Physician Alignment Economics and Lessons Learned
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Southern California

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Premier, Inc.
Strategic Advisory Services
Deliver patients to the physicians (preferably profitable)
  • Get them busy

Provide managed care infrastructure (ACO, CIN, MSSP, HMO patients, etc.) to the physicians

Provide incentives to the physicians to assist the hospital to reduce resource consumption
  • Care model and support (people, IT solutions, clinicians, etc.)
  • Less costly provider setting
  • Shared risk pools
  • Performance criteria with incentives
Physician Alignment Models

- Bundle payment
- Co-management arrangement
- MSSP/Next Gen
- Shared risk pools
- Two-sided risk arrangements
- Clinically Integrated Network (CIN)
- Direct to employer contracting
Success Stories –
Avera Health (St. Luke’s Hospital) & Southwest General

• **Episode Type:** Total Joint Replacement

• **Solution:** Physician engagement, accurate documentation, and transparency of data/information was key to success. Worked with physician champion and established multi-disciplinary team and oversight structure. Employed full-time nurse navigator.

• **Results:**
  - 40% reductions in PAC spend within 1 year.
  - Physicians feel they have a better handle on the health of their patients.
  - Focus has shifted from operational, within the four walls of the hospital, to a comprehensive strategy.

“Having the line of sight on all care for the patient is so important to us. Premier’s Bundled Payment Solution, has been pivotal in helping Avera achieve our success.”

– Stacey Lenker, Vice President, Payor Strategies, Avera Health

• **Episode Type:** Congestive Heart Failure

• **Solution:** Knew that aligning people, processes and technology would be the key to success. Setup process for PCs and Specialists received notifications when a bundle patient arrived and received support from the population health team. Transparent with SNF utilization and PAC spend data.

• **Results:**
  - 15% in 30-day readmissions
  - 17% reduction in 90-day readmissions
  - 9% reduction in unnecessary consults/associated costs
  - Positive NPRA allows for reinvestment into improving patient care.

“Our decision making related to our bundle is impacting our readmission rate, which has been decreasing. This increases our confidence in our work and the information we get from Premier’s analytics tool.”

– Jill Barber, Executive Director of Population Health, Southwest General
Bundled Payment: Direct to Employer

• Example: GE, Boeing, Lowe’s, Pepsi, Verizon, Target, Walt Disney and Walmart

• Employer Goals
  − Improved patient outcomes
  − Reduced costs

• Payment model:
  − Bundled payments cover 100 percent of the charges of an episode of care (pre-surgery screening/work-up, travel to and from facility and recovery/rehabilitation)
  − Employers will sometimes use a third party to negotiate the contract or episode of care
Five Things to Know

1. Third parties have a rigorous selection process
   • Metrics
   • Request performance data
   • Subject to third party audit/verification

2. Rates are competitive
   • Negotiated before patient need between third party and provider
   • Volume guarantee for reduced price

3. Pre-surgery screening process to deny/confirm the need for the surgery

4. Results: better patient satisfaction and outcomes

5. Employers emphasize standardized care protocols and incentivize providers to use them
Co-Management Fundamentals

**Governance**
- The physicians form a management entity (PME) that contracts with the hospital and they, in turn, organize themselves into committees to effectively manage the hospital’s service line and accomplish the fixed duties and performance metric goals.

**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 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.

**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 the service line would command).
A Model of Clinical Co-Management

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

- Clinical Outcomes
- Patient Safety
- Satisfaction
- Operational Processes
- Financial Performance
- Surgical Care Improvement

Governing Committee (Hospital & Physicians)

FMV Compensation
Management Services Contract

Physician Management Entity (PME)

Management Fee Distributions
Investment

Hospital

Physicians/Physician Groups

Fixed Duties

Performance Metrics

Physician Management Entity (PME)

Hospital FMV Compensation
Management Services Contract

Physicians/Physician Groups Management Fee Distributions
Investment

Fixed Duties

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

Performance Metrics

- Clinical Outcomes
- Patient Safety
- Satisfaction
- Operational Processes
- Financial Performance
- Surgical Care Improvement
Governance

- PME formed (either JV with hospital and physicians or physician-owned)
- Physicians to capitalize PME start-up (costs typically minimal)

- PME contracts with the hospital to manage service line for FMV compensation
- Two components of management services commonly called fixed duties and performance metrics
- Term of contract must be at least 1 year, can extend up to 5 years (contingent upon hospital’s bond covenants)
Fixed Duties

Fixed duties involve the more typical day-to-day components of managing a service line.

Physician involvement often includes participation and leadership in joint hospital-physician committees and/or subcommittees.

Small contingent of physician leaders typically assume majority of responsibilities.

Physicians submit regular documentation of physician efforts.

PME may hire administrator to support its management efforts (LLC overhead).
Committee Structure
• The Heart & Vascular Committee will report to the VP (?)
• The PME Managers will be the 4 physicians on the HVEC
• Hospital representatives will sit on the Finance & Capital and Invasive Labs Committees to assist the physicians in business management

CASE EXAMPLE
Performance Metrics

- Performance metrics link financial incentives to improvement from current performance in predefined clinical outcomes.
- Physicians responsible for outcome of entire service line, not just PME member performance.

- Metrics and targets can be changed or revised annually.

- Metrics should:
  - Focus on service line needs
  - Drive improvement from baseline performance
  - Align with CMS core measures, national guidelines or international standards
  - Be within the scope of physician control

- Financial performance metrics cannot incentivize:
  - Rationing of care
  - Referrals, volume or revenue
### Performance Metrics – Sample (Cardiology)

<table>
<thead>
<tr>
<th>Performance Metrics - Q4 FY12</th>
<th>BASELINE (2011)</th>
<th>Current</th>
<th>Performance Level</th>
<th>% Weight</th>
<th>Performance Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Performance Compensation Available</strong></td>
<td></td>
<td></td>
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<td>$798,000</td>
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</table>

#### A Clinical Outcomes Metrics

<table>
<thead>
<tr>
<th>Metric</th>
<th>BASELINE (2011)</th>
<th>Current</th>
<th>Performance Level</th>
<th>% Weight</th>
<th>Performance Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 CHF patients receiving discharge instructions.</td>
<td>97.0%</td>
<td>100.00%</td>
<td>3</td>
<td>7.0%</td>
<td>$55,860</td>
</tr>
<tr>
<td>2 Creatinine assessed pre and post PCI procedure</td>
<td>88.4%</td>
<td>94.6%</td>
<td>2</td>
<td>7.0%</td>
<td>$37,240</td>
</tr>
<tr>
<td>3 Beta Blocker at discharge for all AMI</td>
<td>89.5%</td>
<td>100.0%</td>
<td>3</td>
<td>7.0%</td>
<td>$55,860</td>
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#### B Complications and Patient Safety Metrics

<table>
<thead>
<tr>
<th>Metric</th>
<th>BASELINE (2011)</th>
<th>Current</th>
<th>Performance Level</th>
<th>% Weight</th>
<th>Performance Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 30-day readmission rate for recurrent CHF (All adult, includes planned readmits)</td>
<td>8.5%</td>
<td>7.7%</td>
<td>1</td>
<td>7.0%</td>
<td>$18,620</td>
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<tr>
<td>2 30-day CHF readmission rate for any reason (CMS Payor, includes planned readmits)</td>
<td>22.0%</td>
<td>17.0%</td>
<td>2</td>
<td>7.0%</td>
<td>$37,240</td>
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<tr>
<td>3 Overall AMI - unadjusted risk mortality (STEMI and non-STEMI)</td>
<td>6.2%</td>
<td>3.62%</td>
<td>3</td>
<td>7.0%</td>
<td>$55,860</td>
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#### C Process and Efficiency Metrics

<table>
<thead>
<tr>
<th>Metric</th>
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<th>Current</th>
<th>Performance Level</th>
<th>% Weight</th>
<th>Performance Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Inpatient echo reports read and documented in Camtronics within 24 hours of procedure performance</td>
<td>94.3%</td>
<td>98.0%</td>
<td>2</td>
<td>5.0%</td>
<td>$26,600</td>
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<tr>
<td>2 Early diagnostic catheterization for AMI patients (within 24 hours)</td>
<td>65.4%</td>
<td>70%</td>
<td>3</td>
<td>6.5%</td>
<td>$51,870</td>
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#### D Satisfaction Metrics

<table>
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<tr>
<th>Metric</th>
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<th>Current</th>
<th>Performance Level</th>
<th>% Weight</th>
<th>Performance Total</th>
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</thead>
<tbody>
<tr>
<td>1 Invasive Lab Satisfaction</td>
<td>66.1%</td>
<td>70.8%</td>
<td>1</td>
<td>2.5%</td>
<td>$9,975</td>
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</table>

**Total Compensation Earned**

- Level 1 Compensation
- Level 2 Compensation
- Level 3 Compensation

$349,125

*Metrics not achieved are not included in this example, weighting has not been altered
# Performance Metrics - Scorecard

<table>
<thead>
<tr>
<th>Cardiology Co-Management Scorecard</th>
<th>July</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>YTD Result</th>
<th>YTD Score</th>
<th>% Earned</th>
<th>Level 1 Compensation</th>
<th>Level 2 Compensation</th>
<th>Level 3 Compensation</th>
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<tr>
<td><strong>Clinical Outcomes</strong></td>
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<tr>
<td>Core Measures - Overall Mean Percent</td>
<td>1.7%</td>
<td>98.0%</td>
<td>99.4%</td>
<td></td>
<td></td>
<td></td>
<td>99.00%</td>
<td>1</td>
<td>0.45%</td>
<td>&gt; 99.7%</td>
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<tr>
<td>Surgical Site Infections Index (Act/Pred) - CABG(chest/</td>
<td>1.7%</td>
<td>0.05</td>
<td>0.01</td>
<td></td>
<td></td>
<td></td>
<td>0.03</td>
<td>3</td>
<td>1.8%</td>
<td>&lt; 0.96</td>
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<tr>
<td>Severity Adj Avg LOS Index (Act/Exp) - AMI</td>
<td>1.8%</td>
<td>1.13</td>
<td>1.25</td>
<td></td>
<td></td>
<td></td>
<td>1.19</td>
<td>2</td>
<td>&lt; 0.83</td>
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<td>Severity Adj Avg LOS Index (Act/Exp) - HF</td>
<td>1.8%</td>
<td>1.22</td>
<td>1.22</td>
<td></td>
<td></td>
<td></td>
<td>1.22</td>
<td>2</td>
<td>&lt; 0.84</td>
<td></td>
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<tr>
<td>Severity Adj Avg LOS Index (Act/Exp) - CAGB</td>
<td>1.8%</td>
<td>1.22</td>
<td>1.04</td>
<td></td>
<td></td>
<td></td>
<td>1.13</td>
<td>2</td>
<td>&lt; 0.81</td>
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<tr>
<td>Severity Adj Avg LOS Index (Act/Exp) - PCI</td>
<td>1.8%</td>
<td>1.37</td>
<td>1.27</td>
<td></td>
<td></td>
<td></td>
<td>1.32</td>
<td>2</td>
<td>&lt; 0.81</td>
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<tr>
<td>Risk Adjustment Mortality Index (Act/Exp) - AMI</td>
<td>1.8%</td>
<td>1.02</td>
<td>0.68</td>
<td></td>
<td></td>
<td></td>
<td>0.85</td>
<td>2</td>
<td>&lt; 0.53</td>
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<tr>
<td>Risk Adjustment Mortality Index (Act/Exp) - HF</td>
<td>1.8%</td>
<td>0.84</td>
<td>0.58</td>
<td></td>
<td></td>
<td></td>
<td>0.91</td>
<td>2</td>
<td>&lt; 0.53</td>
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<td>Risk Adjustment Mortality Index (Act/Exp) - CAGB</td>
<td>1.8%</td>
<td>0.3</td>
<td>0.1</td>
<td></td>
<td></td>
<td></td>
<td>0.2</td>
<td>1</td>
<td>&lt; 0.15</td>
<td>&lt; 0</td>
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<td>Risk Adjustment Mortality Index (Act/Exp) - PCI</td>
<td>1.8%</td>
<td>0.75</td>
<td>1.21</td>
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<td></td>
<td>0.98</td>
<td>2</td>
<td>&lt; 0.15</td>
<td>&lt; 0</td>
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<tr>
<td>30D Readmission Rate - AMI</td>
<td>1.8%</td>
<td>15.0%</td>
<td>12.1%</td>
<td></td>
<td></td>
<td></td>
<td>13.57%</td>
<td>1</td>
<td>0.45%</td>
<td>&lt; 12.99</td>
<td></td>
<td></td>
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<tr>
<td>30D Readmission Rate - HF</td>
<td>1.8%</td>
<td>24.1%</td>
<td>17.6%</td>
<td></td>
<td></td>
<td></td>
<td>20.85%</td>
<td>1</td>
<td>0.45%</td>
<td>&lt; 17.49</td>
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<td>30D Readmission Rate - CABG</td>
<td>1.8%</td>
<td>8.6%</td>
<td>13.2%</td>
<td></td>
<td></td>
<td></td>
<td>10.89%</td>
<td>3</td>
<td>&lt; 1.8%</td>
<td>&lt; 11.25</td>
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<tr>
<td>30D Readmission Rate - PCI</td>
<td>1.8%</td>
<td>8.5%</td>
<td>7.4%</td>
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<td></td>
<td></td>
<td>7.96%</td>
<td>2</td>
<td>0.9%</td>
<td>&gt; 7.76</td>
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<td><strong>Safety</strong></td>
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<tr>
<td>Patient Safety Indicators - AMI</td>
<td>6.25%</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td>6.25%</td>
<td>3</td>
<td>&lt; 0.25</td>
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<td>Patient Safety Indicators - HF</td>
<td>6.25%</td>
<td>0</td>
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<td></td>
<td>6.25%</td>
<td>3</td>
<td>&lt; 0.25</td>
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<td>Patient Safety Indicators - CABG</td>
<td>6.25%</td>
<td>1.92</td>
<td>0</td>
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<td>0.96</td>
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<td>&lt; 0.24</td>
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<td>Patient Safety Indicators - PCI</td>
<td>6.25%</td>
<td>1.55</td>
<td>0.41</td>
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<td></td>
<td></td>
<td>0.98</td>
<td>3</td>
<td>&lt; 0.24</td>
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<tr>
<td><strong>Satisfaction</strong></td>
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<td>Patient Satisfaction - Physician Domain</td>
<td>7.5%</td>
<td>76%</td>
<td>75%</td>
<td></td>
<td></td>
<td></td>
<td>76%</td>
<td>3</td>
<td>7.5%</td>
<td>95%</td>
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<td>Patient Satisfaction - Discharge Domain</td>
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<td>91%</td>
<td>92%</td>
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<td>91%</td>
<td>3</td>
<td>7.5%</td>
<td>95%</td>
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<tr>
<td><strong>Cost</strong></td>
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<tr>
<td>Estimated Costs - AMI</td>
<td>8.75%</td>
<td>1.42</td>
<td>1.6</td>
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<td></td>
<td>1.51</td>
<td>1</td>
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<td>&lt; 0.77</td>
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<td>Estimated Costs - HF</td>
<td>8.75%</td>
<td>1.58</td>
<td>1.52</td>
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<td></td>
<td>1.55</td>
<td>1</td>
<td>2.2%</td>
<td>&lt; 0.77</td>
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<tr>
<td>Estimated Costs - CABG</td>
<td>8.75%</td>
<td>1.61</td>
<td>1.49</td>
<td></td>
<td></td>
<td></td>
<td>1.55</td>
<td>1</td>
<td>2.2%</td>
<td>&lt; 0.77</td>
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<tr>
<td>Estimated Costs - PCI</td>
<td>8.75%</td>
<td>1.45</td>
<td>1.38</td>
<td></td>
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<td></td>
<td>1.41</td>
<td>1</td>
<td>2.2%</td>
<td>&lt; 0.77</td>
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<tr>
<td><strong>TOTAL</strong></td>
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<td></td>
<td></td>
<td>100%</td>
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</tbody>
</table>

- **Level 1 Compensation**
- **Level 2 Compensation**
- **Level 3 Compensation**
Valuation Overview

- FMV analysis required to determine appropriate compensation for PME

- Breadth and depth of fixed duties assumed by PME physicians drives compensation

- Inclusion of performance metrics with stretch goals is factored into valuation

- Valuation methodology typically consists of:
  - Market approach (more aggressive, “Top Down”)
  - Cost approach (very conservative, “Bottom Up”)

- Critical to select valuation firm experienced with co-management agreements to ensure physician buy-in
Wellness programs (Rand defines two components):
- Lifestyle management (health risk: smoking, obesity, etc.)
- Disease management (chronic conditions)
- Trendy: self monitoring of activity, sleep, calorie consumption, etc.

Centers of Excellence
- Criteria: Ranked providers who provide treatment for a particular disease, procedure or condition
  - Organ transplants
  - Cancer
  - Cardiac surgery
  - Bariatric surgery
  - Joint replacement
  - Spinal surgery
- Incentivize the employee by waiving co-pay, deductible and co-insurance and pay for travel and accommodations for the patient and their designee/caregiver
## Payment Options and Behavior

<table>
<thead>
<tr>
<th>Primary Care</th>
<th>Specialists</th>
<th>Hospital</th>
<th>Risk Pool</th>
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<tbody>
<tr>
<td>CAP</td>
<td>CAP</td>
<td>Case Rate/Per Diem</td>
<td>✔</td>
</tr>
<tr>
<td>CAP</td>
<td>FFS</td>
<td>Case Rate/Per Diem</td>
<td>✔</td>
</tr>
<tr>
<td>FFS</td>
<td>CAP</td>
<td>Case Rate/Per Diem</td>
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<tr>
<td>FFS</td>
<td>FFS</td>
<td>Case Rate/Per Diem</td>
<td>✔</td>
</tr>
</tbody>
</table>
Where Does the Premium Go?

Health Plan

$  

Infrastructure

Physicians  
Facilities  
Ancillaries  
Pharmacy

Risk Pool

D – Distributions
P – Payments
P2P: Shared Risk Pool

- Funding:
  - Medical Group / IPA
  - Risk Pool-Facility
  - Hospital (SNF, Outpatient)

D = Distribution Payments

- Out of Network / Out of Area
- Outpatient
- Inpatient
High-risk Care Management

Hospice/Palliative Care

House Calls Program

High-Risk Clinics

Complex Care Management and Disease Management

Self-Management, PCP

Population Monitoring

Baseline Preventive Care/Wellness programs

Lower Risk Patient

New Care Models Required

High-Risk Patient
IDS Collaboration Opportunities

Target markets:
- Medicare Advantage
- MSSP/ ACO
- Commercial ACO
- Medicaid managed care
- Dual eligible managed care
- Direct to employer

Models/Options (IDS)
- Health plan (own or partner)
- ACO
- CIN/RCIN
- Shared risk pool
- Bundle payment/co-management agreement
Collaboration Opportunities

Payment methodologies

• Shared risk pools (facility payments)
• Health plan ownership-distribute net earnings
• Standardize a Division of Financial Responsibility (DoFR)
• Guidelines:
  » Change payment model before care model
  » Use aligned economic incentives to reward:
    ▪ Quality outcomes (predetermined metrics)
    ▪ Spend targets (predetermined metrics)
    ▪ Economic incentives that target specific areas (problems)
    ▪ Per diems, case rates
• Those that benefit from infrastructure and resource consumption should pay for those resources
How are Shared Savings being Distributed?
Data from PHMC Members who generated shared savings

<table>
<thead>
<tr>
<th>Infrastructure/Reinvestment</th>
<th>PY2013</th>
<th>PY2014</th>
<th>PY2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average</td>
<td>38.4%</td>
<td>45.6%</td>
<td>40.3%</td>
</tr>
<tr>
<td>Range</td>
<td>12-73%</td>
<td>14-83%</td>
<td>9-73%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACO Participants</th>
<th>PY2013</th>
<th>PY2014</th>
<th>PY2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average</td>
<td>64.8%</td>
<td>58.5%</td>
<td>66%</td>
</tr>
<tr>
<td>Range</td>
<td>33-88%</td>
<td>33-89%</td>
<td>33-90%</td>
</tr>
</tbody>
</table>

On average, PHMC ACOs are distributing the majority of their actual shared savings to PCPs, specialists, hospitals, and other providers while the remainder is distributed towards infrastructure and re-designed care processes/resources.
### Example Models: Common Frameworks

<table>
<thead>
<tr>
<th>System A</th>
<th>System B</th>
<th>System C</th>
<th>System D</th>
<th>System E</th>
<th>System F</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACO Type</strong></td>
<td>Commercial</td>
<td>Commercial</td>
<td>Medicare</td>
<td>Medicare</td>
<td>Medicare, Commercial</td>
</tr>
<tr>
<td><strong>Distribution metrics</strong></td>
<td>Quality, Efficiency</td>
<td>Quality, Efficiency</td>
<td>Utilization, Quality</td>
<td>Utilization, Quality, Patient satisfaction</td>
<td>Utilization, Quality, Patient satisfaction, Efficiency</td>
</tr>
<tr>
<td><strong>Hospital: Physician split</strong></td>
<td>15% Hospital / 85% Physician</td>
<td>25% Hospital / 75% Physician after ACO costs</td>
<td>20% Hospital / 80% Physician</td>
<td>50 Hospital / 50 Physician after 15% for ACO costs</td>
<td>66.6% Hospital / 33.3% Physician 50% of Hospital goes to Network infrastructure / 50% to continuum of service</td>
</tr>
<tr>
<td><strong>Specialist: PCP split</strong></td>
<td>66% SCP / 34% PCP</td>
<td>30% SCP / 70% PCP</td>
<td>25% SCP / 75% PCP</td>
<td>50 SCP / 50 PCP</td>
<td>30% SCP / 70% PCP</td>
</tr>
<tr>
<td><strong>Provider Measure split</strong></td>
<td>Quality 50% / Efficiency 50%</td>
<td>Specialist: Quality 65% / Efficiency 35% PCP: Quality 35% / Efficiency 65%</td>
<td>Process, Pat Sat &amp; Outcomes 60% / Utilization-40%</td>
<td>Quality 40% / Pt Sat 40% / Utiliz 20%</td>
<td>Y1 Quality 50% / Utilization 50%</td>
</tr>
<tr>
<td><strong>Physician or Group Payment</strong></td>
<td>Individual provider payments</td>
<td>Individual provider payments</td>
<td>Provider group payments</td>
<td>Individual provider payments</td>
<td>Individual provider payments</td>
</tr>
</tbody>
</table>

First savings are divided among provider categories

Secondly savings are divided from provider categories to the individual or group physician level

Metrics for the individual providers loosely tie to the organizational metrics

The specifics within the framework differ, including the division of payments between the hospital & physicians, between the physicians and if payments are made at the IPA or individual physician level
Define Shared Savings Measures

Overview:

- Metrics should promote the triple aim, and are expected to evolve with increasing data sophistication
- Consider what metrics are already being monitored that can be leveraged (physician groups, managed care, state reporting, etc.)
- Provider shared savings will be scaled based upon an overall performance score

Example Measures, Weighting, Scoring

<table>
<thead>
<tr>
<th>Metrics</th>
<th>Level of reporting</th>
<th>Data source</th>
<th>Scoring</th>
<th>Definition of meeting measure</th>
<th>Weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Engagement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>25%</td>
</tr>
<tr>
<td>Attendance at meetings</td>
<td>Physician</td>
<td>Sign-in sheets</td>
<td>0,1</td>
<td>Attendance at 50% of town hall meetings</td>
<td>50%</td>
</tr>
<tr>
<td>Completion of education modules</td>
<td>Physician</td>
<td>Learning management system; log-in</td>
<td>0,1</td>
<td>Completion of 50% of education modules</td>
<td>25%</td>
</tr>
<tr>
<td>Completion of practice surveys</td>
<td>Practice</td>
<td>Data collection; survey monkey</td>
<td>0,1</td>
<td>Completion of 50% of practice surveys</td>
<td>25%</td>
</tr>
<tr>
<td>Quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>25%</td>
</tr>
<tr>
<td>Annual A1C testing for patients with diabetes</td>
<td>Population</td>
<td>Claims</td>
<td>0,1</td>
<td>75% of patients with Diabetes complete A1C testing in 2015</td>
<td>50%</td>
</tr>
<tr>
<td>Annual influenza vaccination</td>
<td>Population</td>
<td>Claims</td>
<td>0,1</td>
<td>55% of patients have influenza vaccination completed in 2015</td>
<td>50%</td>
</tr>
<tr>
<td>Utilization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>25%</td>
</tr>
<tr>
<td>ED visits per 1000 beneficiaries</td>
<td>Population</td>
<td>4Q15 E&amp;U report</td>
<td>0,1</td>
<td>5% reduction from benchmark report</td>
<td>50%</td>
</tr>
<tr>
<td>Admissions per 1000 beneficiaries</td>
<td>Population</td>
<td>4Q15 E&amp;U report</td>
<td>0,1</td>
<td>5% reduction from benchmark report</td>
<td>50%</td>
</tr>
<tr>
<td>Patient experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>25%</td>
</tr>
<tr>
<td>Access</td>
<td>Practice</td>
<td>Secret shopper; survey</td>
<td>0,1</td>
<td>Same day access for urgent visit/consult as measures in 4th quarter 2015</td>
<td>100%</td>
</tr>
</tbody>
</table>
Example of Distribution and Performance Metrics

**Shared Savings Produced**

CMS Retains Percentage

**Shared Savings Available to CIN multiplied by Overall Quality Score**

70% Distribution to providers: 50% PCP, 20% SCP, 30% Hospitals; individual distributions based on # of lives/visits & performance metrics

30% to infrastructure

**Sample Performance Metrics**

- **Provider Engagement**
  - Examples:
    - Educational meeting attendance
    - Website utilization
    - Care management adherence

- **Patient Experience**
  - Examples:
    - Access – telephonic and appointment
    - Post-discharge visits

- **Quality**
  - Examples:
    - Annual A1C testing
    - Annual influenza vaccination
    - Ambulatory sensitive readmissions

- **Utilization**
  - Examples:
    - ED visits per 1000 beneficiaries
    - Admissions per 1000 beneficiaries
Areas of Opportunity

In Premier’s experience, the greatest opportunities for improving utilization and cost per beneficiary are in these areas:

- Implementing **care management** for high-risk and rising risk populations
- Optimizing **post-acute care optimization** through high-value networks
- Implementing processes to reduce **readmissions**
- Reducing **avoidable admissions**
Summary of Lessons Learned

- There is no one right model
- Incentive distribution should not be confused with physician compensation
- Take strategic goals and savings opportunities into consideration in developing the plan; focus is very important
- PCPs, in most instances, have more impact on generating savings, and, the dollars available to specialists in most models are not significant enough to generate behavioral change
- Clearly communicate the distribution model early to incentivize participants
- Ensure distribution of “hard dollars”; avoid the temptation to immediately cover the ACO network’s costs at the expense of distributing funds to physicians
- Balance developing internal measures and systems that crosswalk the CMS attribution by TIN to correctly assign it to the NPI with not letting the perfect get in the way of the good
- Less is more – keep the model simple and modify over time, if necessary
Strategy: Guiding Principles

- Move to population health (continuum of care)
- Move to deliver value (payment systems pushing you there)
- Broad Access points (expand population served)
  - PCP, UCC, Retail, APPs, Health Plan, TeleHealth
- Move to risk payment/global payment (control spend)
- Improve quality (track Core Measure Quality Collaborative)
- Competitive cost structure
- Prepare physicians for MACRA
- Aligned payment systems:
  - Narrow networks
  - Alternative Payment Methodologies (ACO, PCMH, BP)
  - Shared risk pools to link with physician organizations
Guiding Principles for Value Based Payment

- Care models designed in response to payment models and incentives
- Those that hold the risk, should be responsible for the cost and delivery model
- Medicare Advantage, the better your performance (infrastructure, care model, metric results, less variation, etc.) you want a sicker patient (get paid more: coding)
- Medicaid, Commercial, Medicare and Dual eligibles are distinct populations and have different needs/access issues
- Quality outcomes and spend matter
- Clearly identify what you are at risk for (DoFR)
- Providers will optimize their economics
What Should I Pay Attention To?

Quality indicators:
- HEDIS
- MSSP Measures
- MACRA metrics
- CMS Star Ratings (target 4-5 Stars)
- Anything specific to the contract
- Patient satisfaction surveys

Utilization indicators:
- AD/1,000 and PD/1,000
- LOS
- ED visits/1,000
- SNF days/1,000
- Out of Network use (who and for what?)
- Pre-authorization rate (target 95%, designate doctors)
- Other areas where you have a spend problem

Primary care referrals to specialists (rate)
Who is the Region?

The Southern California Region is:

- 50% of the employee workforce
- 50% of the system volunteers
- 49% of the physician workforce
- 47% of patients admitted
- 56% of babies delivered
- 38% of emergency room visits
- 40% of the net revenue
- 40% of EBIDA
What Do We Bring to the Care in Southern California?

Health & Prevention
- Two Wellness & Therapy Centers

Ambulatory Network
- 10 Primary Care Sites: 56 providers
- 2 Multispecialty Sites: 26 Providers
- 14 Specialty Care Sites: 31 Providers
- 4 Urgent Care Sites: 35 Providers
- 4 Clinics/YMCA Partnerships
- 1 Federally-Qualified Health Center
- 1 LA Market IPA: 209 Physicians & 25,000 lives
- 1 Simi Valley CIN: 90+ Physicians
- 1 Kern County CIN: 100+ Physicians

Post-Acute
- Home Health & Hospice Care

Acute Care
- 5 Acute Care Hospitals

Outpatient Centers
- 4 Outpatient Surgery Centers
- 6 Imaging Centers
- 3 Cancer Centers
Large Employers Still Want To Provide Health Benefits, But What Are They Looking For?

- More Predictable Price & Increased Transparency
- “Value” Networks Have Input on Network Participants
- Wellness & Disease Management
- Closer Relationships with Providers
## What Are Their Options?

<table>
<thead>
<tr>
<th>Employer Option</th>
<th>Trend</th>
<th>Important News</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Traditional Model</strong></td>
<td></td>
<td>• Large employers costs continue to rise at an unsustainable pace  \</td>
</tr>
<tr>
<td>“Status Quo”</td>
<td></td>
<td>• Some employers looking to either reduce their role in the process or gain more control of it</td>
</tr>
<tr>
<td><strong>Private Exchange</strong></td>
<td></td>
<td>• Mercer grew from 975,000 members to 1.4 million  \</td>
</tr>
<tr>
<td>“We Give Up” (Walgreens, Hallmark)</td>
<td></td>
<td>• Aon Hewitt grew from 750,000 members to 1.0 million  \</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Accenture estimates exchanges grew 35 percent to approximately 8.0 million in 2016</td>
</tr>
<tr>
<td><strong>Direct Contracting</strong></td>
<td></td>
<td>• Aon Hewitt survey reports that nearly 30 percent of employers are interested in some form of direct relationship with providers within</td>
</tr>
<tr>
<td>“We Want More Control” (Boeing, Intel, SHCA)</td>
<td></td>
<td>the next three to five years.  \</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Boeing direct-to-employer in Orange County</td>
</tr>
</tbody>
</table>

Sources:
- [http://www.forbes.com/sites/brucejapsen/2015/10/19/employers-shift-more-workers-to-private-exchanges/#6fd758d41db0](http://www.forbes.com/sites/brucejapsen/2015/10/19/employers-shift-more-workers-to-private-exchanges/#6fd758d41db0)
Our Current Relationship

Highlights of Club Zero

- Population of 5,000, targeting 14,500
- Member must choose a PCP
- $0 monthly contribution from employee
- $0 cost sharing in-network
- 45% cost sharing for out-of-network
- Access to care coordination
- Greater discount on WF groceries
- Potentially extend program to other organizations (41,000 lives)-GPO
Club Zero Network Design

Open Enrollment

Traditional Plan
(High-cost to employee)

Club Zero
Member Selects/Assigned PCP

PPA provides the AH network, medical management, and billing and collections

AH Specialty Network (PPA)
AH PCP Network (PPA)
AH Hospital & Ancillary Network (PPA)

Wrap-Around
(High-out-of-pocket costs to employee)
Early Success

• Club Zero is attracting higher-risk members (HUI Score of 1.21) which is giving AH the opportunity to make a significant impact on Whole Foods’ health benefit costs

• Although still early, the population’s utilization rates appear to be headed lower than expected

• If Club Zero continues to show positive results, there is potential for significant growth in the population at the upcoming Whole Foods open enrollment

• This arrangement is allowing us to further fund and develop greater capabilities around care coordination
Immediate Local Opportunities

Select Large Prospective Employers in Our Market

Private Sector

Public Sector

Note: Additional large employers can be found in the appendix
<table>
<thead>
<tr>
<th>Employer</th>
<th>Number of Employees</th>
<th>Employer</th>
<th>Number of Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>County of Los Angeles</td>
<td>97,500</td>
<td>Walt Disney</td>
<td>10,500</td>
</tr>
<tr>
<td>Los Angeles School District</td>
<td>73,300</td>
<td>Home Depot</td>
<td>10,200</td>
</tr>
<tr>
<td>Federal Government</td>
<td>48,100</td>
<td>Nestle</td>
<td>10,000</td>
</tr>
<tr>
<td>City of Los Angeles</td>
<td>47,700</td>
<td>Wells Fargo</td>
<td>9,500</td>
</tr>
<tr>
<td>State of California</td>
<td>30,400</td>
<td>MTA</td>
<td>9,200</td>
</tr>
<tr>
<td>Northrop Grumman</td>
<td>18,000</td>
<td>AT&amp;T</td>
<td>8,900</td>
</tr>
<tr>
<td>Target</td>
<td>14,200</td>
<td>Cal Tech</td>
<td>8,900</td>
</tr>
<tr>
<td>Kroger</td>
<td>13,200</td>
<td>Edison International</td>
<td>8,300</td>
</tr>
<tr>
<td>Securitas Security Services</td>
<td>13,000</td>
<td>ABM Industries</td>
<td>8,300</td>
</tr>
<tr>
<td>Bank of America</td>
<td>12,000</td>
<td>Raytheon</td>
<td>8,200</td>
</tr>
<tr>
<td>Boeing</td>
<td>11,200</td>
<td>Warner Brothers</td>
<td>8,000</td>
</tr>
</tbody>
</table>

Note: Excludes healthcare providers  
Sources: LA Almanac and Hoovers
By engaging employers with 1,000 or more employees, AH could capture a significant number of commercial members within the market and focus their resources.

<table>
<thead>
<tr>
<th></th>
<th>Los Angeles County</th>
<th>Ventura County</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of businesses with 1,000+ employees (large)</td>
<td>253</td>
<td>16</td>
<td>269</td>
</tr>
<tr>
<td>Number of employees in the 1,000+ cohort</td>
<td>656,000</td>
<td>29,000</td>
<td>685,000</td>
</tr>
<tr>
<td>Estimated commercial beneficiaries in the market</td>
<td>3,900,000</td>
<td>436,000</td>
<td>4,336,000</td>
</tr>
<tr>
<td>Employees in large businesses as a percent of total commercial population</td>
<td>17%</td>
<td>7%</td>
<td>16%</td>
</tr>
</tbody>
</table>

Sources: [http://www.labormarketinfo.edd.ca.gov/LMID/Size_of_Business_Data.html](http://www.labormarketinfo.edd.ca.gov/LMID/Size_of_Business_Data.html) and InterStudy Data 2015

685,000 members make up an estimated 30,000 to 40,000 in acute commercial admissions.
## Critical Success Factors

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Price</strong></td>
<td>• We are price competitive</td>
</tr>
<tr>
<td><strong>Network</strong></td>
<td>• We have a regional network, but will need strategic partners in select markets</td>
</tr>
<tr>
<td><strong>Care Coordination Infrastructure</strong></td>
<td>• We have care coordination through PPA. Will continue to build as we add more contracts</td>
</tr>
<tr>
<td><strong>Relationships</strong></td>
<td>• Employers are already reaching out to Southern California regional management directly</td>
</tr>
</tbody>
</table>
Where Might We Have Gaps in Our Network
Whole Foods Employees and Covered Lives – Glendale Area

Map shows employee zip codes. Green represents employees within 10 miles of PCP, yellow within 15 miles, and red farther than 15.
Whole Foods California

Whole Foods California Employees

<table>
<thead>
<tr>
<th>City</th>
<th># of Mbrs</th>
<th>% of Total CA Mbrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOS ANGELES</td>
<td>1992</td>
<td>12%</td>
</tr>
<tr>
<td>SAN FRANCISCO</td>
<td>830</td>
<td>5%</td>
</tr>
<tr>
<td>SAN JOSE</td>
<td>800</td>
<td>5%</td>
</tr>
<tr>
<td>SAN DIEGO</td>
<td>444</td>
<td>3%</td>
</tr>
<tr>
<td>OAKLAND</td>
<td>390</td>
<td>2%</td>
</tr>
<tr>
<td>SANTA ROSA</td>
<td>358</td>
<td>2%</td>
</tr>
<tr>
<td>SACRAMENTO</td>
<td>249</td>
<td>2%</td>
</tr>
<tr>
<td>All Others</td>
<td>11107</td>
<td>69%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>16170</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
1. The Network is your value—build it intentionally

2. Care Navigation/Care Management is the secret sauce that differentiates from traditional Health Plan Network

3. The price point for Hospital Based services sells the network

4. Quality above Quantity