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The Megatrends Reshaping Healthcare: Managing Change and Maximizing Opportunity

Jon Glaudemans, Managing Director

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Alex Morin, Manager

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Our Speakers

JON GLAUDEMANS, MANAGING DIRECTOR,

Mr. Jon Glaudemans is a managing director of Manatt Health Solutions, an interdisciplinary policy and business advisory practice of Manatt, Phelps & Phillips, LLP. Mr. Glaudemans has more than 30 years of senior leadership experience in healthcare operations, policy issues management, financial analysis, communications and health insurance. His areas of focus include insurance regulation, payer-provider market dynamics, provider payment policy, e-health, health plan administration, health disparities and quality improvement initiatives across a variety of care settings.

Prior to joining Manatt, Mr. Glaudemans was Chief Advocacy and Communications Officer at Ascension Health, the nation's largest nonprofit healthcare system, with over 120 hospitals in more than 20 states. Mr. Glaudemans spent five years as the Senior Vice President/Chief Operating Officer at Avalere Health, LLC, a Washington-based advisory group. Earlier in his career, Mr. Glaudemans held a leadership role in the Washington, D.C., office of Public Strategies, Inc., which was at the time the largest independent public affairs firm serving Fortune 100 clients. In 2001 Mr. Glaudemans was asked to serve as Co-Transition Coordinator for the incoming Administrator for the Centers for Medicare and Medicaid Services. Mr. Glaudemans spent a decade at Aetna, where his roles included General Manager of Aetna U.S. Healthcare's Mid-Atlantic Region. Mr. Glaudemans began his career at the U.S. Office of Management and Budget (OMB), where he was intimately involved in Medicare budget, regulatory and legislative initiatives.

Mr. Glaudemans earned his M.P.A. in Economics from Princeton University and his B.S. from the Massachusetts Institute of Technology.

CINDY MANN, PARTNER

Ms. Cindy Mann has more than 30 years of experience in federal and state health policy, focused on health coverage, financing, access and operational issues. She guides states, providers, plans, consumer organizations and foundations on creating and implementing strategies around federal and state health reform, Medicaid, Children's Health Insurance Program (CHIP), and delivery and payment system transformation.

Ms. Mann joined Manatt from the Centers for Medicare & Medicaid Services (CMS), where she served as deputy administrator and director of the Center for Medicaid and CHIP Services. At CMS, she led the administration of Medicaid, CHIP and the Basic Health Program at the federal level for more than five years during the implementation of the Affordable Care Act (ACA). Prior to CMS, Ms. Mann was a research professor at the Georgetown University Health Policy Institute, where she was founder and director of the Center for Children and Families. Before coming to Georgetown, Ms. Mann served as a senior advisor at the Kaiser Commission on Medicaid and the Uninsured. She also was director of the Family and Children's Health Program Group at the Healthcare Financing Administration (HCFA), now CMS. Ms. Mann came to HCFA from the Center on Budget and Public Policy, where she directed federal and state health policy work. She has extensive experience in state-level matters, having worked on healthcare, welfare and public finance issues in Massachusetts, Rhode Island and New York.

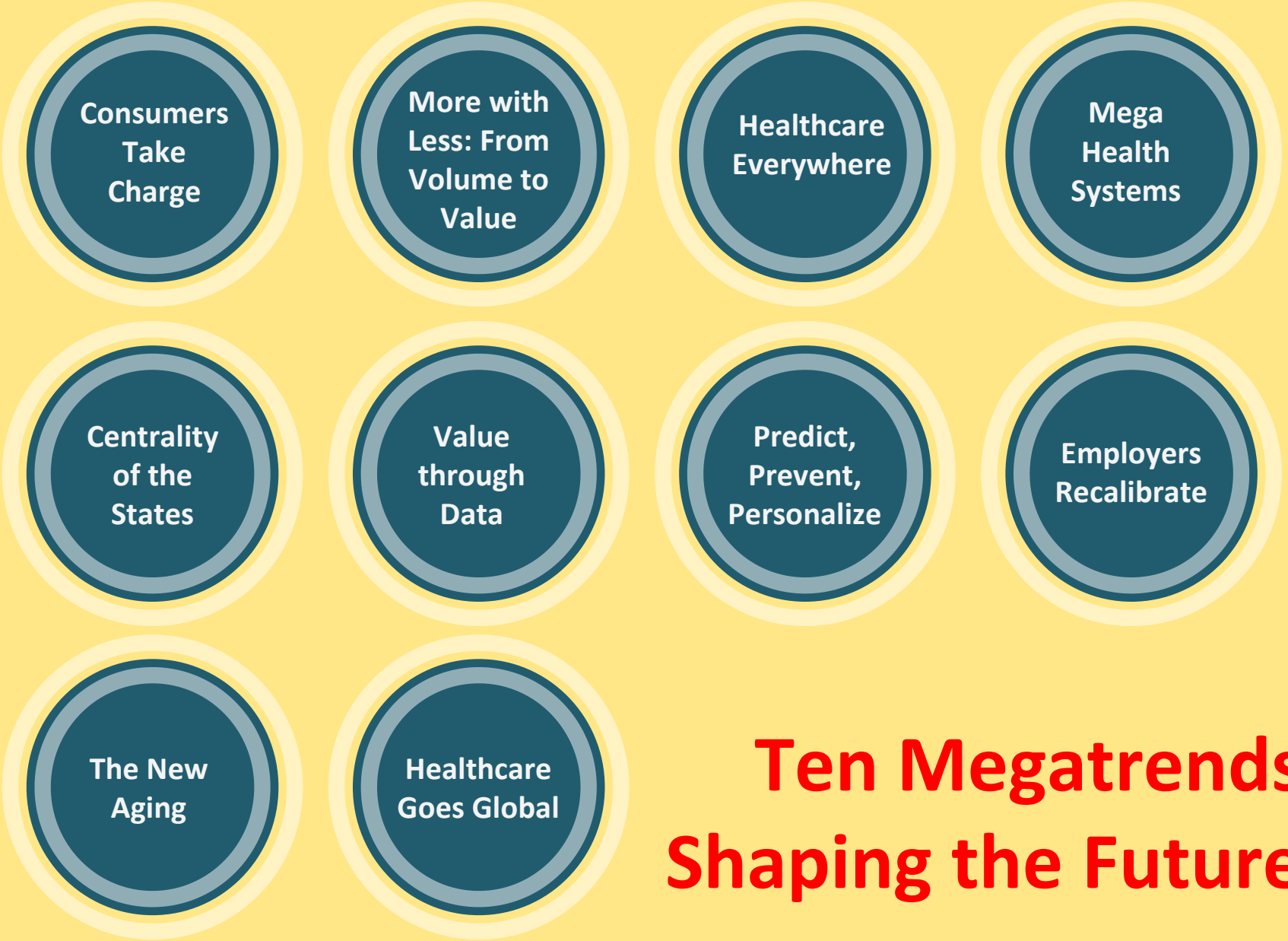
Ms.Mann is admitted to practice in Massachusetts and New York. She earned her J.D., with honors, from the New York University School of Law and her B.S. from Cornell University.

ALEX MORIN, MANAGER

Alex Morin is a manager of Manatt Health Solutions (MHS), an interdisciplinary policy and business advisory division of Manatt, Phelps & Phillips, LLP. Mr. Morin provides policy and quantitative analysis, project implementation support and strategic business services to healthcare providers, payers and other healthcare stakeholders. His project work focuses on diverse topics within the healthcare sector, including public health insurance programs (Medicare, Medicaid and CHIP), payment and reimbursement reform, delivery system reform, health information technology, and federal and state health policy trends.

Prior to joining MHS, Mr. Morin was project manager at Engelberg Center for Health Care Reform at the Brookings Institution, where he led the ACO Learning Network, a learning collaborative of payers, providers and policymakers that developed insights and shared knowledge about Accountable Care Organization strategy, delivery system transformation and payment system reform. He jointly headed the Center's research and reporting on federal health spending, Medicare and Medicaid reform and Affordable Care Act implementation, including issues related to bundled payments, Medicaid and safety-net providers and ACOs. Mr. Morin was also a senior analyst within the IT practice of the Corporate Executive Board, where he conducted trend research, authored white papers and developed diagnostic tools for corporate IT and multi-functional shared services executives.

Mr. Morin earned his M.A., summa cum laude, from Texas A&M University and his B.A., magna cum laude, from the University of Pittsburgh.


Consumers Take Charge
More with Less: From Volume to Value
Healthcare Everywhere
Mega Health Systems
Centrality of the States
Value through Data
Predict, Prevent, Personalize
Employers Recalibrate
The New Aging
Healthcare Goes Global
Ten Megatrends Shaping the Future

Do the trends still hold?

Near-term predictions?

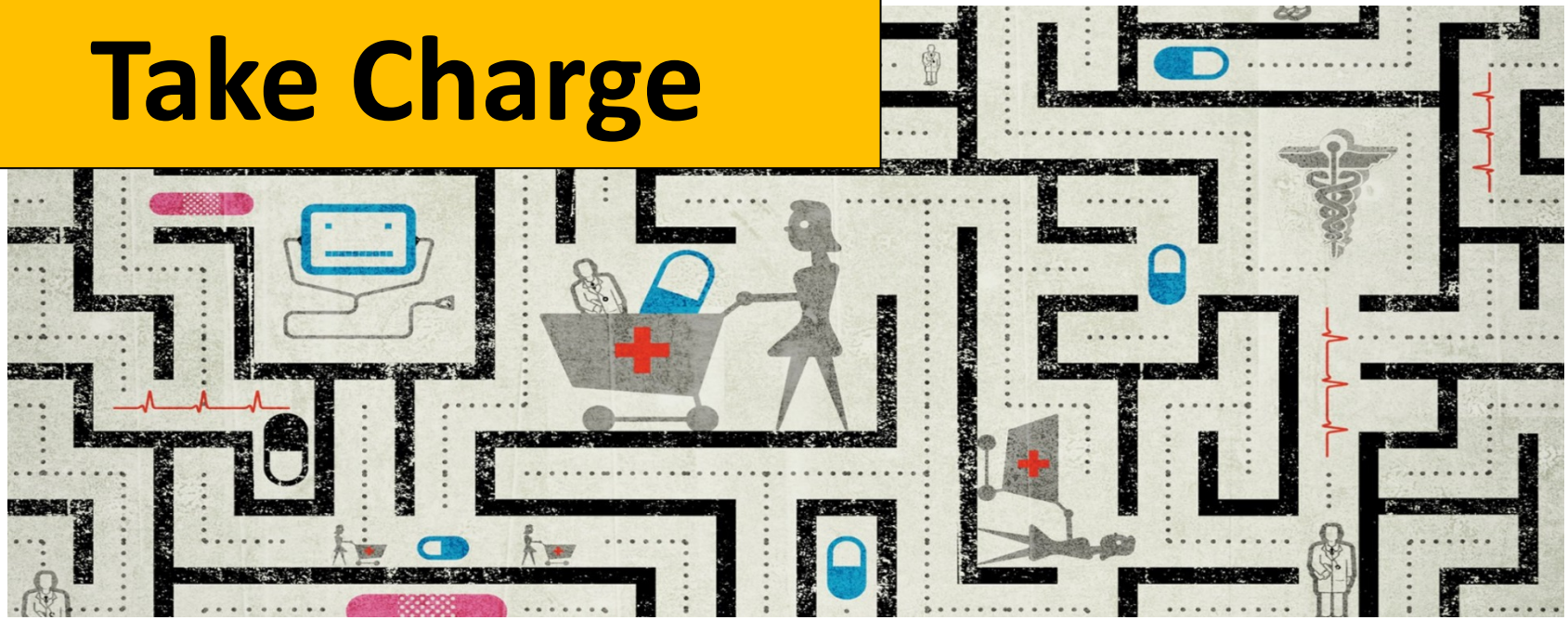
Implications for leadership?

Question 1: Value-Based Payment

For value-based payments, defined as payments where your entity is at partial or complete financial risk based on measureable quality or cost-of-care outcomes, is your organization:

A. Receiving < 25% of revenues
B. Receiving > 25% of revenues
C. Receiving >50% of revenues
D. Paying out <25% in payments
E. Paying out >25% in payments
F. Paying out >50% of payments
G. Not very engaged in value-based payments
H. Not applicable

#1 Consumers Take Charge



Consumers pay more and make more care decisions, using social media/apps to acquire price/network data.

- Reduced employer subsidies and increased reliance on high-deductible health plans force consumers to pay more out-of-pocket, focusing policy attention on costs.
- Consumers will be increasingly able to compare gross and net prices; mounting frustration over apples-to-oranges plan design, coupled with emerging awareness of premium vs. out-of-pocket costs, and narrow network/ out-of-network issues will lead to more regulation.
- Healthcare organizations will double down on the emotional factors that play into customer satisfaction (empathy, communication, etc.) in addition to tangible improvements to the patient experience.
- Wearables and 'internet-of-things' expand presence and utility, making self-care/remote care monitoring easier.

Enrollment in HDHPs has doubled since 2010, to 24% in 2014.

Customer service and delivering on expectations top consumer survey

In Nov. 2015, NAIC and CMS issued network adequacy guidelines.

More micro-marketing, more links to social media/ wearables, managing dynamic network information

Implications

Delivery System
- More micro marketing
- Hospitality demands
- Develop loyalty

Payers/Plans
- Master DTC marketing
- Develop HDHPs
- Help members choose

Regulators
- Transparency reqs.
- Premiums v. copays
- Rx – Med deductibles

Pharma
- Link to wearables
- Manage pricing
- Patient engagement

Consumers
- More responsibility
- More decision-making
- More incentives

How do we navigate TCPA ***and*** engage members?

How do we obtain/provide meaningful data?

How do we compete with MD/plan for loyalty?

#2 More with Less

Providers take risk for population/patient/product outcomes, requiring new care models and contracts.

- Despite initial mixed results of ACOs, continued public and private payer demands for "more-with-less" will force providers, delivery systems and life sciences companies to accept risk for patient and population health outcomes.
- Pressures for all-payer alignment on payment models.
- Imperative emerges for vendor/provider/plan rationalization of quality measures and reporting requirements linked to value-based payment models to ease burdens on providers, payers, and patients.
- New team-based care models and telemedicine will become the norm, placing a premium on systems that can transform their processes and attract, train and retain non-physician providers; develop e-health strategies; and target interventions to costly patients.

38% hospital, 10% specially, 24% PCP payments are value-oriented today.

Team-based care models linked to total cost of care reductions.

Patients treated at 5-Star hospital have 71% lower chance of dying.

More risk sharing, regulating risk-based payments, managing narrow networks, linking to/from pharma

Implications

Delivery System
- More risk-sharing
- More care mgt.
- More quality metrics

Payers/Plans
- Share risk carefully
- Align care mgt.
- Narrow network mgt.

Regulators
- New delivery models
- Risk-based payments
- Anti-trust/FCA issues

Pharma
- Integrate with VBP
- Multiple tiers
- Engage pharmacists

Consumers
- New referral patterns
- Benefit plan selection
- Understand quality

How do we manage FMV-Stark-FCA issues?

How do we link primary and behavioral care?

What's our primary-pharmacy VBP strategy?

Question 2: Mega-Health Systems

From your vantage point, and in general,
will delivery system integrations & consolidations:

A. Increase consumer costs and improve quality
B. Increase consumer costs and have limited impact on quality
C. Decrease consumer costs and improve quality
D. Decrease consumer costs and have limited impact on quality
E. Results will vary by market
F. Decline to answer

#3 Healthcare Everywhere

Care monitoring and delivery move out of traditional settings, shifting the locus of / focus on patient loyalty.

- The increasingly distributed model of care will challenge traditional centralized delivery systems, and favor new management structures that stress outpatient and remote care monitoring and management.
- Delivery systems and payers will compete for patient/ member loyalty and will encounter millennials' distrust of institutions, thus placing a premium on cultivating physician/nurse/employee alignment with system/payer mission and improving the patient experience.
- Retail care providers will adopt technologies to link into medical homes' patient records and form more solid partnerships with large systems, providing points of access for customers closer to home for routine care.

Over 20 states mandate payment parity for telehealth; 8 more in line.

Site of care Δ:
+12% clinic
+17%, home
+9% retail
-2% hospital

Global wearables market expected to reach a value of $53.2 billion in 2019.

Managing multiple data flows, engaging non-traditional sites of care, assuring privacy and security

Implications

Delivery System
- Address telehealth $$
- Engage retail clinics
- Deploy loyalty apps

Payers/Plans
- Define telehealth $$
- Contract retail sites
- Engage employer sites

Regulators
- Oversee new sites
- Privacy and security
- Assess consumer apps

Pharma
- Leverage biometrics
- Engage pharmacies
- Understand FDA role

Consumers
- Understand privacy
- Keep PCPs in the loop
- Site-of-care choices

Which new sites should we contract with and how?

How do we manage cross-state licensure issues?

What are the HIPAA issues in using telemedicine?

#4 Mega Health Systems

Providers and payers consolidate to manage costs and enhance pricing power, fighting for the CM space.

- While big seems better to the C-Suite and investors, systems and payers that lose focus on the relationship between patient and provider do so at their peril.
- Increased demand for more-with-less creates a race for the middle ground of care management (CM), as payers battle it out with delivery systems for "ownership" of the churning population who need active care coordination.
- Delivery system winners will lower costs by optimizing/re-engineering care/administrative process and will face strong pressure to reduce prices from plans/consumers.
- Clinical integration will become a more favorable and cost-beneficial approach to full mergers/acquisitions.
- Network development/management skills will be critical.

95 hospital deals in 2014; plan mergers attracting intense DOJ scrutiny.

Clinical integration activity in 77% of markets

10% of rural hospitals are in current danger of going under; 16 closed in 2014.

Focus starts to shift away from system-formation to system-optimization.

Implications

Delivery System
- Scale vs. complexity
- Careful PH investment
- Integrate or employ?

Payers/Plans
- Assess pricing power
- Define CM role
- Adapt VBP models

Regulators
- Network adequacy
- Capital reserves
- Anti-trust issues

Pharma
- Engage IDNs
- Engage in VBP models

Consumers
- Fewer choices
- More coordinators
- Less/more confusion?

What's the best governance structure for the new IDN?

Can we lower costs to Medicare rates?

How do we achieve the promise of clinical integration?

Question 3: Value Through Data

Does your organization have a data management strategy, addressing governance and stakeholder roles?

A. Yes
B. No
C. In part
D. Not sure
E. Not applicable

#5 Centrality of States

States become more active regulators and purchasers, creating marketplace mosaics and more "experiments."

- With the fiscal benefits increasingly apparent, more and more states will choose to expand their Medicaid programs; budget pressures will drive regulatory integration across Medicaid and exchange plans.
- State efforts to regulate private insurers' network and payment models will intersect with growing federal activism in network adequacy and Medicare payment models – a trend likely to be agnostic to WH control.
- Increased demand for long-term services and supports (LTSS) will challenge state budgets and human capital resources, leading to new models that integrate social, behavioral, medical, and LTSS financing and services.
- Expanded use of CMS waiver authority is likely with the form of waivers driven by the 2016 Presidential election.

As of July 2014, 47 states had some form of Medicaid managed care (71% penetration).

$27 billion in DSRIP funds across 6 states

Medicaid ACOs in 11 states, 19 states with health home programs

Aligning payment models across payers, managing waivers, navigating multiple regulators

Implications

Delivery System
- More CBO contracts
- M'are/'aid rate-setting
- VBP pressures

Payers/Plans
- Align with M'are/'aid
- State VBP programs
- More CMS req'ments

Regulators
- Premium-cost sharing
- Scrutiny on access
- 1115 & 1332 waivers

Pharma
- Engage Medicaid
- Engage Marketplaces
- Engage MCOs

Consumers
- Age-band rating
- Premium-cost sharing
- Too many care mgrs.?

How do we become better purchasers of services?

How do we measure value and assess progress?

How do we expand into new populations?

#6 Value Through Data

Data on health status & effectiveness become widely available, changing practice and payment patterns.

- Legacy issues surrounding the interoperability/integration of clinical data across settings of care will persist, increasing the value of all-payer claims databases.
- Delivery systems will struggle in balancing between "big data" analytics for improved population health, and "small data" information for improved patient-care delivery.
- Doing more with less will require integrating patient-specific clinical, claims, pharmacy, 'wearable' and demographic data for effective targeting / measurement of provider/patient-centric interventions.
- Life sciences companies that leverage rapid learning insights into effective product-care management payment models will be differentiated in an increasingly-scrutinized marketplace that rewards demonstrable value.

40% of HC executives report +50% increase in data volume since 2014.

By 2018, 80% of systems will use data analytics as a tool to predict/ manage health.

23% of hospitals have capability to receive **and** use health data with outside hospitals.

Reconciling clinical and claims data, establishing governance structure, preparing for breaches

Implications

Delivery System
- Difficult IT decisions
- Governance issues
- Ex-system data flows

Payers/Plans
- Provider performance
- Member engagement
- Prepare for breaches

Regulators
- Push interoperability
- Adjust MU demands?
- Prepare for breaches

Pharma
- 3rd party CE/pricing
- Easier clinical trials?
- Targeted genomics

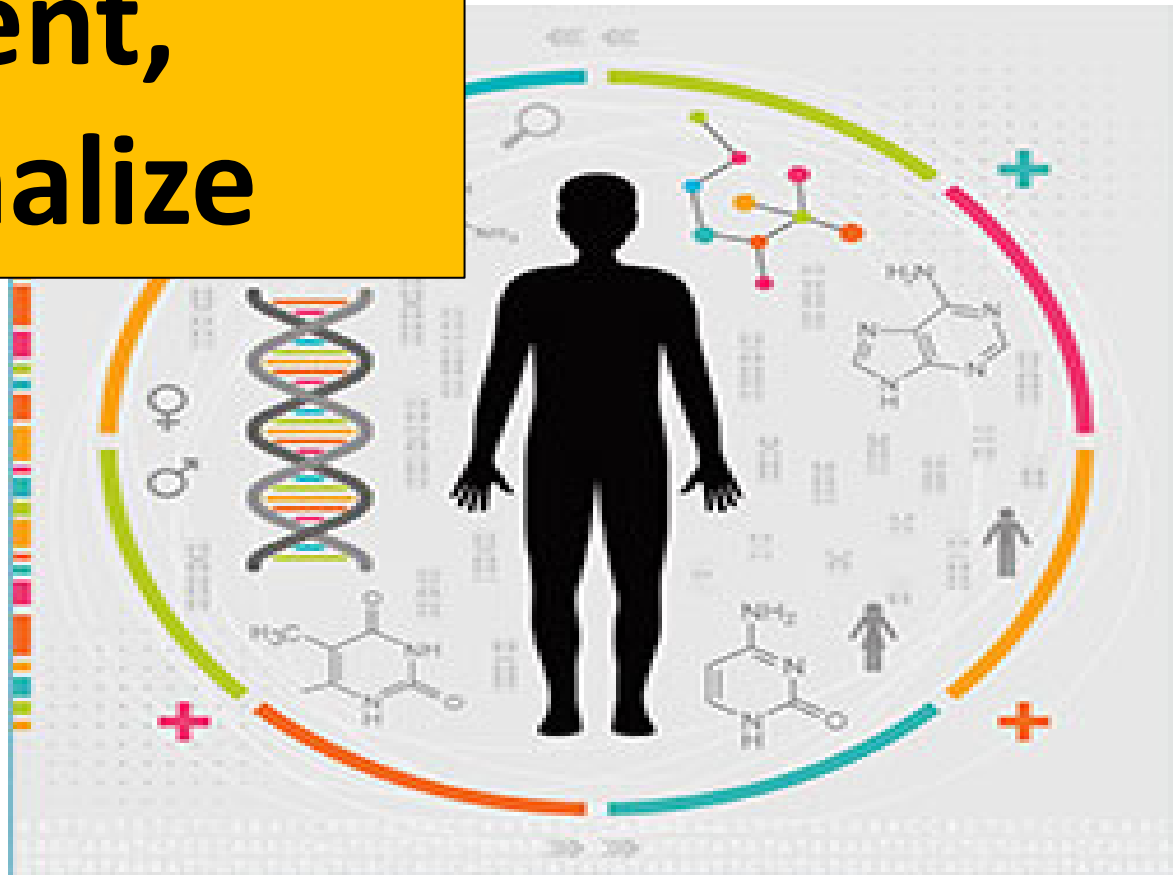
Consumers
- Prepare for breaches
- Compare & contrast
- Manage privacy

How do we set up a data governance structure?

Where can we get timely claims and Rx data?

Can we plan in advance for a possible data breach?

#7 Predict, Prevent, Personalize



Bigger datasets yield insights, informing personalized care and challenging price-setting and patient privacy.

- A new generation of physician and non-physician providers is open to updating practice patterns if the changes are supported via technology, new workflows, timely information, and new payment models.
- Genomic medicines that are customized to the individual patient will face unprecedented price and value scrutiny by public and private payers and independent assessment organizations. Payers, systems and life sciences companies will compete to shape this nascent coverage and payment landscape.
- Personalized prevention & targeted care management strategies derived from medical, socio-economic and genomic data sets will increase the receptivity and effectiveness of care management and increase ROI.

$215M "Precision Med. Initiative" announce by Pres. Obama.

In 2014, 47% of MCOs possessed predictive analytic tools.

Personalized prevention decreases MA costs by up to 50%.

Central vs. local analytics, connecting Rx and medical, developing new pathways, patient targeting strategies

Implications

Delivery System
- Predictive analytics
- Governance issues
- Small data & big data

Payers/Plans
- Predictive analytics
- Rx-medical linkages
- Member engagement

Regulators
- Bio-similar coding etc.
- NIH & CURES impact
- Testing and privacy

Pharma
- More $$ on genomics
- Predictive diagnostics
- Unique clin. pathways

Consumers
- Bioethical issues
- Cost of new Dx/Rx
- Privacy / breaches

What systems are best for targeting care management?

How can we provide usable insights to our providers?

How do we work with payers? with IDNs? With life sciences?

#8 Employers Recalibrate

Employers' role continues to erode, while exchange plans sharpen focus on multi-year patient loyalty.

- Employers will continue their gradual retreat from providing insurance to their employees, with smaller employers dropping coverage more quickly, even as larger employers experiment with private exchanges.
- Employers retaining coverage will face a balkanized set of requirements as state and federal regulators each seek to impose and integrate network and marketplace conduct standards on fully-insured plans.
- As employees/consumers face a wider range of coverage choices, systems and plans will be challenged to earn and retain patient/family loyalty to offset CM investments and retain visit/premium revenues.
- Integrating employee and legacy retirement health benefits takes on urgency with baby boomer exits.

Only 50% of ERs offered insurance in 2014, down from 56% in 2005.

Only 37% of FT workers with incomes between $15-20k accepted ESI.

39% of QHP issuers offer Medicaid MCO plans in same state (+7% in 2015)

Engaging employees, negotiating plan/network parameters, managing coalitions and retirees

Implications

Delivery System
- Direct contracting
- Employee productivity
- Pricing pressures

Payers/Plans
- Employer coalitions
- ERs pick and choose
- Private exchanges

Regulators
- Cadillac tax in or out?
- Benefit designs
- Formulary tiers

Pharma
- QHP formularies
- Engage employers
- Rx cost-sharing

Consumers
- Higher OOP costs
- Narrower networks
- More benefit designs

What's my Medicare Advantage strategy?

What are some feasible value-based payment models?

How can/will formulary management work?

#9 The New Aging

Digital natives' and baby boomers' interests coalesce, forcing focus on new 'late-life/end-of-life' care models.

- While medical/surgical/pharmaceutical advances may delay boomers' demand for home-based long term services and supports (LTSS), increased boomer volume and growing incidence of chronic conditions will strain traditional family/community support systems.
- Federal or expanded state financing of LTSS remains a pipe dream given political environment re: spending and pressing other needs (e.g., infrastructure, education).
- End-of-life planning and societal acceptance of hospice and palliative care will take center stage as patients & families and their partner providers seek to ease the overall stress of the great passage, with payers catching up on reimbursement.

In '15, Medicare announced plans to pay doctors for end-of-life counseling.

1 in 2 adults has a chronic condition; 1 in 4 has two or more conditions.

The annual "cost" of unpaid informal elder care exceeds $500 billion.

Aligning across medical and LTSS, addressing workforce shortages, linking to self-monitoring tools

Implications

Delivery System
- Home care providers
- Post-acute linkages
- End-of-life/palliative

Payers/Plans
- Aligning on duals
- High end-of-life costs
- Post-acute networks

Regulators
- Financing LTSS
- Home care oversight
- Aligning state siloes

Pharma
- Self-monitoring tools
- Baby boom and Part D
- Activity-enabling Rx

Consumers
- End-of-life choices
- Self-directed care
- Managing siloes

What are best practices re: states' LTSS programs?

Can Medicare and Medicaid team more effectively?

What's our hospice and palliative care strategy?

#10 Healthcare Goes Global

Visibility into global prices and care models improves, requiring providers to justify value and pricing.

- Public scrutiny of trans-national Rx pricing differences will continue, and increase US market, political, and/or regulatory pricing pressure, and will ultimately impact US prices, but not likely impact (re)-importation restrictions.
- Non-US care models that generate equal or superior outcomes at lower cost (e.g., cataract surgery, joint replacement) will be adopted by or imposed on US providers in a 'more-with-less' environment.
- Demand by US patients/payers/employers for non-US medical services will continue to grow; creating effective after-care linkages to local U.S. providers is essential.
- Continued growth of middle-class in non-US countries will fuel price-managed growth in life sciences sector.

US per capita Rx spend is 175% of the UK, and 51% higher than Germany's.

US medical tourism visits grew from 500k to 1.25M over 2007-14.

Brazil's Rx market will grow 7-10% annually through 2020

Managing trans-national price differences, linking local after-care to out-of-country procedures, licensing

Implications

Delivery System
- Ex-US partnerships
- In-US post-care mgt.
- X-border telehealth

Payers/Plans
- Ex-US contracting
- Ex-pat coverage

Regulators
- Provider licensure
- Continuity of care

Pharma
- Reference pricing
- Patent/data transfer
- Reimportation

Consumers
- X-border care coord.
- X-border Rx trips

What are our feasible value-based pricing strategies?

How do we navigate Medicaid best price?

What barriers exist to relying on non-US providers?


But Wait...
THERE'S MORE!

#11 Focus on the Whole Person

Social determinants accepted as major cost driver, leading to increased focus on service integration.

- For high-cost populations, building effective linkages to "upstream" social service/safety net organizations is essential as payers and delivery systems race to occupy the middle ground of care management.
- Effective adoption of data-driven, targeted care management strategies to prevent avoidable ER and inpatient visits and readmissions is the price of admission for any integrated delivery system or health plan.
- Managing the cultural and regulatory inhibitors to effective coordination of behavioral, social, (e.g., housing), and medical services will prove challenging to any organization that has failed to develop and implement a broad and deep community-based outreach and engagement strategy.

80% of MDs say meeting social needs is as important as meeting medical needs.

40% of outcomes can be attributed to social and economic factors.

Building strong local relationships, aligning payment/ reimbursement, addressing regulatory barriers

Implications

Delivery System
- Expand to community
- Integrate BH & SA
- Social determinants

Payers/Plans
- VBP incentives
- Expand relationships
- Holistic "quality"

Regulators
- Novel networks
- New payment models
- Access & quality

Pharma
- Value pricing models
- Partner with non-MDs

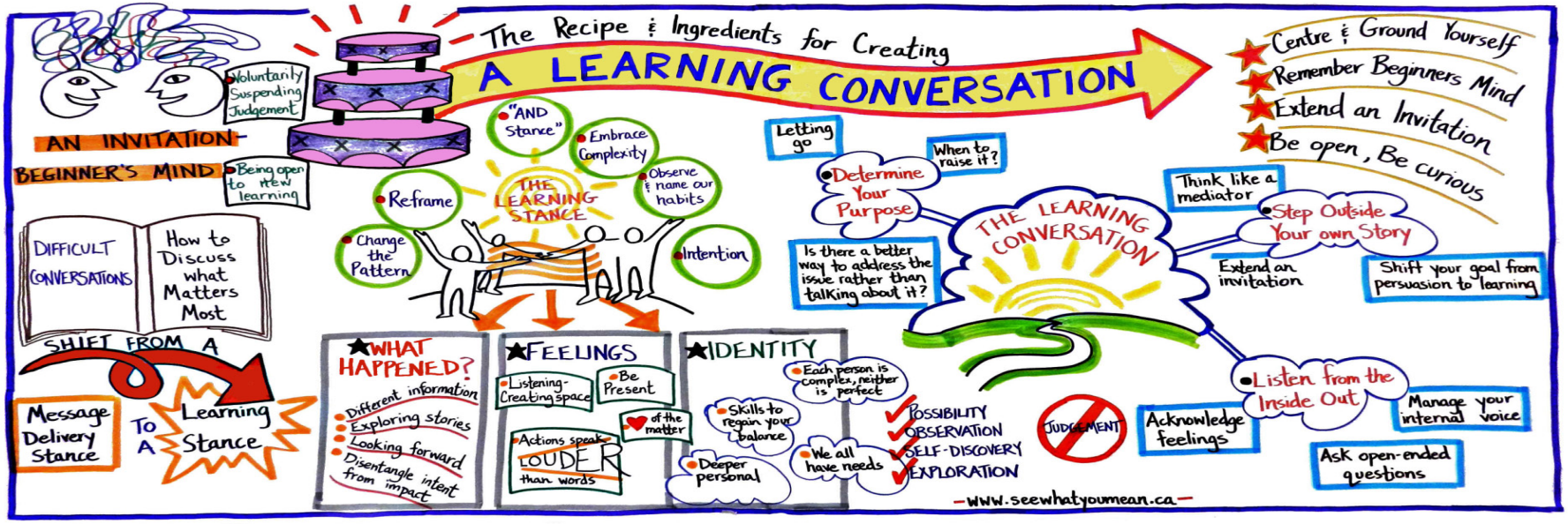
Consumers
- New "providers"

Can we align & finance medical/ social payment models?

How do we measure ROI for integrated care?

How do we engage non-traditional local providers?

Continue the Healthcare Conversation



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The Megatrends Toolkit from Manatt Health

- Healthcare Megatrends 2016-2020 - Webinar
- Healthcare Megatrends 2016-2020 - White Paper (Released week of Dec. 14)
- Megatrends Implications – Insights by Sector on the Implications of the 11 Megatrends in 2016 (Released Q1, 2016)
- Manatt on Medicaid – Update on 10 Trends for 2016 (Released Q1, 2016)

Please visit www.manatt.com to track the release of these materials.

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Q&A

More Questions?

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