

## 2019 Health Care Trends and Critical Success Factors for Health Systems

As 2019 begins, health care plans and provider systems are rightfully perplexed by the clamor of continued Trump Administration efforts to erode the Affordable Care Act (ACA), as well as the broad, and somewhat conflicting, policy assertions of other transformation initiatives. Examples of conflicting policy assertions are found in the Centers for Medicare and Medicaid Services (CMS) recently published, *“Reforming America’s Healthcare System Through Choice and Competition”*<sup>1</sup> where relationships between third party payors and Medicare Advantage (MA) are discussed. Further, the federal court’s ruling in *Texas v. Azar* declaring the entire ACA unconstitutional in a decision rife with questionable legal analysis, has added to this policy haze with a virtual “Sword of Damocles” hanging over the ACA, commonly referred to as Obamacare<sup>2</sup>. Additional uncertainty results from the varying degrees of willingness from health plans (across plans and geographies), to offer meaningfully rewarding risk-based contracts. Complicated by mixed messaging from the Trump Administration on its support of value-based payment (VBP), and the operational complexity of pulling the many required “value-based” components into a high-functioning health system.

As a result, many health systems lamentably believe it is still necessary to continue to keep “one foot on the dock” of fee-for-service reimbursement and “one foot in the canoe” of VBP and population health management. That said, it is clear the health care systems and provider groups that will be most successful over the long-term in 2019 must become experts at managing the health care premium dollar to improve outcomes and reduce total cost for large, attributed populations. These systems and groups need to move from their current core business of health care delivery methods to ones focused on the management of health, wellness and total cost of care for defined populations.

Despite the conflicting messages and moves at the administration and federal court levels, CMS’ articulated policy directives actually intensify the pressure on health care organizations to focus on an ability to thrive in pluralistic payment environments, need to incorporate value into their strategy and manage both health and costs at a population level. This requirement for profitable and sustainable long-term survival stems from several factors:

- **CMS and Alternative Payment Models (APMs).** CMS continues its admonition for the need for payment reform. Its clear intention in 2019 is to move participating provider organizations in value-based payment models away from upside-only or shared risk and towards fully accepting downside risk<sup>3</sup>.
- **Mega-acquisitions and mergers.** New alignments among hospital systems to gain geographic reach, the drive for system efficiencies and contracting advantage create imperatives for value and MSO-like administrative capabilities among provider competitors.
- **Value-based care models that embrace “whole person” care capabilities.** Increasingly, federal, state and even private payors are seeking significant delivery system reforms that combine access to the right level of care at the right time and place with social services support. In particular, employers remain focused on moving the cost and quality needles through value-based payment and innovations.
- **CMS proposals for block grants to states for Medicaid instead of the traditional open-ended entitlement based on matching limits.** Although highly controversial, CMS seeks to impose spending limits on states but will ease rules to run the low-income health program that serves nearly 75 million Americans, from poor children, to disabled people and even to impoverished seniors in nursing homes. Though it is hard to say if or when such a proposal might move to policy (given it will greatly



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affect traditionally Republican strongholds with higher federal to state matching dollars), it is clear health providers and systems must move away from fee-for-service billing as a core strategy.

While many of the noted trends are a continuation from previous years, they remain highly salient to sustainable success for 2019:

- 1. The provider playing field is simultaneously broad and deep.** Mega “horizontal” health system alignments, including Dignity/Catholic Health Initiatives (now known as CommonSpirit Health) and Baylor Scott & White Health/Memorial Hermann Health System, will play out in certain geographies. In some instances, expect to see continued growth in both national and regional health systems. The potential impacts to the health care business of mega-deals such as the CVS-Aetna acquisition, create deep vertical alignments that must be acknowledged in strategy and business planning. 2017’s hiring announcements by J.P. Morgan, Amazon and Berkshire Hathaway continue to create expectations of “radical” change. Finally, health plan owned/affiliated providers, such as the Optum acquisition of Healthcare Partners and the ramped up deployment of Caremore by Anthem and CVS, will be competing for the premium dollar.
- 2. The most advanced health systems and IPAs are developing “narrow networks” of high-performing primary care and specialty physicians.** Health systems committed to accessing more of the premium dollar are using data to better understand the total cost of care impact on the behaviors and referral patterns of primary care physicians and specialists. Even in cases in which the IPA or health system cannot mandate referrals to higher performing specialists, they are working more closely to align high-performing specialists with high-panel density primary care physicians and clinics. This often includes incentivizing and facilitating the development of consensus care and referral guidelines, easing access to high-performing specialists – both in office and through e-consult/tele-medicine and re-aligning financial incentives. Incentives should reflect primary care physicians and clinics ability to manage lower acuity and chronic members while specialists can be more accessible for acute members (including post-discharge) and to enable emergency department diversion.
- 3. Health systems and IPAs are developing provider networks beyond hospitals, physicians and traditional post-acute providers in order to better control total cost of care and take responsibility for more of the premium dollar.** These ventures challenge the trend of outsourcing key profit areas, such as the care of dual eligible and behavioral health, to niche players by putting into place high-risk clinics and proven care management models. At the same time, developing a network that includes high-performing skilled nursing facilities (SNFs) with wound care and other key capabilities as needed, home care that includes remote monitoring and is coordinated with primary care and care management, behavioral health that is both integrated as appropriate and closely coordinated with primary care and community-based organizations with well-defined roles and services enables successful management of all lines of business within defined geographies.
- 4. New health plans popping up.** Some of these are evolving from the provider and MSO world rather than from traditional commercial plans. They focus on provider alignment, member engagement and often offer more flexible sub-capitation and MSO delegation options. These plans are aggressively marketing to health systems and IPAs, particularly for Medicare Advantage (MA). The aim is to co-design MA products targeted at specific markets and collaborate with physicians and the broker community to enroll patients into plans. These plan relationships allow the health system of an IPA to assume incrementally more premium risk and obtain delegation for MSO services as they achieve network adequacy and audit readiness for MSO services.
- 5. A plethora of new and re-made MSOs.** As organizations look to manage more of the premium dollar, more and more health systems and IPAs are looking into building or buying MSOs, even though existing MSOs are changing their business models.

Health systems and IPAs need to determine the exact MSO services they want to excel at in-house and those they rather lease from a highly qualified vendor. These MSO software systems include claims, referral management, utilization management, physician portals, data analytics and other key functionalities all on one platform. A high-performing MSO can add tremendous administrative and operational capacity for a provider IPA or health system. These capabilities can bridge gaps in care and add sophistication to a care management program. However, a poorly run MSO, whether in-house or through one or more vendors, grabs a share of the health care dollar with often little return.

- 6. Data, data everywhere...but how do you use it?** More and more health systems and IPAs are using claims data to understand their opportunities for utilization management. The key is to deploy the right data to the appropriate decision-makers - from primary care physician to care manager to hospital executive and of course, the member or patient - in order to enable better choices. Organizations need to understand how to optimize their contracts (risk-based or not) from a holistic, system-wide viewpoint, looking at all lines of business, facilities, providers and patients. The system electronic medical record (EMR) is inadequate for this purpose; it requires scrutinizing claims data to identify costly network gaps, opportunities for clinical redesign and determine how to transparently and equitably flow funds based on provider impact on total cost and quality of care.

These continuing and even accelerating trends influence our view of critical success factors moving into 2019:

1. Moving beyond the “hunker down” strategy of focusing on reducing costs, improving performance and enhancing revenue cycle to affirmatively building VBP infrastructure elements.
2. Partnering with the right health plans to create a roadmap to premium risk transfer agreements and delegating medical management and key administrative services over time.
3. Developing and implementing a care model that leverages non-licensed care team members in order to maximize top of license value-add for nurses and social workers.
4. Creating and optimizing local networks of high-value physicians and other providers, including those outside the “traditional” health care network, such as FQHCs, behavioral health and community and home-based care.
5. Building a workforce pipeline and training program in order to cultivate the culturally, linguistically and technically competent licensed and non-licensed workforce needed for long-term success.
6. Aligning financial incentives across the network based on key performance indicators salient to various provider types, including primary care, specialists, hospitalists, SNFs, behavioral health, post-acute and others.
7. Leveraging claims data for financial and clinical analytics to identify and drive high-value initiatives.
8. Engaging suppliers, particularly pharmaceuticals and durable medical equipment (DME), in value-based payment relationships that support the overall premium risk contracts for attributed members of health plans and government payors.

The health care universe in 2019 continues to include splashy news stories on new “innovations” and government policy announcements – particularly around the fate of the ACA that often obscures the enduring and undeniable trend to value-based reimbursement among government payors at a minimum. Commercial payors are coming on board the VBP “train” when they identify sufficiently sophisticated provider partners capable of high performing administrative and care management competencies. These trends suggest that the stakes for not “getting in the game” of value-based payment

through shared savings and downside risk arrangements continue to escalate.

## Endnotes

<sup>1</sup> "Reforming America's Healthcare System Through Choice and Competition" <https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf>

<sup>2</sup> Texas v Azar, November 2018 ruling ACA unconstitutional by a conservative Texas federal judge

<sup>3</sup> Texas v Azar, November 2018 ruling ACA unconstitutional by a conservative Texas federal judge that sets a new direction for the Medicare Shared Savings Program (Shared Savings Program). Referred to as "Pathways to Success," this new direction for the Shared Savings Program redesigns the participation options to encourage Accountable Care Organizations (ACOs) to transition to performance based risk more quickly to increase savings for the Medicare and Medicaid Trust Funds.

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