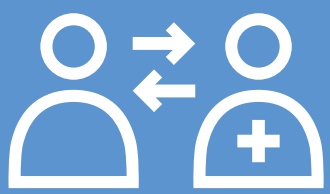
HEALTHCARE TRENDS
Insight for Resilience

HANYS®
Always There for Healthcare

2019 Edition

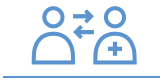


Understand consumers

Control the dollar

Embrace technology

Innovate in workforce



In 2018, the HANYS board of trustees undertook a long-range scenario planning process to help members adapt and thrive in a changing world. The board focused on factors and trends influencing healthcare, with a special emphasis on the role of technology and the growing gap between haves and have-nots in our communities. By examining how these trends could plausibly play out, the board developed strategies to prepare New York's healthcare providers for an uncertain future.

This process identified four overarching strategies to help member organizations be resilient regardless of how the future unfolds:

- **UNDERSTAND CONSUMERS** — The needs and expectations of the healthcare consumer are changing and demands for affordability, quality and convenience are rising. Keeping pace with consumer expectations is critical for future success.
- **CONTROL THE DOLLAR** — Given the large share of government-funded healthcare, declining revenue, shifting patient volumes and ever-increasing costs, gaining control of the healthcare dollar is a critical resiliency strategy for hospitals and health systems.
- **EMBRACE TECHNOLOGY** — Every industry is impacted by technology, including healthcare. Providers must swiftly adopt the right technologies and partners to thrive in the changing healthcare landscape.
- **INNOVATE IN WORKFORCE** — Healthcare will continue to be the number one source of jobs in the U.S. As healthcare delivery models change, non-traditional workforce roles have emerged, demanding that the market keep pace and innovate to remain competitive.

To guide the association and our members' work in these four areas, HANYS formed a Strategy, Innovation and Policy Committee in early 2019. Comprised of board members, the committee is charged with developing strategies and positions on emerging issues, exploring promising new policies and care delivery developments and guiding advocacy and policy positions.

Leveraging our four resiliency strategies and the expertise of our SIP committee, ***Healthcare Trends, Insight for Resilience*** is a resource for healthcare decision makers charting a future course at the macro level, micro level or anywhere in between. This document identifies intersections between the healthcare trends and our four resiliency strategies. The endnotes section identifies resources leveraged to create this report.

We hope this report is helpful as you chart your future course.

HEALTHCARE TRENDS: Insight for Resilience is a product of HANYS' Strategy, Innovation and Policy Committee

Questions about HANYS' healthcare trends?

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RESILIENCY STRATEGIES KEY

- UC Understand Consumers
- CD Control the Dollar
- ET Embrace Technology
- IW Innovate in Workforce

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Healthcare Cost and Payment

National healthcare expenditures continue to exceed general inflation.

Control the dollar

Healthcare spending growth continues to exceed general inflation rates. From 2013 to 2017, national health expenditures increased annually by an average of 4.5% — almost four times the increase of general inflation as measured by the Consumer Price Index for All Urban Consumers.[1]

U.S. healthcare spending in 2017 hit $3.5 trillion; 17.9% of Gross Domestic Product, dwarfing other developed countries. However, spending growth dropped in 2016 and 2017 compared to 2014 and 2015, when Affordable Care Act coverage expansion and prescription drug costs drove higher growth rates.[2]


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The population is aging and becoming more diverse.

In 2016, there were 49.2 million Americans age 65 and older, comprising 15% of the total population. By 2030, the population for this age group will balloon to 73.1 million (comprising 21% of the population).[3]

This demographic trend is similar in New York, with an expected 40% increase in the population age 65 and older, from 3.1 million in 2016 to 4.3 million in 2030. As a percentage of the state's population as a whole, this would represent an increase from 16% to 21% by 2030.[4]

These population trends are important because providing healthcare to the elderly is five times more expensive than kids and three times more expensive than adults.[5]

The race and ethnicity of the U.S. adult population continues to shift substantially. Driven by declining birth rates and an aging population, the non-Hispanic white population is the only group projected to shrink in size. By 2060, the following groups will see the largest shifts: the white population overall will decline from 76.9% of the population to 68%; the Hispanic population will grow from 17.8% to 27.5%; the Asian population will grow from 5.7% to 9.1%; and those with two or more races will comprise 6.2% of the population, growing from 2.6% currently.[6]

Likewise, for children, the non-Hispanic white population will drop from 51.1% of the population to 36.5% by 2060. Like adults, substantial population increases are projected for children who are Hispanic, Asian and those with two or more races.[7]

Long-term care costs put Medicaid fiscal stability at risk.

Control the dollar

In New York, 63% of state Medicaid spending is directed to the aged and disabled, reflective of about 22% of enrollees. This is comparable to the nation; however, there is wide variation in per-enrollee spending levels between states for these populations.[8]

New York reduced its average Medicaid per-beneficiary "spend" by 18%, from $10,684 to $8,731 between 2010 and 2014.[9] However, spending levels remain high, especially for the aged and disabled. New York's average spend on the aged is about 60% higher than the nation and New York's spend for the disabled is 50% higher than the nation.[10]

Two drivers of this higher spend in New York are home- and community-based services and nursing home care.

Specific to HCBS, New York's program of personal care for the elderly and disabled living at home pays for more hours of home attendant services than are authorized in any other state.[11]

The high use of community-based care has not reduced nursing home utilization. New York has the greatest number of nursing home facilities in the nation and ranks second for total volume of nursing home days.[12] More than 70% of nursing home residents in New York are insured through Medicaid.[13]

The future of Medicaid spending for long-term care is further complicated by the expected growth in the aged population over the next decade. Demographic projections for New York show a 40% increase in the population age 65 and older between 2016 and 2030. Enrollees over the age of 65 accounted for about 11% of New York's 6.6 million Medicaid enrollees.[14] Given commensurate growth in the aged population, Medicaid could see an increase of more than 290,000 people age 65 and older by 2030.

Control the dollar

The increasing federal debt threatens healthcare funding; New York State faces comparable budget challenges.

Currently, the U.S. debt held by the public stands at about $16 trillion or 78% of GDP — up from $5 trillion or 35% of GDP at the end of 2007.[15] The total debt for the U.S. is currently $22 trillion or 105% of GDP.[16] About 60% of federal spending is defined as mandatory (mainly Social Security, Medicare and Medicaid).[17] Funding these mandatory priorities and others, and/or changes in tax revenue, each year lead to federal budget deficits and subsequently increased federal debt obligations.

With the expectation that federal budget deficits will continue, debt held by the public is expected to increase from 78% to 144% of GDP by 2049. To maintain debt levels at the current share of GDP in 2049 (78%), the federal government would need to increase revenues by 11% or decrease spending by 10% each year. To reduce the U.S. debt to 42% of GDP (the 50-year average), the federal government would need to increase revenues by 16% or decrease spending by 15% each year.[18]

The increasing federal debt is compounded by predictable increases in federal spending to manage Social Security and the aging population, anticipated healthcare spending growth above general inflation and increases in federal spending to address security and infrastructure needs, among others.

Given the spending increases that will be needed to address both mandatory and discretionary items, increases in federal revenue/taxes would likely need to occur. Those increases may ultimately have no controlling effect on the ballooning debt.

Efforts to manage these debts and deficits would put federal spending across the board, including healthcare, at risk.

Comparable to the federal government, New York state faces perennial budget challenges — though state budgets are required to be balanced each year. New York's fiscal year 2019-2020 budget is about $176 billion.[19] While year-to-year budget increases have been relatively stable, averaging about 3% annually over the last decade, the overall budget spend in New York (population 19.5 million) is second only to California, whose 2019-2020 budget is $215 billion (population 39.6 million).[20]

With 61% of New York's budget targeted toward healthcare and education (inclusive of state and federal spending),[21] if increases to state revenue/taxes are not pursued, lawmakers will no doubt look to these sectors for relief from structural budget challenges.

Medicare and Medicaid payment rates are not keeping pace with provider costs.

Control the dollar

New York hospitals lose billions of dollars each year treating Medicare and Medicaid patients. On average, Medicare pays 93 cents for each dollar of care provided in New York; Medicaid pays 73 cents for each dollar of care provided.[22] These underpayments are exacerbated by new costs hospitals face to meet unfunded regulatory mandates. In addition, societal changes require increased spending on physical and virtual security to protect workers and patients.

Medicare and Medicaid underpayments have an acute effect on New York hospitals' finances, as about 70% of inpatient discharges and 63% of outpatient visits are linked to Medicare and Medicaid beneficiaries.[23] This underpayment has been consistent over many years, with Medicare payment levels deteriorating notably over the last decade.

The state has identified a high Medicare patient mix combined with low patient volume as an indicator for being considered a "distressed" hospital. A high Medicaid patient mix combined with high patient volume is a leading indicator of distress for downstate hospitals. Distressed hospitals receive state funding to retain services in vulnerable communities.

Specific to Medicare, ACA provisions and other congressional and regulatory actions are expected to reduce Medicare and Medicaid funding to hospitals and health systems by about $40 billion over the next decade (2019-2028). These reductions include update factor and sequestration cuts, site-neutral, 340B Drug Pricing Program and Disproportionate Share Hospital funding cuts. These cuts will reduce Medicare funding in aggregate to New York's hospitals by 13% over the next 10 years.[24]

Specific to Medicaid, baseline payment rates were recently updated for the first time in more than a decade. This payment suppression has been exacerbated by ACA coverage expansion, as 78% of ACA's coverage expansion in New York was in Medicaid/Child Health Plus.[25]

While more coverage expansion is good for New Yorkers, it has impacted hospital finances. Data reported by hospitals on the Internal Revenue Services' tax Form 990, Schedule H, shows that financial assistance provided by hospitals decreased by 8% from 2013 to 2016 — a response to more covered lives in the state.[26] However, reported Medicaid losses on Schedule H have spiked increasing by 51% in that same period from $2.2 billion to $3.4 billion (this does not include Medicaid losses of New York's public hospitals, which are exempt from reporting on Schedule H).[27]

The state has recognized persistent Medicaid underpayments to hospitals and health systems in recent years with specific state-funded investments: $3.8 billion in capital and "capital-like" funding, $2.7 billion in operating funds for distressed hospitals and $775 million in other supportive funding (e.g., quality pool, Vital Access Provider, safety net). DSRIP funding has also been used as a mechanism to fill Medicaid funding gaps.[28]

Control the dollar

The gap in providers' fiscal health continues to grow.

The average operating margin for New York state hospitals and health systems has increased over time (from +0.4% in 2013 to +1.4% in 2017), driven by the financial performance of higher-revenue institutions.[29] The median operating margin, however, has declined from +0.4% in 2013 to +0.2% for 2017.[30] This difference is an indicator of the growing gap in fiscal health between providers in New York.

The gap in fiscal health is stark, as seen when comparing payer mix, volume and revenue trends for New York's distressed hospitals with those of the top 15 grossing hospitals in the state. Distressed hospitals are a subset of about 40 hospitals, inclusive of New York City Health + Hospitals, which receive supplemental funding from the state to sustain healthcare services in vulnerable communities. The top 15 grossing hospitals reflect those posting a 3% or greater aggregate operating margin over the past five years.[31]

Payer mix: For the distressed group, 74% of revenue is tied to Medicare and Medicaid, compared to 45% for the top 15 group. Revenue from the better-paying commercial insurers is at 17% for the distressed group; 53% for the top 15 group. Both groups show a trend of increased rates from commercial payers and declines from government payers.[32]

Patient volumes: Inpatient volume declines of 20% are observed for the distressed group since 2009 compared to a 2% increase for the top 15 group. Outpatient volume has remained unchanged for the distressed group since 2009, with a 74% increase for the top 15 group.

Revenue: The influence of these payer and volume trends is substantial. Patient service revenue has remained flat for the distressed group since 2009, compared to a 71% increase for the top 15 group.[33]

These payer, volume and revenue results give insight into the fiscal complications hospitals and health systems can face and how the fiscal status of a hospital is very much tied to the communities it serves and the financial strength needed to capture and retain market share.

For nursing homes, financial pressures, including from inadequate Medicaid rates, have facilitated the sale of numerous hospital-operated nonprofit nursing homes to for-profit operators.

APMs and VBP are leading tools to reform care delivery and reimbursement.

Control the dollar

Innovate in workforce

Despite mixed financial and quality results, Medicare, Medicaid and commercial insurers continue to use value-based and alternative payment models as tools to reform the delivery of care and payment.

The number of Accountable Care Organizations engaging in Medicare continues to increase. In 2014, there were 338 ACOs nationally participating in Medicare's voluntary Shared Savings Program — touching 4.9 million Medicare beneficiaries.[34] By 2018, the program had doubled, with 561 ACOs touching 10.5 million Medicare lives. Comparable increases in ACO activity have been observed in the commercial market.

While two-sided financial risk-based models have been generally limited in Medicare, their APM models appear to be trending as voluntary models that will require participants to assume more financial risk sooner. Medicare's new ACO and bundling models both require more financial risk. Medicare's Bundled Payments for Care Improvement-Advanced bundling program has seen a 16% drop in participation (from 1,547 hospitals/provider groups to 1,295) as financial risk increased;[35] changes in ACO participation rates will have to be assessed as program changes take hold.

Despite these challenges, Medicare, via its Centers for Medicare and Medicaid Innovation, continues to advance new voluntary payment bundling models for hospitals and physicians and is pressing the APM track as the best way for practitioners to engage in Medicare's Quality Payment Program. Currently, only an estimated 5% to 15% of clinicians use the APM track to meet the QPP standards.[36]

In New York, the state's Delivery System Reform Incentive Payment model requires hospital and clinician engagement in value models. DSRIP demands at least 80% of Medicaid managed care spending be tied to APMs by March 2020, with a recent survey indicating about 63% of spending is currently tied to such models (driven by capitated arrangements with provider-sponsored plans).[37] Of the 63% of Medicaid spending tied to value models, the state reports that about 27% is tied to partial or full financial risk models.[38]

Despite the focus on alternative and value-based models in healthcare, consumers remain relatively unaware of what these models mean to them or their care, with about 80% consistently reporting that they are not at all or only slightly familiar with terms like ACOs, bundled payments and value-based care.[39]

Access to Care and Insurance Coverage

The cost of health insurance premiums continues to grow.

Understand consumers

The average family annual health insurance premium was about $20,000 in 2018, a 47% increase over the last decade.[40] For seniors, the Medicare Part B premium has increased by 40% since 2010 and now sits at $135 each month.[41/42]

High-deductible health plans are now used by 29% of workers; up from 11% from a decade ago.[43] While HDHPs are attractive to workers because the premium price point is typically lower than traditional medical plans, premium growth for HDHPs (68%) has out-paced growth for traditional plans (47%) over the last 10 years.[44]

Wages are not keeping pace with increases in healthcare costs for workers. Over the 10-year period 2006 to 2016, worker wages rose by only 29%.[45] Without wage increases that are comparable to rising healthcare costs, consumers will continue to face healthcare costs that are unaffordable and unsustainable over the long term.

Understand consumers

Out-of-pocket healthcare costs continue to rise.

Out-of-pocket cost sharing, consisting of deductibles, copays and coinsurance, is up 54% for the period 2006 to 2016 for those with employer-based insurance coverage.[46] As a result of the increased use in HDHPs, deductible spending has spiked by 176%, with copayments declining by 38%.[47] The average deductible for covered workers was $1,573 in 2018.[48] For seniors, the Medicare inpatient deductible has increased 24% over the last decade.[49/50]

The rise in deductible costs is a major factor in health insurance affordability and care outcomes for consumers. Four in 10 people enrolled in an HDHP cannot afford the deductible.[51] One in four skip care because of cost; nearly 50% of Americans are concerned that a health emergency will cause bankruptcy; consumers borrowed $88 billion last year to pay for care.[52]

These out-of-pocket costs not only impact consumer finances, but also the finances of hospitals and other providers. Unpaid deductibles and copays equate to direct revenue shortfalls for providers.

Public and private initiatives are calling for price transparency.

Understand consumers

Control the dollar

To propel the healthcare industry toward the broad-based disclosure of provider-specific pricing strategies, in June 2019, President Trump issued an executive order on price and quality transparency. The expansive order directs agencies to issue rules for how hospitals would make privately-negotiated price information public, how information about out-of-pocket costs could be made available to patients before they receive care and what public and private factors are impeding healthcare price and quality transparency for patients. The consequences of this executive order will emerge in the near future.[53]

The order builds upon the Trump administration's efforts to make hospital charge data (pre-negotiated prices) more widely available and expand the availability of hospital pricing information via electronic health records and related technology.

There is no evidence that the broad-based disclosure of hospital charges or insurer-hospital negotiated prices across a full suite of hospital services helps consumer decision-making or lowers overall health system costs. While cost information may not drive decision-making, 65% of consumers report that transparency about cost information before healthcare services are provided is a factor in determining satisfaction.[54]

Countless private initiatives leverage commercial and public insurance claims data to provide consumers with comparative cost and quality data. Additionally, many public initiatives exist, with at least 25 states pursuing price and quality transparency initiatives.[55] In New York, the "NYS Health Connector" is a public-facing component of the state's developing All-Payer Database and includes hospital-level average volume and cost data across planned cardiac, newborn, joint replacement, bariatric and spinal procedures. Quality performance data are also provided.[56] All of these disparate initiatives will be impacted based on how the president's executive order is implemented.


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Single payer, other coverage expansion ideas gaining traction in quest for access and affordability.

Single payer and other coverage expansion ideas are gaining more traction in public discourse about healthcare because of healthcare cost increases and concerns about coverage adequacy. Since the election of President Trump in November 2016, the uninsured rate has increased from 10.9% to 13.7%.[57] Additionally, total U.S. healthcare spending hit $3.5 trillion in 2017, or $10,739 per person; 17.9% of GDP.[58] From 2013 to 2017, national health expenditures increased annually by an average of 4.5% — increasing almost four times the rate of inflation.[59]

These spending factors, along with premium and out-of-pocket costs and the approaching 2020 presidential election, have positioned single payer concepts as potentially viable options to address these issues.

Generally, single payer ideas, whether national or state-based, would provide medical coverage to all (both citizen and non-citizen depending on the proposal), replace premiums with new business and individual tax levies and seek to control costs by controlling payment rates to providers; reducing administrative expenses and using government leverage to limit other major healthcare spending, such as pharmaceutical spending. These ideas also hold the promise of eliminating consumer out-of-pocket spending, a leading problem with healthcare affordability for consumers.

There are currently 10 proposals in Congress that would establish a single payer system or push the U.S. toward a single payer system with the availability of Medicare or Medicaid expansion and/or public insurance options.[60] However, Nancy Pelosi, Speaker of the U.S. House of Representatives, has insisted that strengthening the ACA is the first step before single payer models can be further explored.[61]

In New York, the state-based single payer proposal, the New York Health Act, has passed the New York state Assembly consistently but has yet to receive consideration by the state Senate. With both chambers of the New York state legislature controlled by the Democratic Party, the adoption of the NYHA is a persistent consideration.

Technology and Consumerism


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Major tech firms are expanding their footprint in the healthcare marketplace.

Operating on the premise that healthcare is ripe for digital transformation, technology giants are advancing their healthcare footprint.

Google, Amazon, IBM, Microsoft and others all have HIPAA-enabled clouds and a variety of wrap-around services, including traditional analytics, deep/reinforcement analytics for the provision of care (artificial intelligence and machine learning), consumer engagement, data-interoperability support and genomics work to advance precision medicine.[62]

In the most compelling example of major tech firms growing their healthcare footprint, in June 2018, Amazon purchased PillPack for $750 million, allowing Amazon[63] immediate entry into the $500 billion prescription drug business for millions of customers. Amazon touts using design, service and technology to improve consumer medication management.[64]

Additionally, since last year, Apple substantially grew the number of providers leveraging its Apple Health Records app, which is live now with more than 300 hospitals, health systems and other providers.[65] This app allows patients using an iPhone to aggregate patient-generated data from the user's health apps with data from their participating hospital's electronic health record. For Apple alone, its larger healthcare initiatives from wearables to its EHR work could drive an estimated $15 billion in revenue by 2021 and $300 billion by 2027.[66]

There is also a growing market for voice-enabled healthcare products and services from tech giants such as Google, Apple, Microsoft and Amazon. Hospitals and other providers across the country are exploring opportunities to leverage these options for allowing patients to access medical records, helping surgical teams prepare for surgeries and supporting nurses with administrative tasks — hands-free.[67]

All of these tech firms report partnerships with healthcare providers, government and other healthcare entities, and all see healthcare trending toward information science where the provision of care will demand the use of traditional sensor data (e.g., blood pressure), behavioral data (various wearables) and molecular data.

Between 2013 and 2017, Alphabet (Google's parent company), Microsoft and Apple filed applications for 313 healthcare patents.[68] These tech firms carry enormous financial capabilities that dwarf health systems and traditional healthcare technology vendors, and their experience and expertise in emerging technologies, including social networking, mobile devices, user experience, the "internet of things" and artificial intelligence have created a new and powerful force for disruption.

Digital technologies expand as hospitals and health systems define where to engage.


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As a result of greater individual engagement in healthcare and the continued push for the democratization of healthcare data, digital and mobile healthcare and artificial intelligence are expanding. Hospitals and health systems are working to define where and how to engage this trend.

The number of digital health mergers and acquisitions hit 56 in 2018; up from 33 just five years ago. These tech deals focus on telemedicine, remote patient monitoring, pharmacy, patient engagement and chronic disease management, among others. Thirteen of the 56 disclosed the value of their deals at $7.6 billion in aggregate. In one example, in an effort to expand its digital strategy for the age 65 and older market, Best Buy purchased a firm with a series of connected safety products and services for aging-in-place individuals for $800 million.[69]

Digital and mobile engagement continues to increase across the age spectrum. Fifty-three percent of adults in the U.S. own smartphones, up from 18% in 2013. Almost everyone in the 18 to 29 age group own a smartphone.[70/71] From 2016 to 2019, there has been an increase in consumers seeking digital engagement from providers across all categories (requesting prescriptions, reminders for care, scheduling appointments, use of remote monitoring, etc.).[72]

Wearable devices are one of the more tangible digital health examples for consumers. The number of connected wearable devices worldwide hit 526 million in 2016 and is estimated to reach 1.1 billion by 2022. Smart watches currently make up more than 50% of the wearable market.[73]

Wearables in healthcare, however, go well beyond smart watches and fitness trackers and include monitors and tech devices that can improve care in the home and self-maintenance of chronic conditions. Ninety percent of consumers report a willingness to share data from a wearable or app with a doctor.[74] These technology advancements are expected to thrive in the developing fifth generation (5G) cellular network environment.

The growth in secure application programming interfaces — with more easily accessible and standardized data for developers — holds the promise of digital and mobile applications focused on healthcare. Secure APIs in healthcare data allow for the creation of mobile applications where consumers can combine clinical, fitness and other healthcare data to become more engaged in their health. The availability of healthcare data via secure APIs is an emerging priority of the federal government.

Data from existing and new sources also helps to advance the developing artificial intelligence/machine learning market. While AI in healthcare is generally used to scour large amounts of data for trends and patterns that can help define provider actions, AI holds promise for advancements in disease detection, virtual nursing care, robot-assisted surgery and more.[75] Current annual spending on healthcare-related AI exceeds $2.1 billion and is expected to increase to $36.1 billion by 2025.[76]

Hospital and health system engagement in this complex, technical and expensive environment is wide-ranging. Some are on the leading edge of engagement, while others are watching closely — sometimes hindered by lack of resources. More than half of healthcare executives report that IT budgets will increase by 10% or more in 2019 but suggest that competing priorities and margin pressures complicate the advancement of digital initiatives.[77]

With cybersecurity always a focus of healthcare provider IT resources, other reported healthcare IT and digital investments include: health information exchange, pharmacy workflow, shifting data to the cloud, population health and customer management, nursing communication systems and voice technologies.[78]

Consumer preference drives a rise in telemedicine and urgent, retail and direct primary care.

Healthcare consumers in search of convenience and affordability, along with generational shifts, are changing the "front door" of healthcare. With 84% of baby boomers reporting a relationship with a primary care physician and just 67% of millennials and 55% of Gen Z reporting a relationship, it is no surprise that urgent care, telemedicine and retail care are the growing top funnel access points for consumers.[79]

Urgent care focuses on the delivery of primary care and ambulatory care services outside of an emergency room. Last year alone, the urgent care industry grew 8% and hit a valuation of $18 billion. Urgent care offers operators the promise of low margins and high patient volumes. About 9,000 centers currently operate in the U.S. Their use has grown significantly recently (1,725% from 2007 to 2016), outpacing emergency department growth sevenfold.[80]

Most providers are more willing to operate urgent care facilities in urban and affluent areas. Of the 350 urgent care centers located in New York state in 2015, 103 were in New York City. However, research shows an appetite for urgent care in rural areas. From 2007 to 2016, urgent care services in rural areas nationally had a higher increase of utilization (2,308%) compared to urban areas (1,675%).[81]

Telemedicine is the remote diagnosis and treatment of patients by means of telecommunications technology. The use of telemedicine is becoming more popular with providers, consumers and employers, growing 960% from 2007 to 2016.[82]

From 2016 to 2017, the use of telehealth surged 53%, the highest of all sites of care.[83] Today, 76% of hospitals report using telehealth services, with more than 60% reporting remote patient monitoring capabilities.[84] Despite its growth and potential, telehealth services currently represent less than 1% of total outpatient visits.

Retail clinics are walk-in clinics outfitted within retail pharmacies, supermarkets and department stores. A concept first introduced in the early 2000s, more than 2,700 retail clinics stand today, with 75% of the U.S. locations operated by CVS and Walgreens. The use of retail clinics grew 847% from 2007 to 2016.[85] About 90% of visits to retail clinics are for simple conditions such as upper respiratory infections, sore throat and swimmer's ear. Retail clinics are positioned to influence patient encounters and keep consumers in their retail ecosystem. Like most brick-and-mortar primary care services, retail clinics are more likely to be located in affluent, urban areas. Growth of retail clinics has wavered, indicating that retail healthcare as a niche is still being explored.[86]

Direct primary care, a relatively new option, generally offers "high-touch" primary care, focusing on stellar patient-physician relationships, convenient access and traditional primary care services such as blood tests,


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vaccinations and wellness monitoring. Multiple DPC companies have launched in the last two decades, with about 900 DPC facilities operating in the U.S. — mainly in large urban affluent areas. While it is too soon to determine how the DPC option will trend, it presents yet another "front door" option for consumers seeking convenience.[87]

The reimbursement landscape of providers using these care options will continue to require new regulatory flexibility and new thinking from federal and state governments.

Interventions to address social determinants of health are moving into care delivery models.


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Consensus continues to build that better recognition, management and funding of housing, nutrition and food assistance, literacy and early childhood education may improve health outcomes and reduce healthcare system costs. Traditional healthcare services make up an estimated 20% of a person's health; the remaining 80% of what contributes to a person's health is based on underlying social, physical and health factors.[88]

Healthcare provider and insurance plan engagement in the social determinants of health of patients not only holds the promise of better outcomes, but also can improve the healthcare consumer experience. These approaches have also supported provider and plan engagement in risk-based contracts as volumes and service revenues decline — a double-edge sword for providers.

Results from various SDH-type initiatives in New York show the potential, with a $641 million/seven-year supportive housing initiative focused on high-cost Medicaid members, reducing inpatient admissions and emergency room visits by 40% and 26%, respectively. An environmental conditions initiative reduced asthma-related hospitalizations by 70% when home mediations were deployed.[89]

While there is currently no stable funding mechanism in place, support for SDH interventions is trending in a positive direction. The federal government is developing opportunities under CMMI that could allow providers to access funding for services such as food and housing.[90] In New York, a Bureau of Social Determinants of Health was established in 2017 to help focus SDH efforts in the state.

The framework for Medicaid value/risk-based contracting encourages payers and providers to identify and secure SDH investments from third parties. Additionally, to encourage health plan investment in SDH interventions, New York now allows health plans serving Medicaid participants to classify SDH spending as a medical expense.[91]

Market Shifts

Vertical integration continues to shift the healthcare landscape.

A recent flurry of vertical integration deals reflects a clear strategy, regardless of the entity involved: to control or influence patient encounter points across the entire continuum of care delivery. This integration is creating diverse industry partnerships between payers, pharmacies, providers, tech firms, supply chain firms and others.[92]

Payers and retail pharmacies have been front and center in the recent wave of vertical integration deals. These moves are not only being made to boost their own profits, but also to gain larger market share to better compete and strengthen their negotiating position with providers. Combined, five national insurers (Aetna, Anthem, Cigna, Humana and United Healthcare) currently manage 51% of covered lives in the U.S.[93]

The $70 billion CVS-Aetna merger is one of the most significant vertical integration deals.[94] The merger connects Aetna's 22 million insured lives directly with CVS' 10,000 retail stores, pharmacies and Minute Clinics.[95] More than 80% of Americans live within 10 miles of a CVS retail location.[96] In February 2019, CVS opened its first three integrated HealthHUB stores in Houston, with more floor space dedicated to healthcare services, including spaces for yoga classes and expanded treatments, while pharmacists will make regular calls and in-person consultations for medication adherence.[97]

While the payer and retail pharmacy vertical deals have a lot to do with owning more of the U.S. drug supply chain, they will also erode providers' margins by impacting their referrals and top-of-funnel strategies — drawing consumers away from hospital-owned primary and urgent care clinics and toward retailer-owned, lower-cost and more convenient care options and services.[98]

Control of this market share also allows these entities to keep referrals to in-network caregivers. Eighty-eight percent of hospital and health system executives have expressed concern about this vulnerability.[99]


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Innovate in workforce

Horizontal integration continues to consolidate the provider landscape.

Hospital mergers and acquisitions have accelerated over the last decade. The nation saw more than 400 hospital transactions during the last five years.[100] The largest provider system merger occurred in 2019 with the alignment of Dignity Health and Catholic Health Initiatives. The $29 billion system serves 21 states with more than 700 care sites and 142 hospitals.[101] In New York, hospital affiliation activity has been steady, with at least 85% of hospitals now participating in some form of organizational affiliation.[102]

The majority of hospital transactions in New York involve a larger hospital or health system becoming an active parent and co-operator of another facility. These active parent arrangements, which are frequently preceded by a clinical affiliation, are short of full-asset mergers and allow the hospital to retain a separate operating certificate and board of trustees. This enables the system to play a greater role in operations and governance without taking on the hospital's debt.[103]

While up-front corporate mergers have become less common, there is a trend toward progressive integration over the first three to five years of a new organizational affiliation. There is considerable variation in the progression of these relationships among different health systems in New York, and full asset mergers have followed in several cases recently.[104]

Consolidation activity is happening in both upstate and downstate New York. Large systems based in metropolitan areas have branched out into suburban and rural communities to increase their networks. State borders have become permeable. Out-of-state systems based in Pennsylvania and Vermont have affiliated with hospitals in New York. Conversely, there are now out-of-state hospitals — in Pennsylvania and Connecticut — that are parented to New York-based hospitals. This year, we also saw the first cross-border health system affiliation with health systems based in New York and Connecticut coming together to form a new system.[105]

New York State's statutory prohibition against investor-owned hospitals has shielded New York from some trends occurring across the nation, such as the proliferation of massive multi-state systems. Beyond the cross-border relationships described above, some national religiously-sponsored systems have a modest presence in New York, with Trinity Health, Ascension Health and Bon Secours Health System representing less than 10% of hospitals statewide.[106]

Payers are increasingly squeezing providers through denials for payment and other tactics.

Control the dollar

Revenue cycle management teams are facing worsening payment trends. Hospitals nationwide lose about $260 billion per year from denied claims, with 9% of hospital claims denied on average.[107] Upon appeal, payment is secured for more than 60% of claims originally denied. Hospitals in New York state report that 10% of claims are denied upon submission, an increase from 7% three years earlier.[108] Fighting these denials is expensive for hospitals and diverts resources from care.

Coupled with a rise of denials is a growth in pre- and post-payment audits, new rules around authorization and utilization and unilateral policies impacting patient steerage away from hospital-based services.

Setting prices using a common reference point is gaining traction as a means for payers to reduce their costs. There are early harbingers of this approach, including Anthem's reference pricing on radiology services and congressional action to reference Medicare payment for lab services to private payer rates — with the latter expected to cut Medicare spending by $2.5 billion over 10 years.[109]

Medicare has also established reference price payment for many services at hospital-owned off-campus outpatient departments and payment for drugs to 340B hospitals.

CalPERS, California's public employees' retirement system covering about 1.5 million lives, has placed limits on what it pays for certain procedures. In the first two years after its implementation of reference pricing, CalPERS reported saving $2.8 million for joint replacement surgery, $1.3 million for cataract surgery, $7.0 million for colonoscopy and $2.3 million for arthroscopy.[110]


Understand consumers


Control the dollar


Embrace technology


Innovate in workforce

The healthcare workforce is adjusting to consumer and worker needs.

Healthcare is the largest source of jobs in the U.S. — a sector that has proven to be recession-resistant and currently supports nearly 17 million workers nationally.[111/112]

The aging population, longer life expectancies and growth in rates of chronic conditions will drive demand for healthcare services, with employment in the healthcare and social assistance sector projected to add nearly four million jobs by 2026, about one-third of all new jobs.[113]

The healthcare occupations that will see the most growth from 2016 to 2026 include home health aides (47% growth), personal care aides (39% growth) and advance practice clinicians: physicians' assistants and nurse practitioners (37% and 36% growth, respectively).[114]

As healthcare delivery models change, several non-traditional workforce roles have emerged (e.g., patient navigator). New York's DSRIP program has been a catalyst for the expansion of these workforce innovations.

Additional care management approaches such as community paramedicine are growing in popularity, allowing first responders to provide care beyond their traditional scope to reduce hospital use and improve patient outcomes. The federal government estimates its new ET3 program — which encourages EMS treatment in place or transport to appropriate non-hospital alternatives — can save $1 billion in Medicare spending by treating beneficiaries at home or in non-hospital settings.[115]

Leveraging the rapid expansion of app-based services, non-traditional market entrants, such as the ride sharing services of Lyft and Uber as well as the Ford Motor Company, are expanding the non-traditional healthcare workforce role. Targeting the spike in the aging population, Lyft currently has contracts with several Medicare Advantage plans and has stated its intent to be working with most of these plans by 2020. Lyft's partners cite reduced transportation costs and lower wait times for patients.[116] The growing role of the non-traditional workforce will be shaped by the gig economy.

Expanding roles of the non-traditional workforce, combined with scope of practice clarity within existing job roles, will allow the new workforce to address social determinants of health and keep pace with consumer demands. These models will require new regulatory flexibility and leadership from federal and state governments.

Despite the growth in the traditional and non-traditional healthcare workforce and their increasing role in healthcare delivery, it is still projected that there will be a national shortage of 47,000 to 122,000 physicians by 2032 (21,000 to 55,000 primary care physicians; 25,000 to 66,000 non-primary care specialties).[117]

Endnotes

Endnotes

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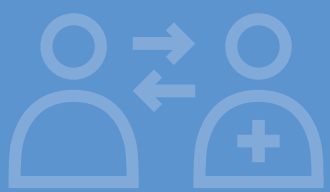

Understand consumers

Control the dollar

Embrace technology

Innovate in workforce