NextGen® ADVISORS

Top Trends for Ambulatory Practices in the New Era of Healthcare

Risks, strategies, and opportunities

nextgen healthcare

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A NextGen® Advisors Publication

NextGen® Advisors, a multidisciplinary team of healthcare experts, partner with medical practices to solve strategic and operational challenges faced by organizations as they navigate the changing healthcare landscape.

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INTRODUCTION

The flexibility and adaptability that healthcare providers have demonstrated in response to COVID-19 has transformed the pandemic into a watershed event for the healthcare industry, propelling us into an uncertain future. Trends ranging from the growth of virtual visits and value-based payment to the emergence of disruptive market players, such as Walgreens-VillageMD, as well as increases in merger and acquisition activity, will shape ambulatory care for the foreseeable future. As with all change, new risks and opportunities arise.

This e-book examines healthcare trends from four perspectives:

1. The healthcare marketplace
2. The patient's perspective
3. Changes to the clinical model
4. Changes to the business of healthcare

Understanding your risks and opportunities in these different contexts can help you refine strategies for achieving future goals.

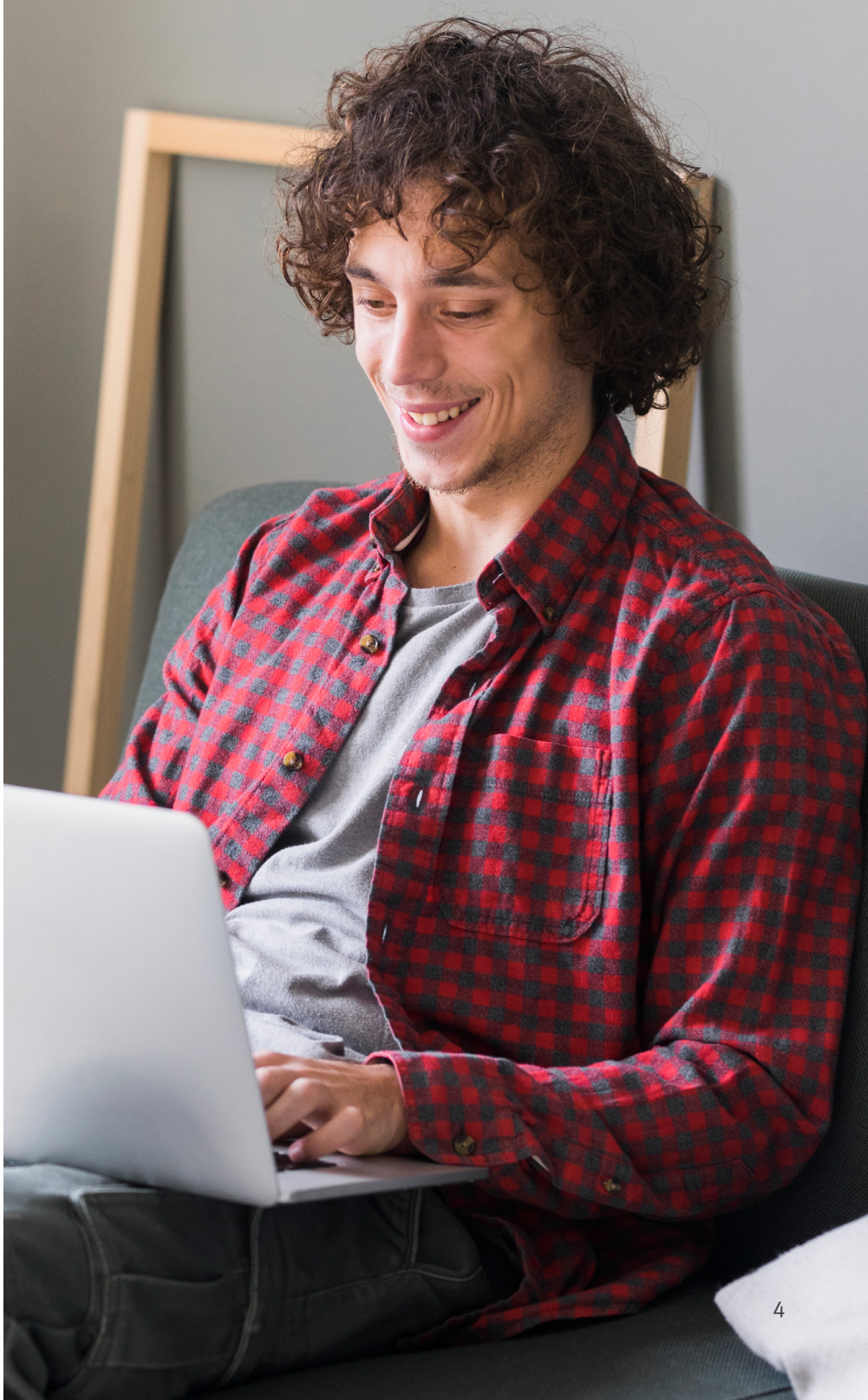
THE HEALTHCARE MARKETPLACE

The passage of the Affordable Care Act in 2010 set the stage for new trends to emerge in the healthcare marketplace, notably:

- The separation of insurance coverage tied to employment
- The expansion of Medicaid eligibility
- Centers for Medicare and Medicaid Services (CMS) focus on improving quality measurement while controlling medical inflation

Furthermore, an overall push for price transparency, a reduction in utilization, and increased profitability drove provider consolidation and mergers and acquisitions, along with the entrance of non-traditional players in healthcare delivery.

The health insurance marketplaces, established within state jurisdictions—or in their absence, the federal insurance marketplace—provided access to individual insurance coverage for millions of Americans. Enrollment in these products—which for the first time put in place coverage standards, promoted transparent pricing, and prevented applicants being rejected due to pre-existing health conditions—grew from about **8 million enrollees in 2014 to almost 13 million per annum in 2016.**[1] Since the exchanges began selling coverage directly to consumers, attaining insurance was no longer tied to having a job. For many Americans who had multiple jobs but no employer-sponsored health coverage, the marketplaces created access to care for millions previously left behind.



The Affordable Care Act expands coverage

Prior to 2010, federal law required states to provide Medicaid coverage to certain groups of individuals including low-income families, qualified pregnant women and children, and individuals receiving supplemental security income. The Affordable Care Act created the opportunity for states to **expand Medicaid** to cover nearly all low-income Americans under age 65.[2] Eligibility for children was extended to at least 133% of the Federal Poverty Level (FPL) in every state (most states cover children to higher income levels), and states were given the option to extend eligibility to adults with income at or below 133% of the FPL.

These actions however did not entirely curtail the growth of medical inflation, which continued to outpace annual cost of living increases and the consumer price index. This resulted in employers testing out new methods to constrain the mounting costs of providing health insurance coverage to employees and their dependents, such as defined contributions, only covering "full time" employees, or even changing the nature of employment relationships to reduce those eligible for coverage. These factors influenced the rise of the "gig" economy and a large cohort of workers who now are reliant on, but thankfully eligible for Medicaid or narrow-benefit insurance products with high deductibles, co-pay, and co-insurance requirements.

COVID-19 Impact

Continued growth in the Medicare population is an inevitable consequence of our aging demographics. Given these facts, the probable impacts include:

- Shifts in employer-sponsored insurance will accelerate Medicaid rolls and marketing of insurance products directly to patients
- Insurance dollars in aggregate are going to go down
- Patient out-of-pocket costs will rise as they move to lower-benefit level plans
- Reimbursement from payers will lower as government programs grow

The COVID-19 pandemic has thus increased the risk that the millions who have lost their jobs and associated employer-sponsored insurance will defer care, seeking care only in emergency situations or utilize emergency-level resources. Alternately, those individuals that may be able to purchase insurance coverage but struggle with their out-of-pocket costs, or if their income drops low enough, be eligible to qualify for Medicaid if they live in one of the 39 states who expanded coverage.[3]

Competition from disruptive entrants

While disruptive activities and consolidation have understandably slowed since the pandemic, those trends will resume and will be even more robust in the post-COVID world. The emergence of vertically integrated healthcare companies, such as CVS/Aetna, blur the historic lines between insurance carriers and providers of care. As such organizations grow and mature, their market power, retail footprint, and price advantage enable a disaggregation of the traditional provider landscape. Now primary care providers **find themselves in competition** with Walgreens and VillageMD who, amid the pandemic, inked an agreement to open up approximately 500 primary care practices across the U.S.

Position yourself for success and sustainability

The efficiency and effectiveness of both clinical and business processes will drive success in this brave new world. Changes to payment codes, managing the intricacies of payer billing and documentation requirements means **effective revenue cycle management** will become both more complex and more critical.

When the core of many ambulatory practices' value proposition is focused on patient care, now is the time to think carefully about outsourcing complex and rapidly evolving administrative functions. You can't afford to have those functions distract you from strengthening your core value. At the same time, you need to not only keep up, but stay ahead of the constantly changing benefit structures in reimbursement.

The emergence of vertically integrated healthcare companies, such as CVS/Aetna, blur the historic lines between insurance carriers and providers of care.

TAKEAWAYS
Healthcare Marketplace

- The loss of employer-sponsored insurance will shift millions onto Medicaid or to insurance exchange products that narrow covered benefits
- Vertically integrated "pay-vidors" will continue to mature and diversify
- A robust business continuity strategy is essential for survival

THE PATIENT'S PERSPECTIVE

In the past decade, increasing co-pays and deductibles have gradually put individuals and families at greater financial risk for healthcare costs. As they have experienced the convenience and value of online services in other parts of their lives, patients have been struggling to find convenient and cost-effective ways to receive healthcare. With the sudden arrival of the pandemic, virtual encounters immediately became the safest way to both provide and receive healthcare services. Just as people had learned to expect the convenience of shopping and banking online, they now see that they can effectively use virtual visits and **receive a variety of healthcare services in a similar way.** As noted above, the pandemic's economic impact will likely drive more people to Medicaid and exchange-based health insurance, and away from employer-based coverage. Added to the trend toward virtual visits will be an increase in the use of personal devices to create patient-generated health data. The onus will be on providers to find ways to capture relevant information, integrate it into the medical record, and effectively support patients in their self-care activities.

Providers can and should play a number of roles as this transition evolves. Patients will need help to improve their health literacy; choose devices and applications that provide valid and reliable information; and maintain a level of engagement with their provider to ensure safety in the context of increased self-care.

The acceleration of consumerism will heighten the need for providers to have a **population health platform** that integrates disparate sources of data, as well as patient engagement capabilities that bring information to the point of care efficiently and effectively. Providers and healthcare organizations will also need to remove the constraints of time and place for delivering, receiving, and documenting care.

TAKEAWAYS

Patient's Perspective

- Consumerism will continue to intensify
- Patients will expect availability of virtual visits
- Patient-generated data and self-care will increase with time
- Providers will need a flexible and robust **patient engagement platform**
- Providers will need a population health platform that can integrate disparate sources of data

CHANGES TO THE CLINICAL MODEL

Prior to the COVID-19 pandemic, very little care provided in the U.S. occurred in a virtual manner. This was the result of a combination of factors, such as restrictive payment models applied to this care modality and provider reluctance. The COVID-19 pandemic dramatically changed this. According to Doximity's 2020 State of Telehealth Report, up to $106 billion of current U.S. healthcare spend could be virtualized by 2023. Before the pandemic, only 14% of Americans tried virtual visits. Since the outbreak, the number increased to 57%.[4] Patient acceptance of this care modality has been high, and it is anticipated that patient demand for virtual visits will continue post-COVID-19 as well.

It is important to remember that much of the future of virtual visits depends on whether federal, state, and commercial payers will continue to support reimbursement parity or levels of reimbursement that are sustainable for providers and healthcare organizations. From statements made recently by CMS leadership and some of the commercial payers, it appears at this time there is positive intent in this regard.

Integrating behavioral health and primary care

A trend that started prior to COVID-19 and saw an acceleration, was the integration of behavioral health and primary care services. Organizations with a behavioral health focus were hiring and integrating primary care physicians; and multispecialty organizations with primary care as their focus were adding behavioral health services. Of note of course is that many Federally Qualified Health Centers had long had this model deployed and perfected. The hardship imposed by COVID-19 is unfortunately anticipated to increase the demand for behavioral health services, including addiction and substance abuse services.

Co-located model

There are several approaches to integrating behavioral health into a practice. The first is a co-located model in which the behavioral health practitioners and the physicians share a common physical space, allowing patients to be treated by both disciplines seamlessly. This model also fosters coordination, relationships, and interaction among the patients' different providers as they share the same office space and interact on a daily basis.

A **recent study** found that only 44% of primary care providers are co-located with behavioral health clinicians.[5] In rural practices, the number of co-located practices was even lower at only 26%. **Another study** found that practices that had undertaken co-location with behavioral health were motivated by a desire to improve access to behavioral health services for their patients as well as improve their responsiveness to patient needs identified in the behavioral health screenings all practices are now required to conduct.[6] There was also a perception among practices that having this type of practice model enhanced the reputation of the practice.

Collaborative model

The second model is the collaborative model whereby off-site behavioral health clinicians collaborate with providers to create common care plans or joint interventions. In some cases, psychiatrists might be off-site but offer collaborative support to a team of behavioral healthcare managers on-site who are interacting directly with the patient.

Unite disparate health data

Up until now, most primary care platforms have been designed to capture data about the health services a primary care provider would typically offer, while leaving out behavioral health. Likewise, behavioral health practices have used EHRs designed as specialty-specific systems.

An integrated EHR should provide robust content to support behavioral health services, such as substance abuse programs, inpatient and outpatient psychiatric care, depression assessments, family services, individual and group therapy, suicide prevention and crisis intervention, support for learning disabilities, and more. When the EHR unites traditionally disparate data into one record on a single platform, every provider is better equipped to support whole-person care.

Take a tour to **see how behavioral health content can be integrated** into your EHR.

Other factors influencing outcomes

Social determinants of health

Much work remains to truly **integrate the collection and response to Social Determinants of Health (SDOH) data at the practice level.** It is anticipated that deeper connections across different community agencies will be enabled by increasing interoperability and connectivity, which will allow a more effective response to the collected SDOH information.

Team-based care

Team-based care will continue to evolve, and the addition of virtual care and self-care will add another dimension to this evolution. Clearly there will be a need to re-evaluate the traditional office team roles with a shift to less in-person care. Effective integration of nurse practitioners and physician assistants will continue to be a recommended approach particularly in areas of physician shortage. Learning optimal ways to utilize their skill sets in virtual visits is going to be essential. **Population health management** tools embedded within the EHR can help you achieve integrated care because these tools aggregate patient data from multiple sources and facilitate the analysis of this data.

Effective integration of nurse practitioners and physician assistants will continue to be a recommended approach particularly in areas of physician shortage.

Public health agencies

The COVID-19 pandemic has clearly amplified the role of public health agencies and created an urgent imperative for practices to partner with public health authorities in their area. Testing, tracking, and reporting of cases are among the key activities being undertaken by these agencies. Many areas have had relatively small agencies that have atrophied over the years; we anticipate funding and renewed attention will be focused on them in order to ensure more robust preparedness in the future.

Interoperability

Integrated care is only possible through rich data exchange among all treating providers. Fortunately, interoperability standards have come a long way. Direct messaging capabilities within the EHR are an important factor in data exchange. The Direct Protocol provides standards for sending authenticated, encrypted health information to trusted recipients over the Internet.

To further promote nationwide care coordination, providers, EHR vendors, local and regional HIEs, and payers are participating in the Carequality Interoperability Framework as a preferred way to find out where medical records reside and share these records. Carequality is a network supported by many organizations: provider groups, regional data-sharing networks, standards development organizations, and others.

By participating in the Carequality network, healthcare providers who work on separate EHR platforms and are not part of the same health system **can share data efficiently.**

TAKEAWAYS

Clinical Model

- Virtual care is here to stay
- The need for behavioral health will continue to grow, along with integration in primary care
- Social determinants' influence on health outcomes will drive collaboration across social and healthcare providers
- SDOH data and services will increasingly be integrated into medical records
- Team-based care will continue to enable practices to serve larger panels of patients
- Public health will be re-prioritized around preparedness, disease surveillance, and management of chronic disease
- The importance of home health monitoring, wearable devices, and patient-derived data will continue to increase

CHANGES TO THE BUSINESS OF HEALTHCARE

As businesses have increasingly turned to high-deductible plans as a cost control measure, individual patients continue to push for price transparency. Adding fuel to this trend are provider groups entering into value-based contracts who want to understand the price of services for their patients. Hospitals and health plans have resisted transparency, stemming hospital leadership concerns that it will lead to a “race to the bottom” in terms of reimbursement and health plan fears of the opposite.

The pandemic may very well provide the impetus to overcome this resistance. With the loss of fee-for-service revenue from the halt in visits and procedures, providers will likely view prepayment, value-based arrangements as even more attractive. Businesses crippled financially by the pandemic, will move more aggressively to high-deductible and defined contribution healthcare benefits, accelerating the role of consumerism.

Aside from the move to value-based care and price transparency, the pandemic will also spur more merger and acquisition activity. Providers who have struggled financially because of COVID-19 will be more likely to seek the financial shelter of employment, while existing large groups and venture capitalist will see new acquisitions as a “bargain.”

These seismic shifts in the business environment demand a commitment to mission and vision—a thoughtful strategy that anticipates future needs, and a technical infrastructure that supports the transition to value-based care even as it maximizes efficiencies and revenue in the current environment.

The keys to success will include a management team that builds a culture and capability that is aligned around their strategic imperatives and maintains a focus on process improvement. Process improvement will be increasingly dependent on an integrated platform that supports the complex workflows across a range of services, and also offers the flexibility of office-based, virtual, and mobile encounters. An integrated technology platform must also have the data and reporting capabilities to ensure success in managing quality and cost for cohorts of patients, even as it continues to support the complex needs of coding and billing for FFS revenue. Given the uncertainty and complexity of these challenges, obtaining the expertise of an external **trusted advisor that can support your strategic planning** will be more helpful than ever before.

TAKEAWAYS
Business Model

- The need for patients and providers to understand costs in real time will drive cost and price transparency
- The uncertainty of volume-driven FFS will accelerate the move toward prepayment and value-based payment arrangements
- Financial pressure and revenue loss foretell provider consolidation, and merger and acquisition activity
- Now is the time to make sure you're ready for these changes via the guidance of a trusted advisor

BETTER STARTS HERE.

Contact us at 855-510-6398 or advisors@nextgen.com.

Choose a strategic partner to empower your transformation in the new era of healthcare.

NextGen Healthcare partners with medical, behavioral, and oral health providers in their journey to transform ambulatory care. We go beyond EHR and practice management. Our integrated solutions help increase clinical productivity, enrich the patient experience, and ensure healthy financial outcomes. We believe in better.

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