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2020 Health Care Forecast: 4 Key Trends and 10 Essential Strategies

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The new decade has barely begun, but already 2020 is shaping up to be another pivotal year in health care. With all the innovation taking place in payment models, service delivery, technology and other areas, it is easy to lose sight of the fundamental drivers of the emerging health care industry. This article outlines four rock-solid, multi-year trends that continue to define the biggest opportunities and challenges facing both providers and payers. It also lays out 10 strategies that are essential to success in health care in 2020 and in the years ahead.

Trend: Consumerism combined with value-based care is turning patients into members

Whether it's their phone company, their bank, a local grocery store or their favorite restaurant, people today expect ease of access, ease of use, a pleasant experience and high quality. The same is true for their health care providers and payers. People expect to be treated as a customer, to get value for their dollar, and that the organizations they deal with have well-trained staff, have the right technology, and provide a consistent, dependable experience.

"Ah, but health care is different," we say. Well, times are changing. Consumerism, transparency and technology are forcing health care providers to engage with people in the way other industries always have. With more access to information, consumers are more informed than ever, and they expect health care providers to be more accountable and transparent. This consumer-driven behavior has both encouraged and been encouraged by new entrants into the health care space such as retail and technology companies.

To respond effectively to this trend in 2020, health care leaders need to understand how health care consumerism interacts with another key development: value-based payment. The potent combination of consumerism and pay-for-value is changing the roles of both providers and payers vis-a-vis the populations they serve.

Traditionally, the health care "customer" has primarily been the patient — both a recipient of care services and a source of revenue when accessing that care (the more expensive the care, the greater the revenue). As more providers enter value-based payment agreements, and patients demand greater choice and control, the health care customer increasingly becomes a member. In this new relationship, providers are accountable for engaging members proactively to improve their health, ensure their satisfaction and reduce their total cost of care year-round.

Trend: M&A activity is beginning to mature

Health care leaders should expect to see more purchases and combinations take place, particularly activity aimed at vertical consolidation across the health care continuum. As this trend matures, organizations that have already achieved vertical integration will begin to leverage their network resources in key markets, some doing so already. This will take the form of physician and payer exclusivity and aggressive direct-to-consumer marketing and engagement, with some vertically integrated players already engaged in this behavior. With that said, M&A activity that does not rapidly and consistently produce value will likely not survive. Starting now and over the next few years, expect to see larger systems re-organizing in order to maximize value within their geographies.

Trend: Outside capital is driving disruption

Private equity and venture capital will continue to play a major role in health care in 2020. These investors will focus predominantly on disruptive care models that deliver

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or enable delivery of services outside traditional hospital and ambulatory care settings. The good news is that traditional provider and payer organizations that are willing to innovate can benefit from this trend. Health care is still very local, and both investors and investor-funded solutions can generally gain great value from collaboration or integration with local health care infrastructure and presence. Outside investors are also not just supplying cash. They are coming to the table with experience and strategic insights that can help payers and providers be more successful in the emerging health care environment.

Trend: Payers are continuing to transfer risk to providers

One of the few consistent trends in recent decades is the transfer of risk from government payers to health care providers. Under successive administrations, the Centers for Medicare & Medicaid Services (CMS) has clearly focused on both growing Medicare Advantage enrollment and putting providers at risk for Medicare fee-for-service revenue. At the same time, CMS has encouraged states to introduce provider risk for Medicaid reimbursement. Most recently, Medicare Direct Contracting has put capitation at the forefront, taking a page from both the California model and the Medicaid "Innovator" model in New York State. Meanwhile, self-insured employers are learning that they can and must demand the same from their provider contracts. Employers increasingly see risk-based contracting as a way to reduce costs, and they are less and less interested in subsidizing Medicare and Medicaid through higher premiums. If there is an economic downturn in 2020, providers should expect employer pressure on premium costs to increase dramatically.

So what does this all mean for payers and providers? Based on our recent experience with hundreds of health care organizations, the following strategies are essential to success in the next 12 months:

1. For health systems, leverage your employee health plan to learn how to manage risk

Value-based payment and delivery transformation are not the future, they are the present. The good news is that most health systems can start the transformation to value-based payment with the one population for which they are inherently taking full financial risk: self-insured employees. The beauty of this strategy is that lessons learned managing your employee health plan can directly translate to your broader risk strategy. Key learnings include understanding benefit design, leveraging social determinants of health (SDOH) and biometric data, increasing member engagement, using digital health tools and remote visits, and managing the total cost of care from both a payer and a member perspective. These are all essential skills, whether the next move is a direct-to-employer program or any other value-based contracting strategy. If your health care organization is not currently treating its own employees as members, begin laying the foundation for a risk-based arrangement in 2020 and make it a top priority for 2021.

2. Focus on the total cost of care, not just the cost of services

Cost reduction is no longer primarily about per-visit cost, but rather total cost of care per member per month (PMPM). In addition to looking at cost from the payer perspective, cost reduction must also be viewed in terms of the member's out-of-pocket expenses. Put another way, providers must aim to reduce the totality of medical costs for each member they manage, rather than focusing only on the costs for a member when they show up at a clinic or hospital. Farsighted organizations are currently seeking innovative ways to reduce total costs, both medical and administrative. For example, administrative costs are five times higher in the U.S. than they are in Canada. This represents a large opportunity to reduce costs through automation and efficiency. Consider partnering with key payers to reduce duplication and waste by creating more efficient workflows for revenue cycle management, care management and other processes. A provider system that can partner with a payer to provide a high-quality, low-cost product will get more business because this enables the payer to market a more competitive product for both commercial and Medicare Advantage. This approach is much more likely to lead to success as a long-term

financial play than continuing to squeeze health plans for higher fees for services as they in turn are being squeezed for premium by employers, CMS and states.

3. Put member engagement at the center of your risk strategy

Successful health systems, hospitals, medical groups, Federally Qualified Health Centers (FQHCs) and other providers are those that seek to engage with members to improve their health and total cost of care, rather than simply providing episodic services when a patient is sick. Focus on greater engagement through "well care" and high-touch customer service, adopting the mindset of taking accountability for and working to be the first choice for your attributed or assigned members. Excellent customer service is a strategic imperative, since it is a key part of providing a high-quality experience to your member population. Success requires incorporating patient convenience into your engagement strategy, including all of the various touchpoints for entry into and use of your network. In today's health care environment, convenient access is often the primary influence on provider selection. Health system leaders can learn from those such as Kaiser Permanente and cutting edge medical groups that offer expanded hours, team-based care, and easy-to-use member engagement platforms integrated with the electronic health record (EHR). These patient-centered organizations will continue to challenge health systems that focus primarily on hospital revenue.

4. Put value at the center of your network strategy

The topic of member engagement leads to the critical issue of network design. A robust network does not necessarily include the most well-known health systems or the highest-end services. Instead, it means including those providers that deliver the highest value and easiest access. Going forward, network design must focus on delivering highly efficient primary care, urgent care, specialty care and diagnostics close to where members live and work. The system should also include easy access to virtual visits. This approach to network building enables cost control that often does not exist in broad network designs. In addition, the most successful providers will build or contract for exceptional home care and home hospitalization capabilities. Organizations should also begin curating a network of high-performing community-based services to support members with SDOH factors that must be addressed.

5. Expand your definition of quality

Quality is not just "checking the box" on a list of process measures. CMS, employer groups and state Medicaid programs are now encouraging a focus on outcomes to help drive down the overall cost of care. In addition, consumers increasingly expect high-quality care that is effective. As a result, the key metrics going forward will focus on customer satisfaction, total cost of care (and utilization) and actual health outcomes. In 2020, providers and payers should work to align their quality metrics and find collaborative ways to both improve outcomes and reduce the cost to achieve those outcomes. As part of this effort, organizations should streamline their quality metrics and ensure financial incentives are aligned across all entities. Partnering organizations successful in this endeavor will come out ahead over time.

6. Adopt a new definition of market share

Market share is more than just how many people in a region are treated by an organization's specialists and hospitals. In the years ahead, market share will increasingly mean an organization's percentage of the total health care spend for the people in a given geography. In this emerging environment, pure volume will not equate to a dominant market share. Instead, the strategic imperative for providers will be to increase the portion of a given population's premium dollars they are responsible for and therefore have access to. This shift requires a more mature and sophisticated strategy and definition of market share. Providers should not only look at the percentage of various services they provide in an area. To achieve true dominant market share, they should concentrate on maximizing the percentage of the population attributed or assigned to them and maximizing the total accessible premium for those members.

7. Invest in data

Data analytics and clinical Informatics are maturing in their ability to leverage administrative claims data, clinical and lab data, SDOH information, biometric data, ADT feeds and more. This information is critical to performing well in risk arrangements, because it enables provider organizations to predict costs and target interventions to decrease the total medical spend. Going forward, providers should invest in building the capabilities to get timely and actionable data to the right members of the care team and the administrative team. In parallel, data will need to be built into the daily work of key members of the administrative and care teams such that data is provided at the right time to the right team members who are trained to use that data to make key decisions, improve care, reduce today cost and improve quality.

8. Invest in partnerships

Traditionally, payers and providers have been competitors. Going forward, "co-opetition" will be critical for both parties. Success in the new health care environment depends on providers and health plans working together to grow market share, reduce medical and administrative costs, and improve quality. But what about Medicare Direct Contracting? Doesn't this model give providers a new option for bypassing commercial payers and contracting directly with CMS for capitation? Yes and no. The fact is that the vast majority of customers for high-performing health care organizations will remain commercial managed care, Medicare Advantage and Medicaid managed care. Even in direct-to-employer relationships, the third-party administrator (TPA) is often a commercial health plan. The bottom line: Providers need to put more work, not less, into collaborating with payers and payers need providers more than ever as CMS, states and employers demand value based payment provider networks.

9. Invest in people

Health care is a people business. It is made up of people serving and caring for people. That means talent is foundational. Stephen A. Schwarzman, founder and CEO of Blackstone, recently wrote that he only hires candidates who are "9s" and "10s" for executive roles. We need 9s and 10s to want to stay in health care, and we have to give them a career pathway and financial model that will draw and keep them here. In 2020, health care leaders must prioritize creating a pipeline of future talent coupled with training and support programs to prepare current staff for the roles and competencies of the future. This should include the entire spectrum of team members, from care navigators and food preparation teams to physician/executive dyad leaders, advanced practitioners, therapists, technologists and interventionalists.

10. Remember that short-term results are critical to long-term success

Revenue from non-value-based payment sources is still very important in order to fund transformation, particularly for health systems with a more balanced mix of business across Medicaid, Medicare and commercial insurance. Providers must maximize fee-for-service revenue capture while working to transition toward value-based payment. Deeply understanding your cost structure in granular detail and identifying ways to reduce waste are essential. The corollary is understanding and maximizing the unique subsidies available in health care, from Medicaid and Medicare disproportionate share payments to graduate medical education funding, Medicaid provider fees, 340b drug discounts, FQHC wrap rates and others. During the transition to value-based payment, health care leaders must not lose sight of these funding sources and how they fit into the overall revenue and profitability model. This is a critical success factor in an industry with very complex regulations that add significantly to the cost of care.

Embrace change

Many of the "new" ideas and models in health care today are in fact borrowed from other industries. This is forcing most health care leaders into unfamiliar territory. However, it also presents a valuable opportunity to leadership teams that know how to learn and adapt.

In the coming year, it will be important for providers and payers to focus on how consumers are making choice and be able to evolve accordingly. New entrants will continue to rush into the health care space and force innovation on a more rapid timetable than the industry will be ready for. Providers and payers that embrace these changes and build expertise in customer service and value-based payment will thrive in 2020 and the coming decade.

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