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Colorado Hospital Association

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Environmental Scan 2015

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About the Colorado Hospital Association

The Colorado Hospital Association (CHA) is the leading voice of Colorado's hospital and health system community. Representing over 100 member hospitals and health systems throughout the state, CHA serves as a trusted, credible and reliable resource on health issues, hospital data and trends for its members, media, policymakers and the general public. Through CHA, Colorado's hospitals and health systems work together in their shared commitment to improve health and health care in Colorado.

About This Report

The Colorado Hospital Association commissioned the Colorado Health Institute (CHI) to conduct this environmental scan of conditions facing Colorado's hospitals. CHI is a trusted source of independent and objective health information, data and analysis for the state's health care leaders. The Colorado Health Institute is funded by the Caring for Colorado Foundation, Rose Community Foundation, The Colorado Trust and the Colorado Health Foundation.

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Introduction

We mark the halfway point of the 21st Century's Teens Decade – from 2010 to 2019 – this year. And perhaps there's not a better analogy for Colorado's post-Affordable Care Act health marketplace than a coming-of-age story. We see signs of this adolescent development across the country and certainly within Colorado. This report documents these changes.

Colorado is in the midst of growing up, and growing up fast. The Affordable Care Act, signed in 2010, ushered in the new decade. It provided a blueprint for the way forward, building from experiments and initiatives attempted in many different states, including Colorado. We have spent the past five years planning for the changes that were encouraged by the legislation. The next five years will be marked by our efforts to fully mature in this changing world, subject at any time to the uncertainties of the politics.

Colorado has invested heavily in the ACA's innovations, becoming a leader among the states in many ways. We expanded Medicaid, built our own health insurance exchange, created our own health insurance co-op and won several transformation grants from the newly minted Center for Medicare & Medicaid Innovation (CMMI). In high school vernacular, we joined every club on campus.

And now, Colorado is doing the work. Implementation of any one of these initiatives would be hard. Doing them simultaneously is even more challenging. When we combine key state and federal efforts with private market responses to the ACA, the environment is even harder to navigate. We also are trying to adapt our strategies as we learn from our successes and failures in implementation. Collectively, these efforts are reshaping the market and changing the dynamics, strategies and trends for all stakeholders, especially hospitals and health systems.

Changes in technology, financing, branding and consumer-oriented services are further disrupting the environment in which we work. Hospitals across the state are seeking ways to balance demands from both the public and private sectors, as well as cope with Colorado's changing demographics. For example, Colorado's population is aging rapidly and becoming increasingly diverse. Over the next 25 years, the proportion of elderly Coloradans will grow to three times what it is today: one in five Coloradans will be over 65. And as our existing younger and more diverse population ages, non-white Coloradans will comprise nearly 30 percent of our elder population, requiring significant adaptations across the health services industry.

This Environmental Scan identifies seven trends that CHA anticipates its members will grapple with over the next three to five years. We hope this report helps all our members successfully navigate these tricky teen years and better anticipate what might follow.

Trend #1
Integrated Care is the New Normal

Big Idea:

Patient-centered care that integrates a number of care disciplines will soon be the expectation for care delivery. From both the public and private sectors we see the promise and the challenge of providing that care. As part of an expansion of medical home models, early emphasis in Colorado has been placed on integrating behavioral health into the primary care setting.

We anticipate that expectations of integration will expand in breadth and depth to include a broader range of services such as oral health, behavioral health, public health, specialty care and even some home and community based services.

Colorado's $65 million State Innovation Model (SIM) award has brought new attention to integrating physical and behavioral health services, which are inclusive of both mental health and substance use services. The idea itself, however, has been around for decades. Colorado has a solid legacy of integrated care, particularly the development of the medical home model, on which to build.

This heightened awareness brings a number of critical issues to the forefront of our thinking and policy dialogue, including:

- **Workforce Evolution.** Creating a robust health care workforce – particularly for primary care, specialty services and behavioral health – is already challenging. While we may have enough providers as a state, many segments of the health care workforce are not geographically distributed in a way to adequately meet the need of all our residents. For example, CHI has identified the eastern plains and Weld and El Paso counties as places in which the primary care capacity relative to the population is very low, demonstrating that workforce shortages impact both slow- and fast-growing areas of the state. [1]

  Building a robust workforce will be a heavy lift for providers and the state as a whole. However, addressing this trend has important implications for hospitals, especially as it relates to behavioral health. Individuals with comorbid physical and behavioral health care issues – representing 17 percent of the adult population in the United States – are at higher risk for hospital admissions and re-admissions when their behavioral health care needs are not addressed.[2] Further complicating the picture, most patients who are referred to behavioral health services in their doctor's office never go. Having immediate access to services makes sense.

- **Payment Reform.** The promise of integration sometimes overlooks an essential component: how will we pay for these additional services as they are incorporated into primary care practices? This is a long-standing issue and one closely tied to the goals of value-based payment. The goal of integrated care is to not only effectively treat behavioral health issues, but also impact diseases influenced by lifestyle and health behaviors. Behavioral health intervention can help patients with weight management, smoking, exercise and other lifestyle changes. That's where we anticipate the most cost savings.[3]

Impact on CHA Members:

As hospitals and health systems continue to expand their scope to include more primary

care practices and employ primary care providers, focusing on the nuts and bolts of integrated care will distinguish market leaders. Evidence indicates that integration of care across treatment settings reduces readmission rates and improves overall health outcomes. Capital investments will be required to transform practices and finance integrated care.

Federal grant opportunities for this kind of work will be available through a variety of mechanisms; SIM, the Comprehensive Primary Care (CPC) Initiative and Project SHEPERD (through the Agency for Healthcare Research and Quality) are current examples. Members can anticipate more federal initiatives (under the current administration) that encourage integration of all stripes – from services to breaking through institutional silos. Members may also see private sector payers adopt integrated care payment models that have demonstrated success, which could create fragmented financial incentives for care providers.

Disruption on the Horizon:

Imagine a day when your greatest competitor beats you hands-down on value, providing superior care quality at a much lower cost. Now imagine that your greatest competitor is a cloud-based health coordinator, managing patients and their needs across multiple facilities and services, without touching the traditional hospital or system. Integration means that facilities (hospitals, nursing homes, primary care clinics) need to work together seamlessly. As this market evolves, new competitors will not be traditional hospitals or delivery systems.

Trend #2

New Competitors are Narrowing Service Line Margins

Big Idea:

Payers and other non-traditional providers are entering the care delivery business. In some areas of the country, these new providers are entering the primary care space. Some are siphoning off profitable hospital-based, acute-care procedures.

Large national employers are sending patients with specific conditions to selected providers, regardless of where that patient lives or the quality of providers in their immediate market. Walmart, for example, sends employees who need hip replacements to the Mayo Clinic, bypassing local options.

Importantly, this trend is also occurring at the intrastate level. Small hospitals, often located in rural areas, are losing profitable surgeries such as knee and hip replacements to lower-cost providers in Denver and other urban centers.

Some recent developments:

- **Freestanding Emergency Departments and Micro Hospitals.** New market entrants in emergency services could spell opportunity or danger to existing health systems. First Choice Emergency Room serves as an example. The company entered Colorado by establishing independently-owned free-standing EDs, and now its nine sites – mostly in the Northern Front Range – are affiliated with University of Colorado Health. Trinity

Mother Frances Hospitals and Clinics, based in Tyler, Texas, reportedly plans to open four "micro hospitals" in Colorado soon.[4] In addition to emergency care, so-called micro hospitals have limited number of inpatient beds, creating new competition for emergency and inpatient services. Absorption or alliance with new market entrants may present interesting opportunities for health systems in the future.

- **UnitedHealth Group.** Insurers across the country, in an attempt to diversify their holdings, are buying up provider groups and launching physician management companies. UnitedHealth Group, the parent company of UnitedHealthcare, is leading the pack with its subsidiary, OptumHealth, which is acquiring practices and instituting new technology and analytics to drive better care. While the ACA was intended to rein in insurers, it is pushing them toward new business ventures where potential conflicts of interest exist with traditional health care delivery systems.

- **DaVita.** DaVita recently purchased Colorado Springs Health Partners, a multi-specialty care practice with more than 100 physicians in 11 Colorado Springs locations.[5] The extent to which non-traditional players continue to enter care delivery remains to be seen.

- **Walgreens.** Walgreens has entered into a partnership with Theranos Labs to provide blood tests and screening at some Walgreens retail clinics.[6] This development, combined with similar market moves by Walmart and CVS, signals the arrival of non-traditional players into the primary care space. Walgreens also has stated it is moving quickly from providing screening and diagnostic services to chronic disease management. We anticipate that this expansion of the range of retail services will continue.

Impact on CHA Members:

New market entrants in key hospital service lines will force hospitals and health systems to compete on a procedure-by-procedure basis. Each service line must be competitive in both the local and regional markets. Shifting costs and balancing non-profitable lines with profitable ones will no longer suffice for member sustainability and success.

Disruption on the Horizon:

Imagine a day when all facilities in your system are asked to only function "at the top of their license." Anything that can be performed in a lower cost setting will be done in that lower cost setting. Your primary care referral network will be Walmart and Walgreens; your high-end procedures will be sent to the center of excellence in Colorado or another state.

Trend #3

It's All About Maintaining Loyalty

Big Idea:

There's plenty of talk in the media about pricing transparency and consumer engagement. But the impact – real changes in behavior and health care utilization – remains elusive.

While consumers purchase health insurance based on price, this is not the case in their use of health care services. Consumers remain loyal to the care providers, facilities and communities they know and are not persuaded by using new tools to select providers and services. At least, not yet.

Recent observations call into question just how much consumer preference and choice are factoring into utilization.

- **Report Card Confusion.** A recent paper

in Health Affairs begins, "Public report cards with quality and cost information on physicians, physician groups, and hospital providers have proliferated in recent years. However, many of these report cards are difficult for consumers to interpret and have had little impact on the provider choices consumers are making." The paper elaborates on how varying report card methodologies are not only confusing to consumers but also far removed from the decisions patients could make about their care.[7]

- **Value-Based Insurance Design (VBID) is Gaining Traction**. However, its effectiveness is limited in improving quality and reducing spending across large plans. Nonetheless, around 80 percent of large employers either have VBID programs or are interested in pursuing them. As VBID evolves, it will be important for hospitals to think through whether they participate and support this trend.
- **Use of Transparency Tools for Consumers is Mixed.** While provider data is increasingly available, evidence suggests that consumers do not use quality data on providers in a meaningful way. Despite limited evidence, the market is betting on a big payoff. Large investors like New Atlantic Capital, HLM Venture Partners and Venrock are investing hundreds of millions of dollars into transparency companies.
- **Consumers Are Much More Willing to Use Payment Tools.** The rise of high deductible health plans and the ability to shop for insurance through exchanges has led to greater consumer engagement and comparison shopping for health insurance. In order to lower their premiums, consumers are increasingly choosing high deductible plans. High deductible plans are not very effective in controlling high-priced services, like those provided in hospitals, because the services quickly can exceed the deductible.

What's important to note is that while tools may be available to assess quality and pricing, there is both consumer confusion and a lack of "know how" in terms of how consumers can use these tools. The result is that consumers frequently resort to less formal mechanisms for selecting a health care provider: recommendations of friends and family, previous experience, loyalty and what they know or perceive about the health care delivery system. This underscores the importance for hospitals and health systems to build and maintain a strong relationship with likely customers in their community.

Impact on CHA Members:

Local consumers and patients remain loyal to their hospitals in part because they are not using comparative tools that are on the market. This presents a significant opportunity for local hospitals. The patient-hospital relationship and loyalty can be strengthened and intensified with effective community engagement strategies.

Community benefit programs are a key component of community engagement, and they are undergoing a significant transition. Nonprofit hospitals have historically used these programs to maintain their IRS nonprofit status. They traditionally have been quantified based on the amount of uncompensated care a hospital provides, a factor that has drastically changed with the expansion of Medicaid in Colorado. Having more Medicaid patients has resulted in less uncompensated care, potentially threatening hospitals' nonprofit status.

Although this federal IRS requirement only applies to nonprofit facilities and does not apply to Colorado's for-profit or special district hospitals, the requirement is changing the market. Some health systems are conducting these assessments even though they are not required to do so by law. Because a majority of hospitals have community benefit programs or something similar, the changes are affecting the competitive landscape and health system differentiation strategies.

Creating a broader story of community benefit is imperative, even if community benefit requirements don't apply to every hospital and health system. Community benefit should be recast as much broader than covering the costs of charity care to include programs and services focused on population health, disparities of care, consumer engagement and related areas. While skeptics may view this as a communications and marketing exercise, the financial fundamentals suggest that investments in new strategies and programs may be needed, presenting the opportunity for hospitals to strengthen their relationships in the communities in which they work to promote health and their public image.

We advise getting an early start on this strategy.

When pressure comes to change providers because of more accessible comparative tools, the switching costs related to loyalty and likeability will be higher.

Disruption on the Horizon:

Imagine a day when Consumer Reports dictates your patient volumes as much as it dictates automobile sales today, and when your hospital or health system is incented to keep more people out of the hospital than in the hospital. Comparison-shopping tools need to be refined and consumers need to learn to use the tools wisely, but your institution's financial success could be greatly influenced by your relationship with the community as well as published reviews.

Trend #4
Technology Promises New Solutions … at a Price

Big Idea:

Technology presents both upsides and downsides for hospitals and health systems in this changing health care landscape.

The downside is that large investments can also put profitable service lines at risk, because these technologies are also big cost drivers. On the upside, investments in new technologies can enhance specific service lines and offer a competitive advantage. They also can expand the reach of the delivery system.

Digital health applications, especially telehealth and telemonitoring programs, offer the opportunity to reach new markets. Even continuing medical education options are expanding through programs like Project ECHO, which creates training opportunities for remote providers that ultimately result in expanded services and capacity. Project ECHO, pioneered in New Mexico, is gaining traction in Colorado through independent initiatives shepherded by the Department of Health Care Policy and Financing (HCPF) and the University of Colorado.

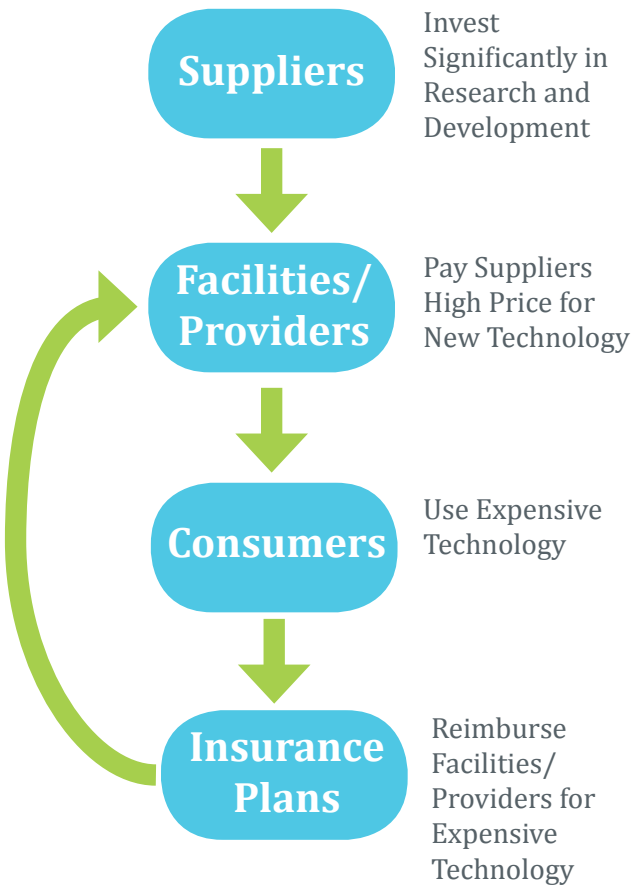
Other digital technologies will expand home monitoring systems and direct-to-consumer health care options. And still others are changing inpatient procedures, often increasing the cost. Innovation, while expensive, is a hallmark of the American medical system, but it is in tension with consumer demands for products and services to be continuously faster, easier and cheaper. Hospitals must plan and balance the need to be relevant and current with sound financial modeling. At the same time, hospitals and health systems should be on the lookout for emerging technologies that intend to bypass

the traditional health care delivery system altogether.

Another downside of technological growth is its overall expense to the systems providing those services. There is a growing body of literature that confirms that technology drives costs within the system, accounting for between 40 percent and 50 percent of health care cost growth.[8]

How hospitals and health systems balance the need for technology with the impact on overall costs will distinguish long-term winners and losers in this environment.

CHI offers this observation on the technology conundrum. While new technological investments are alluring, they are also costly. As this diagram illustrates, the system places lots of demands on technological advancements and little incentive to reduce costs.



Here's the conundrum: At the top level, suppliers are making significant investments in research and development around technology. They do this because providers are willing to pay for it, making it a profitable enterprise.

Consumers want the technology, even if they often don't have much information about the technology other than that their provider has told them they need it. Consumers often equate higher prices with quality because, in many competitive markets (but not necessarily in health care), quality is more expensive.

But consumers are not directly bearing the costs of this technology unless they have a high deductible plan. Even if they did, they don't typically have the tools to evaluate the quality or effectiveness of high-cost technology. Instead, insurers reimburse providers for using new technology.

The upshot is that no one entity has an overwhelming incentive to break out of this cycle. That will continue to be the case until fee-for-service is no longer the predominant method of payment.

Impact on CHA Members:

Hospitals will need to be increasingly selective about their investments in technology. Service line competitiveness and profitability will be essential determinants of these investments.

Disruption on the Horizon:

Imagine a day when your board has a technology review committee that gauges opportunities and threats from emerging technologies. You also set aside reserves to invest in or respond to technologies that bypass inpatient stays or deliver care in other settings.

Trend #5
Regional Capacity is the Next Frontier

Big Idea:

The old adage that "health care is local" is changing. The new saying will be "health care is regional."

Our traditional frame is to think that specific geographies, unique demographics and local cultural patterns are the main drivers of health care utilization. While much rhetoric still surrounds this idea, market changes suggest a different picture. Local health care concerns, while significant, are diminishing in delivering health care. Regionalism will shape the future.

Here's why:

- Few independent community hospitals remain in Colorado's urban and suburban areas. Colorado has only two hospitals with more than 50 beds that remain unaffiliated with a larger health system. Colorado has five large health systems: Banner Health, Centura Health, HealthONE, SCL Health and University of Colorado Health. Regional approaches to care delivery and population health management are top-of-mind in strategic planning. Size and scope of services matter in the new paradigm of care delivery.
- Medicaid has reconfirmed its regional approach to care. Regional Care Collaborative Organizations (RCCOs) suggest something beyond local. The required networks are big – some cover nearly 40 percent of the geography of the state. A recent announcement from HCPF suggests an intent to move away from a fee-for-service payment model. In this shift in payment, size will matter. The goal is to have RCCOs assume risk for both physical and behavioral health. A regional approach, with scale and significant covered lives, will be essential.
- Other regional approaches to care delivery are also emerging on the private side. Centura's Medical Neighborhoods division is a case in point. Facilities that are essential to effective care transitions, such as long-term care facilities and hospices, are matching their geographical markets to these emerging regional markets. The recent merger of two nonprofit hospices – TRU and the Hospice of Northern Colorado – is an example of this trend. Rocky Mountain Health Plans is advancing payment reform with a regional approach as exemplified in a pilot it is conducting with HCPF that integrates physical and behavioral health under a capitated model.
- Rural and small hospitals deserve special note and remain connected to this regional approach. Colorado health systems are all actively building rural and statewide strategies and affiliations. We can anticipate these strategic moves to increase in the coming years. As health systems begin to think about building their own accountable care organizations (ACOs), managing larger populations will be a financial imperative.

Impact on CHA Members:

Hospitals and health systems are shoring up resources and sharpening strategies to become premier regional players. Medicaid's commitment to the Accountable Care Collaborative will favor hospitals and health systems that provide care in the entire defined, regional market areas. Other payers are either following suit and in some cases are experimenting with non-traditional payment models, all of which require patient populations large enough to bear risk.

Disruption on the Horizon:

Imagine a day when your hospital or health system is aligned or merged with a regional network and your financial sustainability is contingent on successfully managing the region's population, regardless of whether they use your services.

Trend #6

Risk is Here to Stay. Get in the Game.

Big Idea:

From the U.S. Department of Health and Human Services (HHS) to community-based local health alliances, the buzz about payment reform is everywhere. The consensus is that pushing risk to providers is essential to address costs.

But the conversation seems far ahead of the reality.

Figuring how to operationalize risk-based principles remains challenging. The Colorado market continues to give mixed messages about the expectation for when and how providers and hospitals should assume risk. Here are a few examples

- **ACO Results – Underwhelming but Improving.** Twenty-three Pioneer and 220 shared savings Medicare ACOs generated savings of $372 million in the first two years of the program (2012-2014). ACOs that achieved savings tend to be concentrated in parts of the country with excess capacity and large variance in spending. As excess capacity and inefficient spending declines, it is unclear if savings will continue to materialize in the upcoming years.

  Colorado has seen a notable withdrawal from the Pioneer ACO model when Physician Health Partners (PHP) decided to leave the program in 2014. PHP stepped back to a shared savings program in which down-side risk is not shared with CMS.[9]

  Despite the fact that 13 of the 23 Pioneer ACOs, including PHP, dropped out of the program, the federal government appears to be staying the course. It has announced intentions to move more Medicare payment outside of fee-for-service. Substantive results in the next few years will be crucial if the program is to achieve longevity.

- **Medicaid May Move Off of Fee-For-Service.** Colorado Medicaid continues to struggle with defining its vision of payment reform. Lawsuits from HMOs in the early 2000s have left HCPF reluctant to engage in managed care. HCPF, however, is interested in moving incrementally, potentially implementing a sub-capitation model for primary care services. In 2013, HCPF launched a global payment pilot with Rocky Mountain Health Plans called Medicaid PRIME and has mentioned its interest in launching more payment reform pilots. There is mounting pressure to move away from fee-for-service, but it is questionable whether the changes can be made quickly, given the number of initiatives HCPF has under way. HCPF is rebidding its ACC contracts with a goal of moving past fee-for-service arrangements. The new contracts take effect in July 2017. SIM and Medicare also have recently set alternative payment goals. SIM aims to provide integrated behavioral health care – with a payment structure to support the change – for 80 percent of Coloradans by 2019. In Medicare, HHS has set a goal of making 30 percent of its payments in alternative payment models by the end of 2016, and 50 percent by the end of 2018.

- **Incentives for Innovation Continue.** SIM is predicated on payment shifting to include some level of sub-capitation. Medicaid is a player at the table, and it is expected to be one of the first movers. To be successful, SIM must be a multi-payer initiative. Early signs indicate that the payers involved in another federal initiative, the CPC, are well on their way to participating in SIM. These include Aetna, Anthem, Cigna, ColoradoAccess, Colorado

Choice Health Plans, Colorado Medicaid, Humana, Rocky Mountain Health Plans and United Healthcare.

Impact on CHA Members:

The uncertainty around payment reform puts hospitals in a dual strategy position. First, they must successfully plan and execute in today's fee-for-service environment. They also must plan for a future state even without knowing when that future will arrive.

Operationally, moving from a fee-for-service payment system is an enormous task. Federal opportunities, such as Pioneer ACOs and SIM, may provide some support to practices and systems undergoing these changes. Hospitals must choose wisely about their participation in these initiatives.

Disruption on the Horizon:

Imagine a day when you must invest in IT systems that measure the total cost of care, patient by patient, in all types of facilities, throughout their life. Your ability to project these costs will determine how well your organization performs in a non-fee-for-service environment.

Trend #7

Are Hospitals in the Hot Seat?

Big Idea:

Hospitals have traditionally been at the center of discussions on how to address health care costs. Although recent reform efforts may have temporarily taken the heat off hospitals to some degree, the reprieve is likely to be short-lived. Hospitals should be thinking through how they want to participate in discussions about mitigating costs, which is the next frontier of health reform. Simply by virtue of its name, the ACA may have established false expectations that health care costs would decrease over time and care would become more "affordable." Health care insiders recognize that – at best – reform efforts may only reduce the growth of health care costs, and hospitals and health systems should expect continued and increasing pressure to reduce costs and develop ways to use limited resources more efficiently and effectively.

Recent developments in the Colorado market call for close attention and potentially a shared strategy for hospitals and health systems:

- **Expect Greater Scrutiny of Costs With More People Insured.** Medicaid expansion is the ACA policy change with the greatest impact on health insurance coverage in Colorado. Rough estimates indicate that around 240,000 Coloradans gained insurance in 2014, but Medicaid comprised most of this gain. With the Medicaid caseload at 1.2 million and Medicare at 675,000, 40 percent of the state's population is insured through Medicare, Medicaid or CHP+. With their growing influence, the federal and state governments may be more likely to leverage their market power and more closely scrutinize their fee schedules, especially if the economic recovery is short-lived.
- **Colorado Commission on Affordable Health Care.** After passing legislation creating a state-based exchange and expanding Medicaid, Colorado policymakers are turning their attention toward addressing the cost of health care services. The Colorado Commission on Affordable Health Care is charged with recommending ways to address health care cost growth in Colorado. With a diverse set of interests and political perspectives,

the commission will spend significant time building consensus. The commission is likely to address issues that appeal to a broad political constituency.

- **Early Signs Indicate That Hospitals Are Not Big Drivers Of the Rebound In Health Care Cost Growth.** Between 2009 and 2012, the United States experienced the lowest health care cost growth rate in 50 years. However, as the economy rebounds, so are health care costs. Health care spending in the third quarter of 2014 grew at an annual rate of 5.0 percent. Hospitals, however, are not in the hot seat — yet. Prescription drug spending, which grew 10.9 percent in 2014, is the main driver of the acceleration. New breakthrough medications for hepatitis C account for some of this increase. The expected increase in the use of hospital and physician services during the first half of 2014 did not materialize even with millions of newly-insured people. However, that may be related to the newly insured not using their health insurance for complex services yet. Early signs indicate that during the fourth quarter of 2014, utilization of hospital and physician services started picking up.

Impact on CHA Members:

For hospitals, this "hot seat" spotlight feels like an old issue. Market perception has not kept up with recent insights and supporting data about the most significant cost drivers in the system. Collaborating at the state level to change these perceptions may be a valuable use of CHA's time and resources.

This also relates to loyalty, discussed in Trend #3. It is important to tell the story – locally and at the state level – about the community benefit offered by hospitals and the work they do to improve the health of the communities they serve. Hospitals must bring to light the availability of other important services they provide, including protecting the community through disaster preparedness and being ready to respond when emergencies happen.

Disruption on the Horizon:

Imagine a day when hospital margins are mandated in the same way that insurance companies are managed today. Markets, either through regulation or by payers, could mandate service-line-by-service-line cost and profit reports. It would mean more scrutiny and transparency than ever before.

Conclusion

While 2015 is a year of implementation, there are new trends, challenges and opportunities on the horizon. Hospitals and health systems are now living in two worlds – the one of today, based on fee-for-service and traditional care models, and the one of the future, with payment based on value and outcomes, population health management, a different consumer environment and other new reimbursement models. This environmental scan sheds light on a way forward and provides a reality check on what can be anticipated.

End Notes

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