Industry Trends and Stats

August 2, 2011

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

Industry Trends

Growth in Number of ASCs

ASC Consolidation

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

- 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

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

Public opinion mixed
Reform law changes landscape …

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<thead>
<tr>
<th>Where is $ spent?</th>
<th>Coverage $946 B</th>
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<tr>
<td></td>
<td>• Medicaid/CHIP - $434B</td>
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<td></td>
<td>• Exchange Subsidies - $466B</td>
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<td></td>
<td>• Employer Tax Credits - $40B</td>
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<td>• Temporary High Risk Pool - $5B</td>
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<th>Part D $94 B</th>
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<tr>
<td>• Closing the “Donut Hole” - $56B</td>
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<td>• Coverage Gap Discount - $38B</td>
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<th>Providers $52 B</th>
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<tr>
<td>• Long Term Care - $13.5B</td>
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<td>• Maternal Care - $2.2B</td>
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<td>• Preventive Care - $17.7B</td>
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<td>• HC Workforce - $6B</td>
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<td>• Community HCs - $12.3B</td>
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<th>Payment cuts $402 B</th>
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<tr>
<td>• Hospitals - $190B</td>
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<td>• Home Health - $40B</td>
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<td>• Medicare Adv - $132B</td>
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<td>• Imaging Providers – $2.3B</td>
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<td>• Medicaid drugs- $38B</td>
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<th>Consumers &amp; business $279 B</th>
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<td>• Penalty on Uninsured - $17B</td>
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<td>• Penalty on Employers - $52B</td>
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<td>• Taxes on income - $210B</td>
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<th>Industry taxes $140 B</th>
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<tr>
<td>• Insurers - $60B</td>
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<td>• “Cadillac” Plans - $32B</td>
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<td>• PhRMA- $28B</td>
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<td>• Medical Devices - $20B</td>
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Who pays?
## Timeline... a long, phased implementation

*Future regulations will clarify HC Reform law*

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<tr>
<td><strong>Coverage:</strong> 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</td>
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<td><strong>Immediate Insurance reforms:</strong> high risk pool, dependent coverage to age 26, no pre-ex for kids, loss ratios/rate review</td>
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<td><strong>Coverage:</strong> Small business premium tax credit</td>
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<td><strong>Medicare/Medicaid Savings:</strong> Medicare provider updates, Medicaid prescription drug rebates</td>
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<td><strong>Medicare Savings:</strong> MA payment reductions, productivity offset to FFS updates</td>
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<td><strong>Medicare/Medicaid Savings:</strong> DSH reductions, IPAB Medicare proposal</td>
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<td><strong>Delivery System Reform:</strong> Center for Medicare and Medicaid Innovation</td>
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<td><strong>Delivery System Reform:</strong> ACOs, hospital value-based purchasing</td>
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<td><strong>Delivery System Reform:</strong> Hospital readmissions, payment bundling</td>
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<td><strong>Delivery System Reform:</strong> Physician quality reporting penalties</td>
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<td><strong>New Revenue:</strong> Tax on prescription drug manufacturers</td>
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<td><strong>New Revenue:</strong> Excise tax on medical device makers, Medicare tax on high earners</td>
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<td><strong>New Revenue:</strong> Tax on health insurers</td>
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<td><strong>New Revenue:</strong> Tax on high-cost health plans</td>
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**Timeline**... a long, phased implementation

*Future regulations will clarify HC Reform law*
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

- Active Implementers
- Passive Aggressive
- On Hold
- Send It Back

Source: Harris Interactive, Ian Morrison
States suing Federal Government over Health Bill (as of 4/5/11)

State has filed suit (27 states)
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

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Feb 14, 2011
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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...

http://nextlevel.gehealthcare.com/government-health-policy-brief
GEHC Customer Reimbursement Site
www.gehealthcare.com/reimbursement

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  - GE comment letters
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  - 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
Questions?

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10 Key Observations on the ASC Deal Market

GE Webinar – August 2, 2011

Presented by:

Scott Becker, McGuireWoods, LLP, Partner
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
3. **Headwinds**

   A. **Cases – Independent Doctors**

   B. **Reimbursement**
      i. **Out of Network**
      ii. **General Negative Trends**
4. **6 Best Specialties**

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

1. Payor Issues
2. Doctor Employment and Doctor Recruitment
3. Increased CMS and State Regulations
6. The Turn Around Market - Harder to make improvements in Turn Aroun
ds

7. Pricing of Deals – Exhibit A
   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?
9. Growth in Doctor Employment
   1. Specialty by specialty
   2. Market to market

10. ACOs – very unclear of role of ASC – **Exhibit B**
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.
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.
Exhibit B
ACOs – 17 Key Points – Not clearly a Real Spot for ASCs or Specialists

3. **Regulations limit business involvement.** The program sets 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.
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.
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.
10 Key Observations on the ASC Deal Market

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.
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.
Questions or Comments?

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

Scott Becker – sbecker@mcguirewoods.com - 312.750.6016
#32287153

www.mcguirewoods.com

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