“View from the Top” or Looking Out from the Ground

ACLGIM Winter Summit
December 6, 2010

Richard P. Lofgren, M.D, M.P.H
Vice President for Healthcare Operations
Chief Clinical Officer, UK Healthcare
University of Kentucky
Objectives

- Understand the current economic realities (business model) for most AMCs
- Stimulate discussion about planning for health care reform

Agenda

- Review of the Economic Realities of AMCs
- Case Study: UK Healthcare
- AMCs and Healthcare Reform
- Looming Storms
Most AMCs mainly make money on a very small portion of (very sick) patients – now and the foreseeable future.

UK Healthcare response to health care reform? Not so much (different)

We need to continue to attract “core” (highly sick) patients

We must continue to attend to our internal issues of quality/safety, throughput/access and efficiency/lowering costs
Economic Realities of Academic Medical Centers

Acknowledgement of Content:
Tom Robertson, University HealthSystem Consortium
Academic Medical Centers Make All Their Money on Train Wrecks
Financial Reality For AMCs

- Highly reliant on complex care for margins
- Seeing a high volume of simple cases quickly often not a core competency
- Tough competing with high service community providers for low complexity cases
- Low complexity services most susceptible to commodity pricing
Real Epicenter = “Financial Core”

Distribution of Net Income by Patient Percentiles
(Inpatient and Outpatient Facility)

Source: Midwestern UHC Member

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AMC Core vs. Commodity 1-10 24
AMCs Highly Dependent On Narrow Financial Core

Inpatient and Outpatient Net Income by Patient Percentiles

Top 5%
$132 million

Bottom 5%
<$83 million>

Top 25%
$212 million

Middle 50%
$13 million

Bottom 25%
<$142 million>

Source: UHC Contract Compass

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Very Narrow AMC Core “Per Se”

- Cancer – brain, head/neck, liver, leukemia, myeloma
- Intracranial nervous and circulatory
  - Cerebral arterial aneurysm/hemorrhage
  - Brain conditions (includes hydrocephalus, encephalitis)
- Chronic diseases
  - Epilepsy/seizure disorders
  - Cystic Fibrosis
  - Lupus/auto-immune disease
  - Sickle cell anemia
  - Complications of type 1 diabetes (organ manifestation)
- Neonatology & congenital anomalies
- Transplants
- Burns
- Pediatric sub-specialty services
Outliers*

- Managed Care/Commercial/Government Payments are based upon DRG until a specific hospital charge threshold Outlier is reached.
- Outlier payments are then generally based on percent of charge.

<table>
<thead>
<tr>
<th>Managed Care</th>
<th>No outlier</th>
<th>Outlier</th>
</tr>
</thead>
<tbody>
<tr>
<td>MS DRG</td>
<td>207</td>
<td>207</td>
</tr>
<tr>
<td>MS DRG Weight</td>
<td>5.21</td>
<td>5.21</td>
</tr>
<tr>
<td>Length of Stay</td>
<td>9</td>
<td>17</td>
</tr>
<tr>
<td>Hospital Charges</td>
<td>$79,162</td>
<td>$158,789</td>
</tr>
<tr>
<td>Payment</td>
<td>$31,036</td>
<td>$90,146</td>
</tr>
</tbody>
</table>

* UK Hospital data: Average threshold $130,000 at 60% of charges
Distance Translates To Margin

**Average Revenue/Discharge (By Distance to AHC)**

<table>
<thead>
<tr>
<th>Distance in miles from patient origin to AHC</th>
<th>Less than 5</th>
<th>5 to 10</th>
<th>10 to 20</th>
<th>20 to 30</th>
<th>30 to 40</th>
<th>40 to 50</th>
<th>over 50</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$5,000</td>
<td>$10,000</td>
<td>$15,000</td>
<td>$20,000</td>
<td>$25,000</td>
<td>$30,000</td>
<td>$0</td>
</tr>
</tbody>
</table>

**Average Contribution Margin/Discharge (By Distance to AHC)**

<table>
<thead>
<tr>
<th>Distance in miles from patient origin to AHC</th>
<th>Less than 5</th>
<th>5 to 10</th>
<th>10 to 20</th>
<th>20 to 30</th>
<th>30 to 40</th>
<th>40 to 50</th>
<th>over 50</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$2,000</td>
<td>$4,000</td>
<td>$6,000</td>
<td>$8,000</td>
<td>$10,000</td>
<td>$12,000</td>
<td>$14,000</td>
</tr>
</tbody>
</table>

Two additional cases per week from over 50 miles away worth $1 million in incremental operating margin for the typical AHC

Source: University of Pennsylvania
Margins Higher On Commercial Transfers

Contribution Margin Per Commercial Discharge

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Non-Transfer Cases</th>
<th>Transfer Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>$4,922</td>
<td>$5,875</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>$8,072</td>
<td>$10,038</td>
</tr>
<tr>
<td>Cardiology</td>
<td>$7,180</td>
<td>$9,596</td>
</tr>
<tr>
<td>Neurology</td>
<td>$5,811</td>
<td>$8,218</td>
</tr>
<tr>
<td>CT Surgery</td>
<td></td>
<td>$21,482</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td></td>
<td>$15,518</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$32,837</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$29,527</td>
</tr>
</tbody>
</table>

% Change
- General Medicine: 19%
- Orthopedics: 24%
- Cardiology: 34%
- Neurology: 41%
- CT Surgery: 53%
- Neurosurgery: 90%

Source: UHC Clinical Data Base, UHC Financial Data Repository

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Specialist Referrals More Profitable

Average Contribution Margin Per Case by Referral Source

- Cardiac Surgery
- Thoracic Surgery
- Neurosurgery
- Trauma Surgery
- Hematology
- Otolaryngology
- General Surgery
- Vascular Surgery
- Cardiology
- Orthopedics
- Pediatrics (Inpt and OP Spec)
- Pulmonary
- Urology
- Plastic Surgery
- Gastroenterology
- Nephrology
- Rehabilitation

Source: University of Wisconsin
University of Pennsylvania Example

Average Contribution Margin Per Discharge

- Moved orthopedics from HUP to Presbyterian Hospital
- Ortho earning healthy margin at less costly Presbyterian
- Higher margin business replaced orthopedics at HUP
- “System economies” finally realized

Source: University of Pennsylvania
## FY10 Congestive Heart Failure Cost Summary

### FY2010 Congestive Heart Failure Inpatients

<table>
<thead>
<tr>
<th>MSDRГ</th>
<th>MSDRG Description</th>
<th>Volume/Cost Element</th>
<th>Chanl</th>
<th>Sam</th>
<th>Var</th>
</tr>
</thead>
<tbody>
<tr>
<td>291</td>
<td>HEART FAILURE &amp; SHOCK W/MCC</td>
<td>Discharges</td>
<td>67</td>
<td>43</td>
<td>(24)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ALOS</td>
<td>6.49</td>
<td>7.21</td>
<td>0.72</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total Direct Cost Per Case</td>
<td><strong>$8,097</strong></td>
<td><strong>$7,881</strong></td>
<td><strong>($216)</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Direct Var Cost Per Case</td>
<td><strong>$4,383</strong></td>
<td><strong>$3,721</strong></td>
<td><strong>($62)</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Direct Fixed Cost Per Case</td>
<td><strong>$3,404</strong></td>
<td><strong>$3,828</strong></td>
<td><strong>$424</strong></td>
</tr>
<tr>
<td>292</td>
<td>HEART FAILURE &amp; SHOCK W/C C</td>
<td>Discharges</td>
<td>68</td>
<td>46</td>
<td>(22)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ALOS</td>
<td>4.15</td>
<td>4.09</td>
<td>0.05</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total Direct Cost Per Case</td>
<td><strong>$4,334</strong></td>
<td><strong>$3,705</strong></td>
<td><strong>($629)</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Direct Var Cost Per Case</td>
<td><strong>$2,383</strong></td>
<td><strong>$1,803</strong></td>
<td><strong>($581)</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Direct Fixed Cost Per Case</td>
<td><strong>$1,784</strong></td>
<td><strong>$1,723</strong></td>
<td><strong>($61)</strong></td>
</tr>
<tr>
<td>293</td>
<td>HEART FAILURE &amp; SHOCK W/O CC/MCC</td>
<td>Discharges</td>
<td>29</td>
<td>26</td>
<td>(3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ALOS</td>
<td>3.28</td>
<td>2.65</td>
<td>0.62</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total Direct Cost Per Case</td>
<td><strong>$3,537</strong></td>
<td><strong>$2,401</strong></td>
<td><strong>($1,136)</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Direct Var Cost Per Case</td>
<td><strong>$2,020</strong></td>
<td><strong>$1,095</strong></td>
<td><strong>($925)</strong></td>
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<tr>
<td></td>
<td></td>
<td>Direct Fixed Cost Per Case</td>
<td><strong>$1,370</strong></td>
<td><strong>$1,178</strong></td>
<td><strong>($192)</strong></td>
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<tr>
<td>Group Total</td>
<td>Discharges</td>
<td>164</td>
<td>115</td>
<td>(49)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ALOS</td>
<td>4.95</td>
<td>4.93</td>
<td>0.02</td>
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<tr>
<td></td>
<td></td>
<td>Total Direct Cost Per Case</td>
<td><strong>$5,731</strong></td>
<td><strong>$4,972</strong></td>
<td><strong>($759)</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Direct Var Cost Per Case</td>
<td><strong>$3,136</strong></td>
<td><strong>$2,380</strong></td>
<td><strong>($756)</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Direct Fixed Cost Per Case</td>
<td><strong>$2,373</strong></td>
<td><strong>$2,387</strong></td>
<td><strong>$14</strong></td>
</tr>
</tbody>
</table>

Note: CHF inpatients on this slide have BOTH a principal diagnosis in range from 428-428.43 and MSDRG 291, 292, or 293. Data obtained from the Service Line Data Base (batched from ADS 11/10/2010)

*Total Direct Cost = (Dir Var Cost + Dir Fixed Cost + Provider Tax)
On a practical level how does this play out?

Chasing Complexity
The Emergence of an Academic Referral Center

UK Healthcare
UK Healthcare Experience
Background

- Prior 2003 - Chancellor model
  - Hospital, COM and Practice functioned independently
    - Strained relationships
  - Losing market share, NIH ranking and faculty

- Strategic Intent/Planned Response
  - Increase volume and market share
  - Define role in the marketplace – provider of advanced specialty services
  - Develop and invest in specialty service lines
  - Focus on referral cases (chasing complexity)
    - Attract transfer patients from a distant location
Creating a functional structure
UK Healthcare Experience

2004 – EVPHA / Integrated Clinical Enterprise Model

- Integrated corporate structure
  - Governance & management of all units

- Integrated & coordinated strategic planning
coupled with a rational and realistic financial plan

- Financial Planning “All Money is Blue”
  - Single CFO - Responsible for all budgets
  - Transparent (no deals)
  - Move resources to meet strategic goals
UK Healthcare Experience
Strategy

- Focus on Advanced Subspecialty Care
- Regional Care – Preserving Rural Providers
  - Keeping local care local
- Efficiency, Quality and Patient Safety
Marketplace Results

Market Growth

- Strong growth in all markets
- Dramatic shifts relative to other hospitals
  - Increased market share from 28.5% to 43.3%
  - Dominate tertiary market (51.6% market share)

Payer Mix Data

- Growth occurred equally across all payer classes
- No evidence of adverse selection/referrals with “open door” approach
Market Share - Hospital Comparisons

**All Markets**
- Primary Market: 25.8%
- All Markets: 43.3%
- Secondary Markets: 28.5%

**Secondary Markets**
- Tertiary Markets: 36.5%
- Primary Market: 22.9%

**Primary Market**
- Tertiary Markets: 40.4%
- Secondary Markets: 34.9%

**Tertiary Markets**
- All Markets: 51.6%
Increased the CMI by Capturing More Distant Referrals

FY Comparison of Market Distribution of the Patient’s Origin

CMI Comparison by Region
Capacity Management
Purchased Low Cost Community Hospital

Spring 2007 – Watershed Moment
  - Continued to ↑ volumes but medical > surgical volumes (↓CMI)
  - Not making money despite record volumes

  - Purchased Samaritan Hospital located on campus ~ 1 mile away
  - Actively moved “low cost” patients to “low cost” hospital
  - Profitable in first year (loss $500K/month to profit ~$1M/month)

Medical Services
  - General Internal Medicine
  - Non teaching hospitalists
  - >50% teaching services
  - Family Medicine
  - Combined psychiatry units
  - On Site: Cardiology & GI

Surgical Services
  - Ortho – Elective Joints, Spine
  - Endocrine
  - Benign GYN
  - Vein/Wound Services
  - Plastics
  - Others: colorectal, general, ENT
  - Planned: MIS, pelvic floor
Phase II Results

UK HealthCare CMI Trends

Note: DRG weights have been normalized
COTH Benchmark Data
UNIVERSITY OF KENTUCKY CHANDLER HOSPITAL

COTH CMI Benchmark

Total Discharges Benchmark

Shaded area includes Good Samaritan & Chandler

Source: AAMC•COTH Quarterly Survey of Hospital Operations & Financial Performance
Note: Valid n varies from 145 to 165.
Gaps in the graph (or slides without data) may indicate missing data, zero values, or periods when UNIVERSITY OF KENTUCKY HOSPITAL did not respond to the survey.

For questions or more information, contact Erika Steinmetz, Manager of Data Services, Division of Health Care Affairs; 202.862.6144; esteinmetz@aamc.org.

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Draft Document – For Discussion Purposes Only
Health Care Reform and Academic Medical Centers
Health Care Reform to Consultants is like a Beached Whale to Eskimos

Food for Winter
What is UK Healthcare Doing in Response to Health Care Reform?

- “We are actively not doing much (different)”

- Realist (versus cynic)
  - Need to anticipate what will happen, when and how
  - Despite the very rapid CMS timeline, there remains many hurdles
  - Our community partners are nervous, are calling and we are listening
Health care bill is like the Blob fish – Jeff Goldsmith
Two Types of Reform

Coverage Expansions
- Individual mandate
- High Risk Pools
- Health Insurance Exchanges
- Insurance Reforms
- Medicaid Expansion

Delivery System Reforms
- Outcome-based payments
- New payment systems
  - Value-based purchasing
  - “Bundling” around episodes of care
### What Patients Will See, When

<table>
<thead>
<tr>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indoor tanning 10% service tax</td>
<td>Guaranteed issue for children under 19 (per regulation)</td>
<td>Prohibition of lifetime limits</td>
<td>Medicaid expansion</td>
<td>Individual and employer mandates</td>
<td>Prohibition of annual limits</td>
</tr>
<tr>
<td>Prohibition of lifetime limits</td>
<td>Extend dependent coverage</td>
<td>Start to fix the donut hole in Part D ($250 rebate)</td>
<td>Benefit requirements and community rating</td>
<td>Guaranteed issue and renewability</td>
<td>Prohibition of annual limits</td>
</tr>
<tr>
<td>Coverage expansion of preventive services</td>
<td>Part D coverage gap closing begins</td>
<td>Center for Payment Innovation</td>
<td>State / multi-state exchanges on-line</td>
<td>Premium and cost sharing subsidies</td>
<td>Independent Payment Advisory Board recommendations effective</td>
</tr>
<tr>
<td>2010</td>
<td>2011</td>
<td>2012</td>
<td>2013</td>
<td>2014</td>
<td>2015</td>
</tr>
<tr>
<td>2010</td>
<td>2011</td>
<td>2012</td>
<td>2013</td>
<td>2014</td>
<td>2015</td>
</tr>
</tbody>
</table>

**Benefit requirements and community rating**
- **Election**

Additional .9% tax increase for Medicare on high earners
Initial Assessment

- **Personal Assumption**
  - The only intervention that has been shown to reduce costs involves some form of restrictions
    - (i.e. capitation or capitation in drag)

- **There is Currently No Political Will**
  - “Any limitation of choice is off the table”
    - Across the political spectrum

- **Preludes Before the Expansion of Coverage**
  - Need to implement a major tax hike
  - Another national election
  - Emergence of Social Security funding crisis
“Shared Savings” Program (Accountable Care Organizations)

- Currently confusing, complicated
- Thus the potential benefit is uncertain
- Value proposition for the patient?
  - Ability to control costs if patients can “opt out”
  - Potentially not visible to the patient
- Potentially attractive for those with an existing primary care network
  - For the rest of us, is it a core competency?
Market Response
Back to the Future

- Hospitals are back in full force buying stuff
  - Physicians, SNFs, etc.

- Why did it fail last time?

- Why will it be different this time around?
  - 98% of PCPs do not get a discharge summary
# POTENTIAL EFFECTS OF MANAGED CARE ON SPECIALTY PRACTICE AT A UNIVERSITY MEDICAL CENTER

**John E. Billi, M.D., Christopher G. Wise, Ph.D., M.H.A., Elizabeth A. Bills, B.S., and Rita L. Mitchell, M.P.H.**


Table 3. Managed-Care Enrollees Needed to Maintain the 1992 Level of Professional Specialty Revenue at the University.*

<table>
<thead>
<tr>
<th>Specialty</th>
<th>All-Services Model</th>
<th>Network Model</th>
<th>Combined Model</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NO. OF ENROLLEES</td>
<td>NO. PER</td>
<td>NO. OF ENROLLEES</td>
</tr>
<tr>
<td></td>
<td>FACULTY MEMBER</td>
<td>FACULTY MEMBER</td>
<td>FACULTY MEMBER</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>471,223</td>
<td>13,351</td>
<td>1,283,677</td>
</tr>
<tr>
<td>Dermatology</td>
<td>275,116</td>
<td>47,460</td>
<td>4,195,523</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>409,163</td>
<td>6,940</td>
<td>5,273,652</td>
</tr>
<tr>
<td>Neurology</td>
<td>591,712</td>
<td>57,434</td>
<td>4,881,626</td>
</tr>
<tr>
<td>Obstetrics and gynecology</td>
<td>157,179</td>
<td>10,091</td>
<td>2,847,706</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>563,041</td>
<td>40,405</td>
<td>1,714,714</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>363,087</td>
<td>63,110</td>
<td>1,984,875</td>
</tr>
<tr>
<td>Pathology</td>
<td>542,099</td>
<td>30,213</td>
<td>11,926,176</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>2,010,943</td>
<td>33,138</td>
<td>Not available</td>
</tr>
<tr>
<td>Physical medicine</td>
<td>387,785</td>
<td>32,576</td>
<td>1,163,356</td>
</tr>
<tr>
<td>Radiation oncology</td>
<td>530,013</td>
<td>106,128</td>
<td>6,093,155</td>
</tr>
<tr>
<td>Radiology</td>
<td>357,972</td>
<td>7,913</td>
<td>5,727,550</td>
</tr>
<tr>
<td>Emergency services</td>
<td>168,797</td>
<td>25,869</td>
<td>5,063,910</td>
</tr>
<tr>
<td>General surgery</td>
<td>595,583</td>
<td>54,702</td>
<td>3,527,684</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>1,463,046</td>
<td>268,252</td>
<td>2,560,330</td>
</tr>
<tr>
<td>Orthopedic surgery</td>
<td>526,099</td>
<td>62,986</td>
<td>2,008,743</td>
</tr>
<tr>
<td>Pediatric surgery</td>
<td>2,124,289</td>
<td>531,604</td>
<td>Not available</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>801,691</td>
<td>152,997</td>
<td>865,826</td>
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<td>Thoracic surgery</td>
<td>1,600,464</td>
<td>289,561</td>
<td>4,201,219</td>
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<tr>
<td>Urology</td>
<td>533,151</td>
<td>98,084</td>
<td>1,821,600</td>
</tr>
<tr>
<td>Vascular surgery</td>
<td>837,294</td>
<td>466,844</td>
<td>1,196,134</td>
</tr>
</tbody>
</table>
Realization – We Must Expand the Footprint

Market Definition

- **Primary** - 0.3M population
- **Secondary** - 0.5M population
- **Tertiary** - 1.0M population
- **Other** - 2.5M population

<table>
<thead>
<tr>
<th>Organ</th>
<th>Kentucky Incidence (CY07/08 Transplants per Million KY Residents)</th>
<th>Aspirational Volume</th>
<th>Population Required to Achieve Aspirational Volume</th>
<th>Population Required with 70% Retention Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kidney &amp; K/P</td>
<td>42.5</td>
<td>110</td>
<td>2,600,000</td>
<td>3,700,000</td>
</tr>
<tr>
<td>Liver</td>
<td>24.0</td>
<td>60</td>
<td>2,500,000</td>
<td>3,600,000</td>
</tr>
<tr>
<td>Lung</td>
<td>7.2</td>
<td>25</td>
<td>3,500,000</td>
<td>5,000,000</td>
</tr>
<tr>
<td>Heart</td>
<td>6.2</td>
<td>25</td>
<td>4,000,000</td>
<td>5,700,000</td>
</tr>
</tbody>
</table>
Real Epicenter = “Financial Core”

Distribution of Net Income by Patient Percentiles
(Inpatient and Outpatient Facility)

Source: Midwestern UHC Member
Choosing A Frame Of Reference

Global
Managing the entire health needs of a population

VS.

Selective
Managing the complex health needs of a population

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AMC Core vs. Commodity 1-10 31
## A Flaw In The Funnel

<table>
<thead>
<tr>
<th>Financial Core Business</th>
<th>Median AMC Program Volume</th>
<th>Incidence Per 1,000 Population</th>
<th>“Covered Lives” Required</th>
<th>Ambulatory Encounters to Manage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Craniotomy (bleeds/implants)</td>
<td>80</td>
<td>0.08</td>
<td>1,038,961</td>
<td>4,155,844</td>
</tr>
<tr>
<td>Heart Transplants</td>
<td>30</td>
<td>0.01</td>
<td>4,285,714</td>
<td>17,142,857</td>
</tr>
<tr>
<td>Cardiac Valves</td>
<td>165</td>
<td>0.31</td>
<td>532,864</td>
<td>2,131,455</td>
</tr>
<tr>
<td>Brain Cancer</td>
<td>75</td>
<td>0.06</td>
<td>1,171,875</td>
<td>4,687,500</td>
</tr>
<tr>
<td>Leukemia</td>
<td>85</td>
<td>0.12</td>
<td>696,721</td>
<td>2,786,885</td>
</tr>
</tbody>
</table>

Population management is a blunt instrument to protect complex core – high risk / low reward unless systemic overhaul of delivery system occurs.
Payment Reform Has Commodities In Cross Hairs

Percentage of total Medicare spending on episodes

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ischemic Heart Disease</td>
<td>14.0%</td>
</tr>
<tr>
<td>CHF</td>
<td>4.3%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>4.0%</td>
</tr>
<tr>
<td>CVA</td>
<td>3.6%</td>
</tr>
<tr>
<td>COPD</td>
<td>3.4%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>3.2%</td>
</tr>
<tr>
<td>Joint Degeneration - Knee, Lower Leg</td>
<td>3.1%</td>
</tr>
<tr>
<td>Joint Degeneration - Back</td>
<td>3.0%</td>
</tr>
<tr>
<td>Chronic Renal Failure</td>
<td>2.8%</td>
</tr>
<tr>
<td>AMC Core Cases</td>
<td>0.01 - 0.5%</td>
</tr>
</tbody>
</table>

Bundled pricing focused on 20 commodity episodes addresses 60% of CMS spending...over 100 times the amount spent on AMC core business

Source: MedPac, June 2010 Data Book
Looming Clouds on the Horizon

- What keeps me up at night?
- Internal concerns >> External issues
**Internal Issues**

- Improving quality/safety outcomes
- Improve efficiency/cost to produce the desired outcome
- Reduce supply costs
- Throughput and access to services
- Demand on capital
- Employee/Faculty Challenges
  - Impending retirement of Boomers
  - Competition for scarce talent
  - High expectations of Gen Y workers
Afterhours Care

- **Internal Issues**
  - ↓ Resident work hours
  - ↓↓ In-house call by senior residents and fellows
  - Marked expansion of services and volumes

- **External Issues**
  - Few specialist in the State “on-call” after Friday at 5PM

- Handoffs, Handoffs, Handoffs
Pay For Performance

- Our Local Market – not significant issue in the commercial side

- Public reporting – currently does not appear to affect referral patterns, patients, payers, etc.

- CMS – Mounting Pressure w/ incentives & penalties
  - Hospital
    - Continue to “play the Core Measures game”
    - Attend to readmissions, HAC, PSIs, never events
  - Practice ⇒ Accelerate implementation of EMR
    - Chase ARRA dollars
    - Increase participation of PQRI
## External Threats/Concerns

<table>
<thead>
<tr>
<th>Price Pressure</th>
<th>Social Contracts</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Relentless pressure to reduce reimbursement, especially by government payers</td>
<td>• Reduction or elimination of DSH if uninsured fully covered</td>
</tr>
<tr>
<td>• Consolidation of commercial insurers is well underway</td>
<td>• IME/DME may be uncoupled from clinical reimbursement; advocacy needed to preserve support for medical education</td>
</tr>
<tr>
<td>• New financial models</td>
<td></td>
</tr>
</tbody>
</table>
Changes Will Occur

- Fits & Starts
- Uneven and unplanned changes
- Multiple demonstrations, pilots and experiments
- More evolutionary than revolutionary
- Consolidation out of fear
- Relentless pressure on price
  - Will challenge fee for service
So What Are We Doing Now?

- Continue the same strategic game plan
  - Chase “core” business

- Aggressively address our internal issues
  - Quality/safety
  - Throughput/access
  - Efficiency/lowering costs

- Prepare for changes in reimbursement model
  - (i.e. episodes of care – bundled payments)