Kenai Peninsula Borough
Regional Health Care System Development Strategy

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Stroudwater

Report Outline

Project Overview

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Financial Summary

- Individual Hospital Performance and Opportunities
- Financial Projections

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- Stakeholder Interviews
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- Strategic Transformation
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Project Overview

Executive Summary

- The national healthcare industry is moving rapidly from FFS to PBPS and the bottom line of hospitals will be threatened by payment reductions and utilization declines
  - While PBPS has not reached Alaska, emerging factors call for its adoption
    - Changes in federal law (MACRA - Medicare Access and CHIP Reauthorization Act of 2015) and legislation (ACO improvements)
    - Current Alaska state deficit, driven by drastic and unprecedented reduction in price of oil, will require the Medicaid program to cut payments and/or reduce services
    - Private healthcare insurance on the Kenai Peninsula has become so expensive (with prices still increasing) that it threatens the financial viability of all other business entities outside of healthcare
- The service areas of all three Kenai Peninsula hospitals are distinctly separate due to geographic location and are supported by communities that are staunchly independent
- Advantages of Borough-wide ownership are limited from a cost-reduction perspective, but are valuable for developing an alignment strategy

Executive Summary (continued)

- There is opportunity now to position the Kenai Peninsula hospitals for the future
  - Address individual hospital opportunities
  - Seek Kenai Peninsula-wide efficiencies
  - Set in motion restructuring that will enable the transition of hospitals to delivery systems through alignment of the hospitals with
    - Physicians
    - Capital/insurance partners
    - Tertiary partners
- A regional alignment strategy is recommended to best-position the KPB healthcare delivery system in achieving core strategic priorities while maintaining maximum flexibility in the rapidly changing healthcare environment

Overview

- **Kenai Peninsula Borough (KPB)**
  - KPB is an organized governmental entity presided over by nine assembly members elected to represent each district of the Kenai Peninsula. As a second-class borough, the KPB is only capable of exercising powers granted to it by state statute or voter approval, or transferred to it by a city within the borough.
    - Voters authorized the KPB to exercise specific healthcare-related powers* ("health" and "hospital") across several service areas including the following:
      - Central Kenai Peninsula Hospital Service Area (CKPHSA) and South Kenai Peninsula Hospital Service Area (SKPHSA)
      - The KPB is not authorized to exercise health-related powers outside of these specific service areas without additional voter approval
  - The KPB owns both Central Peninsula Hospital and South Peninsula Hospital, which are leased and operated by separate nonprofit boards, and overseen by separate service area advisory boards. KPB assembly approves major capital decisions for each hospital, with input from local service area boards.

*Note:

- "Powers" are authority for an entity (city, borough, state etc.) to carry out government activity.
- "Health powers" is a general phrase for authority relating to healthcare services, not a specific term.
- "Hospital powers" relate to the delivery of hospital services in general.

Overview (continued)

Central Kenai Peninsula Hospital Service Area (CKPHSA) authorized hospital powers:

- To construct, maintain and operate a hospital or hospitals
- To provide other health services or health facilities within the service area including, but not limited to:
  - Alcoholism treatment, Primary health care, Health promotion, Chronic disease services (including psychiatric treatment, mental health and rehabilitation services), Outpatient service, Health education, Preventive medical care & wellness program, Home health service, Personal care services, Long term care and Hospice care

South Kenai Peninsula Hospital Service Area (SKPHSA) authorized hospital powers:

- To construct, maintain and operate a hospital or hospitals
- To provide other health services as follows:
  - Wellness programs, Community based health care services, Home health care services, Personal care attendant service, Long-term care services

Source: Alaska Statutes Title 29.10.159

Overview (continued)

- **Central Peninsula Hospital (CPH)**
  - CPH, located in Soldotna, AK, is a 49-bed acute care hospital serving a significant portion of the Kenai Peninsula population totaling over 40,000, including the ZIP codes of Kenai, Soldotna, and Sterling
  - CPH is owned by KPB, which leases CPH facility and operations to Central Peninsula General Hospital, Inc., a private, nonprofit corporation governed by an appointed 11-member volunteer board
  - The Central Kenai Peninsula Hospital Service Area Advisory Board advises the KPB assembly on healthcare-related activity within the Central Peninsula Health Service Area and provides minimal annual property tax support (0.01% Mill rate) to CPH
- **South Peninsula Hospital (SPH)**
  - SPH, located in Homer, AK, is a 22-bed Critical Access Hospital (CAH), serving a much smaller portion of the Kenai Peninsula population totaling approximately 13,500, including the ZIP codes of Homer and Anchor Point
  - SPH is owned by KPB, which leases SPH facility and operations to South Peninsula Hospital, Inc., a private, nonprofit corporation governed by an appointed nine-member volunteer board
  - The South Kenai Peninsula Hospital Service Area Advisory Board advises the KPB assembly on healthcare-related activity within the South Peninsula Health Service Area and provides annual property tax support (2.3% Mill rate) to SPH of approximately $3.8M

Overview (continued)

- **Providence Seward Medical and Care Center (PSMC)**
  - PSMC, located in Seward, AK, is a six-bed Critical Access Hospital (CAH) with separate skilled nursing facility, serving a Kenai Peninsula population totaling approximately 5,000 comprised primarily of the Seward ZIP code
  - PSMC is owned by the City of Seward, which leases PSMC facility and operations to Providence Health and Services (PHS), a Washington nonprofit corporation with affiliated facilities throughout AK including Anchorage, Valdez, Kodiak Island
  - Under the operating agreement, PHS manages PSMC while all financial risk and rewards from the operations remain with the City
  - The KPB's health-related powers do not extend to PSMC since Seward is not geographically located within either of the two hospital service areas

Overview (continued)

- **Healthcare Reform**
  - Healthcare reform was passed in 2010 and upheld by the U.S. Supreme Court in 2012 and 2015
    - With a majority of significant provisions, such as payment system reforms, insurance reforms, and delivery-system reforms currently being implemented, the healthcare industry is moving rapidly to address future market changes including:
      - Payment systems transitioning from volume-based to value- and population-based
      - Quality/patient safety as a new driver of hospital market share
      - Payment cuts that are real, forcing increased efficiency
    - Rural hospitals must position themselves for the new market-based competitive environment through sound financial and operational management, adoption of technology, pursuit of high quality care, alignment with primary care providers, and development of future affiliation strategies
- **Recommendations**
  - Recommendations in this report are made in the context of best positioning CPH, SPH, and PSMC for the rapidly evolving healthcare market

Engagement Purpose and Methodology

- **Purpose**
  - To conduct an assessment of the KPB's current health system that considers available resources, structure and market dynamics
  - To develop a broad understanding of strategic options (ranging from preservation of the status quo to privatization), needs, goals, and constraints
    - Governance
    - Management
  - To identify operating cost savings and revenue improvement potential at each hospital and available through consolidation/operational integration of the hospitals
  - To assist the Health Care Task Force in reaching consensus on the optimal health system strategy that best positions the KPB for long-term sustainability

Engagement Purpose and Methodology (cont.)

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- **Approach and Methodology**
  - Gather and review pertinent financial data
    - Current and historical financial statements
    - Most recently filed cost report
    - Hospital inpatient and outpatient volume statistics
  - Conduct intensive three-day site visit
    - Interview CEO, CFO, and leadership team
    - Service area and operating Board members
    - Community stakeholders
    - Physicians
  - Prepare report and options for consideration
  - Conduct community feedback forums at Soldotna, Homer and Seward
  - Conduct onsite, facilitated discussion with taskforce to develop preferred option
    - Present preferred options to local communities
  - Final Report and Recommendations

Engagement Milestone Overview

Milestone	Status
• Project organization and data request	Complete
• Conduct analyses examining demographic trends, provider needs, and high-level performance of CPH, SPH and PSMC	Complete
• Stakeholder interviews with Board, executive leadership, physicians, borough leadership and community members of CPH, SPH and PSMC	Complete
• Identify and develop alternate health system delivery models and strategies	Targeted for week of March 28th
• Conduct financial projection of current operating model to better understand risks of maintaining status quo	Targeted for week of March 28th
• Task Force planning session to review findings and identify optimal strategy	Targeted for week of March 28th

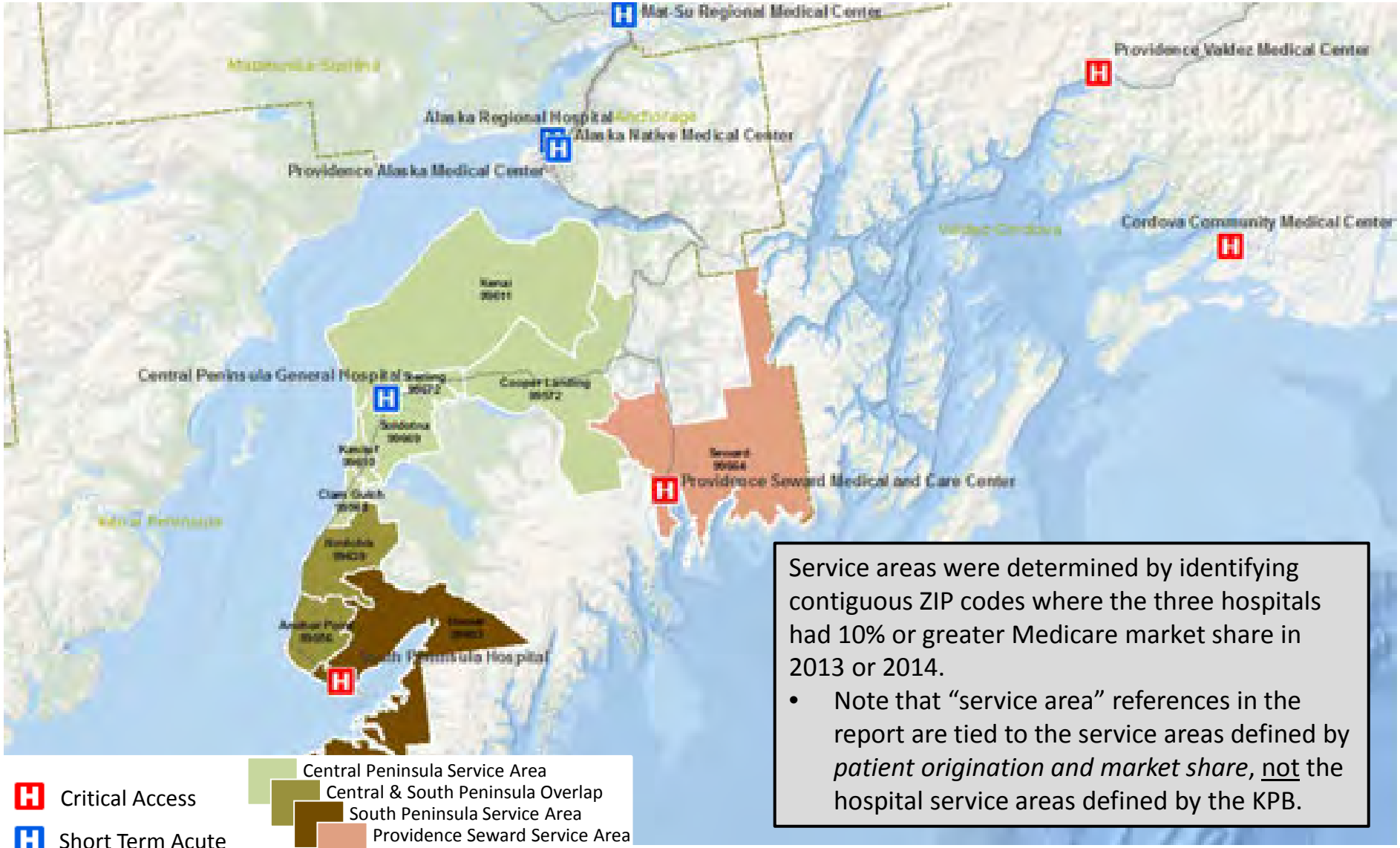
Service Area

central peninsula hospital

Providence Seward Medical & Care Center

South Peninsula Hospital

Service Area Overview



Service areas were determined by identifying contiguous ZIP codes where the three hospitals had 10% or greater Medicare market share in 2013 or 2014.

- Note that "service area" references in the report are tied to the service areas defined by *patient origination and market share*, not the hospital service areas defined by the KPB.

Service Area Population - CPH

2015 Population

Central Peninsula		00-17	18-44	45-64	65+	Total	%of PSA
99611	Kenai	3,989	5,437	4,426	1,853	15,705	38%
99669	Soldotna	3,671	4,871	4,520	2,305	15,367	37%
99672	Sterling	683	1,026	1,154	545	3,408	8%
99556	Anchor Point	528	701	920	447	2,596	6%
99610	Kasilof	402	578	818	354	2,152	5%
99639	Ninilchik	194	267	487	268	1,216	3%
99568	Clam Gulch	81	114	159	72	426	1%
99572	Cooper Landing	52	83	109	77	321	1%
	Total	9,600	13,077	12,593	5,921	41,191	100%

2015 2020 Change

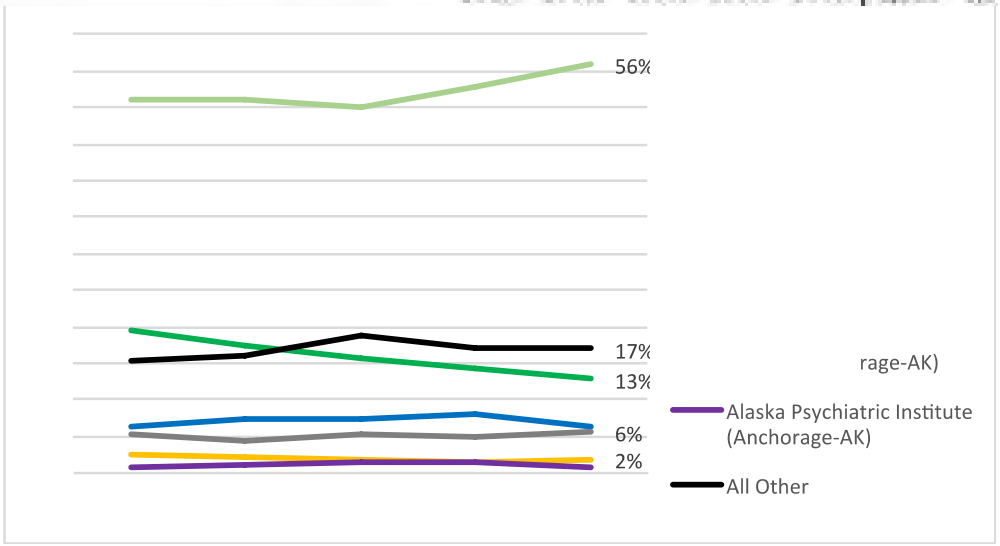
Central Peninsula		2015 Estimate	2020 Projection	% Change	Ab. Change
99611	Kenai	15,705	16,084	2%	379
99669	Soldotna	15,367	16,263	6%	896
99672	Sterling	3,408	3,636	7%	228
99556	Anchor Point	2,596	2,680	3%	84
99610	Kasilof	2,152	2,280	6%	128
99639	Ninilchik	1,216	1,295	6%	79
99568	Clam Gulch	426	454	7%	28
99572	Cooper Landing	321	323	1%	2
	Total	41,191	43,015	4%	1,824

Central	2015	2020	Absolute	Percent	Share of
00-17	9,600	9,796	196	2%	9%
18-44	13,077	13,597	520	4%	23%
45-64	12,593	12,201	-392	-3%	0%
65+	5,921	7,421	1,500	25%	68%
Total	41,191	43,015	1,824	4%	100%

- The service area has an estimated 2015 population of 41,191
- Over the next five years the area is expected to increase by 4%, gaining an estimated 1,824 people
- The 65+ age cohort is expected to see 25% growth over the next five years, gaining 1,500 people and making up 68% of all growth in the service area
- The Kenai Peninsula is a popular tourist destination that experiences a population surge during summer months.

Service Area Medicare Market Share - CPH

Central Peninsula	Medicare Market Share					Medicare Cases				
Facility	2010	2011	2012	2013	2014	2010	2011	2012	2013	2014
Central Peninsula General Hospital (Soldotna-AK)	51%	51%	50%	53%	56%	678	687	630	733	830
Providence Alaska Medical Center (Anchorage-AK)	20%	17%	16%	14%	13%	260	234	197	197	190
Alaska Regional Hospital (Anchorage-AK)	6%	7%	7%	8%	6%	82	99	94	111	93
South Peninsula Hospital (Homer-AK)	5%	4%	5%	5%	6%	69	59	65	69	83
Alaska Native Medical Center (Anchorage-AK)	2%	2%	2%	1%	2%	32	27	25	19	28
Alaska Psychiatric Institute (Anchorage-AK)	1%	1%	1%	1%	1%	11	15	17	18	11
All Other	15%	16%	19%	17%	17%	197	220	234	239	249
Grand Total	100%	100%	100%	100%	100%	1,329	1,341	1,262	1,386	1,484



Source: Medicare datafiles

- From 2010 to 2014, CPH has gained five percentage points in Medicare market share for the service area as a direct result of taking market share from Providence in Anchorage
- No other competitors have made inroads into the CPH service area

Market Service Area - CPH

- **Market Service Area**
  - To plan for needed services and to avoid developing excess capacity, total population of the service area is adjusted down based on the market and service area analysis
  - Current adjusted market service area, as defined below, is 38,506; this is based on 2015 population estimates and is projected to increase 4% over the next five years with the 2020 estimate being 40,224

Primary Service Area	Zip Code	Actual Population	Market Discharges	CPGH Discharges	CPGH Market Share	Hospital Service Area	Care Service Area	Service Area Weighting*	Weighted Population	Population Growth	Service Area Population
Kenai	99611	15,705	491	313	64%	Soldotna	Soldotna	100%	15,705	2%	16,084
Soldotna	99669	15,367	589	350	59%	Soldotna	Soldotna	100%	15,367	6%	16,263
Sterling	99672	3,408	158	102	65%	Soldotna	Soldotna	100%	3,408	7%	3,636
Anchor Point	99556	2,596	129	13	10%	Homer	Homer	20%	519	3%	536
Kasilof	99610	2,152	84	52	62%	Soldotna	Soldotna	100%	2,152	6%	2,280
Ninilchik	99639	1,216	60	23	38%	Soldotna	Soldotna	50%	608	6%	648
Clam Gulch	99568	426	10	5	50%	Soldotna	Soldotna	100%	426	7%	454
Cooper Landing	99572	321	21	5	24%	Soldotna	Anchorage	100%	321	1%	323
PSA Total		41,191	1,542	863	56%			93%	38,506	4%	40,224
Weighted Service Area		**41,191**	**1,542**	**863**	**56%**	-	-	**93%**	**38,506**	**4%**	**40,224**

  - Quantitative: Inpatient Medicare market share
  - Qualitative: Hospital Service Area (Dartmouth), Primary Care Service Area (Dartmouth), proximity of competitors, services offered at CPH, and field experience of Stroudwater consultants

Sources: Truven Health Analytics (Population)
CMS (IP Discharges)

Market Service Area - CPH

- **Market Service Area Conclusions**
  - With a 2015 adjusted service area population of 38,506, CPH has a significant population base to support a rural community hospital
  - 4% growth in total service area, comprised primarily from 25% growth in 65+ age cohort (primary users of rural hospitals) provides continued opportunity for CPH
  - CPH had 2014 Medicare inpatient service area market share of 56%, which has increased by 5% from 2010 with nearly all gains taken from Anchorage-based competitors
    - No other competitor making significant inroads into the CPH service area

Service Area Population - SPH

2015 Population

South Peninsula		00-17	18-44	45-64	65+	Total	%of PSA
99603	Homer	2,416	3,183	3,389	1,638	10,626	74%
99556	Anchor Point	528	701	920	447	2,596	18%
99639	Ninilchik	194	267	487	268	1,216	8%
	Total	3,138	4,151	4,796	2,353	14,438	100%

2015 2020 Change

South Peninsula		2015 Estimate	2020 Projection	% Change	Ab. Change
99603	Homer	10,626	11,057	4%	431
99556	Anchor Point	2,596	2,680	3%	84
99639	Ninilchik	1,216	1,295	6%	79
	Total	14,438	15,032	4%	594

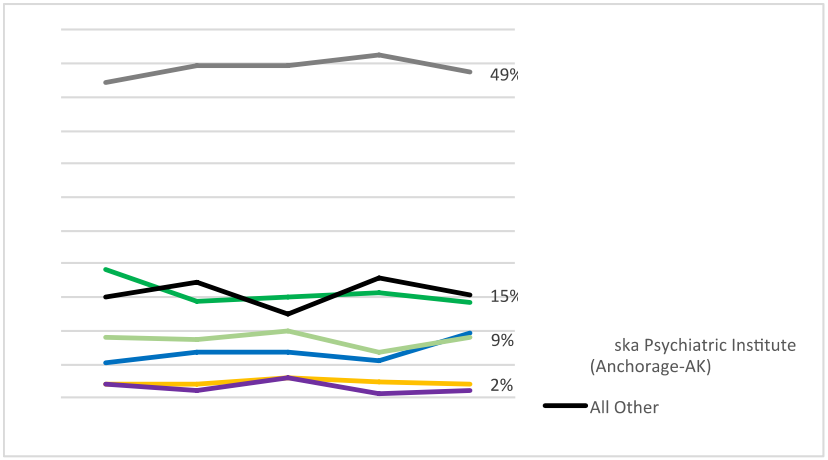
Overlapping ZIP codes

South Peninsula	2015 Estimate	2020 Projection	Absolute Change	Percent Change	Share of Growth
00-17	3,138	3,183	45	1%	5%
18-44	4,151	4,388	237	6%	28%
45-64	4,796	4,531	-265	-6%	0%
65+	2,353	2,930	577	25%	67%
Total	14,438	15,032	594	4%	100%

- The service area had an estimated 2015 population of 14,438
- Over the next five years, the area is expected to increase by 4%, gaining an estimated 594 people
- The 65+ age cohort is expected to see 25% growth over the next five years, gaining 577 people and making up 67% of all growth in the service area
- The Kenai Peninsula is a popular tourist destination that experiences a population surge during summer months.

Service Area Medicare Market Share - SPH

South Peninsula	Medicare Market Share					Medicare Cases				
Facility	2010	2011	2012	2013	2014	2010	2011	2012	2013	2014
South Peninsula Hospital (Homer-AK)	47%	50%	50%	51%	49%	222	254	259	282	253
Providence Alaska Medical Center (Anchorage-AK)	19%	14%	15%	16%	14%	91	74	78	87	74
Alaska Regional Hospital (Anchorage-AK)	5%	7%	7%	6%	10%	24	35	35	31	50
Central Peninsula General Hospital (Soldotna-AK)	9%	9%	10%	7%	9%	43	44	52	37	46
Alaska Native Medical Center (Anchorage-AK)	2%	2%	3%	2%	2%	10	10	16	12	11
Alaska Psychiatric Institute (Anchorage-AK)	2%	1%	3%	1%	1%	9	6	15	3	5
All Other	15%	17%	12%	18%	15%	72	88	65	99	81
Grand Total	100%	100%	100%	100%	100%	471	511	520	551	520



Source: Medicare datafiles

- 49% SPH Medicare market share is significant relative to peer CAHs
- From 2010 to 2014, SPH has gained two percentage points in Medicare market share for the service area as a direct result of taking market share from Providence in Anchorage
- Alaska Regional in Anchorage has increased Medicare market share from 5% to 10% between 2010 and 2014 while CPH has remained relatively constant at 9%
  - Indicative of current lack of referrals between SPH and CPH

Market Service Area - SPH

- **Market Service Area**
  - To plan for needed services and to avoid developing excess capacity, total population of the service area is adjusted down based on the market and service area analysis
  - Current adjusted market service area, as defined below, is 13,311; this is based on 2015 population estimates and is projected to increase 4% over the next five years with the 2020 estimate being 13,849

Primary Service Area	Zip Code	2015 Actual Population	2014 CMS Market Discharges	2014 CMS SPH Discharges	2014 CMS SPH Market Share	Inpatient Hospital Service Area	Primary Care Service Area	Market Service Area Weighting*	2015 Weighted Population	2015-2020 Population Growth	2020 Est. Service Area Population
Homer	99603	10,626	345	185	54%	Homer	Homer	100%	10,626	4%	11,057
Anchor Point	99556	2,596	129	63	49%	Homer	Homer	80%	2,077	3%	2,144
Ninilchik	99639	1,216	60	14	23%	Soldotna	Soldotna	50%	608	6%	648
PSA Total		14,438	534	262	49%			92%	13,311	4%	13,849
Weighted Service Area		**14,438**	**534**	**262**	**49%**	-	-	**92%**	**13,311**	**4%**	**13,849**

  - Quantitative: Inpatient Medicare market share
  - Qualitative: Hospital Service Area (Dartmouth), Primary Care Service Area (Dartmouth), proximity of competitors, services offered at SPH, and field experience of Stroudwater consultants

Sources: Truven Health Analytics (Population)
CMS (IP Discharges)

Market Service Area - SPH

- **Market Service Area Conclusions**
  - With a 2015 adjusted service area population of 13,311, SPH has a reasonable population base to support a rural community hospital
  - 4% growth in total service area, comprised primarily from 25% growth in 65+ age cohort (primary users of rural hospitals) provides continued opportunity for SPH
  - SPH had 2014 Medicare inpatient service area market share of 49%, which has increased by 2% from 2010, and represents a significant market share relative to peer CAHs
    - Alaska Regional Hospital has doubled its Medicare inpatient market share from 5% to 10%

Service Area Population - PSMC

Providence Seward		2015 Population 00-17	18-44	45-64	65+	Total	%of PSA
99664	Seward	893	1,856	1,556	533	4,838	100%
	Total	893	1,856	1,556	533	4,838	100%

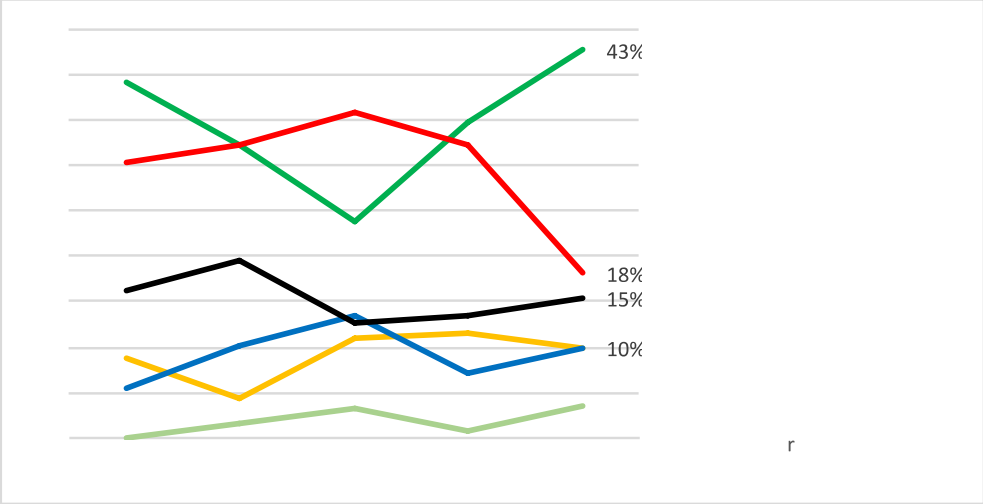
Providence Seward		2015 2020 Change 2015 Estimate	2020 Projection	% Change	Ab. Change
99664	Seward	4,838	4,887	1%	49
	Total	4,838	4,887	1%	49

Providence Seward	2015 Estimate	2020 Projection	Absolute Change	Percent Change	Share of Growth
00-17	893	944	51	6%	23%
18-44	1,856	1,798	-58	-3%	0%
45-64	1,556	1,443	-113	-7%	0%
65+	533	702	169	32%	77%
Total	4,838	4,887	49	1%	100%

- The service area had an estimated 2015 population of 4,838
- Over the next five years the area is expected to increase by 1%, gaining an estimated 49 people
- The 65+ age cohort is expected to see 32% growth over the next five years, gaining 169 people and making up 77% of all growth in the service area
- The Kenai Peninsula is a popular tourist destination that experiences a population surge during summer months.

Service Area Medicare Market Share - PSMC

Providence Seward	Medicare Market Share					Medicare Cases				
Facility	2010	2011	2012	2013	2014	2010	2011	2012	2013	2014
Providence Alaska Medical Center (Anchorage-AK)	39%	32%	24%	35%	43%	36	38	30	39	47
Providence Seward Medical (Seward-AK)	30%	32%	36%	32%	18%	28	38	45	36	20
Alaska Native Medical Center (Anchorage-AK)	9%	4%	11%	12%	10%	8	5	14	13	11
Alaska Regional Hospital (Anchorage-AK)	5%	10%	13%	7%	10%	5	12	17	8	11
Central Peninsula General Hospital (Soldotna-AK)	0%	2%	3%	1%	4%		2	4	1	4
Louisiana Medical Center (Lacombe-LA)	0%	0%	0%	1%	3%				1	3
All Other	16%	20%	13%	12%	13%	15	23	16	14	14
Grand Total	100%	100%	100%	100%	100%	92	118	126	112	110



Source: Medicare datafiles

- From 2010 to 2014, PSMC has lost 12 percentage points in Medicare market share for the service area to system affiliate Providence Anchorage (4 percentage points) and competitor Alaska Regional in Anchorage (5 percentage points)

Market Service Area - PSMC

- **Market Service Area**
  - To plan for needed services and to avoid developing excess capacity, total population of the service area is adjusted down based on the market and service area analysis
  - Current adjusted market service area, as defined below, is 4,838; this is based on 2015 population estimates and is projected to increase 1% over the next five years with the 2020 estimate being 4,887

Primary Service Area	Zip Code	2015 Actual Population	2014 CMS Market Discharges	2014 CMS PSM Discharges	2014 CMS PSM Market Share	Inpatient Hospital Service Area	Primary Care Service Area	Market Service Area Weighting*	2015 Weighted Population	2015-2020 Population Growth	2020 Est. Service Area Population
Seward	99664	4,838	110	20	18%	Seward	Seward	100%	4,838	1%	4,887
PSA Total		4,838	110	20	18%			100%	4,838	1%	4,887
Weighted Service Area		**4,838**	**110**	**20**	**18%**	-	-	**100%**	**4,838**	**1%**	**4,887**

  - Quantitative: Inpatient Medicare market share
  - Qualitative: Hospital Service Area (Dartmouth), Primary Care Service Area (Dartmouth), proximity of competitors, services offered at PSMC, and field experience of Stroudwater consultants

Sources: Truven Health Analytics (Population)
CMS (IP Discharges)

Market Service Area - PSMC

- **Market Service Area Conclusions**
  - With a 2015 adjusted service area population of 4,838, PSMC has a very small population base to support a rural community hospital
  - 1% growth in total service area, comprised primarily from 32% growth in 65+ age cohort (primary users of rural hospitals) provides opportunity for PSMC
  - PSMC had 2014 Medicare inpatient service area market share of 18%, which has decreased by 12% from 2010, and represents an opportunity for growth, in partnership with Providence Anchorage
    - Alaska Regional Hospital has doubled its Medicare inpatient market share from 5% to 10%

Combined Population

		2015 Population						2015 2020 Change			
Combined		00-17	18-44	45-64	65+	Total	%ofTotal	2015 Estimate	2020 Projection	% Change	Ab. Change
99611	Kenai	3,989	5,437	4,426	1,853	15,705	28%	15,705	16,084	2%	379
99669	Soldotna	3,671	4,871	4,520	2,305	15,367	27%	15,367	16,263	6%	896
99603	Homer	2,416	3,183	3,389	1,638	10,626	19%	10,626	11,057	4%	431
99664	Seward	893	1,856	1,556	533	4,838	9%	4,838	4,887	1%	49
99672	Sterling	683	1,026	1,154	545	3,408	6%	3,408	3,636	7%	228
99556	Anchor Point	528	701	920	447	2,596	5%	2,596	2,680	3%	84
99610	Kasilof	402	578	818	354	2,152	4%	2,152	2,280	6%	128
99639	Ninilchik	194	267	487	268	1,216	2%	1,216	1,295	6%	79
99568	Clam Gulch	81	114	159	72	426	1%	426	454	7%	28
99572	Cooper Landing	52	83	109	77	321	1%	321	323	1%	2
	Total	12,909	18,116	17,538	8,092	56,655	100%	56,655	58,959	4%	2,304

- The combined, non-duplicated population of the Kenai Peninsula was approximately 56,655 in 2015
  - This is expected to grow by 4% (2,304 people) over the next five years to an estimate of nearly 60,000

Market Service Area - Combined

- **Market Service Area Conclusions**
  - Although CPH, SPH, and PSMC are all located on the Kenai Borough, they serve separate and distinct markets within the Borough; only two service area ZIP codes are shared between CPH and SPH and none are shared with PSMC
  - CPH and SPH service areas each have a large enough population to support a rural hospital, while PSMC has a limited service area population
    - Partnership with Providence – Anchorage provides necessary support to reduce negative impact of limited service area
  - Interviews with stakeholders across the Borough reinforce the conclusion that Soldotna, Homer, and Seward are distinct communities with limited commercial overlap

Financial Summary

- Individual Hospital Performance
- Financial Projections

central peninsula hospital

Providence Seward Medical & Care Center

South Peninsula Hospital

Financial Summary – CPH

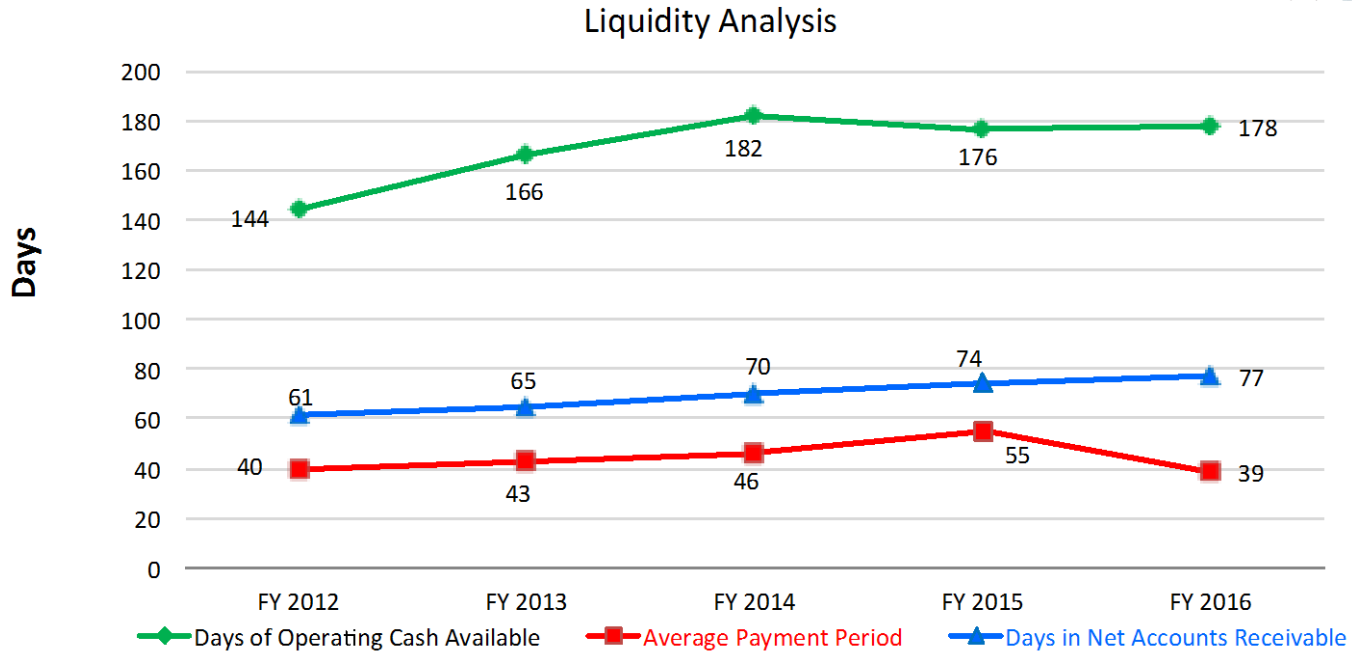
STROUDWATER

	FY 2012 Year Ended 6/30/12	FY 2013 Year Ended 6/30/13	FY 2014 Year Ended 6/30/14	FY 2015 Year Ended 6/30/15	FY 2016 7 - mos. Ann YTD 2016
Operating Revenue:					
Gross Patient Revenue	$ 194,651	$ 215,314	$ 230,595	$ 269,213	$ 300,634
Contractual Allowances	(65,854)	(76,191)	(87,732)	(111,607)	(126,233)
Bad Debt	(9,094)	(9,941)	(11,597)	(12,812)	(11,467)
Charity Care	(7,050)	(9,032)	(8,881)	(6,296)	(7,582)
Net Patient Revenue	112,652	120,151	122,384	138,498	155,352
Other Operating Revenue	4,198	3,801	4,329	5,511	4,509
Plus - KPB Property Taxes	92	95	96	49	-
Total Operating Revenue	116,941	124,046	126,810	144,058	159,861
Operating Expenses:					
Salaries, Wages and Benefits	65,656	66,075	67,176	74,618	79,219
Supplies and Other	20,555	22,272	23,088	26,250	38,726
Prof. Fees and Purchased Services	13,045	13,900	14,100	16,199	5,522
Interest	1,104	1,219	962	969	1,150
Depreciation	8,005	7,959	8,067	8,472	8,937
Total Operating Expense	108,365	111,425	113,393	126,508	133,553
Income (Loss) from Operations	8,577	12,621	13,417	17,549	26,307
Non-Operating Income (Expense)	204	(417)	(205)	(380)	(279)
Capital Contributions	53	2,005	15	7	-
Net Income (Loss)	$ 8,833	$ 14,209	$ 13,227	$ 17,177	$ 26,028
Cash and Investments, End of Period	$ 39,225	$ 46,521	$ 51,956	$ 56,477	$ 60,127
AP and Accrued Liabilities	$ 10,878	$ 12,047	$ 13,254	$ 17,609	$ 13,028
Days of Operating Cash Available	144.2	166.1	181.7	176.1	177.8
Average Payment Period	40.0	43.0	46.4	54.9	38.5
Days in Net Accounts Receivable	61.3	64.9	70.2	74.3	77.1

Profitability Analysis - CPH

- **Operating Revenues** have increased in each fiscal year as a result of continued growth in services (surgery, ER, inpatient, outpatient, etc.), addition of new services (foot and ankle clinic, urology clinic, outpatient imaging facility, etc.), and annual charge increases
- **Operating Expenses** have been increasing primarily to support new and growing services as well as annual cost increases

Liquidity Analysis - CPH



- **Days Cash/Investments on Hand** has increased from 144 to 178 between FY 2012 and FY 2016 as a direct result of continuing profitability, offset by investments in property, plant and equipment
  - 178 Days Cash/Investments on Hand compares favorably to rural hospital standards of 75
- **Average Payment Period** had increased between FY 2012 and FY 2015 and then declined to rural hospital best practices of 40 days for FY 2016
- **Days in Net Accounts Receivable (AR)** have increased from 61 days in 2012 to 77 days in 2016 due primarily to increasing patient co-insurance amounts slowing total cash received; this represents an opportunity for improvement
  - Best practice rural hospitals target 45 Days in both net and gross AR

Financial Statement – CPH Opportunities

- **Opportunities -** While CPH's financial performance is at best practice levels, there are opportunities to continue to improve profitability as discussed during onsite visit, including:
  - 340B Drug Pricing Program
    - Findings: CPH currently generates over 50,000 provider based clinic visits. To the extent CPH is eligible to participate in the 340B program, peer rural hospitals have generated increased revenue of between $350K and $450K per 10,000 clinic visits related to contracted retail pharmacy provision of the 340B program.
    - Recommendation: Evaluate opportunities to meet 340B criteria for participation and consider embracing the program as a strategic priority leading to continued improved financial performance.
  - Swing Bed Program
    - Findings: CPH maintained a swing bed average daily census of 2.6 during FY 2015. The swing bed program offers an opportunity to generate additional services and increase the aggregate cost-based payer mix of the organization because Medicare pays CPH based on a cost basis for inpatient services under the Rural Demonstration program.
    - Recommendation: Continue to develop the swing bed program targeting a minimum average daily census of four.

Financial Statement – CPH Opportunities

- **Opportunities (continued)**
  - Medicare Cost Report – Nursing Administration (NA)
    - Findings: CPH allocates house supervisor costs to nursing administration, which through the cost report, is allocated to a number of revenue-producing departments. Peer rural hospitals generally allocate only the CNO and related support staff to NA, while directly charging house supervisors to departments
    - Recommendation: Consider directly classifying house supervisor costs to the inpatient units, using time studies if necessary, to charge time to ancillary departments
  - Medicare Cost Report – Medicare Outpatient Bad Debts
    - Findings: CPH reports only $50K of Medicare Bad Debts on $2.1M of outpatient co-insurance and deductibles. Peer rural hospitals that actively manage bad debt often report between 10%-20% of deductibles and co-insurance as bad debt, which is then reimbursed at 65% of charges.
    - Recommendation: Evaluate process to ensure bad debts are returned from collection agency within reasonable time period, deemed worthless, and the Medicare portion placed on the cost report for reimbursement. CPH should target between 10% and 20% of co-insurance and deductibles as Medicare reportable bad debt.

Financial Statement Conditions - CPH

- **Overall Condition**
  - CPH's operating margin is at best practice for rural hospitals and is projected to increase with continued growth in services at rates faster than expense growth
  - Liquidity has remained at rural hospital best practices with Days Cash/Investments significantly above peers and Average Payment Period at rural hospital standards
    - Opportunity to target improvement in revenue cycle functions to reduce Days Revenue in AR to rural hospital best practices of 45 days
- **Conclusions and Recommendations**
  - Best-practice rural hospital performance from margin and liquidity perspective has been achieved and should continue to be targeted
  - Additional opportunities as presented should add to best-practice financial performance and allow CPH the flexibility to begin transitioning to emerging value-based payment systems

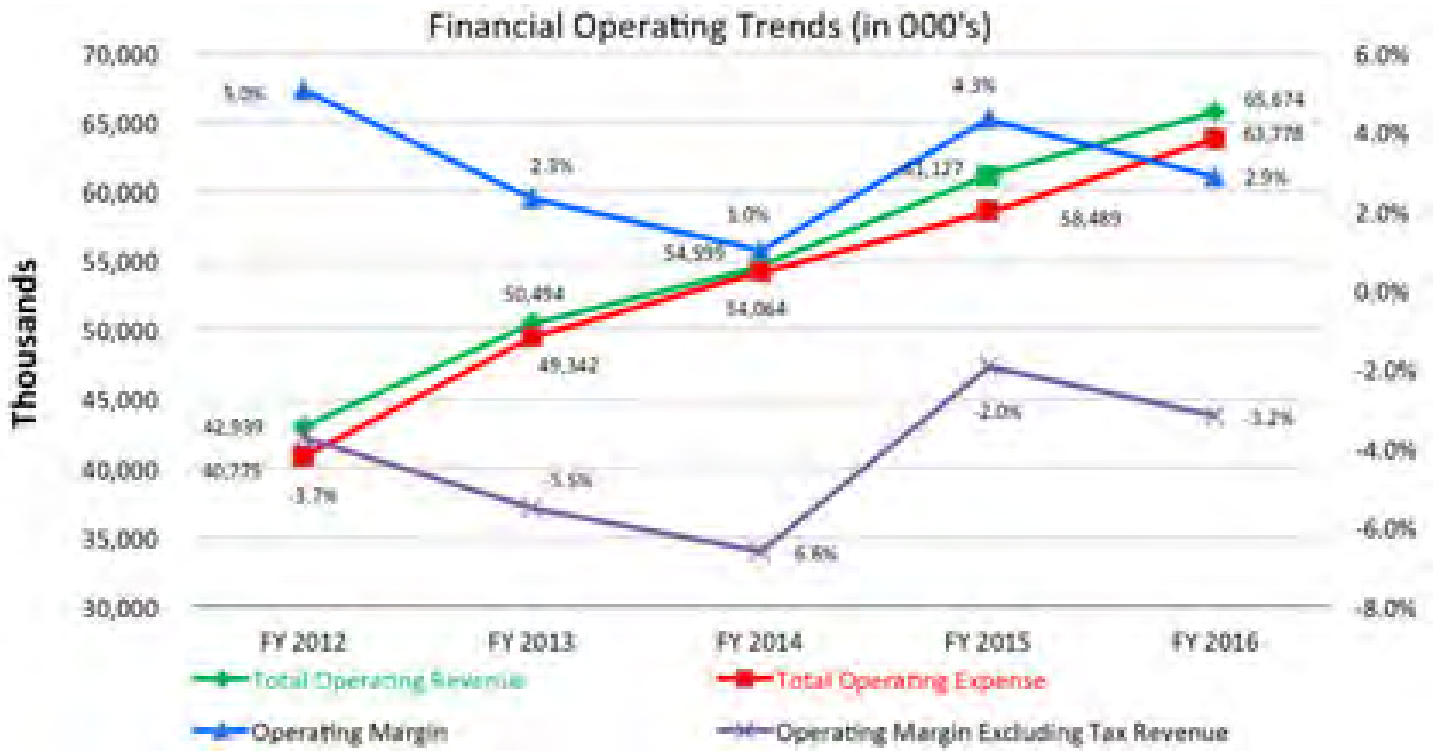
Financial Summary – SPH

STROUDWATER

	FY 2012 Year Ended 6/30/12	FY 2013 Year Ended 6/30/13	FY 2014 Year Ended 6/30/14	FY 2015 Year Ended 6/30/15	FY 2016 7 - mos. Ann YTD 2016
Operating Revenue:					
Gross Patient Revenue	$ 52,886	$ 66,977	$ 72,691	$ 84,809	$ 91,577
Contractual Allowances	(10,678)	(17,429)	(18,585)	(23,984)	(25,656)
Bad Debt	(2,032)	(2,360)	(2,921)	(2,334)	(2,688)
Charity Care	(1,042)	(1,250)	(1,360)	(1,460)	(1,771)
Net Patient Revenue	39,134	45,939	49,824	57,032	61,462
Other Operating Revenue	173	811	875	338	339
Plus - KPB Property Taxes	3,631	3,744	3,900	3,757	3,873
Total Operating Revenue	42,939	50,494	54,599	61,127	65,674
Operating Expenses:					
Salaries, Wages and Benefits	23,452	30,198	34,044	37,127	38,494
Supplies and Other	8,392	10,266	10,577	11,223	12,723
Prof. Fees and Purchased Services	5,215	5,352	5,546	6,316	8,637
Interest	800	817	822	795	763
Depreciation	2,916	2,709	3,076	3,028	3,161
Total Operating Expense	40,775	49,342	54,064	58,489	63,778
Operating Income	2,164	1,152	535	2,638	1,896
Operating Income (Loss) Excluding Taxes	(1,467)	(2,592)	(3,365)	(1,120)	(1,977)
Non-Operating Income (Expense)	82	233	243	33	(2)
Net Income (Loss)	$ 2,246	$ 1,385	$ 777	$ 2,671	$ 1,894
Net Income (Loss) Excluding Taxes	$ (1,385)	$ (2,359)	$ (3,122)	$ (1,088)	$ (1,978)
Cash and Investments, End of Period	$ 7,531	$ 6,304	$ 7,479	$ 12,730	$ 11,941
AP and Accrued Liabilities	$ 3,805	$ 5,539	$ 5,033	$ 5,881	$ 5,334
Days of Operating Cash Available	74.2	50.2	54.4	85.0	72.8
Average Payment Period	37.5	44.1	36.6	39.3	32.5
Days in Net Accounts Receivable	70.8	88.5	92.7	74.1	71.9

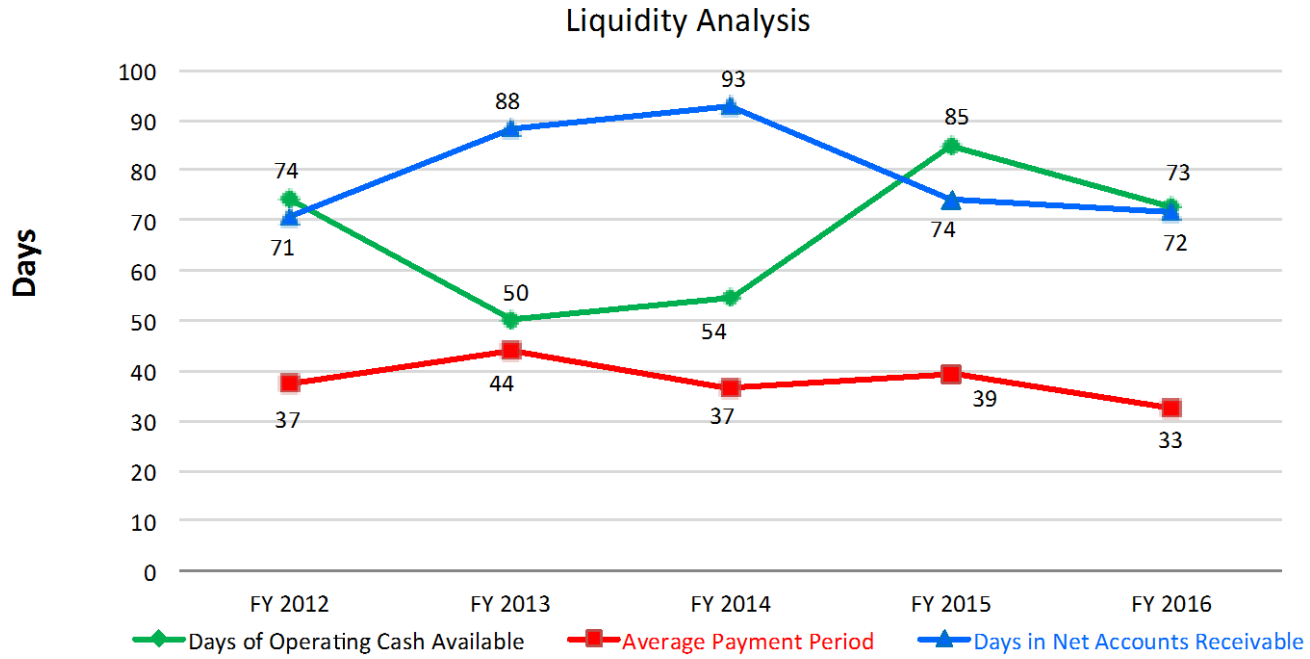
Note: KPB annual property taxes of approximately $3.8M are included as operating revenues

Profitability Analysis – SPH



- **Operating Revenues** have increased in each fiscal year as a result of continued growth in services (inpatient [including swing bed], surgery, imaging, etc.), addition of new services (primary care clinics, addiction clinic, additional visiting specialists, etc.), annual charge increases, and annual cost increases
- **Operating Expenses** have been increasing primarily to support new and growing services, the purchase of medical office building during FY 2016, and annual cost increases
- **Operating Margin** has remained positive throughout the period but is negative without KPB property taxes

Liquidity Analysis – SPH



- **Days Cash/Investments on Hand** had increased in FY 2015 with improved profitability and then declined in FY 2016 with purchase of Medical Office Building
  - 73 Days Cash/Investments on Hand compares reasonably well to rural hospital standards of 75
- **Average Payment Period** has remained relatively consistent between FY 2012 and FY 2015 at rural hospital best practices of less than 40 days
- **Days in Net Accounts Receivable (AR)** have decreased from 93 days in 2014 to 72 days in 2016 due primarily to improving functionality after EHR conversion, but continue to represent an opportunity for improvement
  - Best practice rural hospitals target 45 days in both net and gross AR

Financial Statement – SPH Opportunities

- **Opportunities -** While SPH's operating margin has been positive when including the KPB property taxes, there are opportunities to continue to improve profitability as discussed during onsite visit, including:
  - 340B Drug Pricing Program
    - Findings: SPH currently generates over 22,000 provider-based clinic visits. Peer rural hospitals have generated increased revenue of between $350K and $450K per 10,000 clinic visits related to contracted retail pharmacy provision of the 340B program
    - Recommendation: Embrace the 340B program as a strategic priority targeting $800K of improvement with full adoption of the contracted retail pharmacy provisions.
  - Medicare Cost Report – Emergency Room (ER) Standby Time
    - Findings: During FY 2015, SPH reported an average 90 minutes of ER physician professional time per ER patient visit, resulting in $1.1M of ER physicians costs being removed from the cost report as "professional costs." Peer rural hospitals that perform accurate time studies often report less than 20 minutes of professional time for ER visit.
    - Recommendation: Evaluate process of ER provider time studies to ensure accurate capture of provider time that is considered professional, which should result in an additional $850K of allocate ER costs (assuming professional time is approximately 20 minutes per visit).

Financial Statement – SPH Opportunities

- **Opportunities (continued)**
  - Medicare Cost Report – Delivery Room and Labor Room
    - Findings: SPH maintains three Labor, Delivery, Recovery and Post-Partum (LDRP) rooms of which 100% of the costs and square feet are allocated to the Delivery/Labor Room ancillary department. Best practice CAHs only allocate costs to the Delivery/Labor Room ancillary department based on the percentage of time the mother is in active delivery relative to the total stay, allocating the remainder of the costs to the inpatient unit.
    - Recommendation: Consider accurately classifying inpatient costs from the labor/delivery room ancillary department to the inpatient unit based on time studies.
  - Medicare Cost Report – Medicare Outpatient Bad Debts
    - Findings: SPH reports only $149K of Medicare Bad Debts on $2.6M of outpatient co-insurance and deductibles. Peer rural hospitals that actively manage bad debt often report between 10%-20% of deductibles and co-insurance as bad debt, which is then reimbursed at 65% of charges.
    - Recommendation: Evaluate process to ensure bad debts are returned from collection agency within reasonable time period, deemed worthless, and the Medicare portion placed on the cost report for reimbursement. SPH should target between 10% and 20% of co-insurance and deductibles as Medicare reportable bad debt.

Financial Statement – SPH Opportunities

- **Opportunities (continued)**
  - Medicare Cost Report – Provider Administrative Time
    - Findings: SPH removes 100% of provider compensation related to the Homer Clinic physicians. Best practice CAHs often allocate a portion of provider compensation to Hospital Administration to the extent that the providers were engaged in hospital administrative responsibilities (Medical Director, Quality Committee activity, etc.).
    - Recommendation: To the extent that Homer Clinic providers are active in hospital administrative functions, perform time studies to accurately track and reflect these costs for cost report purposes.
  - Medicare Cost Report – Part A Home Health Visits
    - Findings: SPH reports only Medicare Part B visits and revenue for the home health agency. Peer rural hospitals generally report both Part A and Part B visits and revenue.
    - Recommendation: Ensure that Part A and Part B Home Health visits are being accurately billed and reported on the Medicare cost report.

Financial Statement Conditions – SPH

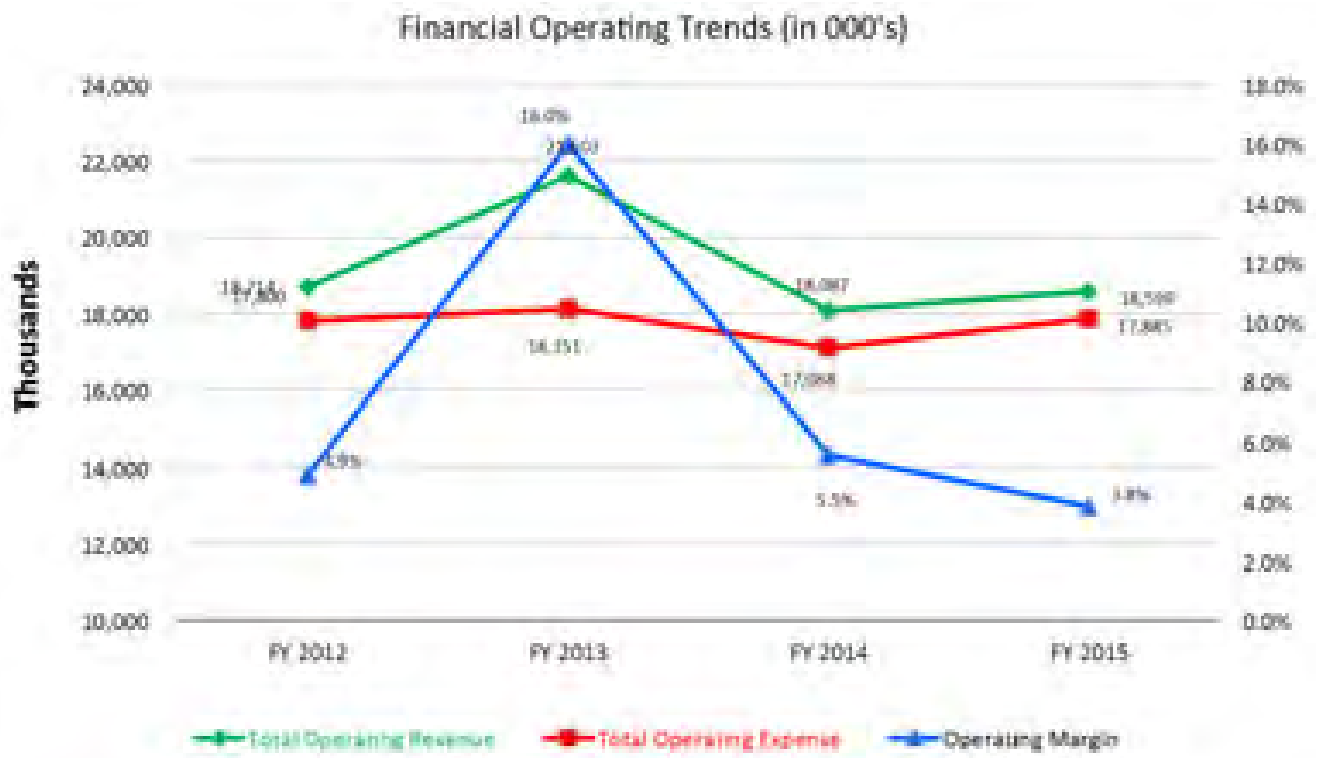
- **Overall Condition**
  - SPH's operating margin, including the KPB taxes, has been reasonably positive over last four years, but would be negative without the tax revenue
    - Continued opportunities to improve financial performance are provided, which would have a significant positive impact if implemented
  - Liquidity has remained at rural hospital standards with Days Cash/Investments and Average Payment Period at CAH peers
    - Opportunity to target improvement in revenue cycle functions to reduce Days Revenue in AR to rural hospital best practices of 45 days
- **Conclusions and Recommendations**
  - SPH has been able to achieve CAH rural hospital standard performance from margin and liquidity perspective
  - Additional opportunities as presented that should be adopted to reduce reliance on tax subsidy

Financial Summary - PSMC

STROUDWATER

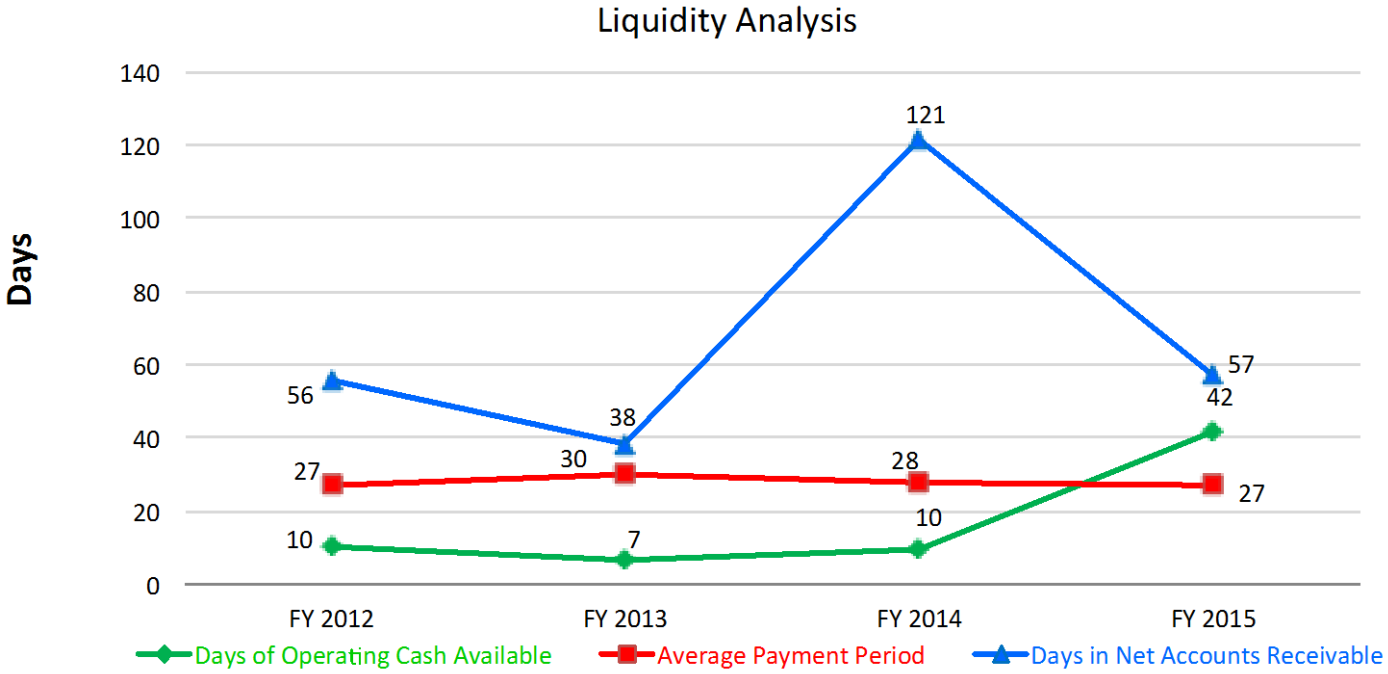
	FY 2012 Year Ended 12/31/12	FY 2013 Year Ended 12/31/13	FY 2014 Year Ended 12/31/14	FY 2015 11 - mos. Ann. YTD 2015
Operating Revenue:				
Gross Patient Revenue	$ 25,044	$ 25,192	$ 24,842	$ 26,146
Contractual Allowances	(6,017)	(2,770)	(5,368)	(5,776)
Bad Debt	(610)	(745)	(1,074)	(572)
Charity Care	(311)	(729)	(547)	(1,589)
Net Patient Revenue	18,106	20,948	17,853	18,209
Other Operating Revenue	608	655	234	390
Total Operating Revenue	18,714	21,603	18,087	18,599
Operating Expenses:				
Salaries, Wages and Benefits	11,959	11,851	11,399	11,984
Supplies and Other	1,779	2,316	1,878	1,867
Prof. Fees and Purchased Services	2,562	2,484	2,311	2,534
Interest (1)	500	500	500	500
Depreciation (1)	1,000	1,000	1,000	1,000
Total Operating Expense	17,800	18,151	17,088	17,885
Income (Loss) from Operations	914	3,452	999	714
Non-Operating Income (Expense)	31	4	1	0
Net Income (Loss)	$ 945	$ 3,456	$ 1,000	$ 714
(1) Interest and Depreciation embedded as allocated through system and not reflected on PSMC internal financial statements				
Cash and Investments, End of Period	$ 465	$ 298	$ 409	$ 1,881
AP and Accrued Liabilities	$ 1,215	$ 1,350	$ 1,180	$ 1,196
Days of Operating Cash Available	10.4	6.5	9.6	41.9
Average Payment Period	27.2	29.6	27.6	26.6
Days in Net Accounts Receivable	55.6	38.3	121.0	57.3

Profitability Analysis - PSMC



- **Operating Revenues** have remained relatively constant between FY 2012 and FY 2015 with exception of FY 2013, which was positively affected by a prior year settlement
- **Operating Expenses** have also remained relatively constant

Liquidity Analysis - PSMC



- **Days Cash/Investments on Hand** has increased from 10 to 42 between FY 2012 and FY 2015 as a direct result of continuing profitability, offset by investments in property, plant and equipment
- **Average Payment Period** had remained relatively constant between FY 2012 and FY 2015 at rural hospital standards of less than 40 days
- **Days in Net Accounts Receivable (AR)** had increased from 38 days in 2013 to 121 days in FY 2014 with the conversion to new IT system; currently being reduced back to targets below 45 days

Financial Statement Conditions - PSMC

- **Overall Condition**
  - PSMC's operating margin is somewhat inflated due to reporting of capital and home office costs through the cost report rather than financial statements, but outcome has been reasonable operating margin to fund improvement in liquidity
  - Liquidity has improved with operating margin and reduction of Days in AR
- **Conclusions and Recommendations**
  - Continue system relationship which has resulted in improved financial performance

Financial Summary

- Individual Hospital Performance
- Financial Projections

central peninsula hospital

Providence Seward Medical & Care Center

South Peninsula Hospital

Fee-for-Service Financial Model

- **Purpose**
  - Develop a 10-year regional trend of the impact of utilization changes on profitability and liquidity in the absence of major organizational restructuring
    - Status quo trended forward
      - Important to recognize that hospital management would take action to reduce losses and preserve cash when profitability declines
        - These actions are NOT factored into the analysis
    - Status quo financial model is not to be used for any other purpose than demonstrating a changing environment for use in this study
  - Directionality and magnitude given a changing healthcare environment
  - Assumption-based
  - Builds off most recent financial statements and cost reports for each of the three hospitals

Fee-for-Service Financial Model

- **Assumptions**
  - Utilization
    - Growth in population as projected by Truven
    - Transition of inpatient care to outpatient care
    - Growth in market share
    - Impact of commercial insurers steerage initiatives to lower cost locations (Lower 48)
  - Revenue
    - Commercial insurance price increases tied to chargemaster increases
    - Cost-based Medicare revenue for CAHs and for inpatient care of Rural Demonstration (CPH)
      - Medicare price increase for non cost-based payment based on ACA formulas
    - Medicaid price decrease projected as a result of state budget deficit
    - Projected decline in commercial payer mix as premiums continue to escalate
      - Related increase in self-pay and Medicaid payer mix
    - Other operating revenue growth in first several years to reflect improvement opportunities
    - Non-operating gains and losses held constant as base year levels
  - Expenses
    - Salaries, wages and benefits
    - Productivity
    - Supplies and other
    - Medicaid enhancement tax

Fee-for-Service Financial Model

STROUDWATER

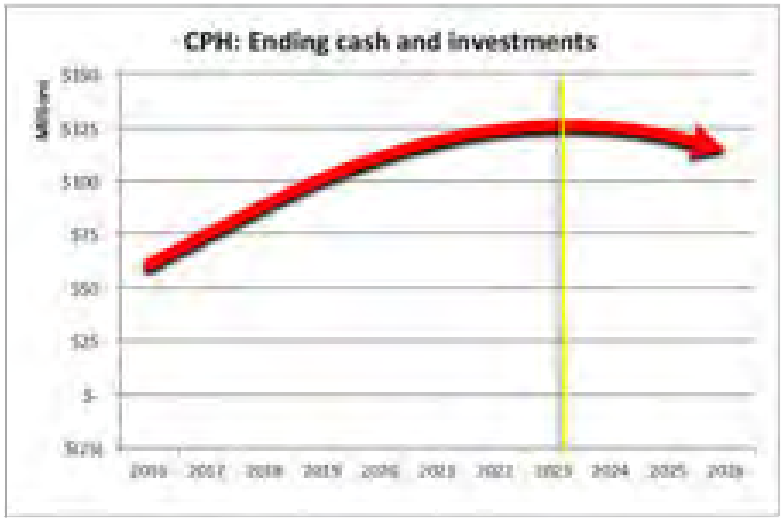
- **Assumptions**

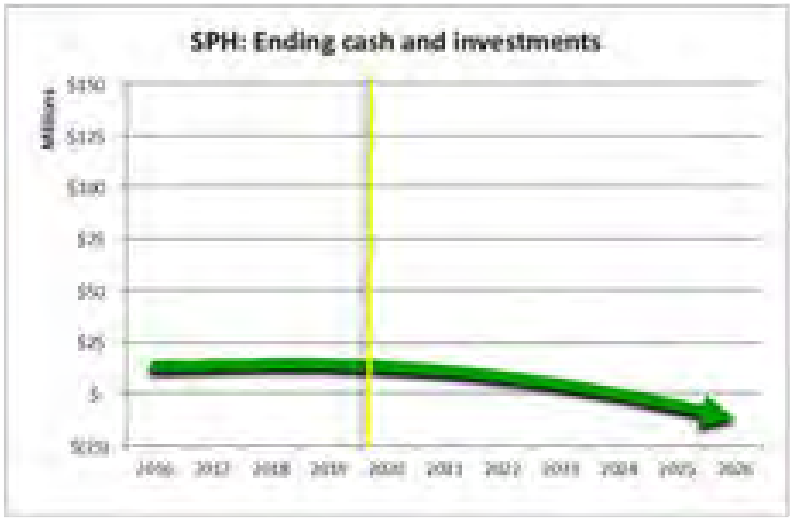
Global Assumptions	2017	2019	2021	2023	2025	2026
Revenues						
Projected Change in Population	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%
Change in Market Share (expressed in Utilization changes)	1.0%	1.0%	0.0%	0.0%	0.0%	0.0%
IP Utilization change from prior year	-1.0%	-1.0%	-1.0%	-1.0%	-1.0%	-1.0%
OP Utilization change from prior year	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
OP Utilization change from prior year: Impact of steerage	-1.0%	-1.0%	-1.0%	-1.0%	-1.0%	-1.0%
OP Utilization change from prior year: Total	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Long Term Care Volume Change	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Long Term Care Price Change	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Commercial/Other Payer Mix Change	-5.0%	-5.0%	-5.0%	-5.0%	-5.0%	-5.0%
Medicaid/Self Pay Payer Mix Change	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Price change from prior year	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%
Medicare Price Increase	-0.5%	-0.5%	-0.5%	-0.5%	-0.5%	-0.5%
Medicaid Price Increase	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%
Expenses						
Salaries, wages and benefits expense change from prior year	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
Supplies and other expense change from prior year	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
Professional fees/purchased services change from prior year	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
Depreciation and amortization expense change from prior year	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Interest expense change from prior year	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Reduction in bad debt due to increased coverage of ACA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

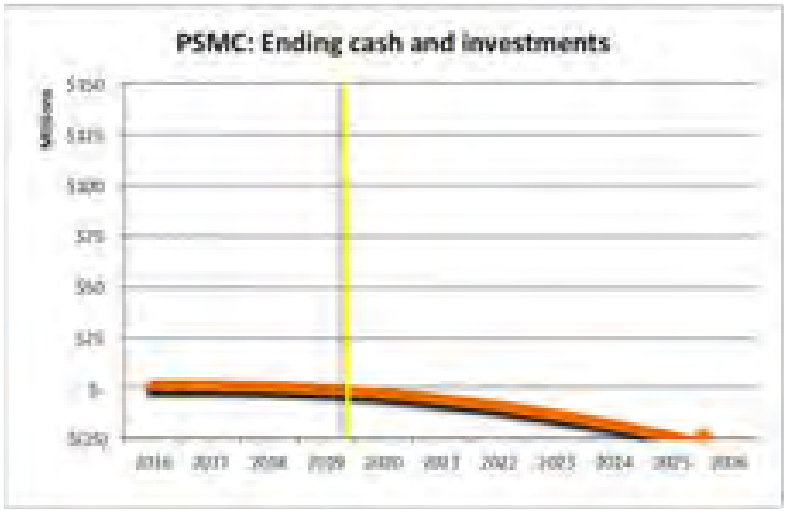
Individual Hospital Assumptions	2017	2019	2021	2023	2025	2026
CPH - Other operating revenues change from prior year	10.0%	0.0%	0.0%	0.0%	0.0%	0.0%
CPH - Non operating gains (losses) net change from prior year	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
SPH - Other operating revenues change from prior year	10.0%	0.0%	0.0%	0.0%	0.0%	0.0%
SPH - Non operating gains (losses) net change from prior year	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
PSMC - Other operating revenues change from prior year	10.0%	0.0%	0.0%	0.0%	0.0%	0.0%
PSMC - Non operating gains (losses) net change from prior yea	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
CPH - Annual capital investments	$ 10,000,000	$10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000
SPH - Annual capital investments	$ 1,000,000	$ 1,000,000	$ 1,000,000	$ 1,000,000	$ 1,000,000	$ 1,000,000
PSMC - Annual capital investments	$ -	$ -	$ -	$ -	$ -	$ -

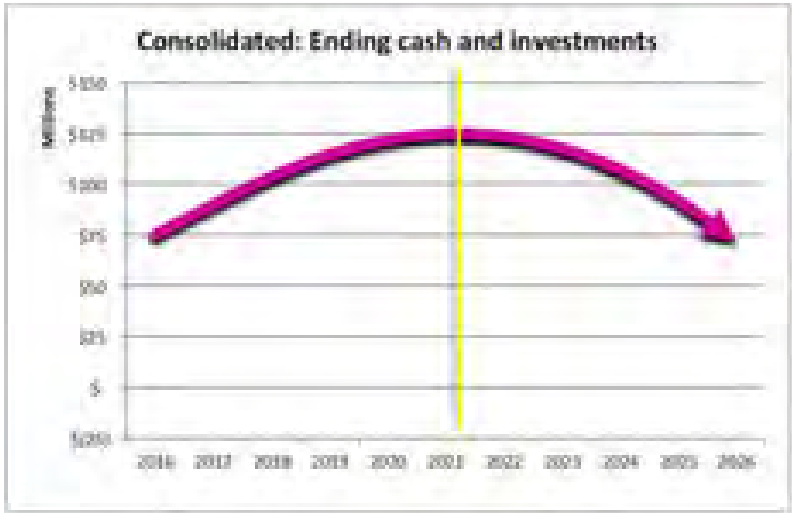
Fee-For-Service Financial Model: Cash and Investments

Cash and investments erode significantly beginning in 2021. Consolidated cash and investments decline by only 5% in 10 years.



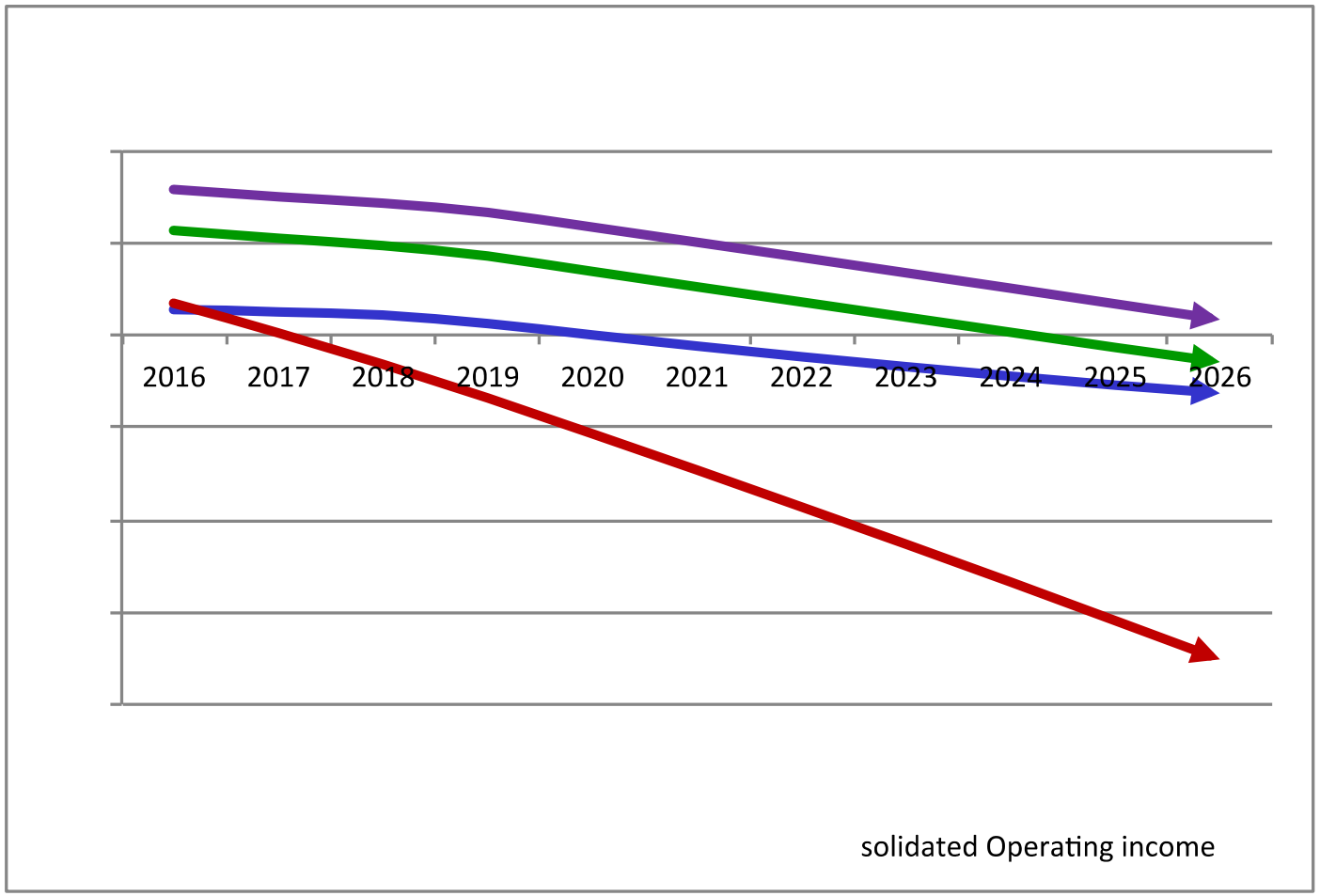






Fee-For-Service Financial Model: Operating Income

Consolidated operating income becomes negative in 2024



Fee-for-Service Financial Model: Scenarios

- **Reduction in Commercial Insurance Payer Mix**
  - As reported during interviews, commercial health insurance premiums on the Kenai Peninsula are extremely high and are continuing to increase at above inflation rates, which leads to employers not offering health insurance, or discontinuing operations
  - The following analysis evaluates the financial impact of annual reductions in commercial insurance under best case (-2.5%/year), likely case (-5%/year), and worst case (-7.5%) scenarios
    - It is assumed that there is an increase to Medicaid and self insurance at mirror % changes

Annual Reduction in Commercial Insurance Payer Mix

Consolidated Operating Margin (in 000's)

	2017	2019	2021	2023	2025
-2.5%	$ 28,145	$ 29,045	$ 25,706	$ 22,200	$ 18,526
-5.0%	$ 26,100	$ 22,465	$ 14,241	$ 5,430	$ (3,967)
-7.5%	$ 24,061	$ 16,575	$ 5,142	$ (6,176)	$ (17,237)

Consolidated Operating Margin %

	2017	2019	2021	2023	2025
-2.5%	11%	11%	9%	7%	6%
-5.0%	10%	9%	5%	2%	-1%
-7.5%	10%	6%	2%	-2%	-6%

Consolidated Cash and Investments

	2017	2019	2021	2023	2025
-2.5%	$ 92,089	$ 127,626	$ 158,168	$ 181,780	$ 198,127
-5.0%	$ 90,044	$ 114,765	$ 124,869	$ 117,646	$ 91,921
-7.5%	$ 88,005	$ 102,830	$ 96,260	$ 66,982	$ 15,431

Fee-for-Service Financial Model: Scenarios

- **Annual Price Reduction for Medicaid Payer Mix**
  - Due to the significant Alaska state budget deficit, and its anticipated longevity due to heavy reliance on mineral taxes, it is highly likely that the Medicaid program will undergo changes to reduce costs, including reductions to amounts paid to providers
  - The following analysis evaluates the financial impact of annual reductions in Medicaid payment under a best case (0%/year), likely case (-2%/year), and worst case (-4%)

Annual Price Change for Medicaid Payer Mix

Consolidated Operating Margin (in 000's)

	2017	2019	2021	2023	2025
0.0%	$ 27,301	$ 26,298	$ 21,004	$ 15,479	$ 9,773
-2.0%	$ 26,100	$ 22,465	$ 14,241	$ 5,430	$ (3,967)
-4.0%	$ 24,899	$ 18,788	$ 7,998	$ (3,482)	$ (15,677)

Consolidated Operating Margin %

	2017	2019	2021	2023	2025
0.0%	11%	10%	8%	5%	3%
-2.0%	10%	9%	5%	2%	-1%
-4.0%	10%	7%	3%	-1%	-6%

Consolidated Cash and Investments

	2017	2019	2021	2023	2025
0.0%	$ 91,245	$ 122,279	$ 144,405	$ 155,592	$ 155,449
-2.0%	$ 90,044	$ 114,765	$ 124,869	$ 117,646	$ 91,921
-4.0%	$ 88,843	$ 107,462	$ 106,375	$ 82,677	$ 34,948

Fee-for-Service Financial Model: Scenarios

- **Scenario Conclusions**
  - Reduction in commercial insurance payer mix
    - A reduction in commercial insurance payer mix has a significant impact on Kenai Borough hospitals with a nearly $22.5M cumulative impact on operating margin in 2025 for a 2.5% annual reduction (difference in operating margin between a 2.5% reduction and 5% reduction for 2025)
    - If commercial insurance payer mix does not decline greater than -2.5%, the consolidated operating margin remains positive
  - Reduction in Medicaid payment
    - A reduction in Medicaid payment also has a substantial impact on Kenai Borough hospitals with a nearly $63M cumulative impact on annual operating margin in 2025 for a -2% annual reduction

Fee-for-Service Financial Model: Summary

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- **Summary Conclusions**
  - Longevity of the current fee-for-service payment system on the Kenai Peninsula is at risk given mounting pressures on "price," utilization, and changes in insurance composition
    - Based on a set of reasonable assumptions:
      - Consolidated operating margin drops below 0% in 2024
      - Cash and investments begin to decline between 2021 and 2022
  - Significant variables could either accelerate or slow the negative financial results depicted in the financial analysis
    - Highly variable assumptions include:
      - Reduction in commercial payer mix
      - Reduction in Medicaid payment
  - Stakeholders should evaluate all assumptions in the model to determine likelihood of occurrence and specific impacts to their organizations
  - Stakeholders must understand the imperative to begin process of transitioning to new and more sustainable payment system while cash reserves are adequate to support the transition

Strategic Options

- Stakeholder Interviews
- Peninsula-Wide System Opportunities
- Strategic Transformation
  - Positioning for Population Health
  - Strategic Options Assessment

Stakeholder Interviews

- Interviews were conducted with the following stakeholder groups over the course of three days:
  - Soldotna
    - KPB leadership (Mayor and staff)
    - Peninsula Community Health Center leadership
    - CPH leadership
    - CPH Board and CKPHSA Advisory Board
    - CPH Medical Staff
  - Seward
    - PSMC leadership
    - Seward Community Heath Center and medical providers
    - Seward city leadership (Mayor, Vice Mayor, City Council, Manager, Finance Director)
  - Homer
    - SPH leadership
    - SPH Board and SKPHSA Advisory Board
    - SPH medical staff

Stakeholder Interviews: Economic Environment

- $3.8B state budget deficit
  - Reported KPB spends approximately $800M (8% of total Alaska population) → 57K residents at $13 - $14K / capita spend
- Oil and gas industry is major economic driver of KBP → $1B of oil revenue
  - Loss of state sales tax revenue with price of oil declining from $100/barrel to $35/barrel
  - Industry contraction could result in significant job losses and economic instability
  - Proposed new LNG (liquid and natural gas) pipeline could bolster economy → + 10K new jobs
- Unchecked healthcare costs have resulted in the KPB experiencing self insurance increases of approximately 10% (based on average of claims/costs/TPA maintenance - premiums) per year ($22K in 2015 to $24K in 2016).
  - This experience is likely a reflection of what is occurring across the Kenai Peninsula, which represents a huge burden for area employers that could result in economic hardship and loss of coverage

Stakeholder Interviews: KPB Healthcare System

- Working Well
  - Access to current "sick care"-based system offered in Seward, Soldotna and Homer is generally good for residents of the Kenai Peninsula
  - All three hospitals are recognized as assets and regarded positively by the communities they serve within the KPB
  - Peninsula Community Health Center (FQHC) and CPH have a good working relationship
    - Collaboration opportunities: behavioral health coordination, chemical dependency, sharing of information (possible linkage of EHR)
  - PSMC has strong tie/collaboration with local FQHC (share same facility – came together one year ago)
  - SPH has strong collaborative relationship with area practices and healthcare agencies
  - Local hospital governance and decision-making have served each community reasonably well

Stakeholder Interviews: KPB Healthcare System (cont.)

- Challenges / Opportunity Areas
  - High cost of healthcare
  - Demand for mental health and substance abuse services exceeds capacity
  - Access to primary care
  - Reduce outmigration of services → approximately 50% of joint replacement orthopedic cases are captured in Anchorage
  - Geography does not lend itself to natural connection with Seward given proximity to Anchorage (closer to Soldotna, yet faster to Anchorage)
  - Significant lack of continuity of EMS with large geographic areas covered by volunteers → approximately 95% of PSMC's medical transport conducted via air instead of ground
  - Lack of transportation infrastructure connection between Soldotna and Seward → public bus service only goes to Anchorage
  - PSMC has difficulty recruiting due to high labor costs and proximity to Anchorage
  - Limited access to continuing care services → Seward has a single small capacity ALF, and no HHA; Soldotna lacks hospice services
  - Lack of awareness (Seward) regarding healthcare service offerings available in Soldotna
  - Lack of obstetrical care in Seward requires majority of patients to be cared for away from home: referral trend is 90% to Anchorage / 10% to Soldotna
  - PSMC has space constraints that limit its ability to expand
  - The current system of care is not focused on prevention. Resources are not in place to fully support population health.

Stakeholder Interviews: Collaboration

- Opportunities
  - Purchasing / supply chain distribution
  - Management support / expertise
  - Revenue cycle
  - Contracted services (laundry, credentialing, legal, etc.)
  - Specialists
    - PSMC is currently supported by the following Anchorage-based specialists: OB, Ortho, ENT, GI, Cardio
  - Telehealth
  - Recruitment of providers and staff (shared staffing)
  - Education and training (staff, leadership, medical staff, Board)
  - IT integration
  - Payer contracting and negotiations

Stakeholder Interviews: Collaboration (cont.)

- Barriers
  - Geography
  - Potential loss of autonomy/identity for historically independent communities
  - Fear of job losses
  - Loss of services
  - Skepticism
  - Politics
  - Community perception
  - Perceived disparities based on how mill levy tax is applied across the KPB service areas
    - (e.g., Ninnilchik residents pay higher mill levy, yet utilize CPH instead of SPH)
  - Lack of full support for expanding KPB's health care powers to area-wide
    - Concerns that "population-based representation" would result in borough-wide board with little representation from SPH service area

Stakeholder Interviews Summary

- Strengths
  - Geographic location – shield and isolation from competitors
  - Well-regarded hospitals generally providing a good array of locally available service offerings
  - Strong alignment with area providers
  - Solid foundation of community support for regional hospitals
- Challenges
  - Significant dependence and linkage to oil and gas industry, which is currently contracting
  - Escalating cost of healthcare
  - Vast geographic area and proximity of hospitals
  - Appetite for affiliation/collaboration may not be fully present across the KPB
- Opportunities
  - Recapture lost market share, stem outmigration
  - Partner with KPB hospitals, providers, FQHCs, other service providers to build community strategy for population health and achieve scale economies

Strategic Options

- Stakeholder Interviews
- Peninsula-Wide System Opportunities
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Peninsula-Wide System Opportunities

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- **Findings and Analysis**
  - Cost reduction opportunities, while limited, exist through combining of CPH, SPH and PSMC functions to achieve scale economies across the following areas:
    - Purchasing/supply chain distribution
    - Management support/expertise
    - Revenue cycle
    - Contracted services (laundry, credentialing, legal, etc.)
    - Telehealth
    - Recruitment of providers and staff/shared staffing
    - Education and training (staff, leadership, medical staff, Board)
    - IT integration
    - Payer contracting and negotiations
  - PSMC has access to the following services through its management contract with Anchorage-based Providence Alaska Medical Center (Providence):
    - HR, accounting, and payroll support, shared EHR (Epic) and IT support, purchased services / supply chain contracting (GPO – Novation), Telerad imaging coverage, Telehealth / eICU, lab services, physician recruitment, access to specialists
      - Withdrawing from these services with Providence and combining these functions with CPH and SPH in the KPB potentially diminishes some of the current cost advantages to PSMC

Peninsula-Wide System Opportunities

- **Conclusions**
  - Adoption of a governance model that enables CPH, SPH, and PSMC to establish a jointly-owned Shared Services Organization (SSO) for consolidating non-clinical and purchased services will be important first step to achieve economies of scale
    - Enables aggregation of volume for joint purchasing programs
      - Facilitates product and utilization standardization
    - Enables consolidation of service vendors
      - e.g., biomedical engineering, utilities and service contracts, reference lab
    - Enables consolidation of labor-intensive back office services
      - e.g., finance and patient accounting
    - Facilitates leveraging of specialized expertise
      - e.g., care management, quality improvement, staff education, recruitment
  - Explore opportunities to contract with third parties through the SSO to provide services for CPH, SPH and PSMC (make-or-buy decision)

Strategic Options

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The Premise

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Finance

Macro-economic Payment System

- Government Payers
  - Changing from F-F-S to PBPS
- Private Payers
  - Follow Government payers
  - Steerage to lower cost providers (Site of Service)

Function

Provider Imperatives

- Transition from
  - Management of price, utilization, and costs (under F-F-S system) to
  - Management of care for defined population (under PBPS)
- Providers assume insurance risk
- New competencies required
  - Network development
  - Care management
  - Risk contracting
  - Risk management

Form

Provider Organization

- Evolution from
  - Independent organizations competing with each other for market share based on volume to
  - Aligned organizations competing with other aligned organizations for covered lives based on quality and value

Network and care management organization

Population-Based Payment Is the Future

- **Population-Based Payment Drivers**
  - Payment for value
    - Value = Quality/Price
  - Accountability for costs and outcomes
    - Requires new relationships
  - Alignment of incentives, resources and processes between and within organizations v. independent competitive organizations
  - Integration of organizational ownership, governance and management
    - Requires new competencies

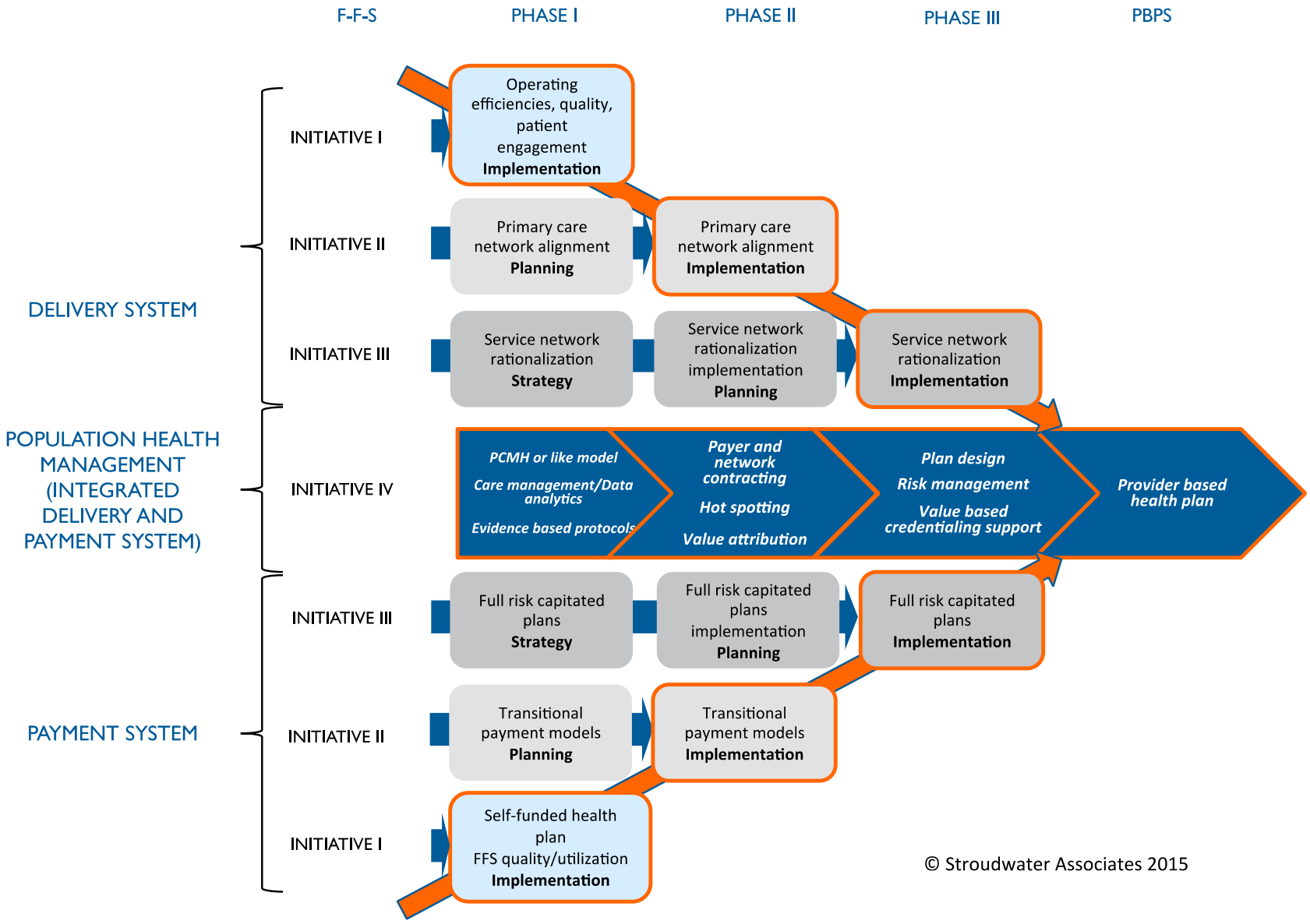
Population-Based Payment Systems Are Coming

- **Changing Relationships**
  - Primary care physicians become the revenue centers
    - Covered lives are revenue-generating asset
    - Value created by operating at the top of license
    - Emphasis on care management and chronic disease management
  - Community Hospitals
    - Maintain primary care, ancillary and urgent care services
    - Maintain specialty services only if high quality and low cost
    - Individual hospital offerings will likely be different from what they are today
  - Specialty services become cost centers
    - Value created by care management models that drive costs down
    - Quality must be demonstrable
    - Make or buy decision
  - Tertiary Hospitals
    - High tech providers of specialty and sub-specialty services
    - Support community hospitals
    - Provider/facilitator of care management infrastructure

Population Health Transition Framework

- The strategic framework on the following page is designed to assist organizations in transitioning from a payment system dominated by the FFS payment model to one dominated by population-based payment models
  - *Delivery system* side addresses strategic imperatives for providers
  - *Payment* side addresses strategies for providers to influence the evolution of the payment system in their market
  - *Population health/care management* requires creation of an integrating vehicle so that providers can contract for covered lives, create value through active care management, and monetize the creation of that value
- Strategic imperatives drive the initiatives that must be designed and implemented to make the transition
  - Each initiative is developed in phases that correspond to the evolution of the payment models
  - Work on each initiative needs to begin now so they will be ready to implement when required

Population Health Transition Framework (cont.)



Positioning for Population Health

- Market will be transitioning to population-based payment systems (PBPS)
  - AK has historically been protected from PBPS adoption due to a lack of cost pressures with oil and gas development proceeds, as well as higher than average federal and state program reimbursement rates adjusted to reflect cost of living and economic pressures across the state
    - The healthcare industry will have to adapt to new market reality as oil and gas development proceeds have declined
  - Impact of federal legislation (ACA and MACRA) encouraging PBPS adoption as a means of controlling Medicare expenditures
- Baseline capabilities for providers to participate in and manage care within PBPS
  - A high-value network of providers
  - Capacity to contract for covered lives
  - Infrastructure to accept risk and manage the care of patients across the network and its providers
  - Structured payment incentives to network providers to provide care within the budget
- Strategic requirements for Kenai Peninsula providers under PBPS
  - Operational efficiencies and quality/patient safety
  - Physician alignment
    - Primary care network development
  - Service area rationalization ("right-sizing" of future cost centers)
  - Population health system creation
  - Proactive payment system transformation

Positioning for Population Health

- **Conclusions**
  - As current payment system is predominately FFS, maximizing current payment system while developing infrastructure to position for PBPS will be real time business imperatives
    - Important "infrastructure" PBPS positioning strategies include:
      - Aligning with primary care providers
      - Aligning with other regional providers to increase scale for diversifying future insurance risk, diluting fixed cost of health, and developing region-wide systems of care
      - Developing healthcare system capabilities including data analytics skills, patient centered medical home services, and improved care management processes
      - Evaluating low risk options for PBP systems including Medicare and Medicaid shared savings ACO models
  - All strategic options must be tested for fit relative to both the current functional priorities based on a FFS payment system, and more importantly, on future functional priorities based on a PBPS

Strategic Options

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The Foundation: Strategic Objectives

- **Strategic Objectives provide:**
  - An opportunity to develop a shared set of goals that reflect the perspectives of key stakeholders: Board, physicians, staff, community residents, and the KPB
  - A communication tool for sharing with stakeholders the objectives/criteria that will guide decision-making
  - The basis for evaluating strategic options on an apples-to-apples basis that also reduces personal bias in choosing a strategic direction
  - Consistency for stakeholder decision-making and a guidepost to ensure the process stays on track

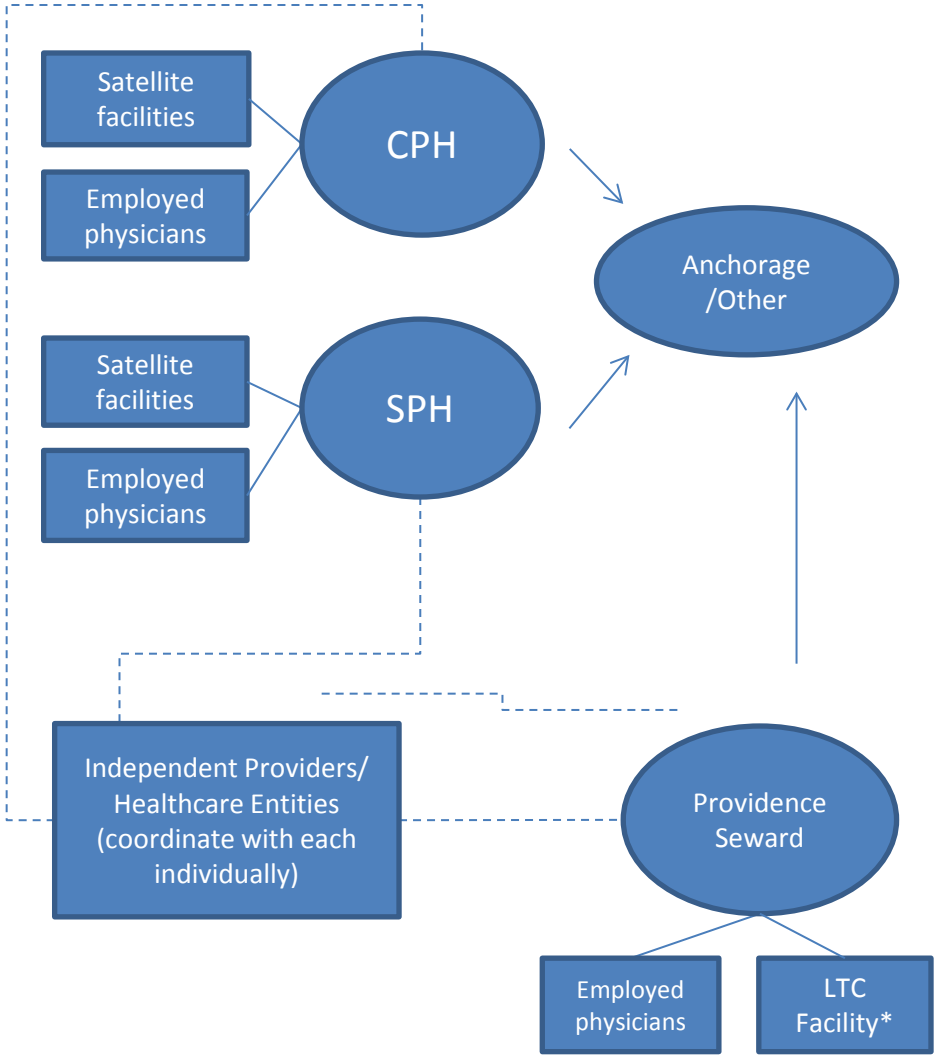
Draft Strategic Objectives

- Maintain or enhance access to services
- Reducing costs to the communities
- Improve quality and value of services
- Maintain financial viability and access to capital
- Preserve a local role in governance
- Develop population health management capabilities/focus on wellness
    - Increase integration and coordination of care locally

Draft Strategic Options

- **Status Quo**
  - Three independent hospitals supporting their own respective communities
    - KPB continues to own CPH and SPH and lease operations to local governing boards
    - PSMC remains owned by city of Seward and maintains management contract with Providence
- **Regional Alignment Strategy**
  - Develop new relationships with regional partners to address strategic objectives and community needs
    - Governance and alignment models evolve to meet strategic priorities in a rapidly changing environment
    - Shared Services Organization development
- **System Partner Strategy**
  - Privatization of the regional hospitals through affiliation or transfer of assets to a larger health system(s)

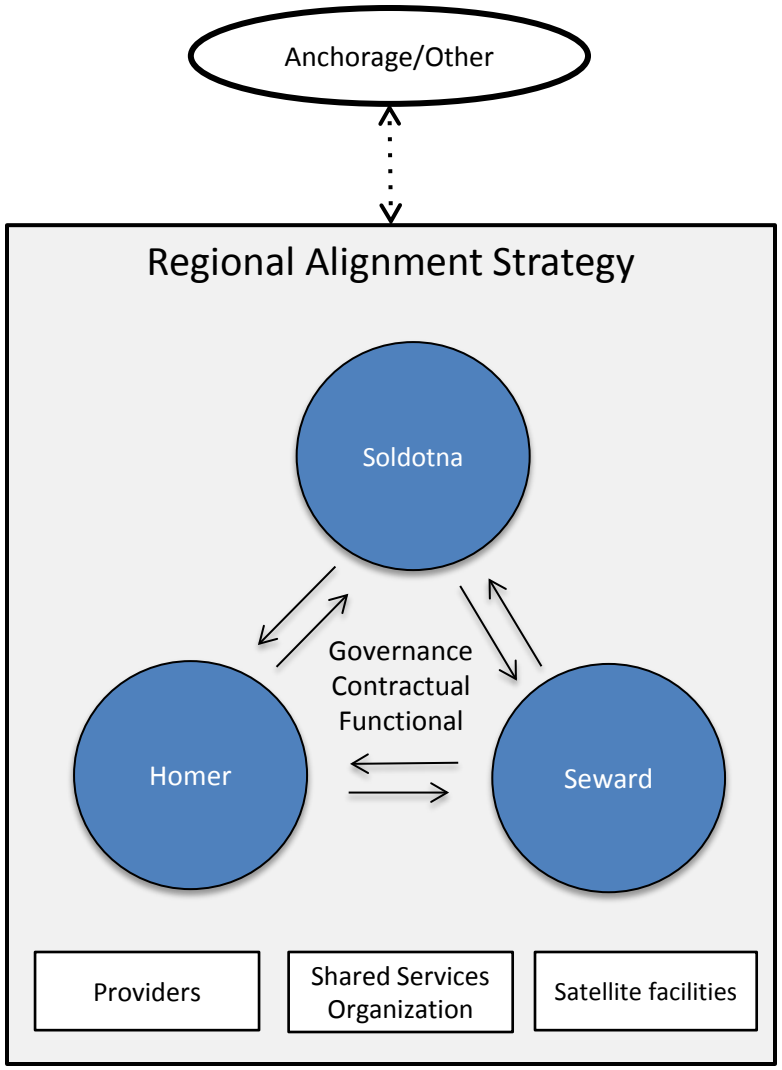
Status Quo



Description

- CPH and SPH are borough-owned
  - Leased and operated by two separate non-profits
  - Dual Board of Directors govern non-profits
  - Dual local Service Area Boards advisory to the Assembly
  - Borough Assembly approves major capital decisions
- PSMC is owned by city of Seward and contract managed by Providence
- Each hospital operates independently

Regional Alignment Strategy



Description

- Align with regional providers through the development of a local integrated network / delivery system
  - Governance
    - Shared decision making for network participants
    - Rationalization of service network
    - Option to maintain current governance structure, or create new models to meet strategic objectives
  - Contractual
    - Providers: High value provider network, incentivize behaviors
    - Payors: Insurance products, aligned financial incentives, attribution of covered lives
  - Functional
    - Economies of scale and expertise through a Shared Services Organization
    - Population health management capabilities

System Partner Strategy

Description

- Privatization of CPH, SPH and PSMC through sale or transfer of assets to a larger health system(s)
- CPH, SPH and PSMC, along with associated facilities and employed providers, are integrated with one or more established health system(s)
- Options could include governance representation from Soldotna, Homer and Seward providing oversight of the local entity with an advisory role to parent system Board
- Affiliation takes many forms

Draft Strategic Options: Pros and Cons (High▲ - Low▼Grade)

Objective	Access to Services	Reducing Costs	Quality / Value	Financial Viability /Access to Capital	Local Governance	Population Health Management
Status Quo	Limited scale and collaboration opportunities reduce locally available options across smaller borough communities ▶	Limited scale and collaboration opportunities reduce options ▼	Limited to local internal resources/ talent ▶	Currently stable (with tax support), yet at risk as demand of new population based payment methodologies emerge ▶	Highest level of local governance and decision rights ▲	Lack of scale undermines ability to invest in capabilities ▼
Regional Alignment Strategy	Collaborations with local and regional service providers enhances access and coordination of care for a regional population ▲	Establishment of joint Shared Services Organization creates vehicle for collaboration, which can increase lower-cost local market share, and achieve operational improvements and efficiencies ▲	Opportunity to develop shared additional resources, greatly enhance coordination and share costs and benefits across multiple organizations ▲	Currently stable (with tax support), with opportunity to reduce future risk through shared savings and collaborative market share initiatives ▶	Maintains local governance and decision rights and enables new forms of regional governance to meet evolving strategic priorities ▲	Affectively achieves scale which enables investment in technology and care coordination resources, as well as enables regionalized health care across a greater geographic region ▲
System Partner Strategy	Possible to secure contractual commitments, yet span of control is delegated for a defined time period; coordinated access to tertiary services ▶	Span of control to manage costs is delegated to system partner(s), which is a significant threat given the geographic monopolies inherent on the KP ▼	May introduce significant additional resources and capabilities ▲	Unlikely to be significantly enhanced as partners will avoid dilution of balance sheets ▶	Diluted local governance and decision rights subject to negotiation and trade-offs ▼	Dependent upon partner's population health strategy and capacity; dilutes local focus, extent subject to negotiation and trade-offs of level of commitments ▶

Summary of Strategic Options

- Current changes in the marketplace, including reduced oil and gas revenue, the likely reduction in commercial insurance payer mix, and the shift in governmental payment systems, require a new and flexible healthcare delivery model
    - Business imperative to organize and align available resources in the manner that best positions achievement of the defined strategic objectives
- Options considered and evaluated for fit with suggested strategic objectives for the KPB include the following:
        - Status Quo
        - Regional Alignment Strategy
        - System Partner Strategy
- The **Regional Alignment Strategy** is recommended as it best addresses the defined strategic objectives while allowing maximum flexibility in terms of how the hospitals choose to partner

Conclusions and Summary

- **Key Points of Emphasis**
  - Nationally, the healthcare industry is moving from FFS to PBPS and the margins of providers will be threatened by payment reductions and utilization declines
  - Alaska's statewide dependence on the oil and gas industry results in economic shifts that positively and negatively impact Alaskan communities
    - With current Oil prices at less than 50% of historic highs, Alaska is at risk for significant negative impacts that will directly impact healthcare providers through reductions in Medicaid payments and indirectly through possible economic recession
  - The current cost of commercial health insurance in Alaska is reported as the most expensive in the world and continuing to escalate at rates in excess of GDP
    - A continued escalation in premiums will result in less demand for health insurance and corresponding increases in Medicaid and uninsured patients
  - The service areas of all three Kenai Peninsula hospitals are separate due to geographic location and are supported by communities that are staunchly independent
  - Advantages of Borough-wide ownership are limited from a cost reduction perspective, but are valuable for developing an alignment strategy

Conclusions and Summary

- **Recommendations and Discussion**
  - Position the Kenai Peninsula hospitals for the future by addressing the following:
    - Focus on individual hospital opportunities
    - Where possible, seek Kenai-Peninsula-wide efficiencies
    - Set in motion restructuring that will enable the transition of hospitals to delivery systems through alignment of the hospitals with
      - Physicians
      - Capital/insurance partners
      - Tertiary partners
  - Pursue a regional alignment strategy to best position the KPB health care delivery system in achieving core strategic priorities while maintaining maximum flexibility in the rapidly changing healthcare environment

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