2012 Market Insights

by:
C-Suite Resources

September, 2012
Overview of Presentation

Five Key Elements in Today’s New Healthcare

- The Centrality of Clinical Integration
- Health IT is a Platform, not a Panacea
- Learning to Live on Medicare and Value-Based Levels of Payment
- Managing Business Model Migration
- Building a Culture of Quality and Accountability
- Summary
The Centrality of Clinical Integration
Centrality of Clinical Integration

- Hospitals and physicians recognize the challenges of going it alone.

- VBP, Bundled payments, quality measures, population health management, continuum of care issues all require an integrated approach.

- Industry consolidation, ACO development are signs of this recognition
## Actions of Providers: Top Five Efforts of Leading Health Systems

### Rank Your Organization’s Top Three Priorities for the Next Three Years

<table>
<thead>
<tr>
<th>Priority</th>
<th>1st Ranked Choice</th>
<th>2nd Ranked Choice</th>
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<th>Combine d Top 3</th>
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Source: HealthLeaders Media Industry Survey 2012 Senior Leaders Report;
Alignment Strategies Currently in Place

Which of the following physician alignment strategies does your organization currently have in place?

- Physician Employment: 57%
- Paid Directorships: 42%
- Other Contracting Relationships: 39%
- Acquiring Medical Groups: 32%
- Clinical Co-Management: 24%
- Gainsharing: 10%


Base = 289
Which of the following ACO strategies or options is your healthcare organization actively pursuing as part of its strategic plan?

- Pursuing clinical integration unrelated to any particular ACO strategy: 54%
- Commercial ACO partnerships with payers: 36%
- Medical Shared Savings Program: 13%
- Pioneer designation: 10%
- None of the above: 21%

Base = 179 Multi-response

Source: HealthLeaders Media; ACO: Tailoring Your Own Solution
Actions of Providers: Development of ACOs

♦ Pieces of Care Continuum Acquired or Strategically Aligned to Prepare for ACO

Which pieces of the care continuum has your healthcare organization either acquired or strategically aligned with in order to prepare for accountable care?

- Independent physician group: 64%
- Home health companies/agencies: 35%
- Payers: 28%
- Hospice: 24%
- Chronic care management: 21%
- Nursing homes: 21%
- Quick care sites: 17%
- Vendors: 4%

Base = 179

Multi-response

Source: HealthLeaders Media; ACO: Tailoring Your Own Solution"
Key Industry Concerns: Operational Challenges

♦ Workforce Issues
  ■ Shortages worsen in all professional fields
  ■ Physicians shortage will increase 7-8%/year for next 5-10 years
    • Shortage will be 14-15% in 2025
  ■ NPs and PAs will increase
First-Year M.D. Enrollment per 100,000 Population has Declined 26% since 1980: Will Decline Another 7.4% in 10 Years

A Growing and Aging Population

Source: AAMC; U.S. Census Bureau; Prepared by Center for Workforce Studies, Feb. 2006
An Association of American Medical Colleges analysis shows a “critical shortfall” in the number of physicians across all specialties, including primary care. This isn’t just due to coverage expansion under health reform, but also retirements and specialty choice.

Source: ©2010 Association of American Medical colleges.
Actions of Providers: Physician Alignment

Total Physicians vs. Truly Independent\(^1\) – Projected Change, 2000-2013 (000s)

- 57% are Independent in 2000, 683 total physicians
- 49% are Independent in 2005, 723 total physicians
- 43% are Independent in 2009, 757 total physicians
- 33% will be Independent in 2013, 793 total physicians

\(^1\) Estimated

Sources: Accenture Analysis, MGMA, American Medical Association
Health IT is a Platform, not a Panacea
Health IT is a Platform, not a Panacea

- Lots of “Meaningless Use” out there.

- IT is the platform for change, but it’s not the end-point.

- Clinical integration, measurements of clinical quality, changes in work flow, reductions in cost are the end-points.
Regarding clinical quality improvement, which of the following areas represents the single greatest strategic challenge for your organization?

- Improving patient experience, including patient flow: 24%
- Care coordination, continuum of care: 21%
- Reducing avoidable readmissions, complications: 13%
- Performance metrics: 12%
- Care episode payment bundling: 9%
- Medical home: 7%
- Hiring quality staff: 7%
- Transparency of quality data: 3%
- Medication reconciliation: 3%
- Infection control: 2%

Which statement best describes how your organization currently uses information technology to guide cost efficiency programs?

- We have robust clinical and financial data integrated with solid business intelligence and analytical tools to guide us. (16%)
- We have some reliable clinical and financial data that we use to achieve results. (67%)
- We lack clinical and financial data for improvement at this time. (17%)

Source: HealthLeaders Media Intelligence Report, Cost Containment: Overcoming Challenges, November 2011
Areas of Need

Which performance data measurement is your most critical need?

- Throughput and efficiency: 32%
- Clinical outcomes: 26%
- Actual labor productivity: 18%
- Individual clinician performance: 14%
- Ambulatory service line costs: 7%
- Other: 3%

Source: HealthLeaders Media Intelligence Report, Cost Containment: Overcoming Challenges, November 2011
Which best describes your organization’s approach to HIT spending?

- An operations investment: 34%
- A cost of doing business: 24%
- A clinical investment: 23%
- A competitive investment: 19%

Source: HealthLeaders Media Intelligence Report, June 2012
HIT Spending Plans

Please describe your organization’s HIT spending plans for the coming two years.

- **Major increase**: 48%
- **Minor increase**: 37%
- **Flat**: 12%
- **Minor decrease**: 2%
- **Major decrease**: 0%

Source: HealthLeaders Media Intelligence Report, June 2012
Please describe the ROI associated with your HIT spending.

- Spending will produce a net cost decrease over time: 42%
- Spending will produce a net cost increase over time: 31%
- Spending will be cost neutral over time: 27%

Source: HealthLeaders Media Intelligence Report, June 2012
**Decision-Support Use**

Considering your hospital-based electronic health system, rate your level of satisfaction with the following elements.

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<th>Somewhat satisfied</th>
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<tr>
<td>Overall functionality</td>
<td>13%</td>
<td>41%</td>
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<td>System speed, responsiveness, and downtime</td>
<td>17%</td>
<td>37%</td>
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<tr>
<td>Ability to share information across internal departments or with other organizations such as medical groups</td>
<td>20%</td>
<td>33%</td>
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<td>Chart review functionality</td>
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<td>Physician portal</td>
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<td>34%</td>
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<tr>
<td>Vendor training and support</td>
<td>18%</td>
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Source: HealthLeaders Media Intelligence Report, E-Health systems: Opportunities and Obstacles; January 2011; http://content.hcpro.com/pdf/content/261348.pdf
Learning to Live on Medicare and Value-Based Levels of Payment
Learning to Live on Medicare and Value-Based Levels of Payment

- 10, 15, 20% of levels of cost reduction will be required.

- Value, not Volume, is the new metric of payment.

- New clinical and patient experience metrics are pressuring IT.

- Revenues are rapidly becoming “zero-sum” with big winners and losers.
Actions of Providers: Top Five Efforts of Leading Health Systems

♦ Seeking Dramatic Reduction in Operating Costs

■ Break even/profit on Medicare

• GuideStar data on 1,739 organizations:
  - Only 25% break even or profit on Medicare
    » Top quartile = 8.9% profit
    » 2nd quartile = 0.3% loss
    » 3rd quartile = 10.8% loss
    » 4th quartile = 31.8% loss

• Lean, Six Sigma, care coordination, change in core processes are some of the techniques
Key Industry Concerns: Health System Finances

♦ August 2011
  - Final inpatient PPS rule for 2012 (Medicare)
    - Scaled back the “coding offset” reduction from 3.15% to 2.0%
    - Increase payments for hospitals will be 1.1% (in 2012) instead of projected reduction of 0.55%
    - Reductions for re-admissions (includes unrelated and planned re-admissions)

♦ April 2012
  - MedPac recommends 0.9% increase for 2013
Key Industry Concerns: Health System Finances

Hospital Inpatient Prospective Rates

Source: Centers for Medicare and Medicaid Services
Sliding Margins Limit Financial Flexibility

Median hospital revenue growth rate hits lowest point in a decade in 2010

Source: Moody’s Investors Service, 2011
Operating Margin Distribution

Number of hospitals

-10%  -8%  -6%  -4%  -2%  0%  2%  4%  6%  8%  10%

Median: 0.2%
Median: 0.5%
Median: 0.7%

101-300 Beds  301 - 500 Beds  500+ Beds

Source: HealthLeaders Media June 2012:
Deloitte Development LLC 2011
Hospitals are getting previews of what Medicare will pay them under the value-based purchasing program that goes live in fiscal 2013.

- **July 1, 2009 – March 31, 2010**
  - Baseline period

- **January 13, 2011**
  - Proposed rule issued

- **May 6, 2011**
  - Final rule issued

- **July 1, 2011 – March 31, 2012**
  - Performance period

- **February 29, 2012**
  - Dry-run reports available on qualitynet.org

- **November 1, 2012**
  - Hospitals notified of exact fiscal 2013 payments

- **November 1 – November 30**
  - Hospitals may review and submit corrections to performance score

**Timeline:**
- **2009**
- **2010**
- **2011**
- **2012**

Source: CMS. Modern Healthcare; March 5, 2012.
Health Reform Update: Value-Based Purchasing

- Value, not volume is the new payment method
- Value will be measured by clinical outcomes (17 measures) and “patient experience” (8 measures) based on HCAHPS scores and cost (“per Medicare beneficiary”).
- Incentives payments will be based on higher of an achievement score or an improvement score
- Incentives are paid from a pool of $ created by reducing all hospital Medicare payments by 1% (2% and 3% in later years)
Change in VBP metrics

- June 12 2012 - CMS (quietly) added “cost-per-Medicare beneficiary” score to VBP payment calculation.

- October, 2014 - 20% of VBP score now on Medicare cost per beneficiary.

Example:
- Los Angeles:
  - L.A. Community Hospital = $24,644; 37% above national median
  - UCLA = $17,988; 2% below national median

Costs higher than median:
- Las Vegas, Fort Lauderdale, Newark, Miami, LA., Orange County

Costs lower than median:
- Anchorage, Des Moines, Honolulu, Minneapolis, Portland (OR)

Source: Centers for Medicare & Medicaid Services
Health Reform Update: Value-based Purchasing

**Implications**
- Hospitals will be competing against each other
- There will be winners at the top, and losers everywhere else
- It’s getting very crowded at the top
- Insurers developing their VBP programs, e.g., WellPoint:
  - 1,500 hospitals in 14 states
  - No payment increases if quality measures not met:
    - 51 indicators:
      » 55% health outcomes
      » 35% patient safety
      » 10% patient satisfaction
Actions of Providers: Preparation for VBP

Most Difficult Measure Expected in Reaching Improvement

In which particular measure do you expect the most difficulty in reaching improvement or performance initiatives?

- HCAHPS: 50%
- Heart failure: 16%
- HAIs: 8%
- Pneumonia: 8%
- SCIP: 7%
- AMI: 2%
- Other: 8%

Base = 179

Source: HealthLeaders Media; Buzz Survey Results; December 2011
Managing Business Model Migration
Managing Business Model Migration

- Currently, providers are straddling two widely different change curves.

- Industry consolidation, physician alignment, and ACO development are each a major change; and all happening at once.
Life in the GAP

**Value-Based Second Curve**

- Payment rewards population value: quality and efficiency
- Quality impacts reimbursement
- Partnerships with shared risk
- Increased patient severity
- IT utilization essential for population health management
- Scale increases in importance
- Realigned Incentives, encouraged coordination

**Volume-Based First Curve**

- Fee-for-service reimbursement
- High quality not rewarded
- No shared financial risk
- Acute inpatient hospital focus
- IT investment incentives not seen by hospital
- Stand-alone care systems can thrive
- Regulatory actions impede hospital-physician collaboration

Source: AHA: Hospitals and Care Systems of the Future
Actions of Providers: Industry Consolidation

♦ **Five Trends That Are/Will Consolidate the Industry:**
  - Hospitals consolidating into systems
  - Physicians consolidating practices into larger groups
  - Physicians being employed by hospitals
  - Hospitals linking with/acquiring post acute care organizations
  - Not-for-profits selling to for-profits
Actions of Providers: Industry Consolidation

Hospital Consolidation

- Current Status
  - 410 systems – up from 352 in 2006, a 16% increase
  - Systems own or control over 3,600 hospitals, or 70% of the total hospitals, up from 56% in 2006
  - Systems own or control over 622,000 beds, or 77% of total hospital beds, up from 62% in 2006

- Trends
  - Investor-owned systems acquiring control, but not total ownership, of hospitals
    - *Example*: Vanguard acquires 51% interest in the assets of Valley Baptist Health System in Texas
  - Catholic systems swapping hospitals to consolidate holdings in a state or region
    - *Example*: Trinity and CHI swapped hospitals in Idaho so that Trinity now owns four hospitals in and around Boise
Physicians Consolidating into Larger Physician Groups

Current Status
- In 2009, out of approximately 750,000 physicians, 43% are practicing independently or 57% are “employed”, either by hospitals or large physician groups
- MGMA recent study, done by Accenture, predicts that by 2013, the number of independent docs will be close to 33%, or 2/3 will be employed

Trends
- As hospital systems consolidate, their employed physician groups consolidate into larger groups within the system
  - Example: Sanford Health in Sioux Falls, SD, a 30-hospital system, acquired MeritCare, the largest group medical practice in North Dakota with over 200 physicians in 44 care locations
Physicians Being Employed by Hospitals

Example:

- Recent surveys of healthcare execs indicate:
  - Physician employment ranks as the #1 “physician alignment strategy” with 52% of executives saying they will utilize this strategy
  - 57% say they currently utilize physician employment as their #1 alignment strategy
  - 71% say they have seen an increase in requests from independent medical groups for employment in past 12 months
Hospitals Linking With/Acquiring Post-Acute Care Organizations

Current Status

• Hospitals currently own or manage about 11% of skilled nursing facilities; about the same for home health agencies
• Value-based purchasing, bundled payments, and re-admission penalties are causing hospital executives to consider linkages with post-acute care organizations
  – *Examples*: SSM Healthcare in St. Louis is building a post-acute care network and developing a nurse navigator program. The nurse navigator would prepare and execute a 90-day care plan for each patient needing services following discharge.
  – BJC in St. Louis has built a post-acute care network of skilled nursing, extended care, assisted living and an extensive home health network.
Actions of Providers: Industry Consolidation

♦ Summary

- The current wave of health industry consolidation is not the “same old, same old” of the past
- This consolidation wave is broader and deeper; involving hospitals, physicians and post-acute care; not-for-profits and investor owned
- The consolidations have a practical purpose, not the ego or stock price consolidations of the past
- Build integrated systems that are accountable for care across the continuum of care
- Build tighter alignments with physicians to better control overall costs and to be able to gain “bonuses” under the new payment rules
- Link with insurers in a “commercial” ACO to gain market share and better payments through lower costs/improved outcomes
Actions of Providers: Physician Alignment

- Plans to Employ a Greater Percentage of Physicians in Next 12-36 Months

In what service lines or specialties?

Base = 119 (among those who plan to employ a great number of physicians)

Health Reform Update: Accountable Care Organizations

♦ Four Types of ACOs

CMS type ACO (2 attempts)
- Part of Health Reform Act (Shared Savings Program)
- Regulations issued March 2011
- Significant pushback:
  - AHA = Cost of implementation
  - AMGA = 93% of its members would not participate
  - Ten largest multi-specialty group practices will not participate
- Final rules issued November 2, 2011
- Unlikely to have much participation

♦ Shared Savings Program
- April 10, 2012 CMS selected 27 entities as the first ACOs
- 18 states
- 10 hospitals, 13 physician organizations, 4 others
- 33 quality measures:
  - Care consolidation
  - Patient safety
  - Appropriate use of preventive health measures
  - Improved care for at-risk populations
  - Patient and caregiver experience of care
Health Reform Update: Accountable Care Organizations

Four Types of ACOs

CMS Pioneer ACO Model

- Alternative to Shared Savings Program
- Designed specifically for organizations with experience offering “coordinated, patient-centered care, and operating in ACO-like arrangements”
- 32 organizations selected
- Began January 1, 2012
- Much more realistic regulations than Shared Savings Program
Health Reform Update: Accountable Care Organizations

♦ Four Types of ACOs
  
  **Private Payer-Provider ACO (“Commercial” ACO)**

  - Great interest
  - Many in formation; rapid growth
    - Estimated 35 formed or announced
  - Led by “integrated” systems

  **Providers Focusing on Delivering Accountable Care**

  - May or may not have an ACO structure
  - Focus on value, not volume
5 Trends in ACO Development

- Number and types of ACOs are expanding
  - Addition of 150 ACOs in last 8 months
  - Total ACOs now at 310
  - 45 states

- ACO growth is most prominent in large metropolitan regions

- Hospitals / systems still primary backer of ACOs
  - Of 310 ACOs, 148 (48%) are hospital led
  - Of 120 (40%) are physician led

Source: Leavitt Partners, June 2012
5 Trends in ACO Development

- Medicare ACOs are restricted; commercial ACOs are expanding
  - Inherent limitations in federal programs
  - Commercial ACOs experiment with arrangements and structure

- Success of any ACO model over another is undetermined
  - Not enough data or length of time to determine

Source: Leavitt Partners, June 2012
## Number of Accountable Care Organizations, by Category

<table>
<thead>
<tr>
<th>Organization Type</th>
<th>Number of ACOs</th>
</tr>
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<tbody>
<tr>
<td>Single Provider ACO</td>
<td>177</td>
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<tr>
<td>Multiple Provider ACO</td>
<td>103</td>
</tr>
<tr>
<td>Insurer ACO</td>
<td>17</td>
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<tr>
<td>Insurer-Provider ACO</td>
<td>13</td>
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<tr>
<td><strong>Total</strong></td>
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*Source: Center for Accountable Care Intelligence: Growth and Dispersion of Accountable Care Organizations: June 2012 Update*
## Headquarters by Type

### ACO Sponsoring Headquarters by Type

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<tr>
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Note: On July 9, 2012 CMS released the names of an additional 89 newly approved Medicare ACOs. Nearly half are physician-led organizations, many serving less than 10,000 beneficiaries. This brings the total of ACO's of all types to 310.

Source: Growth and Dispersion of Accountable Care Organizations: June 2012 Update
Early Results From Large Commercial ACO

- Advocate Care, formed by BCBSIL and Advocate Health Care
- 250,000 PPO members and 125,000 HMO members
- Formed in 2010
- First 6 months of 2011:
  - Hospital admissions down 10.6%
  - ED visits down 5.4%
Building a Culture of Quality and Accountability
Building a Culture of Quality and Accountability

- This is what healthcare is, or should be, all about.

- Perverse financial incentives (e.g., “fee-for-service”) and disintegrated structures (e.g., physicians as independent contractors controlling volumes and costs of care) have driven the industry.

- The previous four key elements have described the drive to a new culture.
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**Life in the GAP**

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Source: AHA: Hospitals and Care Systems of the Future
Nonprofits Face Difficult Future

♦ **U.S. nonprofit health care outlook remains negative for 2012**

- Increased need for capital relating to plant modernization and IT systems
- Greater limitations on access to capital due to wider credit spreads for lower-rated credits
- Cost of compliance with changing regulatory environment and new requirements under health care reform
- Increased reimbursement pressures across all payers
- Large unfunded pension liabilities
- Possibility that benefits of tax-exemption will further diminish
- Benefits of economies of scale, including increased bargaining power with suppliers, payers and labor

Source: Moody’s Investors Service
Fundamental restructuring of the healthcare system is underway—indeed of health reform

Restructuring will take 10-15 years

Tipping point 5-10 years out

All scenarios entail clinical integration, economic integration, and new care delivery models

Historic hospital and private practice physician business models on life support

Options for large vs. small systems different

Impediments to change are enormous—leading transitions will be brutal

Engage stakeholders—develop a diagnosis before a treatment plan