Strategic Partnerships

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UNCHCS CFO System Affiliations

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The Hype Cycle

Gartner, Inc. is an information technology research and advisory firm
UNC Health Care
Significant presence in competitive Triangle market

**UNC Hospitals**
Academic Medical Center in Chapel Hill, outpatient services across NC
- 829 staffed beds (829 licensed)
- >8,000 co-workers
- >1,100 attending physicians
- 780 residents
- >66,000 ER visits
- >28,500 surgeries

**REX Health Care**
Community health system in Raleigh, outpatient services across Wake County
- 665 staffed beds (665 licensed)
- >5,400 co-workers
- 111 employed physicians
- >60,000 ER visits
- >30,800 surgeries

**Chatham Hospital**
Community hospital in Chatham County
- 15 staffed beds (25 licensed)
- >200 co-workers
- 103 physicians on medical staff
- >14,500 ER visits
- 205 surgeries

**Johnston Health**
Community health system in Johnston County
- 147 staffed beds (199 licensed)
- >1,500 co-workers
- 247 physicians on medical staff
- >70,000 ER visits
- 6,650 surgeries

Pending due diligence, target close: Sept 2013
UNC Health Care
Growing footprint west of UNC Medical Center campus

<table>
<thead>
<tr>
<th>Community hospital in High Point, outpatient services in Guilford, Randolph, Forsyth and Davidson Counties</th>
<th>Community hospital in Hendersonville</th>
<th>Community hospital in Caldwell County</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 200 staffed beds (381 licensed)</td>
<td>• 100 staffed beds (222 licensed)</td>
<td>• 74 staffed beds (110 licensed)</td>
</tr>
<tr>
<td>• &gt;2,000 co-workers</td>
<td>• 1,200 co-workers</td>
<td>• &gt;880 co-workers</td>
</tr>
<tr>
<td>• &gt;270 attending physicians</td>
<td>• &gt;230 physicians on medical staff</td>
<td>• &gt;160 attending physicians</td>
</tr>
<tr>
<td>• &gt;63,000 ER visits</td>
<td>• &gt;31,000 ER visits</td>
<td>• &gt;30,500 ER visits annually</td>
</tr>
<tr>
<td>• &gt;6,400 surgeries</td>
<td>• &gt;6,700 surgeries</td>
<td>• &gt;5,300 surgeries annually</td>
</tr>
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</table>
We serve North Carolina. Everyday.
Opportunity to align newly affiliated community physician practices with UNC Physician Communities

**Community-based physician groups serving central NC**
- Primary and specialty care services—practices in Wake, Johnston, Orange, Chatham, Durham, Sampson, Wilson, Nash, Lee, Granville & Person
- 190 providers, 38 practices

**Faculty physician practice primarily serving UNC Hospitals**
- >1,100 primary and specialty care physicians
- 18 clinical departments
- Secondary, tertiary and quaternary care services

**Multi-specialty primary and specialty care physician group serving the High Point area**
- 71 providers, 15 medical specialties, 19 locations
- >215,000 clinic visits

**Multi-specialty primary and specialty care physician group service Caldwell county**
- 40 providers, 7 medical specialties, 11 locations
- >150,000 clinic visits
All the current issues we all face are magnified with reform actions.

- Overtime
- Board of Trustees
- APC
- Billing Errors
- Regulation
- HMO
- Managed Care
- Audits
- DRG
- Budget
- Cash Flow
- Investment Losses
- POS Collections
- Managed Care
- Long-Term Viability
- Staffing
- Productivity Standards
- Reimbursement
- Bad Debt
- Staffing
- 24-Hour Coverage
- Long-Term Viability
- Care Management
- Charity
- Capital Needs
- Medicare
- Recruitment
- Medicaid
- Preauthorization
- Coding
- Capitation
- Settlements
- Benefits
- Recovery Audit Contractors
- Healthcare Reform
- Operating Margin
- Self-Pay
- Medicare
- Denials
- settlements
UNC Health Care is like many other institutions

State Issues
- University Cancer Research Fund
- Med School expansion
- Med School expansion (Wakebrook)
- Not-for-profit tax treatment
- State Benefits Cost Increases
- Unemployment Payroll Tax 1%
- National Institutes of Health (NIH)

National Issues
- UNC Appropriations Eliminated
- SODCA (tax refunds)
- Medicaid Managed Mental Health
- Medicaid reform
- Fund Balance
- Return UNC Hospitals uncompensated care cost to General Fund
- Workers Comp rate cuts
- Medicare rate cuts under sequestration

Department Public Safety
- Indirects
Healthcare core business models must evolve to meet these new era challenges

Declining revenues
- Baby boomer transition to Medicare
- Underfunded Medicaid
- State/Federal budget deficits
- Commercial rates decline
- Reduction in research funding
- Reduction in funding for resident training

Healthcare reform
- Shift from fee for service to new care delivery and payment models based on value
- Increased coverage of the uninsured
- Speed of change uncertain

Increasing demand
- Rising prevalence of chronic disease
- Population aging and living longer
- Newly insured Medicaid and health insurance exchange patients may strain available capacity
Our mindset must shift to creating value

Better health is the goal, not more treatment
Better health is inherently less expensive than poor health

Health outcomes = the full set of patient health results over the care cycle
Costs of delivering outcomes = the total costs of care for a patient’s condition over the care cycle

Source: Value-Based Health Care Delivery; Michael E. Porter, June 22, 2011
At the same time, we must create a sustainable future under Medicare margins

Payment models and care delivery models will transform reimbursement and force revenues toward Medicare levels
*(Timing and magnitude of shift uncertain, preparation is critical)*

Costs must decrease ~30%

Fee for service

Today → 2020?

New payment models

-30%
To transition, organizations must build managerial capabilities along three dimensions of integration simultaneously.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrating a broader network</td>
<td>Provide health care across the continuum in multiple settings</td>
<td>• Pre-acute through post-acute&lt;br&gt;• Primary through quaternary care&lt;br&gt;• Urban, suburban and rural&lt;br&gt;• Academic and non-academic</td>
</tr>
<tr>
<td>Operational and data integration</td>
<td>Enable collaboration within and across the network</td>
<td>• IT integration&lt;br&gt;• Process design and standardization&lt;br&gt;• Organization and incentives</td>
</tr>
<tr>
<td>Financial integration</td>
<td>Change reimbursement models and align incentives</td>
<td>• Pay-for-performance&lt;br&gt;• Provider contracts with employers</td>
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</tbody>
</table>
And recognize that realignment is needed to be positioned for success

**Bigger systems**
- Achieving appropriate scale leads to lower per-episode costs and greater market share
- Extension of administrative expertise
- Expanded IT infrastructure

**Scope**
- Managing and improving quality
- Delivering care in the right setting
- Coordination of care more efficiently

**Alignment & Integration**
- Providing new ways to lower costs
- Expand clinical research opportunities
- Evolving care integration models
- New reimbursement models

**New Models**

How many independents will there be in 5 years?
Partnership relationships should be structured to maximize incentives for both parties

Source: Kaufman Hall & Associates
It’s not just about integrating acute care any longer

<table>
<thead>
<tr>
<th>Primary care</th>
<th>Acute care</th>
<th>Post-acute care</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCHI</td>
<td>BWH</td>
<td>SPAULDING</td>
</tr>
<tr>
<td>Partners Community Healthcare Inc.</td>
<td>BRIGHAM AND WOMEN’S HOSPITAL</td>
<td>REHABILITATION NETWORK</td>
</tr>
<tr>
<td>Supports &gt;5500 physicians</td>
<td>NEWTON-WELLESLEY HOSPITAL</td>
<td>Rehab, Skilled Nursing</td>
</tr>
<tr>
<td></td>
<td>MGH</td>
<td>PARTNERS AT HOME</td>
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<tr>
<td></td>
<td>GENERAL HOSPITAL</td>
<td>Home Health, DME</td>
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<td></td>
<td>NSMC</td>
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<tr>
<td></td>
<td>NSMC</td>
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</tr>
<tr>
<td></td>
<td>NANTUCKET COTTAGE HOSPITAL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>McLean Hospital</td>
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Integrated systems, including data systems, offer
- **Patients**: continuum of care
- **Physicians**: bargaining power with insurers, supply chain, efficiency
- **Insurers**: assurance that quality care is being administered at a reasonable cost
## Systems in NC are using different models for alignment

<table>
<thead>
<tr>
<th>Types of Transaction</th>
<th>Method</th>
<th>Target Hospital</th>
<th>Level of Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acquisition</td>
<td>• Direct purchase</td>
<td>• Attractive NC community hospitals</td>
<td>• MOU signed with 2 hospitals recently</td>
</tr>
<tr>
<td>• Hospital management</td>
<td>• Mgmt agreement</td>
<td>• Community hospitals in multi-state region</td>
<td>• 2009 renewal of Durham Regional agreement</td>
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<tr>
<td></td>
<td>• Partnership with for-profit LifePoint</td>
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<tr>
<td></td>
<td>• CHS Management Company structures deals</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Acquisition (primarily)</td>
<td></td>
<td>• Recently announced deal in Georgia</td>
</tr>
<tr>
<td></td>
<td>• Hospital management</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Direct purchase with cash from operating and bond activity</td>
<td></td>
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</tr>
</tbody>
</table>

- **Duke University Health System**
  - Acquisition
  - Hospital management
- **Carolinas HealthCare System**
  - Acquisition
  - Hospital management
- **Novant Health**
  - Acquisition (primarily)
  - Hospital management

- **Recent Activity**
  - 15+ deals since 2008
### Changing care models are emerging in our local market

#### Bundled payment program

**Example:**

- Collaboration to offer bundling for knee replacements beginning April 2011
- Single payment for episode spanning 30 days pre-admit to 180 days post-op
- Physicians accept upside and downside risk

#### Innovative provider-payer partnership

**Example:**

- Three-year pilot medical practice collaboration to target chronically-ill plan members
- Targeting 5K enrollees over time
- Cost sharing model focused on outcomes
- Use of technology to promote innovative care management to improve outcomes
## Innovative health care models improve outcomes while also lowering costs nationally

<table>
<thead>
<tr>
<th>Providers partnering with large employers</th>
<th>Providers testing new types of payer contracts</th>
<th>Cities partnering to improve resident health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Example:</strong> Lowe's partnering with Cleveland Clinic</td>
<td><strong>Example:</strong> Mount Auburn Hospital AQC contract with BCBS Massachusetts</td>
<td><strong>Example:</strong> Healthways and Blue Zones partnering with CA beach cities to improve vitality</td>
</tr>
</tbody>
</table>

**Lowe's partnering with Cleveland Clinic**
- Bundled rates for complex cardiac procedures
- Employees benefit from waived cost-sharing and covered travel expenses
- Lower readmissions, high-quality care

**Mount Auburn Hospital AQC contract with BCBS Massachusetts**
- Per patient global budget with performance incentives
- First year results showed quality improvements vs. non-AQC control group
- Providers met cost budgets
- Reduced readmissions and non-emergent ER visits

**Healthways and Blue Zones partnering with CA beach cities to improve vitality**
- Program based on study of ten high-longevity cities
- First test city (Albert Lea, MN):
  - average weight loss of 2.8 lbs
  - life expectancy gain of 3.2 years
  - Health care costs among city workers down 49%
At UNC Health Care, we framed our responses to these challenges in 6 areas

<table>
<thead>
<tr>
<th>Leverage unique market position</th>
<th>Innovate care delivery &amp; payment models</th>
<th>Continue improvement initiatives</th>
<th>Become more efficient</th>
<th>Align incentives &amp; integrate</th>
</tr>
</thead>
</table>

Strengthen Business Intelligence/Warehouse capabilities
## Align with capital capacity to determine System strategy

### Business Segments
1. Strategic importance
2. Current position
3. Desired future state
4. Planned tactics
5. Required current investment
6. Implementation timeline

### Financial Plan
1. Prioritized capital plan
2. Identify key operating and financial assumptions
3. Pro forma 5-year financial statements
4. Forecasted debt capacity
5. Establish financial goals

### Master Facility Plan
1. Current state
2. Desired future state
3. Required investment
4. Implementation timeline
Common needs that can be addressed in a System approach

<table>
<thead>
<tr>
<th>Challenges identified by stand-alone facilities</th>
<th>Benefits of a System Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Value-based reimbursement</td>
<td>Share fiscal and clinical management methods utilizing quality data (e.g. HCAHPS)</td>
</tr>
<tr>
<td>2. Information technology investment &amp; functionality</td>
<td>Support infrastructure capability and readiness assessments and development of IT roadmap</td>
</tr>
<tr>
<td>3. Physician and staff recruitment and retention</td>
<td>Share best practices resulting in high employee satisfaction and faster recruitment of professionals</td>
</tr>
<tr>
<td>4. Hospital / Physician Integration</td>
<td>Share lessons learned from physicians and administrators integrating across our system</td>
</tr>
<tr>
<td>5. Profitability and capital</td>
<td>Leverage strong balance sheet positions and competitive market position to support growth</td>
</tr>
</tbody>
</table>
System strategy recognizes need to reprioritize efforts in advance of rapid environmental changes

- Mission
- System strategy
- Guiding Vision

**Capabilities and culture**
- Competitive positioning
- Constraints and risks

**Core Business Model**
- Outcomes
- Cost
- Safety

**Functional Integration Strategies**
- e.g. Finance

**Information Services**
- EMR
- Analytics

**Network**
- Scale
- Scope

**Innovation**
- Business model
- How we work

**Clinical portfolio**

<table>
<thead>
<tr>
<th>Institutions / settings</th>
<th>Service lines</th>
</tr>
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</table>

**Partnerships**
- State of NC
- Insurers
- Other Healthcare

**Governance**
- Level of system-ness/centralization

**State and university mandates**

**Financial strategies**

**Research**

**Teaching**
System strategy recognizes need to reprioritize efforts in advance of rapid environmental changes

- **Mission**
- **System strategy**
- **Guiding Vision**

**Network**
- Scale
- Scope

**Innovation**
- Business model
- How we work

**Core Business Model**
- Outcomes
- Cost
- Safety

**Functional Integration Strategies**
- e.g. Finance

**Information Services**
- EMR
- Analytics

**Clinical portfolio**

**Service lines**

**Institutions / settings**

**Financial strategies**

**Partnerships**
- State of N C
- Insurers
- Other Healthcare

**Governance**
- Level of system-ness/centralization

**State and university mandates**

**Research**

**Teaching**

**Capabilities and culture**

**Competitive positioning**

**Constraints and risks**
The best strategic partner may not be the largest

2011 net revenue ($B) of Larger NC Health Systems

<table>
<thead>
<tr>
<th>Health System</th>
<th>Current Net Revenue</th>
<th>Pending Net Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alamance Regional, Moses Cone</td>
<td>6.5</td>
<td>1.4</td>
</tr>
<tr>
<td>Novant Health</td>
<td>3.8</td>
<td></td>
</tr>
<tr>
<td>UNC Health Care</td>
<td>2.8</td>
<td>0.3</td>
</tr>
<tr>
<td>Johnston Memorial</td>
<td></td>
<td>2.8</td>
</tr>
<tr>
<td>Duke Medicine</td>
<td>2.5</td>
<td></td>
</tr>
<tr>
<td>Vidant Health</td>
<td>1.4</td>
<td></td>
</tr>
<tr>
<td>Mission Health System</td>
<td>1.1</td>
<td></td>
</tr>
<tr>
<td>Wake Forest Baptist Health</td>
<td>1.0</td>
<td></td>
</tr>
</tbody>
</table>

Source: S&P Capital IQ, various news sources, annual reports and estimates
Note 1: Novant Health includes net patient revenues from operations in NC, SC, VA an GA
Note 2: Duke Medicine includes $56M net patient revenues from DukeLifePoint owned hospitals
UNC Health Care believes in keeping care local and making complementary services accessible

- **Maintain community identity**
  - Empowered local board
  - Nurtured hospital culture
  - Patient care kept in the community

- **Enhance capabilities**
  - Clinical service line enhancement
  - Management resources and tools
  - Scale and depth

- **Access academic strengths**
  - Highly sub-specialized care
  - Clinical research/trials
  - Culture of innovation
We structure relationships to maximize incentives for UNC Health Care and our partners

Management Services Agreement

Affiliation

Sale of minority interest (Joint Venture)

Joint Operating Agreement

Sale of controlling interest (Joint Venture)

Change of Corporate Member

Merger

Acquisition

Source: Kaufman Hall & Associates
Key elements of pre-close phase

Opportunity Assessment

- Alignment with Network strategy
- Financial health
- Market area
- Cultural fit

Request For Proposal

- Vision
- Experience
- Capabilities
- High-level terms

Letter of Intent

- Transaction structure
- Board composition
- Capital commitment
- Services

Due diligence / Definitive Agreements

- Liabilities
- Opportunities
- Final deal documents

Go / No Go Decision Points
Typical transaction process

Pre-Close

Opportunity assessment
Request for proposal
Letter of intent
Due diligence
Definitive agreement

Post-Close

Leadership engagement
Integration framework
Opportunity planning/execution
Relationship development
Optimization
Post-Close achievement requires significant effort

## Goals for affiliated entities

<table>
<thead>
<tr>
<th>Execute physician strategy</th>
<th>Improve revenue capture</th>
<th>Reduce operating costs</th>
<th>Reduce outmigration</th>
<th>Evolve HCS identity</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Build Medical Staff capabilities</td>
<td>• Strengthen revenue cycle policies and processes</td>
<td>• Centralize select functional areas</td>
<td>• Reestablish competitive position</td>
<td>• Align information systems and processes</td>
</tr>
<tr>
<td>• Enhance local capabilities</td>
<td>• Position Medical Center to support clinical programs/services</td>
<td>• Engage Value Teams</td>
<td>• Strengthen relationships with community physicians</td>
<td>• Align People services and offerings</td>
</tr>
<tr>
<td></td>
<td>• Prioritize service line development/enhancement</td>
<td>• Outsource functions</td>
<td></td>
<td>• Move towards common branding</td>
</tr>
<tr>
<td></td>
<td>• Enhance clinical documentation</td>
<td>• Renegotiate/align contractual agreements</td>
<td></td>
<td>• Expand academic mission</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Share clinical and administrative best practices</td>
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</tr>
</tbody>
</table>
## Aligned goals drive opportunity prioritization following a transaction close

<table>
<thead>
<tr>
<th>Affiliated entity goals</th>
<th>Expected outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Develop and execute physician strategy</td>
<td>Aligned and engaged physician groups; demonstrated market share growth and quality</td>
</tr>
<tr>
<td>2. Improve revenue capture</td>
<td>Overall net patient revenue growth and &gt; 3% operating margin annually and consistently</td>
</tr>
<tr>
<td>3. Reduce operating costs</td>
<td>Significant primary and secondary market value capture by end of year 5</td>
</tr>
<tr>
<td>4. Reduce outmigration</td>
<td>Enhanced local capabilities and stronger overall System</td>
</tr>
<tr>
<td>5. Evolve HCS identity while preserving local culture</td>
<td></td>
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</tbody>
</table>
### Proposed work plan: Functional Integration

#### Key topics

1. **What is the integration philosophy?**
2. **Which functions should we target to integrate, assuming that our preferred option is integration?**
3. **What returns/value do we expect and how will we measure?**
4. **What aspects of coordination and integration will future partners demand and require?**
5. **What organizational structures, processes and management are necessary to enable the integration?**

#### Key deliverables

- Organizational statement to guide functional integration decision making resulting in overall organizational value
- Develop list of priority focused clinical programs, ancillary services and support areas to integrate under common executive leadership for the Health Care System
- Recommend metrics, timelines and goals that will show functional integration is a success (value)
- Recommend additions or enhancements to leadership, physical and information technology needs
- Understand the implication of integration for future partners
Functional Integration Work Plan: Philosophy

Key topics

1. What is the integration philosophy?

Key deliverables

Organizational statement to guide functional integration decision making resulting in overall organizational value

Functional Integration Value Proposition

Integrated Entity

*will align clinical and support functions,*

*where it will yield improved outcomes,*

*and add value to the System.*
Clinical programs, ancillary services and support areas should be screened for integration potential...

Programs from all component units of new entity will be filtered for feasibility and potential enterprise impact.

The initial filter is based on metrics mutually determined consistent with the integration philosophy.

Resulting in potential areas for integration.

Intangible Check Point
Culture, Fit, Timing, External Concerns