Deloitte.

Georgia Alliance of Community Hospitals

Conference Presentation

October 2016

National Trends

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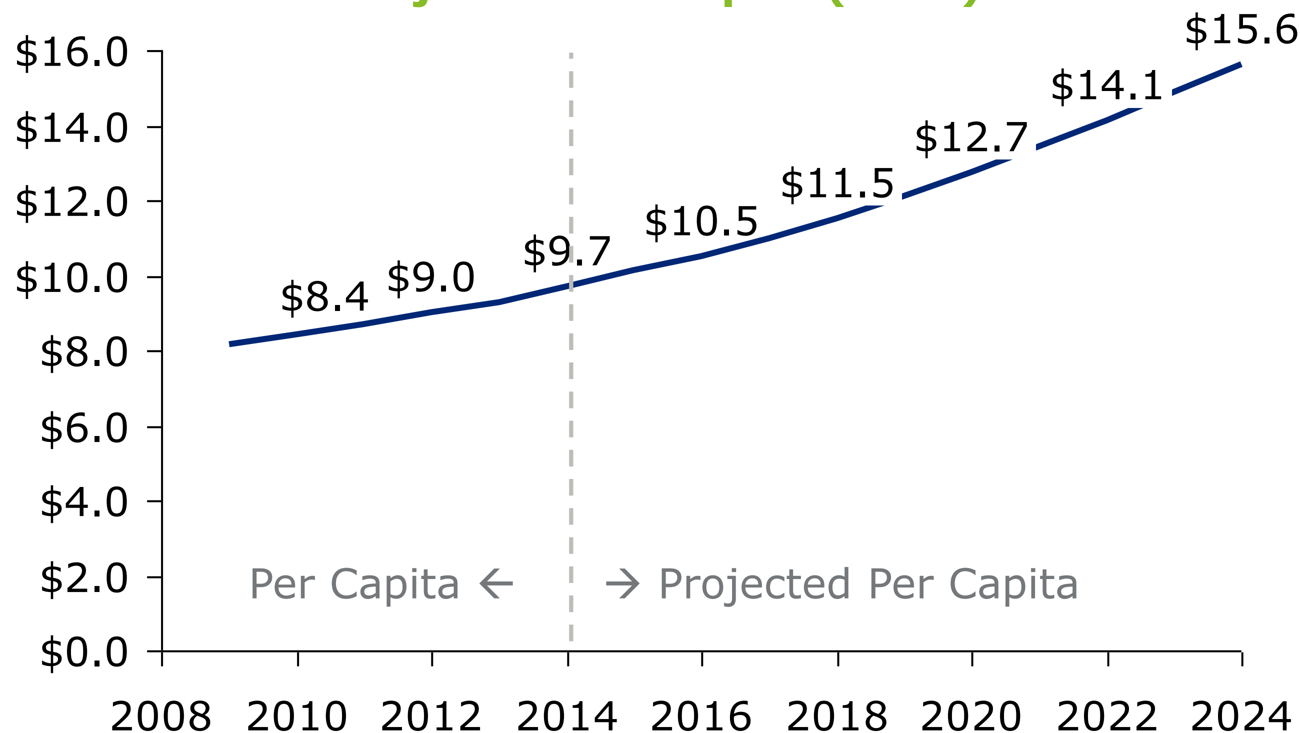
Healthcare cost and spending overview

Healthcare Costs Per Capita / Projected Per Capita (000s)



	2009	2015	2018	2024
Total Health Expenditures ($ T)	$2.5	$3.2	$3.7	$5.3
% of GDP	17.3%	17.8%	18.4%	19.9%

2017 Projected Healthcare Spending

Medicaid	$606 B
Medicare	$721 B
Out-of-Pocket	$364 B
Private Health Insurance (HI)	$1,149 B
Other Third Party Payors	$380 B
Other HI Programs	$129 B
Total	$3,349 B

17.3%
of Total US GDP

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Source: CMS, Projected National Health Expenditure Data, last modified 7/30/15; CMS Office of the Actuary, National Health Expenditure Projections 2015-2025

Shifting payment models

The **shift from "volume to value"** suggest that **value-driven alignment of clinical and financial incentives** is the future strategic direction for the healthcare industry

Volume Focus

- Payment systems based on **fee-for-service**; limited financial risk
- Providers have **incentives to increase payment rates**, specialization/ intensity, and volume; fragmentation of providers ("silos")
- **Limited focus on outcomes** and information sharing

Value Focus

- Focus on **maximizing value (lower cost, higher quality)** of healthcare delivered through alignment of incentives and risk mgmt.
- **Care coordination** driven by standardized protocols, use of **information tech.** for information sharing
- Investment in supporting **clinical integration, population health,** and other **cost reduction/ revenue enhancement opportunities**

Key Market Drivers

- HHS has clear **goals** and timeline for shifting Medicare reimbursements from **volume to value** (90% by 2018)
- Growing **momentum** across mkt. in incentive and value-based contracts (launch of the **Health Transformation Task Force**, 75% by 2020)
- >**600 ACOs** served more than **50 M patients** in 2014; recent changes to **Medicare SGR formula** will accelerate change

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Changing patterns in healthcare consumerism

Today's **customers are more engaged, informed, and involved** with their healthcare decisions…

…and the **increasing burden of healthcare costs** placed on consumers has given customers greater decision-making responsibilities…

…compelling many healthcare consumers to make more choices and to **"shop" for their services**

69%
of patients are at least somewhat interest in engaging with technologies that enable access to healthcare

56%
of customers consider *brand / reputation very important* when choosing a provider

$457: Average OOP Spend per Capita

$855: Average OOP Spend for Age 65+

58%
of all patients are willing to accept smaller networks of hospitals and doctors for reduced premiums

53%
of total healthcare spend is considered "shoppable"

- Customers can determine where they have procedures or receive their care
- Emergency visits may not be as "shoppable" but still impact overall stickiness to a system or provider

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Notes: 53%…"shoppable" fact is specific to spending by individuals <65 with employer-sponsored insurance; **Sources:** Deloitte Center for Health Solutions 2015 Survey of U.S. Healthcare Consumers; Healthcare Cost Institute, 2016; Journal of General Internal Medicine, 2015

Physician burnout and worries over the future of medicine

Growing Physician Concerns

72% of physicians think the "best and brightest" may not choose a career in medicine

62% believe that physicians will retire based on how the future of medicine is changing

57% say that the practice of medicine is in jeopardy

55% of physicians currently practicing will scale back hours based on challenges over the future of medicine

Physician Burnout

Physician burnout levels hover around **50%** across most specialties

Frequently Cited Causes:

1. Long Hours
2. Bureaucratic Tasks
3. Reduced Face Time with Patients
4. Financial Challenges
5. Personal and Relationship Challenges

Out of almost 1 million physicians in the US, about **400 will commit suicide each year**

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Sources: Deloitte Center for Health Solutions, 2013 Survey of US Physicians; Becker's Hospital Review, Aug. 2016

Non-profit hospital revenue growth outlook

2015 (12 to 18 Month) Non-Profit Hospital Revenue Growth Outlook

Moody's projects **median operating cash flow** growth to range from - **0.5 % to 1.5%**

However, for **large systems with more than $2B in revenues** is expected to have **3-4% growth**

Why?

- The largest hospitals are getting stronger while small hospitals are getting weaker
- Bad debt has fallen in Medicaid expansion states; grown in non-expansion states
- Small rate increases from commercial payers
- Rate cuts from Medicare, Medicaid

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Sources: Becker's Hospital Review, Aug. 2015

Consolidation Trends

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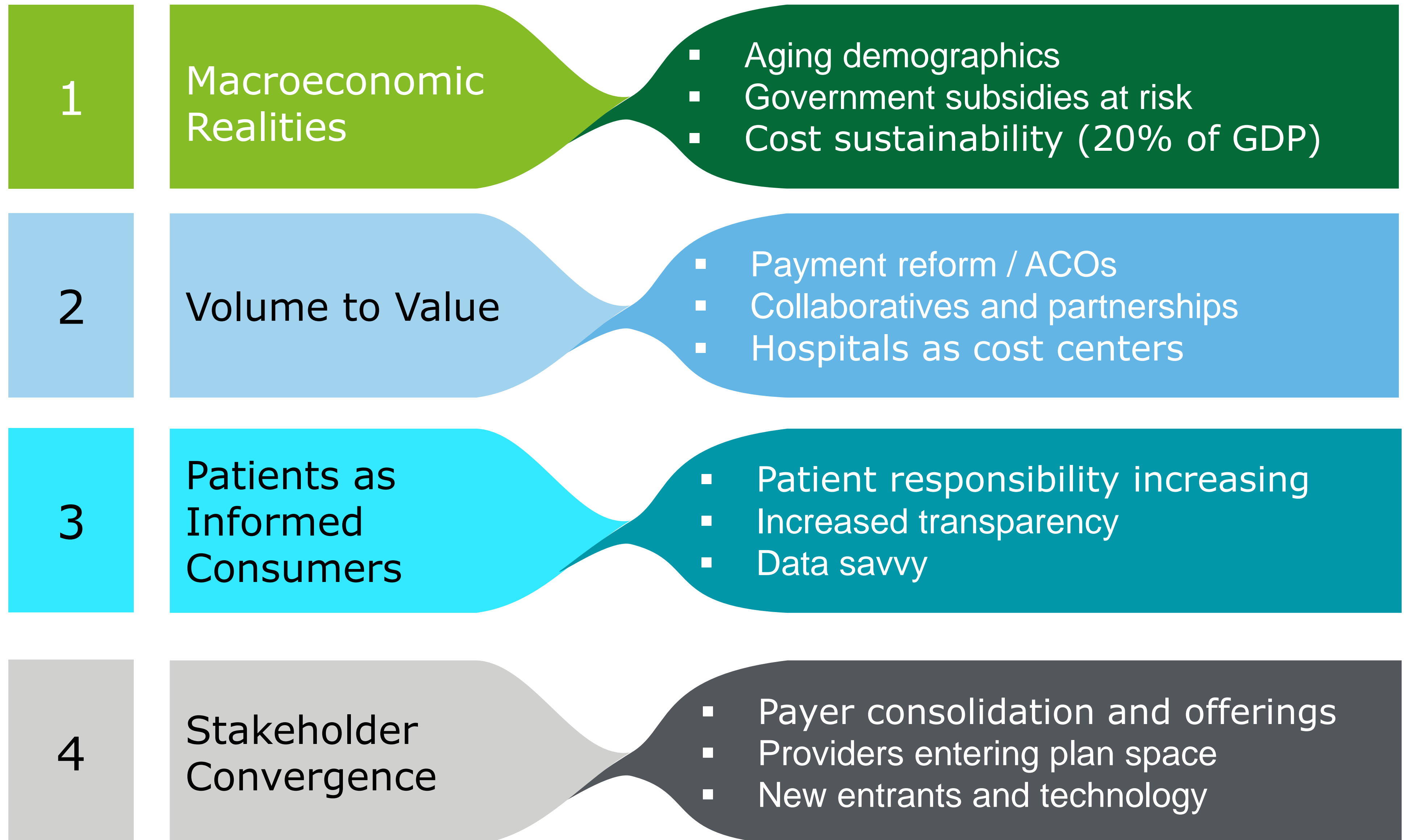
The health care landscape is rapidly evolving……



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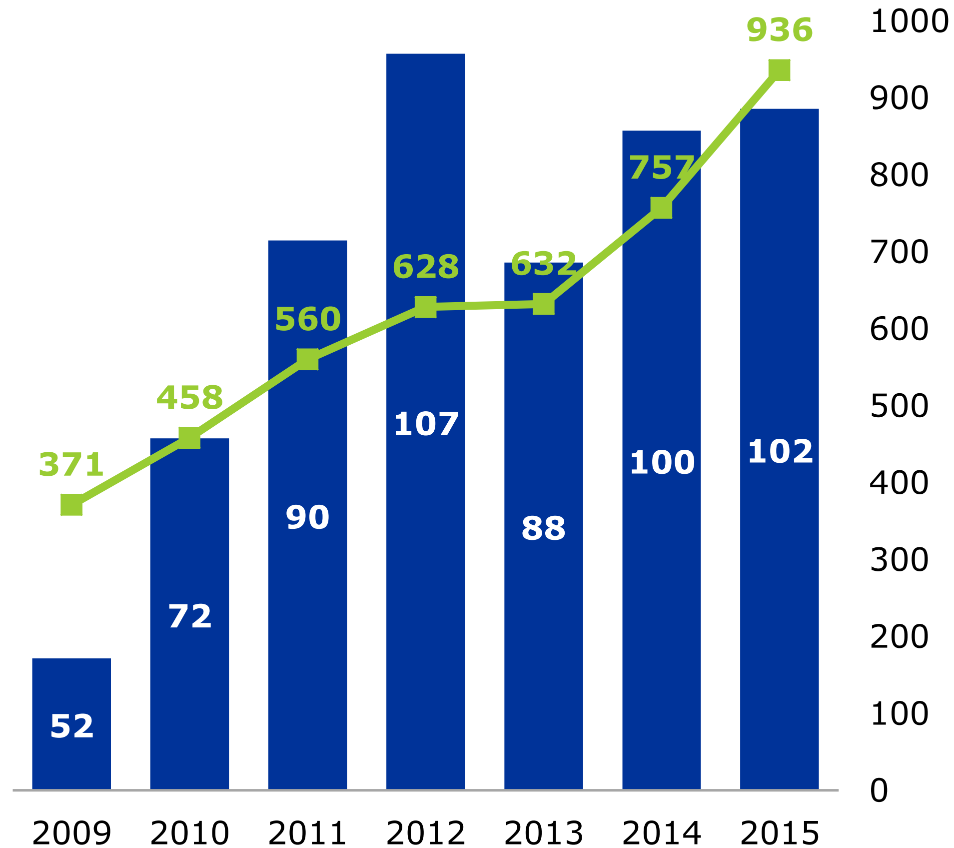
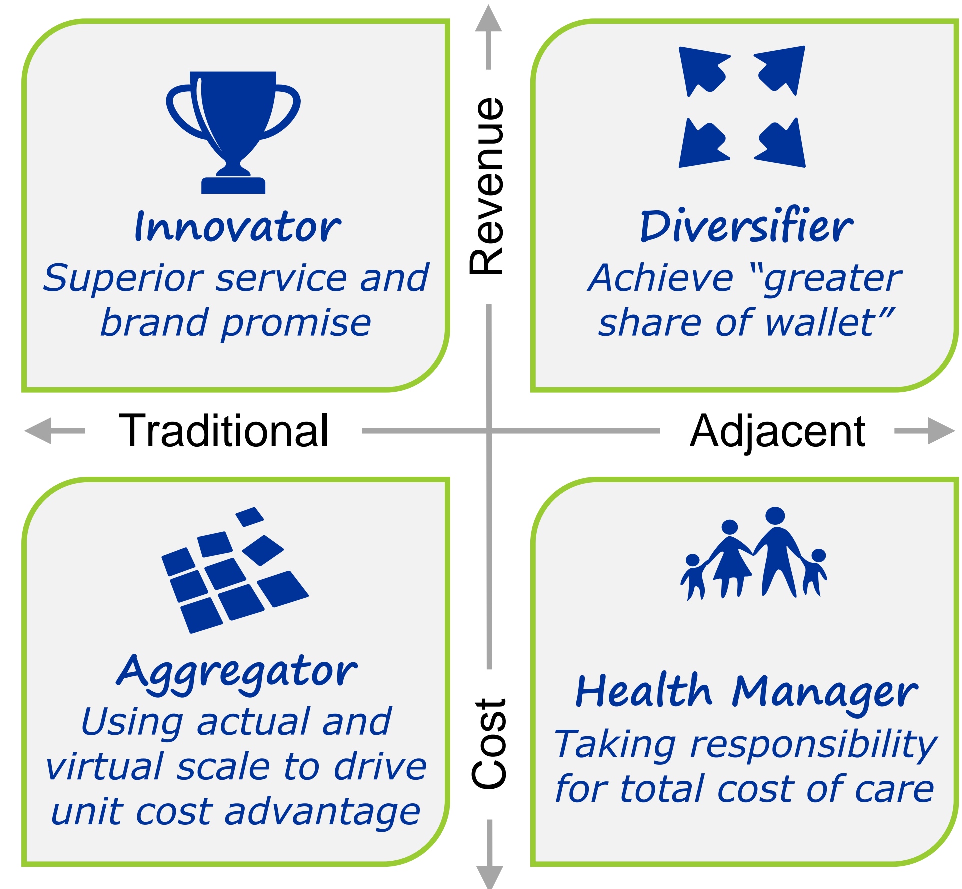
…..leading to rapid consolidation as providers pursue various strategies……

Provider M&A Transaction Growth[1]



Archetypal Provider Strategies



Volume of Reported Transactions: All Providers[2] Acute Care Hospital(s) Only

Notes: 1) Sourced from Irving Levin Associates; each "transaction" may include multiple assets/entities; data includes only significant, reported transactions and omits many common types of affiliations, collaborations and other M&A-spectrum events. 2) "All providers" includes transactions related to non-acute care hospital assets/entities such as: long-term care, home health care, large physician medical groups

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……but how far will it go?

Retail department stores

95 percent fewer U.S. department store chains are in operation today than in the 1960s.[1]

Airlines

75 percent fewer U.S. passenger airlines exist today compared to the 1970s.[2]

Banking

52 percent fewer banks exist today in the U.S. than 1990.[3]

Sources: 1)Clayton Christensen and Richard Tedlow, "Patterns of disruption in retailing," Harvard Business Review, 2000, 78(1), 42-45. Clayton Christensen, "The Innovator's Dilemma: When New Technologies Cause Great Firms to Fail," Harvard Business Press, 1997.; 2) Karl Russell, "Airline Consolidation Continues," The New York Times, February 14, 2013. http://www.nytimes.com/interactive/2013/02/14/business/Airline-Consolidation-Continues; 3) Changes in the Number of FDIC-Insured Institutions," Federal Deposit Insurance Corporation, http://www2.fdic.gov/qbp/grtable.asp?rptdate=2013dec&selgr=QSCAL1

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Consolidation will be driven by underlying strategy……

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....and influenced by a number of unknowns.

? How will the FTC and antitrust regulation influence consolidation?

? What VBC/ACO models will emerge as the most effective? Can providers run their own plans?

? What is the future and fate of health reform and the exchanges? How fast will shift to value really occur?

? How much will technology and technology firms threaten the provider share of wallet?

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Regulatory Trends: Impact of MACRA

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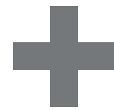
MACRA: Disruptive by design

MACRA is a game changer…the law will drive the future of health care payment and delivery system reform for clinicians, providers, and plans across their payer mix



With the repeal of the SGR formula, MACRA sets updates to the Medicare Physician Fee Schedule (PFS) and for the first time evaluates clinicians' performance **at an individual level**

MACRA offers significant financial incentives for health care professionals to participate in risk-bearing, coordinated care models and to **move away from the traditional fee for service system**

MACRA is poised to drive increased participation in **risk-bearing coordinated care models across all payers, not just Medicare**

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Payment basics under MACRA

MACRA replaces the SGR formula for payments under the Medicare Physician Fee Schedule (PFS) with fixed annual payment updates for all years in the future

MACRA creates separate paths for payments under the Medicare Physician Fee Schedule:

Advanced Alternative Payment Models (APMs)

- From 2019-2024, **lump sum payments** equal to 5% of all reimbursement for services rendered under the Medicare PFS
- Beginning in 2026, annual payment updates of **0.75%** to the Medicare PFS
- CMS has indicated which Accountable Care Organizations (ACOs) and models under the Center for Medicaid and Medicare Innovation will likely be considered Advanced APMs

Merit-based Incentive Payment System (MIPS)

- For 2019 and subsequent years, **positive or negative** payment adjustments based on clinicians' performance relative to scores of their peers across four categories: quality, resource use, clinical performance improvement activities, advancing care information
- Beginning in 2026, annual payment updates of **0.25%** to the Medicare PFS
- Eligible clinicians who do not achieve the APM revenue or patient thresholds will participate in MIPS and be subject to certain reporting requirements

Beginning in 2019, clinician Medicare payment adjustments each year will depend on which track the clinician's medical group falls into.

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Source: Public Law 114-10 (April 16, 2015)

Key takeaways from the Proposed Rule

Timeline

- The proposed rule moved up the MACRA timeline.
- The first performance period begins January 1, 2017, giving clinicians less than four months to prepare.
- Performance scores will be publicly available in advance of the 2019 payment adjustments. In addition, 2019 will be the first performance year under the combination All-Payer Model.

Reorganization of Clinical Networks

- The organization of clinicians under a tax structure will become increasingly important.
- Specifically, the manner in which clinicians are organized under Tax Identification Numbers (TINs) will affect performance reporting and how they are associated with Advanced APM participation across clinically integrated networks.

Merit-based Incentive Payment System (MIPS)

- All Medicare Part B clinicians will report through MIPS during the first performance year.
- Most clinicians will fall under MIPS—CMS estimates that between 687,000-746,000 clinicians will fall under MIPS, while only 30,658-90,000 clinicians will qualify for the Advanced APM track.
- MIPS performance measures could be updated, removed, or changed annually.

Advanced APMs

- There are limited options for Advanced APMs that could shape future plan design options.
- In the proposed rule, CMS suggested that only six existing payment arrangements would initially qualify as an Advanced APM.
- Application window is closed for 2017 Advanced APM options.

Based on what we have learned, health systems, plans, and clinicians can begin to strategically prioritize how to proceed with MACRA in the next four months.

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Source: Public Law 114-10 (April 16, 2015)

Options for participation under MACRA

CMS announced new options for participation in MIPS that are intended to give clinicians more flexibility for reporting in the Quality Payment Program (QPP) in 2017 with payment adjustments in 2019

Participation Option	Payment Adjustment / Incentive Payment
Clinician does not report data	Negative adjustment
Clinician reports some data	No adjustment
Clinician reports full set of data for reduced number of days	"Small" positive adjustment
Clinician reports full set of data for full calendar year	"Modest" positive adjustment
Clinician qualifies in an Advanced APM	5 percent incentive payment

More detail will be provided in the final rule, which is expected to be released by November 1, 2016

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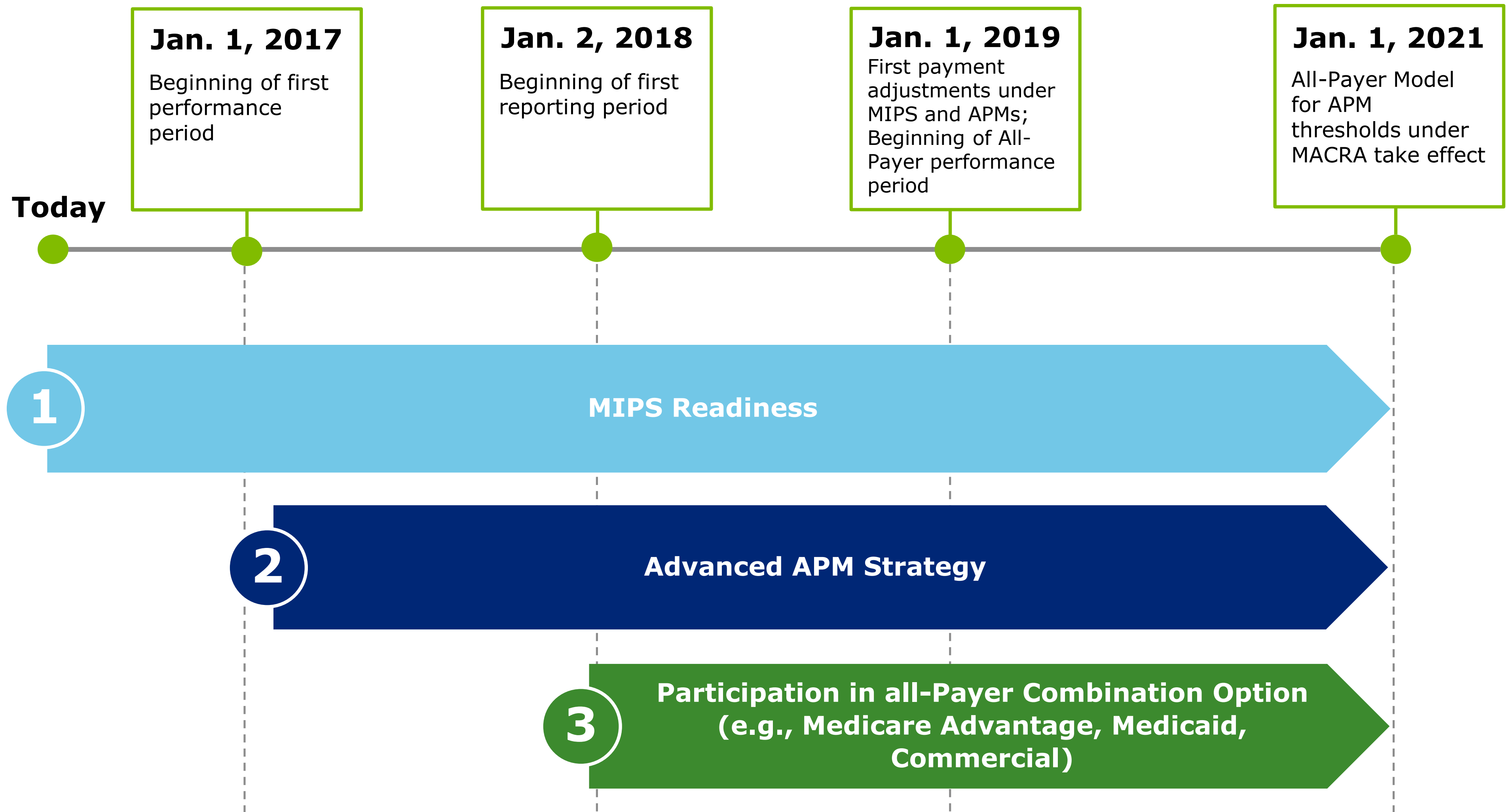
Source: CMS Blog, "Plans for the Quality Payment Program in 2017: Pick Your Pace", September 8, 2016

Strategic activities timeline based on key regulatory dates

The new MACRA law significantly impacts a number of key areas across health care provider organizations



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Source: Public Law 114-10 (April 16, 2015)

What we are hearing from health systems

In order to be successful, we'll need access to real-time claims data.

Which physicians are likely to perform well under risk-based contracts and MIPS?

What does the future provider-plan relationship look like?

How do we change our care delivery model to better deliver better outcomes more efficiently?

How should our physician compensation and incentives change, if at all?

Into which Advanced APM's should we move and in which performance year?

Do we need to re-examine all of our joint ventures?

What does this mean for our Medicare Advantage business?

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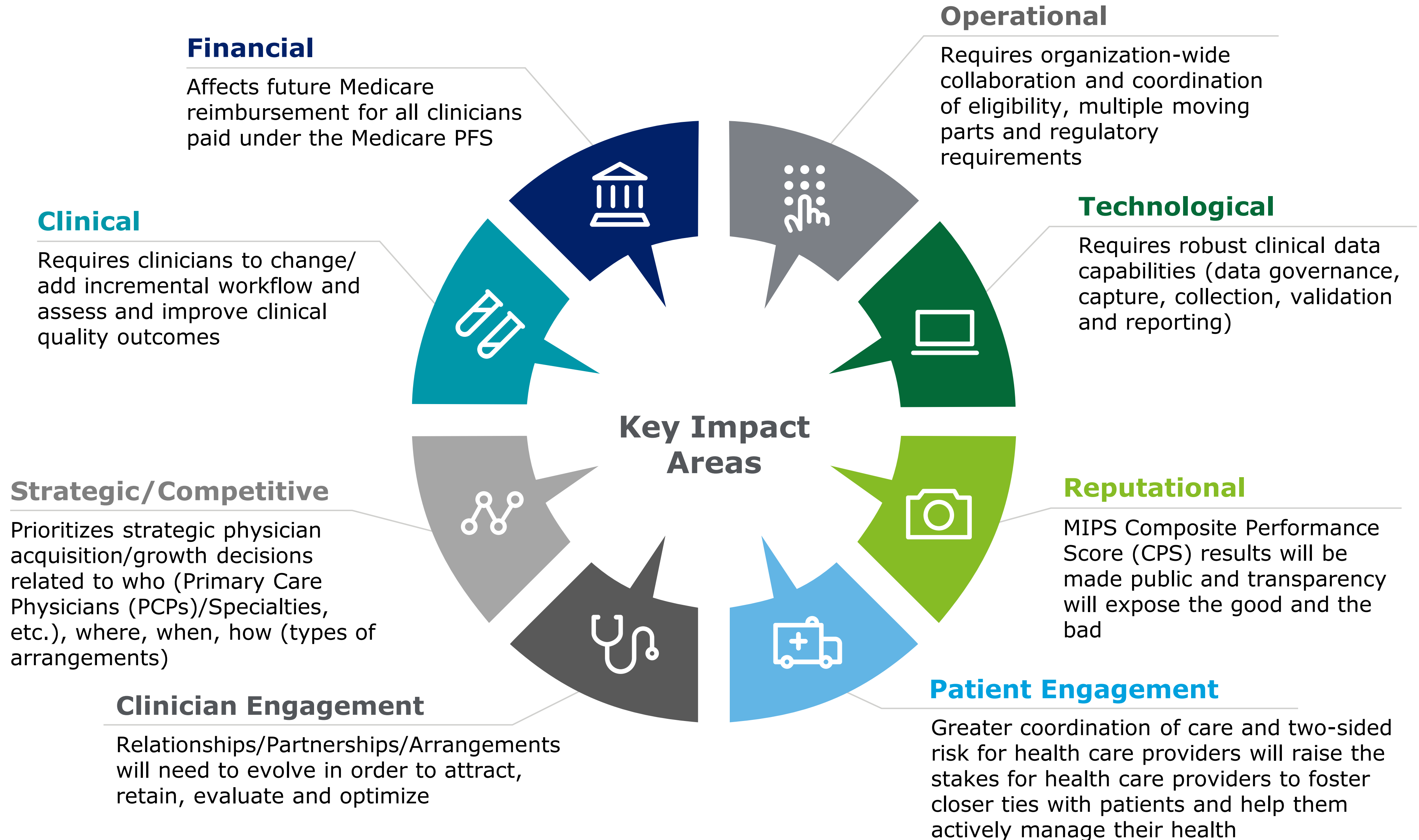
Implications of MACRA across health care organizations

The new MACRA law significantly impacts a number of key areas across health care provider organizations



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MACRA impact framework

Several categories of enterprise impact will require MACRA response strategies

Strategic

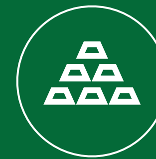
- Competitive positioning
- Transparency
- Consolidation
- Transformation readiness

Financial

- Professional and facility revenue
- Fixed cost infrastructure and new investment requirements
- Risk and physician contracting
- Financial transition management

Operational

- Clinical engagement & integration
- Data, analytics and reporting
- Process transformation
- Compliance management



Organizational

- Executive leadership alignment
- Talent & skills requirements
- Incentive re-alignment
- Change management and culture

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Smart first steps

Begin internal discussions with key enterprise stakeholders (including potentially the board of directors) on forthcoming MACRA impacts

Perform a thorough impact assessment to understand how MACRA will impact Strategic, Financial, Clinical, Technological, Operational, and Organizational priorities as well as exploration of strategies to gain access to higher percentage of the premium dollar

Plan and prepare for tactical changes and/or enhancements associated with MIPS readiness particularly given the Performance Range begins January 1, 2017

Make informed, strategic choices around moving in a swift and responsible manner towards Advanced APMs and Other Payer Advanced APMs

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