Scanning the Health Care Environment: From Providing Care to Managing Health

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California Hospital Association

Environmental Scan: US Deficit

![Graph showing total deficits or surpluses as a percentage of gross domestic product from 1974 to 2024. The graph indicates periods of deficits and surpluses, with a notable deficit period from 1995 to 2001. The data is sourced from the Congressional Budget Office, April 2016.]
Environmental Scan: Debt as Percent of GDP

**CRUSHING BURDEN OF DEBT**
(Debt as a Share of the Economy)

- **1940**
- **1950**
- **1960**
- **1970**
- **1980**
- **1990**
- **2000**
- **2010**
- **2020**
- **2030**
- **2040**
- **2050**
- **2060**
- **2070**
- **2080**

Source: OMH/CHIO

Environmental Scan: Health Care Cost Growth

**National Health Expenditures from 1960-2012**
Environmental Scan: National Health Expenditures

- Hospital Care, 42.67%
- Physician Services, 20.25%
- Other Professional, 7.1%
- Home Health Care, 1.01%
- Prescription Drugs, 5.11%
- Other Medical Durables and Non-durables, 3.35%
- Nursing Home Care, 6.48%
- Other, 11.4%

1980: $235.6B  
2009: $2,330.1B

Environmental Scan: Hospital Inpatient Case Mix

CMI

- 2001: 1.10
- 2002: 1.15
- 2003: 1.20
- 2004: 1.25
- 2005: 1.30
- 2006: 1.35
- 2007: 1.40
- 2008: 1.45
- 2009: 1.50
Environmental Scan: California Health Care Cost and Growth

Per capita health expenditures, 2009

- **CA**
- **UT**
- **NV**
- **WA**
- **U.S. average**
- **IL**
- **FL**
- **NJ**
- **NY**
- **MA**

**Dollars**

- 4,638
- 3,972
- 4,569
- 5,092
- 5,283
- 5,293
- 5,483
- 5,807
- 6,535
- 6,683

CA growth of 5.7% CAGR vs. 5.9% CAGR for U.S. overall from 1994-2009

Environmental Scan: California Utilization Rates

Consistently lower utilization levels have been a major contributor to California’s healthcare cost advantage

<table>
<thead>
<tr>
<th>Utilization rates in 2010¹</th>
<th>California</th>
<th>U.S.</th>
<th>California ranking²</th>
<th>U.S. ranking²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission</td>
<td>92</td>
<td>114</td>
<td>13th</td>
<td></td>
</tr>
<tr>
<td>ER visits</td>
<td>294</td>
<td>412</td>
<td>2nd</td>
<td></td>
</tr>
<tr>
<td>Inpatient days</td>
<td>468</td>
<td>614</td>
<td>7th</td>
<td></td>
</tr>
<tr>
<td>Outpatient visits</td>
<td>1,388</td>
<td>2,108</td>
<td>5th</td>
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</table>

¹ Number of encounters/days per 1,000 population
² Ranking based on comparison to U.S.
Environmental Scan: California’s Population Growth

- Population Growth Rate
  - California: 3.0
  - US: 3.1

Environmental Scan: Aging Population

- Virtually all projected growth in the state will be driven by seniors (aged 55+)

- Year 2010:
  - Under 55: 29
  - 55 to 65: 4
  - Over 65: 4

- Year 2020:
  - Under 55: 29
  - 55 to 65: 5
  - Over 65: 7

CAGR:
- Under 55: 0%
- 55 to 65: 3%
- Over 65: 6%
Environmental Scan: Chronic Illness

Beyond coverage shifts, aging will also drive a significant increase in the utilization of inpatient services.

For every 1% change in the incidence of chronic disease, there is a corresponding increase in utilization of 6%.
Nationally, nearly one quarter (24.7%) of the active physicians in the workforce are age 60 or older.

California has the highest percentage of those over 60 years of age at 29.2%, or nearly one-third of all active physicians.

| Active Physicians in California - 2009 | 89,254 | 242.8 | 3,309 | 9.0 |
| Active Patient Care Physicians – 2009 | 77,208 | 210.1 | 2,868 | 7.8 |

Licensed Beds and Population Growth - California:
- Licensed Beds
- Population

2001 2002 2003 2004 2005 2006 2007 2008 2009 2010
Environmental Scan: Access
Primary care physician supply could constrain the ability to manage the increase of chronic disease and other increases in utilization in several parts of the state.

The combination of low caregiver supply and poor health status is evident throughout California.

Environmental Scan: Payment Reform
While many hospitals report operating profits today, most will likely be unprofitable as reimbursement approaches Medicare rates.
Environmental Scan: Payment Reform

Hospitals face more than $22 billion in Medicare payment reductions over the next ten years, creating massive financial burdens on top of historical payment shortfalls.

Expected Medicare Shortfall Over the Next 10 Years

- Hospital Medicare Losses
- Medicare Reductions ACA, Cliff & Other

Environmental Scan: Cost Shift

Reductions in Medicare and Medi-Cal reimbursement have required hospitals to increase charges to private payers to maintain overall profitability.
Environmental Scan: Coverage Shifts

Despite an increase in the total insured, the net effect of this shift will be a significant dilution of margin.

- **Key Shifts**
  1. Reduction in the uninsured from 20% to 12% improves margin profile ($\Delta = +1.2\%$, now 3.2%)
  2. Aging into Medicare and the Exchanges (SHOP / HBEK) reduce proportion of Commercially insured from 50% to 44% and dilutes margin ($\Delta = -1.5\%$, now 1.7%)
  3. With a higher mix of 'Government' business, ACA reimbursement reform significantly degrades margin ($\Delta = -10.0\%$, now -8.3%)

Weighted Average Operating Margin

- **Initial Margin**: 2.0%
- **New Margin**: -8.3%
- **$\Delta$ Margin**: -10.0%

Environmental Scan: Hospital Vulnerability

- **Capacity in Question**
  - Near-term threats may challenge these providers, despite readiness for tomorrow
- **Acutely Vulnerable**
  - These organizations are most at risk for failure and potential acquisition
- **Challenged Sustainability**
  - Repositioning will be required for these organizations to survive longer-term
- **Transformational Leaders**
  - These organizations are best in a position to lead and thrive in the new environment

Capacity in Question

- 43% of Care
- 24% of Care
- 11% of Care
- 23% of Care

Acute vulnerability

- Higher Readiness
- Lower Readiness
Environmental Scan: Conclusions

<table>
<thead>
<tr>
<th>Conclusions</th>
<th>Core Strategies</th>
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<tbody>
<tr>
<td>Demographic and coverage shifts will require organizations to innovate their care model to, among other considerations, address caregiver supply, cost levels, the needs of an aging population and the transition from &quot;providing care&quot; to &quot;managing health&quot;</td>
<td>• Begin testing methods for reducing cost and improving quality beginning with hospitals’ self-insured populations</td>
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<td>• Acquire care management technology that incorporates performance management and predictive analytics capabilities</td>
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<td>Scale is important, but integration will be critical in driving revenue and cost leadership to support sustainable margins at significantly reduced levels of reimbursement</td>
<td>• Develop new models to drive greater clinical integration by aligning incentives with community physicians</td>
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<td>• Develop strategic partnerships that augment actual and virtual scale, leveraging shared networks and technology as enablers</td>
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<tr>
<td>California’s high proportion of small business and active legislature will likely increase the impact of the health insurance exchange, which will be a key future driver of financial risk</td>
<td>• Evaluate and prioritize current health plan relationships in preparation for Exchange-based competition</td>
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<td>• Increase outreach to employers and other institutional purchasers to drive stickiness and explore pay-for-performance</td>
</tr>
<tr>
<td>California hospitals show early signs of readiness for the future, but some face significant near-term challenges to sustainability</td>
<td>• Develop initiatives to boost cost performance in preparation for additional payer and purchaser pressure on reimbursement</td>
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<td>• Access financing to support needed infrastructure and capability investments</td>
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From Providing Care to Managing Health

The Business Model Is Changing *Because it Has to Change*

Fee-for-service costs the entire health care system. When paying for volume, a sick patient is worth more than a healthy patient, and this status quo results in uncoordinated care, duplication of services, and fragmentation. After all, the more doctors and providers do, the more they get paid.
From Providing Care to Managing Health

Population Health Manager: Integrated delivery system and health plan with the ability to provide and/or contract for a full continuum of services across all levels of acuity; well positioned to develop own insurance products and manage full plan-to-plan risk and direct contracting.

Population Health Co-Manager: Regional provider organization, clinically integrated with other organizations that capitalize formation of a value-based delivery system and financing vehicles; well positioned to participate in PHM and risk-bearing arrangements, in a delegated and/or direct fashion.

Multiple Participant: Provider organization that works within a network(s) managed by a Population Health Manager to provide a defined set of services in an efficient manner to serve a broad population base comprised of both government and private pay patients; critical role in future delivery system.

Single Product Participant: Provider organization working within a network managed by a Population Health Manager to serve a specified and targeted service and/or population; these organizations will be critical components of narrow networks for specific plans/products.

Contractor: Smaller, less essential and/or niche providers, some of which may serve rural communities, provide population access points; not critical to future delivery systems and face significant risk of commoditization.

Source: Kaufman Hall and Assoc.
From Providing Care to Managing Health
Mega–System Formation to Manage Health

**Full Integration**

**Partial Integration**

Acceleration of Number of Large Health System Transactions – Targets Over $1 Billion in Revenue

Source: Kaufman Hall and Assoc. and Modern Healthcare

From Providing Care to Managing Health
From Providing Care to Managing Health

“I want you to find a bold and innovative way
to do everything exactly the same way
it’s been done for 25 years!”

Reform Solutions — Government

Federal Funding is Supporting Medicaid Reform

<table>
<thead>
<tr>
<th>State Innovation Models (SIM)</th>
<th>Center for Medicare and Medicaid Innovation (CMMI)</th>
<th>1115 Demonstration Waivers &amp; DSRIP</th>
<th>Coverage Expansion</th>
</tr>
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<tbody>
<tr>
<td>CMS awarded over $300 million in SIM grants to States to support the development of multi-payer payment and delivery system transformation.</td>
<td>CMMI’s Health Care Innovation Awards (HCIA) provide three-year grants to transform financial and clinical models and test models that improve population health. To date, $2B in funding has been announced.</td>
<td>Several states are pursuing 1115 waivers that include Delivery System Reform Incentive Payment (DSRIP) pools that tie investments in provider-led delivery system reforms to improvements in quality, population health and cost containment.</td>
<td>Many states are expanding Medicaid to ensure sustainability of broader delivery system and payment reforms. With expansion, Medicaid becomes the single largest payer.</td>
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State Innovation Model

California State Health Care Innovation Plan

The California innovation Plan includes four initiatives and six building blocks, which are collectively designed to achieve savings within three years, as well as to catalyze longer-term transformations of the health care delivery system. The Innovation Plan brings together leadership from California’s public and private sectors to work together to implement these initiatives and building blocks.

The Innovation Plan has three overarching goals designed to advance the Triple Aim:

1. Reduce health care expenditures regionally and statewide.
2. Increase value-based contracts that reward performance and reduce pure fee-for-service reimbursement.
3. Promote state significant progress on the Let’s Get Healthy California dashboard.

TRIPLE AIM

Lower Costs | Better Health Care | Better Health

Let’s Get Healthy California (LGHC) is the foundation for the Innovation Plan. LGHC identifies six goals to achieve health and create health equity; Healthy Beginnings, Living Well, End of Life, Redesigning the Health System, Creating Healthy Communities, and Lowering the Cost of Care.

State Innovation Model

INITIATIVES

MATERNITY CARE

More are more costly than vaginal deliveries and can lead to adverse maternal outcomes. Caesarean sections have increased from 22% to 33% from 1998-2008. Reduce elective early deliveries, reduce Caesarean sections, increase Vaginal Birth After Delivery.

HEALTH HOMES FOR COMPLEX PATIENTS (HHCP)

Issue: 1 in 4 million CA adults have 1 or more chronic conditions; 3% of CA population accounts for over 50% of health care expenditures. Goal: Expand HHCP model to provide high-risk patients with better coordinated care.

PALLIATIVE CARE

70% of California’s report preferences to die in their homes only 12% do. Patient preferences with new benefit and payment approaches.

ACCOUNTABLE CARE COMMUNITIES (ACC)

More than 70% of health care costs are due to chronic diseases, which are highly preventable, and in which significant racial and ethnic disparities exist. Goal: Implement ACC to improve health of the entire community by linking community prevention activities with health care.

BUILDING BLOCKS

BIKE ROUTE
State Innovation Model

Twenty-Five States Have Been Awarded SIM Grants

[Map showing states with SIM grants]
Medicaid Solutions

Provider Led Accountable Care Models

Medicaid: Moving from Volume to Value

- 43 states have established Medicaid Patient Centered Medical Homes, with financial incentives to coordinate care — enhanced fee for service (FFS) rates, per member per month capitation rates plus shared savings
- 14 states have implemented Medicaid Health Homes, providing coordinated care to enrollees with chronic condition or serious mental illness
- Several states are using Bundled or Episodic Payments, paying providers based on capitation or fee-for-service with upside and downside risk for a limited number of services over a limited time or for an episode of care
- 11 states are using Regional or Accountable Care Organizations where provider networks are paid capitation or fee-for-service with shared savings for meeting cost containment and quality metrics

Medicaid Solutions

Medicaid Is Becoming a Strategic Purchaser

Medicaid: From Funder to Purchaser to Leader

- Medicaid expansion brings the program squarely into health insurance market; concerns regarding sustainability remain
- Increased use of managed care with expansion of covered benefits and high need population, increased contracting requirements
- Focus on provider accountability and delivery of integrated services for physical and behavioral health care & social supports
- Aligning public and private insurance, leveraging Medicaid to drive multi-payer reform
DHCS 1115 Waiver

The draft list of potential waiver concepts developed by DHCS contained eight broad areas:

- Federal/State Shared Savings Initiative
- Payment/Delivery Reform Incentive Programs
- Safety Net Payment Reforms
- FQHC Payment/Delivery Reform
- Successor Delivery System Reform Incentive Payment Program
- California Children's Services (CCS) Program Improvements
- Medicaid Funded Shelter for Vulnerable Populations
- Workforce Development

Coverage Expansion

Medicaid Eligibility Today
Limited to Specific Low-Income Groups

Medicaid Eligibility in 2014
Extends to Adults ≤138% FPL

- Elderly & Persons with Disabilities
- Pregnant Women
- Children
- Parents
- Adults
Coverage Expansion

**Medi-Cal**
Oct. Feb. Enrollment

1,786,000

- Likely eligible
  - 1,136,000
- Transitioning from LIHP
  - 650,000

36% of 650,000 Transferring to Medi-Cal from LIHP

64% of 1,136,000 Likely Eligible

*Number reflects new Medi-Cal applicants and some ongoing overload eligibility activity that is conducted via the state's marketplace.

New Models for a New Environment
Characteristics of Change

- Leadership
- Stakeholder Participation
- Common Goal/Principles
- Ambitious but Realistic Reforms
- Multi-Payer (Public and Private)
- Expanded Coverage
- Funding and Other Investment

QUESTIONS?
Thank You
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