Governance Forecast: Strategic Considerations under a New Administration's Policies

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With the new administration pursuing major shifts in the approach to healthcare reform, governing boards must understand the context and direction of expected policy changes, trends, and shifts in power that are likely to occur.

Following is a succinct synopsis of who and what to watch, and the potential strategic impacts and opportunities this change will create for hospitals and health systems.

Leadership Perspectives: Clues to Healthcare Policy Shifts

Representative Tom Price and Seema Verma were nominated to lead the Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS), respectively. Representative Price is a former orthopedic surgeon who serves as a Congressman from Georgia. He has been very engaged in healthcare policy as the Chairman of the House Budget Committee and as a member of the powerful House Ways and Means Committee. Representative Price supported the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) legislation, which transforms clinician reimbursement to a value-based model. However, upon CMS's issuing of the associated regulations, he articulated concerns with MACRA's implementation, particularly physician reporting requirements. A staunch critic of the Affordable Care Act (ACA), Dr. Price has criticized the Center for Medicare & Medicaid Innovation, as well as the former administration's approach to mandatory bundled payment programs, such as the Comprehensive Care for Joint Replacement (CJR) model.

Ms. Seema Verma's healthcare background has been as the Founder and President of SVC, Inc., a national health policy consulting firm. She was the architect of the nation's first consumer-directed Medicaid program, Healthy Indiana Plan (HIP), under Indiana Governor Mitch Daniels, and designer of Governor Mike Pence's HIP 2.0 waiver proposal. She has assisted a number of other states with 1115 waiver applications, including Iowa, Ohio, and Michigan.

What to Watch: Implications for Governing Boards

In light of the backgrounds of Representative Price and Ms. Verma, as well as the policies articulated by President Trump, expect full steam ahead to repeal and replace the ACA (likely a two- to three-year implementation). In anticipation of these reforms, governing boards of hospitals and health systems can expect to see the following trends and shifts in healthcare policy and payment direction.

Increased flexibility for states: Given Ms. Verma's background, it is likely that the new administration will work with states to reform Medicaid delivery and payment models. This trend will shift decision making from CMS to governors and state legislatures. As part of this shift, a potential movement to state block grant funding will likely signal payment cuts to providers.

What to watch: Longer term, hospitals and health systems should prepare for the possible increase of underinsured beneficiaries and greater levels of bad debt. There will be an increased focus on care management and patient coordination strategies by providers. Expect states to move away from fee-for-service reimbursement toward alternative payment models (APMs) (case rates or capitation). Pay attention to your state's approach to restructuring its Medicaid program—benefits to be provided, eligibility, funding, payment models, etc.

Medicare reform: Both Representative Price and Representative Paul Ryan have proposed reforms to Medicare that couple entitlement reform with payment changes (possible use of vouchers with health plan choice and competition). Congress and the administration may pursue a similar approach, which will lead to a stronger health plan marketplace (choice) coupled with restructuring of co-pays and deductibles through a shift toward defined contribution/premium support (vouchers, means testing, etc.). There should be continued support for Medicare Advantage health plan offerings (Medicare HMO).

What to watch: Assess your payer (health plan) alignment and contracting strategies relative to Medicare Advantage enrollees, as there will likely be an increased emphasis to move away from fee-for-service Medicare, through the pursuit of value-driven health plan options. Having a partnership or close working relationship with a medical group, independent practice association (IPA),

Key Board Takeaways

Boards must not be distracted by short-term uncertainty resulting from a new administration. A longer-term vision and orientation is essential to see opportunities for innovation and different approaches to healthcare delivery. A few considerations for boards include:

- "Repeal and replace" intentions for the ACA will be more difficult to do than to talk about. Expect change to occur over a two- to three-year implementation period.
- Prepare for increases in underinsured beneficiaries and higher bad debt for hospitals and health systems.
- Expect to see more support for Medicare Advantage programs, and a move away from fee-for-service Medicare with emphasis on value-driven health plan options.
- Physician alignment will be essential. Develop high-value provider networks and relationships with aligned financial and clinical incentives.

or employed physician base will be critical moving forward. If you do not already have alignment with clinicians, consider alignment with clinicians to form an accountable care organization (ACO) (or partner with an existing ACO or Medicare Shared Savings Program) as a mechanism to improve quality and contain costs. Partnering with a Medicare Advantage health plan could be a good option as well.

Power shift to insurance companies: Deregulation of provisions of the ACA related to insurers, such as the elimination of the medical loss ratio (MLR) target, rate regulation, and standard benefit design, coupled with allowing plans to be sold across state lines will likely provide additional power to the insurance industry. Deregulation combined with the current trend of insurers partnering with physicians in an effort to commoditize hospitals will force them to find ways to maintain essentiality and demonstrate value.

What to watch: Ensure that your hospital or health system is actively developing and implementing high-value provider networks with economic alignment (incentives) that will ensure collaboration, relevance, and competitive advantage in negotiations with payers. Simply said "be relevant" in the market. In addition, providers with employed physicians should attempt to use MACRA as a motivator to align with clinicians. Seek out health plans to partner with that are interested in moving toward value-based shared savings arrangements.

Shift to physician-led delivery and payment reform models: Between MACRA and Representative Price's criticism of mandatory bundled payment programs and preference for physician-focused models, expect to see the development of additional models available for clinicians. MACRA will lead to even more focus on value-based care and APMs. These models will likely have similar designs and characteristics to the Comprehensive Primary Care Plus (CPC+) model, which is designed to facilitate a more comprehensive and coordinated approach to primary care services and patient care (provide enhanced value).

What to watch: MACRA provides hospitals and health systems with significant opportunities for further integration (economic alignment) with physicians. It will be important to evaluate appropriate ways to assist clinicians with reporting, strategic direction, benchmarking data, care models, and other vehicles to boost income in either the Merit-Based Incentive Payment System (MIPS) option or through participating in APMs. Monitor Trump policy and market activity of competitors developing APMs that exclude your organization. Examine broader partnership opportunities in these areas to accelerate your ability to participate in new models. Continue developing and implementing other integration strategies with clinicians.

Reduced revenue per service to providers: Regardless of the Congressional approach to repeal and replace the ACA, there is still a major challenge with federal spending on healthcare and we expect that the continued trend of holding Medicare and Medicaid spending in line will continue. As a part of this dynamic, federal and state budgets will continue payment increases below expense increases and will move toward value-based payment models.

What to watch: To address reduced Medicare and Medicaid reimbursement, hospitals and health systems should evaluate the potential for alternative arrangements utilizing ACOs, Medicare Shared Savings Program organizations, clinically integrated networks, participation in APMs, and direct-to-employer agreements. This will create opportunities to integrate and align incentives with physicians and be rewarded for reducing costs and improving quality. Additionally, providers should seek annual productivity increases in reimbursement and shared savings agreements from commercial and risk payer agreements.

Final Word

Predicting the future accurately is difficult at this time due to the change in administration and healthcare policies (recognizing many other "new directions/approaches" will also have a major impact on healthcare). However, it is the responsibility of governing boards to not be distracted by short-term turbulence, and to look through the lens of a longer-term vision. Each wave of disruptive change brings with it opportunities for innovation, new approaches, new partnerships, and different ways of thinking. Make this wave a catalyst for ensuring that your organization becomes stronger, more sustainable, and serving the communities within the reach of your organization. Don't panic, change of this magnitude will take time to implement and there will be much debate in public about the impact.

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