2015 West Michigan Healthcare Economic Forecast

Presented by the Office of the Vice Provost for Health
Seidman College of Business and
the Alliance for Health

Sponsored by:

Blue Cross Blue Shield Blue Care Network of Michigan

Priority Health
GVSU
Healthcheck
Team

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Figure 1: Annual Population Growth Rate, 1991-2013

- U.S.
- Michigan
- KOMA
- Southeast Michigan
Figure 2: Population Distribution as a Percent of KOMA

- 5-19
- 20-34
- 35-44
- 45-64
- 65 and over
Health Care Overview

Risk Factors, Access to Care and Health Outcomes
Unhealthy lifestyle choices by WM

• 23% report no leisure time physical activity
• 20% report that they smoke
• 19% report that they binge drink
• 30% report no routine check up in the last year
• 17% report they are in poor or fair health
• 33% report being obese (BMI > 30)
  o 5.5% increase in one year
  o Aging population
• 17% report having no health care coverage

**Consequence?**

• Increased health care spending on diseases related to behavioral choices
  o Diabetes
  o High Blood Pressure
  o Heart Disease
  o Cancer
Women’s Health

- 51% of the population
- Majority in childbearing ages
- Differences in onset of, symptoms for and responses to treatment for disease
- Women often are primary caregivers for children and/or elderly
Incidence of preterm, LBW and very LBW babies

- Smallest in KOMA
- Increases with poverty and unintended pregnancies
- Marital status
- Maternal age
- 30% of live births are cesarean deliveries
- Reducing LBW by 20% can lead to $13.4 m in savings annually
Low birth weight babies by maternal age
Notable differences

• Compared to the # of women hospitalized for heart disease, a much smaller proportion receive treatments such as bypass graft/stents.
• Women are far more likely to die from Alzheimer’s disease or stroke in KOMA followed by diabetes.
• Alzheimer’s disease costs society $300 b/year
Notable differences

- **Ambulatory Care Sensitive Hospitalizations**
  - KOMA does a superior job of managing primary care over Detroit and MI
  - All 3 regions can do a better job of providing primary care to women
    - Overall average of F/M ratio for all ambulatory care sensitive conditions, all avoidable hospitalizations and all acute and chronic hospitalization is greater than 1.
Economic Analysis

Comparing Expenditures and Prices for Health Care Services Across Communities
Health Care Expenditures

Adjusted Medicare Expenditures per FFS Enrollee

- Grand Rapids
- Rochester, NY
- Louisville
- Buffalo
- Cleveland
- Milwaukee
- Portland
- Akron

Dollars

- 2003
- 2012
Health Care Expenditures

Adjusted FFS Medicare Expenditure Growth Rate, 2003-2012

Growth Rate, 2003-2012

- Grand Rapids
- Rochester, NY
- Louisville
- Buffalo
- Cleveland
- Milwaukee
- Portland
- Akron
Health Care Prices

Healthcare Bluebook Fair Price
Total Knee Replacement

- Grand Rapids
- Rochester
- Louisville
- Akron
- Buffalo
- Cleveland
- Milwaukee
Health Care Prices

Healthcare Bluebook Fair Price
Cesarean Section

<table>
<thead>
<tr>
<th>City</th>
<th>Price</th>
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<tbody>
<tr>
<td>Grand Rapids</td>
<td>$11,200</td>
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<tr>
<td>Rochester</td>
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<tr>
<td>Louisville</td>
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</tr>
<tr>
<td>Akron</td>
<td>$10,700</td>
</tr>
<tr>
<td>Buffalo</td>
<td>$11,300</td>
</tr>
<tr>
<td>Cleveland</td>
<td>$11,100</td>
</tr>
<tr>
<td>Milwaukee</td>
<td>$11,000</td>
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</table>
Health Care Prices

Healthcare Bluebook Fair Price
Coronary Angioplasty

<table>
<thead>
<tr>
<th>City</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grand Rapids</td>
<td>$18,000</td>
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<tr>
<td>Rochester</td>
<td>$18,500</td>
</tr>
<tr>
<td>Louisville</td>
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</tr>
<tr>
<td>Akron</td>
<td>$19,500</td>
</tr>
<tr>
<td>Buffalo</td>
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</tr>
<tr>
<td>Cleveland</td>
<td>$19,000</td>
</tr>
<tr>
<td>Milwaukee</td>
<td>$19,500</td>
</tr>
</tbody>
</table>
Potential Explanations for Expenditure/Price Increases

- Patient demographics
- Utilization
- Market structure
- Technological advances
ACA Rollout in Michigan

October 2013  Health Insurance Public Exchange opens in Michigan

April 2014  Michigan expands its Medicaid program to those living at or below 138% of the poverty line

As of December 2014: 470,000 new Medicaid enrollees, 270,000 enrollees in exchange plans
Physician Survey

- Fall 2014
- Includes KOMA and Eaton, Kalamazoo & Ingham counties
- 50 return surveys
- Questions specifically asked about changes due to the ACA.
Graph 1: Physician Perceptions of the ACA

- 16% positive
- 37% negative
- 47% neither positive nor negative

Data based on 38 observations
Changes Attributed to the ACA

One-quarter see increases due to the ACA:

• Volume of patients (24%)
• Administrative work (25%)
• Difficulty finding a physician for referrals (29%)
Changes Attributed to the ACA

Approximately 75-85% see no change in:

- Time Spent with Patients
- Use of NPs and PAs
- Volume of wellness visits
- Volume of chronically ill patients
Graph 3 Changes to Physician Practices Because of the ACA

- **Time Spent with Patients**
  - Increased due to ACA: 72%
  - Decreased due to ACA: 8%
  - No change: 19%

- **Use of NPs and PAs**
  - Increased due to extraneous variable: 20%
  - Decreased due to extraneous variable: 9%
  - No change: 9%

- **Volume of Wellness Visits**
  - Increased due to extraneous variable: 86%
  - Decreased due to extraneous variable: 3%
  - No change: 9%

- **Volume of Patients with Chronic Illness**
  - Increased due to extraneous variable: 15%
  - Decreased due to extraneous variable: 12%
  - No change: 74%
Medicaid Expansion: volume of new patients

- More than half (65%) of physicians have not seen a change in the volume of Medicaid patients.
- Fifteen percent (15%) have limited the number of Medicaid patients.
- Eight percent (8%) have increased their Medicaid loads.
Does the temporary higher reimbursement rate increase the acceptance of Medicaid patients?

- 15% said 'yes'
- 18% said 'no', because the increase is only temporary
- 67% said the rate does not affect their acceptance of Medicaid patients
Questions?
Hospital Market Concentration

- Grand Rapids
- Rochester
- Louisville
- Akron
- Buffalo
- Cleveland
- Milwaukee
- Portland

HHI - 2003
HHI - 2012
Panel Discussion

Mike Faas
Karen Kennedy
Corey Waller
Mike Faas

President

Metro Health
WHAT IS “DRIVING” WEST MICHIGAN HEALTHCARE TRENDS?

January 9, 2015
Health Care Reform: Impact To Occur in Three Distinct Phases

Before 2014
- Interpretation and regulatory rule writing
- Competitive positioning

2014-2017
- New entrants and strategies
- Reactions and rule rewriting

“New Normal”
- Winners and losers
- Market share and pricing stabilize

Source: Blue Cross Overview 2011
The Changing Landscape - Health Systems

At one time, a health system needed to have any one of these characteristics in order to be successful and sustainable. Now, in order to be sustainable, and to meet the region’s needs, *a health system must accomplish all or most of these*:

- **Access system-wide economies of scale** - taking advantage of scale to reduce supply costs, improve operational processes, get access to national quality expertise in highly specialized business areas.

- **Be in the right locations with the right services** - right hospital location(s), right ambulatory services locations, right physician practice sites, ...

- **Achieve regional economies** - work together to serve a large patient population across a region and population large enough to support highly effective and efficient care management processes.

Source: McManis Consultants
Factors Driving Strategic Plans for the Future

Capital Access
(Net income, Days Cash on Hand)

Healthcare Reform
(the overall new direction of how healthcare will be organized and paid)

Essentiality
(scale, importance to the community)

Competition with Large Regional Systems

Independence • Choice • Culture
Three Potential Scenarios

- **Consolidation** - become the acquirer or the acquired to achieve key strategies
- **Collaboration** - build strategic relationships and partnerships to achieve key strategies
- **Status Quo** - attempt to survive under prior models, behaviors and strategies
Mergers and Acquisitions Continue to Rise

Hospital Mergers and Acquisitions

<table>
<thead>
<tr>
<th>Year</th>
<th>Mergers and Acquisitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>65</td>
</tr>
<tr>
<td>2011</td>
<td>89</td>
</tr>
<tr>
<td>2012</td>
<td>95</td>
</tr>
<tr>
<td>2013</td>
<td>98</td>
</tr>
</tbody>
</table>

Number of Hospitals Part of a Health System

2000-2012

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>2542</td>
</tr>
<tr>
<td>2003</td>
<td>2626</td>
</tr>
<tr>
<td>2006</td>
<td>2775</td>
</tr>
<tr>
<td>2009</td>
<td>2921</td>
</tr>
<tr>
<td>2012</td>
<td>3100</td>
</tr>
</tbody>
</table>

M&A Plans for the Next 12 Months

- No M&A Activity Planned: 12%
- Planning to Pursue M&A Within the Next 12 Months: 88%


1) September 2013.
# Overview of Accountable Payment Models

## Key Attributes

<table>
<thead>
<tr>
<th>Definition</th>
<th>Value-Based Purchasing</th>
<th>Bundled Payments</th>
<th>Accountable Care Organizations (ACOs)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>Pay-for-performance program differentially rewards or punishes hospitals (and likely ASCs and physicians in coming years) based on performance against predefined process and outcomes performance measures</td>
<td>Purchaser disburses single payment to cover certain combination of hospital, physician, post-acute, or other services performed during an inpatient stay or across an episode of care; providers propose discounts, can gain share on any money saved</td>
<td>Network of providers collectively accountable for the total cost and quality of care for a population of patients; ACOs are reimbursed through total cost payment structures, such as the shared savings model or capitation</td>
</tr>
<tr>
<td><strong>Purpose</strong></td>
<td>Create material link between reimbursement and clinical quality, patient satisfaction scores</td>
<td>Incent multiple types of providers to coordinate care, reduce expenses associated with care episodes</td>
<td>Reward providers for reducing total cost of care for patients through prevention, disease management, coordination</td>
</tr>
</tbody>
</table>

Source: Marketing and Planning Leadership Council interviews and analysis.

1) Center for Medicare and Medicaid Innovation.
The Changing Landscape -- Payment

Health care’s rate of change is accelerating. Metro seeks to be alert to the changes ... and use them constructively.

– **Patient changes.** More patients have insurance, often through the exchanges. Some are new Medicaid patients, some are commercial, especially with small employers. These patients need help in navigating the health system.

– **Payer changes.** While Medicare, BCBS and Priority dominate -- there are a wider number of payers. Also some self-funded employers are interested in working more closely with payers.

– **Payment changes.** Health care markets are changing how physicians, health systems and others will be paid. The direction of the change is from the volume of care provided to the value of care provided:

\[
\text{Value} = \frac{\text{Clinical Outcome + Safety + Patient Experience}}{\text{Cost}}
\]
Public HIX Participants Choosing High Deductibles

Annual Deductibles of Individual Plans Selected on eHealth

October 2013 – March 2014

- $6,000+ (39%)
- $3,000-$5,999 (30%)
- $2,000-$2,999 (11%)
- $1,000-$1,999 (13%)
- $500-$999 (3%)
- < $500 (5%)

Volumes Continuing to Shift Outpatient

Medicare Volume Growth

Cumulative Percent Change

<table>
<thead>
<tr>
<th>Year</th>
<th>Outpatient Services per FFS Part B Beneficiary</th>
<th>Inpatient Discharges per FFS Part A Beneficiary</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>28.5%</td>
<td>(12.6%)</td>
</tr>
<tr>
<td>2012</td>
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</tbody>
</table>

1) Outpatient services represent entire market regardless of site of service (includes hospital-based settings, ASCs, other freestanding providers and physician offices)

A Growing Network of Immediate Access Choices

Markets Responding to Unmet Needs

Consumer-Oriented Service Delivery Sites Filling the Gap

Traditional Access Points
- Primary Care Office

Consumer-Oriented Access Points
- Urgent Care Center
- Retail Clinic
- Virtual Visit

Low Acuity
- ED (Emergency Department)

High Acuity

Driving Provider Questions:

- Should we partner to establish retail clinics?
- Should we build or expand our urgent care footprint?
- Is virtual care something that we should provide?
- When should we enter into partnerships to meet patient demands?
“There may be no greater predictability of impending doom nor may there be anything that makes organizations and the individuals that run them more vulnerable than entrenched, long-term success”

Ken Clark, Professor
Harvard Business School
Karen Kennedy
Lead Physician

Browning Claytor Center
Mercy Health Saint Mary’s
Corey Waller MD
Director
Center for Integrative Medicine
Spectrum Health
Questions?
Closing Remarks

http://www.gvsu.edu/vphealth/