episodes
• Avoid unnecessary readmissions

Maintain Exceptional Quality
• Develop quality care standards
• Create care pathways across providers
• Coordinate care across sites of care, over time

Operate Under Elevated Transparency
• Adopt IT systems that allow for data capture and use
• Continue to provide data to ACO partners and CMS
• Develop communication strategy amongst participants

Source: The Advisory Board Company
<table>
<thead>
<tr>
<th><strong>Traditional</strong></th>
<th><strong>ACO</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient base split among multiple providers with competing interests</td>
<td>Organization is physician-led system of care encompassing all patient services</td>
</tr>
<tr>
<td>Responsibility for patient care transitioned from one provider to the next</td>
<td>Organization is held accountable for overall clinical results, cost and efficiency</td>
</tr>
<tr>
<td>System designed to react to acute events rather than focus on prevention</td>
<td>Population served receives prevention and wellness services</td>
</tr>
<tr>
<td>Current payment system supports specialist services over primary care</td>
<td>Core of organization is primary care supported by specialists</td>
</tr>
<tr>
<td>Non-clinical demands on physicians time increasing diverting physicians attention from providing medical services</td>
<td>Physicians supported by practice teams that increase practice efficiency and quality</td>
</tr>
<tr>
<td>Technology adoption and use varies among PCP, specialists and hospitals</td>
<td>IT infrastructure coordinated to measure and report standardized metrics focused on quality</td>
</tr>
<tr>
<td>Fee-for-service delivery system rewards non-coordinated care throughout system</td>
<td>Delivery system capable of coordinating care across all settings</td>
</tr>
</tbody>
</table>

Source: AMGA
Co-Management
Co-Management Objectives

• Integrate physicians’ clinical expertise into hospital’s management competencies

• Align incentives and enhance clinical, operational and satisfaction outcomes

• Improve quality and increase access, regionalization and standardization of services

• Position both hospital and physicians for healthcare payment reform (bundled payments, P4P, etc.) in either / or an employed physician or independent physician scenario

• Provide legal, FMV to physicians for their time, effort, expertise, and results

• Create a successful recruitment platform for high-quality physicians
Co-Management

Governance Committees

- FMV Compensation
- Management Fee Distributions

Physician LLC

Hospital

- Committee Involvement
- Day-to-Day Management
- Strategic Plan Development
- Clinical Care Management
- Quality Improvement
- Staff Oversight
- Materials Management
- Budget Development

- Equipment*
- Staffing*
- Supplies

- Clinical Outcomes
- Patient Safety
- Satisfaction
- Operational Processes
- Financial Performance

*Only one of two may be included
Co-Management Fundamentals

Valuation

• In return for provision of management services, physicians receive compensation at Fair Market Value (i.e., commensurate with what a full-time, 3rd party manager of CV services would command).

Fixed Duties

• Physicians are tasked with specific, non-clinical duties that further the goals of the service line and are paid for their time and effort.

Performance Metrics

• Physicians are expected to improve upon historical hospital performance in key areas such as clinical outcomes, quality, efficiency and satisfaction and are paid according to their level of success in achieving pre-determined targets.

Governance

• The physicians form a physician LLC that contracts with the hospital and they, in turn, organize themselves in committees to effectively manage the hospital’s service line and accomplish the fixed duties and performance metric goals.
Committee Structure

- The Heart and Vascular Executive Committee will report to the VP
- The LLC Managers will be the 4 physicians on the HVEC
- Hospital representatives will set on the Finance & Capital and Invasive Labs Committees to assist the physicians in business management
Sample Metrics List

Development of Performance Incentives and Supporting Metrics
Fosters Hospital/Physician-Manager Collaboration

SAMPLE:

**Clinical Outcomes** (35%)
- Patients given ACE inhibitor/ARB for LVSD
- STEMI patients receiving PCI
- Patients receiving aspirin w/in 24hrs of arrival
- Patients with Beta Blockers at discharge

**Patient Safety** (35%)
- Lead dislodgement in patients with pacer/ICD
- Pneumothorax in patients with pacer/ICD
- PCI in-hospital risk-adjusted mortality rate

**Operational** (20%)
- On-Time Catheterizations (All Cases)
- Turnaround Time

**Satisfaction** (10%)
- Increase in PG “Overall Communication with Doctors”
- Increase in PG “Would Recommend”
Development of Performance Incentives and Supporting Metrics Fosters Hospital/Physician-Manager Collaboration

SAMPLE:

Median fluoro time (PCI Only). Measures the length of radiation exposure to patients during the PCI.

REFERENCE: ACC-NCDR PCI Metric

CURRENT PERFORMANCE: 11.8 Minutes

The following table sets forth the targeted levels of performance and the compensation associated therewith:

<table>
<thead>
<tr>
<th>Range Floor</th>
<th>Range Ceiling</th>
<th>Annual Payout</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 8.3 Minutes</td>
<td>&gt; 10.0 Minutes</td>
<td>$0</td>
</tr>
<tr>
<td>&gt; 6.5 Minutes</td>
<td>≤ 10.0 Minutes</td>
<td>$20,000</td>
</tr>
<tr>
<td></td>
<td>≤ 8.3 Minutes</td>
<td>$40,000</td>
</tr>
<tr>
<td>≤ 6.5 Minutes</td>
<td>-</td>
<td>$60,000</td>
</tr>
</tbody>
</table>
Co-Management Benefits

- Facilitates collaboration between hospital and physicians on service line improvement
- Creates platform for improved quality, reduced cost and enhanced access in preparation for pay for performance and bundled payments
- Provides reasonable and stable financial return to physicians for new and existing management functions
- Requires minimal capital investment by physicians or hospital
- Minimizes regulatory risk due to favorability with CMS and OIG
- Arrangement is reversible if it fails to achieve results
- May lead to decreased costs based on physician engagement
- Positions hospital and physicians for future integration models
Co-Management Benefits

Improved Quality Outcomes
Sample Hospital 1 – CABG Mortality Rates

- Pre-Adoption: 4.2%
- Year 1: 1%
- Year 2: 2%
- Year 3: 1%

Sample Hospital 1 – CABG Complication Rates

- Pre-Adoption: 15.1%
- Year 1: 13.2%
- Year 2: 10.7%
- Year 3: 11.1%

Effect on Top 100 Hospital Rankings

Top Quintile (1 Year)
- Physician-Led Management: 8%
- Administrative Management: 92%

Top Quintile (3 Years)
- Physician-Led Management: 32%
- Administrative Management: 68%

Source: Thomson Reuters 2009 | Advisory Board 2009
Co-Management Benefits

**OR Utilization**
Sample Hospital 2 – OR Utilization Rate and % Volume of Budget

- Before: 60%
- After: 141%

**Service Line Excellence**
Sample Hospital 3 – Quality and Volume

After one year....
- Quality
  - Ranked the **#1 provider of overall orthopedic care in Ohio**
- Volume
  - Experienced an increase of **1,000 cases per year**

**Physician Engagement**
Sample Hospital 4 – Number of Active Staff Surgeons

- Before: 40
- After: 76

Source: Beckers ASC 2010 | HFMA 2009 | DHG Client 2010
Questions
Reform Challenges

Reform Challenges our Personal Paradigms

- **High Resiliency**
  - Paralyzed by Confusion
- **Low Resiliency**
  - Existing in Denial

- **Low Understanding**
  - Resigned to Acceptance
- **High Understanding**
  - Embracing the Opportunities
Physician Alignment Models

Degree of Alignment

High

Resources

PhO
IT Deployment
Individual Employment Contracts
Physician Enterprise
Foundation
Institute
Bundled Payments
PCMH
Clinical Integration
ACO
HIZ

Low

Tactical

Directorship / Pay for Call
Recruitment Support / Income Guarantee
Volunteer Medical Staff

Transformational

Strategic

MSO
PSA
Co Management

Source: Sg2
"To avoid large and ultimately unsustainable budget deficits, the nation will ultimately have to choose among higher taxes, modifications to entitlement programs such as Social Security and Medicare, less spending on everything else from education to defense, or some combination of the above . . .

These choices are difficult, and it always seems easier to put them off -- until the day they cannot be put off anymore . . . unless we as a nation demonstrate a strong commitment to fiscal responsibility, in the longer run we will have neither financial stability nor healthy economic growth."

Ben Bernanke – Federal Reserve Chairman
Speech to Dallas Regional Chamber 4/7/10
Proposed PFS Reimbursement Changes

- Family Practice: 7%
- Pedsitrics: 5%
- Internal Medicine: 5%
- Geriatrics: 5%
- Urology: -2%
- Oncology: -1%
- Endocrinology: 1%
- Neurology: 1%
- Critical Care: 0%
- Colon and Rectal Surgery: 1%
- Gastroenterology: 0%
- Psychiatry: 0%
- Cardiology: -3%
- Orthopedic Surgery: -1%
- Radiology: -4%

Source: Beckers, 2012
Critical Success Factors

1. Trust
2. Communication & Transparency
3. Change Management
4. No “One Off Deals”
5. Physician Leadership
6. Adapt Guiding Principles/Physician Compact
5 Key Issues

1. Does the hospital have sufficient urgency?

2. Is there enough trust between the hospital and physicians?

3. Can we measure and document what we are good at and not so good at?

4. Do we fully understand the legal and tax issues associated with true Physician Alignment?

5. Do we have the infrastructure and the ability to finance the alignment strategy?
GI Interest in Employment Moderate to Low

Specialty Level of Interest in Hospital Employment

Least Interested in Employment

Interested in Employment

Most Interested in Employment

Source: PwC 2010, DHG 2012
Physician-Hospital Organization (PHO)

Joint Venture between the Health System and Physicians.

Allows physicians to maintain ownership of their practices while agreeing to accept manage care patients

Ownership interests dictate board structure, investment, and distribution methodology
**Professional Services Agreement (PSA)**

- **Physicians**
- **Hospital**
- **PSA**

**Clinical Services Management Services**

**FMV Compensation**

**Billing and Collection for Technical and Professional Component of IR Procedures**

<table>
<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better professional reimbursement</td>
<td>Possible time away from clinical work</td>
</tr>
<tr>
<td>Increases economic feasibility for program growth</td>
<td>Possible coverage constraints</td>
</tr>
<tr>
<td>Dedicated and fairly compensated</td>
<td></td>
</tr>
<tr>
<td>Maintain autonomy</td>
<td></td>
</tr>
</tbody>
</table>
## Employment Models

### Physician Practice Responsibility

<table>
<thead>
<tr>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>wRVU Model</td>
<td>Bump Model</td>
</tr>
</tbody>
</table>

### wRVU Model
- Easy to understand model
- Incents physician for productivity
- Payor blind
- Quality incentives incorporated into model

### Bump Model
- Incents physician equally above defined baseline for all wRVU’s
- Payor blind
- Quality incentives incorporated into model

### Practice Management Model
- Incents physicians to manage practice expenses
- Payor blind
- Quality incentives incorporated into model

### Net Income Model
- Maintains physicians commitment to practice success
- Most similar to private practice
- Adjusted frequently to reflect practice changes
- Quality incentives incorporated into model

### Pros
- No direct allocation of centralized costs
- No payor risk to physician
- Physician assumes allocation of centralized costs
- Hospital must be able to deliver data quickly and accurately to assist physician in practice management

### Cons
- Limited incentive for expense management
- No payor risk to physician
Clinical Integration

Win | Win Criteria

Health System

 Physicians

Clinical Integration Program

Payers

- Quality
- Membership
- Contracting
- Information Technology

Care Redesign

The Value of Clinical Integration to...

<table>
<thead>
<tr>
<th>Health System</th>
<th>Patients &amp; Communities</th>
<th>Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Enhanced Reimbursement for Demonstrated Quality</td>
<td>• Improved coordination of care, resulting in higher patient satisfaction and demonstrated quality of care that is cost efficient</td>
<td>• Enhanced Reimbursement for Demonstrated Quality</td>
</tr>
<tr>
<td>• Transformational Care Redesign (System of Care)</td>
<td></td>
<td>• Long-term Viability of Private Practice</td>
</tr>
<tr>
<td>• Co-leadership with Physicians</td>
<td></td>
<td>• Position for Physicians in Governance</td>
</tr>
<tr>
<td>• Reduction in Operating Costs (Waste)</td>
<td></td>
<td>• Improved Network Coordination</td>
</tr>
<tr>
<td>• Demonstrated Quality</td>
<td></td>
<td>• Enhanced Patient Care and Satisfaction</td>
</tr>
</tbody>
</table>

DIXON HUGHES GOODMAN
SCHA South Carolina Hospital Association

98
Models of Group Alignment

Low  Degree of Integration  High

IPA
Independent practices align under Association guidelines for purposes of joint contracting

ASC Investment
Physician buy into ASC (or other facility) that provides efficient workshop and supplemental income with limited management responsibility

Group Practice Consolidation
Merger of existing independent practices into large practice with defined governance, management, billing and income distribution

ACO
Physicians (and other providers) align around health management and accountability of defined Medicare beneficiary population. Shared Savings drive compensation
IPA is a owned by the Physicians and contracts with health systems and payers as one network for services.

Creates a large network of providers that retain control, ownership and the financial accountability over medical decision-making.
Joint Ventures contract with Health Systems and Payers as one network for services.

Employed and Independent Physicians buy into ASCs or other facilities that provide supplemental income with little management responsibility.

Ownership interests dictate Board Structure, Investment, and Distribution Methodologies.
Group Practice Consolidation

**ADVANTAGES**

- Merger or Acquisition Into a Larger Medical Group
- Control Over Referral Sources
- Combined Interests & Talents
- Payor Relationships
- Enhanced Market Access
- Risk Sharing
- Peer Consultation / Review
- Pooled Capital

**Single-Specialty Group**
- Information Sharing
- Economies of Scale
- Negotiating Leverage
- Support for Ancillaries
- Shared Cost of Technology and Practice Overhead

**Multi-Specialty Group**
- Advantages of SSG ... plus ...
- Greater Coordination of Care
- Internal Referrals
- Market Presence
Medicare Is Moving Toward Value-Based Purchasing

Pay for Performance

<table>
<thead>
<tr>
<th>Year</th>
<th>HHS Submits Report to Congress</th>
<th>RHQDAPU</th>
<th>VBP Implementation</th>
<th>Additional Measures</th>
<th>Performance Areas Where Gaps Are Identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>2007</td>
<td>2008</td>
<td>2009</td>
<td>Outcomes</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>2011</td>
<td>2012</td>
<td></td>
<td>Patient safety</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td></td>
<td></td>
<td></td>
<td>Care coordination</td>
<td></td>
</tr>
<tr>
<td>2007</td>
<td></td>
<td></td>
<td></td>
<td>Emergency care</td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td></td>
<td></td>
<td></td>
<td>Efficiency</td>
<td></td>
</tr>
</tbody>
</table>

Transforming CMS from a passive payer to an active purchaser of high-quality, efficient care

RHQDAPU = Reporting Hospital Quality Data for Annual Payment Update; HHS = US Department of Health and Human Services; VBP = value-based purchasing; CMS = Centers for Medicare & Medicaid Services.

Source: Sg2 Analysis, 2009.
Co-Management

Value Proposition

Comanagement OPPORTUNITIES
- Quality
- Efficiencies
- New program development

Genesys Regional Medical Center OPPORTUNITIES
- Supply chain/costs
- Average length of stay
- Reimbursement changes
- Value-based purchasing
- Bundled payments
- Coding and documentation

Specialist IMPACT
- Quality
- More efficient hospital environment
- Real decision-making authority
- Positioned for global/bundled payments

PHO IMPACT
- Quality
- Institutional pool surpluses
- More competitive position in market with payers
- Positioned for global/bundled payments

Primary Care Physicians IMPACT
- Quality
- Patient experience
- Venue to clinically design continuum of care handoffs

Source: Sg2
### Genesys Health System Co-management Companies

#### Number of Physicians Covered by Service Line/Eligible/Invested

<table>
<thead>
<tr>
<th></th>
<th>Number of Physicians Covered by Service Line</th>
<th>Number of Physicians Eligible</th>
<th>Number of Investors</th>
<th>Percentage Invested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
<td>96</td>
<td>39</td>
<td>26</td>
<td>67%</td>
</tr>
<tr>
<td>Ortho-Neuro</td>
<td>55</td>
<td>19</td>
<td>14</td>
<td>74%</td>
</tr>
<tr>
<td>Surgical Services</td>
<td>97</td>
<td>63</td>
<td>36</td>
<td>57%</td>
</tr>
<tr>
<td>Overall</td>
<td>248</td>
<td>121</td>
<td>76</td>
<td>63%</td>
</tr>
</tbody>
</table>

Source: Sg2
# Genesys Health System
## Comanagement Companies (Cont’d)

<table>
<thead>
<tr>
<th></th>
<th>Cardiovascular</th>
<th>Ortho-Neuro-Podiatry</th>
<th>Surgical Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Investors</strong></td>
<td>26</td>
<td>14</td>
<td>36</td>
</tr>
<tr>
<td><strong>Investor Criteria</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board-certified in area of expertise</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non compete clause</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At least 30 patient encounters in the last 12 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active medical staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non compete clause</td>
<td></td>
<td></td>
<td></td>
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<td>Active medical staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non compete clause</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Board of Managers</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 physicians</td>
<td></td>
<td>7 physicians</td>
<td>7 physicians</td>
</tr>
<tr>
<td>3 administrators</td>
<td></td>
<td>3 administrators</td>
<td>3 administrators</td>
</tr>
<tr>
<td><strong>Quality Committee</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 physicians</td>
<td></td>
<td>7 physicians</td>
<td>7 physicians</td>
</tr>
<tr>
<td>2 administrators</td>
<td></td>
<td>2 administrators</td>
<td>2 administrators</td>
</tr>
<tr>
<td><strong>Finance Committee</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 physicians</td>
<td></td>
<td>5 physicians</td>
<td>5 physicians</td>
</tr>
<tr>
<td>2 administrators</td>
<td></td>
<td>2 administrators</td>
<td>2 administrators</td>
</tr>
<tr>
<td><strong>Medical Directors</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 cath lab</td>
<td></td>
<td>1 orthopedics medical director</td>
<td>1 operations medical director</td>
</tr>
<tr>
<td>1 cardiology</td>
<td></td>
<td>1 neurosciences medical director</td>
<td>1 quality medical director</td>
</tr>
<tr>
<td>1 CRDC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 quality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 echo and diagnostics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 CICU</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CRDC = cardiac rapid diagnosis center; CICU = cardiac intensive care unit.

Source: Sg2
Incentives Achieved

Genesys Comanagement Companies Incentives Achieved by Tier Level
July 2009–June 2010

CV = cardiovascular; ONP = orthopedics, neurosciences and podiatry; SX = surgical services.

Source: Sg2
Provider-Based Status Rules

- Provider-based rules can apply to a hospital-licensed service on campus or at hospital satellite.
- If off campus, must be within 35 miles of hospital campus and financially, administratively and clinically integrated with the hospital.
  - Management contract limitations apply: clinical staff must be directly employed by hospital, except for practitioners who can bill independently under Medicare fee schedule (eg, MDs, NPs).
- If management agreement is in place for off-campus or joint ventured service line, beware of provider-based rules.
- **See 42 CFR 413.65.**

NP = nurse practitioner; CFR = Code of Federal Regulations.

Source: Sg2
Hospitals and Physicians Are Engaging in a Range of Relationships

% of Medical Staff Involved
- Small (<10% of the medical staff)
- ~25% of the medical staff
- ~50% of the medical staff
- ~75% or more of the medical staff

Clinic model
Full integration
Foundation models
Clinical integration PHO
Traditional employment
Comanagement
Traditional PHO
Joint ventures
Gainsharing
Expansion of employed hospital-based specialists
Call coverage agreements
Medical directorships
Voluntary model
MSO
IPA
Next-generation PSA
IT subsidy

Supports System of CARE Development
High
Low

Source: Sg2
Match Physician Relationship and Care Redesign Strategies

Elements for Care Redesign

- System Optimization
- Clinical Restructuring
- Unnecessary Care Reduction
- Variance and Cost Reduction

Description

- Shifting focus to upstream, preventive care with an emphasis on clinical integration and population health
- Ensuring treatment in the most optimal setting with the most appropriate level of provider
- Reducing avoidable, unproductive and duplicative services
- Improving operational efficiencies

Source: Sg2
Match Physician Relationship and Care Redesign Strategies (Cont’d)

Elements for Care Redesign

- System Optimization
- Clinical Restructuring
- Unnecessary Care Reduction
- Variance and Cost Reduction

Description

- Shifting focus to upstream, preventive care with an emphasis on clinical integration and population health
- Ensuring treatment in the most optimal setting with the most appropriate level of provider

Robust Strategic

- Clinic model
- Full integration
- Foundation models
- Clinical Integration PHO

Source: Sg2
Hospital Margins At Risk

Cumulative Impact of Market Basket Update and Productivity Factor Reductions

2013-2015
Hospital Readmissions Penalties Phased-in

2014
Disproportionate Share Hospital Payment Reductions Phase-in Begins

2015
Acquired Hospital Infection Penalties Phase-in Begins

Source: AHA, MedPAC, PPACA & assorted documents
Payment Models Shifting Risk

Payors Ratcheting Up Performance Risk to Target Inefficiencies

**Performance Risk**
- Cost of Care

**Utilization Risk**
- Volume of Care

**Bundled Pricing**
- Episodic Efficiency
- Readmission Reduction
- Care Standardization

**Pay-for-Performance**
- Process Reliability
- Clinical Quality
- Patient Experience

**Shared Savings**
- Chronic Care Management
- Care Substitution
- Disease Prevention

Source: The Advisory Board
Provider Coordination Required

Risk to Provider

- Fee for Service
- Bundled Payment
- Episode-Based Payment
- Risk-Sharing/ACOs
- Traditional Prospective Capitation

Lower Risk/Value Potential → Higher Risk/Value Potential

Source: Sg2