Healthcare Tipping Point and Beyond: Let’s Talk Strategy

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What About Strategy in This New World?

• Shopping patients with these options:
  – $400 MRI’s through Walmart
  – Teledoc e-visits for $40
  – Smart phone apps to monitor bio-metrics and keep them out of the doctor office
  – Cloud based care managers

• $15B - $30B regional health systems that span multiple states

• 80% of payment from Government and driven by a government moving to value and risk based reimbursement
2015: We Hit The Tipping Point

FEDERAL, STATE, AND PRIVATE PAYMENT CHANGE

BENEFIT AND INSURANCE MODEL CHANGE

ENABLING CONSUMER TECHNOLOGY ACCELERATION

Primary Forces of Change That WON’T go Away!
Follow the Money: Who Will Drive Payment Change?

Your Biggest Payer: The Government (Not the Blues)
The Nation is Moving to 58% Medicare, 73% Government Payer Mix by 2022

Source: CMS 2013 Annual Report; Kaiser Family Foundation 2016

MINNESOTA:
- 17% Medicaid
- 40% Medicare
- 42% Commercial
- 1% Uninsured
Reminder: 80%+ of Health System Volume Growth Will be Medicare and Medicaid

2012 – 2021 Projections

Average Medicaid Margin -35%

Average Medicare Margin -9%

16%
7%
2%

Source: HCAB 2011; Sg2; MedTrend
Must Do Strategy

Make Money on Medicare
2015: “The Year of CMS” Tipping Point

The Medicare Game:

Reward High Quality, Lower Cost Providers

(or at least punish them less!)
How Payers Will Pay: Payment is Moving to More Risk

Pay for Performance

MANDATORY
- Hospital Value Based Purchasing
- Hospital Readmissions
- Hospital Acquired Conditions
- MD MIPS

Bundled

OPTIONAL
- Bundled Payments for Care Improvement (BPCI)
- MD APM

MANDATORY
- Joint Bundle

ACO/TCOC Shared Savings

OPTIONAL
- ACO MSSP Track 1 (50% shared)
- Total Cost of Care - TCOC with commercial

ACO Shared Risk

OPTIONAL
- ACO MSSP Track 2 (60% shared)
- ACO MSSP Track 3 (75% shared)
- Next Generation ACO (80-85% shared)

Full Risk

OPTIONAL
- Next Generation ACO full risk option
- Capitation/Global
- Provider sponsored Medicare Advantage Plan
2015: Medicare Doubles Down on Move to Risk Payment

Existing FFS Will be Tied to Value: HAC, VBP, Readmissions, MIPS

New Targets to Move to Risk: ACO/Bundles

% Medicare payments tied to quality

<table>
<thead>
<tr>
<th>Year</th>
<th>2015</th>
<th>2016</th>
<th>2018</th>
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<tr>
<td>%</td>
<td>80%</td>
<td>85%</td>
<td>90%</td>
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% Medicare payment tied to risk models

<table>
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<tr>
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<tbody>
<tr>
<td>%</td>
<td>20%</td>
<td>30%</td>
<td>50%</td>
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9% of U.S. Hospitals in Optional Bundled Payments

About 400 Hospitals = 9% of All Hospitals in the US are in BPCI

Make-Up of BPCI Participants

- Physician Groups: 18%
- Hospitals: 26%
- Post Acute Providers: 51%

3 days pre-admission through 90 days post discharge

Source: CMS; AHA Statistics.
NEW 2016: CMS Mandatory Orthopedic Bundles (DRG 469/470)

>700 hospitals/ 67 markets
  – Charlotte/Concord/ Gastonia
  – Florence

• Regional pricing/ (Retrospective Model)

• Hospital controls the $$$

Source: HCAB, Modern Healthcare July 20 2015

BUNDLE = Part A + Part B + all in 90 days post discharge

- hospice
- home care
- outpatient
- SNF
- re-admit
- MD
- admission
More Bundles Coming

• MD Oncology Care Model
  – Episode payment (bundle) for chemotherapy administration
  – Optional today
  – Just started in 2016

• Future? Heart, Spine
Medicare ACO’s / Shared Savings – **Growing!**

ACO = Population Health and More Risk

**Total ACO’s Now At 685**

**Key Stats:**

- 26% of MSSP ACOs share in savings
- 9.0M Medicare FFS beneficiaries treated by an ACO. (10%)
- 23.5M Total Lives in All ACOs

Source: CMS, Health Affairs, Robert Wood Johnson Foundation
Now: Next Generation ACOs

- March 10 2015 CMS announcement
- 21 Systems Have Opted In
- Ability to take on *full capitated risk* by year 2
CURRENT SOUTH CAROLINA NEW PAYMENT PARTICIPANTS
2015 SGR Physician Fix – MACRA –

DOCTORS TAKING NOTICE

– .5% annual increase 4 years then 0%

– Opportunity for 5% bonus if 25% is in alternative payment: By 2022 Total Increase is +19% versus 0% under FFS annual update

– Incentive for doctors to begin their move away from FFS
New Payment Models Are Working For CMS

• HAC Savings:
  – $364M. CMS says at least $50M annually.

• Re-admissions Savings:
  – $280M annually. Expect $8.2B over 7 years.

• ACO Savings:
  – $411M in 2014.

Source: CMS; Commonwealth Fund
How are South Carolina Hospitals Doing?

Value Comparison by State, All Medicare Spending vs. Overall Quality Score
(updated 01/16)

Medicare Advantage Enrollees Expected to Double by 2025
(Capitated Payments)

- ACA moving payments to align with other Medicare payments (versus 14% higher)
- **High motive for these plans to push risk to providers/doctors**
- Many systems developing their own MA plans

Source: Kaiser Family Foundation, 2015; McKinsey

South Carolina is at 23% today
Medicare Testing Cost Sharing???

CMS Announces Medicare Advantage Value-Based Insurance Design Model Test

A 5-year demonstration program will test the utility of structuring consumer cost-sharing and other health plan design elements to encourage patients to use high-value clinical services and providers.

*Red denotes states included in V-BID model test*
CMS Payment Direction

- FFS
- Site specific
- Per unit based
- Value based
- Site neutral
- Bundled/Episode/Shared Risk

Expectation to take care of more Americans, do it better, do it for less $/patient
Commercial Insurers Move to Risk/ Value

• Blue Cross Blue Shield (37 Plans) 570 Value based programs, 450 ACO’s in 32 states.  
  – Goals of 80% of payments by 2018

• Anthem MD Shared Savings Program – saved $81M (largely hospital admissions, outpatient surgeries, ER visits)

• Cigna has a goal of 90% payments value based and 50% alternative models by 2019.

• United Health Group has a goal of 80% by 2018. Using episodes in Oncology.
Does it work for payers?

Commercial Episodes Save Money.

– BCBS NJ Episodes of Care
– 100% fewer hospital re-admissions after knee arthroscopy
– 37% fewer hospital re-admissions for Hip replacement
– 22% fewer hospital re-admissions for knee replacement

Source: CMS; BCBS NJ
REALITY

- It might be slow
- It will be clunky and imperfect and frustrating
- BUT PAYMENT IS CHANGING
Minnesota Payment Learnings: Tension Points and Strategies

**TENSION POINT/ REALITIES**

- ACO/ TCOC Payment built around Primary Care. Hospitals not at the center.

**STRATEGY**

- Drive for MD Integration and Partnership – Build Your System of Care!
  
  - All about Enough LIVES for payment
  - Specialists critical in ACO/ Bundled
Minnesota Payment Learnings: Tension Points and Strategies

**TENSION POINT/ REALITIES**

- Fragmented, lagging data (required for care management)

**STRATEGY**

- **Build Data Infrastructure to Manage Care in Real Time**
  - Integrated data and analysis (warehouse)
  - Big Challenge, Big MD Pet Peeve
  - Risk: Health Plans Have it, we Don’t!
# Minnesota Payment Learnings: Tension Points and Strategies

<table>
<thead>
<tr>
<th>TENSION POINT/ REALITIES</th>
<th>STRATEGY</th>
</tr>
</thead>
</table>
| • Lack of care standards/ protocols prevents best outcomes and $ | • Create MD Led Clinical Pathways and Care Standards  
  – Can’t Have Multiple Ways and One Brand |
| – Can’t Have Multiple Ways and One Brand | – Make it their work/ their ideas |
Minnesota Payment Learnings: Tension Points and Strategies

TENSION POINT/ REALITIES

• MD Resistance to Change Practice Patterns

STRATEGY

• Create MD Led Aligned Incentives. Go Slow.
  – Example: Spine
  – Employed – Compensation Model
  – Partners – ACO/ Bundled Incentives
Minnesota Payment Learnings: Tension Points and Strategies

TENSION POINT/ REALITIES
• Still too much Tertiary/Specialty Capacity (10-20%)
  – “Feed the Beast” Challenge

STRATEGY
• Build Best Network/Steal Share
  – REALITY: Someone will have to downsize
Minnesota Payment Learnings: Tension Points and Strategies

**TENSION POINT/REALITIES**

- Culture, Governance and Incentives Still FFS

**STRATEGY**

- Design Clear Transition Paths for Shift to Value and Include MDs
  - Start with Governance and Leadership Models with Strong MD Involvement
  - Re-think incentives beyond bottom line budgets
Minnesota Payment Learnings: Tension Points and Strategies

TENSION POINT/ REALITIES

• Commercial Payers Don’t Want to Share More Risk – Won’t Give up Margin and Control.
  – But Getting the Savings From our Medicare/ Medicaid re-design work.

STRATEGY

• Own the Premium Dollar
  – Build Medicare Advantage Product
  – Go direct to Employer
  – Keep working on Insurers to Share More Risk
Minnesota Payment Learnings: Tension Points and Strategies

TENSION POINT/ REALITIES

• Not Ready to Go All In on Population Health, But Have To Start

STRATEGY

• Start with Employees
  – Already Own 100% of the Risk
  – Learning Lab Approach
  – Presbyterian (NM)
How Consumers Buy: Public Exchange Uptick Still Developing

- Why the slower uptake?
  - Employers are not dropping coverage and pushing employees to exchanges
  - Individuals going direct to health plans

Source: HHS
No Surprise: 64% of Public Exchange Consumers Pick Cheapest or 2nd Cheapest Plan

85% chose cheaper Bronze and Silver

50% of Bronze Plans Require the patient to pay 30% of Doctor Fees

National Plan Selection

Plan Choice Within All Metal Levels:

- 43% pick lowest cost plan
- 21% pick 2nd lowest cost plan

High Deductible Products Have Already Grown 4X Since 2006

US household economics

- Median incomes stuck at 1998
- 48% don’t have $400 cash
- Worker contribution to premiums +83% since 2005

Source: Kaiser Family Foundation
Public Exchange Selection Dominated by High Deductibles; 68% Have A Deductible $3000+

Level of Deductible Chosen on Exchange Market

<table>
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<tr>
<th>Deductible Range</th>
<th>2015</th>
<th>2014</th>
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<tr>
<td>$6000+</td>
<td>34%</td>
<td>39%</td>
</tr>
<tr>
<td>$3000-$5999</td>
<td>34%</td>
<td>30%</td>
</tr>
<tr>
<td>$1000-$2999</td>
<td>23%</td>
<td>16%</td>
</tr>
<tr>
<td>&lt;$1000</td>
<td>10%</td>
<td>16%</td>
</tr>
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Average HSA/ HRA Account Balance, 2014

$2,077
Exchange Products: Narrow Networks Dominate

Narrow Networks confer a 15-23% premium discount.

Source: McKinsey

Narrow = Only 70% of hospitals
Ultra Narrow = Only 30% of hospitals
This is Tipping Point for Retail:
What Matters to Consumers When Purchasing Health Products or Services?

- Price: 82%
- High Quality Ratings by Customers: 64%
- Quality Ratings by Govt or Well Known Groups: 47%
- Word of Mouth: 42%
- Brand name: 35%

Patients Shop When It’s Their Money!!
The New Retail Market

• 50% of patients seek out cost information before seeking care;

• 20% compare costs across providers before choosing

• Typical services below $6K
  – Primary care visit $150
  – Specialist visit $275
  – Ultrasound $400
  – Suture $850
  – MRI $900
  – Endoscopy $1000
  – Colonoscopy $2000

Source: Advisory Board Company; Healthcare BlueBook; Employer Health Benefit Survey 2014, Claxton et. Al.
Cost Transparency Will Drive Cost Competition – Value WILL WIN

• 2014 Total Cost of Care Results from Minnesota Community Measurement

  – North $368
  – HealthPartners $392
  – Fairview $409
  – Park Nicollet $424
  – Allina $434
  – Mayo Clinic $826

• BIG CHANGE:
  – 66% of consumers do not believe high cost = high quality

Source: Accenture; Kaiser/HRET Survey; MN Community Measurement
Exchanges and Employers Demand Pricing Transparency for Point of Service Decisions

- $400M in Venture Capital for transparency tools to show pricing and quality or care provider options

*Source: Catalyst for Payment Reform Survey*
Our Strategy:
Build Products for Employers/ Exchanges

• Be value competitive in the market

• Position to “go around” the health plans—another way to get the premium dollar/ margin

• Clinically Integrated Networks / Narrow Networks/ System of Care
New Competitors

• Retail Clinics/ Urgent Care Centers

• Tele-docs

• SMART apps (Apple, 23&me, Stanford Medicine)

• IBM Watson – just spent $2.5B to buy Truven Health Analytics
Which Way Will The Market Go?

**Integrated Delivery**
- Buy integrated network
- Win lives
- Manage across continuum
- Providers take more risk

**Unbundled Niche Market**
- Buy best in class solution
- Service line competition
- Fragmented care with possible third party care manager
Who Wins in the New World?
Will Scale Win?

2025 Provider Landscape Dominated by 100 Super Regional Mega Systems

- $10B+ of Revenue
- 30+ Hospitals
- 300+ Clinics

Size

Ability to Manage Risk

- Low
- High

Small IDN

Independent Hospital

Standalone AMC

National Mega System ACO

Allina Health

Sanford Health

Aurora

Sutter Health

Mayo Clinic

HCA

Cleveland Clinic

Dignity Health

Trinity Health

Intermountain Healthcare

Kaiser Permanente

Advocate Health Care

Johns Hopkins Medicine

MedTrendInc

Intelligent Strategies
Shift Toward System Ownership

% of Hospitals with a System Ownership

<table>
<thead>
<tr>
<th>Year</th>
<th>National</th>
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<tbody>
<tr>
<td>2000</td>
<td>52%</td>
</tr>
<tr>
<td>2010</td>
<td>60%</td>
</tr>
<tr>
<td>2016</td>
<td>65%</td>
</tr>
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Source: MHA; AHA Guide 2016
Providers with Superior Value
How do payers and employers see you versus competition?

REGARDLESS OF PAYMENT MODELS, VALUE PROVIDERS WILL WIN!

![Graph showing cost per episode, surgery, admission vs overall quality score. The graph indicates a sweet spot where both costs and quality are high.](image)

Cost per Episode/ Surgery/ Admission

Overall Quality Score

State Average

State Average

MedTrendInc. Intelligent Strategies
Systems Who Create Re-Designed Systems of Care

- Patient Centered
- Coordinated
- Seamless hand-offs
- Navigation

Source: Navigant
Systems Who Embrace Population Health
Heart Disease: What will save the most lives?

- # lives saved/1000
  - Defibrillators in place 2
  - Hypertension controlled 3
  - Best cardiac care in hospital 5
  - No second hand smoke 7
  - Heart patients take meds 10
  - Physical goals met 48
  - Nutrition goals met 74

Source: HealthPartners
Systems Who Deliver The Triple Aim

The IHI Triple Aim

Population Health

Experience of Care  Per Capita Cost
The New Success Metrics

• Lives/ Bed
• Spending on the top 5-10%
• Cost for a visit for other 90%
• Patients/ Community Engaged in Wellness
## Core Competencies to Drive Integration’s Value

### Cost Efficiency
- Scale enabled lean structure
- Rationalized services portfolio
- Rightsized footprint

### Trend Control
- Analytics to understand patient segments and get patients to the right resources/care sites
- Care managers and navigators

### Coordination
- Interconnected care infrastructure that enables patient flow
- Single IT infrastructure with seamless transfer of information

### MD Led Standardization
- Uniform care processes to produce consistent outcomes
- Dissemination of best practices across the enterprise

Source: HCAB 2016, MedTrend
The Playbook – Your Road Map
What are You Working On?

New Channels for Growth: Employers, Exchanges, Individuals

- Provider Alignment/System Partnerships
- Redesign Processes & Care Models to Improve Value
- Reach for Scale and Efficiency
- IT and Measurement Infrastructure
- Grow PC share & create leverage with payers
- New Channels for Growth: Employers, Exchanges, Individuals

Alignment of Governance and Structure

Alignment of Culture
### Implications for Hospital Associations

**FROM**
- Focus on every FFS reimbursement issue
- Focus on hospital market protection with today’s hospital model
- Focus on protecting “sacred cow” service lines or providers
- Focus on protecting old FFS/ volume world

**TO**
- Aligning policy/ reimbursement to a value driven world
- Preparing hospitals to transform to create the new system of care
- Develop the efficient care model putting right provider in right place
- Building the new capacity for health improvement and new payment
"You can't connect the dots looking forward; you can only connect them looking backwards. So you have to trust that the dots will somehow connect in your future."

Steve Jobs
1955-2011

“Stay hungry, stay foolish.”