



Health Reform Passes / Are You Prepared for Historic Change?

Healthcare Facilities Implications

April 2010

Avalere Health LLC



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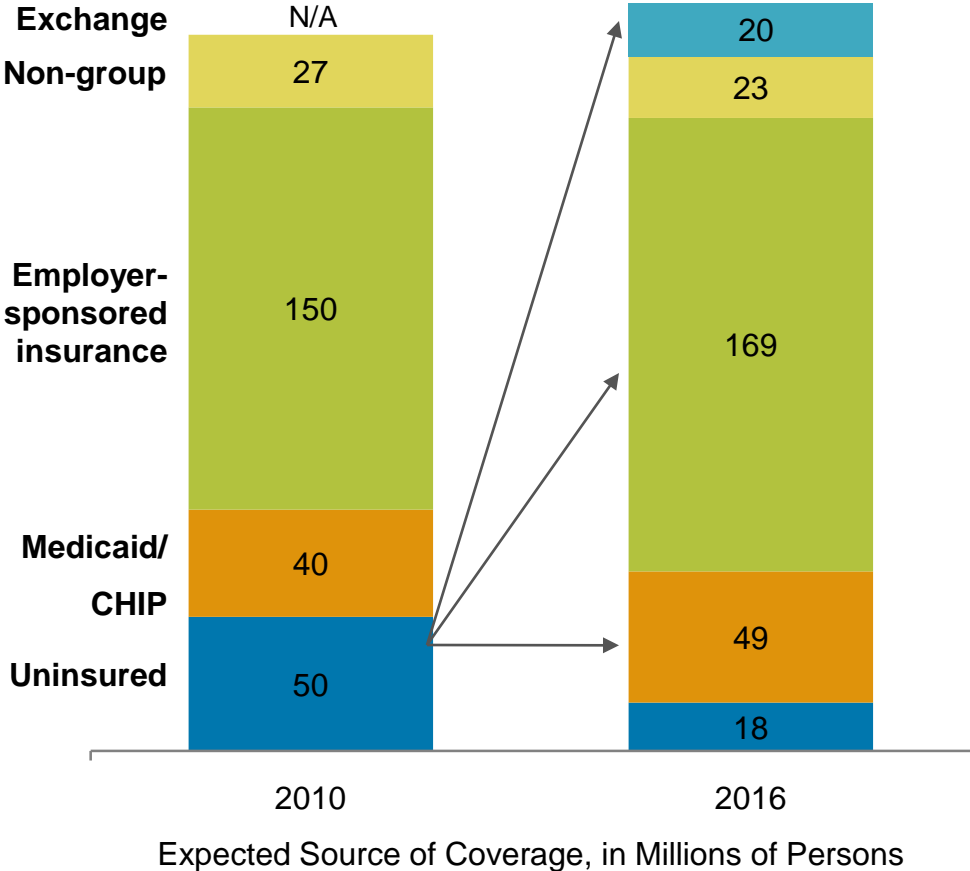
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Agenda

- **The Emergent Landscape of Reform**
- The Near-Term Outlook for Facilities under Reform
- Long-Term Implications for Delivery Reform

Source of Coverage Post-Reform

Potential Effects of Coverage Expansion on Non-Elderly Population



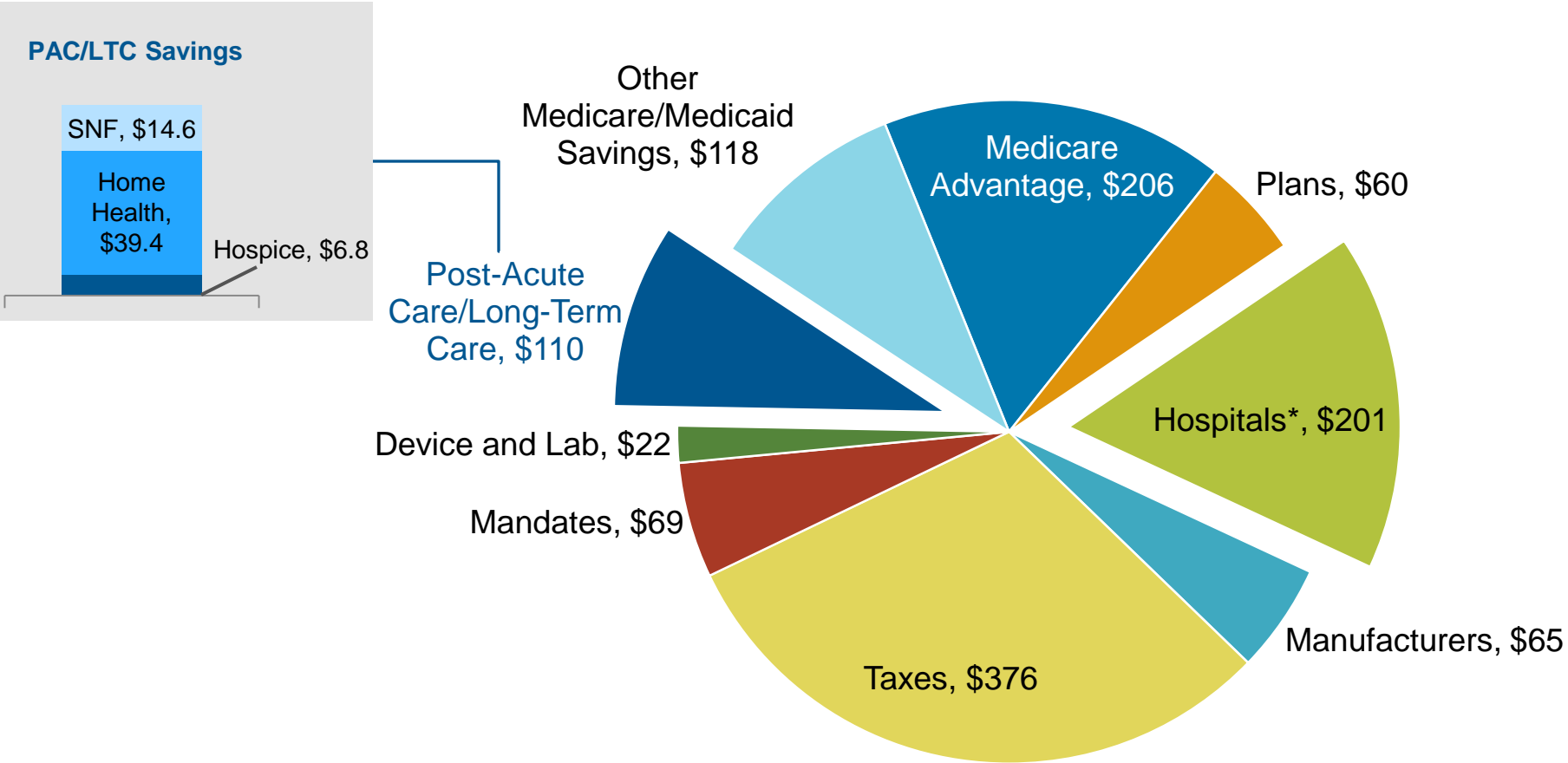
Implications

- Increased coverage
- Higher utilization
- Variable: discounts / networks in exchange, other segments

Source: Avalere Estimates

Facilities Generate a Disproportionate Source of Funding

Federal Source of Funds (\$Billion/10 Years)



*LTACHs and IRFs are included in Hospital Savings, not in Post-Acute/Long-Term Care Savings
 Source: Source: CBO and JCT Score of H.R. 4872, the Reconciliation Act of 2010 , proposed March 18, 2010, in combination with the Senate Patient Protection and Affordable Care Act (H.R. 3590), as passed December 24, 2009. Score published March 18, 2010.
 Note: Other Medicare/Medicaid Savings proposals include Medicare Commission, imaging, ASCs, fraud and abuse and others.

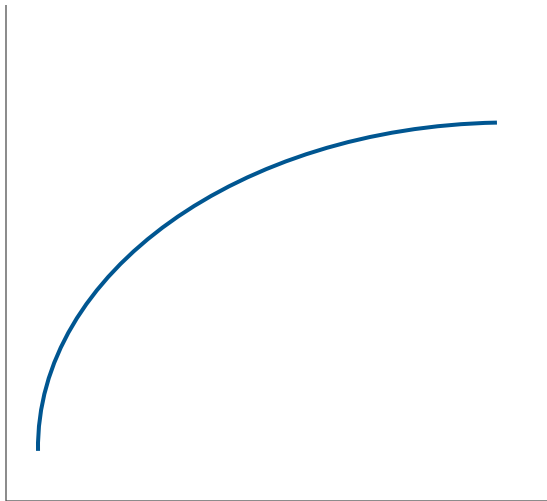
Timeline of Savings vs. Coverage Expansion

	2011	2012	2013	2014	2015	2016	2017	2018	2019
Newly Covered Lives	(1M)	0	(1M)	17M	24M	30M	30M	30M	31M
New Federal Subsidies	(\$1B)	(\$0)	(\$2B)	\$51B	\$100B	\$149B	\$168B	\$178B	\$193B
Medicare/Medicaid Spending Reductions	(\$8B)	(\$12B)	(\$21B)	(\$39B)	(\$46B)	(\$56B)	(\$70B)	(\$82B)	(\$97B)

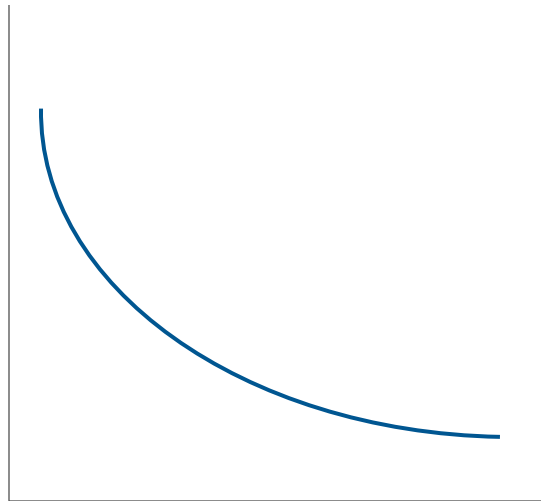
\$41B in savings “banked” in the near-term to fund long-term coverage expansion

The Rationale: A Price-Volume Trade-off

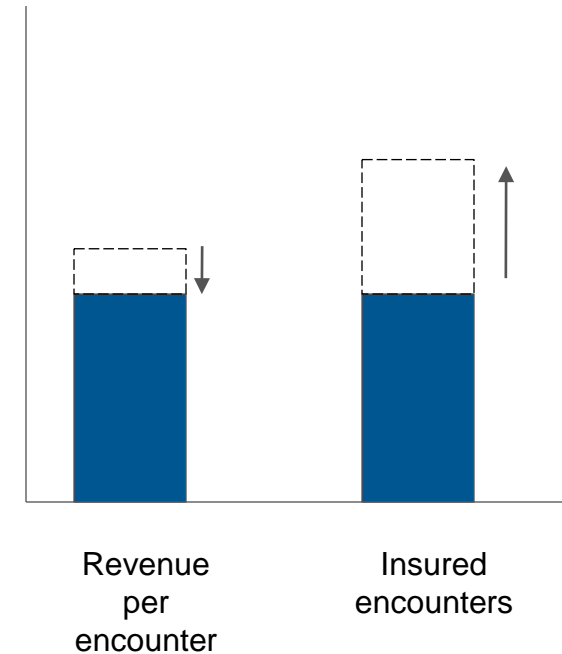
As the insured population rises...



...uncompensated care falls over time....



...and payment cuts will be offset by volume



Except...Hospitals will Continue to Treat Uninsured and Face Increased Medicaid Losses

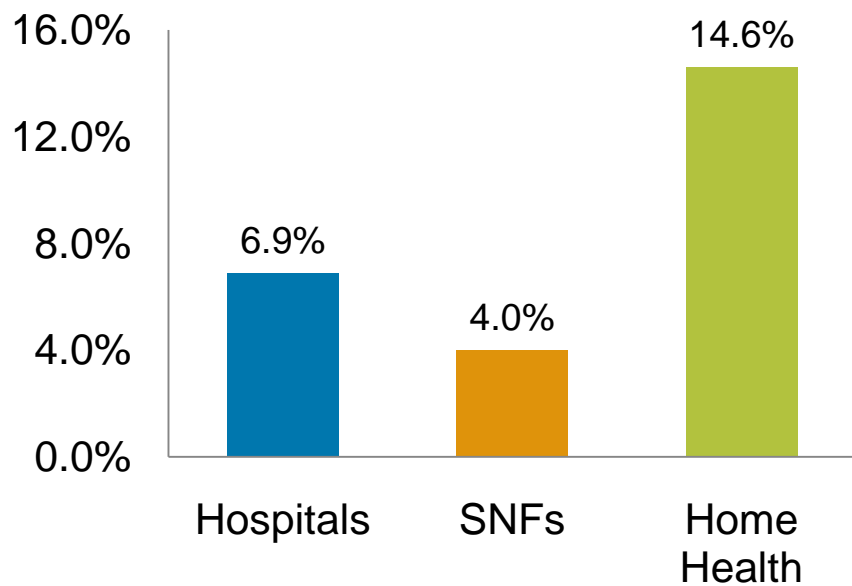
- There will continue to be a population with no health insurance – for example, illegal immigrants and individuals who decline to participate.
- Hospitals in many states lose money on Medicaid payments. Any Medicaid expansion will result in additional unreimbursed hospital costs.
- The Medicaid disproportionate share hospital (DSH) program in many states currently provides funding to hospitals for uninsured costs and Medicaid losses. Reductions to Medicaid DSH will limit hospitals' ability to recoup these losses through targeted payments.
- Hospitals will be differentially affected by decreases in Medicare DSH. MedPAC suggests DSH funding is poorly correlated with hospital uninsured costs. Hospitals that currently receive substantial DSH funding but have limited uncompensated care costs will be disproportionately affected.

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Hospital and PAC Providers Face Substantial Reductions in Medicare Payments

Cuts to Fund Health Insurance Expansions as a Percent of 10-Year Medicare Revenues



Estimated Medicare margins 2010 (2011 for HHAs)

Reform Implications

- Health reform-related payment reductions will threaten PAC Medicare provider margins and further depress already negative Medicare hospital margins
- Many nursing facilities rely on Medicare margins to help cross-subsidize care for Medicaid patients. The health reform payment reductions may threaten nursing facilities' ability to cross-subsidize Medicaid payments.

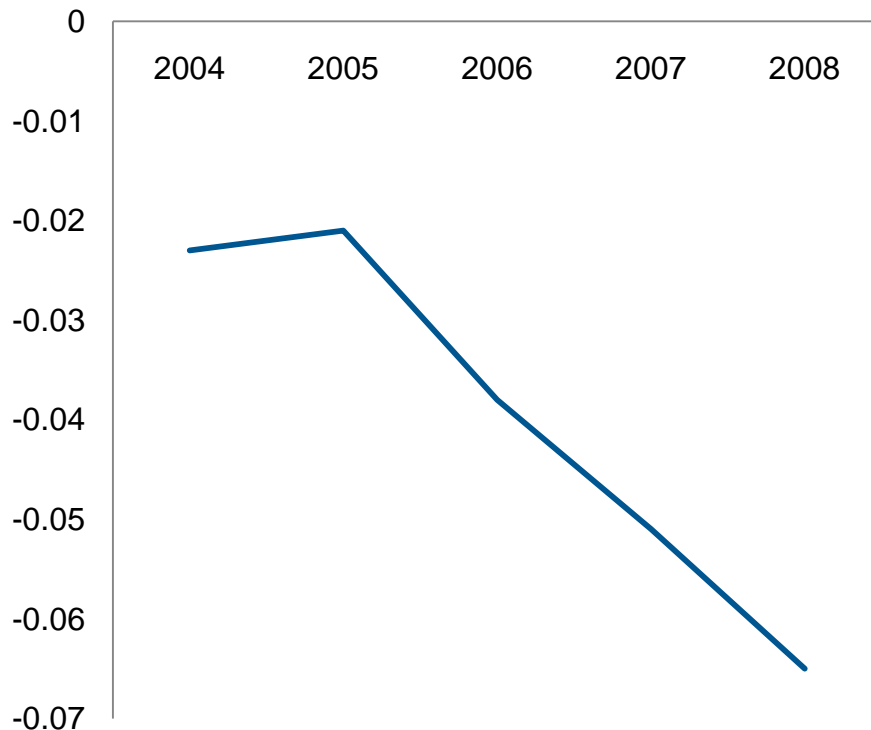
Sources: Medicare reductions based on 10-year CBO savings estimates. CBO Document, "Distribution of Savings Among Type of Provider." March 19, 2010. Total Medicare revenue based on National Health Expenditures Margin estimates, MedPAC Report to Congress, March 2010.

Hospitals – Description of Key Provisions

	Senate Bill as Passed	Reconciliation Language
Market basket update	<ul style="list-style-type: none"> Reductions in market basket update: 0.25% in 2010 and 2011, 0.1% in 2012 and 2013, and 0.2% in 2014-2019 	<ul style="list-style-type: none"> Reductions in market basket update: 0.25% in 2010 and 2011, 0.1% in 2012 and 2013, and 0.3% in 2014, 0.2% in 2015-2016, 0.75% in 2017-2019
Productivity adjustment	<ul style="list-style-type: none"> Incorporates productivity adjustment in 2012 	<ul style="list-style-type: none"> No change from Senate
Reduction in Payments for Readmissions	<ul style="list-style-type: none"> Reduces payment to hospitals for preventable readmissions for three National Quality Forum (NQF) - endorsed conditions beginning October 1, 2012; condition list expands in FY 2015 	<ul style="list-style-type: none"> No change from Senate
Value-based purchasing	<ul style="list-style-type: none"> Starting in FY 2013, a portion of the hospital payment will be tied to performance on quality measures 	<ul style="list-style-type: none"> No change from Senate
Disproportionate share adjustment (DSH) - Medicaid	<ul style="list-style-type: none"> Reduces States' DSH allotments by 50% when uninsurance rate in State decreases by 45% (25% for low DSH states). DSH reduced as uninsurance rates decline but never below 65% of FY2012 allotment. 	<ul style="list-style-type: none"> Changes the methodology for DSH reductions to reduce the aggregate allotments to states by specific amounts from 2014 onwards. Results in slightly lower savings than original Senate bill
DSH - Medicare	<ul style="list-style-type: none"> In FY2015 reduces Medicare DSH proportionately to lower uninsured 	<ul style="list-style-type: none"> Starts Medicare DSH reductions in FY2014, but lowers the annual reduction in DSH payments compared to original Senate bill

Pricing Pressures to Continue in Medicare

Hospital Medicare Margins (Inpatient and Outpatient)

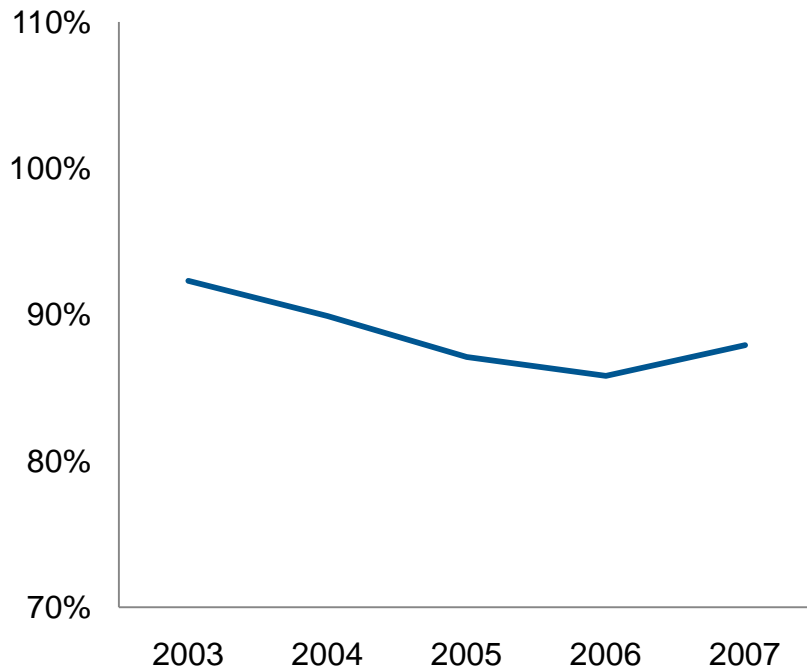


Reform Implications

- Medicare margins will only suffer as MS-DRG adjustments and market basket reductions compound already negative margins
- Medicare inpatient days rising steadily as share of overall hospital inpatient days, limiting hospital flexibility in managing revenue streams and payer mix

Medicaid Pricing Pressures Likely to Intensify

Medicaid Payment to Cost Ratio¹



Reform Implications

- Increasing Medicaid caseload beginning in 2014 – more covered lives under the low-cost payer in most markets
- State budget constraints will continue to place Medicaid reimbursement on the front-burner for state spending reductions

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A Paradigm-Shift in Healthcare Delivery and Payment

Old Paradigm

- Siloed payment system with separate payments at each site of care
- Payments based on service rather than quality and/or outcome
- Different payments for similar patients
- Limited coordination or shared risk among providers
- CMS constrained in testing and implementing new payment models

New Paradigm

- Bundled payments for most providers in Medicare across settings
- Direct link between payment and outcome
- Site-neutral payment, i.e., payment based on patient characteristics not site of service
- Encourage care coordination and primary care; allow providers to share in savings
- Broad CMS authority to test and implement new payment models

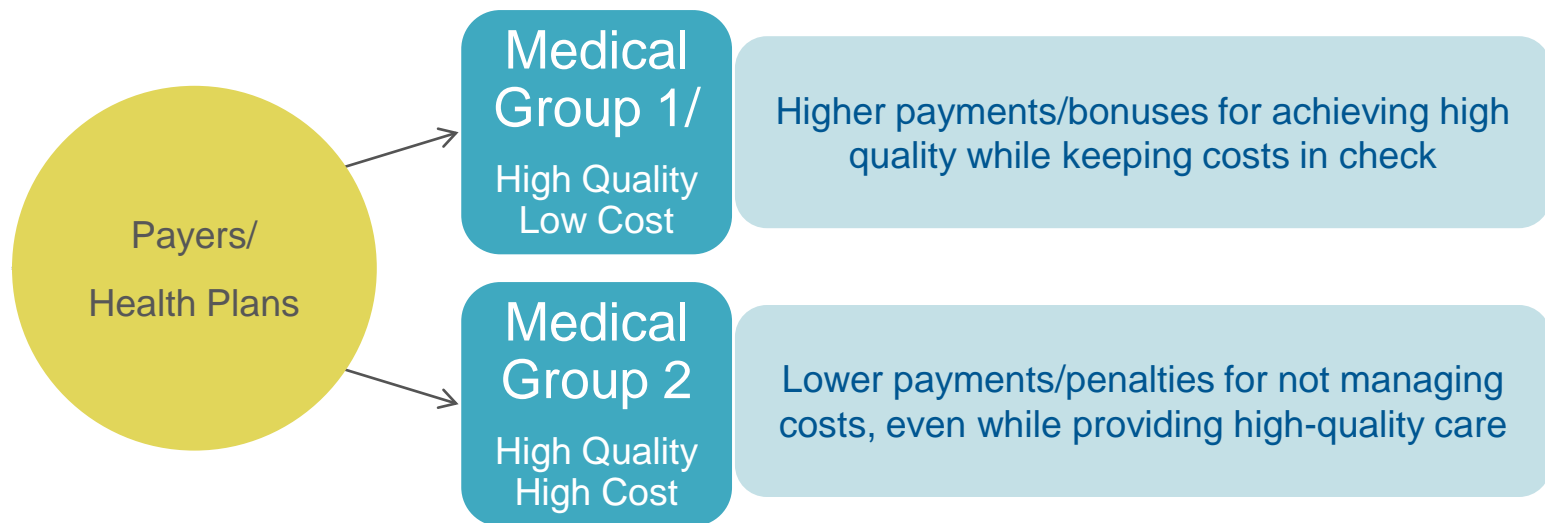
New Payment Models Focus on Incentivizing Providers to Improve Patient Outcomes

The new payment models focus on incentivizing providers to better manage and coordinate care to achieve better outcomes. Some demonstrations are targeted, focusing on a single outcome, whereas others foster broader coordination of care through episodic or population-based care models.

Category	Proposed Pilots and Demonstrations
Target single outcome	<ul style="list-style-type: none">Reduction in hospital readmissionsElimination of payment for HAIs
Focus on episode-level care	<ul style="list-style-type: none">Bundling
Population-based management	<ul style="list-style-type: none">ACOsPCMHs

ACO: A System of Care Is Accountable for the Overall Costs and Quality of Care

- An accountable organization is responsible for controlling health care cost and spending growth, while assuring or improving quality of care
- This model accepts a greater accountability for reducing costs, but does not take on insurance-type risk for an enrolled population

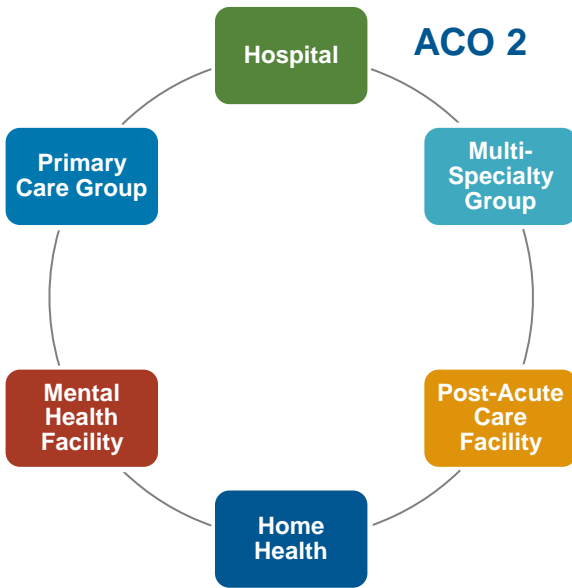


ACOs Can Have Many Configurations, Supported By Public or Private Payers/Health Plans

Illustrative ACO 1

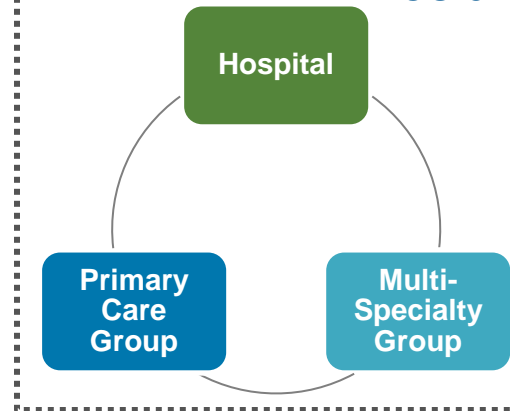
Multi-Specialty Group

Illustrative ACO 2



Payers/
Health Plans

Illustrative ACO 3



Providers Outside the ACO

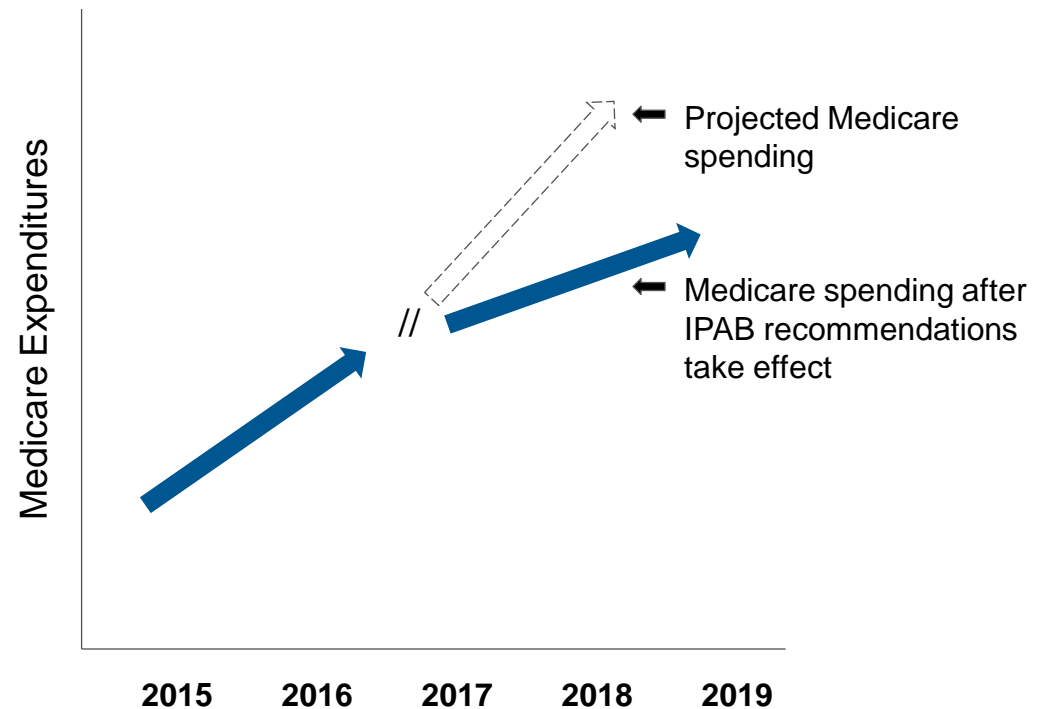


New Cost Containment Authority Vested in the Independent Payment Advisory Board (IPAB)

IPAB Administrative Authority

- Beginning in 2015, the IPAB has authority to change reimbursement policy for various classes of providers if projected per capita Medicare spending exceeds targets
- IPAB recommendations take effect unless Congress takes action to amend or overturn them
- Recommendations cannot raise beneficiary cost-sharing requirements or restrict benefits
- Moreover, recommendations cannot compound previously enacted inflationary or productivity adjustments
- Recommendations for the private sector and Medicaid are non-binding

Forcibly Bending the Cost Curve



Taking the Long View: The Post-Reform World

Risks to Providers

- Financing outside of the 10-year budget window appears to be tenuous
- Greater scrutiny of provider costs
- Payments increasingly contingent on outcomes requiring rapid implementation of process improvements
- Decreased leverage with physicians due to shortage
- Expectation of shared financial risk with payers and other providers

Opportunities for Providers

- Increased patient volume due to coverage expansion
- Opportunity to take-on/share risk with partners, payers
- Greater alignment of hospital, physician, post-acute care payment incentives
- More opportunities for innovation, partnering with CMS to explore new models of care and payment
- Potential for more leverage with health plans due to provider consolidation