SPEAKER

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The Board Role in Driving Value & Equity Transformation

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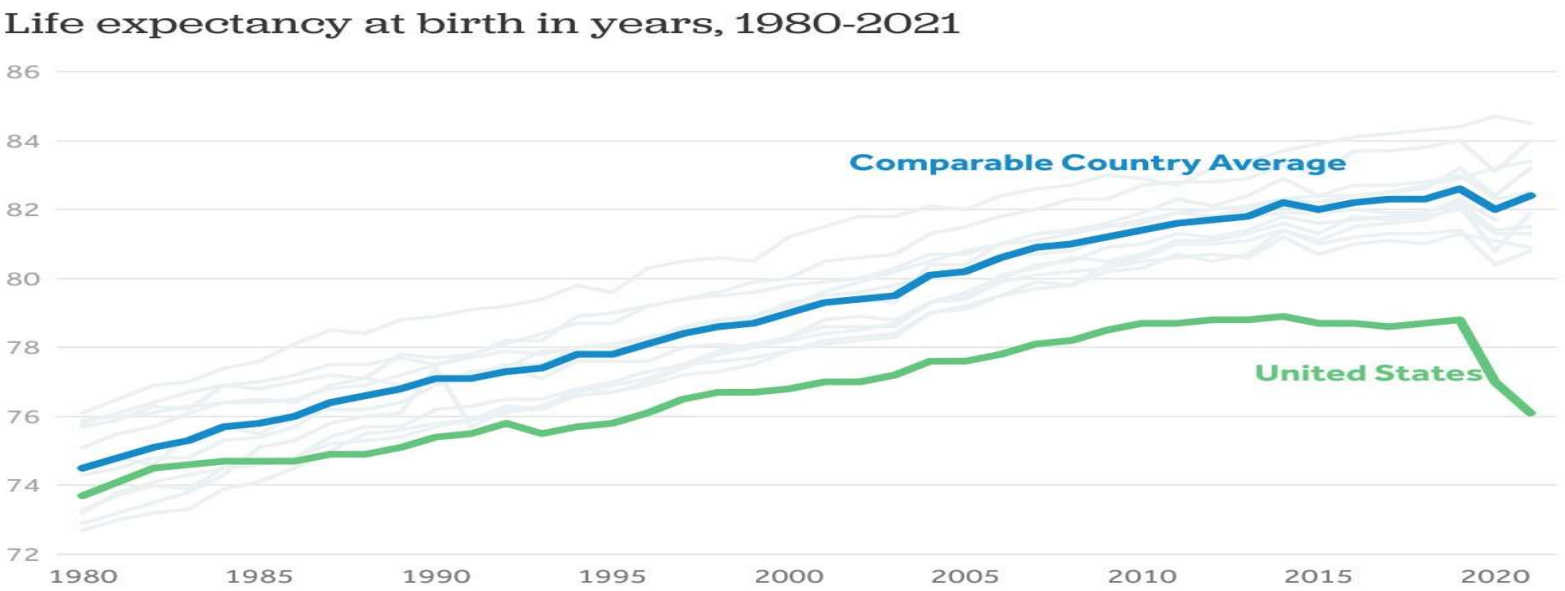
Thank You

For all you and your care teams did and continue to do in response to Covid

Why America needs a transformed healthcare system

1. Our underlying health status is declining
2. There are gross inequities in Health Status and Life Expectancy
3. The U.S. Healthcare System consumes too many resources that could be used to improve the social drivers of health

U.S. Life Expectancy has fallen behind other similar countries for 40 years – now 6 years

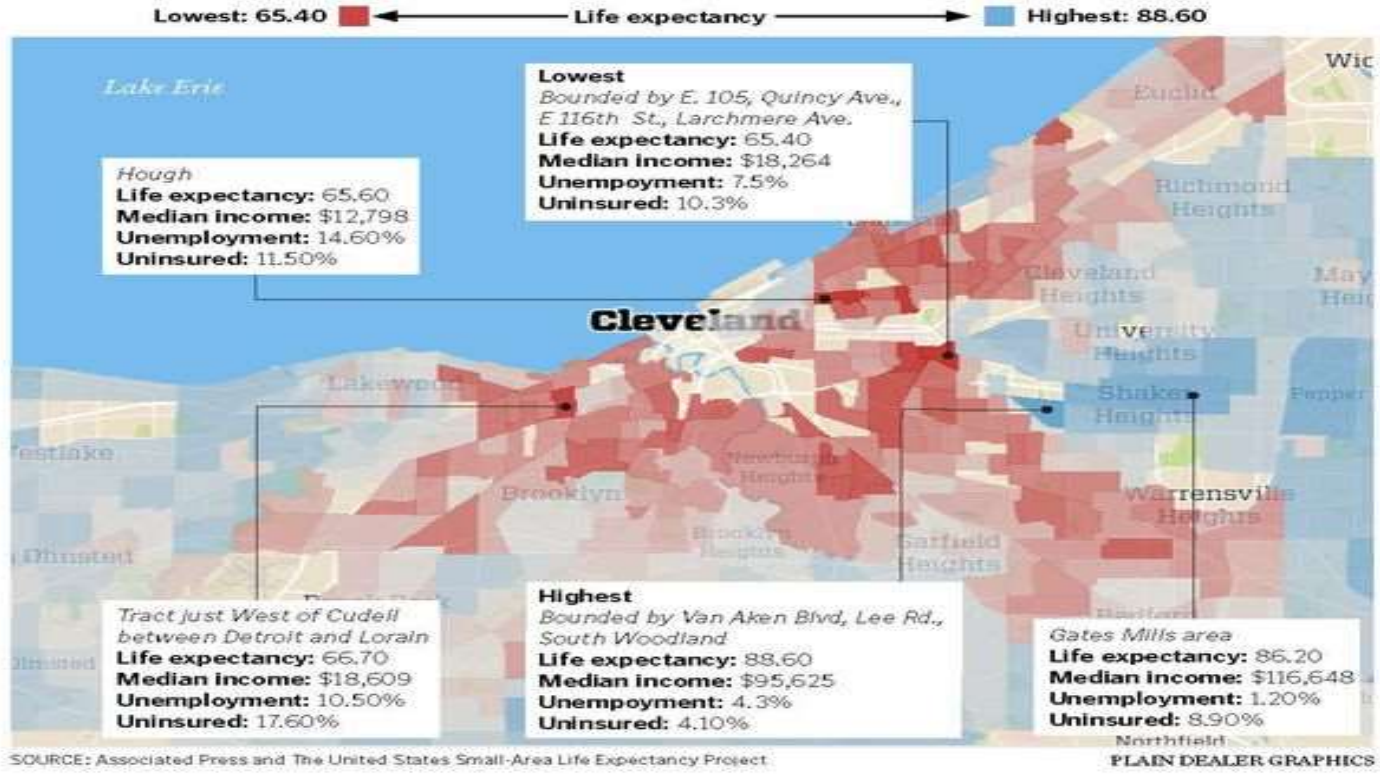


Notes: Comparable countries include: Australia, Austria, Belgium, Canada (except for 2021), France, Germany, Japan, the Netherlands, Sweden, Switzerland, and the U.K. See Methods section of "How does U.S. life expectancy compare to other countries?"

Source: KFF analysis of CDC, OECD, Japanese Ministry of Health, Labour, and Welfare, Australian Bureau of Statistics, and UK Office for Health Improvement and Disparities data

Peterson-KFF
Health System Tracker

With dramatic Health Inequities: 23 years difference across Zip Codes in Cleveland and most cities. . .



*Cleveland Plain Dealer Dec 19, 2018

…while we spend twice as much of GDP on healthcare . . .

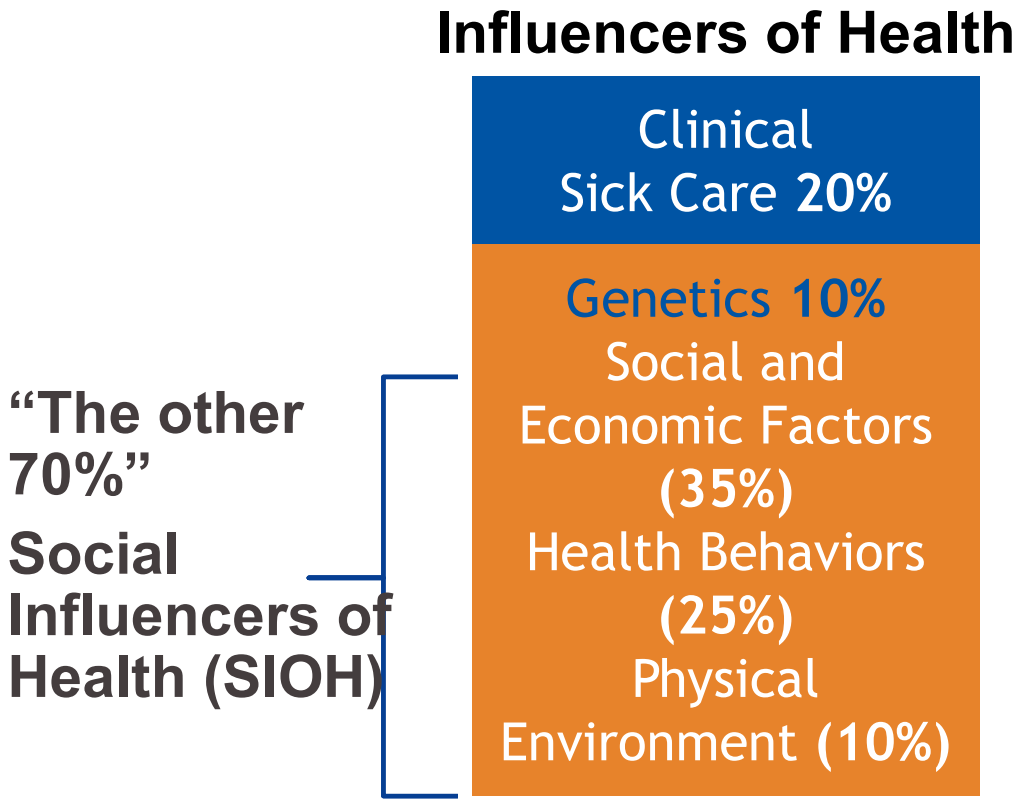
Country	Life expectancy	Health spending/capita	GDP Percentage
United States	**76.1**	**$12,914**	**18.6%**
Comparable Country Average	**82.4**	**$6,003**	**9.6 ***
Australia	83.4	$5,627	
Austria	81.3	$6,693	
Belgium	81.9	$5,274	
France	82.5	$5,468	
Germany	80.9	$7,383	
Japan	84.5	$4,666	
Netherlands	81.5	$6,190	
Sweden	83.2	$6,262	
Switzerland	84	$7,179	
United Kingdom	80.8	$5,387	

* Commonwealth Fund 2022.

… and despite a much higher poverty rate, spend much less on social services.

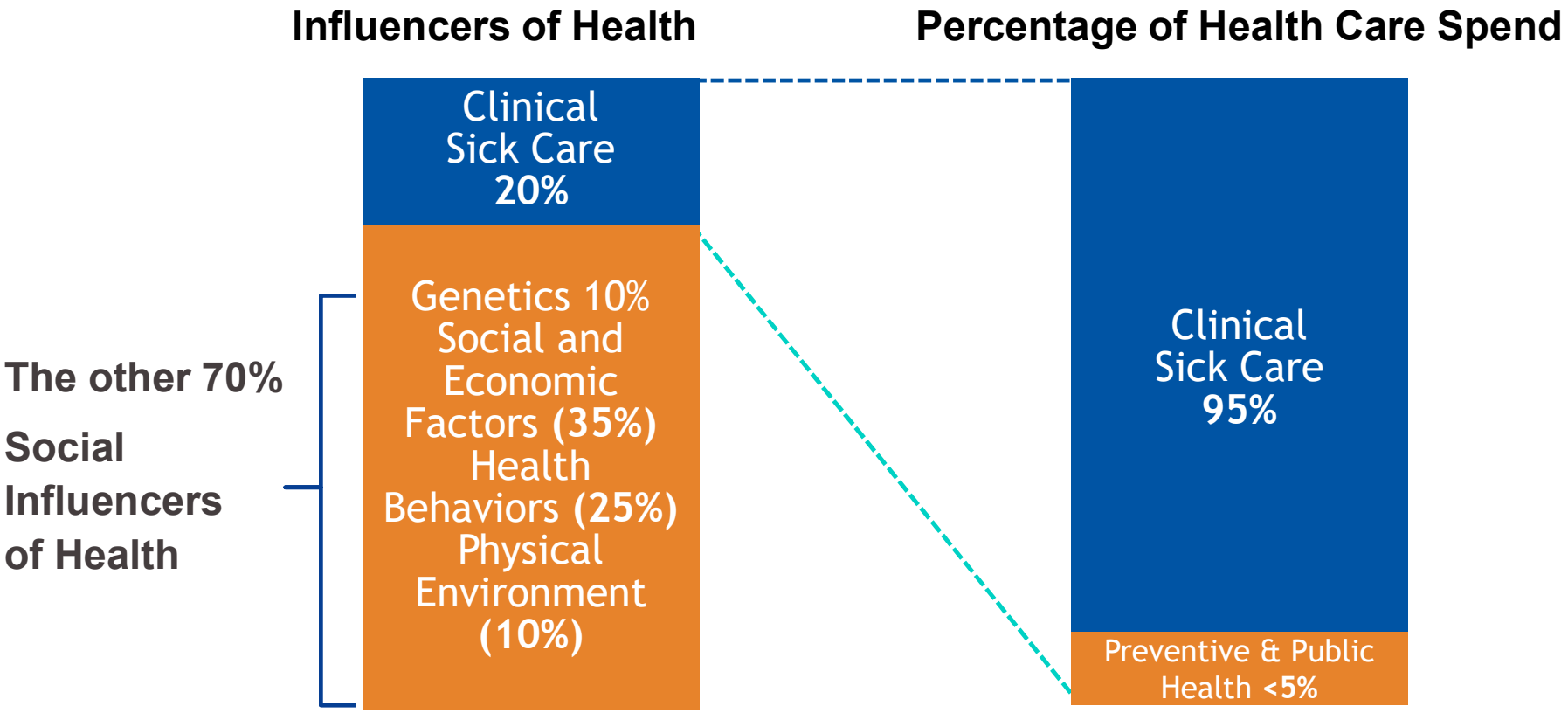
Source: AAMC, What can we learn from comparisons of other countries health carer spending, 2022

Healthcare only accounts for 20% of the differences in Health Status; SIOH = 70%



A.L. Sensenig. 2007. "Refining Estimates of Public Health Spending as Measured in the National Health Expenditures Accounts: The U.S. Experience." Journal of Public Health Management and Practice 13 (2): 103-14.

U.S. health care spend is almost entirely focused on sick care, not preventive care or public health



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We need to move to an Equitable High Value Healthcare System

- To provide resources for improved social services
- To address healthcare inequities
- To optimize the impact of healthcare

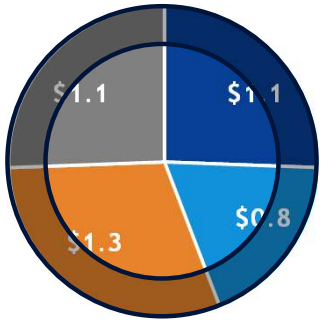
Intersection of Equity and Value Transformation

- Commitment to less resource use
- Commitment to a Social Justice Advocacy Agenda
- Commitment to creating deep connections with community-based organizations

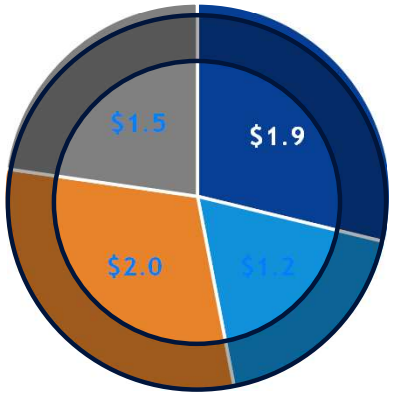
- Kevin Barnett spoke about this yesterday

Investor Gold Rush: Healthcare is the largest and fastest growing business opportunity in America

2023
Total Health Spending
$4.3 Trillions



2031
Total Health Spending
$6.6 Trillion



■ Medicare ■ Medicaid + CHIP ■ Commercial ■ Other ■ Medicare ■ Medicaid + CHIP ■ Commercial ■ Other

Administrative Expenses

Medicare Advantage (MA), privatized Medicare, already has $450 B of it

- Now covers >50% of all Medicare Beneficiaries
- Offering better benefits and lower premiums to members
- Highly concentrated among 4 large non-profits
  - United Healthcare
  - Humana
  - Aetna
  - Elevance Blue Cross (Anthem)

- **MA Subsidies are 20-30% above the actual CMS Cost**

Total Cost of Care Risk Contracting now puts most of the $6.6 T up for grabs

Total Cost of Care Risk Contracts:

- Payer gives provider all the medical cost
- Provider arranges for all medical services
- Lower service costs = Profits
- Higher service costs = Losses

The Gold Rush started with for-profit small locally focused PCP firms taking Total Cost of Care Contracts…

Medicare Advantage

- Oak Street Health - Chicago
- ChenMed - Florida
- Agilon Health - Ohio

Commercial Insurance

- Summit Health – New Jersey
- DuPage Medical Group - Chicago

These contracts drive providers to change behavior; provide significant patient benefits – but don't decrease spending!

	Incent Provider Behavior Changes	Patient Benefit	Net Result to Payer
Medicare	Increase coding to increase CMS payments	Lower Copays Lower Premium OOP Cap Food Cards	Increased Costs for CMS and Part B Beneficiaries
Commercial	Move care out of hospitals and to owned sites	Lower OOP Costs due to lower unit prices	Maintain High Commercial Costs

All under the banner of “Value Based Care”

- Value Based Care – Providing better outcomes while also decreasing the total cost of care.

- The Reality:
  - Medicare Advantage - CMS, beneficiaries, taxpayers pay more
  - Commercial Risk – Profits to providers but still high prices for employers

. . . Total Cost of Care Contracts are poised for national scale through large Health and Tech Firms' acquisitions

	Acquirer
Medicare Focused	
– Oak Street Health	AETNA
– Iora Health	AMAZON
– Caravan Health	AETNA
– VillageMD	Walgreens
– ChenMed	
– Agilon Health	
– Previa	
– Aledade	
Commercial Focused	
– Summit Health	Walgreens
– DuPage Medical Group	

The major savings targets are the major drivers of hospitals' sustainability

	Historic Reality	Threats	Players
Inpatient Volume	Profitable Surgical Admissions Marginal Medical Admissions	Major movement to Outpatient Surgery Shifting site of service Observation Stays Hospital at Home	Insurer Denials Physician owned surgery centers CMS Site of Service Rule Insurer Downgrades PE Start-ups
Inpatient Price - Commercial	250% of Medicare Hospital pricing	Surprise Billing Rules Reference Based Pricing Payer push back Narrow Network Products	Congress For-profit Start-ups Risk group steerage to low cost Employers
Outpatient Volume	Still Hospital Dominated	Capital Light at Risk Models Orthopedic Owned Joint Replacement Centers	ASC/Imaging/Cardiac PE Firms Physician owned Surgery Centers Optum/United; Aetna/CVS; Walgreens
Outpatient Price	200% of Medicare hospital pricing	Site of Service shifting Medicare Site of Service differentials Direct to Employer Reference Based Pricing	Risk Groups CMS Insurer Policy Reference based pricing firms
Medicare Volume	Traditional Medicare unmanaged MA enrollment at well below 50%	Growing MA Market Share Medicare Advantage Denials Hospital at Home/ COs	

Meanwhile, non-profits Hospitals and Health Systems (H&HS) are focused on Covid Care and the financial aftermath

- Capacity
- Revenue Shortfalls
- Staffing shortages
- Cost Inflation
- Decreased Surgical Volumes
- Negative Margins

Some with pricing market power have recovered – most still struggle

Control of dollars = Control of care delivery
Who will drive the direction of healthcare?

- For Profit Payer/Providers – United/Optum, CVS/Aetna, Humana,
- For profit Institutions – HCA, Tenet, Agilon, Walgreens/Village MD/Summit
- Tech Giants - Amazon/Google/ Apple/Microsoft
- Private Equity
- Non-profit Hospitals and Health Systems

The ACA in 2010 created a way for providers to become accountable for total cost and quality:

- Accountable Care Organizations – ACOs – Physicians and hospitals take responsibility for total population cost and quality
- 2023 Participation:
  - 500 Plus ACOs
  - 13 M Medicare Beneficiaries
  - 1,400 Hospitals & 550,000 providers
- Results:
  - Annual savings of 1-2 %
  - 2022 Savings: $4.3 B
  - Physician ACOs savings = twice as much as Hospital ACOs

ACO growth has plateaued with enrollment moving to physician and for-profit ACOs

- ACO Program has stalled at about 30% of Traditional Medicare Enrollment
- ACO Reach – 130 ACO's – 2 Million Enrollees
  - For Profit Entities – 60%
  - Hospital System < 10%

Medicare Advantage grows on subsidies while ACOs plateau with none

- MA Receives subsidies of 20 - 30% above FFS
- ACO's targets is about equal to FFS
- Financial Returns on MA for providers are enormous
- Financial Returns for ACOs are small

- The MA deal is much better and allows MA Plans to offer better benefits to members.

10 Years later many doubt that non-profit Hospitals and Health Systems are capable of making the necessary changes

- Doubters:
  - PCPs and other Clinicians
  - Payers
  - DC Policy Makers
  - Healthcare Policy Community
  - FTA/DOJ – anti-trust authorities

Why: 10 years of limited ACO Commitment by H&HS's with marginal results

H&HS's "Innovator's Dilemma"

- The Dilemma: Drive maximum from todays business model even as I see tomorrow's innovative business model taking root – I can't make the decision to disrupt myself.
- The Result: Incumbent gradually loses to aggressive innovators who are unencumbered by yesterday's business model.
- H&HS – could be left with the least profitable and dwindling inpatient segments
- *"Managers of industry-leading businesses need to watch vigilantly in the right places to spot these trends as they begin because the processes of commoditization and de-commoditization both begin at the periphery, not the core."*

Can H&HS's be effective as hybrid organizations?

- Robbie Pearl MD – Former CEO Permanente Medical Group:

  "*. . . a hybrid model never works. You get picked off on both sides. Fee for service can do it better than you can do it because you're not willing to make the bad trades that fee for service requires, and the capitation people come by because you have all the inefficiency of that side upon you.*"*

- Greg Adams, CEO Kaiser on Risant Health:
  - "*. . . how do we bring so much of what we have into those community health systems and help them . . . stay connected to the community and achieve the kind of outcomes and the kind of health that we are we've achieved . . .* "

*Beckers Hospital Review August 17,2023

Which future do you prefer?

- Continue fighting with insurers to get adequate funding and let them determine what you will be and do?
- Become the community provider of inpatient care?
- Take Accountability for Total Cost of Care and Outcomes to meet the broader needs of your community?

Why engage and lead Equity & Value Transformation

- Institutional Sustainability and Control
- Social Mission - improve health – not only provide hospital care
- Maintain a Mission Driven Health System in U.S.

Systems can work on Health Equity using the RWJ "Raising the Bar" Framework:

- Key Roles for Health Systems:
  - Provide Whole-Person Care to achieve Health Equity
  - Employ and Support a Diverse Workforce
  - Engage with Individuals and Organizations in the Community prioritizing those most affected by Inequities
  - Advocate for and Invest in Health Equity

  - See: Raising the Bar: Healthcare's Transforming Role

The only way to spend less on healthcare is to spend less

- Medical Costs: Spending less means providing fewer services and paying less per unit of service
- Administrative Costs - Decrease from 20-30%
- Higher quality care has not been shown to be the cure for high costs – despite 30 years of talking about it!

- Conclusion:
  - Providers will have to be paid less - and differently
  - H&HS's need to transform to become high value providers

How might a High Value H&HS look different?

	Today	High-Value Health System
Patient Population Served	Those needing acute care	50% - PCP Attributed ; 50% - Acute Care
Overall Reimbursement	Fee for Service (FFS)	50% Capitated for Total Cost of Care; 50% Acute Episode Based Payments
Primary Care Payment	Fee For Service	Capitated
Employed Physician Compensation	RVU Incentives increases services	Salary with quality bonus, no RVU incentives; only necessary services
Employed Physicians Payment	Facility Based	Office Based
Outpatient Services	Hospital based – high cost	Freestanding – lower cost/capital light
Emergency Room	Preferred referral site	Last Resort/Urgent Care Sites
Acute Hospital Services	Preferred site of care	Last Resort Site of Care/Hospital at Home
Appropriateness Screening	None	Routine for most procedures

Major barriers to Value Transformation

- Internal
  - Today's Financial Challenges
  - "Status Quoism"
  - Fear of self-disruption

- External:
  - Limited Payer Commitment
  - Policy Maker view of non-profits
  - Competition

There are many No-Regret Strategies

- Build Primary Care Network to grow accountable population
- Build low-cost outpatient network
- Build Care Coordination across the system – including hospitals
- Grow Attributable Population
- Build Relationships with other Accountable entities
- Consider owned MA Plan or partner with insurer
- Decrease Cost of Production
- Continue digital transformation
- Participate in Medicare ACO Programs
- Participate in Medicare Episode Based Payment Program (BPCI)
- Build Analytical Capabilities

And other strategies that will impact current results

- Invest to build an effective population health platform
- Change Physician Compensation – no RVU incentives
- Eliminate Facility based billing for professional services
- Install Appropriateness Screening System
- Shift capital investments towards a non-hospital based delivery system
- Advocate for movement from State and Federal Government
- Advocate for movement from ultimate payers - employers

But the most potent driver is Total Cost of Care Risk Contracts – particularly capitation

- Medicare Advantage Plan
- MA Contracts with other insurers
- Medicare ACO Tracks
- Commercial ACO Contracts
- Episode/Bundled Payments

If you don't take total cost accountability – are you prepared to work under those who do?

Boards need to understand and commit to the Transformation Strategy

- Change is hard
- Institutions don’t like change
- Status quo obstruction scales with organizational size
- Transformational change requires CEO leadership and Board Commitment

Two Areas of Attention for Boards

- Internal - System Transformation Strategy, Commitment and Execution
- External - Advocacy to create a reasonable business opportunity

Key Questions for the Board:

Strategy, Commitment and Execution:

1. Are we facing a fundamental shift in our business dynamics or is this just slow post-Covid recovery?
2. How are we different from for-profit institutions?
3. What is our strategic intent re Healthcare Equity and Value Transformation?
4. Are we really committed or just “dipping our toe”?
5. If we are committed, is the CEO visibly leading the initiative?
6. Do we have a clear strategic framework for addressing Health Inequities?
7. Do we have a clear strategic framework for Value Transformation?
8. Is our organizational structure conducive to this strategy?
9. What are the specific goals we will monitor what is the frequency of reporting to the Board?
10. How does the Organization overcome the core barriers to transformation?
11. How are our payer contracts aligned with the Value & Equity Transformation?

Key Questions for the Board:

Strategy, Commitment and Execution:

12. How will we ensure an adequate PCP base?
13. What is the size of our accountable population and how will we grow it?
14. What “no-regret strategies’ are we pursuing?
15. Are the internal incentive systems aligned with the Value Transformation and Health Equity objectives?
16. Do physicians get paid based on RVUs or number of procedures?
17. Do we have an appropriateness screening system in place?
18. Does the financial reporting system explicitly identify the expenses and revenue associated with these initiatives?
19. Are the resources provided for the Value and Health Equity objectives adequate to drive the desired results?
20. How are we making the cultural changes required to be successful?

External Advocacy: H&HS's need to become partners in change rather than the obstacle

- Pushing AHA/CHA to make this point nationally
- Congressional Engagement on these topics
- Direct Administration Pressure
- State and Local engagement re Payer issues
- Medicare Advantage Overpayments – leveling the playing field for ACO initiatives to avoid total MA conversion
- Engage on designing new systems that are sustainable rather than preserving unsustainable systems

Key Questions for the Board:

External Advocacy:

1. Do the Advocacy positions of the organization reflect the strategic commitment to Value and Equity Transformation at the local, state and national levels?
2. Does the AHA prioritize Value Equity Transformation?
3. How have we informed our Members of Congress of our need to be supported in this transformation?
4. How has the Board been involved in interacting with payers to ensure they are supporting our transformation?
5. Has the Board been involved in discussions with State leaders regarding support for Value Transformation?
6. Has the Board considered supporting more dramatic public policies?
   - Medicare for All
   - Public Option

Questions?

Virtual

Please enter your questions in the Ask a Question Box

Ask a question…

In-Person

1. Proceed to microphone stand
2. Provide us your name & location of your organization
3. Ask your question

Or submit your question through Live Q&A on the mobile app.