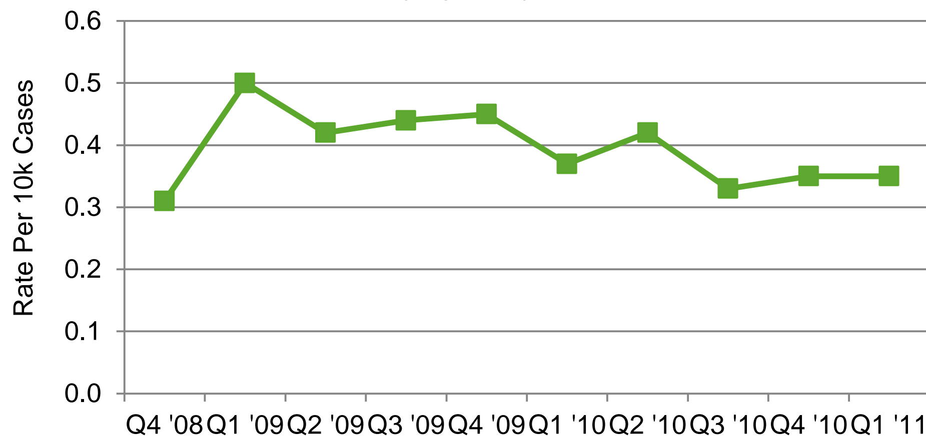
Industry Trends and Stats

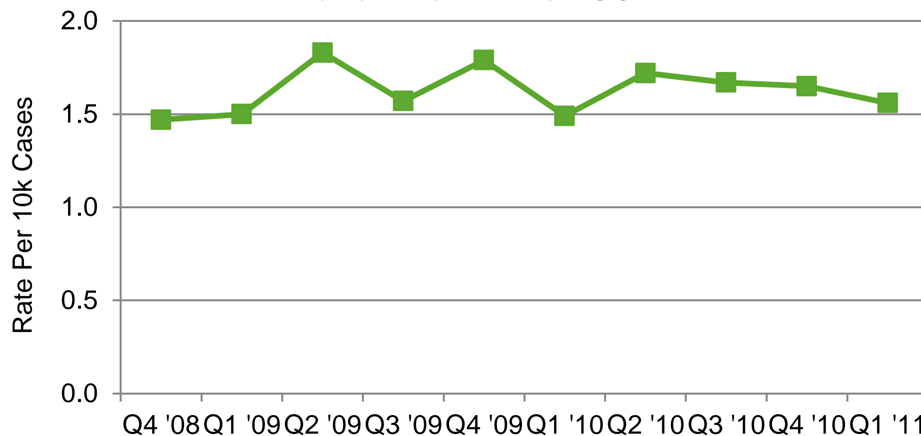
August 2, 2011

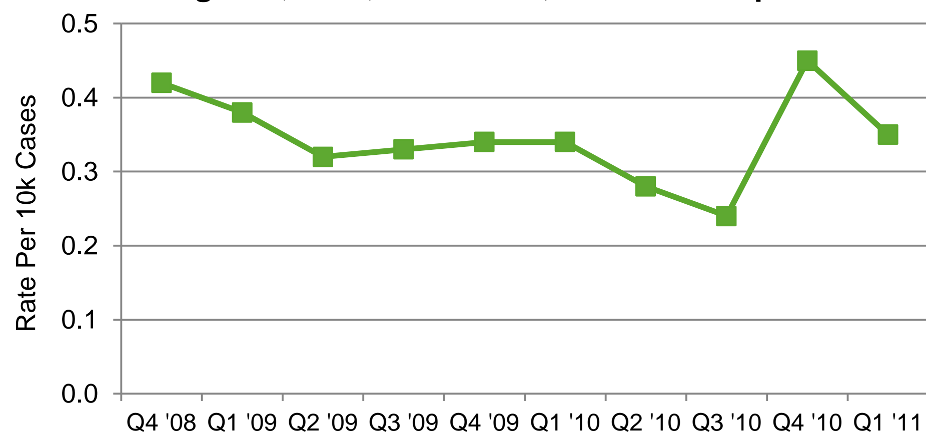
Surgical Care Affiliates

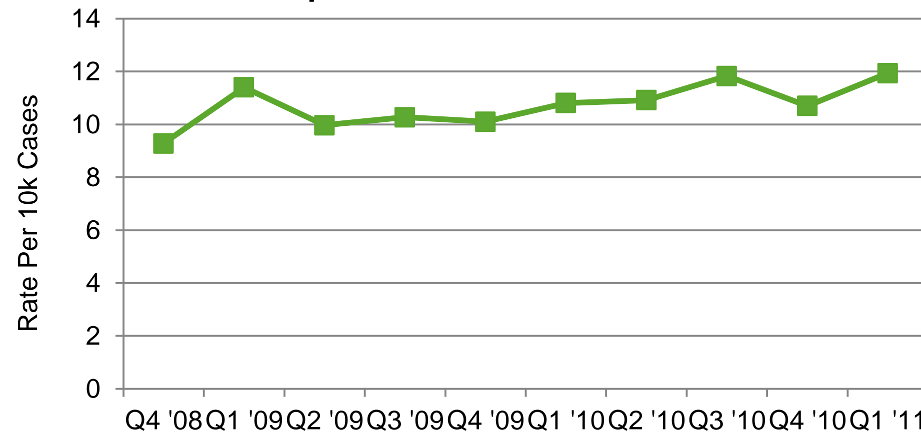
Clinical Trends www.ascquality.org

SCA Surgical Care Affiliates





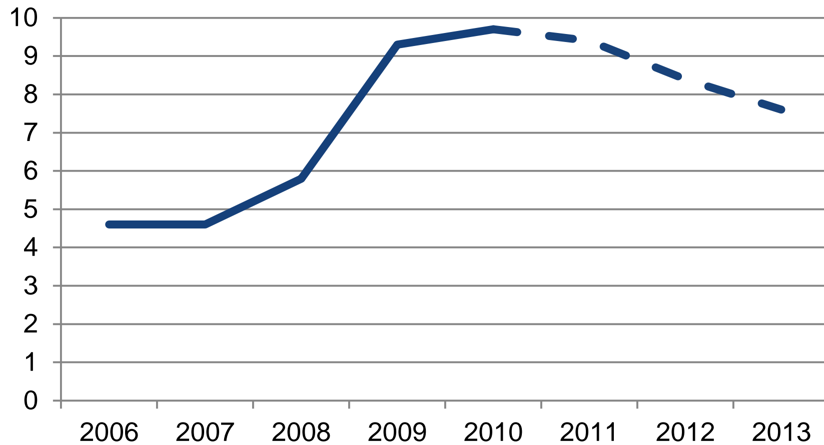


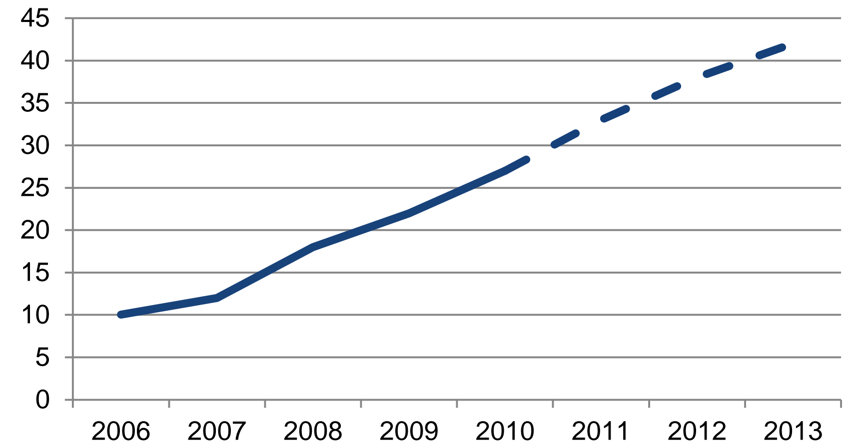


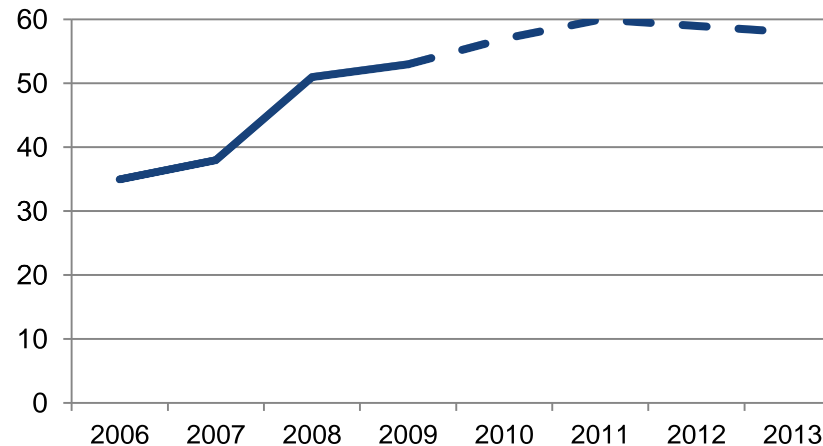
Burn: Unintended tissue injury caused by any of the six recognized mechanisms: scalds, contact, fire, chemical, electrical or radiation, (e.g. warming devices, prep solutions, electrosurgical unit or laser). Fall: a sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object, excluding falls resulting from violent blows or other purposeful actions. Wrong Site: not in accordance with intended site, side, patient, procedure or implant. Hospital transfer/admission: any transfer/admission from an ASC directly to an acute care hospital including hospital emergency room.

3 Distinct Sources of Headwinds

SCA
Surgical Care Affiliates







Sources: BLS, WSJ, CBO, Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2010, New York Times, Medical Group Management Association. *Physician Compensation and Production Survey.* 2003-2009

Industry Trends

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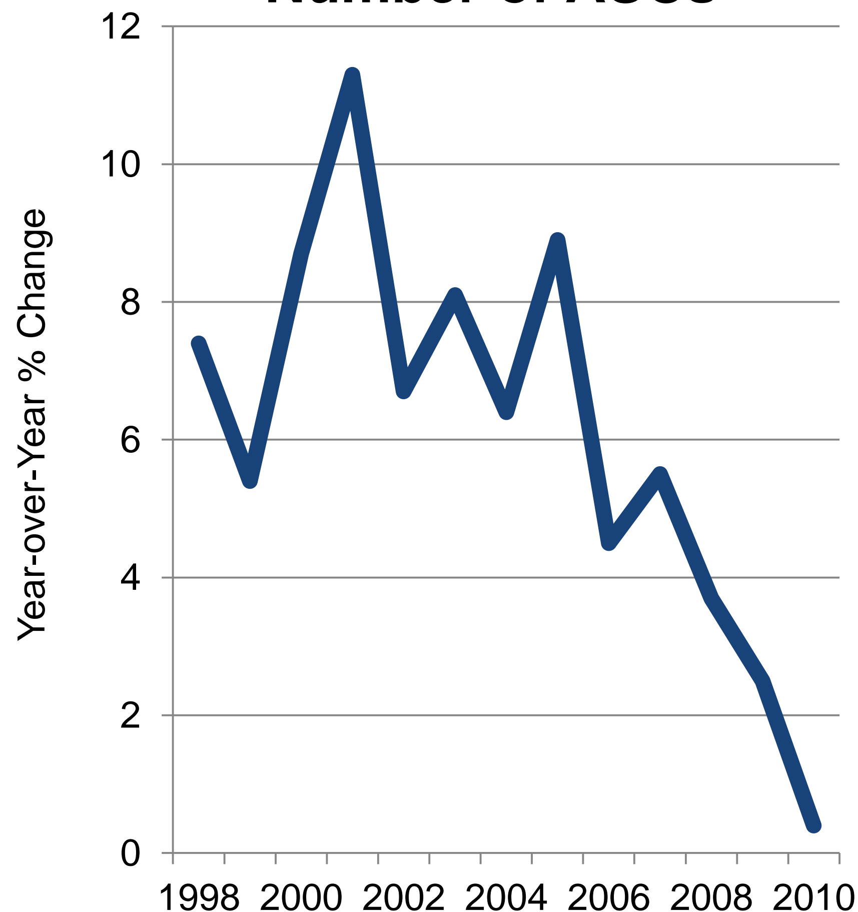
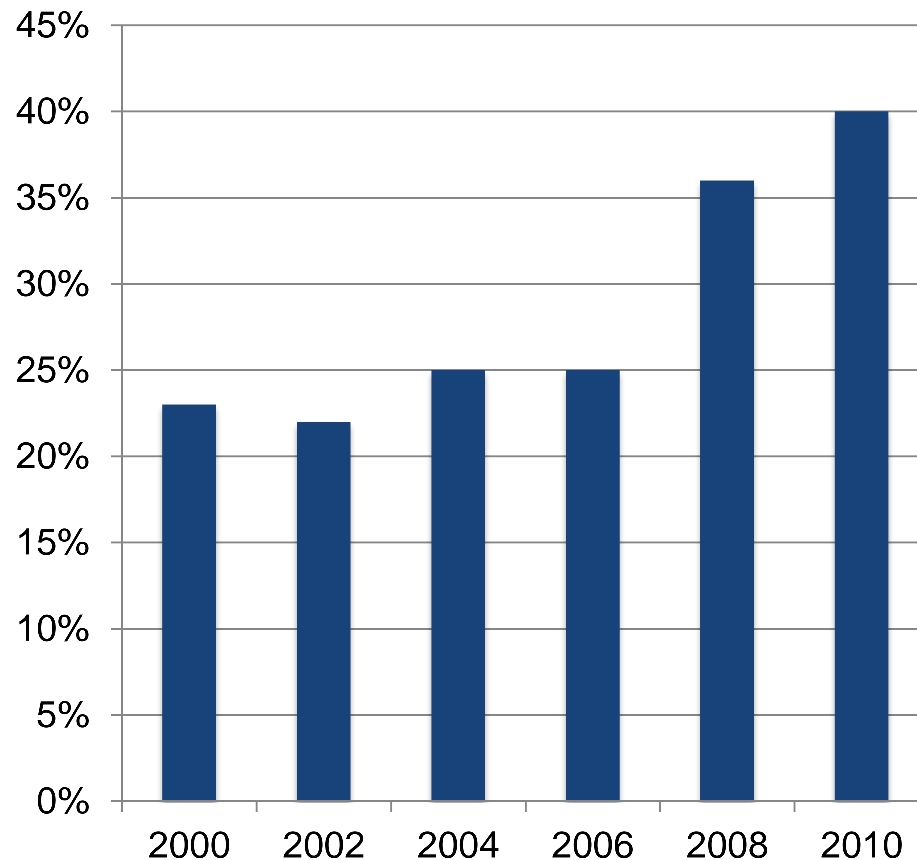
Surgical Care Affiliates





Sources: American Hospital Association, Verispan Profiling Data, CDC, Census Bureau, Kaiser Foundation, SCA Analysis.

Pressure ➔ Systems

SCA
Surgical Care Affiliates

- Continued need to establish reputation for quality
- Saturated market ➔ challenging volume environment
- Commercial + Medicare rates flat to declining
- Costs continuing to climb

Need for Systems

- Clinical systems
- Detailed understanding of costs and revenues of every case
- Heat map every physician + physician recruiting capabilities

Future

- Quality Reporting + Transparency
- Slower Growth
- Focus on Margins
- Tighter Competition
- Continued Consolidation

- ASCs Known for Quality!
- ASCs Viewed as Solution!

GE Healthcare

Healthcare Reform Update

Julie Dietz
Orrin Marcella

August 2, 2011

Today's discussion

Health reform review

Accountable care – more than government shared savings

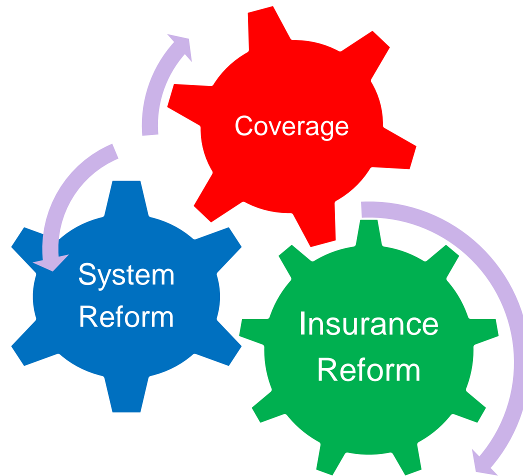
Where can I go for more information?

HC Reform legislation overview

Health Reform – 16 months in

Coverage

32 million additional lives by 2019
Medicaid expansion in 2014
State based exchanges in 2014



Public opinion mixed

Insurance Reform

No pre-existing conditions for kids
No lifetime limits
No rescission of coverage
Dependents covered to age 26
No cost sharing for prevention

System Reform

CMS Innovation Center
Value Based Purchasing Rules
Accountable Care Orgs
National Quality Initiatives
Imaging Cuts

Reform law changes landscape …

Category	Details
Coverage $946 B	• Medicaid/CHIP - $434B • Exchange Subsidies - $466B • Employer Tax Credits - $40B • Temporary High Risk Pool - $5B
Part D $94 B	• Closing the "Donut Hole" - $56B • Coverage Gap Discount - $38B
Providers $52 B	• Long Term Care - $13.5B • Maternal Care - $2.2B • Preventive Care - $17.7B • HC Workforce - $6B • Community HCs - $12.3B

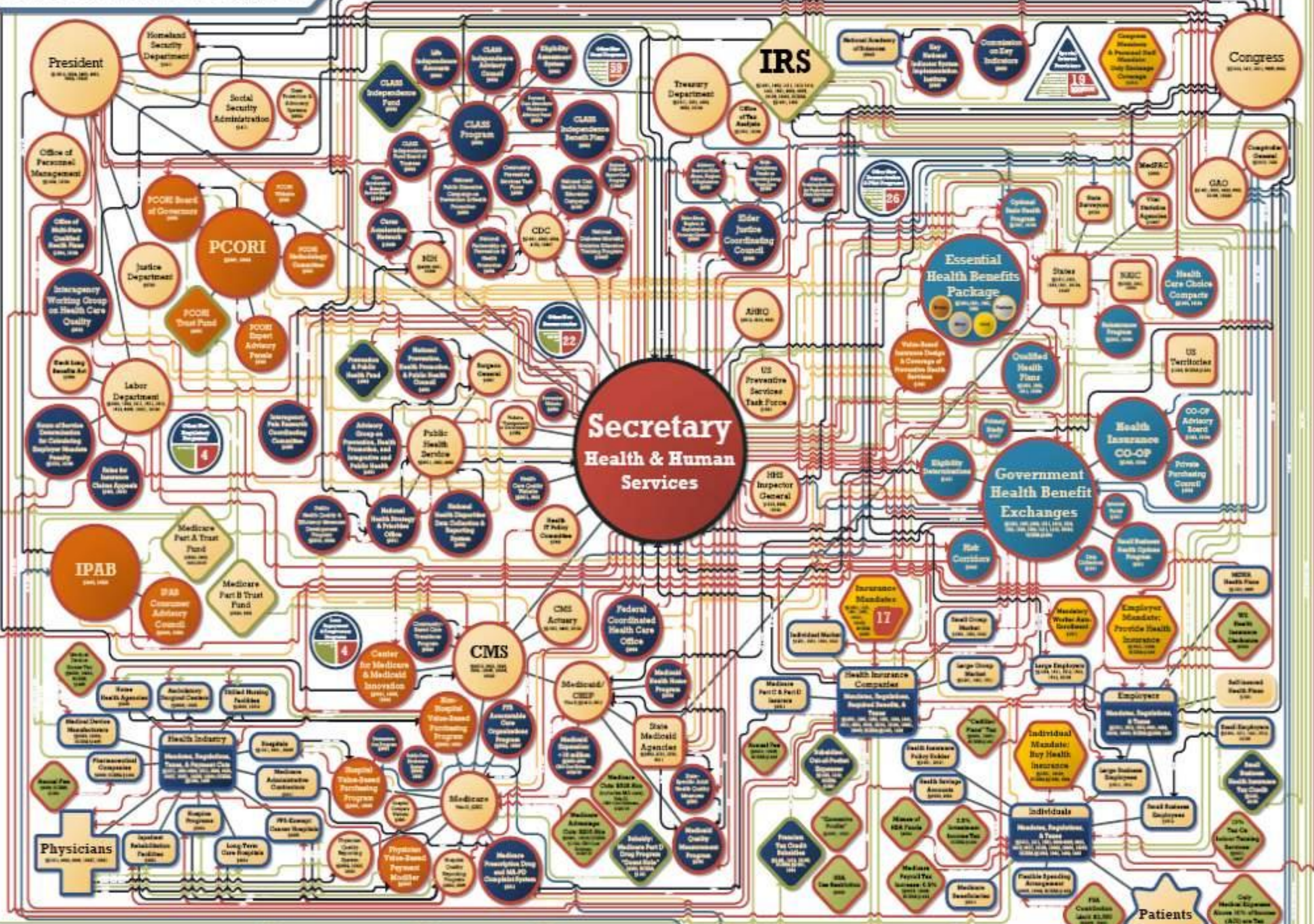
Category	Details
Payment cuts $402 B	• Hospitals - $190B • Home Health - $40B • Medicare Adv - $132B • Imaging Providers – $2.3B • Medicaid drugs- $38B
Consumers & business $279 B	• Penalty on Uninsured - $17B • Penalty on Employers - $52B • Taxes on income - $210B
Industry taxes $140 B	• Insurers - $60B • "Cadillac" Plans - $32B • PhRMA- $28B • Medical Devices - $20B

Timeline… a long, phased implementation

Future regulations will clarify HC Reform law

2010	2011	2012	2013	2014	2015	2016	2017	2018	2019

- (2014–2019) **Coverage:** Medicaid expansion, major insurance reforms (eg, guaranteed issue, rating rules, no pre-ex for adults) insurance exchanges, premium / cost sharing subsidies, individual / employer responsibility requirements
- (2010–2019) **Immediate Insurance reforms:** high risk pool, dependent coverage to age 26, no pre-ex for kids, loss ratios/ rate review
- (2010–2019) **Coverage:** Small business premium tax credit
- (2010–2019) **Medicare/Medicaid Savings:** Medicare provider updates, Medicaid prescription drug rebates
- (2012–2019) **Medicare Savings:** MA payment reductions, productivity offset to FFS updates
- (2014–2019) **Medicare/Medicaid Savings:** DSH reductions, IPAB Medicare proposal
- (2010–2019) **Delivery System Reform:** Center for Medicare and Medicaid Innovation
- (2012–2019) **Delivery System Reform:** ACOs, hospital value-based purchasing
- (2013–2019) **Delivery System Reform:** Hospital readmissions, payment bundling
- (2015–2019) **Delivery System Reform:** Physician quality reporting penalties
- (2011–2019) **New Revenue:** Tax on prescription drug manufacturers
- (2013–2019) **New Revenue:** Excise tax on medical device makers, Medicare tax on high earners
- (2014–2019) **New Revenue:** Tax on health insurers
- (2018–2019) **New Revenue:** Tax on high-cost health plans



Your New Health Care System
President
Congress
IRS
Secretary
Health & Human Services
PCORI
IPAB
CMS
CDC
NIH
Essential Health Benefits Package
Government Health Benefit Exchanges
Health Insurance CO-OP
Treasury Department
Labor Department
Justice Department
Social Security Administration
Homeland Security Department
Office of Personnel Management
CLASS Program
Public Health Service
Medicare
Medicaid/CHIP
State Medicaid Agencies
Federal Coordinated Health Care Office
Center for Medicare & Medicaid Innovation
Medicare Part A Trust Fund
Medicare Part B Trust Fund
IPAB Consumer Advisory Council
PCORI Board of Governors
PCORI Trust Fund
Elder Justice Coordinating Council
US Preventive Services Task Force
HHS Inspector General
AHRQ
States
GAO
MedPAC
US Territories
Health Industry
Health Insurance Companies
Employers
Individuals
Individual Mandate: Buy Health Insurance
Employer Mandate: Provide Health Insurance
Insurance Mandates
Physicians
Patients
New Government
Expanded Government
Private
New Relationships

Medicare Shared Savings Program

You are eligible if you are:

1. Group practice
2. Network of practices
3. Hospital/professional JV
4. Hospital with ACO professionals

January start date measuring:

1. Patient experience
2. Care coordination
3. Patient Safety
4. Prevention
5. At-risk population

ASC Quality and Access Act of 2011

HR 2108 – 19 cosponsors (Rep. Sessions – TX)

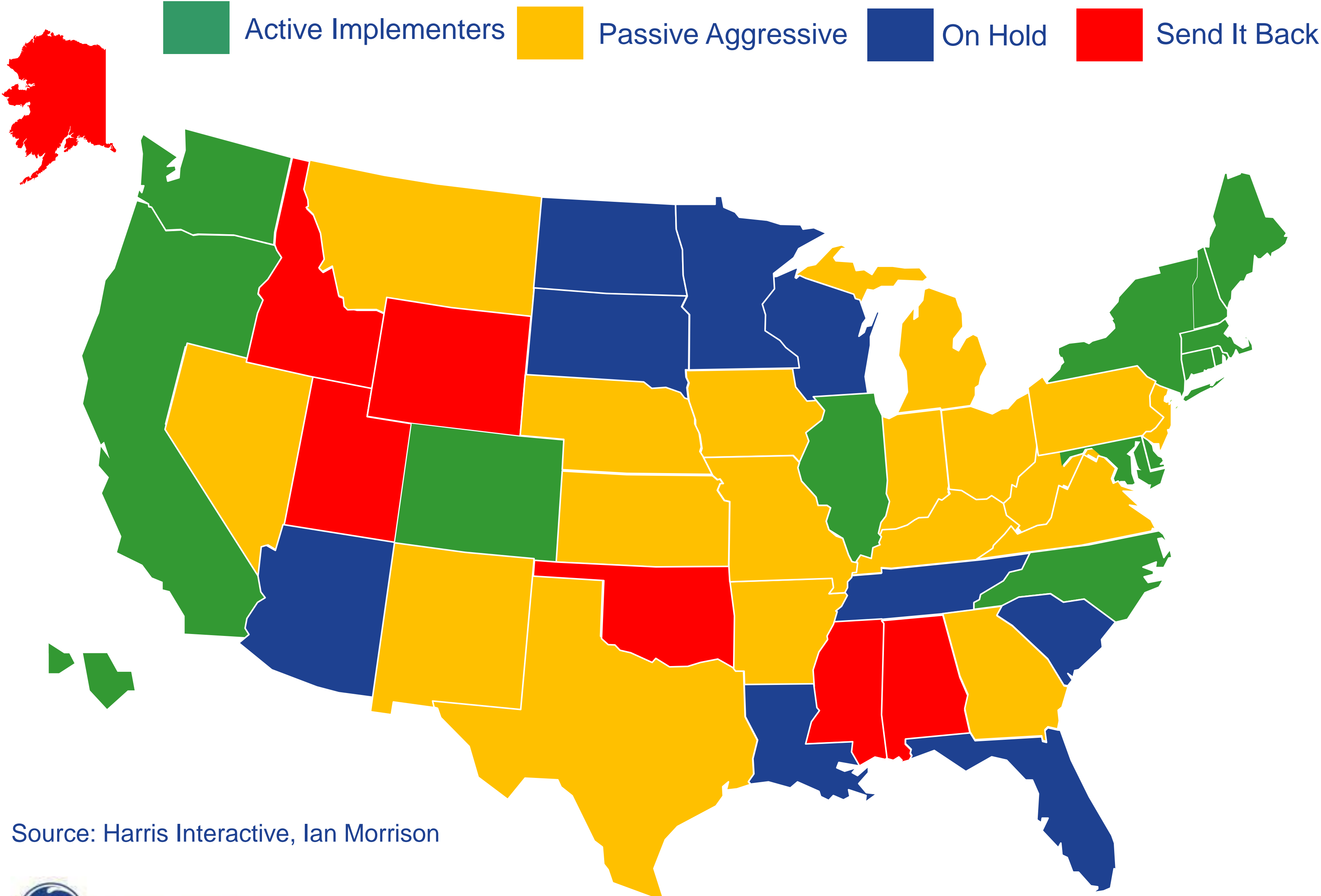
S 1173 – 4 cosponsors (Sen. Wyden – OR)

Aligns updates for ASCs with hospital outpatient rates

Develops quality measures for ASCs and HOPDs

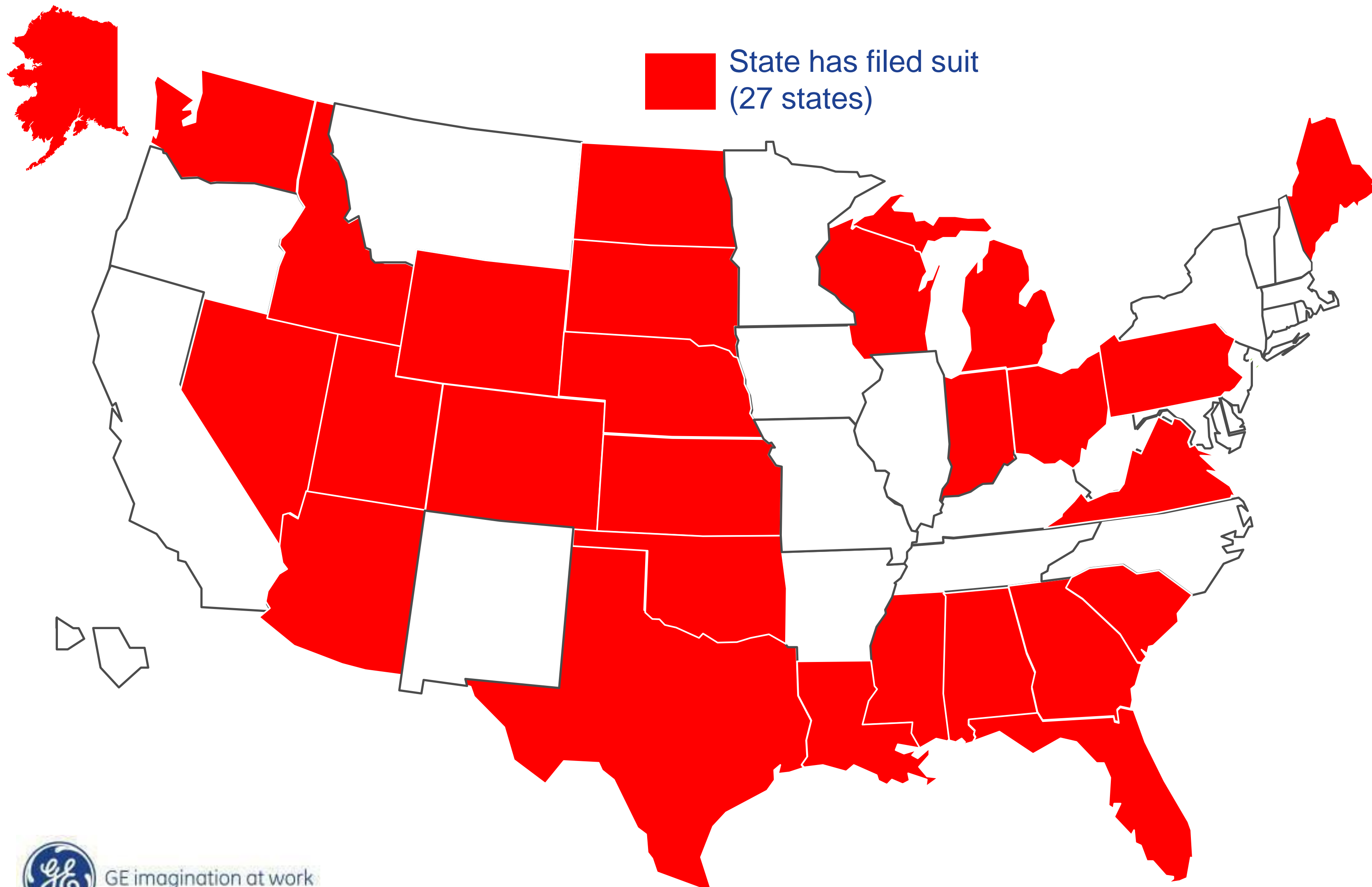
Creates a shared savings program for ASCs starting in 2015

Reform archetypes



Source: Harris Interactive, Ian Morrison

States suing Federal Government over Health Bill (as of 4/5/11)



GE imagination at work

What will happen politically?

Full repeal unlikely in 2011 or 2012

Repeal and replace approach won't work

Oversight/ investigations will be robust

States are labs for reform

Will increase in volume materialize?

Supreme Court ruling?

Deficit reduction and entitlement reforms

What is GE Doing?

GE Healthcare Business

- Elevated the Performance Solutions business
- Bringing GE HIT and Performance Solutions under same leadership
- HIT and care coordination focus – efficiencies are key
- Patient Safety Organization, Home Health, Clarient acquisition (personalized medicine)
- Increasing commitment to clinical and economic evidence generation—driving the business and lobbying
- One GE Healthcare approach

Where to go for the latest information?

Quarterly updates on GEHC Next Level site

Government Health Policy Brief

This section is designed to provide straightforward and timely information regarding major healthcare reform provisions, relevant federal regulations, emerging national and state legislation, and key opportunities for healthcare providers in this new post-reform era.

Sort by: Popularity Date

Showing page 1 of 1

Story

Healthcare Reform: Looking Back

Feb 14, 2011

Since healthcare reform legislation was signed into law on March 23, 2010, a number of key provisions have been put in place. Several of these... Read more...

Story

Key Appointments Made Under Reform

Feb 14, 2011

As the government prepares to oversee and roll out a number of additional new policies under healthcare reform, the President and Administration have appointed several... Read more...

Story

What Happens Next With Reform?

Feb 14, 2011

Many of the details under healthcare reform implementation will be fine-tuned through additional regulatory guidance and rulemaking. Additionally, CMS will play a substantial role... Read more...

GOVERNMENT HEALTH POLICY BRIEF NEWSLETTER

This quarterly report brings you timely information on healthcare reform, regulatory issues, and emerging federal and state legislation-the news you need to stay on top of evolving healthcare policy in the post-reform era.

Sign up for the Government Health Policy Brief newsletter.

HEALTHCARE REFORM RESOURCES

www.healthcare.gov
Run by the U.S. Department of Health and Human Services (HHS), the website provides consumer-friendly information on new insurance options, preventive care resources and understanding how the new law works.

www.whitehouse.gov/issues/health-care
Provides healthcare reform legislation myths and facts, positive stories about reform from each of the 50 states and key statistics on U.S. healthcare and reform.

www.reuters.com/subjects/healthcare
Offers an ongoing collection of Reuters news clips and videos regarding U.S. healthcare reform and key provisions.

web.mhanet.com/aspx/articles.aspx?navid=70&pnavid=2&articleid=521
Compiled by the Missouri Hospital Association, its healthcare reform resources library offers general resources, an implementation timeline, grant opportunities, "ask the experts" section and more

http://nextlevel.gehealthcare.com/government-health-policy-brief

GEHC Customer Reimbursement Site

www.gehealthcare.com/reimbursement

Updated Content

- Legislative & Medicare Policy
  - GE comment letters
- Customer Advisories
  - General
    - Stark Law
    - Multiple Procedure Discount
  - Procedure specific:
    - BMD, CT, MR, Mammo, Nuc, PET, U/S & Vscan
    - High interest procedures: CCTA, CTC, fMRI & Breast MRI
- Medicare Payment Rate Calculators
  - New! - CodeMap® 2011 Medicare Reimbursement Calculator

GE imagination at work

Questions?

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imagination at work

10 Key Observations on the ASC Deal Market

GE Webinar – August 2, 2011

Presented by:

Scott Becker, McGuireWoods, LLP, Partner

10 Key Observations on the ASC Deal Market

1. More uncertainty than at any time in 10 years - - ASCs and Healthcare
   - A. Will healthcare all be vertically integrated and system owned?
   - B. Independent versus employed physicians – Will reduced reimbursement of professional fees drive employment?
   - C. Are entrepreneurial doctors on the decline?
2. ASC Market Remains a Focus of Several Private Equity Funds and of many Hospitals and Health Systems
   - A. Health Systems with new ASC Strategies – Cluster strategies – 5 to 7 in a broader market – An alternative to physician employment
   - B. Private Equity funds remain hungry for ASC Chains

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3. Headwinds
    A. Cases – Independent Doctors
    B. Reimbursement
        i. Out of Network
        ii. General Negative Trends

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4. 6 Best Specialties

1. Orthopedics
2. Spine
3. GI
4. ENT
5. Ophthalmology
6. Pain

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5. 3 Biggest Challenges
    1. Payor Issues
    2. Doctor Employment and Doctor Recruitment
    3. Increased CMS and State Regulations

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10 Key Observations on the ASC Deal Market

6. The Turn Around Market - Harder to make improvements in Turn Arounds
7. Pricing of Deals – <u>Exhibit A</u>
   1. 6 to 7.5 EBITDA
   2. Out of network lower pricing
   3. Hospitals - 50% (better contracts??) or 100% and convert to HOPD
   4. Hospitals – 6 outpatient cases to make up for 1 lost in patient case
8. Co Management – 100% deals
   1. What will be paid?
   2. Are there real roles?
   3. Do you need management to manage the co-managers?

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9. Growth in Doctor Employment
    1. Specialty by specialty
    2. Market to market
10. ACOs – very unclear of role of ASC – Exhibit B

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Exhibit A

Post Deal Pricing – Fourth Quarter 2010 – 8 Deals

i. Orthopedic-focused surgery center that was mostly in-network, national chain purchaser for approximately 7.3 times EBITDA.

ii. Multi-specialty center, heavily in-network, hospital purchaser, with no co-management agreement ,approximately 8 times EBITDA.

iii. GI center heavily in-network, hospital purchaser, no co-management agreement, approximately 6 times EBITDA.

iv. Multi-specialty center, entered into co-management agreement as part of the transaction, some out-of-network, hospital purchaser 5.75 times EBITDA.

v. Multi-specialty center, in-network, hospital purchaser, some co-management arrangement, approximately 7 times EBITDA.

vi. Multi-specialty orthopedic-focused center, mostly in-network, national chain buyer approximately 7 times EBITDA.

vii. Multi-specialty surgery center, some orthopedic and spine focus, in and out-of-network, national chain purchaser, for 5.65 times EBITDA

viii. Hospital purchaser, a very high multiple, mostly due to the fact that there was a significant drop in income in 2010 and 2010, was not indicative of continued income, approximately 9 times EBITDA.

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Exhibit B

ACOs – 17 Key Points – Not clearly a Real Spot for ASCs or Specialists

1. **Will require massive bureaucracy.** Given the scope of the regulations and the number of actions and approvals to qualify and participate and be accountable as an ACO, the ACO regulations likely will require the establishment a massive bureaucracy. In some ways, it's a different form with much more integration than providers that manage a Medicare advantage plan system but with arguably even more complexity.

2. **Regulations are idealistic.** The regulations in many ways speak of what is viewed by CMS as ideal concepts in healthcare, concepts used as platitudes such as "patient-centered care," "patient engagement" and many other terms. It will be fascinating to see how the actual practical hard-nosed implementation meshes with such ideals.

   Further, the regulations speak of the kind of leadership expected in ACOs as though government can choose leaders or dictate what they look like in what we know is an imperfect world and where the reality of capitalism and a free market. In reality, who leads such organizations is never going to be as clean and clear as the regulations seem to believe and the leaders won't fit a certain stereotype.

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Exhibit B

ACOs – 17 Key Points – Not clearly a Real Spot for ASCs or Specialists

3. **Regulations limit business involvement.** The program set forth the kind of negative attitude that one might expect from CMS towards business and further tends to reflect CMS' demonization of business and insurance. For example, while some might think business involvement is needed to drive this, the regulations specifically require that business interests cannot make-up more than

4. **Regulations require beneficiary representation in ACO governance.** The program requires a means for equal and shared governance in ACOs and requires beneficiaries to have a say in the ACO governance. Specifically, the proposed regulations require the ACO governing body to include including "a Medicare beneficiary serviced by the ACO.“

5. **Regulations favor PCPs.** The ACO regulations — much like intended reform in the 90s — view the primary care physician as the leader of patients' healthcare and really relegates many other parties to being cost centers. Language regarding PCP roles is somewhat glowing, further suggesting this perspective.

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Exhibit B

ACOs – 17 Key Points – Not clearly a Real Spot for ASCs or Specialists

6. **The regulations provide for a once-a-year start date of Jan. 1.** Under the proposed rule, ACOs would apply for the three-year program and, if accepted, would be part of a cohort of ACOs joining the Shared Savings Program every Jan. 1.

7. **ACO agreements will be for three years with one-year performance measurement periods.**

8. **CMS expects 5 million Medicare beneficiaries to receive care from providers participating in a shared savings program.**

9. **An ACO must have at least 5,000 beneficiaries. If an ACO accepted into the program falls short of the 5,000 requirement, it will be placed on a corrective action plan.**

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Exhibit B

ACOs – 17 Key Points – Not clearly a Real Spot for ASCs or Specialists

10. **The board of an ACO must include some Medicare beneficiaries. "Another of the proposed patient-centered criteria discussed previously is the requirement that ACOs provide for patient involvement in their governing processes. We are proposing that, in order to satisfy this criterion, ACOs will be required to demonstrate a partnership with Medicare FFS beneficiaries by having representation by a Medicare beneficiary serviced by the ACO, in the ACO governing body."**

12. **The ACO can enter into a one-sided or two-sided shared savings agreement. Under the first, "one-sided" risk model, an ACO that creates a savings of at least 2 percent would get 50 percent of the money above that threshold, but it would have no penalty if it spent more in the first and second year. Under the "two-sided" model, an ACO could receive 60 percent of the money above the threshold but also would be penalized if it led to higher costs. By the third year of the program, all ACOs would become responsible for losses.**

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Exhibit B

ACOs – 17 Key Points – Not clearly a Real Spot for ASCs or Specialists

12. Cost targets, from which savings will be calculated, will be based on retrospective review of aggregate beneficiary-level data for the assigned population. Spending targets will be compared to actual spending and any savings above the ACO's minimum savings rate (generally 2 percent), will be shared between CMS and the ACO.

13. Generally there is no savings shared or costs to be borne unless savings are at least 2 percent above or below the benchmark. The higher the number of beneficiaries, the lower the minimum savings rate. For smaller populations (e.g., 5,000 beneficiaries), the minimum savings rate can be higher (i.e., up to 3.9 percent). However, there are exceptions to the rule for rural ACOs.

14. ACOs will be subject to a withhold of shared savings to offset possible future losses. "The ACO will be subject to a 25 percent withhold of shared savings in order to offset any future losses under the two-sided model." If an ACO completes its three-year agreement, it can recoup the 25-percent withhold. If an ACO terminates its agreement before the three-year requirement, CMS will retain any portion of shared savings withheld.

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Exhibit B

ACOs – 17 Key Points – Not clearly a Real Spot for ASCs or Specialists

15. **An ACO must develop a process to promote evidence-based medicine, patient engagement and coordination of care.**

16. **Primary care providers may only participate in one ACO. However, a hospital can participate in more than one ACO, as can non-primary care medical and surgical providers.**

17. **At least 50 percent of an ACO's primary care physicians must be meaningful EHR users as defined by the HITECH Act and subsequent Medicare regulations.**

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Questions or Comments?

For follow-up issues, please feel free to contact:

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#32287153

www.mcguirewoods.com

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