# No rest for the weary

## The NEXT imperatives for Healthcare Systems

# Please note

We are a non-partisan firm and retain our ongoing policy of not commenting on the outcome of elections, advocating government policies, or providing policy advice or recommendations to clients.

However, because many of you have asked to understand what effect the new administration's positions– as they currently stand – might have on the healthcare sector, especially given the Republican control of both federal legislature branches, we are providing some information for you to consider.

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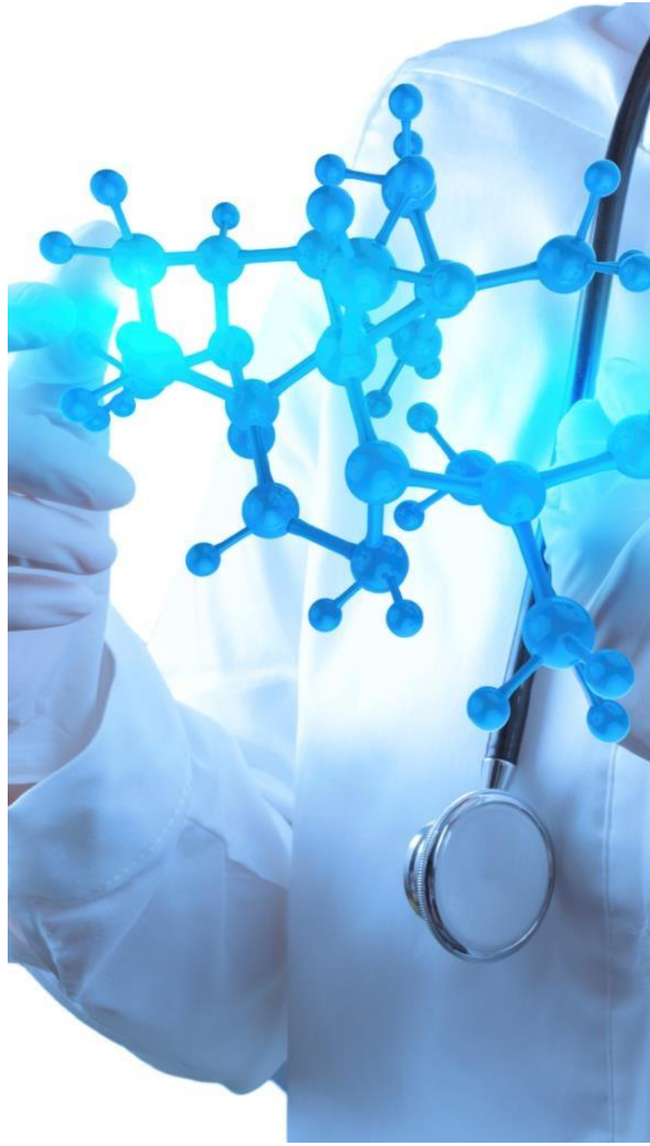
- **Retrospective on ACA**
- “Reform 2.0” Proposals
- Medicaid and Medicare Perspectives
- Implications for Providers



# The ACA had 3 closely related areas of reform

| Provision | Key elements | Rationale |
|---|---|---|
| **Restrictions on payor policies** | ▪ **Guaranteed Issue:** Insurers can't deny coverage or set rates based on health status<br>▪ Rates can only be based on age and geography, and policies cannot be cancelled for illness<br>▪ No annual or lifetime limits on coverage | ▪ Ensure that people who need care can get coverage (and thus get care)<br>▪ Insurers cannot "cherry pick" healthy customers only |
| **The Individual Mandate** | ▪ Everyone be insured, or pay a penalty<br>▪ Penalty is 2.5% of income or $695 ($2085 for families), whichever is greater and inflation adjusted | ▪ Ensures people buy before getting sick, so premiums and costs can be managed |
| **Increasing accessibility to coverage** | ▪ **Medicaid Expansion:** Those making <133% (up from 100%) of the FPL qualify for Medicaid<br>▪ **Federal Subsidies:** States will set up insurance exchanges where people can buy insurance<br>▪ Premium subsidies and limits on OOP1 spending for those <400% of the FPL2 and buy from exchange<br>▪ Children can be covered on parents policy to age 26<br>▪ **Employer Mandate:** Those with more than 50 employees must provide insurance, or be fined | ▪ If there is an individual mandate for people to get insurance, the system must also make insurance relatively accessible (i.e. not too costly) and easy to get, particularly for the lower income, unemployed, etc. |

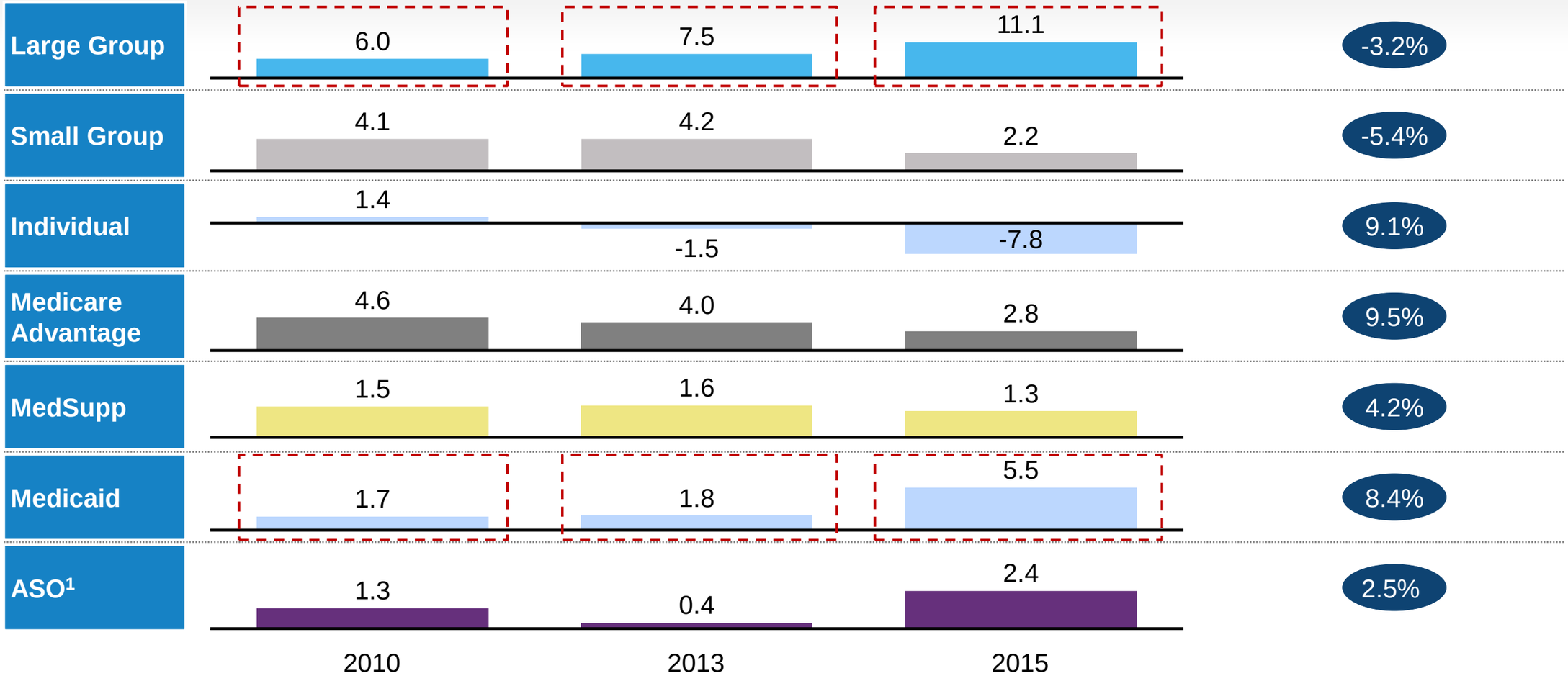
SOURCE: Web; Press

# ACA drove growth for multiple segments of the payor industry

Top 2 Profit Pool Drivers

**Pre-tax Margins for Payors,** $ Billions, %

**Enrollment CAGR (2010-15)**



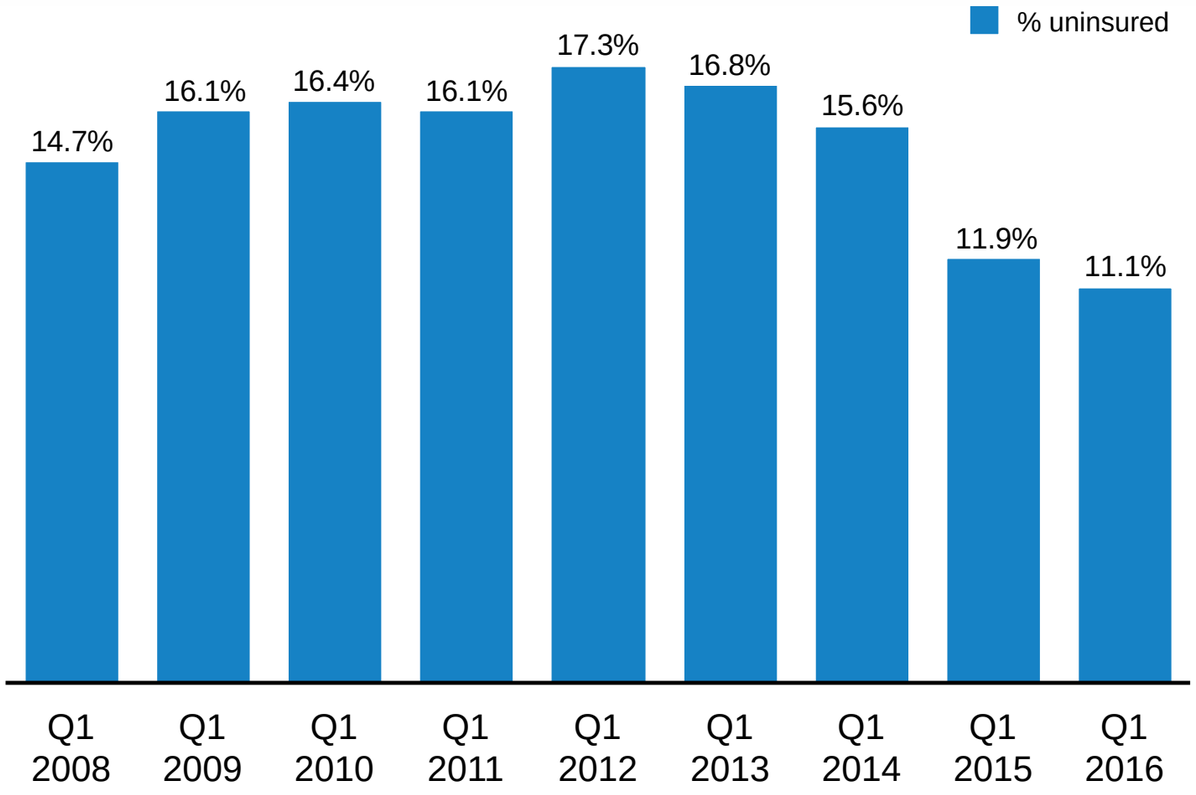

1 ASO lives taken from another database; margins were calculated by an average of segment margins from PFD data, multiplied by the membership numbers from the Interstudy database

SOURCE: Payor Financial Database, McKinsey analysis

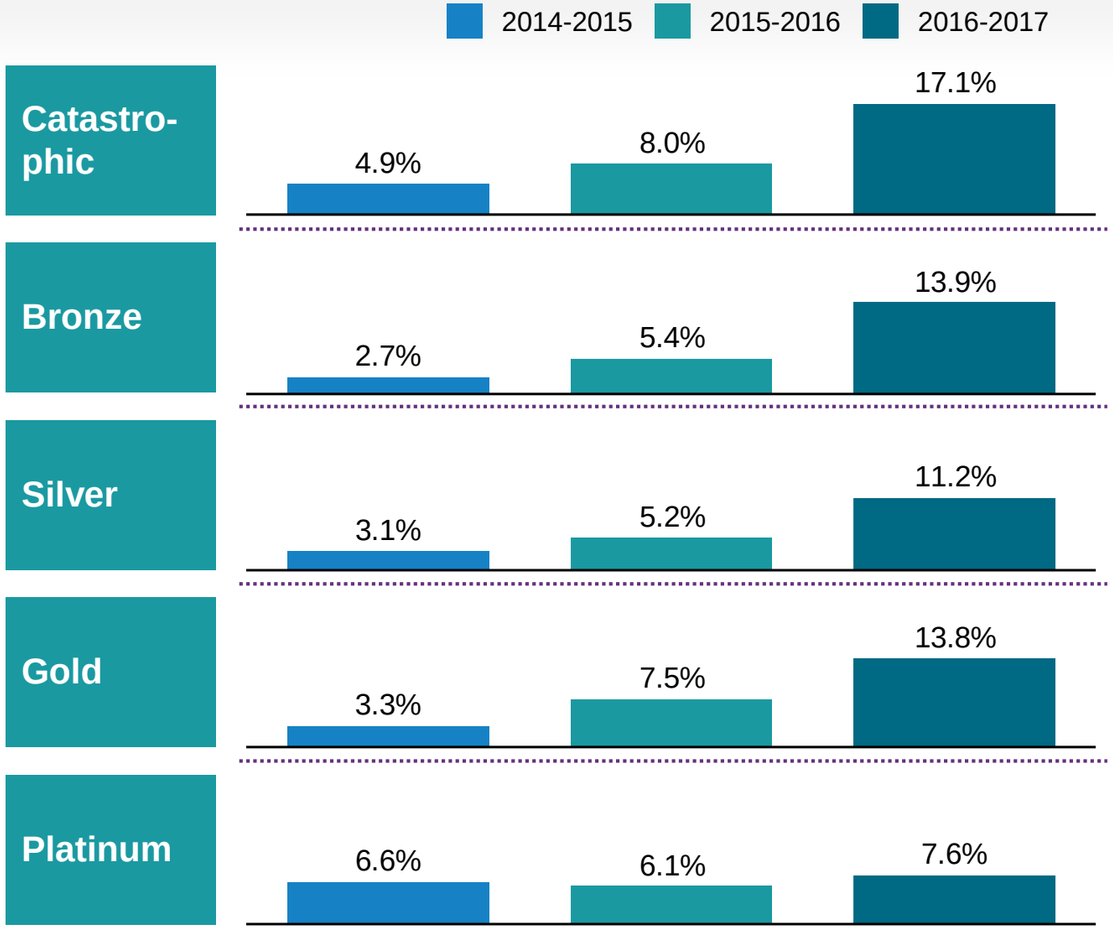
# More (but incomplete) coverage, less affordable, less accessible

## Percentage uninsured in the U.S by quarter

Do you have health insurance coverage? Among adults aged 18 and older




## Change in exchange plan premiums by metal tier[1], 2015-2017




1 Gross premium, before subsidies 2 Annual percentage change from previous fiscal year 3 State general fund growth 4 All Medicaid spend, including federal funds

SOURCE: McKinsey Center for Healthcare Reform, Kaiser Family Foundation; Pew Trust; The National Association of State Budget Offices

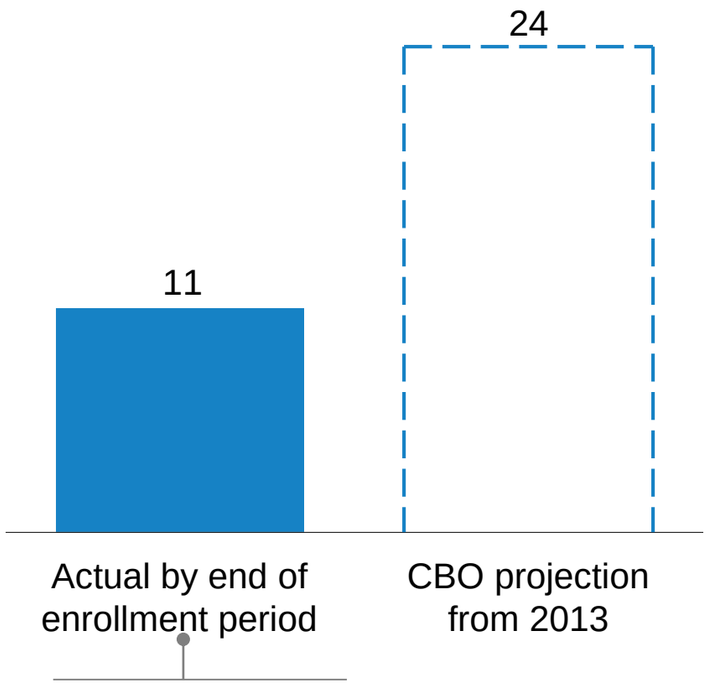
# Exchanges did not reach expectations on enrollment or financials

## Underperformance in Exchange enrollment

## Created unfavorable risk pools and losses for participating payors

### People who signed up for insurance through Exchanges in 2016

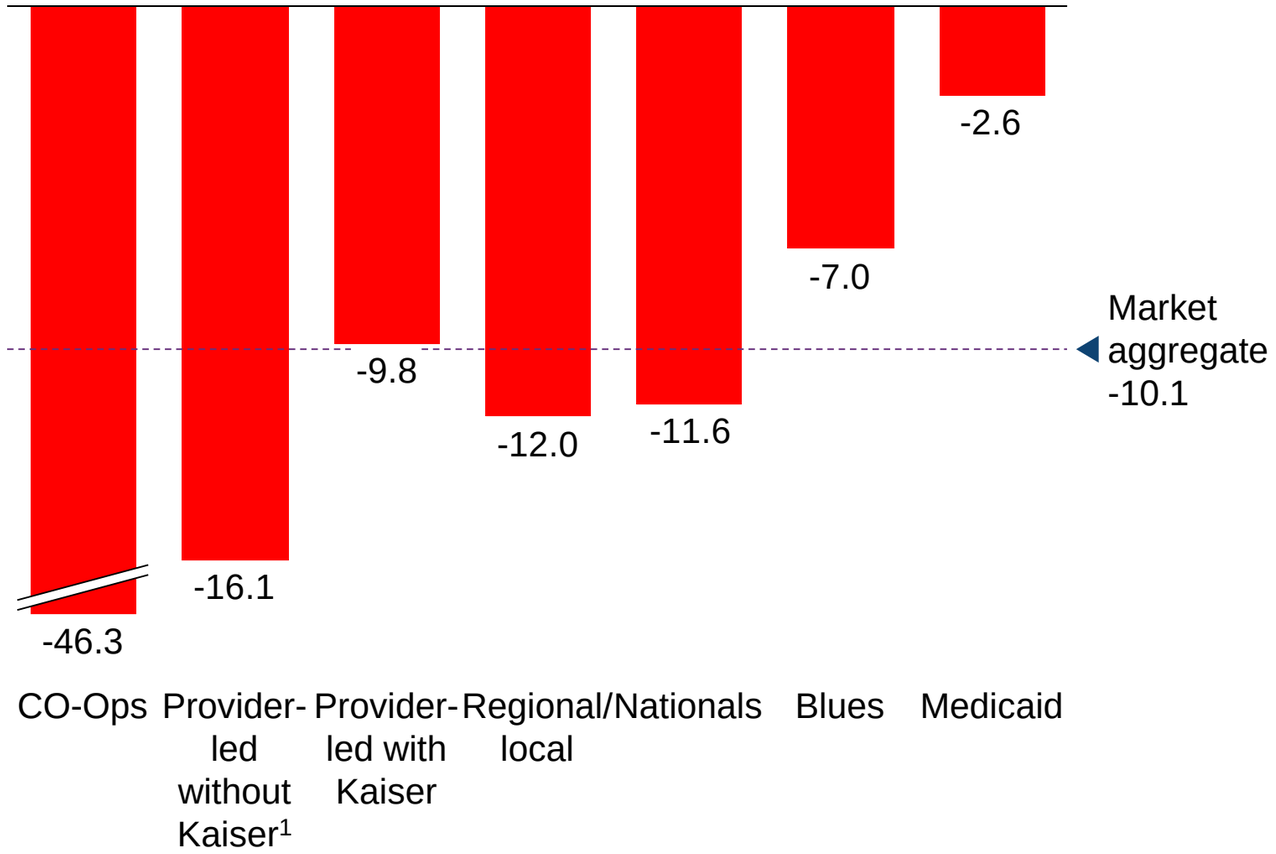
# of people in millions




**~63% previously had insurance** in 2013 (mostly ESI)

### Carrier margins in the 2015 individual market

Aggregate post-tax margin in percent




1 Kaiser comprises 49% of all provider-led plan enrollment

SOURCE: Congressional Budget Office, "Trends in health insurance enrollment" in Health Affairs (2015), RAND Corporation, McKinsey Payor Financial Database

# Major payors have scaled back participation on the Exchanges

## Payors exiting Exchanges…

UnitedHealth Group℠

**34 → 3 states in 2017**

Humana®

**15 → 0 states in 2018**

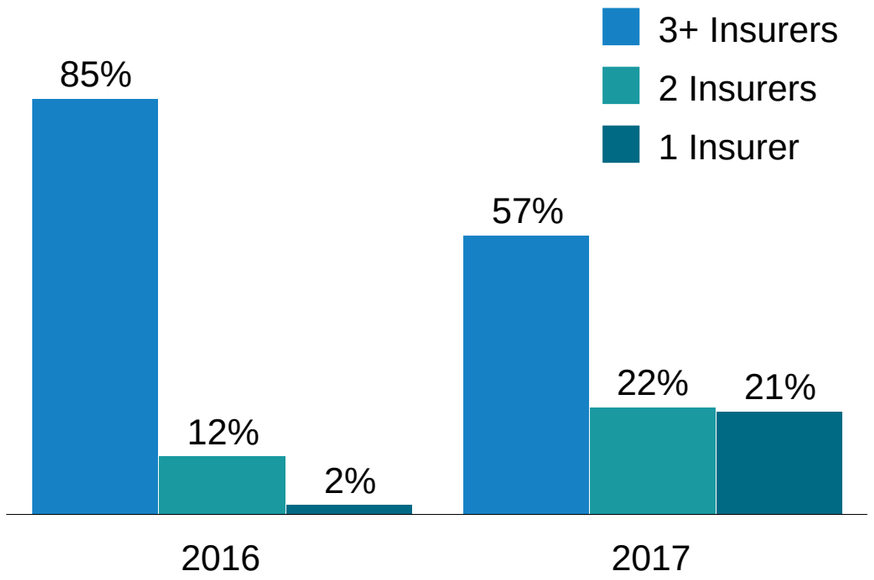
aetna℠

**15 → 4 states in 2017**

## …with fewer offerings…

**Decrease in market competition**

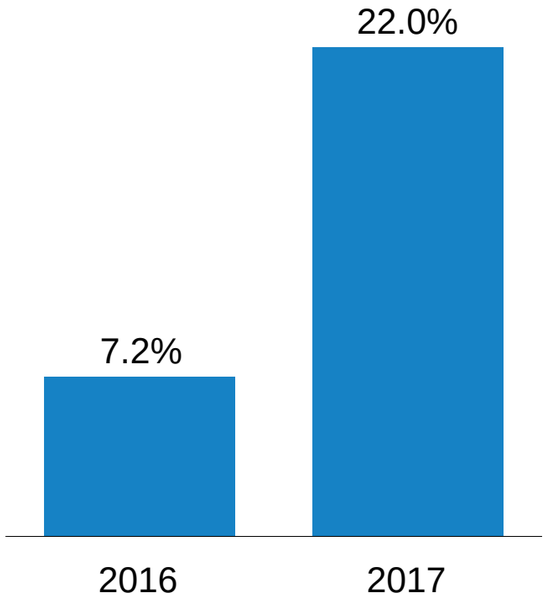
Percent of exchange enrollees with access to…




## …and higher premiums

**Increase in premium prices**

Average percent increase for benchmark silver plan

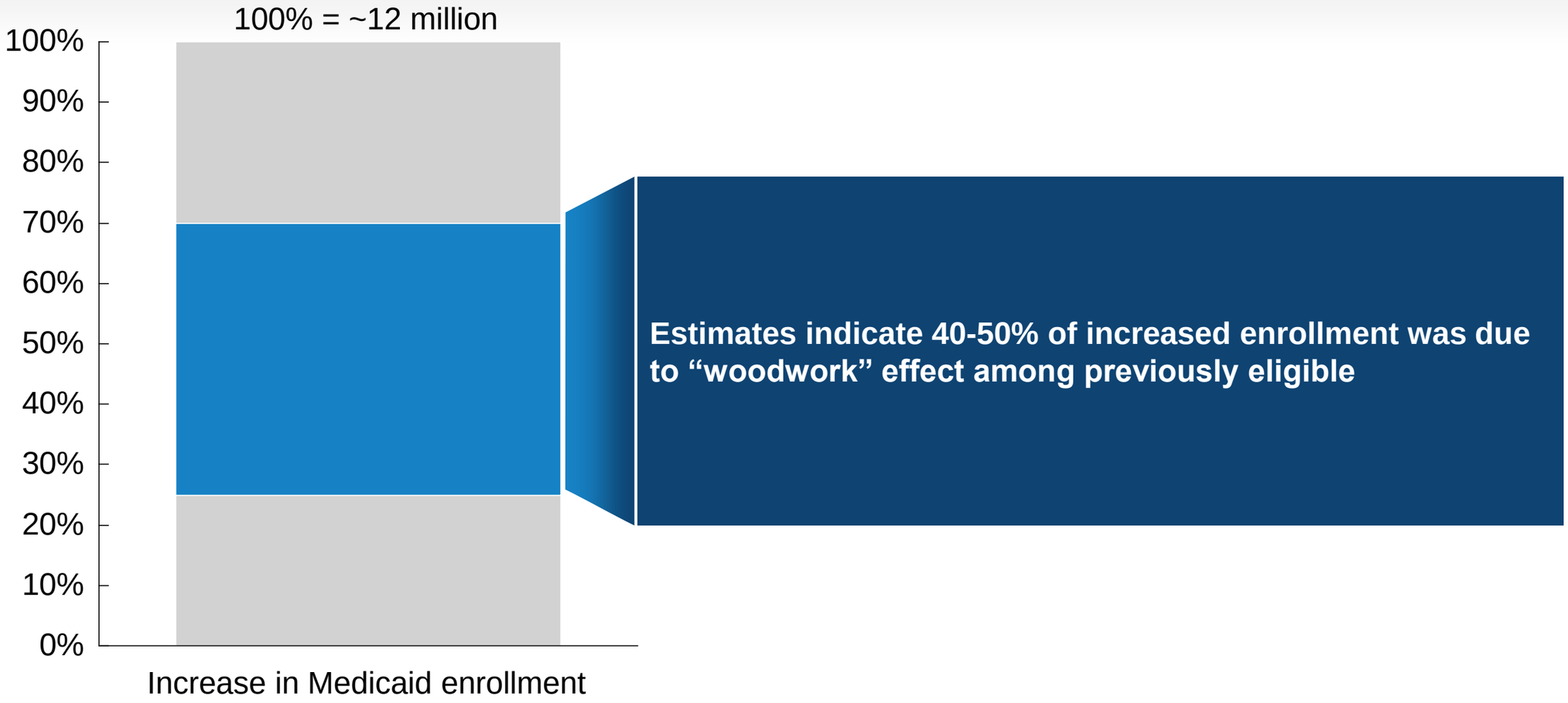



"The individual Obamacare exchanges are in a **death spiral**"
– Mark Bertolini, CEO of Aetna

SOURCE: Kaiser Family Foundation, Department of Health & Human Services, Press Reports

# ACA increased Medicaid enrollment via expansion and awareness

## National estimate of "woodwork" effect on Medicaid enrollment post-ACA

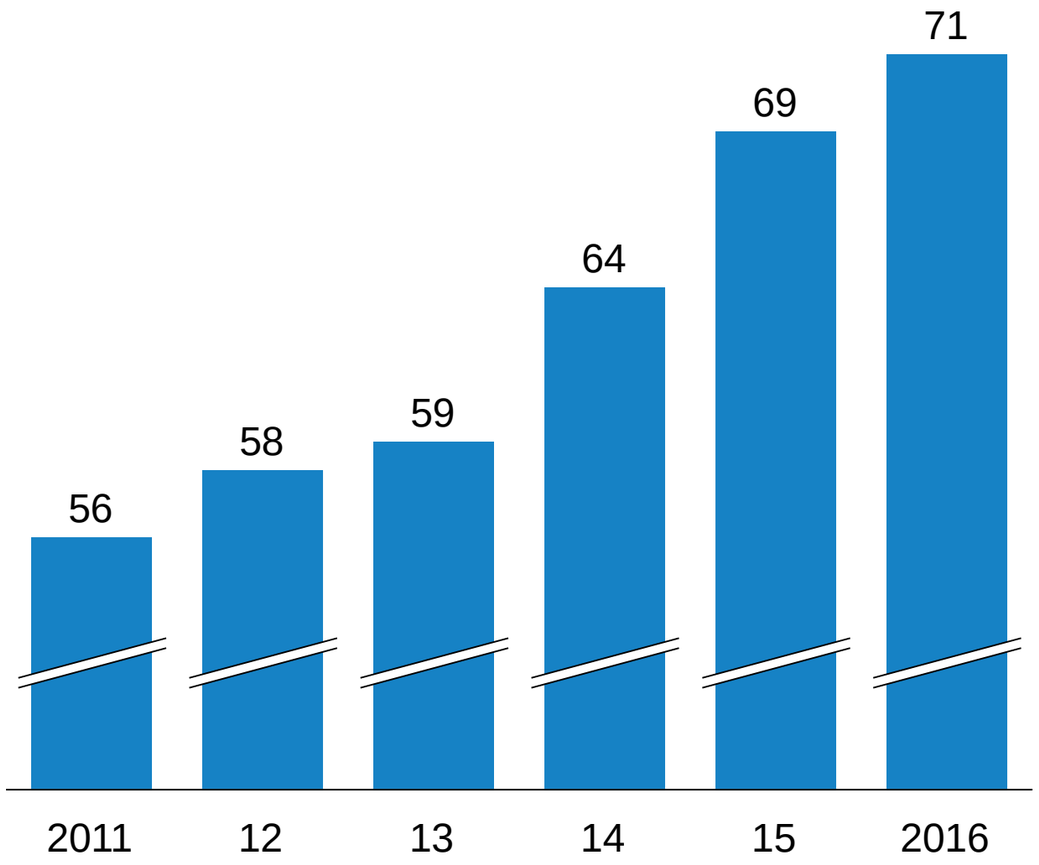



SOURCE: Kaiser Family Foundation, Press review, Medicaid Actuarial Report 2016, "Disentangling the ACA's Coverage Effects — Lessons for Policymakers" (NEJM, Oct 27 2016)

# Medicaid expansion drove growth among MCOs

## Post-ACA period saw increase in Medicaid lives…

**Medicaid enrollees,** Millions




## …with significant benefit to MCOs

**Compared to FFS, MC…**

| | |
|---|---|
| ▼ Payments to providers | ~$24 PMPM |
| ▲ Administrative costs | ~$18 PMPM |

**~89% of expansion adults** have been enrolled in MCOs

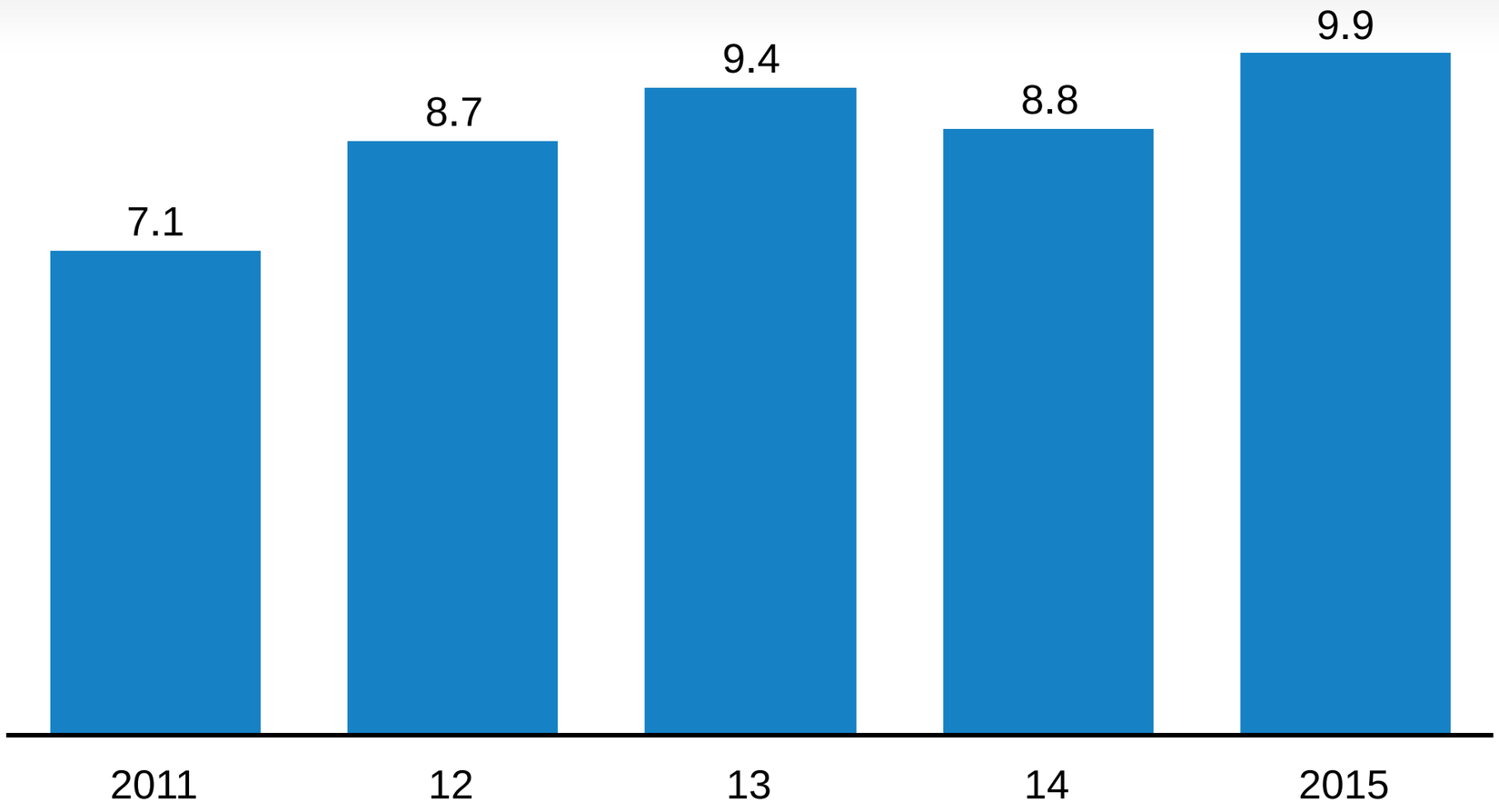
In contrast, MCOs covered 63% of enrollees in 2007

1 Data is not available for 2012, so an average of 2011 and 2013 was used
2 National estimates based on data from 27 states that contain ~81% of total national Medicaid MCO enrollees

SOURCE: Medicaid Actuarial Report 2016, Medicaid Managed Care Enrollment Report (2007-2014), Kaiser Family Foundation, Mercer study

# Bad debt is on the rise with high deductible health plans

**Provision for bad debts of five public, for-profit health systems[1]**
$ Billions

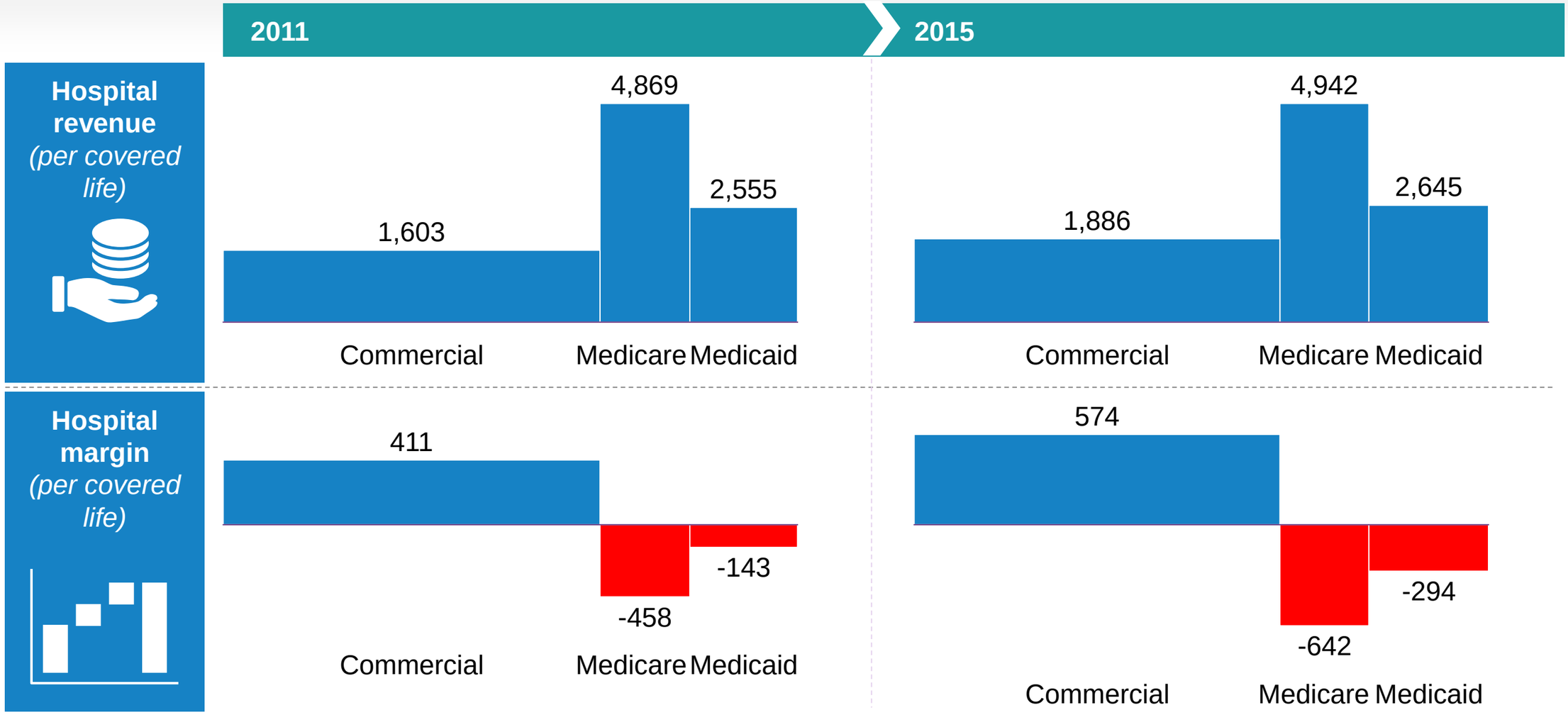



- Almost **90% of individual** enrollees in the ACA marketplaces have a HDHP
- **Deductibles have increased by 67%** in the employer market since 2010
- Almost **25% of workers** are enrolled in a HDHP, up from 4% in 2006

1 CYH, HCA, LPNT, THC, UHS

SOURCE: Financial statements of publically-traded companies, Health Affairs, Kaiser Family Foundation

# Commercial cross-subsidization increased

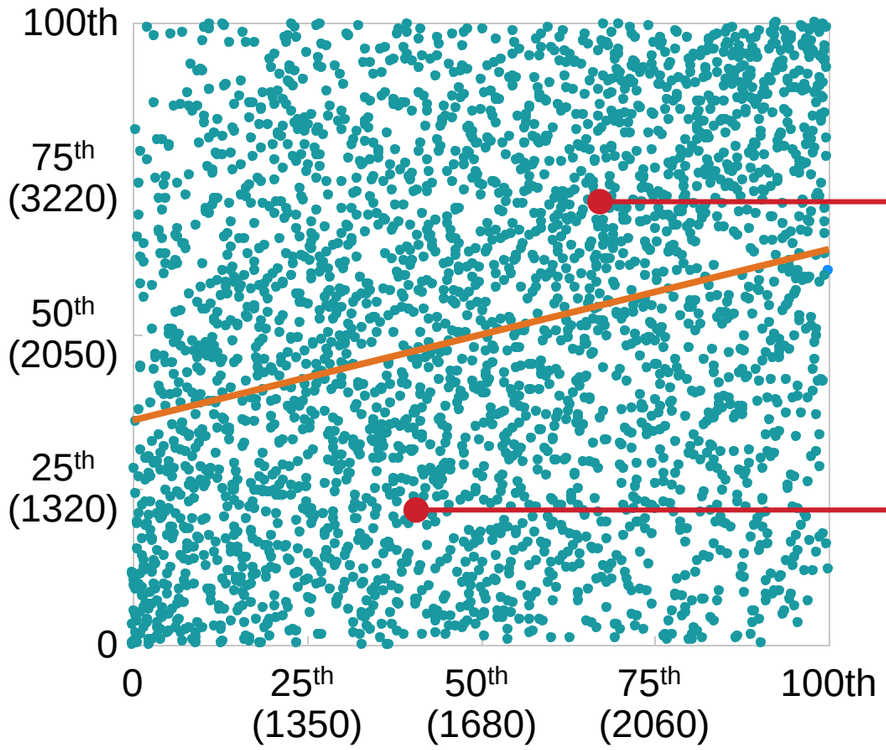



SOURCE: Centers for Medicare & Medicaid Services, US Census, American Hospital Association

# Opportunities to “reform” delivery remain

## Post-acute utilization among Medicare Part B beneficiaries

**Home Health visits per 1000 beneficiaries**
Percentile (county-level)




**SNF covered days per 1000 beneficiaries,** Percentile (county-level)

**There are also major variations across states**


SOURCE: Centers for Medicare & Medicaid Services

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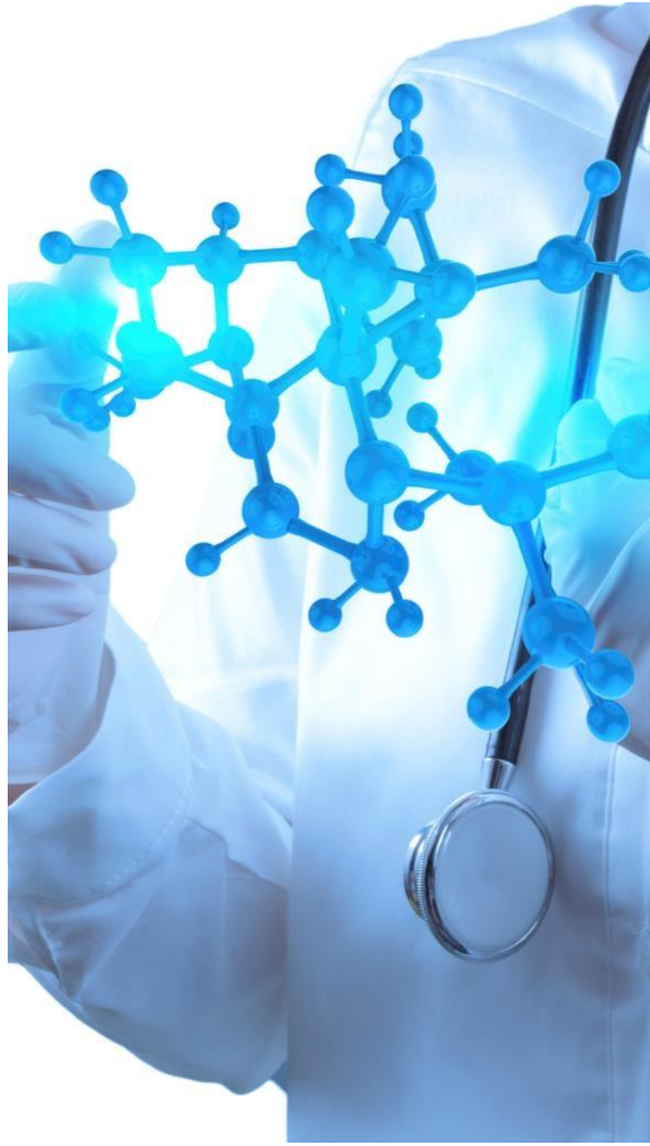


# There are a range of potential scenarios for federal change

Details follow

| Scenario | What this scenario could include, but may not be limited to[1] |
|---|---|
| **Baseline** | ▪ **No change** to the current regulation or funding of the ACA, or<br>▪ **Discretionary authority efforts** to limit effectiveness of the ACA (e.g., no mandate enforcement) |
| **Regulatory and state leadership** | ▪ **Minimal legislative changes** to the ACA (e.g., Congress may appropriate cost-sharing reduction subsidies)<br>▪ **Regulatory changes** within the authority of the Administration (e.g., EHB flexibility)<br>▪ **State discretion** on modifying key ACA provisions via individual market and Medicaid waivers |
| **Federal budget-related changes** | ▪ Despite bill being pulled on March 24, 2017, specific elements of AHCA could still be moved through legislation<br>▪ The American Health Care Act (AHCA) contains budgetary elements that would only require 51 votes to pass through the Senate, many of which are also in Paul Ryan's A Better Way<br>▪ The AHCA includes an **individual market stabilization package** (e.g., cost sharing reductions) for transition as well as "future state" **changes to individual market and Medicaid financing.** However, it does not include Medicare reforms |
| **Trump Plan** | ▪ Potential **Trump administration plan** and/or a deal struck between Republicans and Democrats; details TBD<br>▪ "It's time to get a few moderate Democrats on board" - Reince Priebus, 3/26 |
| **Compre-hensive overhaul** | ▪ "A Better Way", introduced by **Paul Ryan** with input from **Tom Price** in July 2016, serves as a blueprint for the House Republican health care agenda, but requires bipartisan support<br>▪ The proposal seeks a **wide-ranging ACA overhaul**, including financing and market regulation changes across commercial, Medicare, and Medicaid |

1 Each set of proposals would be considered by the House and Senate, scored by the Congressional Budget office, subject to political feasibility, and may undergo change

SOURCE: Paul Ryan "A Better Way", February 2017 House Policy Brief, CMS Proposed Rule to Increase Patients' Health Insurance Choices for 2018. March 2017 American Health Care Act

# A number of uncertainties remain

> “I’ve been saying for the last year-and-a-half that the best thing we can do politically speaking is **let Obamacare explode**. It is exploding right now… the Democrats… own Obamacare … 100 percent. – Donald Trump, March 27th”

| Key facts | Questions to consider |
|---|---|
| **A number of payors have exited the individual market:** About 20% of consumers have only 1 choice of carrier, though the remainder are seeing 2 or more carriers | Will individual market **carriers, who must file by June 21st**, be willing to continue? |
| **Subsidies buffer the rising cost of care:** Average premium increased by ~$1,300 (2014-17);[1] however, a majority (~80%) of consumers received a subsidy[2] | Will the administration **appeal *House v. Burwell (now Price)*[3]** or will cost-sharing reductions end? |
| **Financial performance varies:** Through 2016, payor losses reached ~$20B. However, some carriers, often with narrowed networks and managed plan designs, have performed well | Will HHS work to recover **reinsurance funds** already distributed to insurers? |
| **Despite coverage gains, many remain uninsured:** Although ~10M enrolled on exchanges, close to 50% of the QHP-eligible population is uninsured – and enrollment dropped this year | Will HHS re-establish outreach efforts **to encourage individuals to enroll?** |
| **The status of the individual mandate remains uncertain:** During the first week of his presidency, Trump released an executive order advising agency heads to “minimize the financial burden of Obamacare” | Will HHS/IRS choose **not to enforce** the individual and employer mandates? |

1 Average silver gross premiums; 2 ASPE; 3 Lawsuit is on "pause" until May 2017

# HHS and the states could drive ACA changes

| Scenario | Description |
|---|---|
| 1 ACA changes (without federal legislation) | ▪ **No federal legislation**<br>▪ Includes **regulatory action to stabilize the individual market,** e.g.:<br>– Finalizing individual market stabilization package<br>– Offering 1115 and 1332 waiver flexibility for states<br>– Redefining essential health benefits |
| 2 ACA changes (with minimal federal legislation) | ▪ **Narrow federal legislation**, e.g.:<br>– Appropriation of **cost-sharing reductions** and/or **risk funding**<br>– Passage of broader **1332 waivers**<br>▪ Includes **regulatory action to stabilize the individual market,** e.g.:<br>– Finalizing individual market stabilization package<br>– Offering 1115 and 1332 waiver flexibility for states<br>– Redefining essential health benefits |

**There are more than 2,500 references to the authority of HHS secretary in the ACA**

# What could be changed and what couldn't using a 1332 waiver?

## What could be waived ✓

- **Benefits and subsidies:** States may modify rules governing benefits and subsidies on exchanges. States can reallocate tax credits and CSRs
- **Marketplaces and QHPs:** States may replace marketplaces or supplant the process with alternative ways to provide choice, determine eligibility and enroll consumers
- **Mandates:** States may modify or eliminate the individual and employer mandates

## What couldn't be waived ✗

- **Guaranteed issue and pre-existing conditions**: States can't allow insurance companies to deny coverage or charge more because of health status
- **Rating Bands**: States can't change the limits placed on how much premiums can vary based on age, health status, tobacco use and gender
- **No-cost preventive services**: States must require insurers to cover preventive services, such as immunizations and screenings

- **HHS leadership has stated several principles and priorities in a letter on 3/13**
  - Aims to expedite 1332 applications and provide checklists to assist states
  - Proposals should be "as good or better" in terms of comprehensiveness, affordability, and coverage and be federal deficit neutral
  - Programmatic priorities include high-risk pools and state-operated reinsurance, with the potential for states to receive pass-through funding to offset some costs
  - HHS may be open to applications relaxing EHB requirements

SOURCE: Affordable Care Act; HHS, "Offering states flexibility to increase market stability and affordable choices," March 13, 2017

# Existing and emerging uses of 1115 waivers

## Most common uses of waivers as of Feb 2017

- **Delivery system reform (16 states):** shift from FFS to value-based payment, DSRIP delivery system reforms, funding for safety net hospitals
- **Behavioral health (12 states):** enhanced services to targeted populations or integration with physical health
- **Managed long-term supports and services (12 states):** delivering LTSS through capitated managed care
- **Medicaid program design (7 states):** modified key benefits and eligibility designs as part of expansion model
- **Others (15 states):** locally specific needs, e.g. Flint water crisis, HIV/AIDS services

## Potentially emerging uses

- Price and Verma issued a statement on 1115 waivers (3/14)
- Statement indicated aims to streamline application process
  - Make the State Plan Amendment (SPA) process more efficient/ transparent
  - “Fast track" extension approval; prioritize models already approved in other states
  - Budget neutrality and reasonable public input are expected
- Statement outlined new focus areas:
  - Alternative benefit design: premium contributions, cost-sharing, and healthy behavior incentives (e.g., IN, MI,  PA)
  - Eligibility: limitations on able bodied adults, work incentives (IN, MI, PA have pursued but legality challenged)
  - Promotion of enrollment in ESI, which was previously required to be as rich as Medicaid, but may be loosened
  - Investment in opioid services via MIAP, 1115

SOURCE : www.hhs.gov/sites/default/files/sec-price-cms-admin-verma-ltr.pdf; https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/March-13-2017-letter_508.pdf

# Indiana expanded Medicaid through an 1115 waiver

## Context

- Indiana expanded coverage to ~350,000 new beneficiaries on February 1, 2015 through a 3-year 1115 waiver
- Expansion covered adults ages 19-64 with incomes from 0-138% FPL including non-expansion parent/caretakers, those eligible for Transitional Medical Assistance, and newly eligible adults
- One of the most complex expansions to date, the waiver created multiple benefit packages with common themes of consumer responsibility and cost-sharing

**Most distinctive features**

- Pre-funded health savings accounts ("POWER" accounts) for members in capitated managed care
- Requirement of premium payments for certain benefit packages with coverage not taking effect until date of initial premium payment
- Six month coverage lock-out for non-payment of premiums for beneficiaries above 100% FPL

**Benefit package variation**

- **HIP Plus** for beneficiaries who pay premiums: includes expanded benefits and co-payments only for non-emergency use of the ER
  - Non-medically frail 101-138% FPL must pay premiums to obtain any coverage
  - Premiums capped at 2% of income ($27/month for those at 138% FPL); premiums for those with income below 5% FPL ($49 or less per month for an individual in 2015) are $1.00 per month
- **HIP Basic** for beneficiaries with income at or below 100% FPL who fail to pay premiums: fewer benefits (such as no coverage for adult dental and vision) and required co-payments in state plan amounts

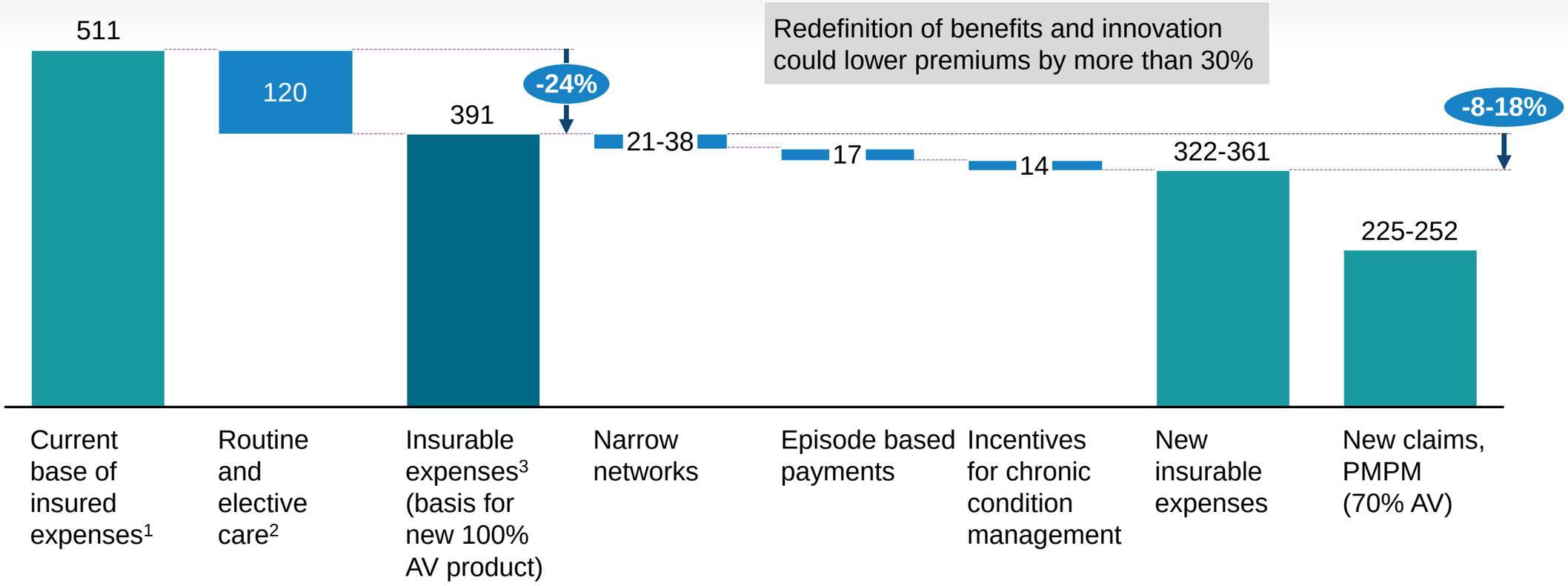
**Key initiatives**

- Tests graduated co-payments (in amounts that exceed federal law - $8 first time, $25 subsequent) vs. a control group for non-emergency use of the emergency room (2-year demonstration)
- Waives provision of non-emergency medical transportation (NEMT) benefit for most newly eligible adults for one year, to be extended based on evaluation assessing its impact on access
- Offers optional Medicaid premium assistance for newly eligible adults with employer-sponsred insurance
- Requires individuals 100-138% FPL enrolled in Marketplace to transition to Medicaid

SOURCE: Healthy Indiana Plan, http://www.in.gov/fssa/hip/

# HHS could redefine the 10 essential health benefit criteria

**If essential health benefits were redefined, only 76% of today's covered health services would be insurable,** $, PMPM




Note: PMPM – Per Member Per Month
1 Based on 2014 exchange premiums and actuarial value.
2 Based on breakdown of 2014 Truven commercial claims data.
3 Includes chronic, catastrophic, and preventive care (excludes routine and discretionary services).

SOURCE: Data from the Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project, Medical Expenditure Panel Survey, National Health Expenditures Accounts, Office of the Assistant Secretary for Planning and Evaluation, Truven, and medical loss ratio reports from the Centers for Medicare and Medicaid Services; McKinsey Payor Financial Database; McKinsey Exchange Offering Database

# The administration has tried to stabilize the individual market

| Change | Description | Application and timing |
|---|---|---|
| Promote appropriate enrollment | ▪ **Proposed to tighten Special Enrollment Period (SEP) rules:** SEP eligibility rules would be tightened to reduce "individuals enrolling in coverage only after they realize they need services" | ▪ Would apply to 100% of FFM exchange enrollees starting in June 2017, pending final rule1 |
| | ▪ **Proposed to allow carriers to require payments of unpaid premiums from the previous year:** Payors could require that any unpaid premiums from the previous year (max of 3 months of premiums) would need to be paid before subsequent coverage begins | ▪ Would apply to individuals re-enrolling in coverage with same insurer, pending final rule1 |
| | ▪ **Proposed to shorten the Open Enrollment Period (OEP):** OEP would be shortened to Nov. 1 – Dec. 15, 2017 (previously ended Jan. 31, 2018) | ▪ Would apply to 2018 OEP beginning in November 2017, pending final rule1 |
| Increase carrier flexibility | ▪ **Proposed to change the de minimis actuarial value (AV range):** AV range would be allowed to drop to -4% for non-silver plans (individual and small group), rather than the -2% today | ▪ Would apply to all plans for 2018 plan year, pending final rule1 |
| | ▪ **Proposed to shift network adequacy rules fully to the states:** Network adequacy would be shifted to State reviews for FFM states; the rule would also relax regulations around essential community providers | ▪ Would apply to all states for 2018 plan year, pending final rule1 |
| | ▪ **Revised QHP certification and rate filing deadlines:** Deadlines for 2018 QHP applications and rate table templates for FFM states are delayed (e.g., filing deadline moved from May 3 to June 21, 2017) | ▪ Applies beginning with initial filing deadline moving to June 21, 2017 for 2018 plan year |
| | ▪ **Extended transitional policies:** Allows for "grandmothered" policies that begin on or before October 1, 2018 for an additional year | ▪ Applies to all relevant policies starting in 2018 plan year |
| | ▪ **Requested a "timeout" on the cost-sharing reduction lawsuit** : the Trump administration and House of Representatives jointly filed to extend the abeyance period, during which Congress will presumably continue to appropriate CSR funds | ▪ Asked the court to continue to abeyance period till May 2017 |

1 Included as part of proposed rule, subject to change in Spring 2017

SOURCE: February 21, 2017 the House of Representatives and the Trump administration Justice Department filed a joint motion in House v. Price (formerly House v. Burwell) asking the court to continue to abeyance period. February 2, 2017 CMS Proposed Rule to Increase Patients' Health Insurance Choices for 2018. QHP Certification in the Federally-facilitated Marketplaces; Rate Review; Risk Adjustment and Reinsurance Revised February 2017

# CMMI's mandate is broad

## Overview of CMMI authority

- Test innovative payment and service delivery models **to reduce program expenditures while preserving or enhancing the quality of care**
- **Through rulemaking, expand the duration and scope** of these models (including implementation on a nationwide basis)
- Applicable to Medicare, Medicaid and CHIP segments
- Can **implement authority through several levers** including modifying existing models, direct Medicare waiver authority, facilitating testing in Medicare Advantage, developing new Medicare demonstrations (with Congressional approval)

## Republicans emphasize several broad healthcare issues, which may be CMMI's focus going forward

- **Multi-payer collaboration** / private payer-friendly programs
  - E.g., General Republican focus on private sector partnerships
- **State flexibility**
  - E.g., "We commit to ushering in a new era . . . where states have more freedom to design programs that meet the spectrum of diverse needs" –Price, Verma, March 2017
- **Consumer-centric** care / consumer accountability
  - E.g., Seema Verma implemented consumer cost-sharing in Indiana Medicaid
- **Provider flexibility**
  - e.g., Price said the goal of ACA replacement legislation, was to "get Washington out of the way while protecting and strengthening the doctor-patient relationship."

**Withdrawing CMMI funding would require legislation, but changes to use of existing funding can happen through regulation only**

SOURCE: Section 1115A of the Social Security Act, as added by section 3021 of the Affordable Care Act; CMMI website; Paul Ryan's "Better Way"

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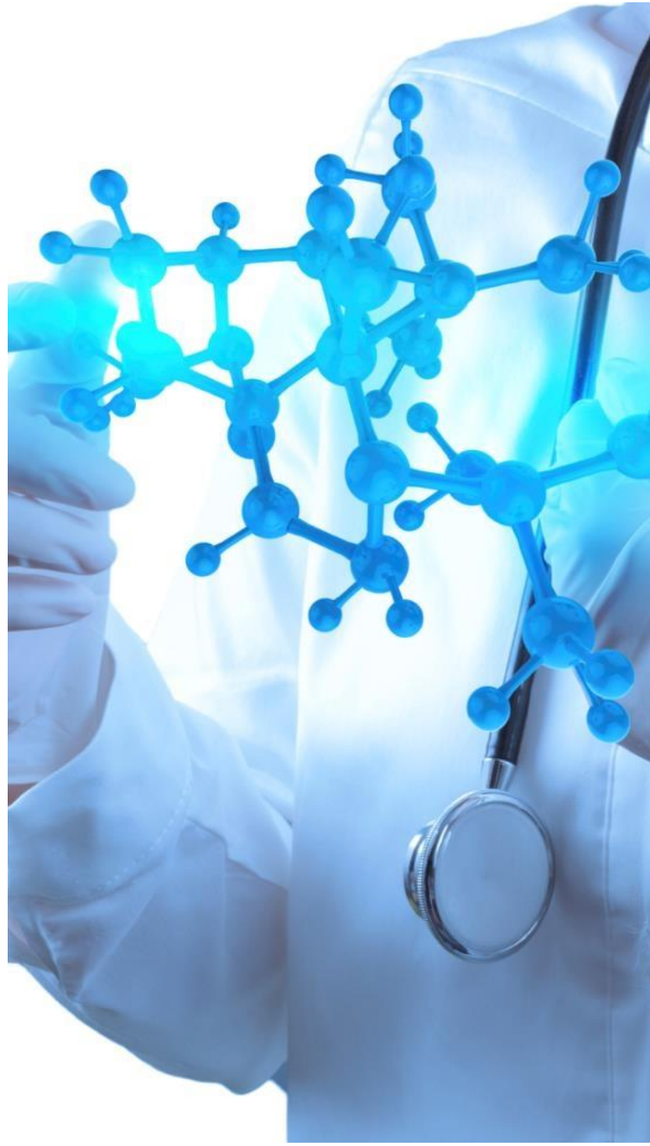


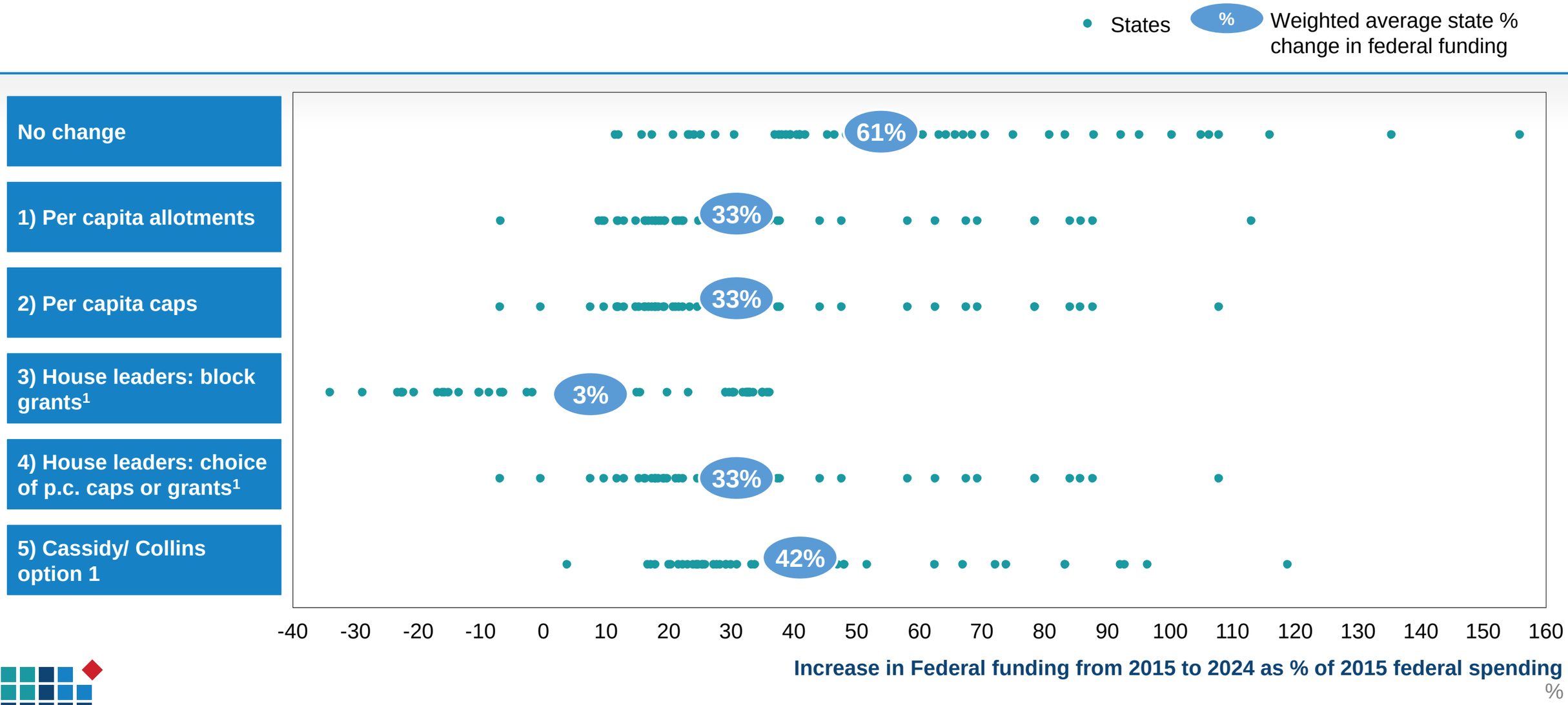
# Multiple proposals to alter federal Medicaid funding

Not defined in plan
In plan, but ambiguous

| Medicaid changes | | Proposal 1 | Proposal 2 | Proposal 3 | Proposal 4 | Proposal 5 |
|---|---|---|---|---|---|---|
| Federal financing | State funding mechanism | Per capita allotments | Per capita caps | Block grants | States choose per capita caps or block grants to maximize overall federal funding[1,2] | Per capita allotments |
| | Growth index | MCPI[3] | MCPI[3] | MCPI[3] | MCPI[3] | CPI + 1%[4] |
| | Base year | 2016 | 2016 | 2016 | 2016 | Assume 2016 |
| | Implementation year | 2020 | 2020 | 2020 | 2020 | Assume 2020 |
| Program eligibility | Medicaid expansion | Maintained through 2019, starting 2020 phased out through churn | Maintained through 2019, starting 2020 phased out through churn | Excluding ACA expansion population | Per cap caps: maintained and then phased out<br>Block grants: excluding ACA expansion population | Maintained |
| | Expansion population match rate | Enhanced FMAP (EFMAP) main-tained for grand-fathered enrollees, reduced to State FMAP via churn[5] | EFMAP maintained for grandfathered enrollees, reduced to State FMAP via churn[5] | EFMAP maintained until implementation | Match rate for caps mimics proposal 2; match rate for block grants mimics proposal 3 | 95% of enhanced FMAP |
| | Future expansion | Allowed, EFMAP through 2019 or additional DSH funding[6] | Allowed, EFMAP through 2019 or additional DSH funding[6] | Allowed, through 2019 or additional DSH funding[6] | Allowed, EFMAP through 2019 or additional DSH funding[6] | Enhanced FMAP, at 95% of ACA |
| | Implementation year | Assume 2020 | Assume 2020 | Assume 2020 | Assume 2020 | Assume 2020 |

1 Proposal notes that long-term care services and supports would be funded in a separate, fixed grant to the states, but the acute-care insurance needs of the elderly and disabled would continue to be addressed by the current Medicaid program structure, including current federal-state matching rates and rules
2 Assume that states choose the option that maximizes federal funding for them
3 Growth rate for both intermediate years between passage and policy implementation as well as cap/block grant growth rate
4 The proposal allows federal contributions to healthcare savings accounts (HSAs) to grow in line with CPI; however the plan does not define a growth rate for federal Medicaid funding
5 For 2020 onwards, assume that any new enrollees or any who lapse for more than one month are reduced to State FMAP
6 States may obtain a share of $2 billion in annual support for safety net providers from 2018 through 2022

# Large variability across states in potential impact

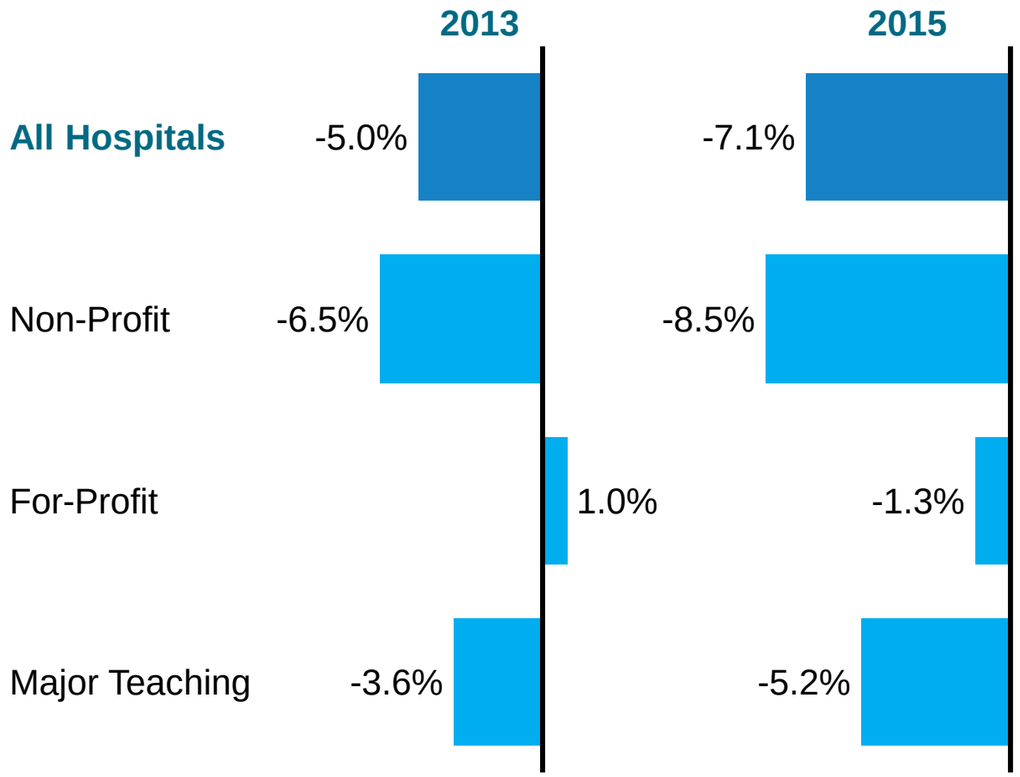



1 Excluding expansion

# Medicare margins have deteriorated across provider types

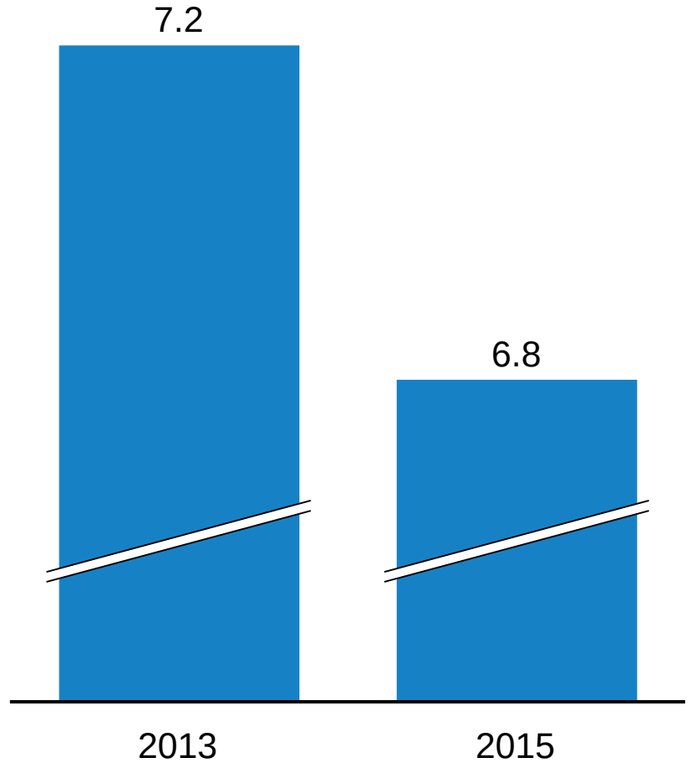
## Medicare margins have deteriorated across provider types …

### Medicare Margin by Provider Type
Percent




## …and have started impacting overall profitability

### All-payor margins across all providers
Percent

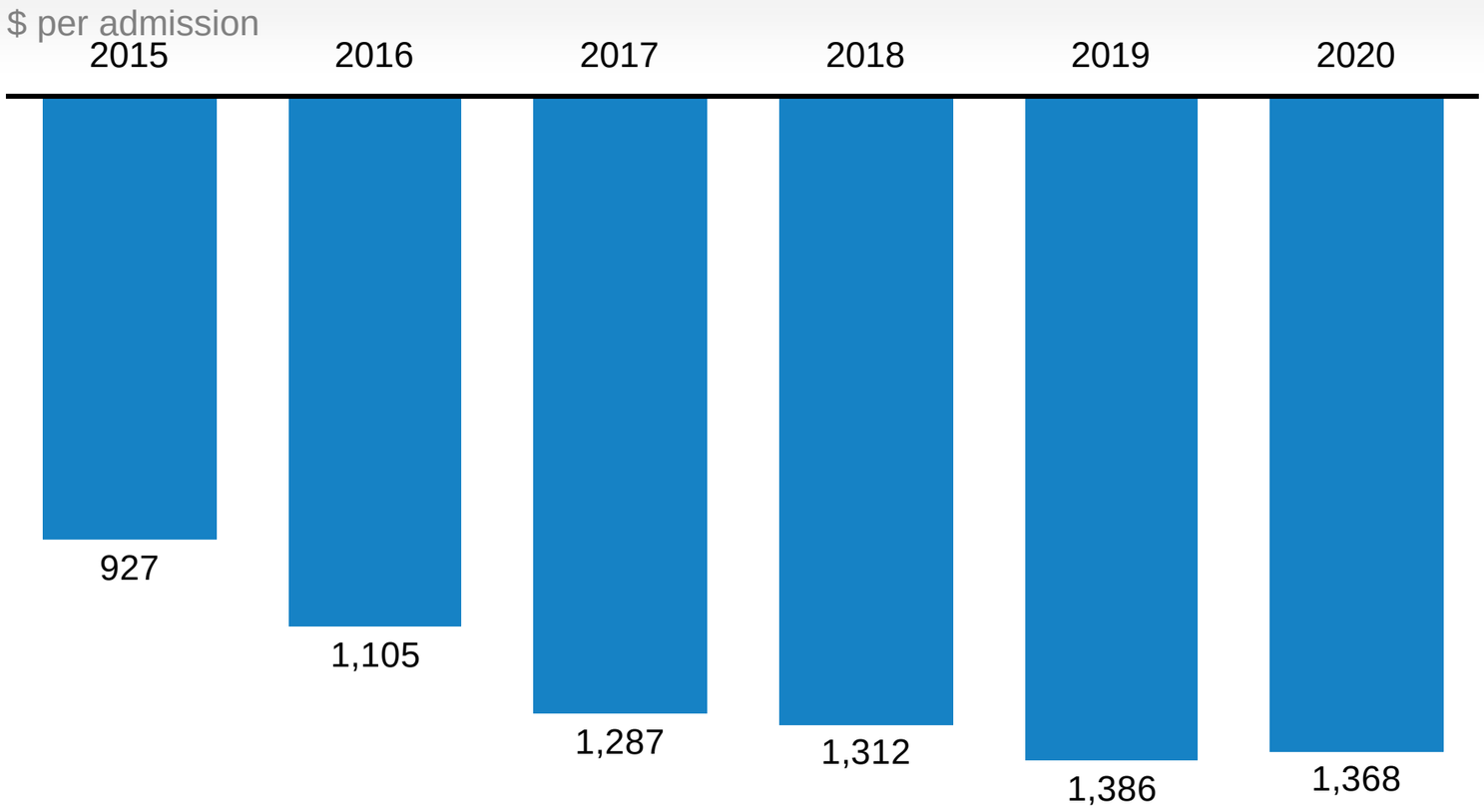



1 2015 data not available

SOURCE : MedPAC Data book, June 2016; MedPAC Report to Congress: Medicare Payment Policy (2017)

# Payment adjustments negatively impact Medicare margins

## Projected per admit loss in Medicare reimbursement rates[1]




## Key levers impacting reimbursement

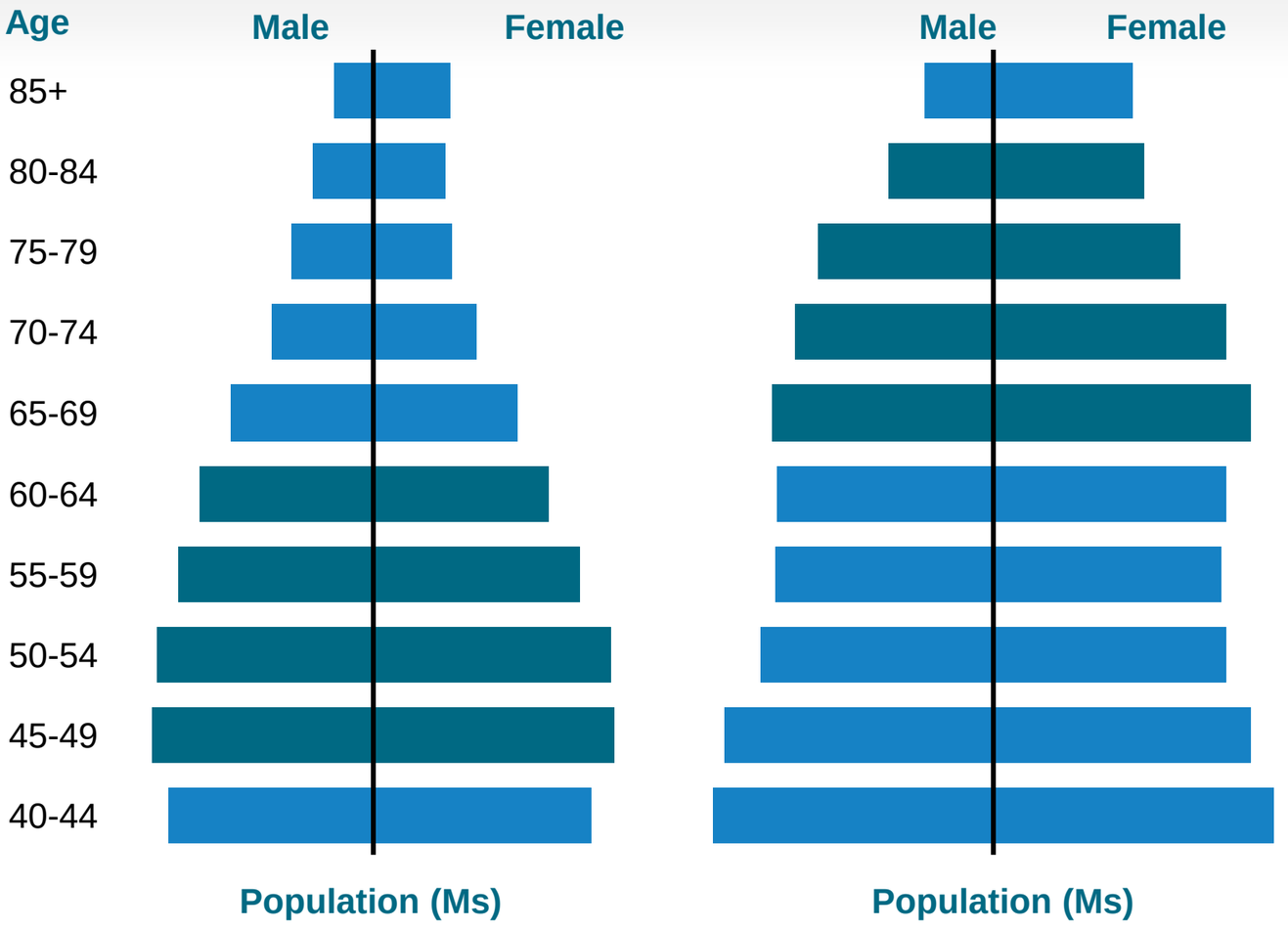
- Recoupment coding adjustments
- ACA-legislated statutory adjustments (end in 2019)
- Two-midnight rule adjustment (One-time increase in 2017)
- Changes to supplemental payments (next slide, not included here)

Note: official payment growth rules for 2018 and beyond have not yet been released

1 Excludes effects of changes to uncompensated care payments, electronic health record incentives, quality penalties, value-based purchasing incentives, and potential Independent Payment Advisory Board (IPAB) recommendations

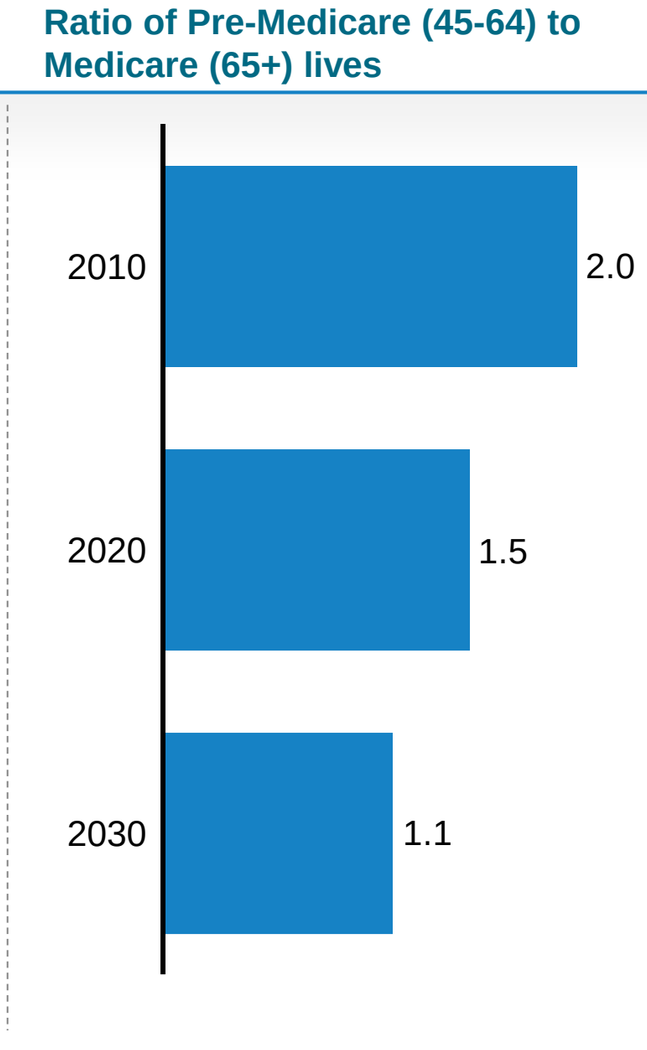
SOURCE : IPPS Rule FY2017, MedPAC Report to Congress (2017)

# Demographic trends underscore the efficiency imperative










SOURCE: MedPAC Report to Congress: Medicare Payment Policy (2017), Medicare Trustees Report (2016)

# Hospitals that reach breakeven margins are not sacrificing quality

## Analysis of quality and margin performance in hospitals identified as 'relatively efficient'[1]

| | | Relatively efficient[1] | Other hospitals |
|---|---|---|---|
| | Share of hospitals | 14% | 86% |
| **2015 Quality performance** (Relative to national median) | 30-day mortality | ↓ 6% lower | ↑ 1% higher |
| | 30-day readmission | ↓ 6% lower | ↑ 1% higher |
| **2015 Margin** (median) | Medicare margin | 0% | -6% |
| | All-payer margin | 7% | 5% |

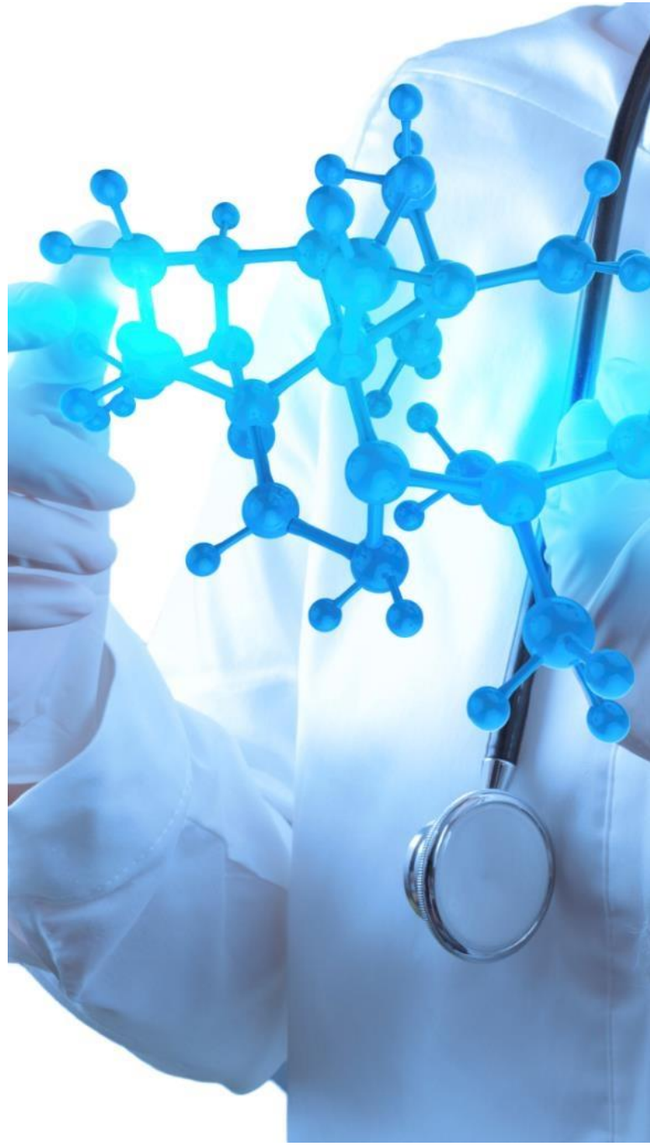
**"Relatively efficient" hospitals varied in geography and a diverse set of characteristics, but were more likely to be larger nonprofit hospitals**

1 For 2012-2014, hospital must have been in top 2/3 of all hospitals for all quality/cost performance measures, also must have been in top 1/3 for either mortality or cost, as well as had at least 60% of patients rate 9 or 10 on HCAHPS "hospital rating," a few other rules were applied to minimize outliers, see appendix 3-B of 2016 MedPAC Report to Congress for details

SOURCE : MedPAC Report to Congress: Medicare Payment Policy (2017)

# Contents





# Providers need to shift their advocacy agendas

| | |
|---|---|
| **Elements of ACA to preserve** | ▪ Medical loss ratio requirements<br>▪ Taxes on pharmaceutical and insurance sectors to fund elements of ACA<br>▪ ACA policies to minimize uninsured (e.g., mandates, subsidies, Medicaid expansion, ban on pre-existing conditions, coverage for children up to age 26) |
| **Elements of ACA to repeal** | ▪ Medicaid DSH cuts<br>▪ Redirect CMMI focus to help providers develop capabilities to manage risk<br>▪ Simplify administrative/regulatory procedures and limit mandatory programs |
| **Non-ACA provisions** | ▪ Increase the number of graduate medical education slots<br>▪ Increase funding for community health centers and for trauma programs<br>▪ Reduce overall reporting and regulatory burdens that do not serve patients |

**As decision-making is increasingly pushed to the State level (e.g., via Section 1332 and 1115 waivers), providers have an opportunity to shape the way these tools are used to create value**

SOURCE: Annals of Internal Medicine, Annals of Family Medicine

# Health system CEOs should address 6 key imperatives

6

**Ruthlessly manage costs** through operational excellence to preserve margins, especially for Medicare and Medicaid patients, engaging medical staff to join in this crusade – with the goal of realizing negative cost trend moving forward

**Focus on healthcare, not hospital care:** Manage patient healthcare in and out of the hospital to targeted populations, and explicitly decide how and how not to participate in episodic care and/or the broader continuum

**Experiment with vertical integration** and build capabilities to engage physicians and payors to ensure value creation results from innovative relationships

**Aggressively develop (or resource) functions and capabilities necessary to win,** taking advantage of scale partnerships with individual hospitals to capture cost synergies and quality benefits

**Create a clear strategy for the future Medicaid market:** Understand how to care for the Medicaid population, given worsening reimbursement on already financially challenged cases, and implications that result

**Capture a disproportionate share of the commercially insured and at least fair share of secular growth in Medicare lives** to mitigate the impact of limited Medicare / Medicaid reimbursement growth rates

# Questions and Thank You

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