“Physician-hospital partnerships: Swing of the pendulum or a new reality?”

Jim Boswell, Vice President – Physician Services
CEO – Baptist Medical Group
Our Environment . . .

- What is driving Physician / Hospital integration?
- Why now?
- What barriers / challenges exist?
- Is it a flash in the pan or the new reality?
- Is it long-term sustainable by health systems?
- Why are physicians moving towards alignment?
- What alignment structures are out there?
- How do recent Health Care Policy decisions impact us?
Health Care Cost – What We Know

- 1983 - $1,200 per capita – today $8,500
- 1983 – 9% GNP – today 17.5%
- Estimated 2020 approx. 20%
We know what we have done with benefit plans . . .

- Restricted networks
- Medical Management and utilization controls
- Reduced benefits ... higher copay, higher deductibles,
  higher out-of-pocket limits, increased premiums, etc.
- Modified, almost eliminated “managed care” due to
  consumer demand for “choice”.

BMG
BAPTIST MEDICAL GROUP
Yet, Our Cost Continues To Increase...

- Aging population
- Technology
- Lifestyle . . . “personal responsibility”
- Increased utilization and demand for services
We know it was a crisis 30 years ago and remains a crisis today . . A crisis which will be difficult to “Fix”
We believe integration/alignment with physicians is the key to transitioning the care delivery system.
Why Are Physicians & Hospitals Integrating?

- Population Health Management
- Health Care Payment Reform – Accountable Payment
- Practice Economics
- Strategic Opportunity
- Efficient, Coordinated Care
- Improve Cost & Quality Care
How physicians and hospitals are creating sustainable relationships

1) Shared governance
2) Aligned compensation
   - Balance production and quality incentives
3) Changing physicians practice patterns
   - Less focus on volume and more focus on system quality and efficiency
   - Elements of health reform such as ACO’s, bundled payments, and medical homes are designed to redesign the care delivery model but likely will reduce utilization
   - Utilization of national guidelines
“At the end of the day, the one thing that must exist in order to survive the health reform is the creation of strong relationships between physicians and hospitals.”
Physician alignment: Why now?

Health reform initiatives and incentives provide the tipping point to accelerate the existing momentum for health system/physician alignment.

**Volume Focused**
- Reimbursed per admission and/or units of work
- Physicians seeking employment models for income security and lifestyle reasons
- Limited incentives to prevent admissions or coordinate care
- Continuum lacks integration
- Declining reimbursement for hospitals and physicians
- Significant uninsured and underinsured
- “Pay-for-compliance” rather than true outcomes-based reimbursement
- Limited access to capital for technology investments required to meet HI-TECH
- Regulatory issues that restrict integration e.g., Stark, Anti-Kick Back, Private Inurement, etc

**Value Focused**
- Competing on quality, patient safety, cost effectiveness, and coordination of care
- Episodic/Bundled payments mechanisms
- Shift of large groups of uninsured to capitated Medicaid population
- HITECH dollars technology use and integration
- Improved documentation of care and information sharing through HIE’s
- Accountable Care Organizations/Medical Homes
- Demonstration projects factor more and more into reimbursement and government payments
- New focus on prevention and population health
The New Integration Imperative
Dual Forces Pushing Physicians and Hospitals Together

Driving Factors for Alignment

1. Economic Concerns
   - Continued cost pressures
   - Payer mix shift
   - Looming physician shortage

2. Health Reform
   - Increased accountability for costs, outcomes
   - Emphasis on care value
   - Inpatient demand destruction
   - Competition to lock in high‐value physicians

Hospitals

Physicians

- Declining volumes
- Ancillary reimbursement cuts
- Professional fee cuts
- Rise in practice costs
- Uncertainty around impact of new payment models, coverage expansion
- Change in incentives
- Specialty demand destruction
- Fear of being left out of accountable care networks

Source: Health Care Advisory Board interviews and analysis.
A Rapidly Rising Tide

Across the Country, Employment on a Clear Upswing

- Five-hospital system
  - 80 physicians employed by foundation, up from zero in 2008

- Two-hospital system
  - 230 employed physicians, up from 25 in 2005

- Two-hospital system
  - 800 employed physicians, up from 50 in 2008

- Three-hospital system
  - 311 employed physicians, up from 70 in 2008

- Five-hospital system
  - 260 employed physicians, up from 70 in 2008

- 210-bed hospital
  - 100 employed physicians by 2012, up from 21 in 2009

Source: Health Care Advisory Board interviews and analysis.
Adding Fuel to the Fire

Emerging Trends Exacerbating Traditional Employment Drivers

**Market Share Protection**
Need to fill critical coverage gaps, recruit for high-growth service lines, or lock in “splitter” physicians

**Physician Instability**
Demographic shifts, worsening financials, reform uncertainty leading to greater proactive physician interest in an employment relationship

**Future Option Value**
Looming reimbursement risk shift—requiring a tightly integrated physician base—giving employment a subtle edge as hospitals consider alignment options

Source: Health Care Advisory Board interviews and analysis.
**Physicians on the Edge**

**Changing Demographics, Financial Woes Sparking Search for Shelter**

**Changes in the Physician Marketplace**

**Demographic Shifts**
- Large number of older physicians approaching retirement
- New generation placing greater premium on work-life balance, team-based care

**Worsening Financials**
- Key specialties (e.g. cardiology, oncology) confronting new reality of reimbursement cuts
- Practice costs rising faster than revenue

**Reform Uncertainty**
- PCPs seeking well-capitalized partners to support investment in care coordination resources
- Specialists seeking tight network alignment to assuage fears of losing referral streams

Source: Health Care Advisory Board interviews and analysis.
Navigating Divergent Payment Models

Incentive Disconnect Complicating Transition

"Navigating this migration is our central management challenge for the next decade. Transitions are always messy, and we’re in a transition period. You can’t have one foot in two boats forever.”

Chief Executive Officer
10-Hospital Health System

Source: Health Care Advisory Board interviews and analysis.
What are some of the barriers to physicians aligning?

- Trust, Trust, Trust
- Voice, Voice, Voice
- Clinical Autonomy
Is it a flash in the pan or the new reality?

They Do Agree on Some Things, You Know

Political Consensus on Flaws in Current Reimbursement Incentives

From the Left

“[The current system] pushes you, the doctor, to see more and more patients, even if you can't spend much time with each, and gives you every incentive to order that extra MRI or EKG, even if it's not truly necessary, ...[Fee-for-service has] taken the pursuit of medicine from a profession -- a calling -- to a business.”

- President Obama

“Today’s payment systems reward providers for delivering more care rather than better care. A redefined health system would realign payment incentives toward improving the quality of care delivered to patients.”

- Sen. Max Baucus

From the Right

“We should pay a single bill for high-quality health care, not an endless series of bills for pre-surgical tests and visits, hospitalization and surgery, and follow-up tests, drugs and office visits.”

- Sen. John McCain

“The fact is, right now, we encourage volume over value...We’ve got to really analyze what is the net outcome.”

- Sen. Olympia Snowe

“Our current fee for service system creates the absolute wrong incentives for both patients and doctors and is what’s driving the health care cost in this country higher and higher”

- Fmr. Gov. Mitt Romney
Getting Paid Less to Do Less

New Payment Models Calling Old Imperatives Into Question

Accountable Payment Models

<table>
<thead>
<tr>
<th>Performance Risk</th>
<th>Utilization Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of Care</td>
<td>Quality of Care</td>
</tr>
<tr>
<td>Volume of Care</td>
<td></td>
</tr>
</tbody>
</table>

**Bundled Pricing**
- Bundled Payments for Care Improvement program
- Commercial bundled contracts

**Pay-for-Performance**
- Value-Based Purchasing
- Readmissions penalties
- Quality-based commercial contracts

**Shared Savings**
- Medicare Shared Savings Program
- Pioneer ACO Program
- Commercial ACO contracts

Source: Health Care Advisory Board interviews and analysis.
Medicare Fired the Starting Gun...

CMS Vaulting ACOs to the Top of the Policy World

Timeline of CMS ACO Activity

- Study of “Accountable Care Organizations” in *Health Affairs* article
- Passage of Patient Protection and Affordable Care Act (PPACA)
- Initiation of Physician Group Practice Demonstration
- Introduction of “Bonus-Eligible Organization” in CBO report
- Release of Final Rule for Medicare Shared Savings Program

...But Isn’t (Necessarily) the Pace Car

Private Market ACOs Developing Nationwide

<table>
<thead>
<tr>
<th>Provider</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providence Health &amp;</td>
<td><strong>Services:</strong> $30 M, two-year contract with public employee benefits board</td>
</tr>
<tr>
<td>Services</td>
<td></td>
</tr>
<tr>
<td>BCBS Minnesota</td>
<td><strong>Shared savings contract with five providers</strong></td>
</tr>
<tr>
<td>Blue Shield California</td>
<td><strong>Two ACOs in Northern California</strong></td>
</tr>
<tr>
<td>Anthem Blue Cross</td>
<td><strong>ACO pilot with Sharp HealthCare medical groups</strong></td>
</tr>
<tr>
<td>Humana</td>
<td><strong>ACO pilot with Norton Healthcare</strong></td>
</tr>
<tr>
<td>UnitedHealth Care</td>
<td><strong>ACO with Tucson Medical Center</strong></td>
</tr>
<tr>
<td>CIGNA</td>
<td><strong>Medical home contract with Piedmont Physicians Group</strong></td>
</tr>
<tr>
<td>Maine Health Management</td>
<td><strong>Coalition:</strong> Multi-stakeholder group supporting ACO pilots</td>
</tr>
<tr>
<td>BCBS Massachusetts’s</td>
<td><strong>Alternative Quality Contract:</strong> Annual global budget, quality incentives</td>
</tr>
<tr>
<td>Alternative Quality</td>
<td>for participating providers</td>
</tr>
<tr>
<td>BCBS Illinois</td>
<td><strong>Shared savings contract with Advocate Health Care</strong></td>
</tr>
<tr>
<td>Blue Shield California</td>
<td><strong>Two ACOs in Northern California</strong></td>
</tr>
<tr>
<td>Aetna</td>
<td><strong>ACO pilot with Carilion Clinic</strong></td>
</tr>
</tbody>
</table>

Evolving Toward a Patient-Centered Culture

Successful Partnership Requires Revamping Organizational Culture

**Hospital Culture**
- Bureaucratic and deliberative
- Siloed mentality
- Seeks alignment
- Focus on high-margin acute care
- Responsible to community at large

**Patient-Centered Culture**
- Principled and responsive
- Collaborative and interdependent
- Commitment to evidence-based care
- Delivery of high-quality, low-cost care
- Responsible to patients

**Physician Culture**
- Agile and reactive
- Siloed mentality
- Cherishes autonomy
- Focus on individual productivity
- Responsible to physician partners

"Putting Patients in the Forefront"

“Virtually all physicians and hospitals throughout the world say ‘Patients come first’—but relatively few are ready to act on the implications of this slogan, which include ‘Physicians come second.’”

Thomas Lee, MD
James Mongan, MD
Partners HealthCare

## Three Objectives for the Hospital-Physician Enterprise

### Live on Medicare and Medicaid Margins

- Create and follow clinical protocols and care standards
- Secure referral streams
- Prevent low-margin medical admissions, ED utilization
- Maximize capture of ambulatory and inpatient revenue

### Prepare for Heightened Accountability

- Treat patients at most appropriate site of care
- Coordinate handoffs across the care continuum
- Proactively manage chronic illness
- Minimize duplicative care delivery

### Advance the Mission

- Build a patient-centric health care delivery system
- Provide high-quality, high-service, low-cost clinical care
- Improve overall health and wellness of the community

Source: Health Care Advisory Board interviews and analysis.
Physicians Currently at a Precipice

Twin Challenges of Economy and Reform Creating Significant Sense of Instability

Twin Challenges for Physicians

Faltering Practice Economics
- Volume decline
- Ancillary reimbursement cuts
- Professional fee cuts
- Rise in practice costs

Uncertainty Around Health Care Reform
- Change in incentives
- Emphasis on value of care
- Increased payment risk
- Demand destruction

Source: Health Care Advisory Board interviews and analysis
A Range of Viable Partnership Options

Reshuffled Deck of Hospital-Physician Relationship Opportunities

“Surging in Popularity”
- Employment
- Clinically Integrated PHOs
- Co-Management
- Bundled Payments

Substantial opportunity to design performance-based physicians incentives

“Staging a Comeback”
- Traditional PHOs
- Gainsharing

Able to create limited performance-based physician incentives

“Down but Not Out”
- MSOs
- Joint Ventures
- Medical Directorships

Limited ability to create performance-based physician incentives or create shared accountability; questionable long term viability

“Dead or Dying”
- Whole-Hospital JVs
- Per-Click Leasing
- Under Arrangements

Increasingly illegal or facing substantial regulatory scrutiny

Source: Health Care Advisory Board interviews and analysis.
Assembling the Physician Enterprise Step One for Accountable Care Preparation

Physician Partnerships Essential for Success in New Accountable Payment Paradigms

Evolution Toward Accountable Care

- Accepting Total Cost of Care Accountability
- Organizing for Performance
- Assembling the Physician Enterprise

Degree of Population Health Management

Journey to Accountable Care

Time

Source: Health Care Advisory Board interviews and analysis.
Success in the new health care economy will — more than ever before — require hospitals to make physicians true partners in the delivery of coordinated, high-quality, low-cost care.
The Legal Structure
Horizontal Integration

BMHCC
501(c)(3) (parent)

Baptist Medical Group
501(c)(3) (sub-parent)
(sub-parent)
(300)

Baptist Memorial Hospital(s)
501(c)(3)

Arkansas
Mississippi
Tennessee
A balanced approach to building a Physician Enterprise

- Design the governance model
- Design the productivity model
- Build the practice management expertise
- Develop systems (EMR, Quality, Practice Management tools)
- Develop the group culture & physician leadership
- Coordinate care
Recent Health Care Policy
The Waiting Game is Over

Chief Justice Roberts Authors Ruling Upholding Majority of ACA

Affirmed and Reversed

“The Affordable Care Act is constitutional in part and unconstitutional in part.”

Chief Justice John Roberts

- Individual mandate upheld as tax; individuals without health insurance starting 2014 will pay tax to IRS
- Medicaid expansion now optional; Federal government cannot withhold current funding if states decide against Medicaid expansion

Source: Supreme Court of the United States, available at:
Not Quite What They Expected

Many Signs Pointed to Striking Down Individual Mandate

“Supreme Court ‘Experts’ Think Mandate Likely to Be Struck Down”

“Intrade Betting Individual Mandate Will be Ruled Unconstitutional”

“Poll Results: Court Will Shoot Down Individual Mandate”

“Constitutional Experts: Mandate Should Be Upheld, But Likely Won’t Be”

“Scholars Say Health Care Reform Law Likely to Be Struck Down”

72.8%

Intrade’s reported probability that the individual mandate would be ruled unconstitutional as of June 27, 2012

Three Constitutional Questions Resolved

High Court Decision Ends Constitutional Uncertainty

Three Key Decisions

Constitutional Discussion

Individual Mandate:
Can the federal government compel individuals to purchase health insurance?

Medicaid Expansion:
Is the ACA's Medicaid expansion a violation of states' rights?

Severability:
Should the remainder of the ACA stand if a portion is struck down?

Supreme Court Decision

Upheld under Congress' power to impose taxes

Medicaid expansion upheld; federal government may not withhold existing Medicaid funds if states forgo expansion

The remainder of the law can stand

Arguments Supporting Individual Mandate

<table>
<thead>
<tr>
<th>Constitutional Authority</th>
<th>Supreme Court Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commerce Clause</td>
<td>X</td>
</tr>
<tr>
<td>Necessary and Proper Clause</td>
<td>X</td>
</tr>
<tr>
<td>Power to Tax and Spend</td>
<td>✓</td>
</tr>
</tbody>
</table>

1) The Court ruled that Congress cannot compel purchase of health insurance but may impose a tax on individuals without health insurance.

Source: Health Care Advisory Board Interviews and Analysis.
# Most ACA Provisions Untouched

<table>
<thead>
<tr>
<th>Year</th>
<th>Coverage Expansion</th>
<th>Financing</th>
<th>Delivery System Reform</th>
</tr>
</thead>
</table>
| 2010 | - Coverage for non-dependent children through age 26  
      - Prohibition on denying coverage for children with pre-existing conditions  
      - Small business subsidies to provide coverage to employees  
      - High-risk pools for those denied coverage | - Tanning salon tax takes effect  
      - Market basket adjustment to DRG updates | - Patient-centered outcomes research  
      - Community transformation grants  
      - Gainsharing, global payment demos  
      - Hospital Value-Based Purchasing |
| 2011 | - Five year opt-in long-term care program begins | - Medicare Advantage payments restructured | - Center for Medicare and Medicaid innovation launched |
| 2012 | | - First industry fees take effect  
      - Medicare Advantage bonuses take effect  
      - Hospital productivity adjustment | - Medicare Shared Savings Program (ACOs)  
      - Hospital Readmission Reduction Program  
      - Independence at Home demonstration |
| 2013 | - Increased payments to primary care physicians take effect | - New Medicare tax takes effect  
      - Passive income tax takes effect  
      - Excise tax on medical devices takes effect | - Bundled payment pilot begins |
| 2014 | - Health Benefit Exchanges created  
      - Individual, employer mandates take effect  
      - Medicaid expanded to 133% of FPL† | - Individual, employer penalties take effect  
      - DSH payment adjustments take effect | - Independent Payment Advisory Board begins submitting recommendations  
      - Payment adjustment for hospital-acquired conditions takes effect |
| 2015 | | | |
| 2016 | | | |
| 2018 | | | \*Excise tax on "Cadillac" health plans |

* Federal poverty level.  
† Source: Health Care Advisory Board interviews and analysis.
The Year in Health Care

Three Flashpoints in Health Care Policy

**November 2012:**
- Economy issues central to elections
- Medicaid budgets influence state elections
- House and Senate majorities potentially shift

<table>
<thead>
<tr>
<th>Supreme Court Ruling</th>
<th>2012 Elections</th>
<th>End of Year Budget Debate</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2012:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decision on:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Individual mandate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Medicaid expansion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Insurance reform</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Severability</td>
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</tbody>
</table>

**December 2012:**
- “Doc fix” worth $18 B to expire
- Bush tax cuts expire
- Federal government hits debt ceiling limit of $16.39 T
- $1.2 T sequester cuts take effect, including 2% cuts to Medicare
- Debt ceiling deal further cuts spending

Source: Medical Group Strategy Council interviews and analysis.
States Face a Complex Calculus

Expanding Medicaid Now a State-by-State Decision

Factors Influencing State-Level Medicaid Expansion Decisions

**Undergoing Medicaid Expansion**

- **Public Benefit**: Will significantly reduce uninsured population among legal residents
- **Cost Shifting**: Over 90% of expanded Medicaid coverage paid for by federal government
- **Provider Pressure**: Pressure from providers seeking relief from uncompensated care and bad debt
- **Employer Pressure**: Pressure from employers of low-wage workers

**Declining Medicaid Expansion**

- **Increased Long-Term Cost**: Financial burden of funding state’s share of Medicaid expansion costs
- **Ideological Objections**: Political views may influence Medicaid expansion decision
- **Financial Exposure from Currently Eligible but Not Enrolled Residents**: Concerns about Medicaid expansion capturing currently eligible but not enrolled residents for whom state would receive current Federal matching rate

Source: Medical Group Strategy Council interviews and analysis.
(Potentially) Facing Another Doughnut Hole

More Questions Than Answers Following Court Ruling

Medicaid Expansion Policy Differs by Income Level

Three Key Questions:

For individuals with incomes between the tax filing threshold$^3$ and 133% of FPL:

- Are they subject to the mandate?
- Are they exempt from penalties?
- Are they eligible for subsidies in the Exchanges?

Source: Medical Group Strategy Council interviews and analysis.

---

1) Federal Poverty Level.
2) Medicaid eligibility levels vary widely by state.
3) The Federal tax filing threshold was $9,350 for an individual and $18,700 for a family in 2010.
# The Second Biggest Decision in Health Care

## 2012 Election: Referendum on Medicare?

<table>
<thead>
<tr>
<th></th>
<th>Obama</th>
<th>Romney</th>
<th>Ryan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicare</strong></td>
<td>• Maintain defined benefit(^1) model</td>
<td>• Repeal ACA</td>
<td>• Replace with defined contribution model(^2)</td>
</tr>
<tr>
<td></td>
<td>• Eligibility age 65</td>
<td>• Promote alternatives to fee-for-service</td>
<td>• Eligibility age to 67</td>
</tr>
<tr>
<td></td>
<td>• Provider cuts</td>
<td>• Competitive bidding on premiums</td>
<td>• Premium support to individuals</td>
</tr>
<tr>
<td></td>
<td>• Pay-for-performance</td>
<td></td>
<td>• to purchaser private insurance</td>
</tr>
<tr>
<td></td>
<td>• New care models</td>
<td></td>
<td>• or traditional Medicare</td>
</tr>
<tr>
<td></td>
<td>• Independent Payment Advisory Board</td>
<td></td>
<td>• Limit premium support increases</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Cap spending growth at GDP plus 0.5%</td>
</tr>
<tr>
<td><strong>Medicaid</strong></td>
<td>• Eligibility expansion</td>
<td>• Block grants to states</td>
<td>• Repeal Medicaid expansion</td>
</tr>
<tr>
<td></td>
<td>• Benefits meet exchange benchmarks</td>
<td>• Limit federal requirements on Medicaid coverage</td>
<td>• Block grants to states</td>
</tr>
<tr>
<td><strong>Commercial</strong></td>
<td>• Individual, small business subsidies</td>
<td>• Prevent discrimination against pre-existing conditions</td>
<td>• No requirement for pre-existing conditions</td>
</tr>
<tr>
<td></td>
<td>• Coverage mandates</td>
<td>• Individuals, small businesses form purchasing pools</td>
<td>• End premium support for exchanges</td>
</tr>
<tr>
<td></td>
<td>• Minimum coverage requirements</td>
<td>• Tort reform</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Purchase insurance across state lines</td>
<td></td>
</tr>
</tbody>
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1) Defined Benefit: The government procures medical goods and services for consumers, as determined by the physician.
2) Defined Contribution: The consumer is provided a monetary payment, but is responsible for procuring medical care.
No Comfort in a Familiar SGR\textsuperscript{1} Tune

SGR Still Looms Uncertain

Recent SGR Intervention Timeline

- Mar 1997: Pres. Obama signs bill extending 0% update until March 31
- Apr 2010: Final 2012 MPFS\textsuperscript{2}
- Jun 2010: President Obama signs bill delaying SGR payment cut until Jan 2012
- Dec 2010: “Super Committee” does not address SGR
- Nov-Dec-2011-2012: Two-month SGR reprieve passed at end of 2011; another 10-month reprieve passes in February, delaying cuts until 2013

27.4\% Decrease of SGR Conversion Factor

- 2011: $33.98
- 2012: $24.67

Pressure to Find Permanent SGR Fix

“The payment cut would have serious consequences and we cannot and will not allow it to happen. We need a permanent SGR fix to solve this problem once and for all. That’s why the President’s budget and his fiscal framework call for averting these cuts and why we are determined to pass and implement a permanent sustainable fix.”

Donald M. Berwick, MD
Former Administrator, CMS


1) Sustainable Growth Rate.
2) Medicare Physician Fee Schedule.
Reacting to the Present Decision, Keeping Future Goals in Sight

"Whatever the politics, today's decision was a victory for people all over this country whose lives will be more secure because of this law and the Supreme Court's decision to uphold it."

"With today's announcement, it's time for us to move forward - to implement and, where necessary, improve on this law."

"What the court did today was say that Obamacare does not violate the Constitution. What they did not do was say that Obamacare is good law or that it's good policy."

"What the court did not do on its last day in session, I will do on my first day if elected president of the United States. And that is I will act to repeal Obamacare."

ACA’s Dual Objectives

1. Expand Access to Coverage
2. Slow Health Care Cost Growth

Twin Objectives of the ACA

Source: Health Care Advisory Board interviews and analysis.
Full Steam Ahead

Delivery System Reforms Well Underway

Multitude of Initiatives Already Taking Place

April 1, 2012
Start of first performance period for 27 organizations selected to participate in the Medicare Shared Savings Program

June 11, 2012
CMS announced new round of MSSP applications for January 1, 2013 start

June 15, 2012
Final batch of Health Care Innovation Award recipients announced; 107 organizations to receive total of $895 M in grants

June 28, 2012
Application deadline for Bundled Payments models 2.1

CMS Innovation Center Demonstrations in Progress

- Five Advance Payment ACO participants selected; more to be announced July 1, 2012
- 15 states selected to receive up to $1 M to participate in Medicare/Medicaid State Demonstrations
- Seven localities selected to implement Comprehensive Primary Care Initiative
- FQHC Advanced Primary Care Practice Demonstration expected to improve care for up to 195,000 Medicare beneficiaries

We Are All Accountable Now

Contingent Payment the “New Normal” for Medicare Fee-for-Service

Pay-for-Performance Payment Changes

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmissions Penalties</td>
<td>• FY 2013 readmissions penalty based upon readmissions performance between July 1, 2008 and June 30, 2011</td>
</tr>
<tr>
<td></td>
<td>• Penalties start at 1% of Medicare inpatient revenue, rising to 3% by FY 2015</td>
</tr>
<tr>
<td>Value-Based Purchasing Program (VBP)</td>
<td>• Performance assessed on 20 quality, satisfaction metrics</td>
</tr>
<tr>
<td></td>
<td>• Payment withheld commences at 1% in FY 2013, rises to 2% by FY 2017</td>
</tr>
<tr>
<td></td>
<td>*Inclusion of Medicare Spending per Beneficiary metric in FY 2015</td>
</tr>
<tr>
<td></td>
<td>• All part A and B payments included during episode of care</td>
</tr>
<tr>
<td></td>
<td>• Includes transfers, readmits, additional admits</td>
</tr>
</tbody>
</table>

Hospital Acquired Conditions (HAC) in FY2015

Distribution of HAC events per 1,000 discharges in hospitals

Based on 16,000 annual discharges, occurrence of 26+ HACs results in bottom quartile performance and Medicare payment penalty

0 0.442 1.627 5.202

75th Percentile 50th Percentile 25th Percentile 5th Percentile

Source: Centers for Medicare and Medicaid Services, “CMS Hospital Inpatient Quality Reporting Program Hospital-Acquired Condition Measures,” March 21, 2011, Health Care Advisory Board Interviews and analysis.
Medicare ACOs Off and Running

Providers Eying Opportunities to Evolve Beyond Fee-for-Service

Expected Beneficiaries
- Pioneer ACOs
- Shared Savings Program ACOs

5,000-9,999
10,000-19,999
20,000+

78% ACOs in April 1 MSSP cohort are physician group only

Source: CMS, Health Care Advisory Board interviews and analysis.
## Not Just a Medicare Mandate

### Private Payers Accelerating Payment Innovation

<table>
<thead>
<tr>
<th>Model</th>
<th>ACA-Based Program</th>
<th>Private Payer Equivalents</th>
</tr>
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| Pay-for-Performance          | • Percentage of hospital inpatient payments withheld, earned back based on quality performance  
                               | • Payment changes commence in FY 2013                                               | • WellPoint launched pay-for-performance program centered on 52 quality metrics        |
| Hospital Readmissions Penalties | • Hospitals with greater than expected readmission rate subject to financial penalty  
                                   | • Penalties start in FY 2013                                                          | • Private insurers, including a number of state BlueCross/BlueShield plans, have begun considering readmissions in setting reimbursement rates |
| Bundled Payments             | • Center for Medicare and Medicaid Innovation (CMMI) bundling initiative starts June 30, 2012  
                               | • National pilot on episodic bundling starts in 2013                                  | • Hospitals in 15 states have partnered with private payers in bundled payment contracts |
| Shared Savings Models        | • Shared savings and Pioneer pilots commenced in early 2012                          |                                                                                         | • Private payers Humana, WellPoint, United, Cigna, Aetna and at least four state BlueCross plans have announced shared savings pilots |

Rethinking Coverage Expansion

Full Steam Ahead—Perhaps Not As Originally Envisioned

**Medicaid Expansion**
- Current coverage levels vary by state
- States expand or maintain coverage to all citizens earning <133% FPL
- Individual mandate does not apply if individual is not required to pay taxes

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**Exchanges**
- Enrollees receive premium and/or cost-sharing subsidies to participate
- Subsidies vary based on income
- Individual mandate applies to all unless premiums exceed 8% of annual income
- Enrollees barred from participating if offered "affordable" employer sponsored insurance

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**Before the Ruling**

**Percent of Federal Poverty Line**

- 133%

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**After the Ruling**

**32 M**
Newly Covered Lives

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**Medicaid Expansion**
- Current coverage levels vary by state
- States *have the option* to expand or maintain coverage to all citizens earning <133% FPL
- Individual mandate does not apply if individual is not required to pay taxes

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**Exchanges**
- Enrollees receive premium and/or cost-sharing subsidies to participate
- Subsidies vary based on income
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**16 – 32 M**
Newly Covered Lives

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Source: Health Care Advisory Board interviews and analysis.