COPE HEALTH SOLUTIONS

Key Trends in 2018 for Health Care Organizations Moving to Value-based Payment and Population Health Management

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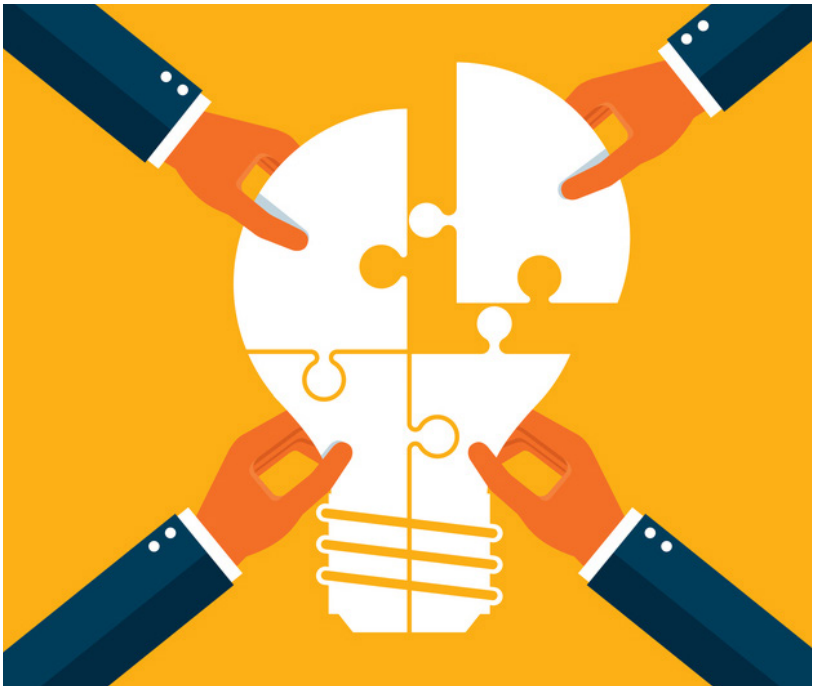

Health care is in a tumultuous time and what's for certain is that nothing is for certain. The passing of the recent Tax Cuts and Jobs Act of 2017 (TCJA) has broad but still not completely understood implications for the business community and economy, including non-profit health hospitals and health care systems, generally adding more complexity and uncertainty. It is also unclear what impact the elimination of Accountable Care Act (ACA) individual mandate penalties will have on uninsured rates. This uncertainty has not stopped, and perhaps has fueled, interest by employers and investors in creating alternative health care financing and delivery models, as evidenced by the recent announcement between JPMorgan Chase, Berkshire Hathaway, and Amazon.

That said, amidst all of the change and noise, there continue to be consistent themes that will enable successful strategy formulation and execution for health care organizations focused on thriving in pluralist payment environments, working to incorporate value into their strategy, and managing both health and costs at a population level. One theme we'll continue to see is fewer health care dollars per person. The baby boomers continue to age into Medicare, and the ACA Medicaid expansion and exchange products continue to cover many Americans. There simply will not be not enough money at the federal, state or employer level to continue to support the continued growth in total health care costs seen in the U.S., particularly given the level of clinical practice variation and inefficiencies in the system, and with expected steep increases in Medicare Advantage enrollment.

As we kick off 2018, we see that some health care organizations are "hunkering down" as they try to ride out the wave of uncertainty and focus on reducing costs, improving performance, and enhancing revenue cycle. Others, particularly those in the process of moving to value-based payment contracts and willing to take financial risk for outcomes and costs, continue to push toward their transformation goals. We believe there are great opportunities ahead for these organizations, particularly as they focus on improving performance under value-based payment contracts, including Medicare opportunities such as Next Generation or Medicare Shared Savings Program (MSSP) ACOs and Bundled Payment for Care Improvement Advanced (BPCI Advanced). Success will require significant delivery system reforms, such as developing well-organized local provider and Community Based Organization (CBO) networks that can combine access to the right level of care at the right time and place with social services support, as well as enhancing care management and utilization review

capabilities while leveraging evidence-based clinical practices and strong data analytics.

Health care organizations that make the right investments in transforming their provider network and population health management capabilities and are strategic and data driven with their transitions into taking financial risk through value-based payment contracts will be well positioned to succeed.

As we look ahead and consider what will impact these organizations, here are a few of the most pressing points that we should keep an eye on:

- **Potential Medicaid Cuts.** Both President Trump and House Speaker Paul Ryan have indicated that "entitlement reform" is on the horizon, meaning that many are expecting Medicaid cuts. While we don't yet know the future of Medicaid expansions, one thing that will hold true for Medicaid is that there will continue to be less premium dollar per member. With this reduction, it will be imperative for organizations to integrate services and create efficient processes to deliver and coordinate care, especially for behavioral health and substance abuse. Having a comprehensive care management strategy that meets the value-based contract objectives will be key. Organizations need to understand how to integrate behavioral health and substance abuse into their networks and care management processes, as well as how to negotiate value-based payment contracts and successfully take financial risk for Medicaid in order to control premium funds flow and design the right financial incentives to power integrated delivery networks.

- **The Grab for Medicare – at the Macro Level.** CMS is more likely to be interested in waivers that give states control to administer Medicare and to share with federal government in savings from reduced Medicare costs. Look for states to find new ways to take accountability for the dollars and reinvest savings locally. That said, there is always the risk that states may take too much off the top to close budget gaps. Those states that can spur innovation between managed care plans and providers, creating Medicare programs that empower providers to redesign care and take financial risk for Medicare the way the New York State Innovator model does for Medicaid will come out the winners. Providers must become experts in managing risk for Medicare Advantage, leveraging MSSP and Next Generation ACOs as gateways to Medicare Advantage.

- **The Grab for Medicare – at the Micro Level.** Hospitals and health systems should expect a continued rise in Medicare enrollment, with more of these enrollees choosing Medicare Advantage. According to CMS, Medicare Advantage enrollment is projected to increase to 20.4 million in 2018, a nine percent increase compared to 2017. More than a one-third of all Medicare enrollees (34 percent) are projected to be in a Medicare Advantage plan in 2018.[1] With the aging population, Medicare will become more and more important as health systems and other providers seek to develop broad-based, whole-person geriatric programs and services, along the full continuum of care, including greatly expanded home care and supportive services. For many, this will require a continued focus on their post-acute strategy and developing narrow networks of high quality home and community care, skilled nursing and other providers (owned or contracted/aligned) in order to reduce avoidable admissions and readmissions while improving quality outcomes.

- **New Value-based Payment (VBP) Models.** CMS announced a new voluntary episode payment model in January, BPCI Advanced, an indicator that there may still be some hope for continued (albeit perhaps not as strong) CMS support for value-based payments. Providers will need to understand their readiness and fit for the various value-based models that are out there, as well as how to optimize and drive value and performance in what we describe as a "pluralistic" environment, where organizations are participating in various value-based arrangements with different payors for different populations. Bundles are just another method of aligning providers and financial incentives, and organizations do not necessarily need to choose between Medicare Advantage VBP contracts and risk, MSSP ACOs, BPCI Advanced and other VBP opportunities. More important is understanding how to optimize and coordinate these models across carefully designed and curated networks serving defined populations across all

[1] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-09-29.html

lines of business. Irrespective of CMS activities, employers are clearly focused on moving the cost and quality needles through value-based payment and innovations.

- **Former Foes, Now Friends.** Look for increasing coopetition between health systems and health plans, and more co-branded insurance products. Health plans will continue to grow their MSO platforms and offerings while being acquisitive to compete in a highly consolidating environment at the macro level. From historically adversarial relations, health systems and health plans are now coming together in many markets to collaborate in an effort to achieve shared goals such as reducing the total cost of care, improving outcomes and increasing patient and provider satisfaction. The key is to pick the right health plan partners and to understand the premium dollar spend and opportunities from a health plan global cost perspective, then to offer specific value to the plan based on network, medical management, performance, coding/data reporting and outcomes.

- **The Return of the Uninsured.** As the current administration continues to put pressure on the ACA exchange products through TCJA and other mechanisms, and more people become uninsured, providers are likely to realize increases in emergency room visits and uncompensated care. Certainly, the proliferation of retail clinics and urgent care centers in the last several years will slow increases, and we are unlikely to see similar numbers to what we saw before the passage of ACA, but new uninsured patient loads may still affect emergency room capacity and throughput, as well as an organization's ability to collect payment for services rendered.

- **Delivery System Reform Will Accelerate.** Despite the uncertain future of the Medicaid waivers and DSRIP specifically, successful providers will continue to restructure the delivery system. Expect more collaboration between large health systems and medical groups, and federally qualified health centers (FQHCs) and CBOs, including housing authorities, schools, civic organizations, and religious institutions, with a focus on providing social support and outpatient services as a means of improving health outcomes and unlocking capacity in the community and inpatient environments. Hospitals and health systems will need to critically evaluate the configuration and capacity of their networks to ensure that they are able to provide the right care at the right time in the right care setting. Some may develop or capitalize on public-private partners and leverage local tax dollars, public and private health care networks and resources to manage both uninsured, underinsured and insured populations through aligned financial incentives. Providers will also need to move more aggressively to eliminate clinical practice variation and coordinate care across the full continuum. Primary care – behavioral health integration, primary care – specialty care co-management, and care transitions will continue to be among the more important micro-trends in the year to come.

- **Workforce Development to Support Population Health Management.** As organizations move to value-based models, ensuring the right culturally, linguistically and technically competent workforce is available to support the care delivery, care management and care coordination infrastructure needed to successfully manage a population is critical. Given several factors, such as the impending nursing shortage and aging population, organizations are looking to create and fill new roles within the traditional care team, such as that of a care navigator, which does not require licenses or clinical experience. Care navigators coordinate care at critical transition points across the continuum, such as by providing follow-ups that identify and help overcome barriers to patient recovery and health, thereby helping to reduce readmissions and other associated costs.

- **Social Determinants and Behavioral Health.** It is the topic on every health care executive's mind and, with the rising opioid crisis, on the front pages of every newspaper. Behavioral health and substance abuse co-morbidities are among the highest heath care cost drivers. Look for continued focus on leveraging CBOs and other partners to come together to help tackle these challenges, as well as social determinants of health, particularly as Medicaid is likely to be hit with cuts. Some more innovative providers will include CBOs in their IPAs or other risk-contracting entities, sometimes offering opportunities such as sub-attribution and total cost of care bonus opportunities to behavioral health, sub-capitation to primary care for certain behavioral health services, and other innovative strategies

that leverage local resources and expertise to address critical issues for community members such as transportation, food insecurity, and inadequate housing.

- **Data, Data, and More Data…but How Do You Use It?** Health care organizations have been investing in data analytics but many still struggle to derive meaning from it. The key is to have the right data in front of the right 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 or not) from a holistic, system-wide view point, looking at all lines of business, facilities, providers, and patients. This starts by looking at not just your own electronic medical record (EMR) but also at claims data, and making the data work to identify network gaps, clinical redesign opportunities and to transparently flow funds based on provider impact on total cost and quality of care.

These are among some of the most critical trends impacting health care organizations that are in the process of transforming and moving to risk and population health management, while continuing to operate in environments still often dominated by volume-based models. Still, there are many other unknowns that may emerge. The big continue to get bigger as M&A activity continues, and we see more and more interesting partnerships emerging that will change the healthcare landscape, such as CVS' acquisition of Aetna and, as mentioned above, the announcement from JPMorgan Chase, Berkshire Hathaway and Amazon that they will kill off the "health care tapeworm."

Also, let's not forget the power of other disruptors and innovation. All of those fitness trackers and wired home devices can be better integrated into care plans, member incentives, cost sharing for health systems interested in innovative coverage of their own employees, and partnerships with other employers. From advancements in precision medicine and the continued growth of retail clinics to new technology like 3D printers, health care can expect shake-ups this year and in the years ahead. Successful health care organizations will take into account all of these trends and considerations (and more) as they continue to work to transform their organizations.

For more information on how to successfully move to risk and optimize value-based models, please contact Allen Miller at amiller@copehealthsolutions.com or (213) 259-0245.