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# Six Big Trends To Watch In Health Care For 2016

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With the upcoming Presidential election, health care is once again keeping us up at night. How much of the current debate is hyperbolic rhetoric? What policy changes are realistic in an election year? What market trends in the private sector will drive the most change?

Below are the top issues we will be watching in 2016.

## MACRAnomics

Physician awareness of the [Medicare Access and CHIP Reauthorization Act \(MACRA\)](#) is limited today. That will change in 2016.

MACRA was enacted in 2015 to replace the Sustainable Growth Rate (SGR) for physician payment. In 2016, new rules will be issued for quality reporting and payment policies that will substantially change the status quo for Medicare's physician

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reimbursement. Although 2019 may seem a long way off, performance measurement for the new payment models begins in 2017, making the year ahead a critical time for physicians to begin learning about the details and implications of MACRA for their practices.

What we will see in 2016?

- First, although hospitals have been subject to the performance-based payment provisions of the Affordable Care Act (ACA), the concept is new to physicians, who need to understand how to improve performance and avoid payment penalties. In essence, this will entail developing more complex governance models, adjusting to more data sharing across the care continuum, and more performance measurement.
- Second, with a choice of payment models, physicians and physician practices will need to conduct financial planning to determine which track presents the greatest upside given current performance.
- Third, once a payment model is selected, physicians must decide how to organize themselves to take advantage of their choice, understanding that unprecedented levels of partner collaboration, testing, and co-innovation will be the keys to long-term success.

For many, the task may be too onerous and expensive to take on alone, which will lead to an uptick in physicians joining or affiliating with health systems that have existing assets and experience with managing performance-based payment. In particular, we expect a dramatic increase in physicians and health systems working together to form clinically integrated networks (CINs), as well as putting together so-called “Super CINs” that include physicians across large regions or states. We also expect an uptick in early retirements as some change-averse physicians opt out of practicing medicine altogether.

### ...Or Your Money Back

As providers face increasing cost pressures under value-based reimbursement, many are looking for an equal amount of “skin in the game” from drug and device manufacturers. Enter the value-based contracting guarantee.

Value-based contracting is an arrangement where manufacturers agree to go at risk for a portion of the purchase price if the product fails to meet or exceed certain performance standards. At Premier, we’ve negotiated several of these deals with device manufacturers, where, for instance, companies agree to pay the price difference if the total cost of care is not reduced by an agreed upon amount, or to pay a hospital’s readmissions penalty if certain clinical quality standards aren’t met. Although more

prevalent among device makers, value-based contracting is starting to gain ground with pharmaceuticals as well. Amgen has agreed to pay rebates to Harvard Pilgrim if its cholesterol drug Repatha fails to replicate results achieved during clinical trials.

Although these deals are still in their infancy, we're expecting many more manufacturers to come to the table with value-based proposals in order to prove innovation and value. The mandatory joint bundled payment program that takes effect this April will hasten this trend, especially since providers have to reduce the cost of the total bundle by 2 percent.

Even without bundled payments, manufacturers in crowded therapeutic categories, such as implantable orthopedics or cardiac drugs and devices, are testing value-based contracts as a way to differentiate their products and win market share. Performance measures and data evaluation partners will be central to the future success of these agreements.

## Docs Ex Machina

Telemedicine has been lauded as an innovative way to manage patient care, particularly for those with chronic illnesses that require daily monitoring and interventions to manage their conditions. In fact, researchers [estimate](#) that chronic diabetes care costs could be reduced by an average of 9 percent per year with the effective use of telemedicine in lieu of more expensive office visits and hospitalizations. Though the potential is clear, telemedicine hasn't taken off per expectations. This is largely due to an incentive problem, as Medicare and many private insurers don't pay for telemedicine outside of rural areas with a shortage of providers.

Even without reimbursement for telemedicine implementation, many advanced providers have found that the investment can pay dividends, particularly if they participate in alternative payment models. Phoenix-based Banner Health provides a sample case. At its own expense, Banner gave tablet computers to its highest-cost chronic care patients, who use health apps and remote monitoring tools—such as blood pressure cuffs and weight scales—to record daily vitals. If the patient experiences a problem or the health app records an anomaly, they can use the tablet to virtually communicate with their care team.

Since implementing the project, Banner has reduced hospitalizations and long-term care stays, producing a savings of 27 percent. And, since Banner participates in the Pioneer Accountable Care Organization (ACO) program, 60 percent of that money returns to the health system in bonus payments to offset some of the up-front cost.

As alternative payments spread, and smart phones and tablets become the normative form of convenient consumer communication, it's finally time to trust the growth projections for this emerging technology. A recent report [projected](#) that the number of consumers using home health technologies will grow to 78.5 million by 2020, a number that could prove conservative given the rapid growth in ACOs and the new MACRA incentives for population health.

Second, Medicare and private insurers are starting to realize that restricting telemedicine to rural areas may be shortsighted. Already, the mandatory Medicare bundled payment program waives the rural-only limitation, and new requirements on private payers may be effective at incenting the use of telemedicine to meet new network requirements in 2016.

### There's Gold In Them Thar Hills!

In 2015, I [discussed](#) the alarming trend of new, high-cost specialty pharmaceuticals entering the market. While that certainly was a major theme this year, we now know that high costs are not just limited to specialty drugs.

Overall drug spending increased 12.2 percent last year, the [highest rate](#) of increase in more than a decade, driven not just by new branded entrants, but also by generics. In fact, an [analysis](#) by market firm Connecture showed that more than 3,500 generic drugs at least doubled in price from 2008-2015, with nearly 400 up more than 1,000 percent. Given the cost trends, it should come as no surprise that 98 percent of [health system CEOs](#) say rising drug costs represent a major financial challenge for their organizations.

Given this and the complicated politics of pharmaceutical spending, 2016 will be a year of increased focus and action to drive market competition. We anticipate the new FDA Commissioner will prioritize speed and market access of new drug approvals.

This is already starting, with the FDA moving from 25 approvals a month to nearly 70 for the last three months. Further, bipartisan legislation giving the Food and Drug Administration (FDA) additional authority to fast track generic drug approvals, particularly in therapeutic categories where scant competition creates price spikes, will pass. The FDA will make significant progress in reducing the 42-month delay in bringing generic drugs to market, and it's fair to assume at least one new biosimilar approval in 2016. Shortening waiting lists as well as the lengthy approval process will go far to unleash positive competitive forces in the market, and drive prices down.

For proof, look no further than Gilead Sciences. Gilead's Sovaldi was last year's poster child for high prices, but as soon as AbbieVie and Merck announced they were entering

the Hepatitis C market, the price came down by 46 percent — virtually overnight. In short, competition really does work.

## Breaking Up With HAL-9000

Despite all the potential of electronic medical records (EMRs) to help providers improve quality and reduce costs, the benefits have yet to be realized. Instead, I hear a lot about problems: clinicians reporting issues with design and technical capabilities, an inability to integrate EMR data into workflows, and continued issues with interoperability across settings and platforms.

Considering how foundational electronic health IT has become, particularly in the context of alternative payment models such as shared savings and bundling, we need EMR performance to improve dramatically in 2016. Just like Dave the astronaut in *2001: A Space Odyssey*, it's time for providers to take control back from the central computers. In 2016, particularly as more physicians put in place IT to capitalize on new MACRA incentives, the [calls](#) to improve overall functionality and interoperability of systems will reach fever pitch. Already, Congress is hearing the concerns, and legislation was recently introduced that would hold HIT vendors accountable for their systems' security, usability, and ability to interoperate with other technologies, giving the Office of the National Coordinator for Health IT the authority to rate products in each of those critical areas.

I see this or similar legislation requiring more usability and interoperability across systems moving next year, to great cheering. With more information and a better ability to compare products, HIT vendors will have incentives to make improvements to their systems, while providers will be able to evaluate products using neutral, third-party data. I also expect there to be at least one significant partnership between an EHR vendor and an application provider that will integrate the app into the EHR and the workflow in a hospital.

## Measure For Measure

Today, a typical health system accepts patients from dozens of payers, including multiple commercial plans, Medicare, and Medicaid. Each of these payers has its own measures for evaluating performance. In the public sector, there are more than 500 different state and regional quality [measures](#), only 20 percent of which were used by more than one program. Private insurers add their own unique evaluation measures to the mix, amounting to more than 550 additional performance measures.

Not only does measure proliferation lead to “measurement fatigue,” it's also a source of enormous inefficiency. One northeast health system [reports](#) spending 1 percent of all

revenues to collect and report measures. Looking at Premier's data on the average service revenues for facilities in the northeast, this equates to \$2.5 million per health system in unnecessary administrative expense.

Providers have long advocated for a more simplified, streamlined approach to measurement. Without the development of a common, consistent quality cycle measurement framework, providers will continue to struggle with measurement proliferation and data collection, to the distraction of patient care.

In 2016, we will see a renewed effort to align and simplify the measurement cacophony among commercial and government payers. Considering that the new leader of America's Health Insurance Plans' (AHIP) is Marilyn Tavenner, a former CMS Administrator, we expect real progress in aligning public and private sector measures, which will benefit consumers and providers alike. MACRA also includes incentives to align payment models between payers. I also think that after years of talking, we'll make real progress in 2016 on developing measures that capture patient reported outcomes data, finally incorporating people's real experiences into how we measure and personalize care.

TAGS: CHRONIC ILLNESS, EMRS, GENERIC DRUGS, MACRA, PHYSICIANS, SOVALDI, TELEMEDICINE, TRENDS