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Your Trusted Advisor for Healthcare Industry Intelligence

A Market Scan of Healthcare Market Opinions and Perspectives: Convergent and Divergent Views of Providers and Suppliers

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Program in HealthCare Administration

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by

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C-Suite Resources

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Overview of Presentation

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I. Introduction

II. What Kinds of Trend/ Current Issue Information or Data are Suppliers Wanting?

III. Different Perspectives of Providers and Suppliers on Selected Issues

IV. What Can/Should Providers do to Extract Major Benefits from Suppliers?

V. Summary

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I. Introduction

Introduction

- Previously, healthcare executives spent time outside the organization learning from others:
  - HRDI
  - Meeting with Suppliers / Insurers
  - Public company healthcare Boards
  - Industry groups
- Current executives find this difficult:
  - Company time commitments
  - Regulatory issues
  - Perceived conflicts of interest
- C-Suite Resources experience

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II. What Kinds of Trend / Current Issue Information or Data are Suppliers Wanting?

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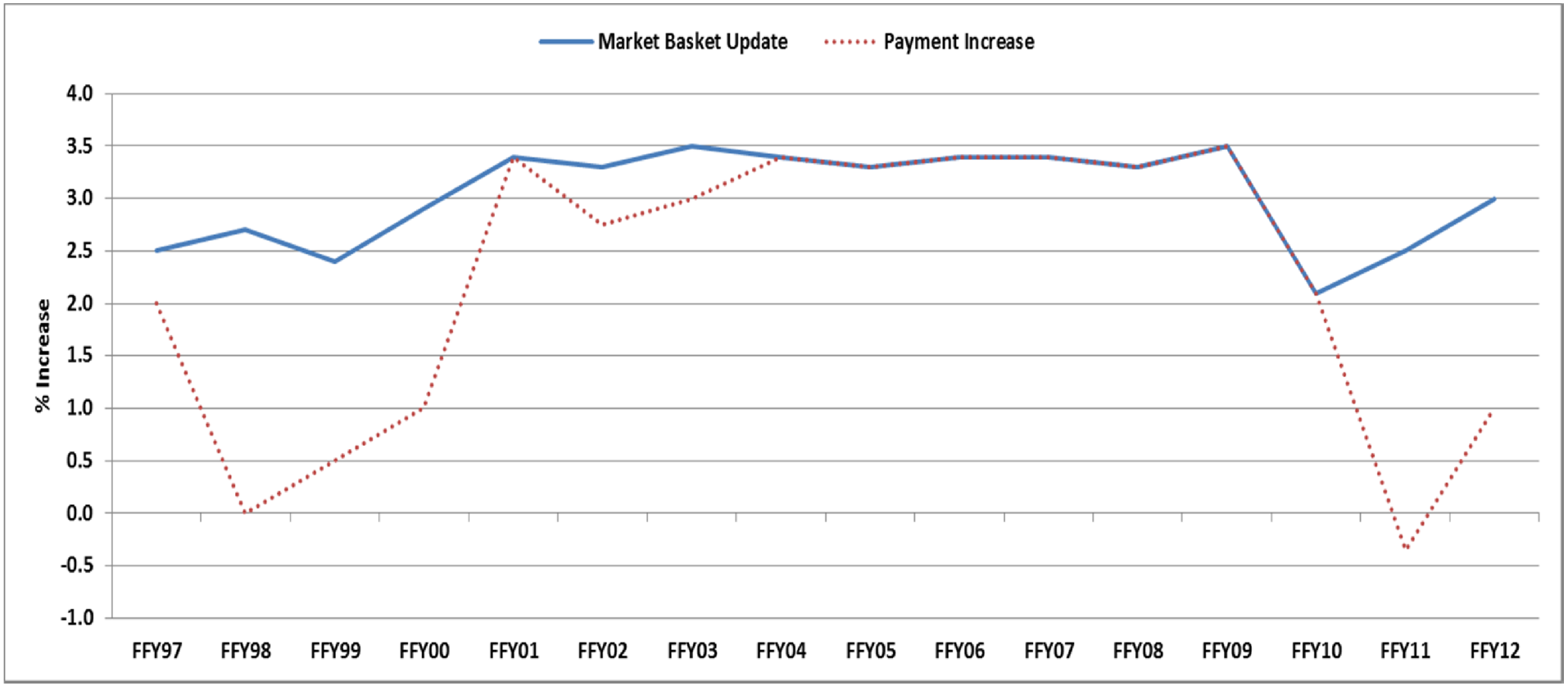
Hospital / System Finances

Hospital / System Finances

- August, 2011
  - Final inpatient PPS rule
    - 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).

Hospital / System Finances (cont.)

- Hospital Inpatient Prospective Rates



Source: Centers for Medicare and Medicaid Services

Hospital / System Finances (cont.)

- Moody's – August 5, 2011
  - We expect the following challenges to revenues:
    - **Medicare:** Despite an uptick in reimbursement rates for 2012, funding pressures and rate reductions are inevitable in coming years as Washington seeks to reduce the deficit and reign in Medicare costs
    - **Medicaid:** Widespread rate reductions caused by federal budget reforms as well as funding pressure at the state level as lawmakers continue to grapple with budget challenges
    - **Commercial Payers:** Lower rate increases as payers face financial challenges and increased regulation; ability to cost shift will abate
    - **Patient Volumes:** Flat inpatient admissions while lower-paying 24-hour observation stays increase

Source: Moody's

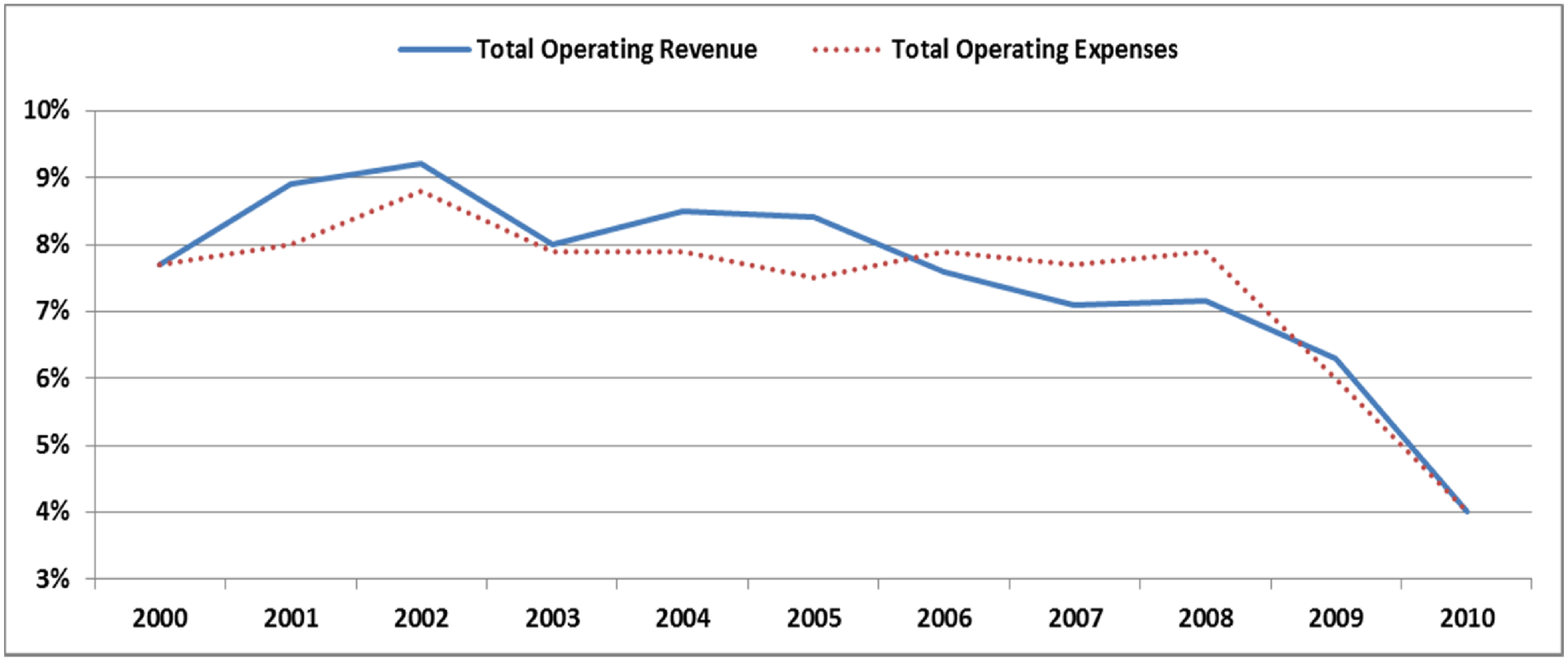
Hospital / System Finances (cont.)

- **Uncompensated Care:** Likely to increase given stubborn unemployment rate and employers discontinue or reduce healthcare benefits; over the longer term uncompensated care should decrease due to greater coverage under healthcare reform.
- **New Disease Diagnosis Classifications (ICD-10):** Will likely disrupt revenues in 2013 unless management teams start preparing now.
- **Fee-for-Service and Bundled Payment:** Simultaneous management of two very different reimbursement schemes will impede revenue management.

Source: Moody's

Hospital / System Finances (cont.)

- Median Hospital Revenue Reaches Low Point of 4% in 2010*



Source: Moody's

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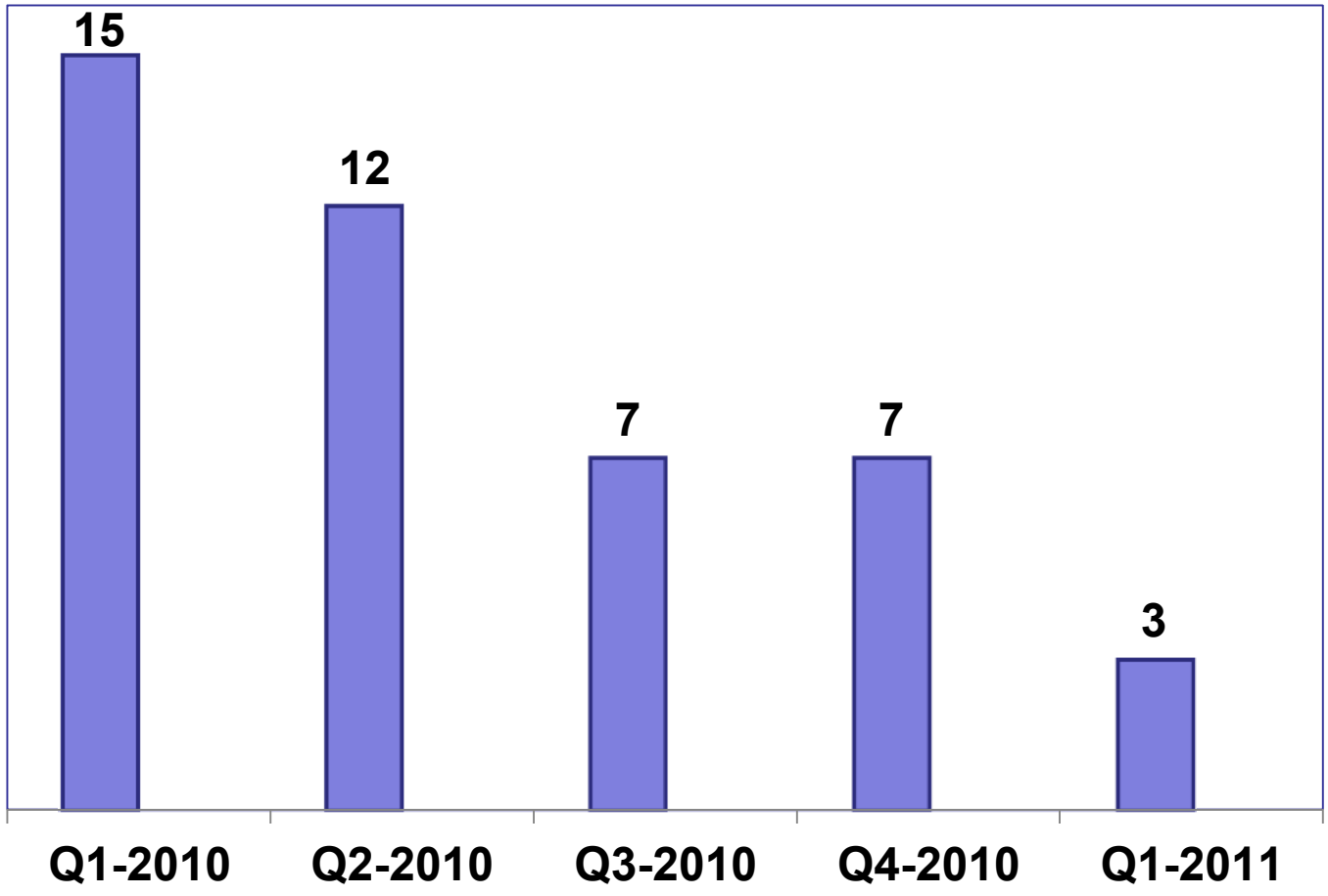
Access to Capital

Access to Capital

Upgrades Decline for 5 Quarters

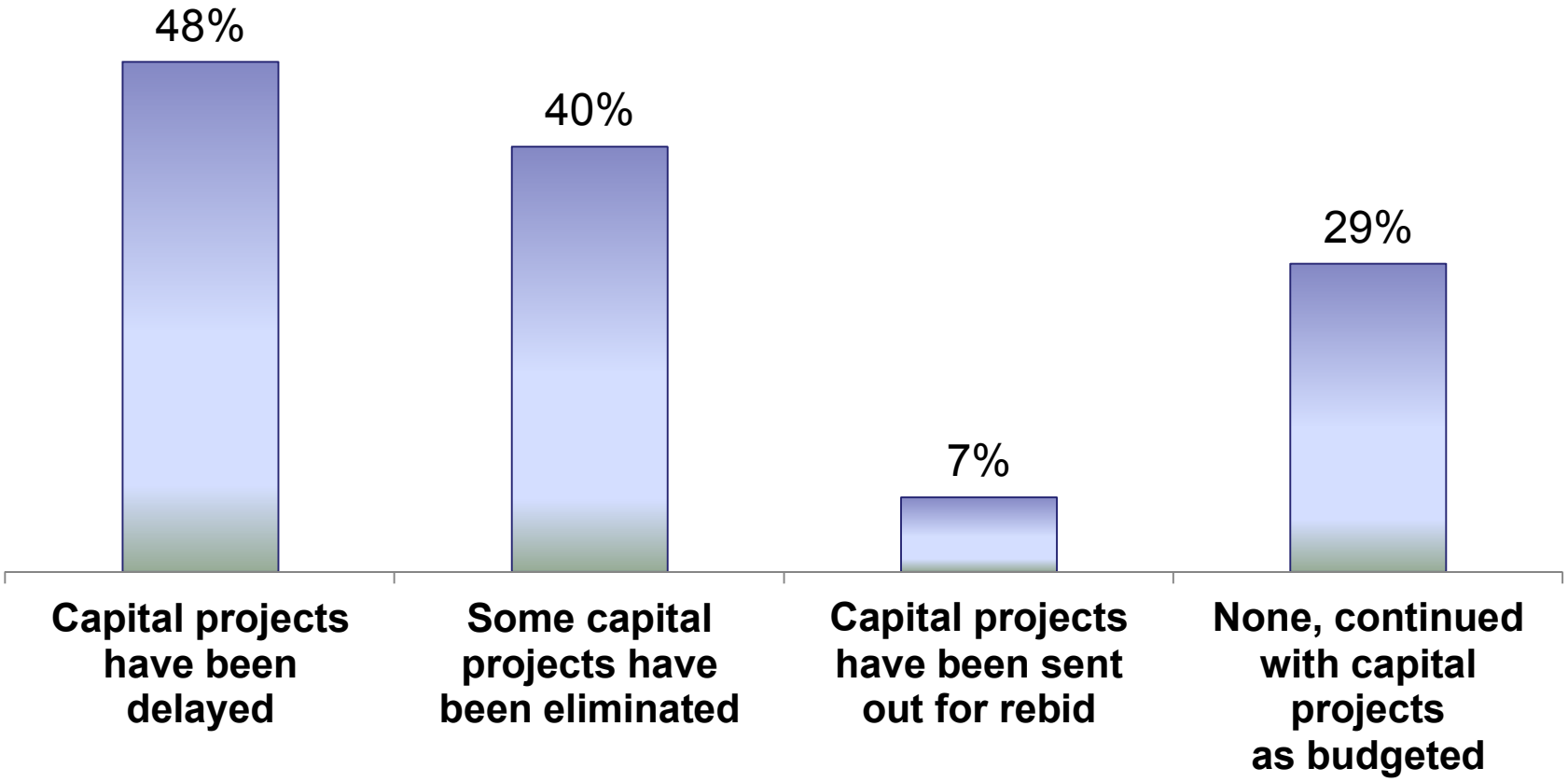


Source: Moody's

Access to Capital (cont.)

Impact of Economic Crisis on Capital Projects

Q: What is the overall impact of the economic crisis on your capital projects for 2011?



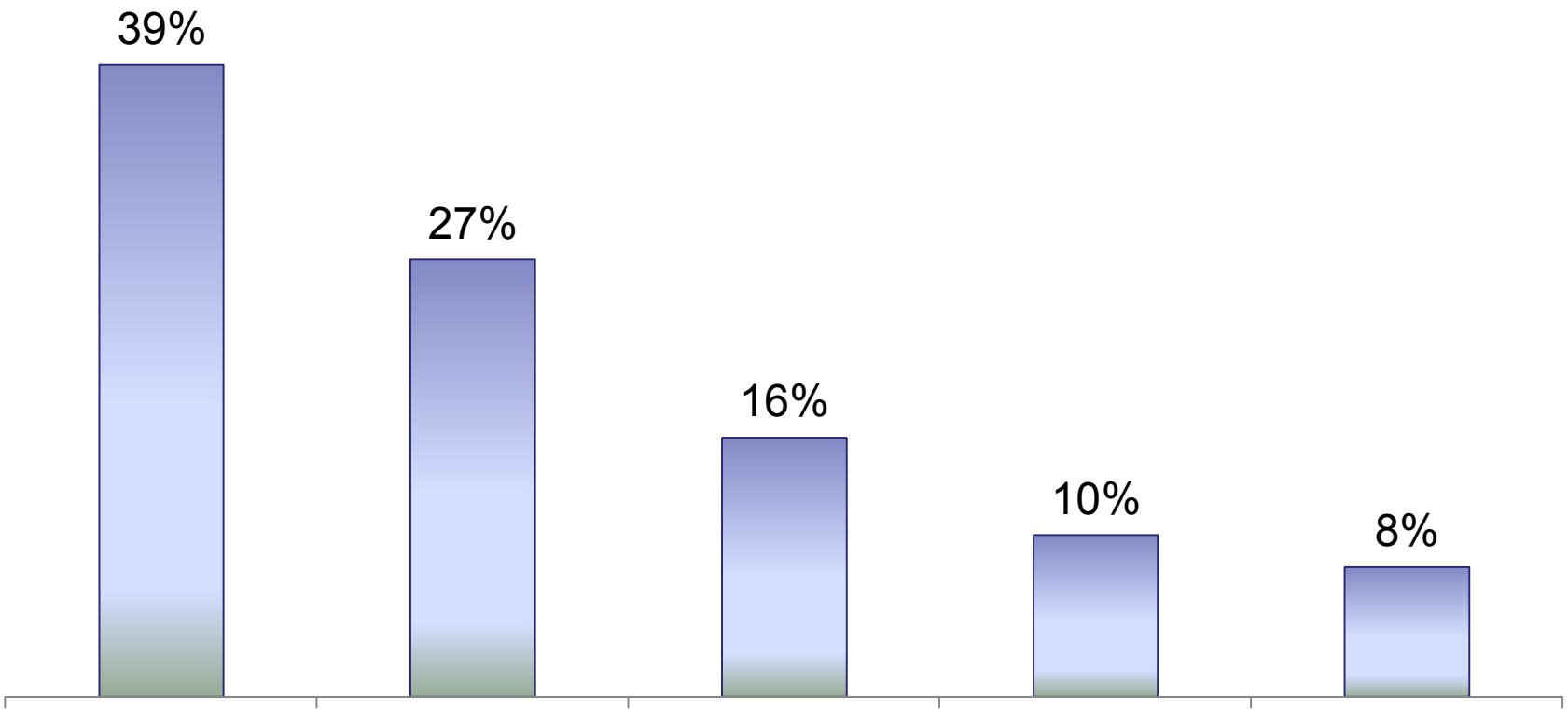
Base=277
Multi-response

Source: March 2011 HealthLeaders Media

Access to Capital (cont.)

Capital Expenditures

Q: In the coming year, which area will receive the majority of your capital expenditures?



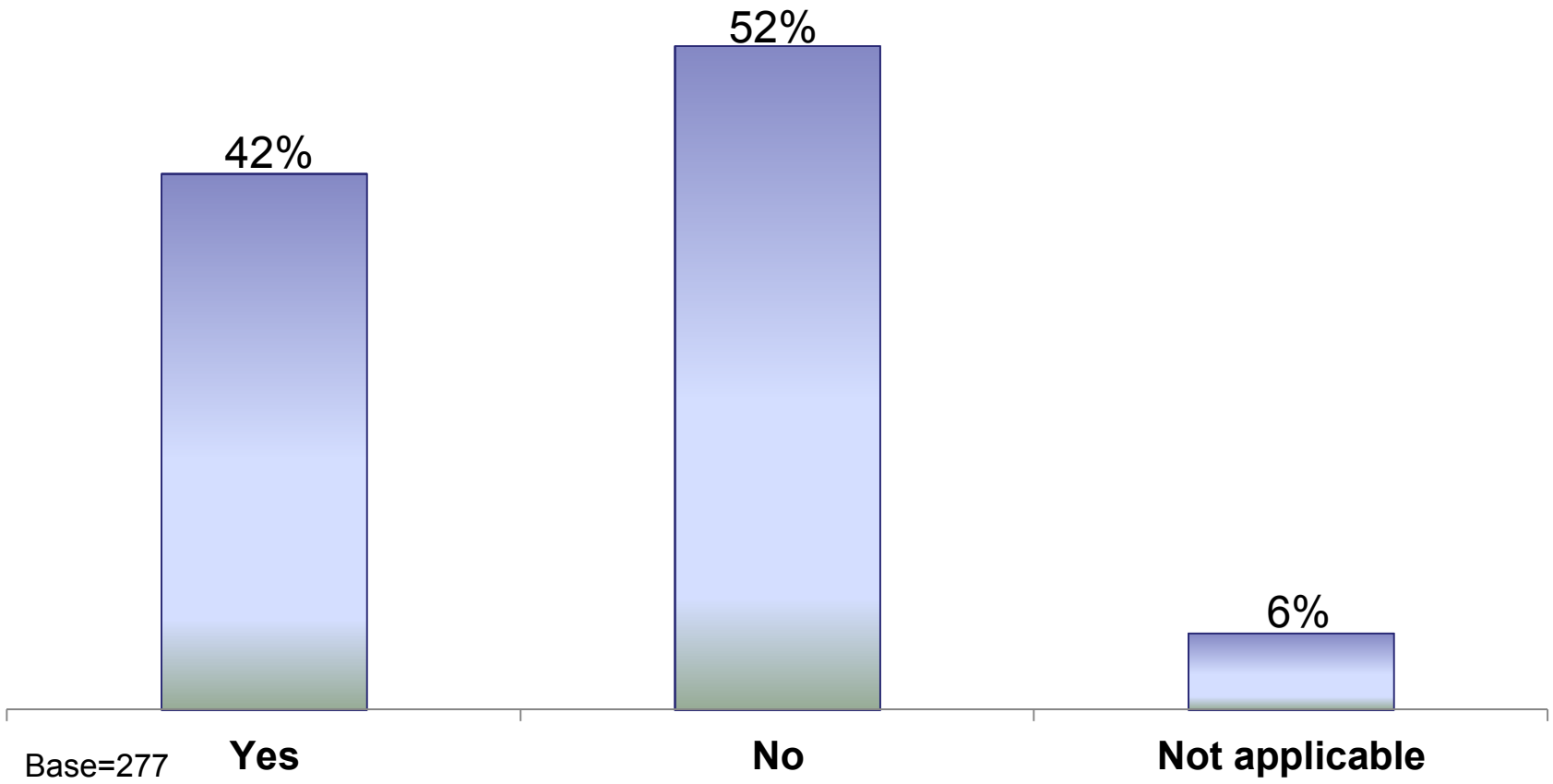
Base=277

Source: March 2011 HealthLeaders Media

Access to Capital (cont.)

Difficulty Accessing Capital in 2011

Q: In 2011, do you anticipate your organization will have difficulty accessing capital for planned capital projects or other organizational needs?



Source: March 2011 HealthLeaders Media

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Industry Consolidation

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

Industry Consolidation (cont.)

1. 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.

Industry Consolidation (cont.)

2. 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.

Industry Consolidation – Physician Consolidation (cont.)

- 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.

Industry Consolidation (cont.)

3. 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.

Industry Consolidation (cont.)

4. 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 orgs.
    - **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.

Industry Consolidation - Summary

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; and
  - Link with insurers in a “commercial” ACO to gain market share and better payments through lower costs/improved outcomes.

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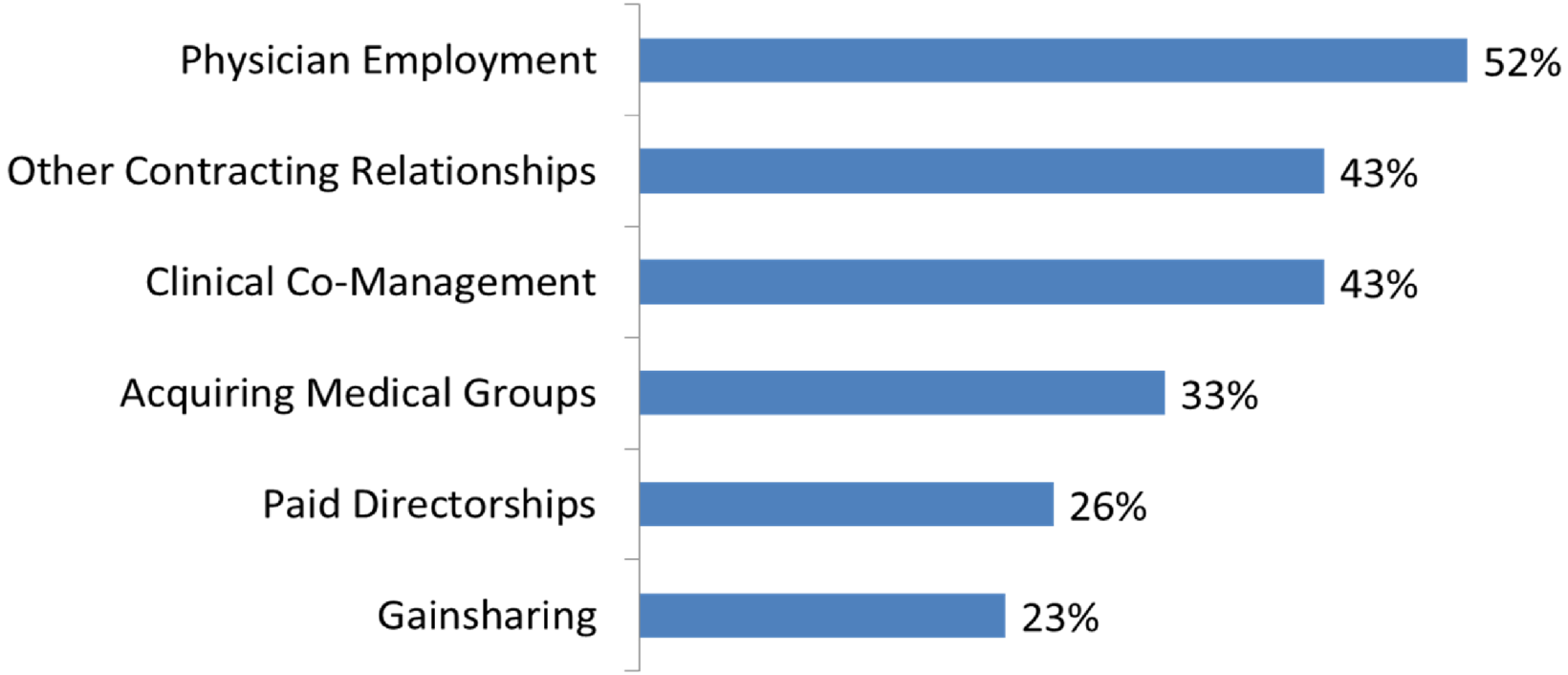
Physician Alignment

Physician Alignment – Actions Being Taken by Leading Hospitals / Systems

- Increase in Physician Alignment Strategies Due to PPACA



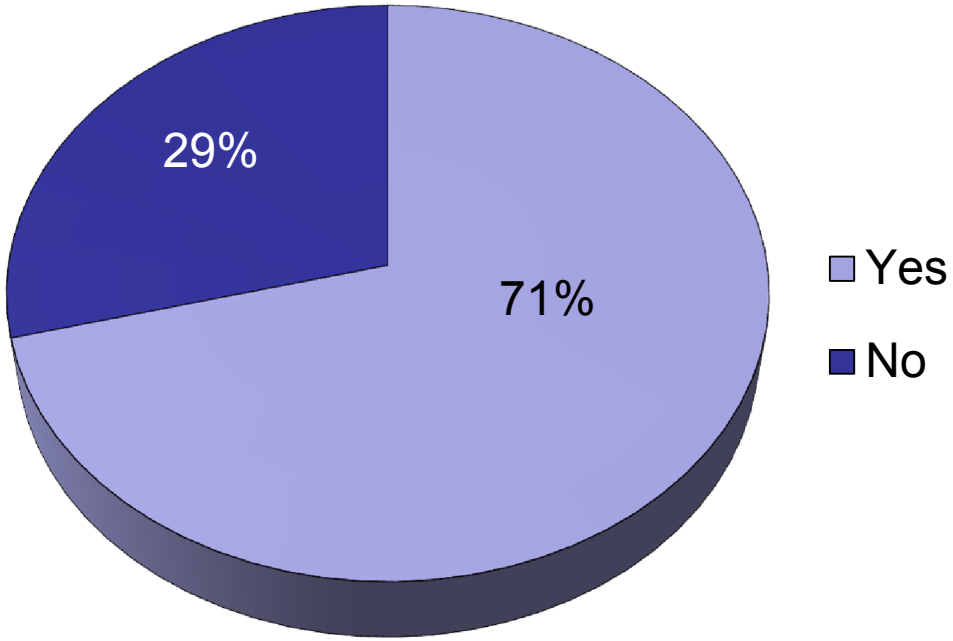
■Which of the following physician alignment strategies do you expect your organization to increase due to the enactment of PPACA?

Base = 289

Source: Healthcare Leaders on Reform Readiness; *HealthLeaders Media*, December 2010.

Physician Alignment – Actions Being Taken by Leading Hospitals / Systems

- Increase in Employment Requests From Independent Physician Groups

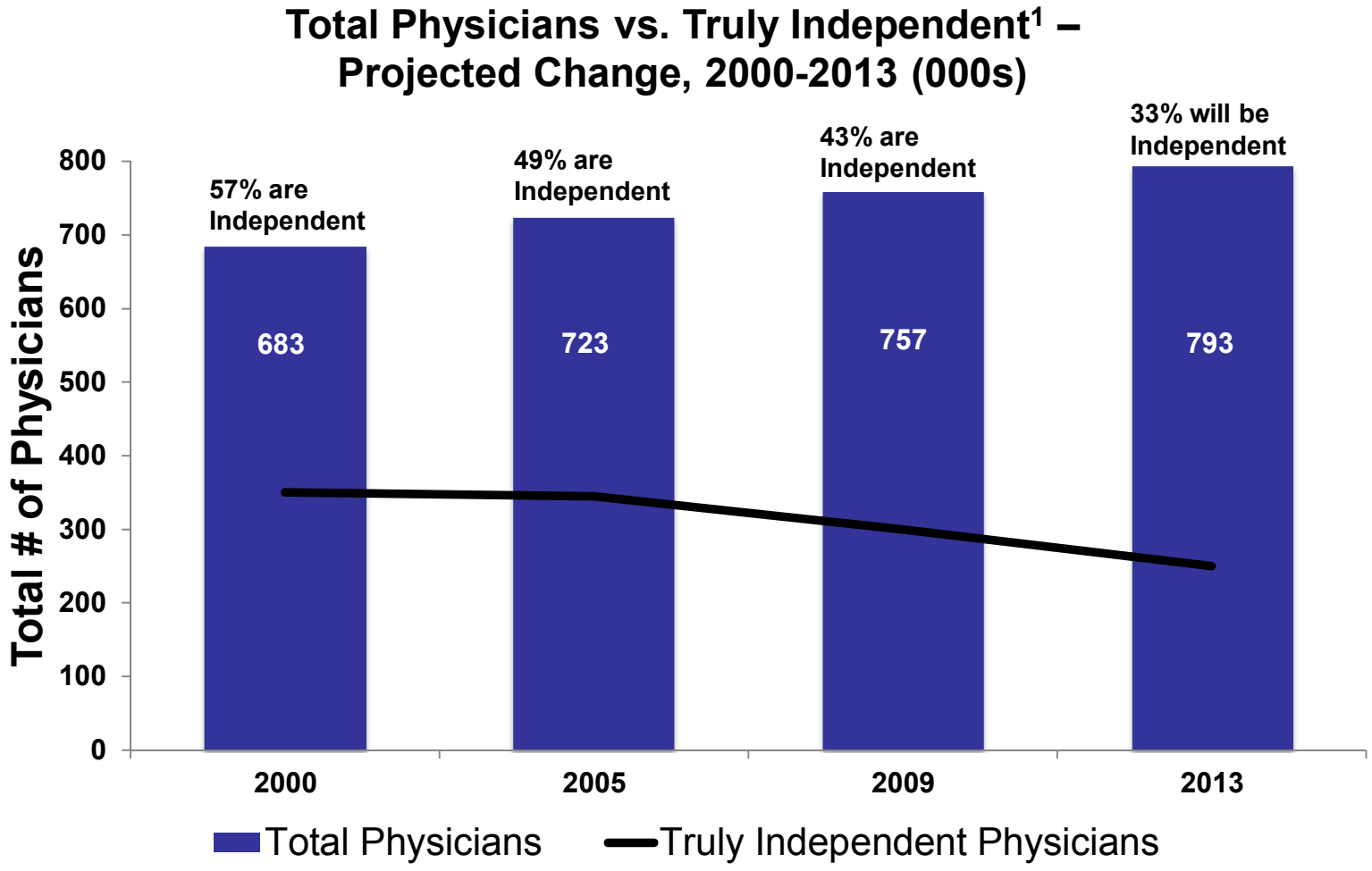


- Has the hospital / system received an increase in requests from independent physician groups for employment over the past 12-36 months?

Base = 289

Source: Healthcare Leaders on Reform Readiness; *HealthLeaders Media*, December 2010.

Physician Alignment – Actions Being Taken by Leading Hospitals / Systems

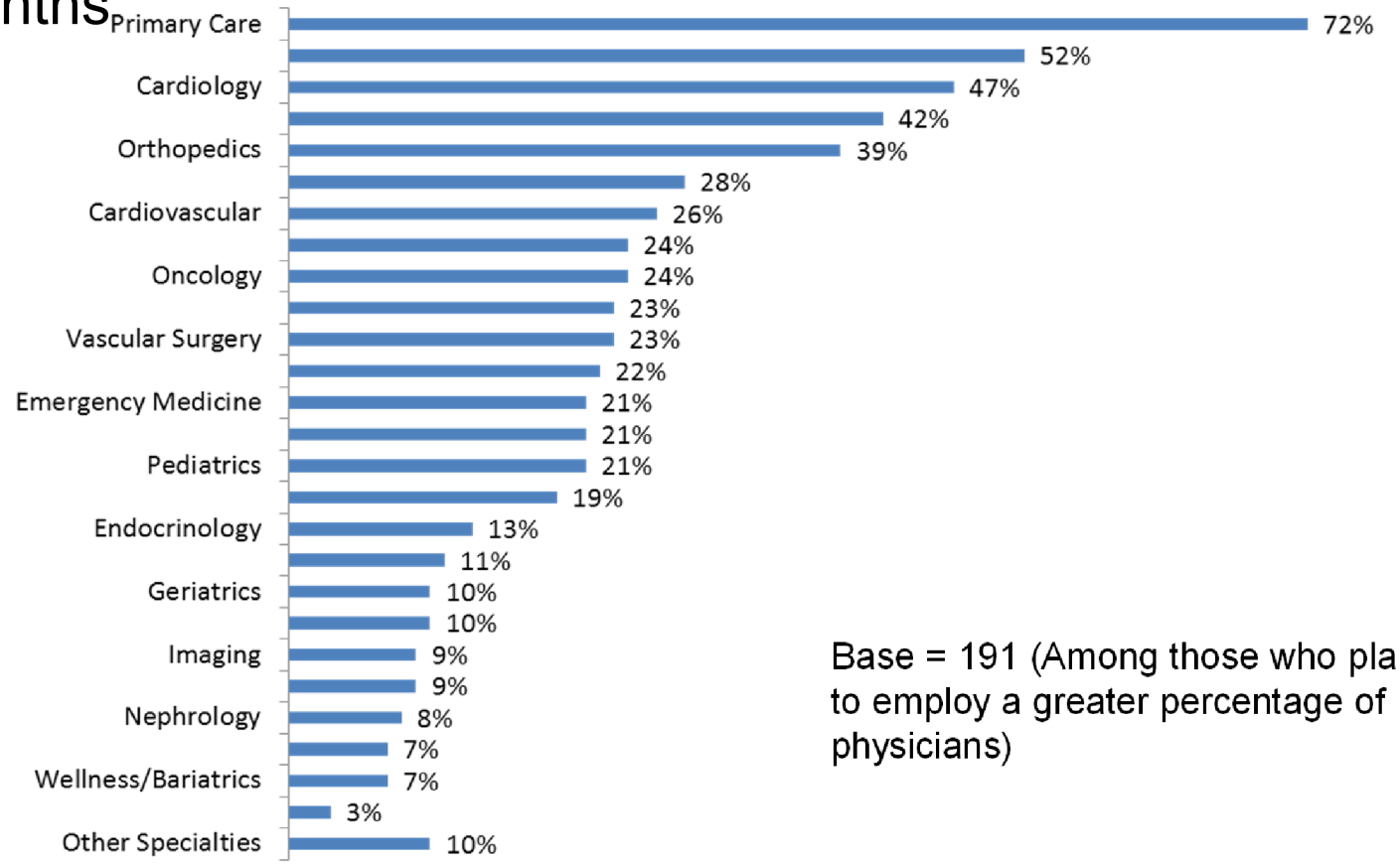


[1] Estimated

Sources: Accenture Analysis, MGMA, American Medical Association

Physician Alignment – Actions Being Taken by Leading Hospitals / Systems

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



Base = 191 (Among those who plan to employ a greater percentage of physicians)

- In what service lines or specialties?

Source: Healthcare Leaders on Reform Readiness; *HealthLeaders Media*, December 2010.

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Something to Watch

Something to Watch

- Insurers Buying Physicians and Hospitals
  - Buying Physicians
    - CIGNA Medical Group started Care Today Clinics
    - Humana purchased Concentra, urgent care system
    - WellPoint acquired CareMore Health Group – 26 clinics
    - OptumHealth (United Health Group) purchasing private medical groups (CA, AZ, Nevada, others)
  - Buying Hospitals
    - Highmark BCBS buys West Penn Allegheny Health

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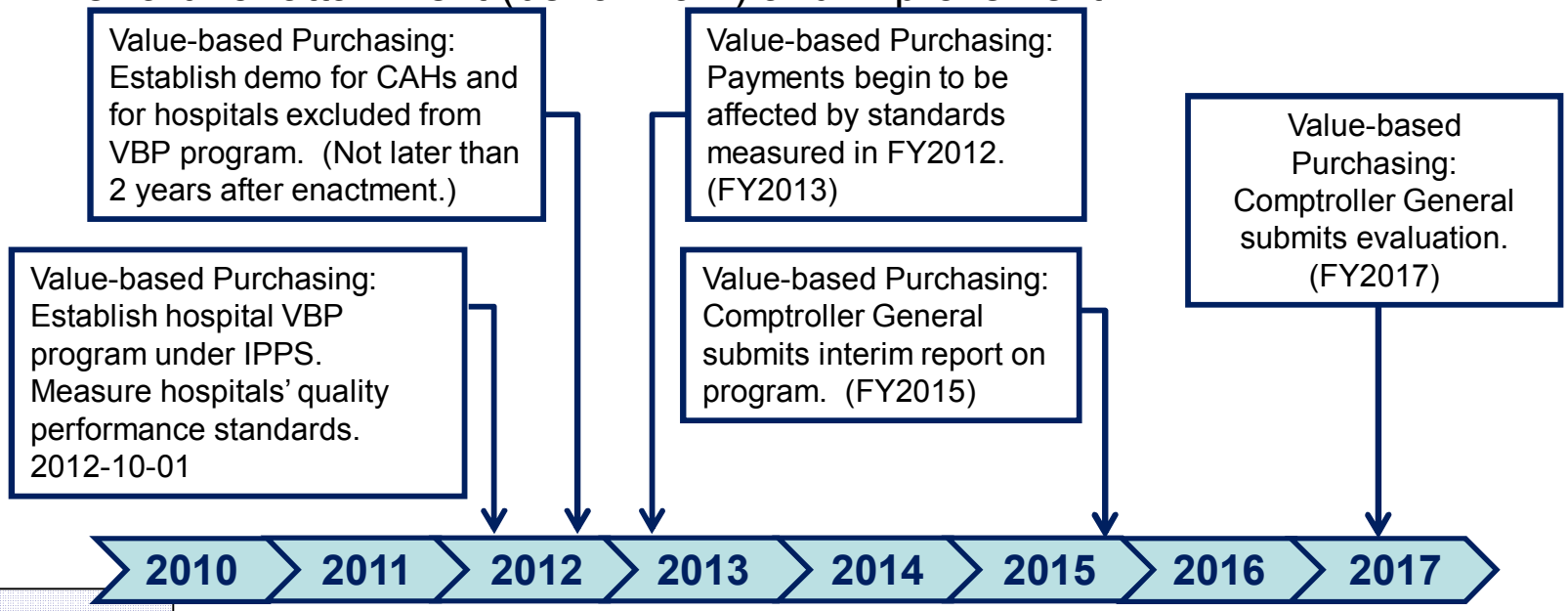
Health Reform

Health Reform

- Reform Issues -- Relative Consensus
  - Reward value NOT volume: Value-based purchasing
  - Bundled payment (end of fee-for-service)
  - Accountable Care Organizations (hospital-physician integration)
  - Focus on reducing hospital re-admissions
  - Transparency in cost and quality
  - Evidence-based care
  - Waste, fraud, and abuse
  - And a few others

Health Reform (cont.)

- Value-Based Purchasing
  - 1% of DRG tied to performance on quality & outcomes measures (FY2013)
  - Incentive pool scales to 2% of DRGs (FY 2017)
  - Incentive pool is not new money—it comes from a 2% reduction in DRG payments
  - Quality measures are those in the Hospital Compare measure set
    - AMI, heart failure, pneumonia, SCIP, patient satisfaction; efficiency and others
  - Reward for attainment (benchmark) and improvement



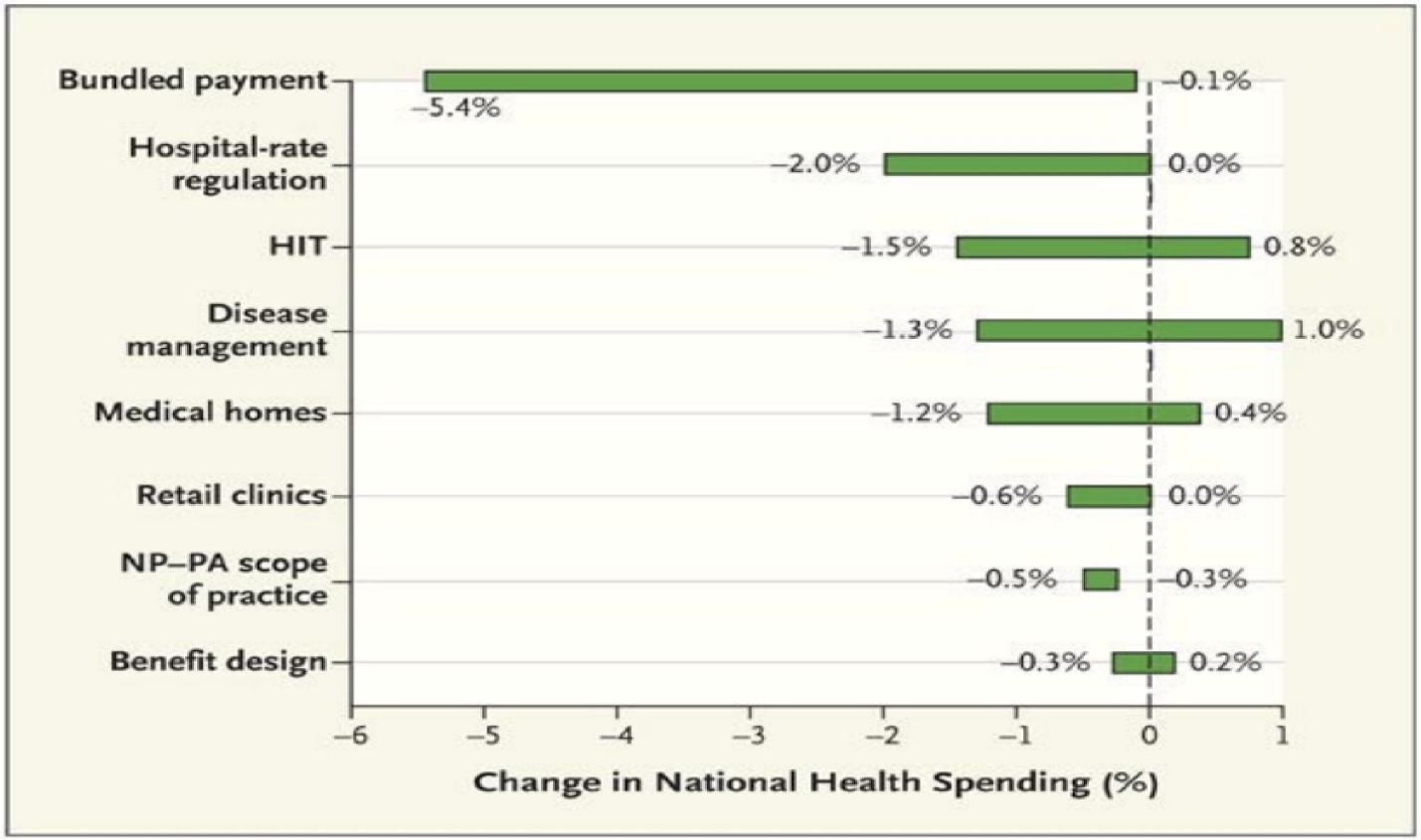
Health Reform (cont.)

- 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

Health Reform (cont.)

- Why Bundled Payment?

Estimated Cumulative Percentage Changes in National Healthcare Expenditures, 2010 through 2019, Given Implementation of Possible Approaches to Spending Reform



Source: Hussey PS, et al. N Engl J Med 2009; 361: 2109-2111

Health Reform - ACOs: Three Different Types

- CMS type ACO
  - Part of Health Reform Act
  - 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
  - Unlikely to have much participation

Health Reform - ACOs: Three Different Types (cont.)

- Private payer-provider ACO
  - Great interest
  - Many in formation
  - Led by “integrated” systems
- Providers focusing on delivering accountable care
  - May or may not have an ACO structure
  - Focus on value, not volume

Health Reform (cont.)

- "Themes" in the Bill That Will Have Potential Impact on Healthcare Providers, Quality, and Safety
  - Value-based purchasing
  - Bundled payment
  - Accountable Care Organizations
  - ***Focus on reducing hospital re-admissions***
  - Increased pressure on eliminating hospital-acquired complications (safety)
  - Going after waste, fraud, and abuse

Health Reform (cont.)

- Re-Admissions
  - Hospitals risk up to 3% cut to payments for all DRGs if their re-admissions are above expected
  - Begins in FY2013 (1%), goes up 2% in FY2014, and 3% in 2015 and beyond
  - Initially AMI, CHF, PN
    - Expands to COPD, CABG, PTCA, and other vascular in 2015

Health Reform - Why Re-admissions?

Table 1. Rehospitalizations and Deaths after Discharge from the Hospital among Patients in Medicare Fee-for-Service Programs.

Interval after Discharge	Patients at Risk at Beginning of Period	Cumulative Rehospitalizations by End of Period	Cumulative Deaths without Rehospitalization by End of Peri
		number (percent)	
All discharges			
0–30 days	2,961,460 (100.0)	579,903 (19.6)	103,741 (3.5)
31–60 days	2,277,816 (76.9)	834,369 (28.2)	134,697 (4.5)
61–90 days	1,992,394 (67.3)	1,006,762 (34.0)	151,901 (5.1)
91–180 days	1,802,797 (60.9)	1,325,645 (44.8)	177,234 (6.0)
181–365 days	1,458,581 (49.3)	1,661,396 (56.1)	200,852 (6.8)
>365 days	1,099,212 (37.1)		
Discharges after hospitalization for medical condition			
0–30 days	2,154,926 (100.0)	453,993 (21.1)	87,736 (4.1)
31–60 days	1,613,197 (74.9)	653,998 (30.3)	113,188 (5.3)
61–90 days	1,387,740 (64.4)	788,535 (36.6)	127,274 (5.9)
91–180 days	1,239,117 (57.5)	1,032,141 (47.9)	147,851 (6.9)
181–365 days	974,934 (45.2)	1,280,579 (59.4)	166,561 (7.7)
>365 days	707,786 (32.8)		
Discharges after hospitalization for surgical procedure			
0–30 days	806,534 (100.0)	125,910 (15.6)	16,005 (2.0)
31–60 days	664,619 (82.4)	180,371 (22.4)	21,509 (2.7)
61–90 days	604,654 (75.0)	218,227 (27.1)	24,627 (3.1)
91–180 days	563,680 (69.9)	293,504 (36.4)	29,383 (3.6)
181–365 days	483,647 (60.0)	380,817 (47.2)	34,291 (4.3)
>365 days	391,426 (48.5)		

19.6% of Medicare patients are re-admitted within 30 days, and 28.2% within 60 days. Only 10% of these re-admissions are "planned."

Source: Jencks S, et al. N Engl J Med 2009; 360: 1418-1428.

Value-Based Purchasing

- 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 HCCAPPs scores
  - 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)

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III. Different Perspectives of Providers and Suppliers on Selected Issues

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Providers -- Partnerships

Providers - - Partnerships

- Interested in “partnerships” with suppliers
  - Want suppliers to focus on lower cost, higher quality goods and services
  - Want guarantees, not promises, of future savings or increased quality, operating efficiency
  - Expect suppliers to put “skin in the game”, e.g., share in savings through putting some of their revenue “at risk”
  - Want “expert” assistance in implementing new processes, work flow solutions, not consulting reports, or “how-to”, not just “what to do”.

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Suppliers -- Partnerships

Suppliers - - Partnerships

- Worry of “partnerships” with providers
  - Company cultures not built for “risk” agreements
  - Have legal and regulatory concerns
  - Worry about other providers reactions
  - “Delayed” revenues from shared savings impact income statements, bonuses, etc.
  - Many companies don’t have “implementation” experts to aid providers

Providers - - Physician Alignment

- See future potential in working as a team, not competing
  - Focus on reducing utilization
  - Reduce duplication in PPIs (physician preference items)
  - Team effort in changing work processes to improve care outcomes, improve work flow
  - Focus on value, not volumes
  - See necessity in managing care across the various sites of care, not just the hospital

Suppliers - - Physician Alignment

- See loss of call points, buyers, influencers being replaced by managers, administrators
  - Focus on value is seen as positive, but concerned over potential loss of volume
  - PPIs have gross margins of 70-90%
  - Sales processes are built around physician / clinician relationships, replaced by managers RFPs, RFIs, cost analyses, focus on price
  - Many suppliers products / services are acute care focused with little to offer in post-acute

Providers - - Value, not Volume

- Are beginning to shift focus to value equation
  - Reforms introduce “payment” replacing reimbursement with care outcomes / patient experience
  - Cost benchmarks being driven on benchmark comparisons, as payers phase out government payer subsidies.
  - Payers (e.g., Well Point) introducing payment increases all based on outcomes, safety, and satisfaction scores

Suppliers - - Value, not Volume

- Are interested, but concerned over value equation
  - Hear providers talk about value, but buy on price
  - Believe their products give good value, but have different definition of value
  - Have very little data re: impact on patient outcomes; lots of data on product efficiency
  - Difficulty getting budget dollars for outcomes trials
  - Difficulty in getting providers to work with them in outcomes trials

Providers - - Adding New Functions / People in the C-Suite

- Shifting functions / decisions / influence to the C-Suite level
  - Hospital decisions shifting more to the system level
  - At system level, more decisions are large scale and increasingly influenced by the C-Suite
  - Addition of new functions (CMIO, CQO, CNO) seen as necessary
  - Other functions gaining influence (CIO, Supply Chain executives)

Suppliers - - Adding New Functions / People in the C-Suite

- Decision makers, influencers shifting away from traditional call points
  - Key practicing clinicians formerly made / influenced many buying decisions; changing as employment of physicians increase
  - Our salespeople unfamiliar with new C-Suite roles
  - Sales programs not geared to C-Suite interests, e.g., value, not product efficiency
  - We have no access to C-Suite influencers, decision makers

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IV. What Can / Should Providers do to Extract Major Benefits from Suppliers?

What Can/Should Providers Do?

- Premise: We have lots to learn and benefit from each other
  - Encourage suppliers to tailor products / services to your needs (e.g., Wal-Mart)
  - Seek longer term commitment to each other
  - Ask for specialized assistance (e.g., market research, product implementation services)
- Meet regularly with key leaders of major suppliers
- Explain your organization to key leaders
  - 2-3 year strategy directions
  - Make your “value” definition and expectations clear

What Can/Should Providers Do? (cont.)

- If you're interested, define your view of a "partnership" and what you're willing to invest (time, people, other resources)
- Seek out "best practices" from your key suppliers; e.g.,
  - Programs / services to reduce re-admissions
  - Programs to reduce hospital acquired conditions
  - Technology resources
- Use your provider membership organizations effectively:
  - National and state associations
  - GPOs

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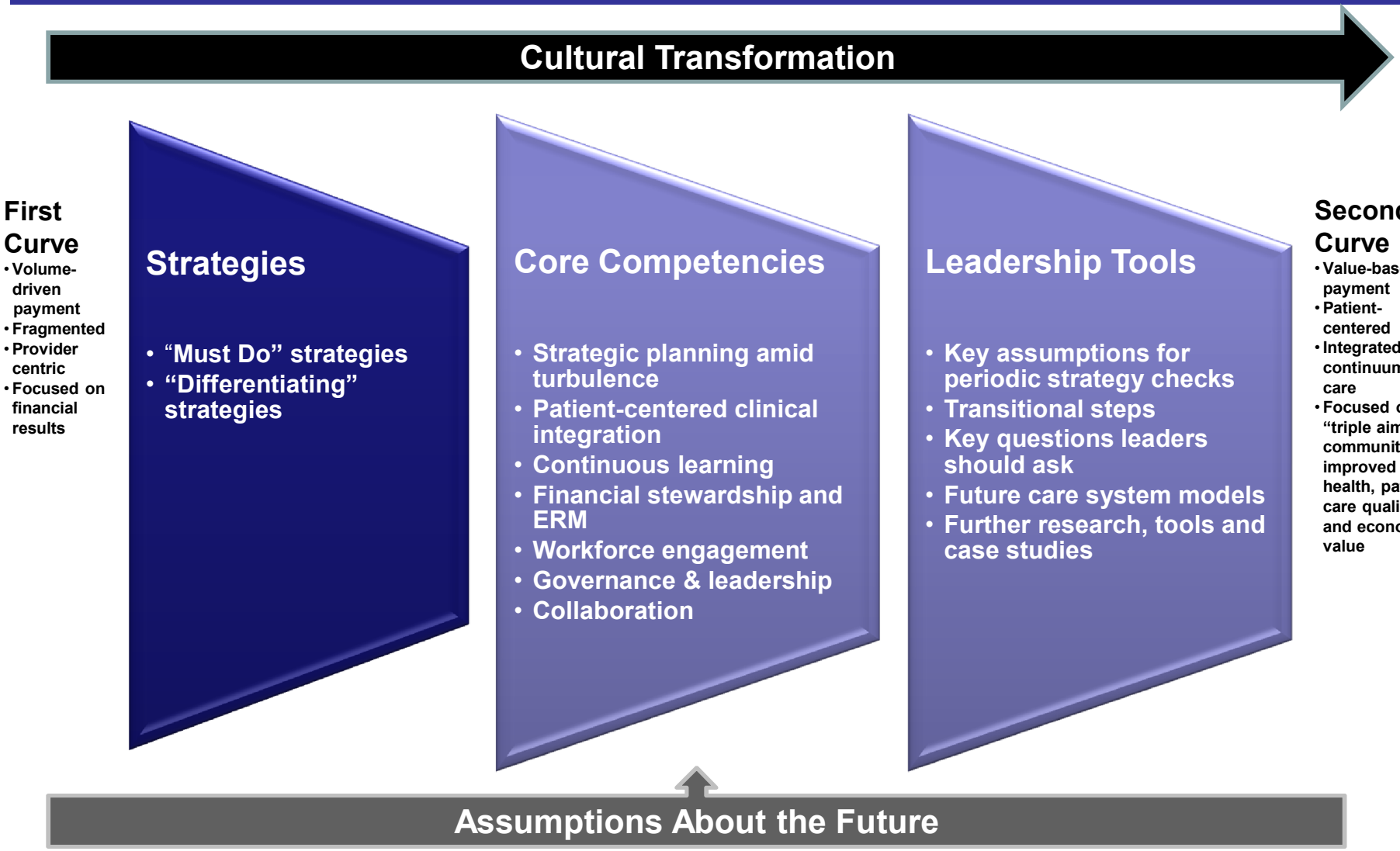
V. Summary

Summary



Source: AHA

Summary (cont.)

Key Elements of the 1st and 2nd Curves in Health Care

1st Curve: Volume-driven payments

Fee-for-service reimbursements reward volume and increasing spending

Reimbursements don't reward higher quality

Delivery system is fragmented leading to problems of waste, inefficiency, and discontinuity of care

Chronic illness consumes majority of health spending but providers have little incentive to reduce costs

Information systems reinforce fragmentation but providers have limited financial incentive to invest in integrated IT

Small care systems can thrive

Legal and regulatory barriers impede hospital-physician collaboration, shared savings, and clinical integration.

2nd Curve: Value-based payments

Payment system rewards value in lowering costs and improving quality for patient populations, including chronic illness

Quality affects reimbursement, e.g., bonuses for quality improvements, penalties for Insurers not providers bear financial risk

Hospitals focus on acute inpatient care

Physicians gravitate to higher-paying, procedure-based specialties vs. primary care

Quality and prices are opaque to consumers avoiding readmissions and preventable adverse events

Integrated providers are better positioned to take accountability for value, participate in shared savings programs, and accept financial risk and rewards for treating patients and populations

Quality and pricing information are transparent to allow consumers (some of whom are incented to be cost conscious) to make more informed choices

Information systems and knowledge management are essential to increasing efficiency and integrating care around the needs of patients and populations

Scale becomes more important

Regulatory reforms needed to align incentives and facilitate provider coordination and integration

Source: AHA