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HEALTH ADVISORS

Evolution of AMC Funds Flow

Academic Medical Group Leadership Roundtable (AMGLR)

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Introductions

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Whitecap Health Advisors (Whitecap) is an advisory firm that focuses exclusively on strategic and financial planning for the healthcare provider sector. 60+% of our work is with academic medical centers

10 OF THE 20 2022-2023 US NEWS HONOR ROLL HOSPITALS

39 OF THE 71 NCI-DESIGNATED CANCER CENTERS

21 OF THE 50 LARGEST PUBLIC HOSPITALS (BECKERS)

72 OF THE 227 CHA AFFILIATED CHILDREN'S HOSPITALS & PROGRAMS

11 OF THE 20 2022 LARGEST HEALTH SYSTEMS BY REVENUE

9 OF THE 20 2023 US NEWS BEST MEDICAL SCHOOLS (RESEARCH)

SECTOR FOCUS

FUNCTIONAL EXPERTISE

	Academic Health Systems	Community Health Systems	Children's Hospitals	Cancer Programs	Public Hospitals	Rural Hospitals
Corporate Strategy	Penn Medicine	Allina Health	Children's Mercy	USC Norris Comprehensive Cancer Center	erlanger Health System	St. Anthony Regional Hospital
Network Development	Wake Forest Baptist Health	St. Elizabeth Healthcare	Children's Specialized Hospital (An RWJBarnabas Health facility)	CARTI	Jackson Health System	St. Croix Regional Medical Center
Partnerships & Affiliations	Yale NewHaven Health	Wellstar	Children's Minnesota	UC Davis Health	HarrisHealth System	Medi-Sota
Organizational Design & Funds Flow	MUSC Medical University of South Carolina	Franciscan Missionaries of Our Lady Health System	Children's Hospital New Orleans (LCMC Health)	PennState Health	Central Health	Vernon Memorial Healthcare
Capital Asset Planning	UNC Health	Providence Health & Services	MaryBridge Children's (MultiCare)	The University of Texas MD Anderson Cancer Center	Maricopa Integrated Health System	Riverwood Healthcare Center
Service Line Planning	UAMS University of Arkansas for Medical Sciences	Adventist Health	Children's Healthcare of Atlanta	UK HealthCare Markey Cancer Center	UMC University Medical Center New Orleans	Tri-County Health Care

Before We Get Started…

AMC Funds Flows Are Complex, but Don't Need to be Complicated

1. The tripartite mission is at the core of every AMC
2. The research and education missions are unlikely to become profit-drivers for the foreseeable future – no matter how efficient they become
3. AMCs will rely on clinical margin growth (health system + practice plan) to support institutional objectives, no matter how successful they are at diversifying revenue streams (e.g., philanthropy, commercialization)
4. For the foreseeable future, there will be downward pressure on payor rates, and upward pressure on expenses, making it harder to generate incremental clinical margin
5. In most markets, professional fees are insufficient to support practice plan expenses, placing even more of a strain on the technical fee stream
6. Every AMC is trying to (1) maximize the dollars coming into the enterprise, and (2) use resources as efficiently as possible. A well-designed funds flow model enables both
7. As an AMC's strategy evolves, its funds flows model must as well (there is no "ideal" model)

Before We Get Started…

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Which of the Seven Dwarfs best reflects your mood right now?

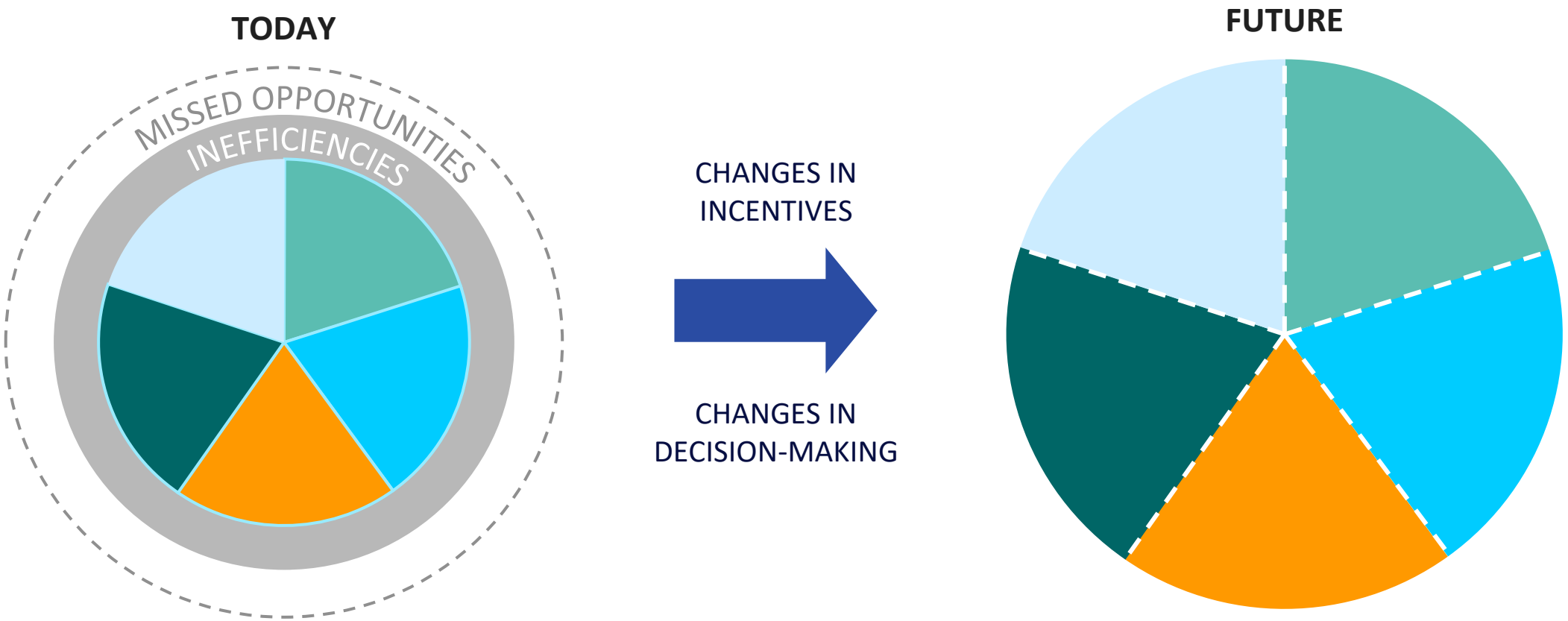
Use one word to describe your current funds flow model

How long has the current iteration/philosophy of the funds flow model in your organization been in place?

Linking Funds Flows Philosophies to Economics

Funds Flows – Money and Control

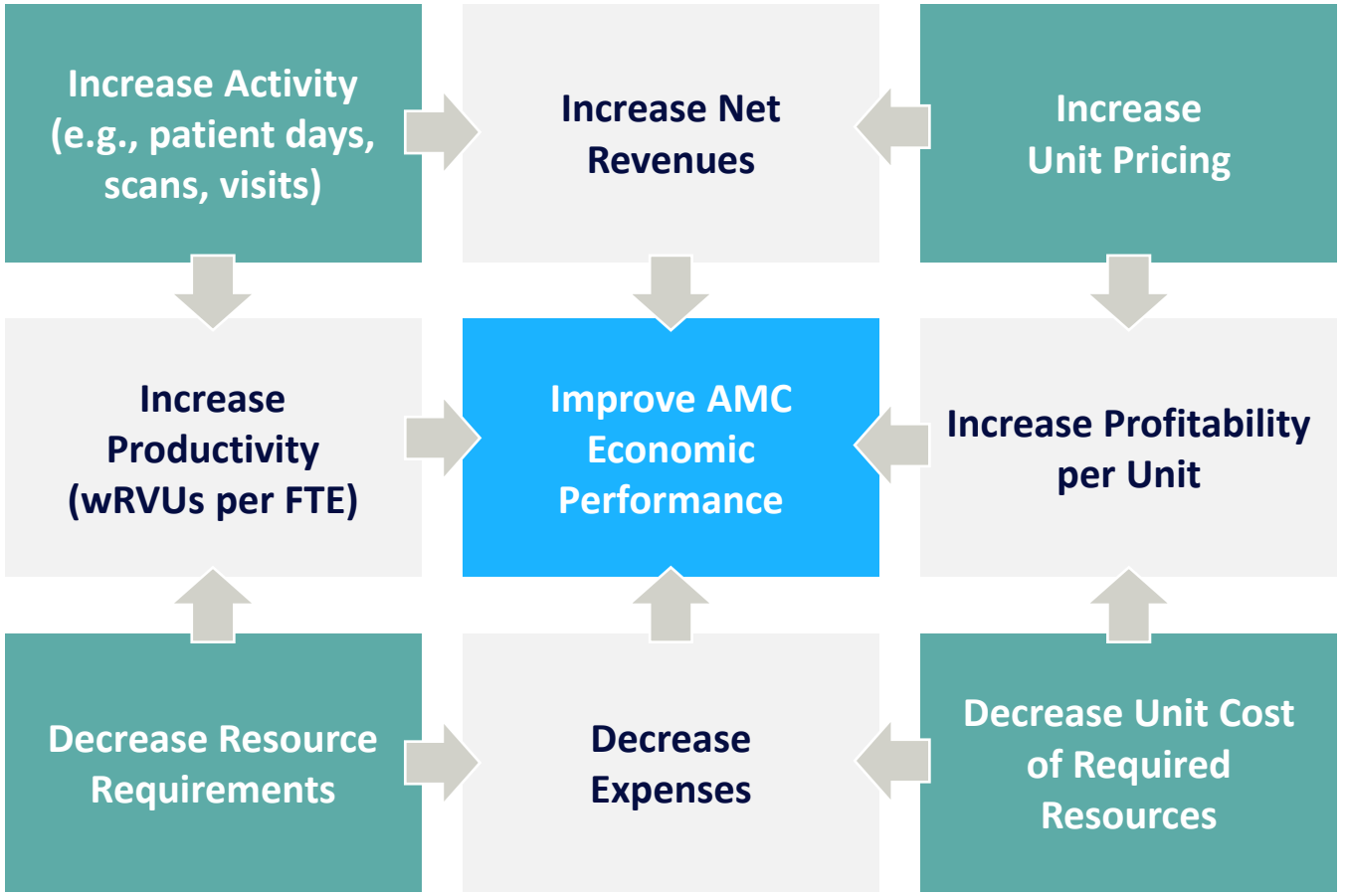
- Well-designed funds flow models use changes in incentives (money) and changes in decision-making (control) to try and "increase the size of the pie". Different funds flow models attempt to do this by emphasizing different levers



Funds Flows – Understanding AMC Economic Levers

Trends	$ Impact
Demographics	↑
Patient Acuity	↑
New Treatments	↑
M&A / Consolidation	↑
Value-Based Care	↓
Non-Traditional Competition	↓

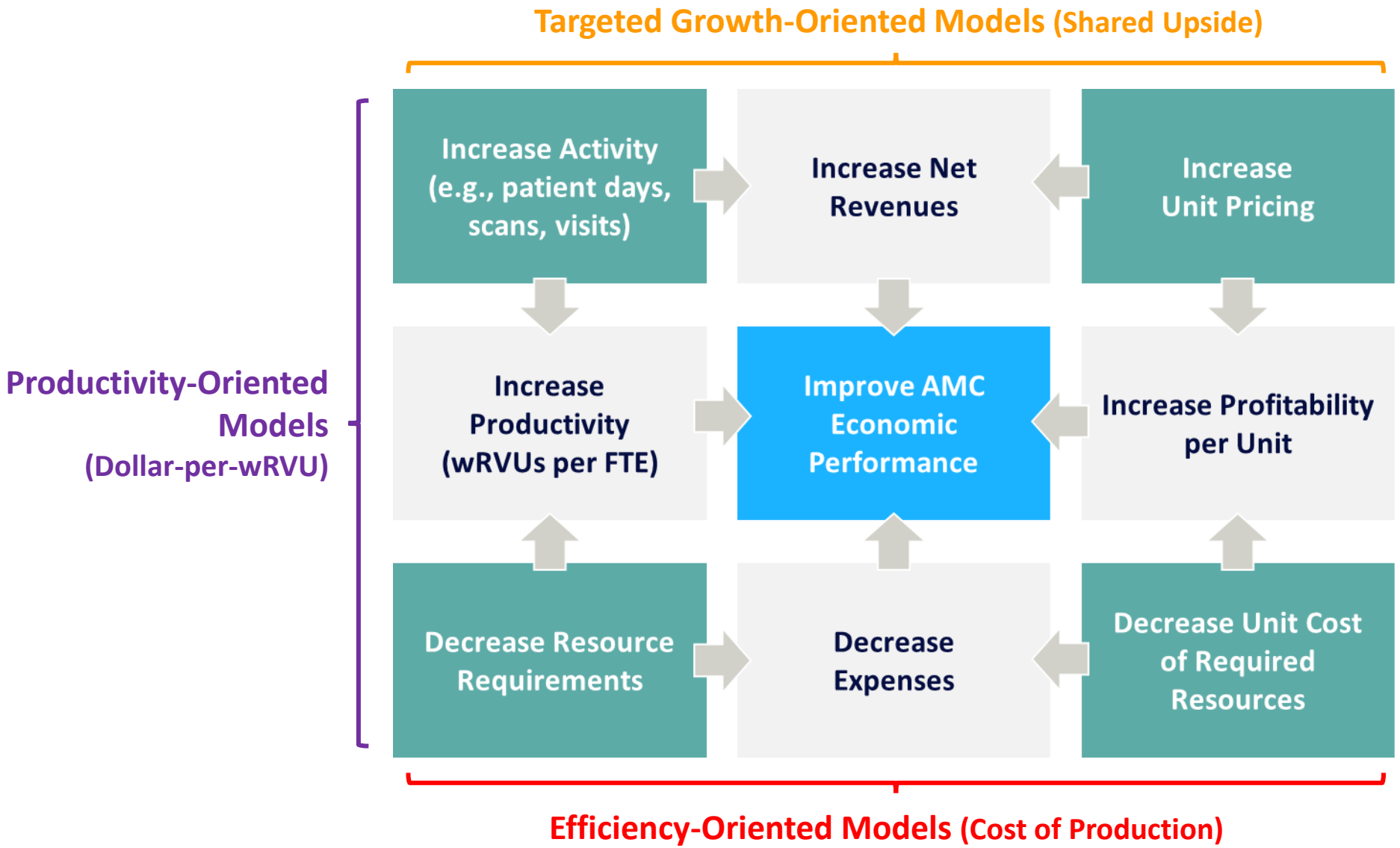
Trends	$ Impact
New Health Professions / Broader Scope of Practice	↑
Virtual/At-Home Models	↑
Automation / AI / ML	↑
Capacity Rationalization	↑
Patient Acuity	↓
Patient Consumerism	↓



Trends	$ Impact
New/More Complex Treatments	↑
Payor Mix Shifts	↓
Virtual/At-Home Models	↓
Non-Traditional Competition	↓
CMS Payment Pressure (e.g., Site Neutrality, 340B)	↓
Patient Consumerism	↓

Trends	$ Impact
Virtual/At-Home Models	↑
Supply Chain Optimization	↑
Labor Expense Escalation	↓
Agency/Temp Costs	↓
Supply/Drug Expense Escalation	↓
Cost of Capital	↓

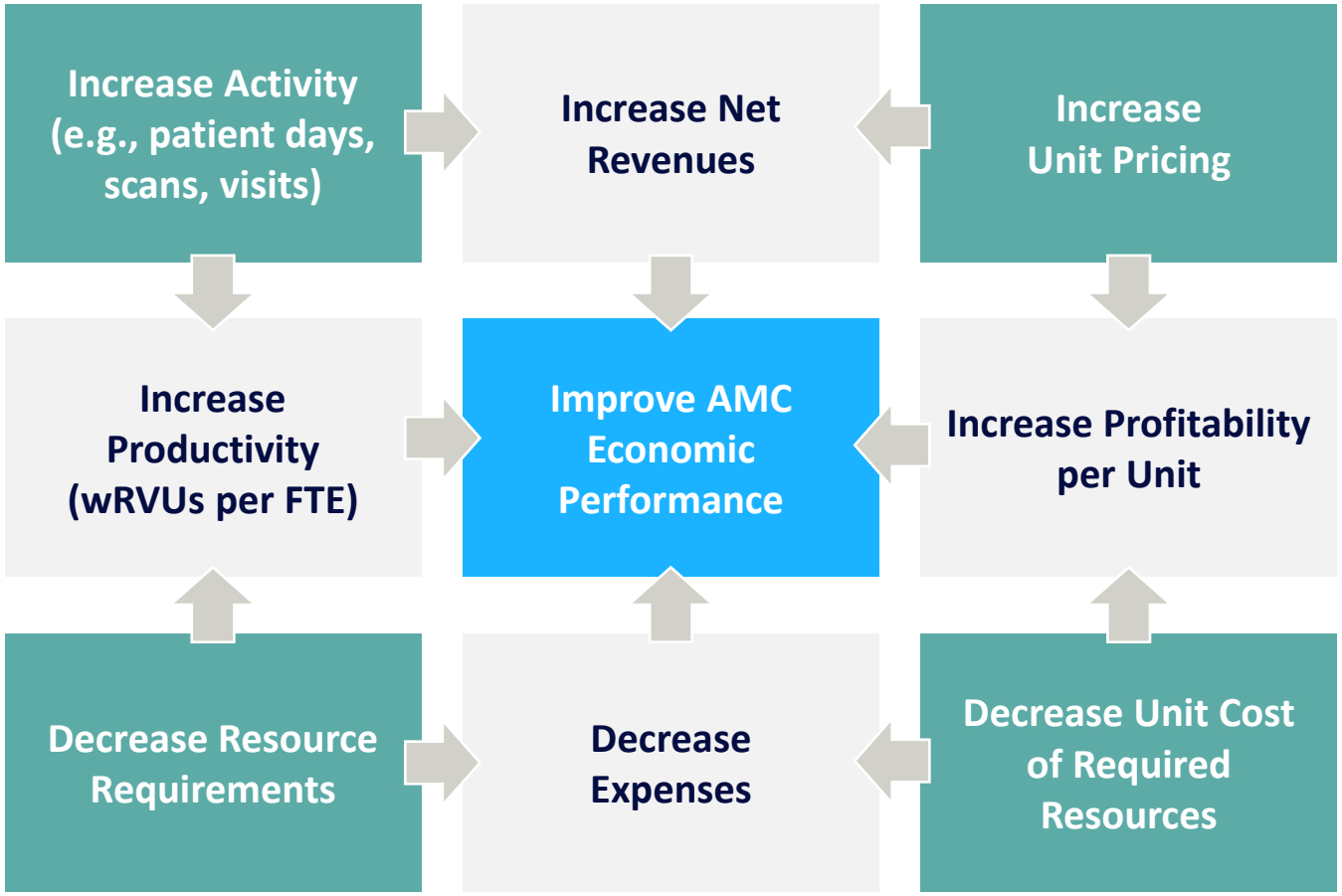
Funds Flows – Different Philosophies



Funds Flows – Current AMC Strategy

AMC Strategic Response

- Own Referral Channels
- Maximize Access / Convenience
- Consolidation / M&A
- Ambulatory as a Destination



AMC Strategic Response

- Centers of Excellence
- Payor Mix / Geographic Targeting
- Capture an Increasing Share of Premium Dollar

AMC Strategic Response

- Increase / Leverage Scale
- Care Team Structure (Scope of Practice)
- Optimize Service Distribution
- Asset Light / Technology Heavy

AMC Strategic Response

- Standardization
- Provider Compensation Strategy
- Workforce / Team-Based Care

Funds Flows – Different Philosophies

Key AMC Objectives / Priorities	Different Funds Flow Philosophies		
	Productivity-Oriented	**Targeted Growth-Oriented**	**Efficiency-Oriented**
Encourage clinical growth	+	++	-
Promote cross-departmental collaboration	-	++	-
Encourage innovation & entrepreneurialism	+	++	-
Provide appropriate rewards for departments that are more efficient with their resources	+	-	++
Encourage improvement in metrics other than wRVU production	-	+	++
Find the right balance between departmental autonomy and centralization	**More oriented towards departmental autonomy**	**Depends on underlying principles**	**More oriented towards centralization**
Transition to population health principles	+	-	++

Before We Get Started…

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Rank the four economic levers in terms of where your organization focuses its resources/efforts (highest to lowest)

Increase activity

Increase unit price

Decrease resource requirements

Decrease unit cost of required resources

In my organization, the practice plan does get a reasonable percentage of its clinical revenues from technical fee streams (i.e., not all technical fees flow to the health system)

… the Next Ten Years

… the Next Ten Years

Key Questions for Discussion

1. Where will clinical revenues enter the enterprise, and what will be included in future iterations of academic funds flow?
2. What level of research growth is desirable/affordable, and how do future funds flow models account for investment in the research mission?
3. How much AMC clinical revenue will truly be “at-risk” in ten years, and what are the implications for funds flow?

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Question 1: Where will clinical revenues enter the enterprise, and what will be included in academic funds flow?

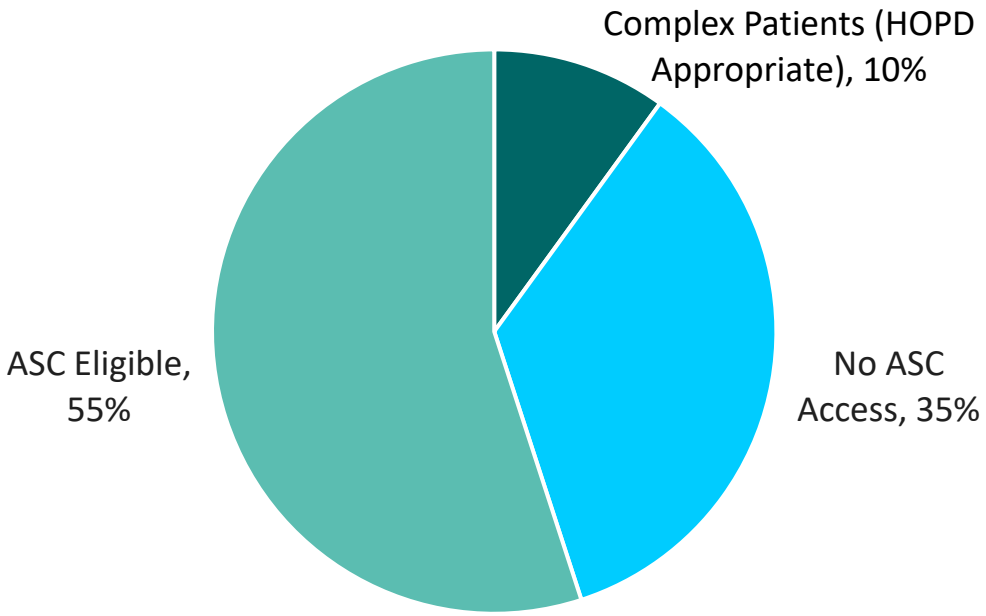
- HOPD Rates and 340B have pushed nearly all technical fee streams to the health system (hospital-license) and out of the practice plan. But payors, federal policy and consumers are all pushing in the other direction
- As AMCs continue to add outlying community hospitals and acquire private practice physician groups, there is resistance to using “community-focused” clinical margin to support the priorities of the tripartite mission

… the Next Ten Years

Question 1: Where will clinical revenues enter the enterprise, and what will be included in academic funds flow?

US Surgery Cases by Setting: IP vs. OP (2005-2020)

UHG Projected Surgical Mix by Location (2030)



UHG is targeting 55% of all member surgeries to be done in an ASC setting by 2030

Source: MedPAC, Life Science Intelligence, VMG Health, LEK Analysis; UHG

… the Next Ten Years

Question 1: Where will clinical revenues enter the enterprise, and what will be included in academic funds flow?

Harder to Grow Clinical Margin Organically, Even as the FTC Makes In-Market M&A Harder

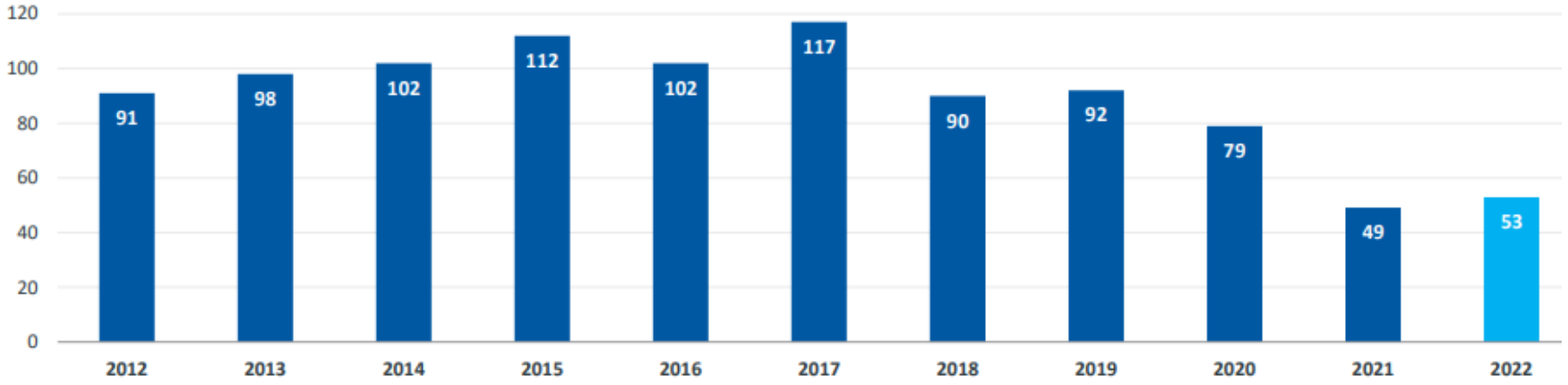
Shrinking number of deals

- Strained balance sheets
- Fewer “high-quality” candidates
- More FTC scrutiny

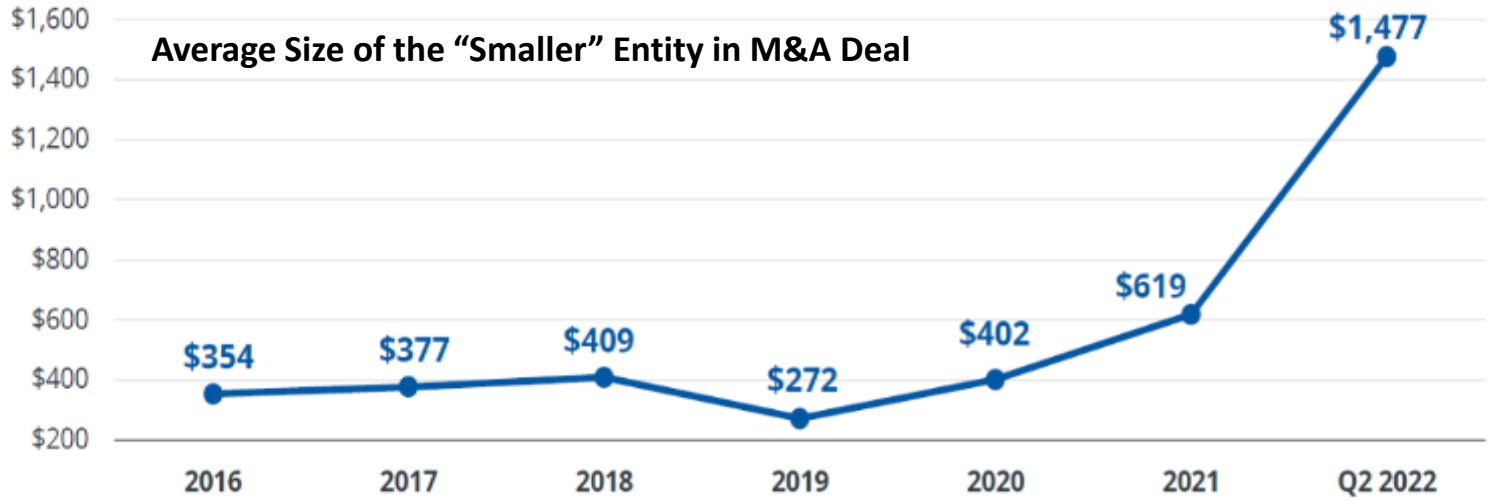
Increasing Deal Size/Mega-Mergers

- Cross-market M&A
- Limited Care Model Synergies
- No FTC challenges… yet

Number of Announced Transactions 2012-2022



Average Size of the “Smaller” Entity in M&A Deal



Source: Kaufman Hall

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Question 1: Where will clinical revenues enter the enterprise, and what will be included in academic funds flow?

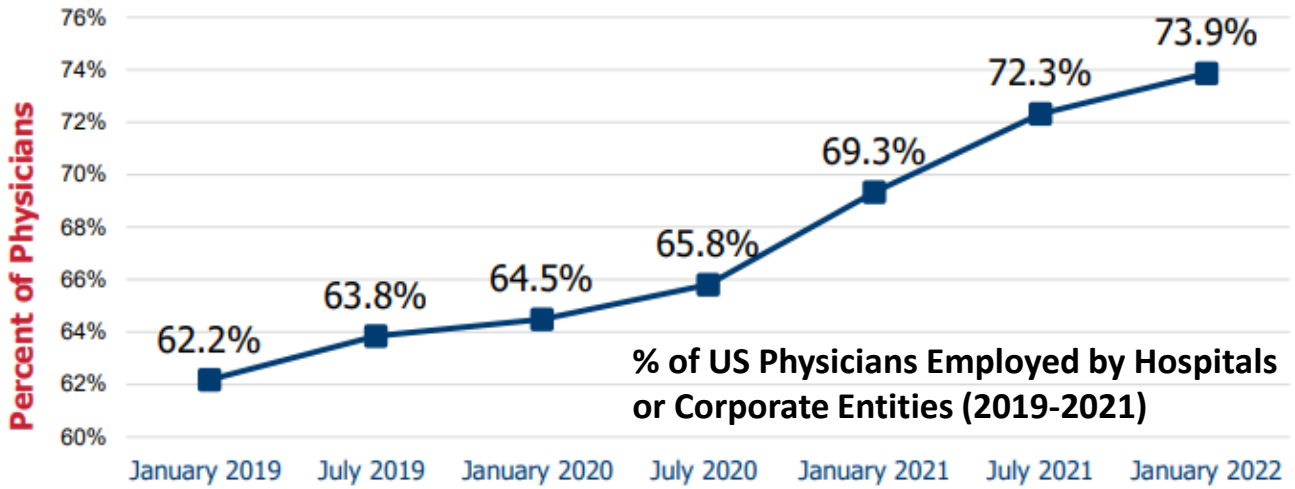
Evolving Characteristics of the Typical Faculty Practice Plan

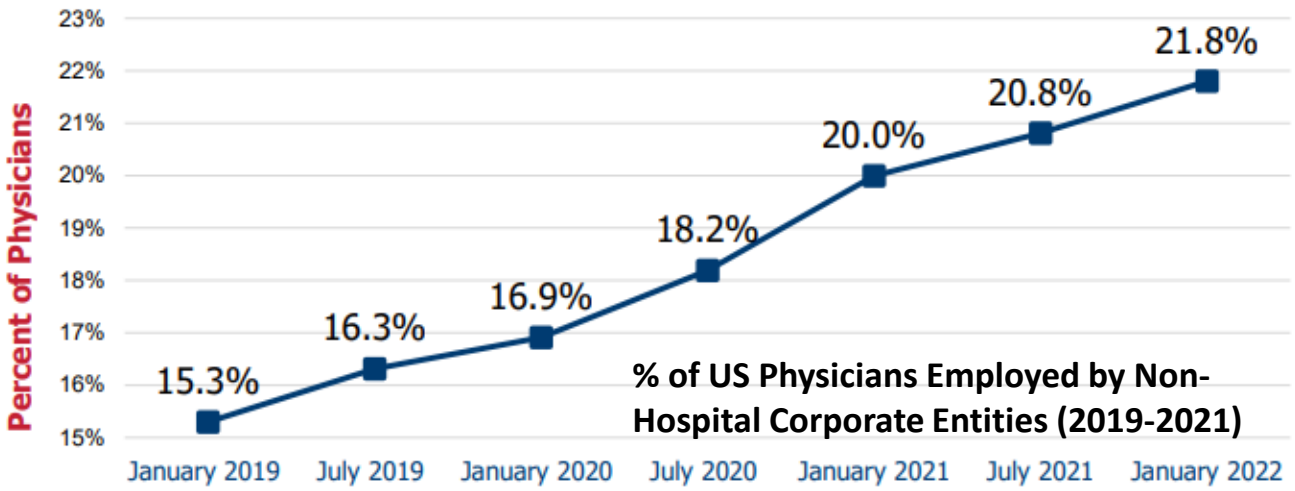
More "Community" Influence

- Fewer true "triple threats"
- More physicians (new grads and acquired private practice) focused predominantly on clinical care
- Comp plans focused on clinical effort
- Less willingness to support unproductive "protected" time

Health Systems Creating Alternative Platforms

- Belief that "academic model" is inefficient
- Unhappiness with "tax" and "tenure" model
- Belief that chairs/Deans tend to be research-focused, not as focused on clinical/business metrics





Source: PhysicianAdvocacyInstitute.org

Over the next ten years, I expect payor and/or regulatory pressure will require a substantial shift of clinical activity out of a hospital-licensed facility

In the next ten years, I expect M&A activity to significantly increase our clinical revenue base (i.e., acquisitions that grow the clinical revenue base by 20% or more)

Which of the following statements is more true in your organization?

My organization has created (or is the process of creating) an alternative physician employment vehicle that I believe will eventually compete with the specialists in the faculty practice plan

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Question 2: What level of research growth is desirable/affordable?

- The cost of research continues to escalate faster than research funding sources, and research investment comes with no guarantee of success (i.e., research publications, NIH funding)
- Correlation between the growth of the clinical enterprise and the growth in research funding is tenuous; and while the academic brand/mission is a competitive differentiator, there's no consensus regarding the true value of the "halo"

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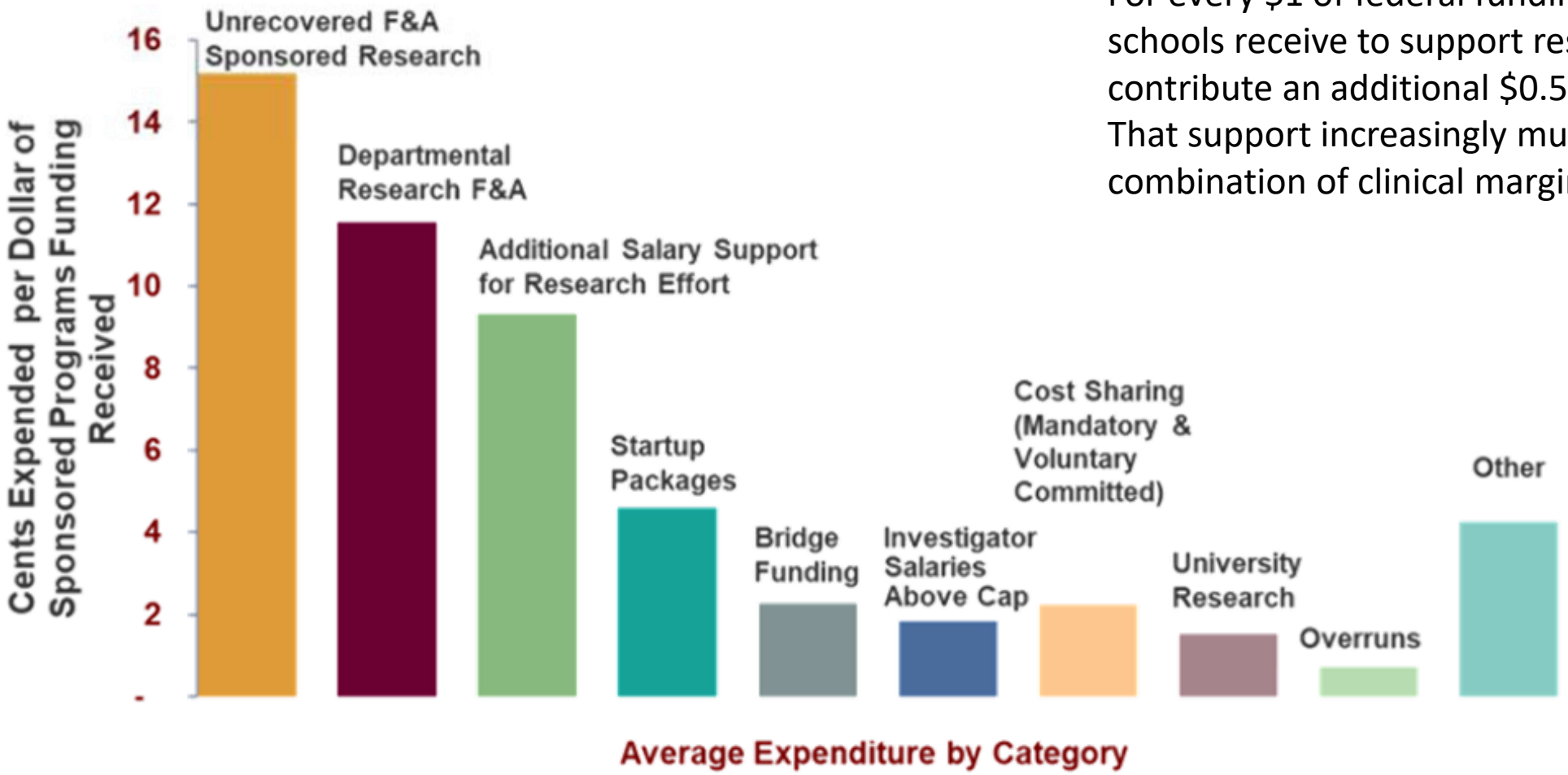
Question 2: What level of research growth is desirable/affordable?



- For every $1 of federal funding that medical schools receive to support research, they now contribute an additional $0.53 of their own funds. That support increasingly must come from some combination of clinical margin and philanthropy

Source: AAMC

… the Next Ten Years

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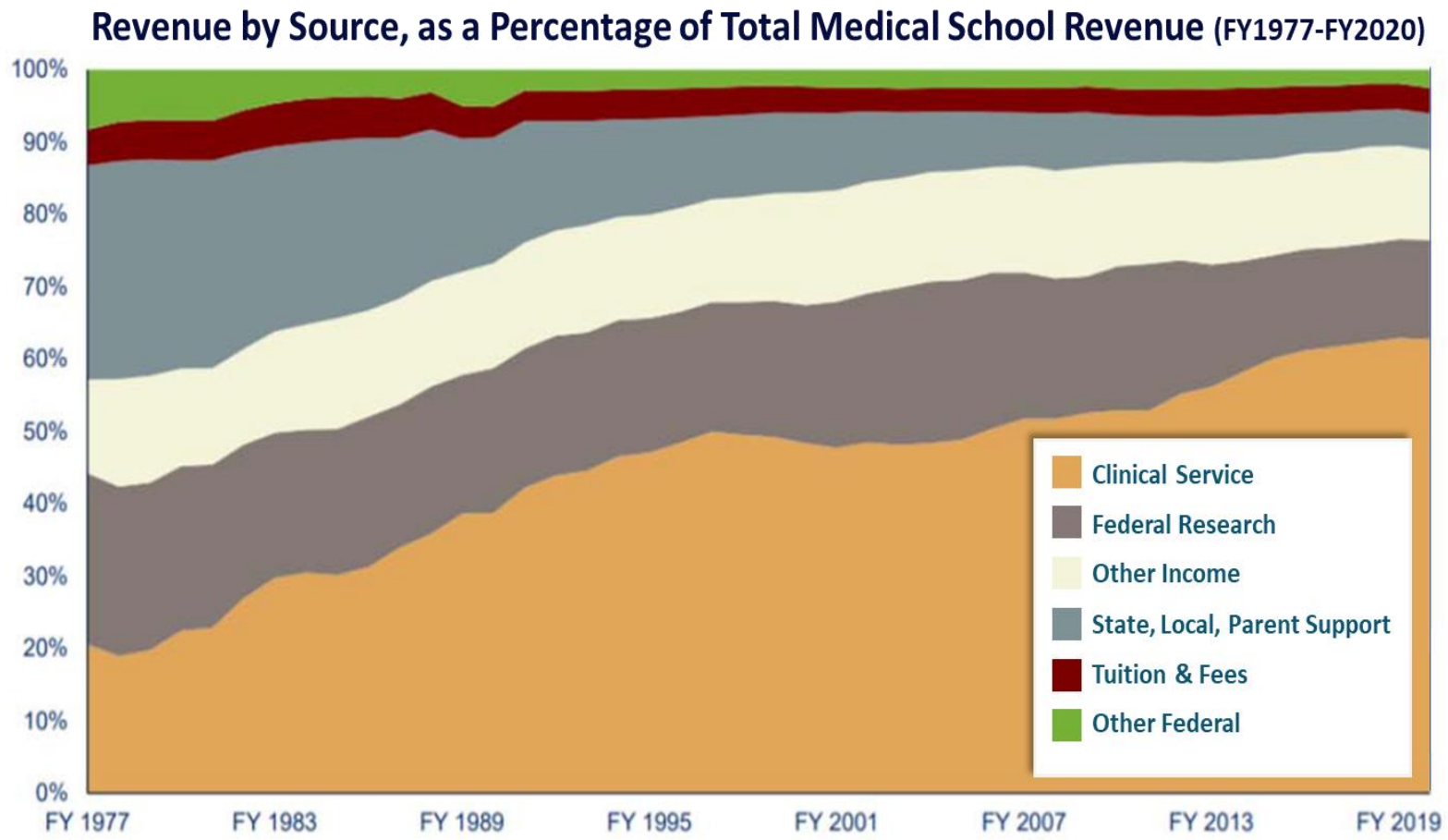

Characteristic	% Δ (rounded) 1960 to 2020
# of medical schools	70%
# of medical students	200%
# of residents & fellows	900%
# of full-time faculty	1,600%
SOM Revenues in millions	29,500%

Sources of SOM Funding	1960-61	2020-21
Federal Research (Grants/Contracts)	31%	13%
Other Gov't or Parent Funding	27%	4%
Tuition / Fees	6%	4%
Clinical Service	6%	63%
All Other (e.g., Gifts, Misc.)	30%	16%

Source: AAMC

… the Next Ten Years

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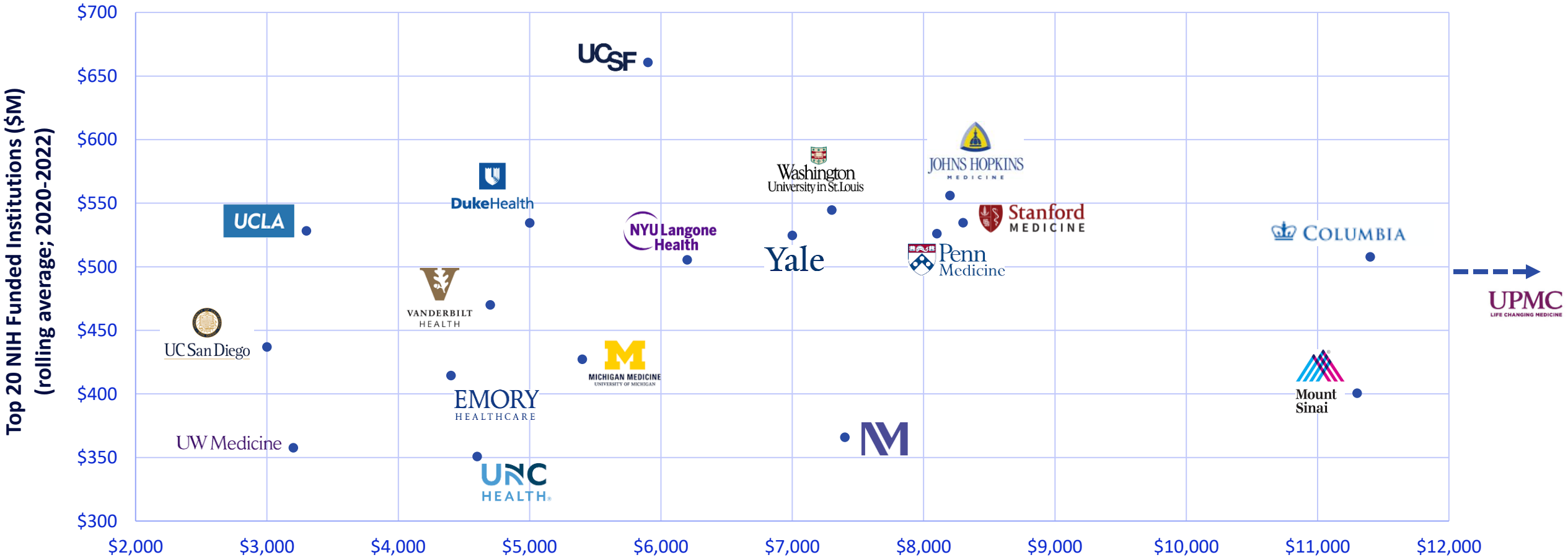

Source: NIH/BRIMR, Audited Financial Reports

… the Next Ten Years

Question 2: What level of research growth is desirable/affordable?

Institution	AMC 1	AMC 2	AMC 3	AMC 4	AMC 5	AMC 6	AMC 7
Clinical Enterprise Revenues	$2.9B	$1.7B	$1.1B	$1.3B	$1.8B	$1.3B	$1.6B
Clinical Enterprise Operating Margin	$111M	$29M	$53M	$31M	$83M	$28M	$118M
Clinical Enterprise Operating Margin %	3.7%	1.9%	4.9%	2.4%	4.7%	2.2%	7.4%
Clinical Support Funds Flow	$111M	$115M	n/a	$91M	$84M	$70M	$102M
Clinical Support Funding as % Clin. Enterprise Rev.	3.7%	6.7%	n/a	7.0%	4.8%	5.6%	6.4%
Academic Support Funds Flow	$18M	$14M	$53M	$24M	$39M	$10M	$6M
Acad. Support Funding as % of Clin. Enterprise Rev.	0.6%	0.8%	4.9%	1.8%	2.2%	0.8%	0.4%
Total Clin. + Acad. Support Funding as % of CE Rev.	4.3%	7.5%	4.9%	8.8%	6.0%	6.4%	6.8%

Source: Whitecap Health (does not include GME passthrough or payment for business activities)

My organization is committed to growing its investment in the research mission, and recognizes that much of this will come from clinical margin

My organization philosophically tries to grow its funds flow to support the research mission proportionately with clinical revenue

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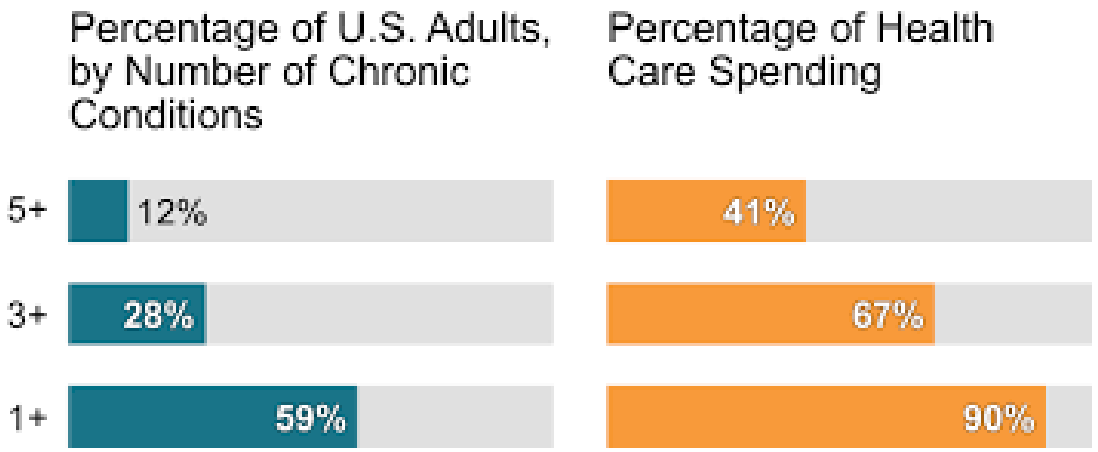
Question 3: How much AMC clinical revenue will truly be "at-risk"?

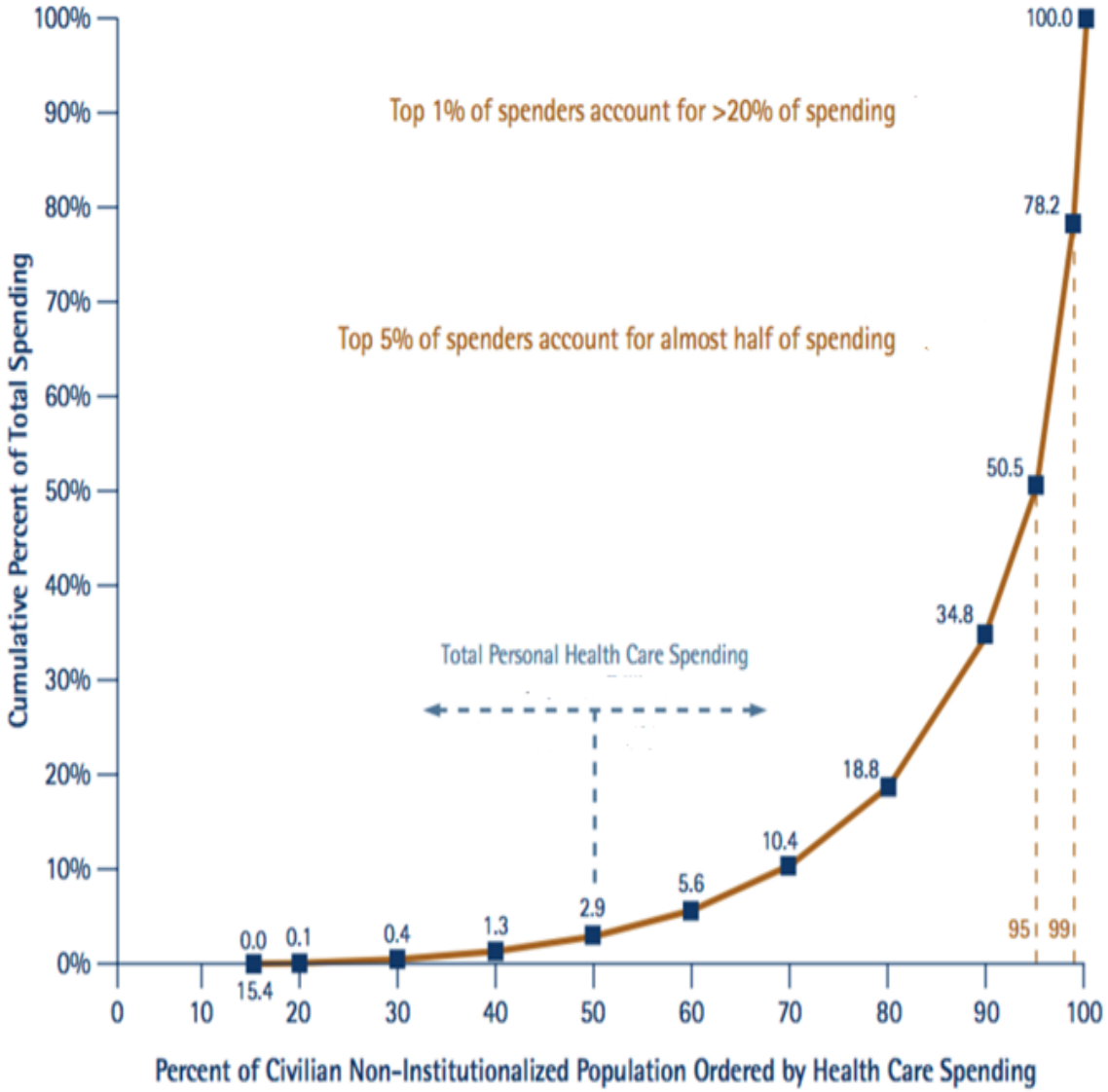
- Current funds flow models are still almost entirely oriented towards fee-for-service clinical revenue streams
- AMCs have complex patient populations that are difficult to risk-adjust (lots of outliers)
- Very few AMCs have successfully created their own health plans and have premium income that represents 25% or more of the total clinical revenue base

… the Next Ten Years

Question 3: How much AMC clinical revenue will truly be "at-risk"?

Anecdotally, AMCs disproportionately care for a much higher percentage of high-complexity patients with multiple comorbidities, which makes it much harder to risk-adjust





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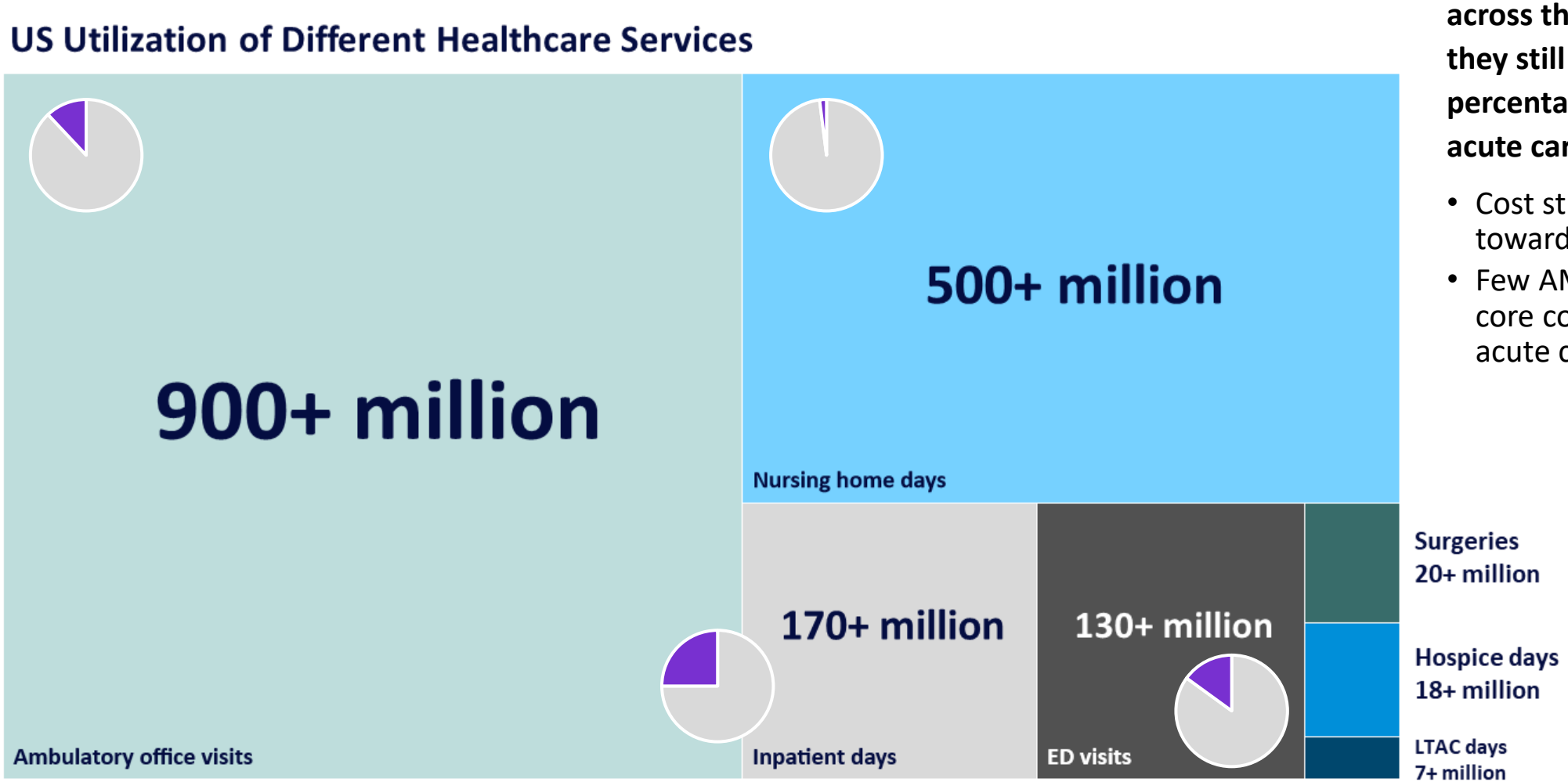

AMC have acquired assets across the continuum, but they still represent a small percentage of pre- and post-acute care capacity

- Cost structure still oriented towards complex care
- Few AMCs have developed core competency in post-acute care management

Source: CDC, Whitecap

… the Next Ten Years

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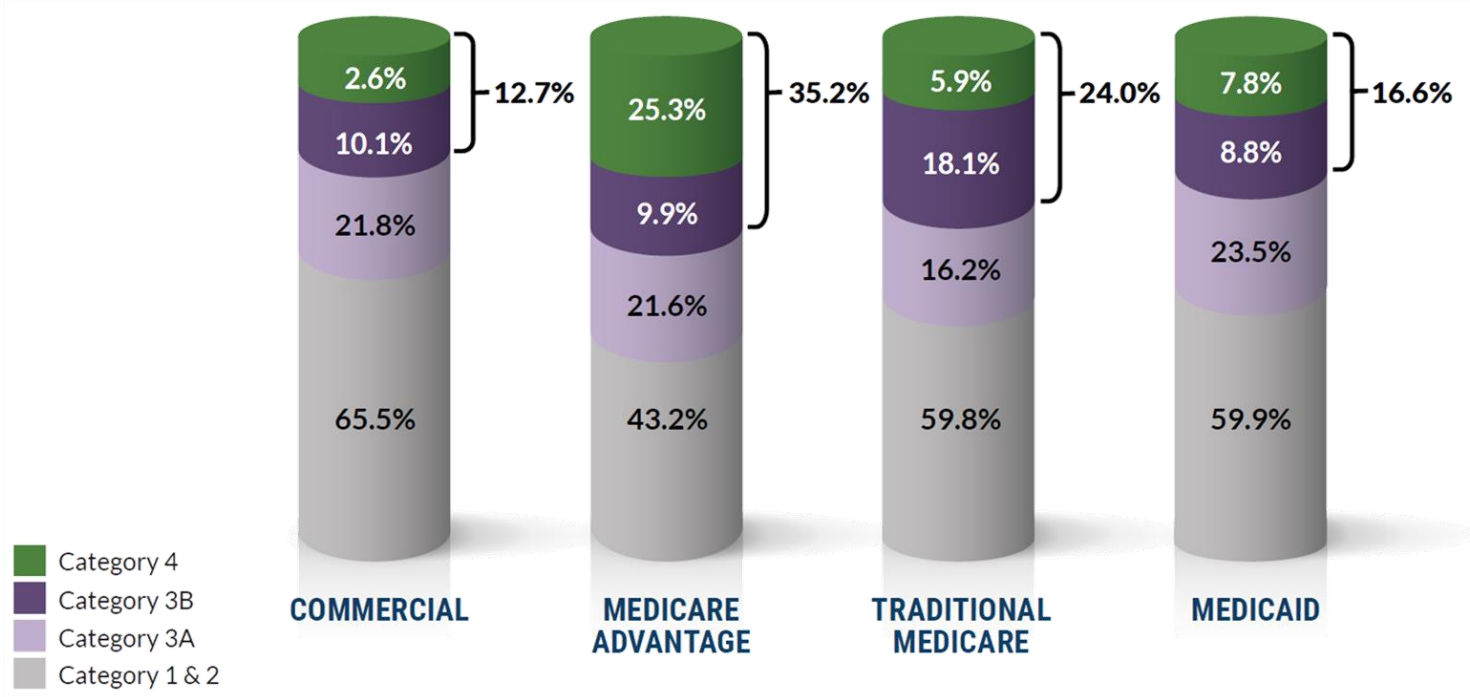

CATEGORY 1: *FEE-FOR-SERVICE - NO LINK TO QUALITY & VALUE*

40.5%

CATEGORY 2: *FEE-FOR-SERVICE – LINK TO QUALITY & VALUE*

A Foundational Payments for Infrastructure & Operations + B Pay-for-Reporting + C Pay-for-Performance

19.5%

CATEGORY 3: *APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE*

A Upside Rewards for Appropiate Care **20.4%**

B Upside & Downside for Appropiate Care **12.2%**

CATEGORY 4: *POPULATION-BASED PAYMENT*

A Condition-Specific Population-Based Payment **2.1%**

B Comprehensive Population-Based Payment **4.5%**

C Integrated Finance & Delivery Systems **0.8%**

19.6% *Combination of Categories 3B, 4A, 4B, & 4C Represents Two-Sided Risk APMs*

Source: HCPLAN 2022 Report

I expect Category 3B/4 payment models (i.e., upside/downside risk and or capitation) will represent at least 25% of my organization's clinical revenues within 10 years

My organization's funds flow model has elements that have been incorporated to support a future transition to population health