Healthcare Predictions 2019

Perspectives from Five Industry Experts

CANTON & COMPANY

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Introduction

5 LEADERS

What happens when you ask the same four questions to an internationally-renowned geriatrician, an opinionated healthcare visionary, a population health trailblazer, a leading physician enablement CEO, and the president of one of the most prominent health IT companies in the US?

You get candid insight into their forecasts for healthcare, some common themes, and a set of unique perspectives influenced by each leader's lens on the industry.

To help kick start the new year, we caught up with five of our favorite healthcare authorities for a peek into their industry predictions for 2019.

We asked:

1. What will happen in 2019?
2. What's driving the trend?
3. What impact will it have?
4. What advice do you have for stakeholders?

Not surprisingly, the underlying themes emerging from the discussions included cost, waste, value, and risk. How each of those themes manifested into predictions was rather enlightening in many cases. Read on for insights into why:

- Waste will continue;
- Community- and home-based care will pick up speed;
- Physicians will wrestle with risk and burnout;
- More non-traditional collaborations will keep shaking things up; and
- A mindset change is the key to real success.

Ron Kuerbitz

Bruce Leff, MD

Don McDaniel

David Nash, MD, MBA

Jon Zimmerman

Ron Kuerbitz

- *CEO, agilon health*
- *25+ years in healthcare leadership*
- *Background in dialysis services, home infusion services, laboratory and diagnostic services, pharmacy services, physician practice management, government health plans, specialty ambulatory surgery, med-tech, and manufacturing*

1. What is your outlook for healthcare in 2019? What will change or not?

Overall, I am tremendously bullish for the industry's abilities to deliver on the quadruple aim, and I expect the current tailwinds to continue. We see pockets of significant innovation across the landscape, the current administration appears to be introducing the right constructs and policies to reward quality and efficiency, and leading practices have shown that investments in coordinating care and identifying and managing outlier populations can effectively bend the cost curve.

On the other hand, we should closely monitor the hardships endured by the majority of physicians who still today practice in smaller independent practices. Many find it difficult to make the necessary investments to make a sustainable transition to managing total cost and quality of care. I especially worry that physician burnout and frustration with the transition to risk will increase for most of these providers.

2. Why will these trends continue?

We continue to closely watch the policymaking coming out of Washington. We applaud the administration's support for the growth of Medicare Advantage and for the continued enablement of providers to assume more risk for the traditional Medicare population. Those trends will continue to support investment into integrated payment and care delivery that are critical to the sustainability of our healthcare system. Our physician partners and health plan collaborators recognize that we are at an important inflection point, and both are committed to working together to create an innovative, yet efficient, delivery system.

I believe, however, the most significant risk we have to fulfilling our mission of achieving the highest-quality value-based care at national scale is the leap required to fully integrate healthcare financing with the provision of care. I consistently see practices and health systems struggle to operationalize a gradual glide path to risk. I don't think that's possible. I believe that practices must be positioned to make significant upfront investments in infrastructure and physician incentives, and without that, are likely to experience a growing sense of burnout and frustration in managing risk. These providers – caught with one leg on the fee-for-service dock and one in the value-based care boat – are doing a lot of work, but they're not seeing a lot of improvement in their quality of life at work or sustainability in the investments they've had to make to support this kind of transition.

This is especially prevalent in primary care. Recent studies report up to 65% of family practice physicians are experiencing burnout. Think about the systems in place today; they aren't designed for physicians to be optimally effective. Physicians are managing patients in different lines of business, across numerous payers, in various reimbursement arrangements. The multiplicity of processes, the impossibility of making the right investment, and the inability to change these circumstances is overwhelming and a catalyst for burnout.

3. What impact will this have?

As I said earlier, I'm extremely bullish for the practices and health systems that have taken the leap and made the necessary investments to be successful in true value-based care. I see that physicians have more time to spend with the right patients at the right time. As a result, these physicians are being rewarded for their mastery and sense of purpose and have the capability to make the right investments to sustain their practice and improve their engagement with patients.

However, today these successful practices are still among the minority. The vast majority of others are seemingly caught in a vicious cycle of too little time and insufficient resources to make the leap to risk. They are inclined to become disenchanted with new team-based care models and protocols and might regress back to a focus on pure fee-for-service economics and paradigms.

4. What advice do you have for industry stakeholders who want to prepare for the forecast you've outlined today?

For industry veterans like myself, we've never seen a time where there are such significant tailwinds for improving our healthcare delivery system. Our technologies, policies, capabilities, and economics are highly aligned around quality and efficiency. But we need to take advantage of it, and as such, we need to embrace a mindset change. We're going to have to become collaborators with one another and build better partnerships to take advantage of the opportunities before us. We need to get physicians constructively engaged in the transition from fee-for-service to risk. We have to think about providing support to get them into organized systems on terms that make sense to them.

It's akin to when the Detroit automotive manufacturers embraced vendors in the supply chain. They realized collaboration needed to happen for quality and value to improve. Vendors started attending design sessions and really participating as partners with the manufacturers. The result was quality cars built at lower prices that better met consumer needs. They understood that simply squeezing your counterparts doesn't create value.

Healthcare stakeholders can partake in that kind of thinking – it's the fundamental change that needs to happen.

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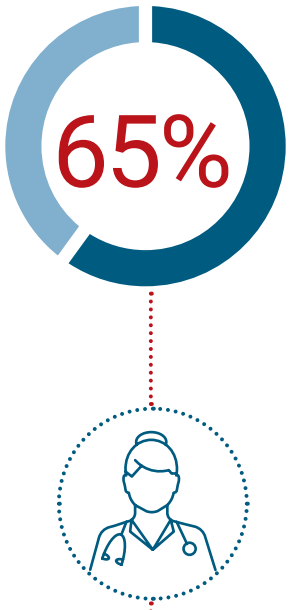


65% of family practice physicians are experiencing burnout.

Bruce Leff, MD

- *Director, The Center for Transformative Geriatric Research at Johns Hopkins, and Professor of Medicine at the Johns Hopkins University School of Medicine*
- *Geriatrician with 30+ years of clinical healthcare leadership*
- *Internationally-recognized leader and researcher in the development, evaluation, and dissemination of novel models of health service delivery for older adults, including the Hospital at Home*
- *Member and Chair-elect of the Council of the American Board of Internal Medicine; past-President of the American Academy of Home Care Medicine; past-member of the Board of Regents of the American College of Physicians*

1. What is your outlook for healthcare in 2019? What will change or not?

Something I've clearly seen increasing at an exponential rate over the last 2-3 years is the broadening interest in care that happens outside of the bricks-and-mortar facility setting. I've been working on the **Hospital at Home** model since the 1990s, which provides acute-level care in the home as a substitute for providing care in the hospital. Over years of study, we've been able to prove that patients want this kind of care. It's been proven to result in lower complication rates, lower costs, and better functional outcomes.

Also, home-based primary and palliative care is seeing a lot of interest, particularly from hospitals where the patient population tends to be older, frail, and with multiple comorbidities and preventable costs.

Even further outside of acute care, the notion of nonskilled or personal care is also undergoing a revolution. If I'm old and frail and I need help taking a bath, that's not a service Medicare will pay for. Plus, these services are not always easy to access, and they tend to be expensive. Now you're seeing innovations where you can use your phone to order one hour of personal care the way you might order a ride from Uber.

As more care moves toward the community, those services will connect with one another, supply chains will develop, and payment models will develop.

2. Why will these trends continue?

I get a dozen cold calls every week from leaders at health systems around the world who are interested in Hospital at Home. What's motivating the interest is: 1) the idea that you can't keep building new beds and expect to create a health system that has economic viability; and 2) the recognition that systems need to develop a repertoire of abilities and competencies if they're going to compete in healthcare in the 21st century.

Hospitals in the last 1-2 years have become savvier about managing readmission penalties, and they're looking for ways to innovate and reduce the inpatient footprint. Also, consider that studies show the range of preventable costs in Medicare is about 5-10% and fully half of those preventable costs are within the frail, older adults. This, too, is driving the interest in hospital at home, and home-based primary and palliative care.

That trend is also driving development of the supply chain and the logistics to provide care in the home. The hospital has an excellent supply chain that generally works well, and it's evolved over time. There's a different supply chain for post-acute, but so far, there's no supply chain for acute care in the home.

3. What impact will this have?

You likely won't see impact in the next year, but you'll see the community-based care trends continuing. We're probably not at the inflection point yet, however, payment model changes will be highly influential. Over 10 or 20 years, you'll see a lot of change. It's a longer horizon to see this play out.

While we're seeing hospitals focused on reducing the inpatient footprint, it's the minority because leadership is still mired in the idea of heads in beds. Over time, the hospital will become a very large intensive care unit – a place where you go for procedures – while all other care will migrate to the community. The challenges in that trend, however, relate to payment. In the next year or so, I think there will be approaches to develop the models for Hospital at Home under fee-for-service.

We'll also see large, innovative companies – the companies who already know how to get products to your door – entering the supply chain space to address the needs driven by home-based care.

4. What advice do you have for industry stakeholders who want to prepare for the forecast you've outlined today?

Stakeholders should think about ways to diversify their healthcare portfolios in an investment sense, but also to think about how to develop competencies that will drive the models to deliver care outside the bricks-and-mortar facility. And it's not something you can learn to do in a few weeks. You must bring the system along with it, including the payers.

Don't take on the whole enchilada at once. For example, maybe start with making sure you're competent in home-based primary care before doing hospital at home programs. There are ways to enter into community-based care without having to do the most expensive model first.

Over time, the hospital will become a very large intensive care unit – a place where you go for procedures – while all other care will migrate to the community.

We'll also see large, innovative companies – the companies who already know how to get products to your door – entering the supply chain space to address the needs driven by home-based care.

Don McDaniel

- *CEO, Canton & Company*
- *25+ years leading and launching healthcare businesses*
- *Serial entrepreneur, noted speaker, author, and visionary*
- *20 years teaching Health Economics for Johns Hopkins University at The Carey Business School and the Bloomberg School of Public Health*

1. What is your outlook for healthcare in 2019? What will change or not?

We're really moving toward an industry – a system – that is going to require more accountability. I'm really struck by the climate of the political and regulatory activity. We will have at least two more years of the current administration creating a macro-environment driving toward greater accountability for the government programs. We're going to see more aggressive movement around true value-based care. Medicare Advantage and managed Medicaid will be a core innovation zone. Hospital and institutional consolidation will continue. The patient-/consumer-as-payer trend will evolve.

This is also the year where organizations will have to start to crack the ROI nut on social determinants of health – is that just a fad or is there really something to it? And the Millennial influence will keep pushing the industry to change its ways.

2. Why will these trends continue?

Medicare and Medicaid are on an unsustainable spending path that needs to be mitigated and controlled – that's the core driver. We're suffering from runaway and disjointed spending and expenses and those pressures are driving the transfer of more accountability and risk to providers. Providers have been trained to believe they have to become bigger in scale to be more competitive and negotiate effectively with purchasers, which is fueling the consolidation trend. The scaling is really about trying to maintain upward pressure on prices.

They're also looking for new ways to curb spend and bring value, which is where social determinants of health (SDOH) could come in. The importance of SDOH has been widely discussed and generally accepted, but it's been largely a science project to date, so organizations will start focusing in on whether there's really a return on those SDOH-related efforts. And it's a really big deal when you consider the federal budget and the bevy of related entitlement programs – Medicare and Medicaid especially. There's a push to driving improvement and making the social safety net more accountable and more efficient.

As the Millennials – the younger generations – mature, so does their purchasing power and influence. They're much more tech-savvy and data-driven than previous generations, and that will continue to place new demands on healthcare.

3. What impact will this have?

The increased transfer of risk will drive more collaboration among organizations, or at least the opportunity for more collaboration – especially between health plans and providers. Corporate purchasers (employers) still aren't getting value from their investments, so expect to see an increased competition from private markets to affect spending.

The transfer of risk might also reinforce the value of provider's investments in capabilities to manage chronic populations, and to manage effectively in non-institutional settings. One of the biggest benefits of digitization is the

"untethering" of patients from hospitals and other bricks and mortar settings. As Hemant Taneja outlines in his new book, *Unscaled*, truly connected health via digitization and supply chain realignment dramatically advances the real possibility of virtual care. In a digital world, we all benefit from the significant legacy investments of those that came before us – like small companies benefit from Amazon's AWS offering. These technological advances, combined with the "regulatory untethering" of payments as we move from pure fee-for-service, will accelerate the importance of new technologies to impact care and lifestyle – like artificial intelligence and virtual reality.

The consolidation trend could go one of two ways. We don't have a good track record of producing benefits for consumers after big hospital combinations, so it will be interesting to see if there's any positive impact on prices as this continues. Also, there are still many incumbents trying to protect the status quo. Those groups coming together and getting bigger could hinder industry progress. Or, those groups could end up getting blindsided by not being able to compete in a market-driven economy.

The Millennial influence, and really the overall push for a better economic situation, will create opportunities for change agents of all kinds. It will also have an effect on the workforce. The Millennials and likely Generation Z are moving toward more of a "gig" economy, where they're going to be increasingly self-employed. That kind of shift will have a massive impact on traditional thinking and employment strategies in healthcare.

4. What advice do you have for industry stakeholders who want to prepare for the forecast you've outlined today?

Start behaving like you're in a much more competitive market. Understand your consumers. Conduct future scenario analyses. If your consumers had the same kind of transparency into your business as they do other retail businesses, like pricing exposure, etc., would they use your services?

Challenge your thinking, stop reading your headlines and don't assume you're "too big to fail." Organizations that don't change over the next 3-5 years won't win.

Invest in knowledge and education for your workforce; ensure they understand what being in a competitive market means to them. Apply technology and tools with visibility into ROI and key performance indicators. Make investments that bring value to your consumers.

Think holistically about health – and the populations you serve. In an economic context, if healthcare organizations become more proficient at serving the "whole-person" there should be more upside. This is especially true with safety-net populations, where enrollees are likely receiving benefits from several different medical and social service organizations – with high probability those services, and the associated spending, are not coordinated.

Challenge your thinking, stop reading your headlines and don't assume you're "too big to fail." Organizations that don't change over the next 3-5 years won't win.

Medicare and Medicaid are on an unsustainable spending path that needs to be mitigated and controlled – that's the core driver.

David Nash, MD, MBA

- *Dean, Jefferson College of Population Health*
- *Author of 100+ peer-reviewed articles*
- *Board-certified internist internationally recognized for his work in public accountability for outcomes, physician leadership development, and quality-of-care improvement*

1. What is your outlook for healthcare in 2019? What will change or not?

I'm still optimistic that we're headed in the right direction. We are inexorably on the road from volume to value. We're not going as fast on the road as I would like and there are a lot of potholes, but I'm optimistic that we're going to continue on this road in 2019, despite the barriers.

What I think will change is greater managed care and government payer attention to value-based payment. What won't change is that we'll continue to have waste: operational (taking years to implement an EHR), individual (obesity, drug addiction), and clinical (inappropriate testing or unexplained clinical variation in physician decision making). We'll also continue to have unnecessary testing, profligate spending, and harm to patients. I don't see fundamental shifts in improving performance at the bedside or in the office.

2. Why will these trends continue?

For-profit payers know that the road to redemption – lower costs and better outcomes – is paved by value-based payment. As for the government, CMS knows that to keep the Medicare Trust Fund solvent they will have to get on the road to risk.

When considering waste, research evidence is accumulating that demonstrates the only way to improve outcomes and reduce cost is by changing economic incentives. Focusing on cost alone is not the way to fix the cost problem. Anybody can cut costs – that's easy. The only way to fix the cost problem is by reducing waste, which is a far more complicated problem.

Reducing waste requires a sea change in our thinking. It takes integration between medical staff, operational staff, and the system itself, but we're not training the kind of practitioners we need to reduce waste. There's very little training in human factors engineering, systems improvement, Lean Six Sigma thinking, behavioral economics, exercise physiology, nutrition counseling, etc. My view is that we're building a Yugo for a marketplace that wants a Tesla.

The same holds true for bedside and office performance. Regrettably, that's not going to change anytime soon because there are fundamental issues in training physicians, nurses, and pharmacists for the future.

3. What impact will this have?

We can expect to see value-based payment models pushed deeper into many markets across the nation, in varying forms such as global payment, capitation, bundled payment, or [initiatives from] the Center for Medicare and Medicaid Innovation.

Regarding waste, the leading organizations – those further down the road on volume-to-value – will make the necessary reductions [in waste] because they know it's the answer to the riddle. The average organization, however, will not be able to make significant progress on that journey.

On the performance side, we'll perpetuate more of the same frustrations plaguing the industry today: unnecessary spending and testing that does nothing to improve health and in some cases causes harm.

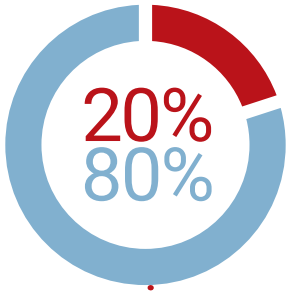
> *What I think will change is greater managed care and government payer attention to value-based payment. What won't change is that we'll continue to have waste...*

4. What advice do you have for industry stakeholders who want to prepare for the forecast you've outlined today?

Change your mindset. Train the leaders today who you want for tomorrow. Embrace a delivery system that understands and harnesses how social determinants impact health.

Delivery of health services is only 20% of the story. The other 80% has to do with poverty, housing, diseases of despair, disparity in income, racism, etc. – the social determinants of health. The delivery system of the future will embrace that definition and deliver better population health management. That means going upstream and shutting off the faucet rather than just continuing to mop up the floor from the flood.

Instead of building another cardiac catheter lab, why not improve nutrition in the community? Instead of investing untold billions on an unrealistic moonshot to cure cancer, why don't we focus on the people [in the community] who still smoke cigarettes? That's where improvements can be made.



Delivery of health services is only 20% of the story.

The other 80% has to do with...the social determinants of health.

Jon Zimmerman

- *President, Virence Health Technologies*
- *Decades of leadership in health IT solutions*
- *Expert in value-based solutions, clinical information exchange, and revenue cycle management*

1. What is your outlook for healthcare in 2019? What will change or not?

It's a big question, and there are a few trends to watch. First, we'll certainly see continued cost, quality and access pressures on the delivery side. Reimbursements are going down, and there's still plenty of waste in the system that must be addressed.

Second is the continued recognition of consumerism. Every single provider will be talking about patient engagement – every single one. It's a top priority. As deductibles go up, consumers are looking at their choices and shopping around for providers, making engagement a big deal.

Another trend we'll see is the movement of the megamergers into their operational phases. CVS-Aetna and Dignity-CHI are two to watch in 2019.

We'll also see the convergence and collaboration of payers and providers accelerate at scale.

2. Why will these trends continue?

Costs are too high and the system is still full of waste. If you look at these economic realities, you can see that stakeholders want to do what it takes to manage costs, while still protecting recurring revenue.

Second, in terms of consumerism, today's technological advancements have allowed consumers to run their entire lives on their smartphones. It's how they engage. That means access to their eyes, ears, and wallets is more distributed than ever before. If you can tie in the services you provide to digital devices, you'll be able to develop consumer loyalty. Also, keep in mind the market demographics are changing. Millennials and Baby Boomers have lifestyle and behavioral characteristics that are fueling the tethering of healthcare to technology devices.

The mergers have reached that point in the process where operational integration starts to happen.

Payers and providers have been co-dependent forever, but they don't understand how each other operates and their interdependent processes are disconnected. The continued movement from volume to value and transition of risk to providers will force more collaboration and interest in understanding each other's businesses.

3. What impact will this have?

There could be new winners and new losers in healthcare because this environment creates a lot of opportunity for innovation and experimentation. That's why you see artificial intelligence start-ups and connectivity initiatives – along with the capital to support it.

We'll see more business collaboration among stakeholders, whether for survival or to allow them to evolve into the next generation of winners. Those who can take advantage of all these changing forces at scale will grow.

We also might see more attempts from national employers to secure direct contracting with risk-based providers. Look at the behemoths: Amazon, Walmart, and Google – they have a tremendous number of employees. Why would they need an insurance company? There's an interesting new mix for healthcare contracting that is built on this type of scale.

In 2019, we'll see more traction among large players trying to consolidate and control the value chain. For example, I bet there's some good dialogue going on at Aetna and CVS about how to take a certain number of steps out of the prior authorization process for specialty pharmacy. As industry synergies become more evident among the players, waste will become more evident in their respective healthcare ecosystems, and there will be natural incentives to make the changes needed to drive out waste. These 'aha' moments will happen at scale in 2019.

We'll see more business collaboration among stakeholders, whether for survival or to allow them to evolve into the next generation of winners. Those who can take advantage of all these changing forces at scale will grow.

4. What advice do you have for industry stakeholders who want to prepare for the forecast you've outlined today?

Take the time to understand your customers' businesses and their ecosystems. Understand your own ecosystem. Figure out how you can take advantage of the shifting dynamics we've talked about today. Understand your partners' businesses. Identify areas of overlap and disconnect – that's what causes all kinds of waste and pain for everybody in the industry. There are many players in the ecosystem, but if we work together, we can create a smart health market. The smart health market will be an intelligent, sensitive, integrated ecosystem that is about more than just healthcare – it's about health itself.

Understand your partners' businesses. Identify areas of overlap and disconnect – that's what causes all kinds of waste and pain for everybody in the industry.

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