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Healthcare Forecast for 2016: Top Trends Driving Board Priorities

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2016 will be notable for the risks and opportunities associated with market change and strategic activity that will continue throughout this significant election year. As the Obama era comes to a close, healthcare can expect further change and uncertainty. Although the ACA and value-based payment is now woven into the healthcare industry fabric, the tapestry is still constantly evolving. These 10 trends are where boards should direct their attention in 2016.

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1. Physician–Hospital Alignment

This trend continues at the top of the list for 2016, as it has been for the past few years. Many hospitals and health systems have already undertaken aggressive steps to engage physicians as partners with aligned financial and clinical incentives. Current estimates are that hospitals employ between 50 to 60 percent of practicing physicians, with mixed financial results. Many hospitals and health systems report losing in the range of $150,000 or more per employed physician. In spite of this, we expect that physician integration models will continue to grow in 2016, including through employment, alignment models (e.g., clinically integrated networks [CINs], contracting networks, accountable care organizations [ACOs], bundled payment, co-management agreements), and other creative arrangements.

Also, in 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) was enacted to replace the sustainable growth rate (SGR) formula for physician payments for Medicare fee-for-service patients. Guidelines will be issued this year outlining requirements for quality reporting and performance measures that will determine physician payments beginning in 2019. However, physician performance tracking begins in 2017. It is essential that physicians (and hospitals that employ or are aligned with them) understand the payment model options available, and the associated financial and operational implications. Their financial future depends on it.

In the boardroom:

- Develop an executive and physician action plan to understand and assess options, impacts, and risks to employed and independent physicians from anticipated MACRA value-based payment changes.
- Do you know the economic status and impact of your employed physicians? Is there a plan in place to reduce and minimize the losses on owned practices?
- Is individual physician performance tracked (and acted upon) using cost, quality, satisfaction, and clinical effectiveness data and measures? Are the metrics being shared with physicians on a timely basis?
- Is effective physician leadership embedded in key impact areas of your organization, including governance, C-suite level, departments and service lines (e.g., co-management administrative structures), IT (informatics, decision support), clinical integration and redesign committees, and

other important areas? Ensure that physicians are leaders in the change management process.

2. Population Health Management

No matter what the size or location of the market, nearly every hospital/health system strategic plan we've seen this year includes goals and strategies regarding population health management (PHM) built upon value-based care models and payment arrangements. This makes sense considering that key elements of healthcare reform incentivize delivering and reimbursing patient care based upon value. The drive toward capturing "defined populations" will continue with vigor into 2016. The populations most suited for a PHM model of care are primarily Medicare, Medicaid, and Workers' Compensation patient segments (and on a smaller scale a hospital's own employee base) and now commercial arrangements and direct contracting. Effective PHM requires critical mass, big data, and sophisticated data analytics to address claims analytics, patient profiles, business intelligence, and patient engagement issues. Make no mistake, creating an infrastructure to implement effective PHM is an expensive proposition. Many organizations that are serious about PHM and accepting more risk are sharing infrastructure costs by forming or joining CINs. Some CINs are now developing and implementing "super CINs," which include multiple CINs on a broader geographic basis. These have the benefit of creating larger critical mass, expanding their geographic footprint, and sharing costs across multiple members.

Under the PHM umbrella, we also expect CMS to further expand the bundled payment program beyond the mandated 68 geographic areas announced in 2015 as part of the five-year Comprehensive Care for Joint Replacement (CJR) program.

In the boardroom:

- Are you participating in bundled payment programs and models? We believe that CJR is just the tip of the iceberg and CMS will expand bundled payment to additional episode of care areas and geographies. If this is the case, what more should you do to anticipate and respond?
- Are your key and relevant physicians on board with aligned economic and clinical incentives to make the program successful?
- Are you utilizing additional strategies such as co-management agreements for key service lines to further prepare, train, and engage your physicians?
- Are you building or part of a CIN, and is it creating the results you expect? Is there a "super CIN" in your future?
- Are there other populations (e.g., commercial or direct-to-employer) you can reach out to and include in bundled arrangements for their benefit?

3. Patient Volume

Volumes should trend upward as more people have insurance, the economy continues to grow slowly, and Medicaid expansion takes hold. Additionally, the aging of the population and increase in both obesity and chronic diseases will create pressure for utilization to increase. Health plans and providers will push back against utilization increase through health plan payment methods that have incentive features focusing on shared savings and value-based performance. The continued emphasis on reducing readmissions, focused efforts on potentially preventable conditions, and use of observation services vs. admission will also slow down the admission increase. New care models in bundled payment, co-management, ACOs, patient-centered medical homes (PCMHs), chronic disease management programs, and specialty medical homes should also slow volume growth. More effective use and performance of hospitalists, case managers, chief medical officers, and use of hospice and palliative care will also slow the growth rate. In most markets, emergency department volume is still strong for the significantly ill and will increase, despite the explosion of alternatives such as retail clinics, urgent care centers, minute clinics, PCMHs, and other ambulatory care sites, which will decrease the non-emergent visits.

In the boardroom:

- Track care model changes that reduce inpatient utilization and increase post-acute and ambulatory care use.

- Should you consider lower cost alternative sites to treat the chronically ill and the non-emergent patient?
- Pay attention to payer mix changes due to healthcare exchanges and Medicaid expansion as it occurs in many states, and corresponding increases in bad debt.

4. Consolidation, Alliances, and Affiliations

Industry consolidation should continue with larger transaction amounts and more broadly defined. The December 2015 acquisition of Target's pharmacy and retail clinic business by CVS Health for $1.9 billion and its aggressive expansion into the population health business (e.g., pharmaceuticals, chronic disease, minute clinics, and other retail health services) are evidence of this trend. The increasing investment by private equity into the urgent care and retail clinic operations is also evidence of this growth and potential acquisition and "roll-up" of operators, all which are attempting to disrupt the traditional healthcare market. Consolidation and roll-up will be focused on elimination of duplication of overhead, recognition of winners and losers in this space, and inevitable fall-out of low-volume performers with an underperforming ROI.

A major driver of hospital and health system mergers or sale is the need to access capital. Bond rating downgrades still outnumber upgrades. Physician organizations will continue to sell to larger organizations to gain access to capital, obtain superior IT systems, access proven managed care models, and enhance infrastructure. Ambulatory providers and post-acute care providers will also seek partners as they see their referral sources change and redirect volume. Health systems will seek to control the continuum of care. All of these efforts will be focused on providing greater value to the patient and the payer.

In the boardroom:

- Monitor transaction and potential disruptive activity in your service area and region to identify trends impacting post-acute care, ambulatory care, and telehealth services. What impact will these have on your approach to the entire continuum of services that you need to provide?
- Also monitor types of affiliations that are occurring and assess their impact on your hospital/health system. We expect to see more affiliations around clinical service lines and specific programs versus typical whole-entity mergers. Are there threats or opportunities for your organization and physicians from these types of alliances?
- What new innovations and non-traditional opportunities are being explored that will provide diversity in sources of revenues and volume (patient and non-patient related)?

5. Public/Private Exchanges and Health Plans

Public insurance exchanges will have modest growth during this current enrollment period. The growth in public exchanges should come in the HMO product, which offers narrower networks and better control of resource consumption. Because it is an election year, politicians will apply pressure to limit narrow networks and look to offer the public exchange to the undocumented population (without subsidy—that will follow in 2019 with a state provided subsidy). Efforts will be made to add transparency to the public exchange Web site.

Private insurance exchanges will grow some in 2016. The private exchange will look a lot like the public exchange, less the public subsidies. Look for growth in high-deductible PPO products and a continued slide in commercial HMO as consumer-driven health plans continue to grow.

Health plans will consolidate in order to eliminate overhead and exert greater market power over providers and drug companies. The health plans will also acquire companies in order to access new proven primary care models, new payment systems with incentives, and managed care knowledge transfer.

In the boardroom:

- Pay attention to the formation of narrow networks that exclude your physicians and organization. What threats do they pose, and what alternative responses should be considered?
- Proactively work with brokers and employers in the community to develop value-based payment models as private exchanges emerge.

- Explore the options, including the development of new value-based payment models, and measure the impacts of additional partnerships and alliances with health plans in your community (and beyond).

6. Information Technology and Security

As noted earlier in the population health management trend, IT is at the heart of future success with nearly every payment and care delivery aspect associated with healthcare reform, the ACA, and value-based reimbursement. Many hospitals and health systems will continue to invest in IT to an equal or greater extent than physical facilities. IT systems themselves are evolving, requiring upgrades, outright replacement, and expansion of capabilities to meet ever-changing needs. As multi-system alliances and mergers occur, common IT platforms are adopted requiring capital investments. Still in the future are IT systems and platforms with the capability and functionality to achieve higher levels of interoperability—to collect and integrate data from multiple sources of patient information (e.g., from retail clinics, ambulatory service providers, ED, physicians, telehealth, post-acute, and others). Add to your 2016 IT checklist capabilities to provide patient portals and registries, a data warehouse linking data across the continuum, telehealth, and patient access to their medical records (anywhere, any device, any time) in sub-second response time.

Expect to see enormous security, privacy, and data breaches in hospitals and health systems that will require a new level of risk management. Experts warn that many systems are vulnerable, and the huge breaches that we've seen in related industries foreshadow the future.

In the boardroom:

- Do you have board members who have a background in security and privacy? Aggressively monitor IT security, and identify/address risks associated with potential breaches of your systems.
- Request specific evidence that your IT expenditures and systems show tangible as well as intangible "returns on investment."
- Goals for IT must be defined—assess them in terms of outcomes (e.g., evaluate the impact on care teams to be more efficient; identify care gaps to improve population health; improve PQRI results; and help primary care physicians to handle larger patient loads).

7. Consumerism

Consumerism is growing and is being broadly defined, especially as consumer-driven health plans grow across the country. The focus of this trend in 2016 is for hospitals and health systems to gain "stickiness" with the consumer. Efforts to drive the public to big-box retail clinic sites, urgent care, consumer Web portals, Web sites to buy insurance and select a provider, use mobile health apps (over 40,000 available), a health system-owned health plan, and direct advertising all come into play. Health systems should be expected to throw a broad net to offer as many access points as possible. More Web sites will pop up offering consumers more information and help with selection of health plans and providers, and to identify lower cost locations for care as the consumer becomes more responsible for a greater percentage of the healthcare costs.

In the boardroom:

- What index level of "stickiness" do you currently have with consumers and patients (overall and from specific market segments)? Identify what strategies work best to attract and draw in specific segments of consumers through patient physician portals, interactive Web sites, and services.
- What techniques are you using to engage consumers in their healthcare decisions and helping consumers take greater responsibility for their health (and related decisions)?
- Monitor levels of consumer access to Web sites and portals to better understand and refine your market segmentation strategy by specific payer type, especially from patients in exchanges, Medicaid, Medicare Advantage, PPO high-deductible plans, and others. Are you using tailored strategies to effectively address the needs and interests of targeted groups?
- Assess how other organizations are effectively targeting specific market segments and learn from their experience (e.g., Oscar Health targets young, healthy, tech-savvy consumers; Oscar boasts a five-

minute enrollment time, with transparency about providers, costs, etc.).

8. Transparency and Integration of Social Media

Transparency will continue to increase through quality and outcomes reporting Web sites, as well as through social media outlets. Social media is a wild card that must be played, and watched vigilantly. A single viral event (negative or positive) can be game-changing. Health systems and hospitals should continue to monitor Web sites (currently more than 40) that report quality, price, and other comparative information. Patient-reported experience and outcomes data will become more accessible and will be incorporated into how quality of care is measured. With a growing amount of revenue at stake, hospitals will focus more attention on strategies to improve their patients' perceptions of their hospital experience and boost their HCAHPS scores, and physicians will seek to improve their PQRI indicators. Health plans will increase their own transparency efforts regarding providers in their networks.

In the boardroom:

- Monitor social media and proactively respond to social media events in a timely, transparent way.
- How is your organization using social media to communicate with the community and patients?
- Make sure that your organization is vigilant at reporting accurate quality and price information and be proactive in these efforts.
- Ensure that plans are in place to monitor and improve HCAHPs and PQRI performance.
- Monitor reports of quality and pricing of competitors.

9. Care Model Redesign and the Next Level

Care models will continue to evolve resulting in higher quality and lower cost, thereby improving value, especially on a per capita cost basis. The development and expansion of bundled payment, ACO, PCMH, specialty PCMH, and post-acute care continuum should continue at a robust pace. The development of these areas will be negatively impacted by limited supply of appropriate human resources, information technology investment, and lagging of new payment models and systems to drive and measure physician behavior change.

Health systems will continue the march toward population health in selected communities (those geographic areas) where they can make a difference. Getting different IT systems to work together in this space will remain a challenge.

In the boardroom:

- Monitor that care model design is integrated with and tied to changing value-based payment methods.
- Ensure that care design incorporates more front-end assessments of patient health status and integration of multiple data sources that will result in more effective care coordination.
- Is your IT system the backbone for effective clinical care delivery? Your systems must achieve interoperability to coordinate multiple data sources that drive analytics and provide real-time information that is essential to eliminating duplication, reducing unnecessary utilization and costs, and providing bedside information that impacts clinical decisions and care paths.

10. Risk-Based Contracting and Financial Sustainability

A common theme through many of the trends noted to this point focuses on the increasingly important need to achieve further efficiencies, economies, value, and quality improvement initiatives to eliminate waste and reduce costs in the system. As the shift from fee-for-service (FFS) to value-based reimbursement (VBR) becomes more pervasive, more financial risk will be shifted to providers. More two-sided and full-risk (e.g., global capitation) reimbursement models will be offered to providers in areas that have not traditionally seen these arrangements from public and private insurance options. Both two-sided and full-risk brings with it clear incentives to proactively track and manage admission rates, referral rates, per-unit costs, the total cost of care, and other metrics that aren't traditionally tracked under FFS. Organizations that still lose money on Medicare FFS business will likely find it more difficult to be financially sustainable on risk-based and VBR models of payment.

2016 will see more sophisticated efforts to create organizations that are capable of pooling resources to accept greater risk while lowering development and infrastructure costs for its members. These include CINs and the super CINs described in the population health trend above.

Other forms of risk that providers are taking on include owning a health plan, two-sided risk with corridors, receiving capitated and global payments for defined services, global capitation by physicians, bundled payment, episodes of care (e.g., MS-DRG), and other forms of value-based incentives. All of these should be assessed for their potential value in creating a sustainable organization in the future.

In the boardroom:

- What is your organization's appetite and plan for taking on greater payment risk? What should it be?
- Does your hospital/health system make money on Medicare FFS patients? If not, initiate a discussion around possible scenarios and conditions where breakeven on Medicare reimbursement could happen (e.g., focus all efforts to reduce costs per discharge).
- Are you now part of a CIN or other affiliation model with other providers that will provide the vehicle to accept more risk-based payments? Is there a super CIN in your future? Will you be the integrator, or the "integratee"?

Final Word

2016 has the potential for surprises so no board can take a "wait and see" attitude. Proactive, difficult discussions are required to address issues of independence, integration, breadth of affiliation and alignment considerations, service offerings, efficiencies, quality, and patient focus. Systems and processes of care delivery need to be streamlined, improved, and made more cost-effective. Are you adopting a "world-class healthcare experience" mindset? Are you courageous enough to adopt a mindset of eliminating any element that does not contribute to the quality of patient care? We are confident that effective boards will see 2016 as a year of hard work, difficult decisions, and great opportunity!

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