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On Healthcare

2018 HEALTHCARE OUTLOOK

Trends impacting providers and payers in 2018, and beyond

Announcer: Welcome to Navigant On Healthcare, offering insights for healthcare leaders striving for success in an evolving industry.

Host: Welcome to Navigant On Healthcare. I'm your host, Alven Weil, and today we are joined by Rich Bajner, a managing director and leader of Navigant's healthcare value transformation segment. Rich and his team have worked with payers and providers in close to 100 markets nationwide, helping them develop integrated network, product, and pricing strategies. This includes design implementation of clinically integrated networks, ACOs and bundled payments. Rich is Lean Six Sigma certified and was recognized by *Consulting* magazine as a healthcare industry rising star of the profession honoring outstanding talent under the age of 35. Welcome, Rich.

Richard Bajner: Good morning, Alven. Great to be with you.

Host: We have the holiday season, we have the wedding season, and we also have what I like to call trend season. Navigant recently released its 2018 healthcare outlook, which looks at the trends that will significantly impact healthcare in 2018 and beyond, and the steps providers and payers should take to prepare for their futures. Rich, can you provide us a few highlights regarding these trends?

Rich: Yeah, certainly. I think over the last 12 to 18 months we, at Navigant, have recognized certain trends developing with our clients and, recently, I started to see increasing literature around some of these trends in industry literature. Certainly, lots of clients and trends around value-based payments and how providers are going to right size their investments in their value-based payment infrastructure to make sure that they're getting their return on investment. Lots of discussion around Medicare Advantage and market opportunities that can present for payers, but also for providers looking for new types of partnerships with payers. Lots of discussion around managing a physician enterprise and moving it from a hosted mentality where physicians are employed by a health system, but really through a hosted mechanism, rather than truly managing a professional enterprise. Then four, what we're seeing, especially with the recent news around large national health systems

SPEAKER

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About Navigant

Navigant Consulting, Inc. (NYSE: NCI) is a specialized, global professional services firm that helps clients take control of their future. Navigant's professionals apply deep industry knowledge, substantive technical expertise, and an enterprising approach to help clients build, manage and/or protect their business interests. With a focus on markets and clients facing transformational change and significant regulatory or legal pressures, the Firm primarily serves clients in the healthcare, energy and financial services industries. Across a range of advisory, consulting, outsourcing, and technology/analytics services, Navigant's practitioners bring sharp insight that pinpoints opportunities and delivers powerful results. More information about Navigant can be found at navigant.com.

developing and growing larger, is how to rein in corporate overhead and maintain an efficient corporate services infrastructure. So, four trends that we're seeing and talking a lot with our clients and with others around the country.

Host: Rich, you mention with regard to value-based investments and reevaluation of those, the need for the providers to dig in and potentially right size the investments that they have made. What are some of the areas in which they really need to reevaluate the investments and what would you say they can do to make sure they optimize those investments going forward?

Rich: I think there's been a little bit of a policy vacuum coming from DC which has created a little bit of a timid stance by some of our providers on what's the future of value-based care. Are the investments that our clients and providers in health systems have made over the last couple years, are they going to pan out over the long term in terms of developing and implementing new business models that can maintain or enhance the financial position of health systems? Over the last few quarters, and about six weeks ago even, we hosted 25 CEOs of leading health systems around the country. The consensus from our discussion with those CEOs was, well it's uncertain what CMS may be doing from a policy perspective, the investments that these leading health systems have made are investments that they're going to continue to make, although they're going to want to right size how they're making the investments to make sure that they can create and drive ROI from the investments they're making.

So, while we know CMS has an aversion to mandatory value-based programs that the current administration's position is these models sway too heavily in hospitals favors, often at the expense of physicians, which has resulted in canceling some of the bundle payment programs or the mandatory bundle payment programs, we're still seeing significant traction in the commercial market from Medicare Advantage plans and how they partner with providers, commercial carriers and how they're looking to partner with providers. So, we still think that there's market opportunity for leading systems to create value from the investments they're making. Especially if they can deliver increased value from the investments. Value in terms of better management of medical loss ratios, MLR, and medical expenses, being able to engage consumers in different ways, being able to create values for employers and end purchasers of care. We still think that there's a market out there for these types of partnerships and ways that health systems can monetize the investments that they're making.

Host: Rich, we've seen recently a few analyses come out regarding the situation specific to hospital revenues and operating margins. For starters, Navigant was working on analyses they recently did that suggests that between 2015 and 2017, average hospital operating margins have dropped 35 percent. Moody's is projecting these trends to continue if not worsen. Moody's recently downgraded a non-for-profit healthcare from stable to negative for 2018. One of the reasons they did that was they're predicting further decline in operating cash flow due to increase or the swelling of staff and technology expenses. All this being said, getting past the "doom and gloom," what can providers do going forward to monetize some of the investments that they've made in value-based care?

Rich: Yeah, and Alvin you mentioned the recent Moody's outlook shifting for not-for-profit healthcare to negative for 2018, which is a recent analysis by Moody's that just came out in early December. However, that being said, it's been our position that some of the underlying trends that changed Moody's perspective and outlook for 2018 are trends that our clients have been asking us about for 12 or even 18 months. Trends related to revenue degradation with shifting and changing of payer mix, to Medicare and Medicaid segments of the business, lower reimbursement rates from commercial segment, not being able to offset and cost shift some of the losses from government payers, shifting of care from inpatient to outpatient settings, etc. So, these are trends that we've been watching, studying and helping our clients solve for the last year or two, so we've been watching these trends with a healthy amount of vigor.

That being said, with these financial pressures a lot of the pressures are on the revenue side of the portfolio, which is requiring our clients to think differently about how to maintain revenue when volume trends are static. Unit pricing is narrowing to more like general economic inflation, and therefore these types of partnerships and these types of business models that can create value for purchases of care and create value for insurance plans still have market attraction to many leading health systems.

Stated another way is, leading health systems have been able to figure out how to create value from these types of partnerships with, whether it's Medicare Advantage plan, Medicaid, managed care organizations, commercial carriers, and how they're caring for the population, how they structure their shared savings agreement and contracts. How they're able to share in some of the premium dollars as they improve their ability to manage care. Certainly, one of the trends that we are seeing from our health system clients is an increased focus on managing care within their system and managing their leakage, or keepage, within populations that they're caring for.

We've been able to, we've seen time and time again in different types of markets from around the country that systems have been able to monetize their investments with the right payer partners, but it does require diligence on the front end to find the right partner, to define the right contract, and then define and get the right logistics in place, whether it's data sharing agreements, etc.

Host: Rich, one of the trends that you pointed to was specific to Medicare Advantage. I just wanted to see if you could just give a quick explanation the difference between a traditional Medicare and Medicare Advantage plan. Maybe include some of the benefits that come with Medicare Advantage, as well as what you're seeing overall in the Medicare Advantage space.

Rich: Yeah, perfect. Medicare Advantage continues to be a rising star in the industry. Enrollment continues to swell. Carriers continue to perform. Providers are more interested in figuring out how to partner in this space. So, it's an area that's generated a lot of interest over the last few years and will continue. Of interest, recently was reviewing United Healthcare investor day documents, and they're projecting Medicare Advantage penetration to continue to rise from about 33 percent nationally today, and for some of their projections at United Healthcare to be about 50 percent over the next decade or so. Certainly, industry market makers are planning huge growth, continued huge growth in this segment.

Why is that? We think that the private version of the Federal Medicare program presents a win-win for Medicare enrollees, payers, and providers. For enrollees, Medicare Advantage plans are often cheaper, less confusing, compared to traditional Medicare. For payers, they like these because premiums are largely paid by the government, insuring a steady revenue stream. Then, for providers, they enjoy the MA plan benefit design that strongly favors in network utilization. It offers a potential revenue stream above traditional Medicare and other commercial revenue sources. So, it offers providers flexibility in accepting risk through value-based plans, with the ability to define what the downside risk looks like and how that contract is structured between them and the Medicare Advantage carrier.

It's really no surprise that MA plans are increasing in popularity. Again, with almost a third, or slightly higher than a third of all enrollees choosing these types of plans, up all the way from 13 percent in 2004. Of interest to us is, again, there's industry examples of how payers and providers have been able to work together to create value both for their organizations, as well as for their enrollees in specific markets. That's differentiated these plans and these types of partnerships from traditional Medicare opportunities.

Host: Rich, any specific examples of how payers and providers are working together to achieve mutual benefits in Medicare Advantage?

Rich: Yeah, certainly. I think there's, I don't want to maybe refer to it too simply as a playbook for how payers and providers are working together, but I think there's some best practices that are emerging and relatively well known in the industry. First and foremost, we know that there are certain levers that payers and providers working together can touch or can influence in order to improve star rating performance. In doing so, a one-star rating improvement could, on average, lead to a year over year 8 to 12 percent increase in plan enrollment. Improving from a three-star plan to a four-star plan could increase revenue anywhere from 10, 15 almost 20 percent. There's revenue growth opportunities by improving star ratings.

Now, we know that plans can't improve star ratings on their own, that they have to work with their provider partners in order to do that. How plans engage providers and things like coding and documentation to make sure that appropriate coding and documentation is a priority and that there's programs to engage physicians in this is

certainly of critical importance. How they work together to engage the patients or the consumers or the members in developing and caring for those patients, whether it's their annual physicals or their annual risk assessments, these tactics really matter and drive employee, or member engagement. They really matter in terms of managing medical loss ratio and they can really matter in terms of improving star ratings, therefore premiums that are available to the health plan and often by contract flow down to the health system partner. So, MA plans can be really attractive and can be a win-win situation or a win-win-win situation for the patients and members, for the health plan, and for the health system partners.

Since MA plan attractiveness is most likely correlated, or is highly-correlated with network provider and enrollee satisfaction, improving star rating requires payers to enhance collaboration with providers through value-based, and often through value-based arrangements. There's recent examples out there. Whether it's the Cleveland Clinic's partnership with Humana and Anthem. Whether it's primary care providers like Oak Street Health collaboration with Aetna, or if it's even some new start up plans that are emerging around the country, but there's an increasing number of partnerships out there between a MA carrier and health system partner.

Host: Rich, one last question for you. We saw a number of significant health system and other healthcare organization mergers and acquisitions at the end of 2017. What's your outlook on M&A activity in 2018, and potentially beyond?.

Rich: Certainly, there's been a lot of press at the end of the year here with some major announcements, whether it's Dignity and CHI or potential Ascension and Providence or some of the vertically-integrated partnerships like CVS and Aetna potentially changing the landscape. Let me maybe address some of what we expect to see in 2018 and what we would anticipate some of these already announced partnerships looking like as we enter the new year. While I think it's really important to recognize that healthcare has made a pretty significant bet that scale and size matters, and underlying that bet is recognition that bringing together two health systems can create efficiencies beyond what that one health system can create on its own, oftentimes those efficiencies are through a centralizing of corporate services or corporate infrastructure.

That being said, we've seen national health systems really struggle with being able to deliver on that promise. Specifically, because healthcare is still very much…is very local. What do we mean by that? One, national health systems have really struggled to define and clarify decision rights under new organizational structures. That's a really important, but often difficult thing to define in a 10 billion, 20 billion, $30 billion health system. Two, health systems need to set very clear performance standards for the new health system. What is acceptable, what isn't acceptable, what type of performance must be achieved. Three, while national in scale, these systems need to be relevant in their local market, especially recognizing that relationships with local employers and physicians are key to driving success both in the short term and the long term.

While these national systems may have an opportunity to reduce duplicative management structures or to streamline some of the corporate service infrastructure, doing so at the expense of some of the local relationships and ignoring some of the local dynamics can backfire as these very large mergers are happening in 2018.

Host: Outstanding, Rich. Thank you so much.

Announcer: That concludes today's episode. Be sure to check in with us for future installments of the Navigant On Healthcare podcast series on navigant.com/healthcarepodcast. Navigant On Healthcare is a podcast series produced by Navigant's healthcare practice. If you enjoyed this episode, please share with friends and colleagues on social media. Learn more at navigant.com.