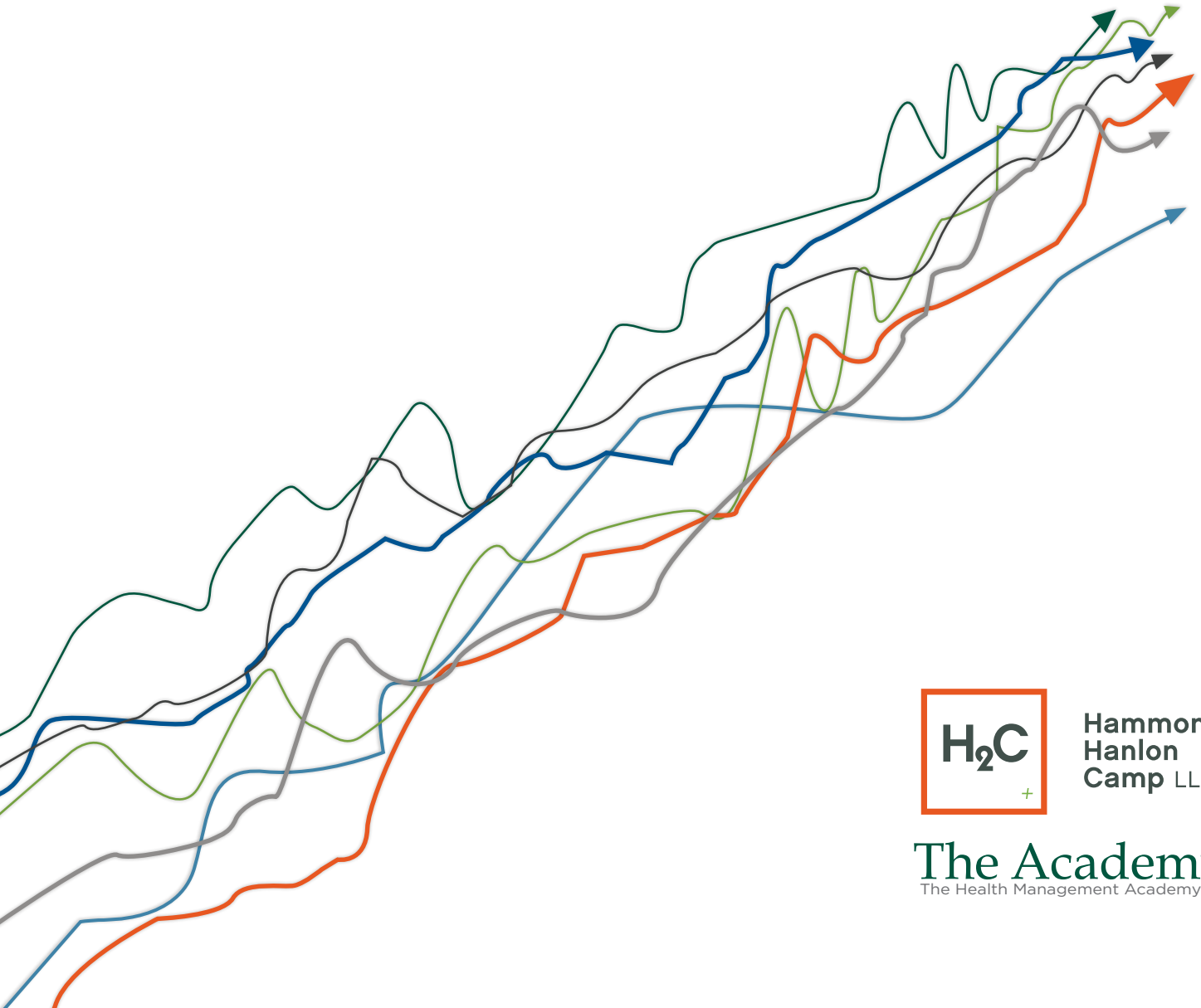
MONITORING THE RATE OF CHANGE AT LEADING HEALTH SYSTEMS

Strategic Survey Q4 2015

presented to you by
The Health Management Academy
and Hammond Hanlon Camp LLC



H2C Hammond Hanlon Camp LLC

The Academy
The Health Management Academy

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The Health Management Academy, "The Academy"

The Academy is a leading research and analysis company serving the largest 100 health systems that own or operate 1,800 hospitals. The Academy provides services to the C-suite, including research, analytics, health policy, consumer research, fellowship programs, and collaboratives.

The Health Management Academy provides unique, peer-learning, complemented by highly-targeted research and advisory services, to executives of Leading Health Systems. These services enable health system and industry members to cultivate relationships, perspectives, and knowledge.

In 1998, The Academy created the first knowledge network exclusively focused on Leading Health Systems. This learning model, refined over 16 years of working side-by-side with members, combines peer learning (Executive Forums, Trustee Institute, Collaboratives), research (Health System, Consumer, Health Policy, Advisory), and leadership development (Leadership Programs and Fellowships).

Hammond Hanlon Camp LLC, "H2C"

Hammond Hanlon Camp LLC ("H2C") is an independent strategic advisory and investment banking firm committed to providing superior advice as a trusted advisor to healthcare organizations throughout the United States. The company traces its heritage back almost 30 years through its predecessor organizations, including Shattuck Hammond Partners.

H2C's professionals have a long track record of success in healthcare mergers and acquisitions, capital markets, real estate and restructuring transactions, acting as lead advisors on hundreds of transactions representing billions of dollars in value. H2C offers securities through its wholly-owned subsidiary H2C Securities Inc., member FINRA/SIPC. For more information, go to h2c.com.

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The Academy – H2C Strategic Survey

The Academy conducts research on key strategic areas of most interest to the largest health systems. High priority topics in 2016 are consolidation, development of an operating model, physician alignment, bundled payments, innovation, and consumer engagement.

Starting in Q4 2014, The Academy began conducting quarterly interviews with senior health system executives at Leading Health Systems. The survey for the interview consists of: (1) a tracking section that provides insight into trends around primary strategic areas; (2) a special topic area that allows for an in-depth look into a timely, developing issue. The tracking section of the survey is comprised of questions related to strategic priorities, consolidation, quality and costs, consumer engagement, market share, and the evolving payment model. Innovation, consumer engagement, ambulatory and real estate strategies, and physician alignment were topics of the first four surveys.

In October 2015, The Academy conducted the fifth round of its quarterly strategic survey among 25 C-suite executives. In addition to an in-depth look at bundling, the strategic survey continues to examine changes in important issues affecting the largest health systems.

Key Findings

Tracking Survey

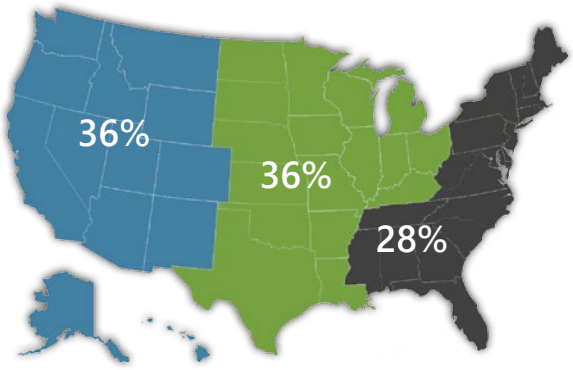
- 50% of health system executives rank cost reduction as a higher priority in 2016 than 2015.
- 63% of executives anticipate that their operating margin will decrease in 2016.

Special Topic: Bundling

- More than one-half (54%) of health systems have at least one hospital in the CMS CJR payment model beginning in April, 2016.
- Nearly 2 in 5 (38%) health systems are participating in the CMMI bundled payment program.

Profile of Participating Health Systems

Representative of the various regions of the U.S.



Average Net Patient Revenue

$4.2 BILLION

Own or operate 402 hospitals with 79,070 beds

48% Have a Provider-Owned Health Plan

68% Single-State Systems

32% Multi-State Systems

Tracking Survey

Consolidation: Merger and Acquisition Frenzy Continues

> **"Acquisitions happen so quickly that one quarter we may say nothing is going to happen, but then the next quarter we have two mergers. It can be a mad dash–a lot happens and then it is quiet." (CMO)**

Over the last twenty years, mergers and acquisitions have been increasing rapidly and are expected to continue to rise, resulting in the formation of mega-billion dollar health systems. (1) Consistent with these projections, the majority of health systems anticipate an acquisition over the next six months (Figure 1B).

For many health systems, the acquisition of physician practices/medical groups is part of their physician employment strategy.

"We may take a physician practice group of 6–7 physicians and employ them. Most of the physician practices do not own the facility. We take over the lease." (COO)

Figure 1A. Over the last 3 months, did your health system acquire any of the following?

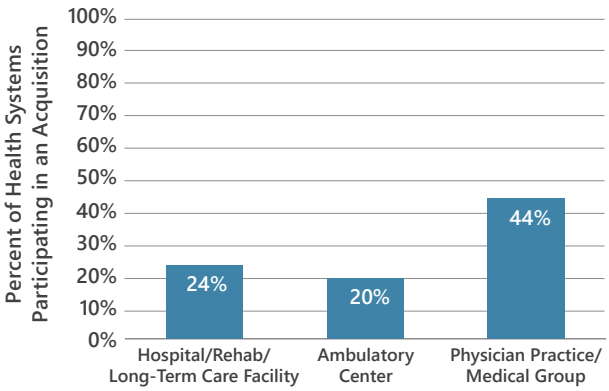
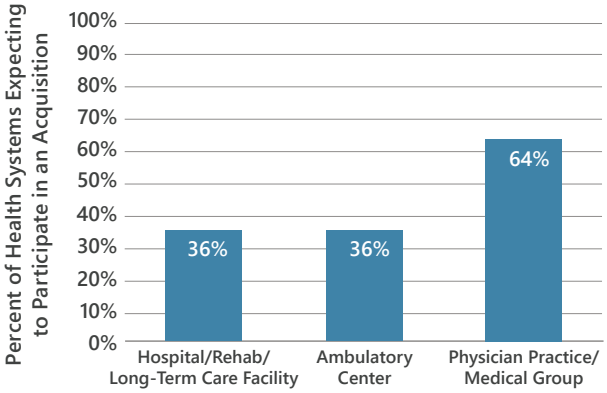


Figure 1B. Do you expect to acquire one of the following in the next 6 months?



The largest health systems are forming strategic partnerships that enable them to enhance their clinical services, expand their geographic reach, and provide more efficient care. Increasingly, health systems are strategically partnering with industry companies and insurers who can provide the resources and expertise in many non-core business areas (e.g., telehealth, data analytics, insurance, revenue cycle) that enable them to provide higher quality, efficient care. Over the next six months, health systems expect to form partnerships around clinical services, retail clinics, physician recruitment, risk assumption, technology, and urgent care.

Figure 2A. Over the last 3 months, did your health system form a strategic partnership? If yes, with whom?

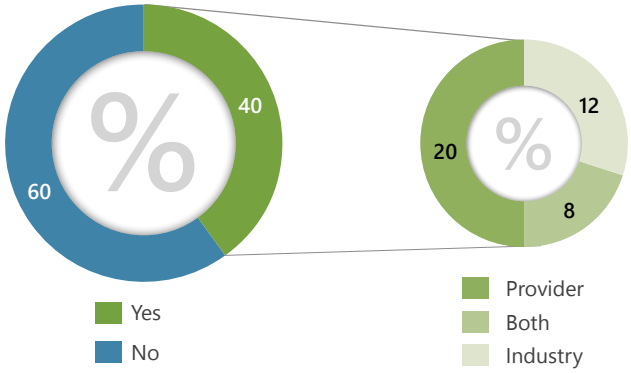
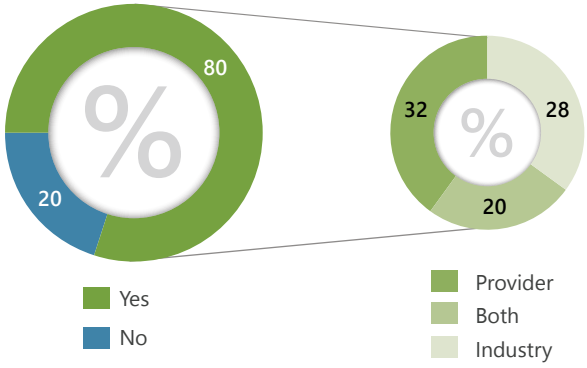


Figure 2B. Do you plan to form a strategic partnership in the next 6 months? If yes, with whom?



Quality and Costs: 63% of Executives Expect Their Operating Margin to Decrease

"One of our core foundational strategic pillars is sustainability, so cost reduction comes up every year." (CMO)

Cost reduction continues to be a central focus of the largest health systems with 50% of health system executives ranking cost reduction or cost control as a higher priority in 2016 than 2015. Health system executives who rate cost reduction as less of a priority or a similar-level priority cite their progress in meeting cost reduction goals over the past 2–3 years.

"We did a lot of cost reduction in 2013 and 2014 so there was less to do in 2015 and 2016." (CFO)

One health system executive commented that the health system is reinvesting, rather than continuing to focus on taking out costs.

"In our situation, we had a very aggressive strategic cost goal, and we think we went too far in some areas. So, we made decisions to reinvest in a couple of areas." (COO)

For 2014, health systems operating margins ranged from less than 1% to 10.7% with an average of 5.1%. In 2015, many health systems observed a moderate increase in their operating margin, averaging 5.9% (range: 1.8%–12.7%). Because many of the largest health systems are experiencing high operating margins, 63% of executives anticipate that their operating margin will decrease in 2016.

Figure 3. Will/does your 2016 strategic plan refresh prioritize cost reduction/control higher than 2015's?

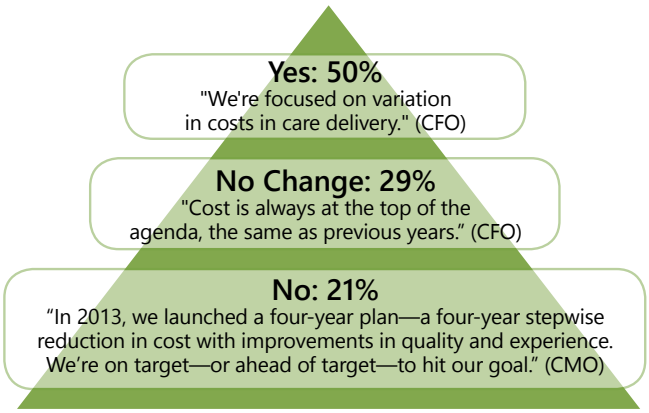
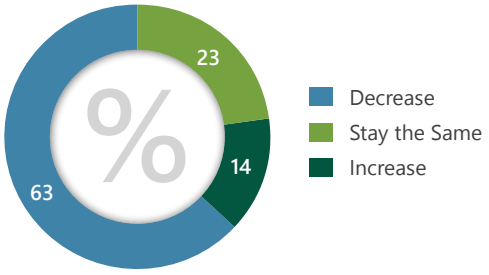


Figure 4. Do you expect your operating margin to increase, decrease, or stay the same in 2016?



"At the rate we're starting out, I think it may decrease. Volumes are good, but our labor costs are through the roof." (COO)

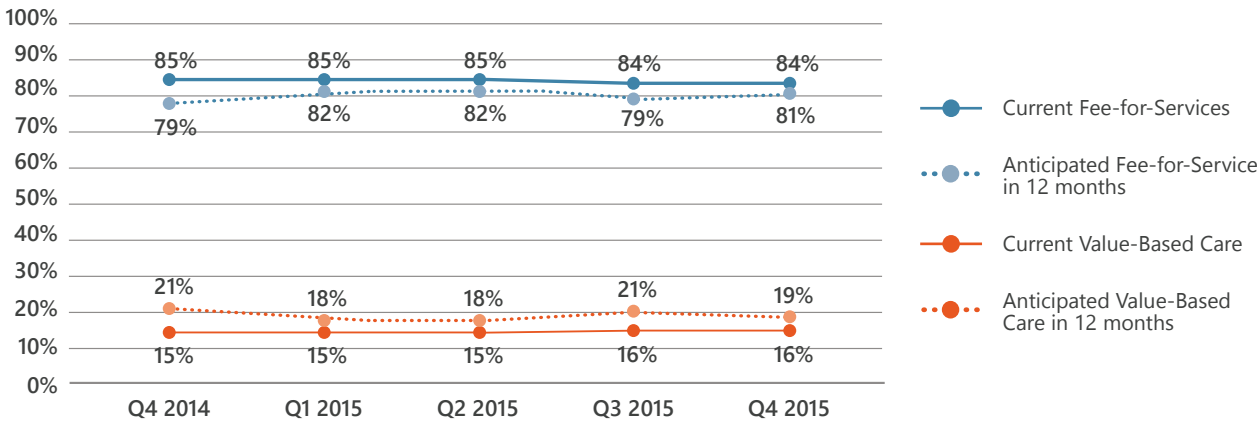
The Evolving Payment Model: A Slow Transition to Value-Based Reimbursement

"We are progressively building capability, but we're not diving into the deep end of the pool." (COO)

Although the largest health systems continue to take on a number of value-based initiatives, such as Accountable Care Organizations (ACOs) and bundled payments, the majority of their revenue remains largely based on fee-for-service (84%) with value-based payments at 16% (Figure 5). Over the next 12 months, respondents expect fee-for-service payments to decline to 81% with value-based payments increasing to 19%.

"With so much going on in the payer side, it may take a while. But when it does, it will be extremely fast. I think there's a lot to be sorted out with the mergers and acquisitions with the payers. In the next 2 years, it could pick up the pace." (COO)

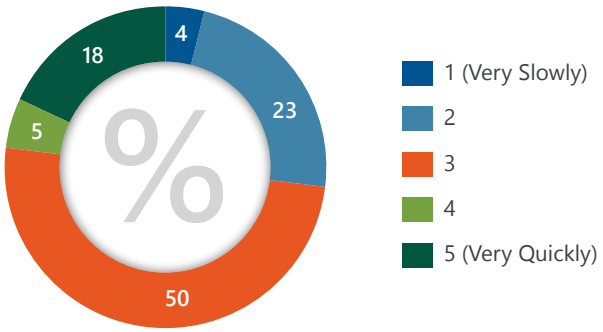
Figure 5. Currently, what percent of your care delivery is fee-for-service and value-based? What do you expect your care delivery to look like in 12 months?



Consistent with a small anticipated change in value-based reimbursement over the next 12 months, only 23% of executives rate the pace of change towards value-based reimbursement as a 4 or 5 on a 5-point scale.

"We see what is happening in Medicare—it's moving very rapidly to value. Medicare is a 4 or 5, but commercial is a 1 or 2." (CFO)

Figure 6. On a scale of 1-5, how would you describe the pace of change towards value-based reimbursement at your health system?



Special Topic: Bundling

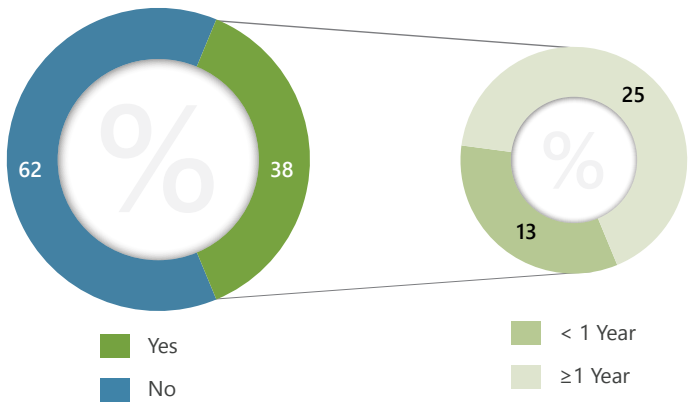
Seeking to better align Medicare payments with quality of care and encourage greater care coordination among providers, the Centers for Medicare & Medicaid Services (CMS) have been piloting payment bundles (e.g., Bundled Payments for Care Improvement Initiative), in which payments to providers are based on episodes of care, rather than the number of services provided. In November, 2015, the CMS finalized its mandate for the Comprehensive Care for Joint Replacement (CJR) initiative, a payment model that bases Medicare payments for high-volume orthopedic surgeries (e.g., hip and knee replacement procedures) on performance for hospitals that reside in 67 regions designated by CMS. (2)

Over 1/3 of Health Systems Are Participating in CMMI Bundled Payments

> **"As we all move into bundles, it is going to be interesting to see how we make them successful in our assessment. There is a cost reduction on the Medicare side—gain-sharing really means that you are sharing in less costs and less revenue. In order to make that work, it is primarily redirecting leakage back into the system from those index cases and maximizing market share." (COO)**

Just over one-third of health systems (38%) are currently participating in CMMI bundled payments with the majority having implemented a CMMI bundling initiative over a year ago (Figure 7). For these health systems, the results of implementing bundled payments has varied with health systems observing significant savings in certain markets and losses in others.

Figure 7. Is your health system participating in CMMI bundled payments? If yes, how long have you been participating?



To prepare for future CMS bundled initiatives, some health systems are participating in commercial bundled payments or risk arrangements with employers that include bundling.

"We are going to pilot bundles internally in a subset of our per member per month risk population. We opted not to do the CMMI demo, and we are not mandated as part of the hip and knee wave—but we are expecting more federal programs in the next 3–5 years." (CSO)

Working with commercial payers or employers enables health systems to test and refine an approach before the next wave of CMS-mandated bundling initiatives.

"We need to move toward population health. Bundles are a good way to experiment and align doctors, so we do it." (CFO)

However, health system executives remarked that moving into commercial bundling has been challenging—in some cases, to the point of delaying or finding alternatives to this payment model.

"From a payor standpoint, we find that the commercial payors are somewhat bound to their 'approved' bundled programs. We are working with a few to try to convince them to consider clinical areas that we want to bundle. We have had more success with large employer groups, although there are a limited number of employers who have (or contract with) the expertise they need to consider bundles. As time goes on, these issues will be resolved, but they have made the ramp up slower." (CNO)

"We are moving towards capitation. Instead of bundling for Medicare, we're moving towards Medicare Advantage." (CSO)

"We are not planning on getting into bundling. We started on that path, and it just never materialized for a number of reasons—getting providers on board to pull it together, getting commercial payers who wanted to pay for it. Commercial payers say they want it, but they want it at such a cheap price it becomes unattractive to us." (CMO)

Instead of focusing on bundling, one health system commented that they are broadening their approach to prepare for full capitation.

54% of Health Systems Have a Hospital Required to Implement the CJR Model

Just over one-half of the largest health systems (54%) have at least one hospital in a region designated by CMS for the CJR model (Figure 8). Number of CJR hospitals per health system ranged from 1 to 19 with a median of 5. Executives' reactions to the CMMI bundling requirement varied from seeking to become a leader in this space to meeting the minimum requirements.

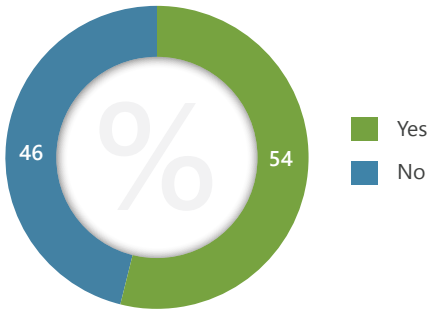
"We think we can win in this region in this space. People who are positioned well to win are high quality, high cost, and high utilization—they have the opportunity to bring that down. Folks with low cost and low utilization don't have many places to go." (CFO)

Among health systems required to participate in the CJR model, most are actively working to coordinate care and prepare for bundling—forming interdisciplinary teams, building enterprise data warehouse marts (e.g., episode mart) and analytics, formulating ways to identify costs, and developing a shared governance model with physicians and independent orthopedic groups.

"We are actively working on this. We've got a task force and various groups that are working on different components of the cost structure, quality, and data." (CMO)

"We are not planning to participate in the sense where we will be industry leaders, but we will do it." (CFO)

Figure 8. Does your health system have one or more hospitals in one of the CMS-designated regions where they are going to start reimbursing hip and knee replacements with a bundling model in 2016?

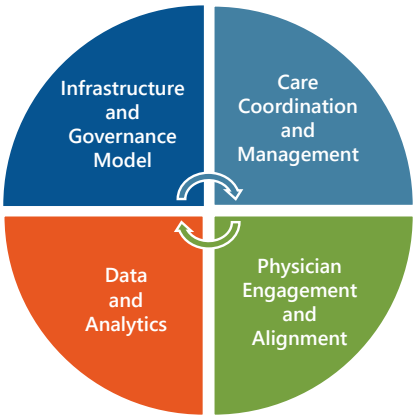


Physician Alignment and Data Analytics Remain Major Challenges in Moving to Bundled Payments

> "The amount of time and effort per bundle is substantial. Participating in dozens of bundles and doing this on a large scale is tricky." (CMO)

In preparing for bundling, health systems face challenges around their infrastructure and governance model, care coordination and management, data analytics, and physician alignment (Figure 9).

Figure 9. What are your biggest challenges related to planning and implementing bundled payments?



Care Coordination and Management

"From a culture standpoint, some of our clinical groups are ready and willing to work together to make specific efforts to coordinate care; others are not." (CNO)

"There are so many entry points to the system, so getting consistency across the system is a challenge. We have a variety of hospitals and surgical centers, and it's getting that all orchestrated to do a bundle." (CFO)

Physician Engagement and Alignment

"I think just getting alignment with our physicians and helping them understand this new payment model and how we can work together to improve quality and lower costs." (CMO)

"We have all the reporting and quality metrics down across the continuum, it's figuring out how the payments will flow and getting strong physician leaders and alignment in that camp." (CFO)

Data and Analytics

"We're trying to understand the underlying economics. Right now, our challenge is the time delays between action and data." (COO)

"Our financial systems make the analysis of potential bundled payment opportunities into a somewhat manual process. We have built models but they take a while to run and review." (CNO)

"Cost accounting could be better to support the bundle. It's not just what's in the hospital. There are some blind spots in that analysis because we don't have the data for everything in the bundle because it does not reside in pre- or post-op hospitalization." (COO)

Infrastructure and Governance Model

"The big challenges are having the right infrastructure in place to support the care redesign needed to support the bundle…managing a bundle implies managing in a horizontal fashion along the continuum of care. We are not structured that way; we're structured in a vertical fashion by hospital and by department." (COO)

"The challenge is that now you have a lot of chefs in the kitchen. Coordination across the organization on structuring these things requires more communication and logistics with people who have not been involved historically—that is the biggest challenge and the biggest change." (CFO)

For many health systems, capturing and understanding the cost of care outside of inpatient facilities is a priority.

"The issue is access to the data outside of the hospital. We have to rely on the data you get from post-acute and ambulatory for inpatient stay. This only gives a piece of the picture, and for joint bundles, it is more important to understand post-acute costs." (COO)

"We have an electronic data warehouse that pulls all the information, but we do not have a comprehensive cost accounting system to define the bundles. We do not have a clear, integrated picture across an episode. Right now, you have to patch it all together." (COO)

These data are important for health systems to coordinate care among providers, refine care processes, and influence physician behavior.

"The biggest issue is getting the costs that are outside of our system under control—distributing people to home versus the skilled nursing facility. We have to come up with a creative way to capture and be responsible for the whole continuum of care." (CFO)

With the exception of one health system that is currently implementing a cost accounting system, nearly all reporting health systems have a cost accounting system that they are planning to utilize to capture holistically the cost of a procedure from surgery to recovery.

H2C Commentary

To achieve the Administration's goals of having 30% and 50% of Medicare payments made through Alternative Payment Models (APMs) by 2016 and 2018, respectively, will require significant participation by the nation's largest health systems in programs like the Comprehensive Care for Joint Replacements (CJR) Bundled Payments for Care Improvement (BPCI) Initiative that begins on April 1, 2016. The financial impact on health systems of these initiatives will be striking as CJR alone represents over $7 billion in inpatient revenue targeted for reduction through bundling. Furthermore, the costs to assemble the delivery system relationships and data analytics capabilities cannot be underestimated. As success is measured in reducing cost to Medicare, while maintaining or improving quality, health systems will be under tremendous pressure to organize and manage not only the workflows within the hospital, but also in the physician office and downstream post-acute settings to achieve maximum efficiencies. Proactive organizations seeking to be rewarded for their ability to meet these challenges early will be able to mitigate program costs in the current reimbursement environment. Those that wait, risk incurring the cost of developing and implementing these new capabilities under potentially diminished FFS reimbursement as Medicare moves its focus to APMs. As these operating risks rise, H2C believes it is important for health systems to reduce risk in other areas. In particular, strong balance sheets will be critical to preserving access to the capital needed to make the transition to Value-based Care.

References

1. Kutscher B. Healthcare merger and acquisition activity likely to stay strong in 2016. *Modern Healthcare*. 1 Jan 2016. http://www.modernhealthcare.com/article/20160101/MAGAZINE/301029931

2. U.S. Department of Health & Human Services. CMS finalizes bundled payment initiative for hip and knee replacements. [Press Release]. Web. 16 Nov 2015.

Methodology

The Academy conducts research to identify and monitor trends on key issues relevant to Leading Health Systems. In October 2014, The Academy launched a research study for tracking trends on strategic issues from quarter-to-quarter and will be conducting quarterly interviews with approximately 25 senior health system executives, including: CEOs, COOs, CFOs, CMOs, CNOs, and CSOs. A summary of the results and conclusions will be published in a report each quarter, and the findings will be presented at Academy meetings.

Participating Health Systems

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