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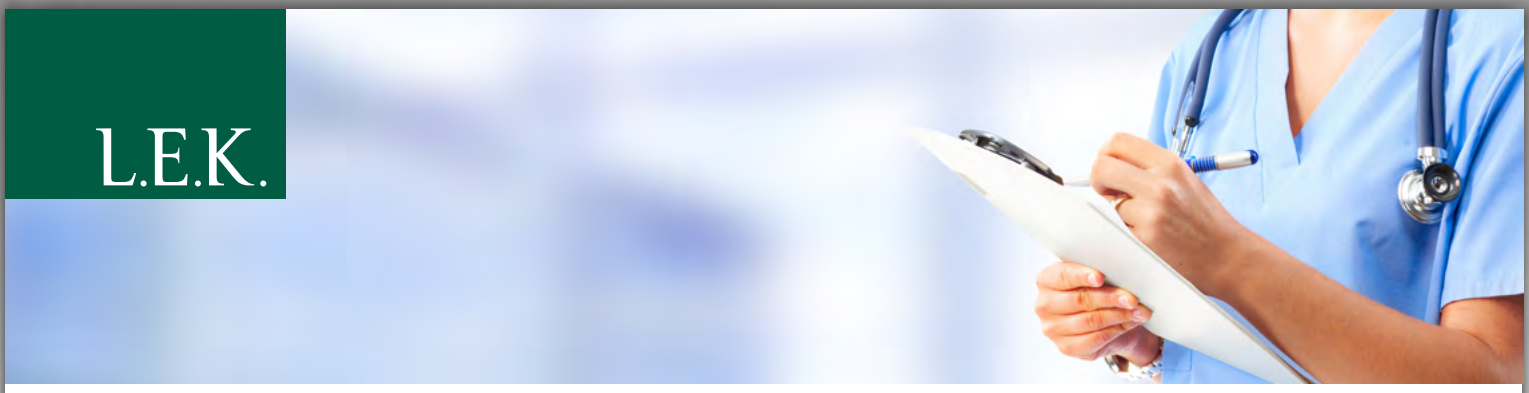

EXECUTIVE INSIGHTS

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Provider Focus: Nine Trends Driving Change in Healthcare for 2015

After a year of unprecedented change due to economic, legislative and care delivery adjustments, 2015 promises even faster changes as we move further along the continuum to value-based care and continue to redefine required competencies and roles in the financing, delivery and support of healthcare in the United States.

The shift toward value-based care has impacted every sector of healthcare from healthcare systems to payers, to physicians and ancillary providers. Healthcare technology and pharmaceutical companies have also not been immune from the impact as they reassess development, purchasing and distribution dynamics, and related processes to meet their customers' demands effectively and efficiently.

What does 2015 and beyond hold for healthcare? What can we expect from all sectors in the trajectory of transformation? How will changes in the overall ecosystem converge to create a value-based care system that will improve clinical outcomes and bend the cost curve?

This *Executive Insights* gives a broad overview of the changes we expect going forward, and the strategies we think healthcare providers will need to adopt to meet these new challenges.

1. The Move Toward Value-Based Care Accelerates

The provision of safe, coordinated, efficient and effective care that not only yields improved quality and outcomes but also reduces costs, sounds like the obvious way to deliver care. However, the traditional fee-for-service healthcare model has not always achieved the positive outcomes expected. Consequently, we are in the midst of a radical change in design and delivery coupled with a move toward "paying for performance" and a related change in provider structure.

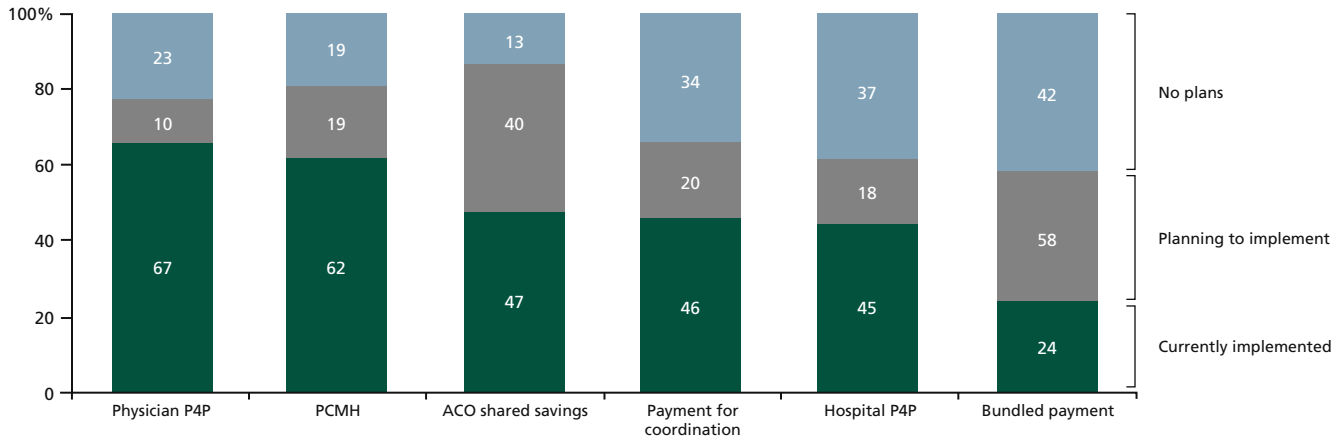
Because the change to demonstrable value will not occur overnight, health systems are feeling the initial shift to a bipolar, often opposing incentivized payment system that addresses the need to align fee-for-service and value-based processes simultaneously, while awaiting the inevitable full shift to value-based care. This bipolar approach is sure to increase costs at a time when reimbursements are being shaved.

All health systems are expected to transition away from the traditional fee-for-service model eventually, and over 90% of providers are currently engaged in some type of value-based care arrangement. Some of the most critical steps of moving from fee-for-service to value-based care include:

Provider Focus: Nine Trends Driving Change in Healthcare for 2015 was written by **Linde Wilson** a global healthcare expert and **Joseph Johnson**, a managing director in L.E.K. Consulting's Healthcare practice. Linde and Joseph are based in New York. For more information, contact healthcare@lek.com.

Figure 1

Current and Future Scope of Value-Based Care Models



Source: Availity, L.E.K. analysis

- Creating an innovative strategy
- Developing an effective model for stakeholder alignment
- Effectively activating a strategy
- Creating a system of measurement and reporting that demonstrates efficacy of care and ensures accountability

2. Pressure for Increased Price Transparency

As consumers share more of the cost of healthcare services, there is increasing pressure for greater price transparency in these services. The theory is if consumers were more aware of pricing for procedures and services and could make more informed choices, healthcare costs could be reduced. Research by The University of Chicago Booth School of Business indicates that price transparency could drive down healthcare costs approximately 7%.[1] With a growing number of consumers paying more out of pocket for healthcare services, health systems are under increasing pressure to make their pricing for the most common procedures and services readily available. Price transparency in other industries is common and has indeed demonstrated a correlation between consumer access to pricing and price reduction.

Achieving cost reduction via transparency in healthcare, however, is far more complex in the sector because 1) consumers are typically part of a health plan that directly negotiates rates with providers; 2) historically, consumers haven't needed to be price sensitive, given that they haven't been responsible for as much of their healthcare costs; and 3) pricing for healthcare services is challenging and depends on acuity, comorbidities and other complicating factors. Despite these challenges, consumers are demanding greater price transparency, and health systems will need to prepare and respond, especially as consumers assume financial responsibility for larger portions of their care.

In response to consumer pressure for transparency, some commercial businesses, employers and even some payers have been developing price comparison tools and pricing estimators. In an unprecedented move this past year, the Centers for Medicare & Medicaid Services (CMS) released a dataset indicating physician payments, by procedure. However, providing consumer access to data that is useful (and not merely retail pricing, which few people actually pay, or regional pricing that is not consumer-specific) remains challenging. Add to this the complexity of adjusting for acuity, comorbidities, geographical differences and practice variation, which has proven daunting.

[1] Christensen, Hans, et al. *The Effects of Price Transparency Regulation on Prices in the Healthcare Industry.* The University of Chicago Booth School of Business. October 2013.

In addition, price comparison without accompanying quality data does not give consumers actionable information to measure value, so it cannot influence their decisions — and ultimately their behavior — in selecting more efficient providers of care. Despite this, the move toward greater price transparency in healthcare is accelerating, and providers and payers should assume it is not going away.

While initial data releases may not reflect precision, price transparency could significantly affect both hospitals and health plans. Couple this with the increase of retail ambulatory healthcare services that are gobbling up volume, and providers are at even greater risk as the move toward such organizations that can easily publish pricing and quality data will escalate in 2015. Providers must be well prepared to respond to this market disrupter.

3. The Retailization of Healthcare

Historically, the U.S. healthcare system has tasked employers with health plan decision-making, access and payment. As a result, healthcare users have been insulated from the impact of lifestyle choices, cost of care and treatment options. This disjointed approach has prevented healthcare providers from developing any significant retail model for healthcare services. Similarly, the approach has made it impossible for users of the system to be true consumers able to make informed choices based on quality and costs. The data to make such choices has not been readily available, and true and lasting incentives have been lacking.

As we continue to see a rapid movement away from the traditional model toward a more consumer-centric one, healthcare leaders need to differentiate their organizations by strategizing and going to market like retail operations. The recent Kaiser Permanente/Target partnership is a good example of how changing market conditions affect providers, and other partnerships and alliances are likely to follow. The retailization of medicine creates an inflection point for traditional healthcare providers, which must rethink their roles and expand their business models.

4. Clinical Integration for Improved Care

Health systems will continue to develop clinically integrated networks in 2015, providing services across the entire care continuum. These services include preventive care, ambulatory care, inpatient acute hospital care and post-acute care (e.g., skilled nursing and rehab, home health services and palliative care) that share clinical and financial information to improve quality and reduce costs. Clinically integrated networks not only allow for longitudinal effectiveness and efficiency, but they also provide a collaborative, pluralistic model that does not have to be owned and controlled by the health system. As a result, the potential to reduce costs can be significant.

Clinically integrated systems will also have well-aligned physicians that are incented to move quickly to this model. Those systems that hesitate to do so may not be able to participate in some payers' innovative reimbursement models and therefore risk losing considerable market share. Since the development of clinically integrated networks requires a complete realignment of the healthcare system and the introduction of additional partners (e.g., post-acute, preventive) into the network, there are five essential elements for success:

1) Effective leadership
2) Aligned incentives
3) Standardized care
4) Coordinated care
5) Enabling technology

5. System Realignment: Turning the Hospital Inside Out

While the health system of the past centered on the inpatient environment, the future health system will continue to shift to more and more ambulatory care, keeping patients out of the highest-cost environment: the hospital. Over the past 10 years, outpatient visits have almost doubled while inpatient admissions and inpatient days per admission are declining.

Since much of the growth emphasis of health systems has previously focused on inpatient care, a renewed emphasis on

the development of ambulatory care as core is necessary in 2015 and beyond. To develop an effective ambulatory strategy, health systems should consider the following:

- Develop goals and objectives for the ambulatory network along with an understanding of the existing portfolio, performance and market-specific competitive threats, which can include disruptive organizations. For example, Walgreens recently submitted an application for three accountable care organizations (ACOs) and is considering the development of a health plan

- Identify opportunities for growth, consolidation or relocation of outpatient facilities through the use of predictive analytic technologies combined with local market intelligence

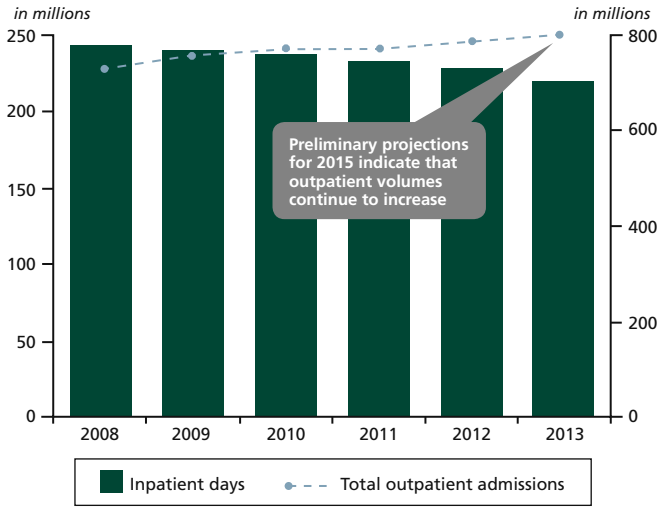
- Create an ambulatory strategic plan composed of a preferred overall model that interfaces well with other parts of the system (e.g., inpatient, post-acute), market-specific strategies and prioritized opportunities

- Ensure robust IT applications are aligned with the rest of the health system

Figure 2

Inpatient and Outpatient Facility Utilization

Growth in Outpatient Admissions is Offsetting Declines in Inpatient Days



Source: AHA, Colorado Hospital Association, athenahealth, Modern Healthcare, L.E.K. analysis

6. Service Lines: Microcosm for Change?

Over the past two decades, hospitals have focused on developing service lines with a marketing focus, demonstrating their expertise and elevating their reputations. Service line models are also an outstanding structure for moving from current models of care and payment to taking on risk. This is especially notable because value-based care organizes care around conditions and their underlying service lines rather than disconnected sites of care.

Currently, most health systems measure their service lines' robustness in a peripheral and often disjointed manner, looking at quality metrics separate from financial performance and efficiency. In fact, many health systems engage in new, innovative programs and services before they gain an in-depth knowledge of each service line-based continuum. A portfolio analysis can benefit the health system by looking at all service lines within the health system and considering not only how resources should be allocated to best benefit the organization overall but also determining areas to strengthen and potential innovations to build out for value-based care. The portfolio analysis assesses the health system's service line based book of business and takes a 360-degree view of each service line including quality, finances and operational efficiency. The purpose of the analysis is to help health systems identify and understand its portfolio of services, and determine areas to consider modifying as a result of value-based care and changing resource allocation.

After completing a portfolio analysis, the health system can better assess changing compensation models and required physician leadership to align incentives. Historical methods to align incentives, such as medical directorships and call agreements, are not sufficient to develop accountability for the performance of the service line. Additional focus on building leadership, changing culture and creating accountability for performance are vital to strategically reposition each service line.

Strengthening service lines is an outstanding way to determine which inclusions are critical to the entire continuum of care.

Health systems can take what they learn from their analysis of each service line and apply it more generally to the entire health system.

7. Impact of Health Exchanges

During the open enrollment period that ended in February 2015, nearly 11.5 million Americans signed up for health insurance through state- and federally run exchanges. Many of these people are newly insured and represent a fresh source of revenue for providers.

But there are also challenges associated with this new group of patients. For example, many have not previously been engaged with the healthcare system. They do not have relationships with primary care physicians (PCPs) or other providers, and will need to be educated on and assimilated into the system. The development of patient-centered medical homes to integrate and educate this population effectively is important to ensure that the system can maintain margins.

Another challenge is that many of the new enrollees are young. While the upside to this is that they are generally healthier than the overall population and require relatively little care, the downside is that they are savvier consumers and have no loyalty to physicians or health systems. As such, healthcare providers will have to work especially hard to develop customer loyalty among these new enrollees.

Finally, new consumers on the exchange also tend to purchase lower-cost options that do not require additional contributions beyond the defined contributions offered. These lower-cost options are often high-deductible plans and have higher copayments. Two trends emerge as a result: first is the bad debt that can potentially occur if consumers are not able to cover the high deductible. Second, and, perhaps even more significant, is that lower-cost plans tend to employ narrow networks. Most providers have little to no experience with narrow networks including the pros and cons of involvement, so they will need to carefully assess their inclusion in these networks. In some cases, narrow networks offer an opportunity for additional market share, but in other cases, the health system can be excluded if cost and quality are not within limits set by the payers.

8. High-Deductible Health Plans

Perhaps the most significant way to bend the cost curve is by giving people more financial responsibility for their treatment and care. That is the idea around high-deductible health plans (HDHPs).

Continued increases in healthcare premiums have prompted employers to find more effective ways to control costs while also providing their employees with expected benefits. HDHPs (also called consumer-directed health plans [CDHPs]), combined with employer- or employee-owned health savings accounts (HSAs), have presented an effective way to contain overall healthcare costs. In addition, combined CDHPs and HSAs provide financial incentives, decision-making tools and wellness programming to encourage employees to choose lower-cost, high-quality providers and eliminate unnecessary care. While only approximately 20% of employers have currently moved toward a total replacement of traditional health plans with a CDHP, 2015 will bring an accelerated shift towards HDHPs with a predicted 9% increase, followed by an expected tripling in adoption within three years.

To adequately address this changing and ever-increasing dynamic, providers need to anticipate and prepare for the following:

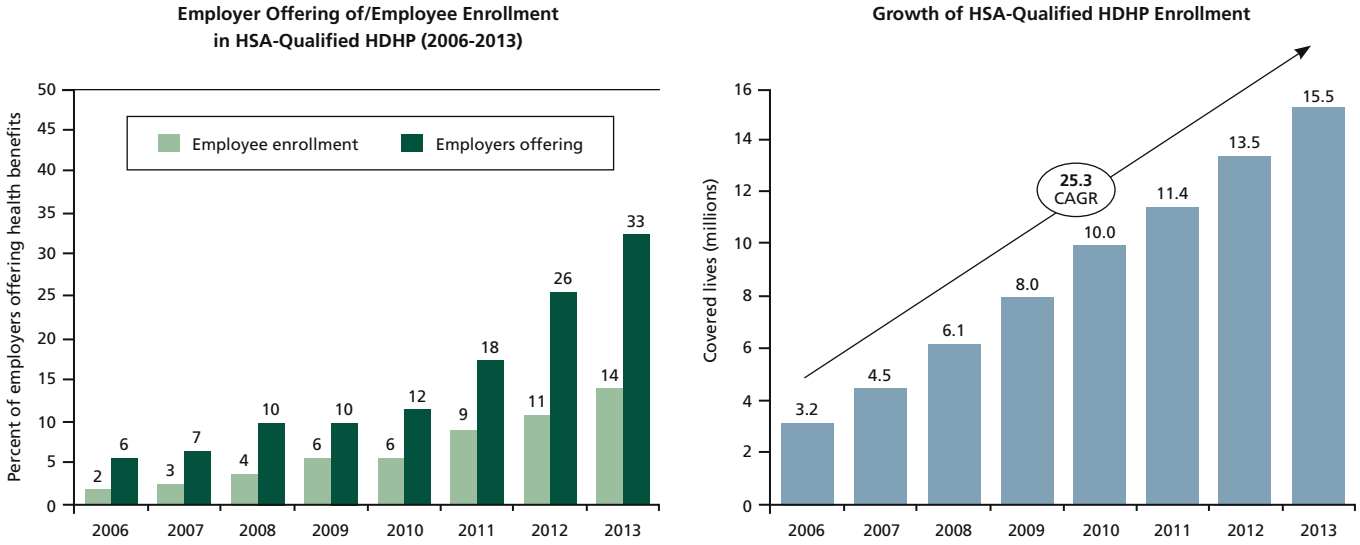
- Fewer people will seek treatment as their financial responsibility increases. Reduced services can have an immediate and long-term effect on providers.

- Patient education on care and finances will need to take a more prominent role. The patient — now the direct consumer — will need to fully understand care delivery options and the associated finances.

- Revenue cycle analysis is essential. In the past, claims accuracy and efficiency were critical, but now, understanding the "holes" in the revenue cycle and thinking more proactively will be more important than ever. Hospitals have had challenges with understanding patients' financial obligations for their care and associated collections. For patients who have high deductibles, it is critical for the hospital to develop

Figure 3

HSA-Qualified High-Deductible Health Plans



Source: America's Health Insurance Plans (AHIP), Boundary Information Group, Citi Research

systems and structures for collection prior to care rather than the current model of collecting 30 or more days after.

- Open and accessible payment plan options are a good way to allow patients to spread the cost of care over time. Most hospitals offer such options but do not often promote or offer them prior to care and treatment or as part of the billing process. Payment plan options may delay payment and increase paperwork, but they also reduce bad debt.

9. Personalized Medicine Moves to the Mainstream

A final trend that is reshaping the market for providers is the move towards personalized medicine — treatments that make use of patients' individual genetic profiles. Personalized medicine can ensure that certain drugs are prescribed only to those who will benefit from them, with fewer side effects. This is particularly evident in cancer treatment.

Personalized medicine will also play an increasing role in the treatment of chronic diseases such as diabetes, asthma and congestive heart failure, because many experts believe these diseases have a combination of causes that includes patients' genetic background. Personalized medicine may be able to control the costs associated with treating these diseases. But this, in turn, will present challenges in tailoring reimbursement to reflect the value of new treatments.

Many progressive healthcare systems have embraced the move to personalized medicine, but the convergence between science and embedded practice has not been as effective. Personalized medicine, therapy and pharmacogenomics have the greatest potential to deliver more efficient healthcare while serving as differentiators for health systems. A great opportunity exists to partner with other health systems to deliver care that is tailored to individual patients and their conditions, lifestyles and goals.

Historically, change in the healthcare model has been slow, but skyrocketing costs; escalating demand from government, employers, consumers and payers as well as advances in technology and treatments, the trajectory of change has been rapid and is expected to increase. Providers that embrace the change will be best suited to serve their communities and ultimately win in the marketplace.

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