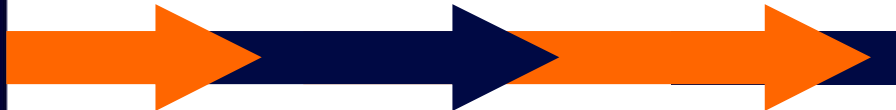




A HORSE OF DIFFERENT COLORS

Rich Williams January 21, 2011

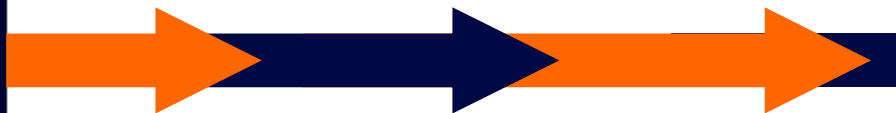


ADVANCED PLAN
FOR HEALTH

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Presentation Objectives

- How Did We Get Here?
- Understand Factors Driving the Need for Change
- The Process and Infrastructure



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Background

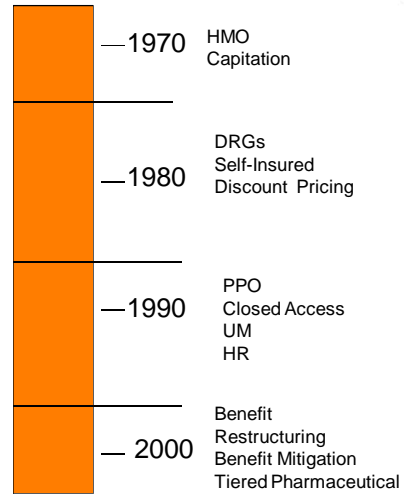
1. Health care spend going from \$2 trillion to \$4 trillion
2. Technology and science leader
3. There is no health care system

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The Jackson Hole Group

- Alain Enthoven, PhD
- Paul Ellwood, M.D.



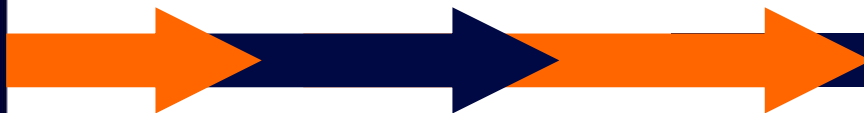
Healthcare is a Market Driven Economic Model = Commodity

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Market Driven Economic Model

$$\text{Cost} = \text{Price} - \text{Volume} - \text{Population}$$

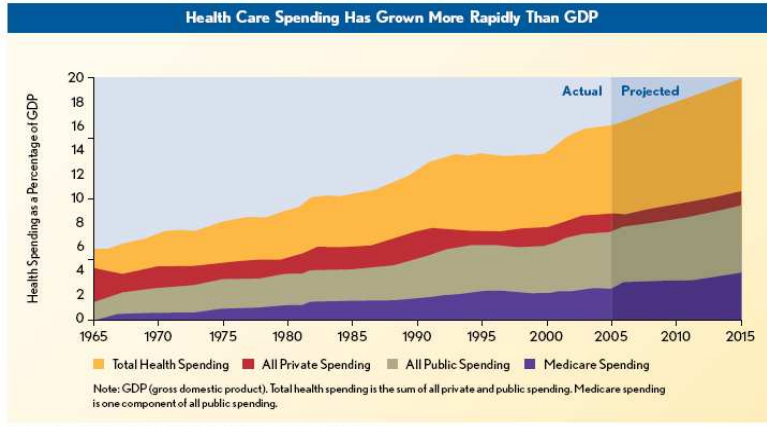


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Exponential Growth

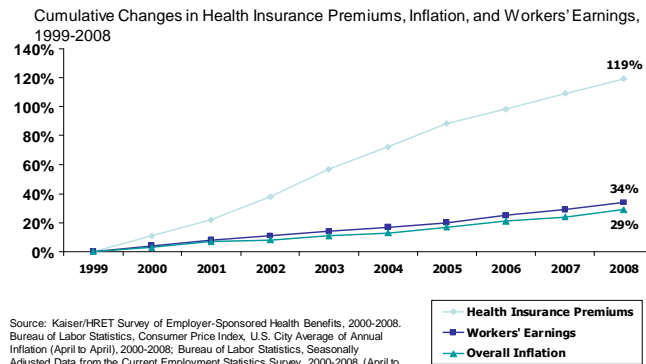
Already Unsustainable Healthcare Costs...



Source: CMS, Office of the Actuary, National Health Expenditure Accounts, 2006.

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Growth In Healthcare Insurance Costs Are Now Making Affordability Difficult for Individuals and Small Businesses

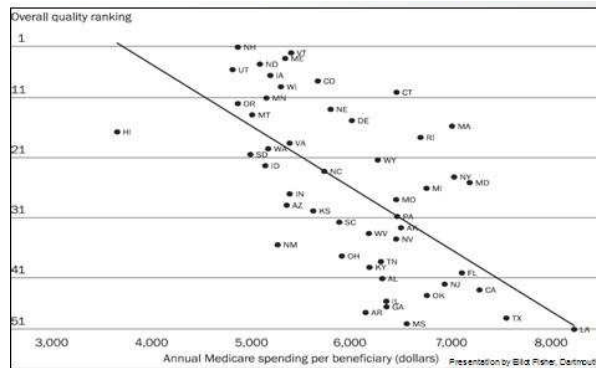


Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2008. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2000-2008; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2000-2008 (April to April).

Health Insurance Premiums
Workers' Earnings
Overall Inflation

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The Opportunity for Quality to Impact Cost



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Government Has a Problem

1. Baby Boomers
2. 10,000 people turning 65 every day for the next 20 years
3. Unfunded liabilities for federal and state
4. Medicare and its companion program Medicaid were signed into law on July 30, 1965 by President Lyndon
5. Older adults are a strong voting group
6. Life expectancy in 1950: Male-65.6, Female-71.10; 1965: Male-66.8, Female: 73.8 In 22 yrs (2032): Male-78.61, Female-84.42 Source: Data360.org
7. My kids don't want to pay double of what I did for Medicare and Social Security

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\$2 Trillion
Healthcare Spend
Moving
to a
\$4 Trillion
Healthcare Spend

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Laying the Foundation

- Health care has evolved dramatically

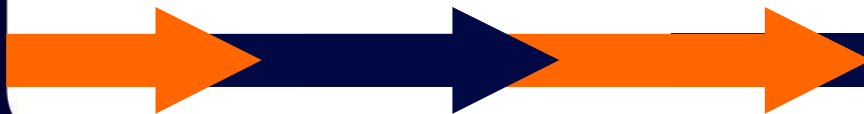


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We have the Greatest Technology in the World

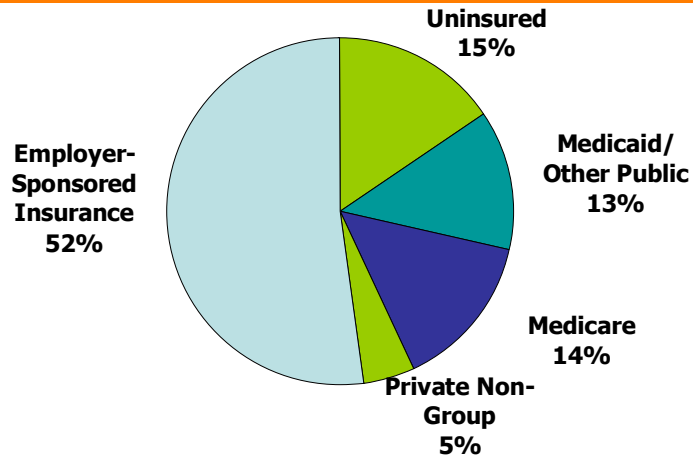
- The U.S. is the center of innovation and technology in healthcare
- There is no healthcare system (although there are some individual systems)
- Don't confuse activity with results



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Health Insurance Coverage in the U.S. 2008



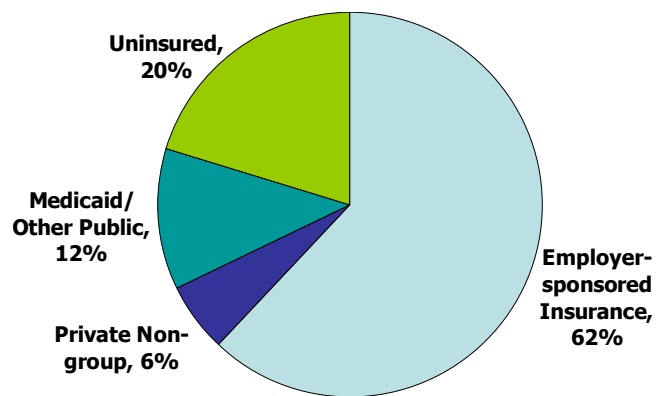
NOTE: Includes those over age 65.
SOURCE: Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of March 2009 CPS

Total = 300.5 million

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Health Insurance Coverage of Non-Elderly Adults, 2008



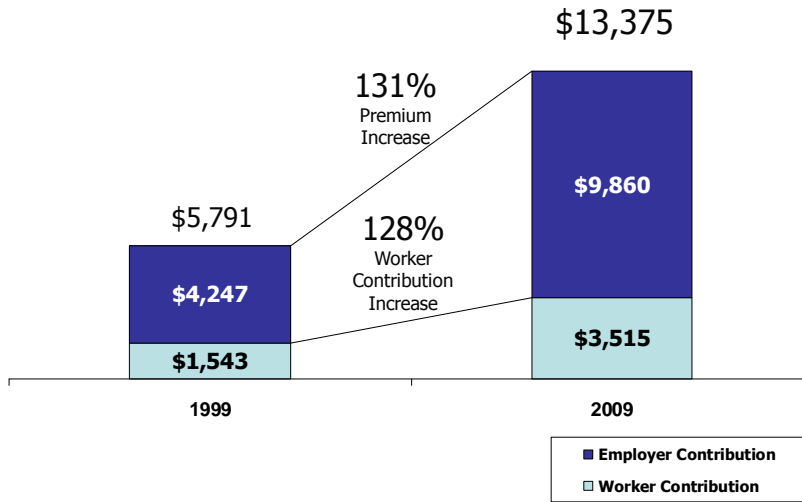
184.1 Million Nonelderly Adults

NOTES: Adults includes all individuals aged 19 to 64.
SOURCE: Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of 2009 ASEC Supplement to the CPS.

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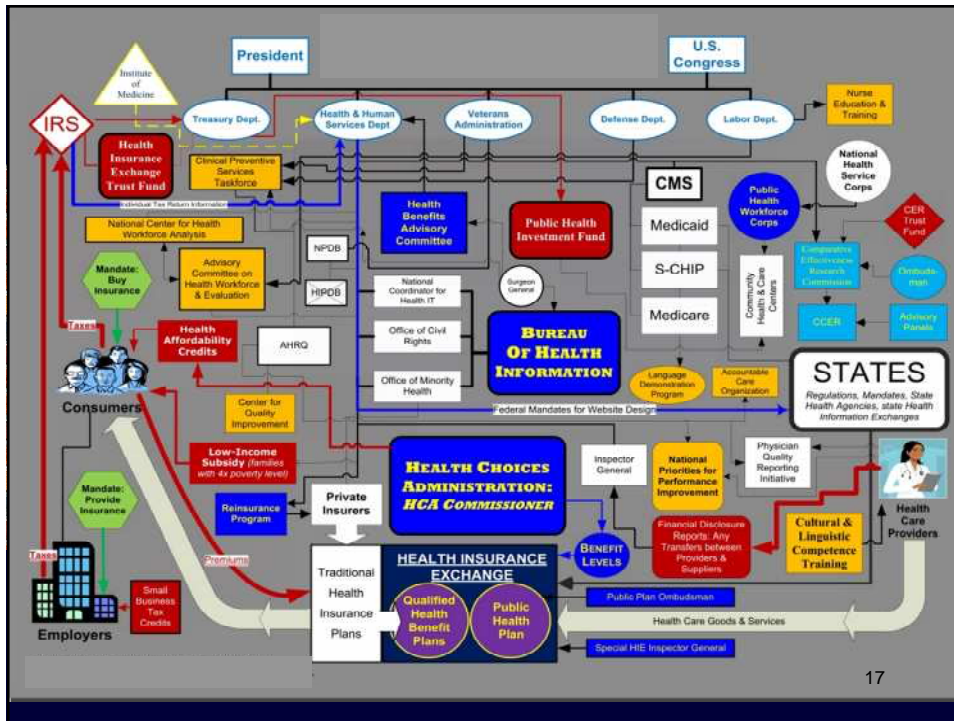
Average Health Insurance Premiums and Worker Contributions for Family Coverage, 1999 - 2009



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2009.

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This is the Best Case Scenario

- Assumes everything goes right
- In Powerball lottery terms - 1 in 195,249,054

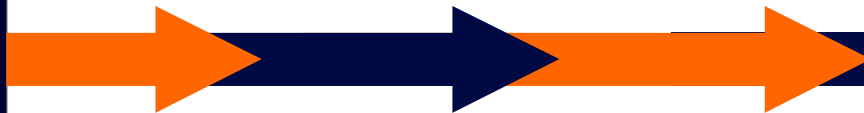


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Physician Group Practice

Medicare Demonstration Project

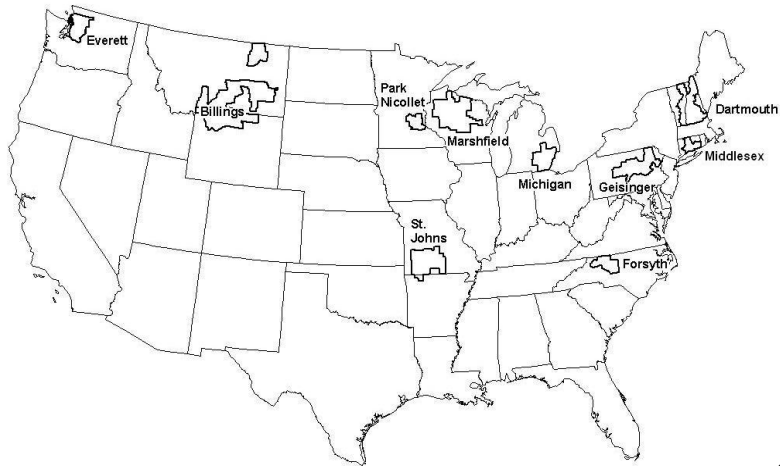


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Physician Group Practices

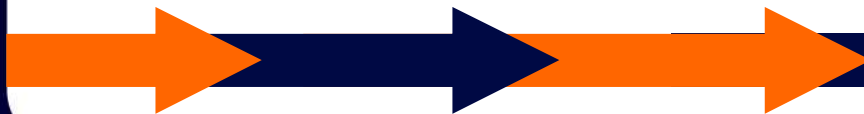
10 Sites



20

PGP Demonstration Overview

- Section 412 of **BIPA 2000** (P.L. 106-554)
- No change in Medicare FFS payments
- Performance payments earned from savings from patient management
- Payments linked to financial & quality performance

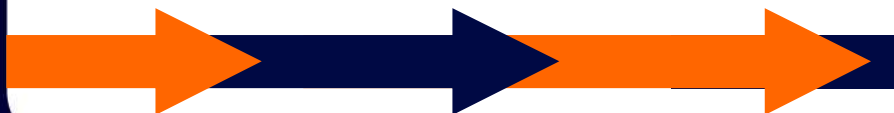


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PGP Demonstration Overview - Cont'd

- Quality assessed using 32 ambulatory care measures
 - Claims and clinical record based measures
 - AMA & NCQA developed, NQF endorsed/reviewed
 - Y1: Diabetes, Y2: + HF & CAD, Y3: + HTN & CA screening Y1-3 Flu & Pneum
 - PGP Quality Thresholds: Absolute or Relative Targets: benchmarks or >10% improvement in gap (100%- baseline)
- 10 physician groups representing 5,000 physicians & >200,000 Medicare FFS beneficiaries
- 3 year demonstration, extended to 5 performance years (2005-2010)



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Common Basis for Strategies among the PCP Groups

1. Focus: High Cost Areas

Components of Medicare Expenditures

- | | |
|---------------|------------|
| • Inpatient | 40% |
| • Hospital OP | 24% |
| • Part B | 22% |
| • SNF | 7% |
| • Home Health | 3% |
| • DME | 4% |

Reduce avoidable admissions, ER visits, etc.

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Common Basis for Strategies among the PCP Groups – Cont'd

2. Focus: Chronic Care & Prevention

- High prevalence and high cost conditions
- Provider based chronic care management
- Care transitions
- Palliative care

Financial Savings are
INPATIENT driven.

Quality Measures are
OUTPATIENT driven.

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Results

PGPs Improve Quality

- All physician groups improved clinical management of patients, with increase in quality

PGPs Share Savings

- Aggregate savings 3 yr. = **\$87M**
- PQRI incentive payments awarded based on quality measure performance

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Results – Cont'd

- 200,000 Medicare Enrollees
- Aggregate Savings 3 yrs = \$87M/3 = \$29M per year
- 5,000 doctors participating/\$29 Million = \$5,800 per doctor
- \$483.00 per doctor per month in Quality Bonus



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Observations

- **PGP lessons may be hidden in the details**
 - Success in individual disease management programs may be lost in the overall financial analysis
- **Look more broadly at interventions**
- **Demo Methodology**
 - Investment in resources/infrastructure (cash flow, risk)
 - Financial bar high, demo too short (→5 years)
 - Lack of real-time data from CMS
 - Methodology for comparison groups too restrictive; “compares groups with themselves”
 - All of the organizations met quality targets, minority met financial targets

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Observations – Cont'd

- Still fee for service
- Lack of aligned incentives between medical group and hospital
- No patient level incentive to anchor with PCP



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Assessment of Readiness as ACO is Vital

- Primary care
- Integration across care continuum, along with primary care focus
- Governance, core values consistent with ACO goals
- Legal structure
- Critical mass of patients
- Clinical decision support, medical management



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Assessment of Readiness as ACO is Vital – Cont'd

- EHR/Technology
- Data management and reporting capability
- Ability to establish actuarial cost and utilization targets
- Track record, experience with gain-sharing/risk arrangements spanning the continuum of services
- Aligned provider incentives

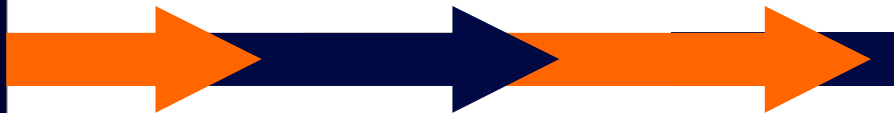


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The New Era

We Must Bend the Quality Curve



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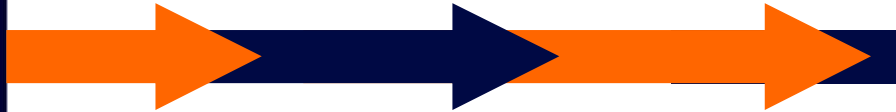
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Taking Care of the Sick

Keeping People Healthy

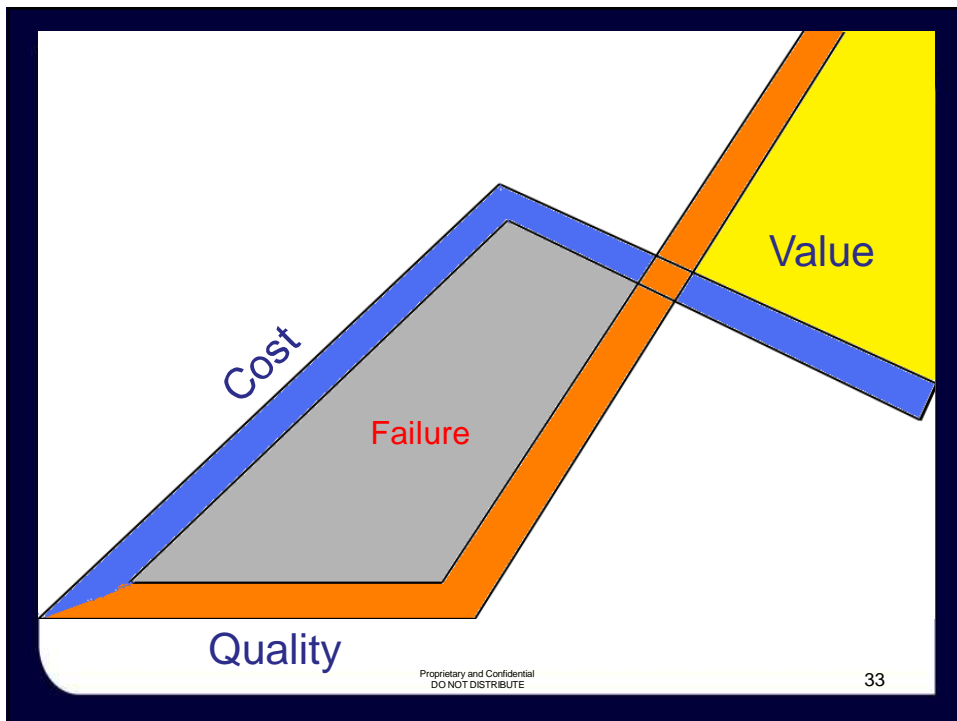
"The best way to predict the future is to invent it."

--Bill Gates



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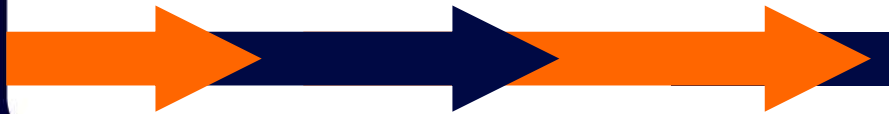


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The NEW Healthcare System
of the Future will be

Virtual



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Care Coordination Quality Delivery Model

- Primary care-centered individualized health supervision



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Care Coordination Quality Delivery Model-Cont'd

•Quality and safety enhanced by

1. Care planning process
2. Evidence-based medicine
3. Clinical decision-support tools
4. Performance measurement
5. Centralized, comprehensive information technology

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The Future

Care Coordination Quality Delivery Model

Virtual Medical Home

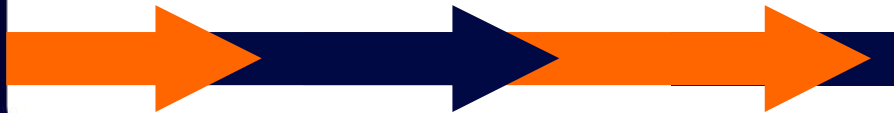
- Translate Data into Knowledge
- Knowledge Equates to:
 - Higher Quality
 - Faster Intervention
 - Significant Compliance
 - Tracking All Levels of Performance
 - Identification of Change Factor/Agent
 - Lower Cost

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Care Coordination Quality Delivery Model

- Quality Reduces Cost
- Goals are Measurable
- Outliers are Managed through Information
- All Players must be on the Same Team

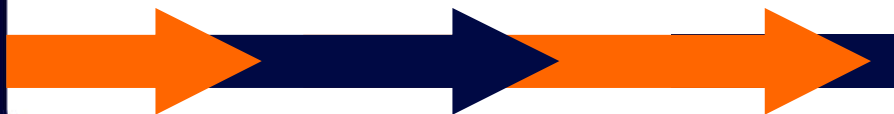


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Care Coordination Quality Delivery Model – Cont'd

- Move Away from Discounted Medicine
- Payors must pay a fair price, even if risk is transferred – self-insured, fully insured, Government
- Providers must charge a fair price and manage cost exposure
- All parties must be accountable for managing quality of healthcare provided to the population.



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Which horse will you ride?

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