2016 Trends
Managed Care and Beyond

HFMA and CHEF's Managed Care Meeting 2016
Updates on Changes and Challenges
February 4, 2016
Introduction

1. Consolidation will continue.
2. Providers will piece together the cost puzzle.
3. Data management will be key.
4. There will be a focus on patient engagement.
5. The consumer will become “the king.”
6. Access will take top priority.
7. Workforces will be retooled.
8. Population health will be defined.
9. IT efforts will move from implementation to optimization/interoperability.
10. Adjustments to the organization’s strategic framework will be necessary.

2016 Trends
Deal Volume Will Remain Strong

“Five years after the Affordable Care Act helped set off a healthcare merger frenzy, the pace of consolidation is accelerating, transforming the medical marketplace into a land of giants.” – Wall Street Journal

Major Health Plan Transactions — 2015

<table>
<thead>
<tr>
<th>Buyer</th>
<th>Target</th>
<th>Estimated Incremental Impact¹</th>
<th>Enrollment (millions)</th>
<th>Premium Revenue (billions)</th>
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<tbody>
<tr>
<td>Anthem</td>
<td>Cigna²</td>
<td></td>
<td>~2.9</td>
<td>$27.2</td>
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<tr>
<td>Aetna</td>
<td>Humana²</td>
<td></td>
<td>~9.3</td>
<td>$45.9</td>
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<tr>
<td>Centene</td>
<td>HealthNet</td>
<td></td>
<td>~3.1</td>
<td>$13.3</td>
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¹ United States Securities and Exchange Commission, Form 10-K statements, as of June 2015.
² Transaction is pending; expected to close in 2016.
³ M&A = mergers and acquisitions.

Transaction volume will likely remain strong in 2016, as payors and providers pursue market share as a pathway to operating efficiencies and profitability.
While M&A dominate headlines, a deeper trend of provider integration is under way.

Rise of Non-M&A Partnerships

In many markets/regions, the adoption of the above tactics will likely solicit a defensive response among competitors, spurring further consolidation.
Historically slow and methodical, the formation of large regional health systems and collaboratives will force academic medical centers (AMCs) to be more aggressive consolidators.

AMC Challenges

<table>
<thead>
<tr>
<th>Traditional</th>
<th>Emerging</th>
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<tbody>
<tr>
<td>Tripartite mission</td>
<td>Limited provider integration</td>
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<tr>
<td>Unfavorable economics</td>
<td>New competitors</td>
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<td>Specialty-care focus</td>
<td>Narrow network exclusion</td>
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<tr>
<td>Inpatient orientation</td>
<td>Referral pattern disruption</td>
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Partnership Objectives

- Performance improvement (operational efficiency, clinical quality, cost positioning)
- Revenue diversification (new revenue streams, referral sources for complex patients)
- Narrow network participation, payor partnerships, and enhanced provider networks


Previous AMC-driven partnerships have proven to yield significant strategic, financial, and operational advantages in an increasingly value-based environment.
With new payment mechanisms being adopted by providers, hospitals and physicians will begin to truly understand the cost of the services they provide.

- Establish better cost allocation and reporting systems.
- Create more robust reporting capabilities.

** BETTER REPORTING **

- Identify high-cost services.
- Implement changes and achieve efficiencies/savings.

** ACHIEVE EFFICIENCIES **

- Create pricing flexibility.
- Establish pricing transparency.

** FLEXIBLE PRICING **

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** The Risk Continuum Associated With Existing and Proposed Reimbursement Structures **

- Less Risk
  - Fee-for-Service
  - Medical Home
  - P4P
  - Bundled Payment
  - Payment for Episodes of Care
  - Gain Sharing
  - Global Payment With Financial Risk

- More Risk
The demand for organizations to be more transparent with their pricing will continue due to pressure from both patients and the government.

Pressure from patients, who are increasingly carrying a greater burden of the costs

Pressure from CMS and state governments forcing organizations to be more transparent

Growth of HSA — Qualified High-Deductible Health Plan Enrollment, Covered Lives (Millions)

- January 2013: Individual 2.0, Small Group 2.6, Large Group 9.6, Other Group 1.2, Uncategorized 0.1
- January 2012: Individual 2.5, Small Group 3.0, Large Group 7.9, Other Group 0.1
- January 2011: Individual 2.4, Small Group 2.8, Large Group 6.3
- January 2010: Individual 2.1, Small Group 3.0, Large Group 5.0

CMS has identified significant variation in pricing and cost of care across the county and has released data that shows what providers charge for common services. This data includes information comparing the charges for the 100 most common inpatient services and 30 most common outpatient services.

Source: AHIP Center for Policy and Research, 2005–2013 HAS/HDHP Census Reports.
With a better understanding of costs, providers will begin analyzing profitability more extensively and begin to manage their organizational assets more akin to other industries.

» Providers will begin to understand not only which service lines are profitable, but also which discreet services within the service line drive positive operating margins.

» Comparing financial performance across regions and services will influence key managerial decisions related to consolidation or location of services and deployment of real estate.
Successful organizations will invest in data management to better enable population health, care coordination, and value-based initiatives.

**Strategic planning will include developing enterprise analytics and data management plans to support value-based initiatives.**

**Early adopters will move “beyond the EHR” to integrate data from multiple platforms and enable population health and value-based care.**

**Organizations will develop new skill-sets, organically or through hiring, to support a data-driven culture.**

**Available patient data, historical and across the continuum of care, will allow providers to develop personalized, integrated plans of care.**
While the term “big data” is on everyone’s tongue, extracting actionable intelligence remains difficult. Investment in advanced analytics will also be directed at removing barriers.

Patient privacy concerns and related regulations inhibit the sharing of data and require investment in security capabilities and compliance.

Advanced analytics requires data integration and harmonization, yet important data is split across disparate data platforms.

Valuable data sets are locked away in challenging formats, such as scanned information and free-text notes.

Analytics is often treated as a “nice-to-have” reporting function. A shift is required to become a truly data-driven organization.
Patient Engagement May Be the Most Important Factor in Impacting Value

The National e-Health Collaborative defines patient engagement as “actions individuals must take to receive the most benefit from the health services available to them.”

- Encourage Frequent Communication
- Provide Access Through Multiple Channels
- Educate Patients and Providers Constantly
- Determine What Is Important to Patients
- Embrace Mobile and Wearable Technology
- Shift From Providing Content to a Focus on the Context of Interaction
- Invest in the Right Technology, Both EHR and Third Party
- Employ Analytics to Collect and Distribute Information

Patient engagement is crucial as organizations seek to demonstrate high value care and reduced costs. This starts with providers educating and empowering patients to become active participants in their care and take the necessary steps toward better health.
Engaging Patients Will Require New Approaches

Imagine the potential benefits of communicating with and monitoring patients post-discharge based on their preferred method of interaction.

EXAMPE

1. A provider asks the patient how he/she would like to be monitored post-discharge, and the patient requests an app that can be accessed from his/her phone.

2. The provider prescribes the app and associated instructions for its use.

3. The patient enjoys this method of tracking, is responsible for inputting the requested data during treatment, and actively participates in care decisions with the provider.

4. The provider is able to monitor vital signs and activity levels and adjust treatment in real time.

Outcome

The patient is not readmitted, and the provider shares in the associated cost savings.

In a 2014 Mayo Clinic study, app usage by cardiac stent patients reduced readmissions by 40%.

Historically, patients have been told how they can and cannot obtain care in a very paternalist approach. For example:

- WHICH INSURANCE PLAN(S) THEY CAN CHOOSE FROM
- WHICH PROVIDER(S) THEY CAN SEE
- WHICH PROCEDURE(S) THEY NEED TO HAVE
- WHAT MEDICATION(S) TO TAKE
- HOW MUCH THEY HAVE TO PAY WITH NO MENTION OF COST

With the shift to consumerism, providers and health plans must adopt a more transparent and collaborative approach by asking the patient what he/she wants and sharing decision-making responsibility with the patient.
Because of shifting trends, organizations are adopting a patient-centered, consumer-driven approach to delivering and financing healthcare.

Healthcare organizations will need to identify the wants and needs of heterogeneous patient populations on an individual patient level.

**Examples**
- Detailed demographics information, patient satisfaction surveys, and patient advisory boards

Patients will look for services or products of varying quality and price.

**Examples**
- Retail clinics, urgent care, telemedicine, concierge medicine, and provider-based versus freestanding

Patients must be able to judge differences in the quality and price of services or products.

**Examples**
- Price and quality transparency tools, CMS Hospital Compare, online reviews, and other third-party reviewers.
As costs are shifted to patients via high deductible health plans, increased out-of-pocket responsibilities, and the implementation of reference pricing, patients will increasingly “shop” for providers based on quality and cost.

As a result, consumers will demand:

» Price transparency for services.
» Outcomes/quality reporting from providers.
» Online reviews from other patients.
» Enhanced customer service, from scheduling the appointment up to paying the bill.
» Personalized visits, information, and health recommendations based on their care needs and desires.
Traditional ways of delivering care are increasingly ineffective at meeting the health needs and expectations of the population.

**Old Paradigm**

**New Paradigm**

- Doctor/APC in-person visits
- Telemedicine
- Phone nurse advice
- Secure messaging
- Retail clinics/urgent care
- In-home visits
Innovation in patient care and engagement technologies is creating a renewed focus on reaching patients virtually.
As providers continue to pursue the Triple Aim, patient access will emerge as a pivotal strategic priority.

The IHI Triple Aim

**POPULATION HEALTH**
- Patients need access to follow-up and preventive care.
- Access to clinicians and health information helps engage patients.

**PER CAPITA COST**
- Managing patient health by providing timely care keeps patients out of high-cost settings.
- Optimizing patient access and throughput increases efficiency and utilization of existing resources.

**EXPERIENCE OF CARE**
- Lack of access is the chief complaint reported by patients who switch providers.
- Utilizing multiple avenues for patients to access care is key to a patient-centric care model.
To promote collaboration, achieve strategic priorities, and foster a culture of innovation, health systems will make changes in leadership, talent, and structure.

» Create new leadership positions.
» Fill leadership positions with candidates without traditional healthcare backgrounds.
» Ask current leadership to develop a broader set of business strategy and technical skills.
» Evaluate and review the composition of the Board.
» Add talent/grow capabilities across data analytics, nontraditional health partnerships, innovation, population health management, and transformation and change management.
» Experiment with different organizational models.
Enhance leadership team competencies by adding new roles:

- Population health management (e.g., chief population health officer)
- Change management and transformation (e.g., chief transformation officer, head of cost containment)
- Data analytics (e.g., head of data analytics)
- Nontraditional health partnerships (e.g., chief partnership officer)
- Innovation (e.g., head of technology innovation/ chief digital officer)
- Consumerism (e.g., chief patient experience officer)
Staff Will Be Asked to Expand Roles and Develop New Skills

- Think beyond the traditional hospital walls.
- Foster collaboration between the clinical and administrative staff.

- Continue to build quality and patient safety expertise.
- Focus on improving service and meeting consumer demands.
- Build skills and competencies around care coordination and health information systems.

- Provide a positive experience and be “service” focused/oriented.
- Become the brand ambassadors.
An ECG study of academic medical center performance showed that more integrated healthcare organizations outperform their less integrated peers across multiple metrics.

**Performance Relative to Level of Integration**

**Key Components of Functional Integration**

- **Strategic Planning**
  - A joint strategic plan or two closely related strategic plans are developed through a collaborative process that ensures the two entities are working toward the same goals.

- **Budgeting**
  - Budgets are developed collaboratively to ensure they are synchronized. One of the entities may be contractually obligated to obtain budget approval from the other entity.

- **Capital and Facilities Planning**
  - Multiyear capital plans are developed collaboratively to ensure they are synchronized. A joint committee may be formed to evaluate major purchasing decisions.

- **Hospital Physician Leadership**
  - Decisions regarding the selection of hospital physician leadership are made jointly by the FGP and primary teaching hospital. The FGP has significant influence in the decision (e.g., veto power).

- **Clinical Service Offerings**
  - Decisions to add or grow clinical service offerings is made through a collaborative process.

- **Physician Recruitment**
  - Recruitment of new physicians is done jointly by the FGP and primary teaching hospital in order for the physician mix to complement the long-term goals of the hospital.
Population Health Will Be Defined by Process and Outcomes

**Population Health**

» **Process** — The iterative process of strategically and proactively managing clinical and financial opportunities and resources for the patient population.

» **Outcomes** — Improve the health, experience, and cost of care for the patient population, over time.

Population health, regardless of the definition, continues to become increasingly prevalent as the defined future-state goal for numerous organizations nationwide.
Organizations Will Have to Segment Populations by Risk

Segmenting your risk and addressing each population appropriately are essential for success under population health, and necessary short- and long-term strategies.

**PATIENT POPULATIONS**

<table>
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<tr>
<th>HIGH RISK</th>
<th>MANAGE</th>
<th>RISING RISK</th>
<th>PREVENT</th>
<th>LOW RISK</th>
<th>SCALE</th>
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**KEY COMPONENTS OF DEFINING PATIENT POPULATIONS**

**RISK FACTORS**
- Age
- Disease Comorbidities
- Utilization History
- Social Issues (e.g., housing and job status, insurance coverage, nutrition, obesity)

**DISEASE STATE**
- Chronic Issues
- Acute Issues
- Episodes of Care Management

**PAYOR PROGRAM**
- Full Risk
- Performance Incentives
- Partial Risk
- Metric-Specific Incentives

The result of this effort is to identify the patients who require the most focus and attention.
Organizations will begin to gain the experience necessary to expand population health programs to manage all high-, medium-, and low-risk patients.

**KEY ELEMENTS**

» Data drives any population health strategy.

» Physician engagement is critical to manage risk appropriately.

» A flexible population health approach must be developed.

» Patient engagement should be supported.

» Ensure ongoing management and improvement as patient needs and risk levels change.

» Incentives in place should be put in place.
Total Population Health Requires a Comprehensive Care Model

ECG believes organizations that are able to develop and apply care coordination and care management principles effectively will be the most successful in transitioning to total population health that is payor and program agnostic.

TRENDS

» Patient demands and increasing complexity will place a premium on care coordination and care management efforts.

» With information and experience, care teams will be appropriately defined and staffing models determined.
New Models for a New Era

The transition to value-based care, supported by the Office of the National Coordinator (ONC) for Health Information Technology’s 10-year interoperability road map will change IT departments, not just their technology.

2016 will see healthcare organizations revising their IT strategy and operating models to set the stage for value-based care.

Such thinking will require IT departments to change and:

» Adopt new organizational structures.
» Develop enterprise-based functions.
» Acquire new skill sets.
The 2016 healthcare IT solution landscape will see an increase in EHR replacement and optimization.

Optimization efforts will focus on interoperability and connectivity with various platforms and data sources across the continuum of care.

Organizations looking to replace legacy systems will have to factor-in the needs of potential integrated care partners into the selection process.

At the same time, smaller organizations in need of EHR replacement may look into third-party arrangements with larger partners.
Transition to FFV Should Frame Every Strategic Decision

Each organization’s pacing to a FFV reimbursement environment will underpin nearly every significant organizational decision, but the adoption of FFV will be based on market-specific factors.

### Factors Impacting Pacing

- Market competition
- Payor/employer interest level
- Nimbleness of organization
- Consumer demands
- Alignment level with providers
- Current reimbursement levels
- Current cost levels

### Implications

- Planning frameworks need to be recasted in light of FFV.
  - Strategic
  - Facility
  - Medical staff development
- Traditional decision-making criteria need to be updated.
  - Population management
  - Total cost of care

Market share, whether measured in terms of volume or “lives,” will continue to be critical.
Questions & Discussion

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**about ECG**

ECG partners with providers to create the strategies and solutions that are transforming healthcare delivery. With more than 40 years of service to the healthcare industry, we can help your organization thrive in a value-based world.