Health Care in Transition

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Meet Sg2

Sg2, a Vizient company, is the industry authority on health care trends, insights and market analytics.

Our unique integration of analytics and expertise helps organizations develop sustainable growth strategies that create an effective System of CARE and ensure market relevance.

Sg2 OFFERINGS

- Powerful Analytics
- Unmatched Expertise
- Industry-Leading Consulting
And the Winner Is...
Chances are good that the Affordable Care Act will be repealed, but how could that play out?

<table>
<thead>
<tr>
<th>Options</th>
<th>Likelihood of Happening</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Repeal and revisions</strong> with bipartisan engagement</td>
<td>Slim-to-none, although Cubs did win World Series</td>
</tr>
<tr>
<td><strong>Full repeal</strong> without bipartisan support</td>
<td>Not too likely, as would require 60 votes in Senate to avoid filibuster</td>
</tr>
<tr>
<td>Repeal components of law through <strong>budget reconciliation</strong></td>
<td>Highly likely, would just require majority vote and GOP got a version to President’s desk earlier this year.</td>
</tr>
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</table>
Budget Reconciliation to Drain Funds from Coverage Expansion Efforts

What’s at Risk?

- Medicaid Expansion
  - The AHA has enabled funding for 10M new Medicaid enrollees by covering the costs (currently 95%) of this expanded Medicaid population
    - Republicans aim to wean this funding and support issuing block grants or per capita payment as a means to give states for leeway to define, administer, and pay for Medicaid beneficiary care
    - House Republicans support tax deductions and health savings plans as ways to incentivize those to stay insured, and also propose work requirements and co-pays for continued eligibility.
  - ACA also included an increase in federal matching (Enhanced Federal Medical Assistance Percentage) for CHIP by up to 23 percentage points
Budget Reconciliation to Drain Funds from Coverage Expansion Efforts

What’s at Risk?

- Exchange subsidies
  - Restructuring could include much more narrow benefit packages and provider options
  - Would likely require higher out of pocket contributions (e.g., eliminating the ban on cost sharing for preventive and wellness visits, more copays, higher premiums, more cost sharing for silver plans)
  - GOP cites health savings plans and tax deductions/credits to help enrollees cover costs
- Medicare as a defined benefit
  - Paul Ryan’s plan is in favor of Medicare as a defined contribution, but uncertain where Trump stands now
What Else Is at Risk?

- Individual and employer mandate for coverage
- Women’s reproductive health care
- Guaranteed issue of coverage for people with pre-existing conditions
  - Paul Ryan’s plan includes people with pre-existing conditions who have had “continuous coverage”
- Elimination of high risk pools
  - Could charge elderly, higher risk enrollees 5x the premium price of younger enrollees (currently maxed at a 3x increase under the ACA).
- Insurance and device taxes
- Future drug pricing
- Limits to sell commercial insurance across state lines
Value-Based Payment Met with Bi-Partisan Support

Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

Sources: HHS. HHS reaches goal of tying 30 percent of Medicare payments to quality ahead of schedule March 3, 2016; Sg2 Analysis, 2016.
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MACRA Paves Path to Pay for Performance

ESTABLISH REPORTING PROCESSES

- Can you effectively report on quality measures?
- Did you adopt certified EHR?

EDUCATIONAL QUALITY REPORTING SYSTEM

Meaningful Use

DEMONSTRATE PERFORMANCE

- Does your practice perform well on cost and quality compared to peers?

Value-Based Payment Modifier

VALUE-BASED PAYMENT STRUCTURE

- How do you perform as part of a team-based approach to population health?
- How are you using your EHR to improve patient outcomes?

MACRA

Sources: CMS. Final Rule With Comment Period: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models. November 4, 2016; Sg2 Analysis, 2016.
What Is MACRA?


- MACRA makes important changes to how Medicare pays clinicians:
  - Ends Sustainable Growth Rate (SGR) formula
  - Impacts Part B items and services, including professional fees (no impact on facility fees)

- Combines physician quality reporting programs into one Quality Payment Program—FFS base with a link between payment and quality.

- Eligible clinicians include physicians, dentists, physician assistants, nurse practitioners, clinical nurse specialists and certified RN anesthetists during the first 2 years of MIPS.

- MACRA contains two tracks:
  - Merit-based incentive payment system (MIPS)
  - Alternative advanced payment models (aAPM)

Note: From the third year, clinicians may also include other providers such as physical therapists, audiologists, nurse midwives, clinical psychologists, clinical social workers, etc.

Sources: CMS. Final Rule With Comment Period: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models (PDF). November 4, 2016; Sg2 Analysis, 2016.
# MACRA Changes to Medicare Clinician Payment Under MIPS

- Performance will be tracked starting in 2017 and payments will be adjusted in 2019.
- Clinicians can avoid a negative payment adjustment in during transition period (2017-2019) by reporting minimal data.

## PAYMENT YEARS

<table>
<thead>
<tr>
<th>Physician Fee Schedule</th>
<th>MIPS Adjustments</th>
<th>aAPM Incentives</th>
</tr>
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<tbody>
<tr>
<td>2019 +0.5%</td>
<td>–4% to 4x%</td>
<td>Exceptional performance bonus for top performers up to +10%</td>
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<tr>
<td>2020 No Change</td>
<td>–5% to 5x%</td>
<td>Automatic maximum negative adjustment for low performers</td>
</tr>
<tr>
<td>2021</td>
<td>–7% to 7x%</td>
<td>Exempt from MIPS +5% lump sum bonus</td>
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<tr>
<td>2022</td>
<td>–9% to 9x%</td>
<td></td>
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<tr>
<td>2023</td>
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<tr>
<td>2024</td>
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Note: Physician Fee Schedule updates are the same across clinicians through 2025. From 2026 onwards, clinicians that qualify for aAPM Incentives will have a 0.75% update while other clinicians receive a 0.25% update. For positive adjustments, a scaling factor “x” of up to 3 can be applied by the HHS secretary to maintain budget neutrality. The performance threshold is 3 for 2019, but future years may set this threshold at the mean OR median of scores; an additional pool of $500M is available annually for 2019 to 2024 as an exceptional performance bonus. The additional performance threshold is 70 for 2019, but future years may set this threshold at a different level.

Sources: CMS. Final Rule With Comment Period: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models (PDF). October 14, 2016; Sg2 Analysis, 2016.
### Final Rule for 2017 Transition Period

<table>
<thead>
<tr>
<th>Minimal reporting required</th>
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<tbody>
<tr>
<td>• 1 quality metric <strong>OR</strong> 1 “improvement activity” <strong>OR</strong> all advancing care information base measures</td>
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<tr>
<td>• Total $199M to $322M in reduced payment</td>
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<th>Increased clinician exemptions</th>
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<td>• 48% of all clinicians will be exempt from MACRA’s Quality Payment Program.</td>
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<th>More clinicians qualify for aAPM incentives</th>
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<td>• 70,000 to 120,000 clinicians will qualify in 2017.</td>
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### Proposed Rule

<table>
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<th>Score above the median to avoid negative adjustment</th>
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<td>• Total $833M in reduced payment</td>
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<table>
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<th>Original criteria estimated that 38% of clinicians would be exempt from MACRA’s Quality Payment Program.</th>
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<tr>
<th>Original projection that 30,658 to 90,000 clinicians would qualify for 5% aAPM Bonus Payment in 2017.</th>
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</table>

**Sources:** CMS. Proposed Rule: MIPS and APM Incentive Under the PFS. May 9, 2016; CMS. Final Rule With Comment Period: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models (PDF). November 4, 2016; Sg2 Analysis, 2016.
Clinicians Under Advanced Alternative Payment Models Must Go at Risk

Key Characteristics of aAPMs:

- Must use certified EHR technology
- Bases payment on quality measures comparable to MIPS
- Must bear “more than nominal” financial risk
- At least 25% of Medicare payments from aAPM (jumps to 50% in 2019)

Qualifying aAPMS eligible for 5% payment bonus include:

- Comprehensive End Stage Renal Disease (ESRD) Care Model
- Comprehensive Primary Care Plus (CPC+)
- Medicare Shared Savings Program ACOs in Track 2 and Track 3
- Next Generation ACO program
- Oncology Care Model (two-sided financial risk arrangement)

Note: It is anticipated the more risk-based payment models will qualify as aAPM, including Medicare ACO Track 1+, BPCI 2.0, Episode Payment Model (AMI, CABG, SHFFT), and Comprehensive Care for Joint Replacement Model.
Advanced Alternative Payment Models Are a Long-term Investment

Don’t run toward risk you aren’t ready for.

- Does this fit within our existing enterprise risk strategy?
- Do we have any experience managing this type of risk?
- Do we have the data tools to analyze performance?
- Do we have the clinical infrastructure to manage care transformation?
- What are our anticipated barriers to implementation?
- Do we have the infrastructure to manage this at the scale required?
The Menu of Options for Embracing Risk Is Broad

Note: Bubble sizes represent number of participating acute care hospitals. ACO = accountable care organization; P4P = pay-for-performance.
Medicare Advantage: Sustainable Growth?

Total Medicare Advantage Enrollment
2003–2016

- **MA Growth Drivers**
  - Lower out-of-pocket costs
  - Additional service coverage
  - Primary care consolidation
  - Decline in FFS rate

- **MA Plateau Drivers**
  - Growth in ACOs with broad networks and incentive payments to beneficiaries
  - MA benchmark reductions increasing premiums

ACA = Patient Protection and Affordable Care Act; FFS = fee-for-service; MA = Medicare Advantage.

Coming Soon: A Truly Integrated Post-Acute Payment System for Medicare

MedPAC proposes to Congress a PAC-PPS based on patient characteristics, not setting.

2014
IMPACT Act enacted.

June 2016
CMS defines and begins collecting quality/cost measures; develops risk-adjustment tool.

2016–2018

CMS Report to Congress

2020

PAC costs drive 73% of regional variation in Medicare spend.

Payment and Policy Push All Markets to Value

- Site-neutral payment post-acute
  - IP Rehab: -7%
  - OP Rehab: +8%

- SNF waivers
  - SNF: +13%

- 2-midnight rule update
  - Observation Visits: +10%

- Mental health parity expansion
  - Partial Hospitalization: +12%
  - Psych Visits ED: +17%

- CMS bundle expansion
  - Diagnostic Caths: -6%
  - MRI for Spine: -5%

5-YEAR FORECAST IMPACT


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Tiered, Narrow and Exclusive Networks Are Gaining Traction

Premium Advantage of Narrow vs Broad Network Plans

- Tiered/narrow networks made up 70% of the lowest-priced plans in 2016.
- 39% of narrow network plans earned a profit vs 26% of broad plans.
- Cobranded plans have doubled since 2014 (36 → 71).
- 31% of provider-led plans were local price leaders.

Source: McKinsey Center for US Health System Reform. Hospital Networks: Perspective From Three Years of Exchanges. March 5, 2016. Confidential and Proprietary © 2016 Sg2
Blue Cross vs the AMCs of Chicago

- BCBS of Illinois captured 92% of exchange market in 2013; 80% in 2014.
- Parent company reported $1.5B in losses for 2015.
- Northwestern, the University of Chicago, Lurie Children’s Hospital and Rush are excluded from all individual networks for 2016.
- There is no out-of-pocket cap for out-of-network services.

AMC = academic medical center; BCBS = Blue Cross and Blue Shield.
CASE STUDY

Expand Access to Care for Consumers in Narrow Networks

FROEDTERT HEALTH, MILWAUKEE, WI

• System comprised of Froedtert & the Medical College of Wisconsin Froedtert Hospital and 2 community hospitals
• In 2014, Froedtert partnered with Ascension Health to acquire a 50% interest in the health plan, Network Health
  • Network Health has 165,000 members with almost $900 million in revenue
  • Plan is the second-largest Medicare Advantage player in the state of Wisconsin

Broadened Access
• Partners with retail sites, CVS and Meijer
• Operates its own network of walk-in care clinics
• Runs on-site clinics among a full variety of employer-focused services
• Provides “virtual clinic” offers $49 consults via phone or web-based video—more than 1,600 in its first 9 months

New access options for primary care—retail, worksite and virtual—help cushion the impact for patients that needed to switch doctors and serves as tools to keep members in-network and shift care to low-cost settings.

Pricing Strategy Is in Play…Almost

- 9% Employers reporting they had eliminated a hospital or system from their health plans to cut costs
- 255% Rise in the average deductible for covered workers since 2006; 67% since 2010
- 65% Sg2 members in narrow network plans
- 77% Sg2 members who believe consumers are actively shopping on price
- 5%-10% Consumers using price shopping tools

Consumerism Is Here…Now What?

High Deductibles
Price Transparency
New Market Entrants
Exchanges
Changing Norms and Expectations
Become a Part of the Consumer’s Ecosystem

Where do I go?

Are they part of a system I trust?

Whom should I see?

How much will it cost?
Understanding Future Health Care Utilization Requires Thinking a Generation Ahead

Projected Population by Generation

<table>
<thead>
<tr>
<th>Year</th>
<th>Boomer</th>
<th>Millennial</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>75</td>
<td>75</td>
</tr>
<tr>
<td>2028</td>
<td>65</td>
<td>81</td>
</tr>
<tr>
<td>2036</td>
<td></td>
<td>81</td>
</tr>
<tr>
<td>2050</td>
<td></td>
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Note: Millennials refers to the population ages 18 to 34 as of 2015.
Understanding Future Health Care Utilization Requires Thinking a Generation Ahead

Projected Population by Generation

<table>
<thead>
<tr>
<th>Generation</th>
<th>Millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baby Boomer</td>
<td>81</td>
</tr>
<tr>
<td>Millennial</td>
<td>30</td>
</tr>
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76% millennials look to online reviews in choosing a provider
60% prefer virtual health option over clinic visit
74% factor online scheduling in choosing a provider

Note: Millennials refers to the population ages 18 to 34 as of 2015.
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Are Physicians the Tie That Binds?

YESTERDAY

Wellness Visits

PATIENT → OB/GYN → HOSPITAL

Downstream Services

OB/GYN = obstetrician/gynecologist.
Consumerism, Shifting Care Patterns Disrupt Traditional Referral Streams

TODAY

Wellness Visits

PATIENT

National **14% decline** in gyn wellness visits between 2012 and 2015

OB/GYN

HOSPITAL

AT RISK:

- Screening mammography
- Downstream breast diagnostics
- Primary care referrals
- Specialty gyn services

**Sources:** Sg2 Ambulatory Market Strategist; Health Intelligence Company, LLC; Sg2 Analysis, 2016.
Sg2 Defines Virtual Health Very Broadly

**Virtual Health**
Connected care services—including clinician-to-clinician, provider-to-patient and consumer-driven interactions—across a spectrum of electronically enabled consultative, direct patient care, educational and self-management services; encompasses a range of different terminologies, including telemedicine, telehealth, e-health and mobile health.
Virtual Health Offerings and Reimbursement Are Beginning to Align With Increasing Consumer Demand

National Trends in Virtual Health

**PAYMENT TRENDS**
- Private payers are starting to be more involved in the space.
- Medicare and Medicaid are steadily expanding coverage for virtual health (Medicare Telehealth Parity Act of 2015 and CMI Telehealth Improvement and Innovation Act of 2015).

**CONSUMER UTILIZATION**
- 64% of consumers are willing to have a video visit.
- Interest in virtual health peaks in 18 to 44 age cohort.
- Consults physicians find most valuable are dermatology, psychiatry and infectious disease.

**PROVIDER OFFERINGS**
- Provider virtual health offerings span many services and sites of care: access to care in rural communities, behavioral health coverage, specialty pediatric care consults.

**EMPLOYER OFFERINGS**
- 48% of the largest companies are currently offering virtual health services.
- Out of those services, most offer nurse coaching for lifestyle and disease management.

CMI = Center for Medicare and Medicaid Innovation. Source: Sg2 Analysis, 2016.
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### Virtual Visits Target Chronic Conditions

**Top Virtual Visits Projected in 2026 by CARE Family, US Market**

<table>
<thead>
<tr>
<th>CARE Family</th>
<th>Percent Virtual</th>
<th>Virtual E&amp;M Visits (Millions)</th>
</tr>
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<tbody>
<tr>
<td>Hypertension</td>
<td>24%</td>
<td>14.1</td>
</tr>
<tr>
<td>Mood Disorders</td>
<td>28%</td>
<td>8.0</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>31%</td>
<td>20.0</td>
</tr>
<tr>
<td>Rash, Nonallergic</td>
<td>26%</td>
<td>13.2</td>
</tr>
<tr>
<td>Hemorrhagic and Ischemic Stroke</td>
<td>21%</td>
<td>0.5</td>
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Breadth of Virtual Health Drives New Value and Opportunities

Virtual conferencing*
Clinical mobile apps
- Data integration
- Peripherals
- Medication management
Remote monitoring
Virtual reality care
Disaster monitoring
Virtual pain management
Virtual multispecialty clinic
International offerings (pre-and postprocedure)

Virtual health wellness/education
Virtual consults*
Remote monitoring
eICU
eED
Virtual reality care
Business model innovation
Disaster monitoring
Virtual pain management
Virtual multispecialty clinic
International offerings (pre-and postprocedure)

LOCAL MARKET PACE
INCREMENTAL STEPS FORWARD
TRANSFORMATIVE LEADER

*Virtual conferencing is defined as clinician-to-clinician consults, whereas virtual consults are provider-to-patient consults.
Source: Sg2 Analysis, 2016.

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Who Is Ralph Walters?

- Socially Isolated
- "Frequent Flyer"
- Has Multiple Conditions
- Noncompliant
Virtual Multispecialty Clinic Minimizes Unnecessary ED Use, Maximizes Ease/Access

Traditional Model

**PCP refers Ralph to a psychiatrist.**

**Ralph presents at PCP office with SOB, heart palpitations and nausea (panic attack).**

**Ralph returns home. Next appt is in 3 weeks or tomorrow 30 miles away.**

**3 weeks later, Ralph sees psychiatrist; new meds are prescribed. Follow-up required.**

**Windshield time a barrier to follow-up appts; medication compliance low. CHF and DM poorly managed due to anxiety disorder diagnosis.**

**1 month later, Ralph arrives at ED with SOB/dyspnea due to CHF secondary to anxiety disorder.**

**PCP refers to psychiatrist, admin connects with system-wide VMSC to find a psychiatrist immediately.**

**Ralph scheduled talk therapy appts with psychiatrist from PCP office. Option to conduct talk therapy virtually from home. CHF and DM managed appropriately.**

**Ralph accompanies by RN to virtually equipped room, connected with psychiatrist via video.**

**Psychiatrist privately talks to Ralph, treating panic attack.**

**Psychiatrist prescribes new meds, talk therapy sessions.**

CHF = congestive heart failure; DM = diabetes mellitus; PCP = primary care physician; SOB = shortness of breath; VMSC = virtual multispecialty clinic.
Questions
Sg2 is the health care industry’s premier provider of market data and information. Our analytics and expertise help hospitals and health systems understand market dynamics and capitalize on opportunities for growth.

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