# Top 10 Trends in 2013

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The move to fee-for-value continues, and 2013 will prove to be a transformational year as healthcare organizations transition into a new era in healthcare. There will be budget constraints, new care models, shortages of clinicians, and the expansion of Medicaid and new insurance exchanges. The focus this year is on preparing and remaining flexible in order to respond to the changing environment. As we look ahead, here are the top 10 trends to expect in 2013.

**1. Healthcare operating expenses will outpace payment increases.**

Cost per unit will rise unless an organization increases throughput, clinically integrates, and reduces resource consumption. Labor will be the single biggest cost followed by supplies. Expect utility cost to outpace inflation. Health system strategy must focus on attracting/capturing a larger population. This means increasing market share in an environment of no per capita growth in volume. Focus on access points such as primary care, urgent care, Federally Qualified Health Centers (FQHCs), community clinics, Rural Health Clinics (RHCs), retail clinics, and freestanding emergency department (EDs). Payer relationships such as participation in health plan narrow networks and with self-funded employers are also opportunities to drive volume. But cost reduction must be at the forefront to assure that these new volumes are profitable.

**2. Health system physician alignment for the continuum of care will be key.**

Hospitals and physicians will pursue patient-centered medical homes (PCMHs), bundled payments, ACOs, clinical integration, co-management, and joint ventures. A significant focus of health system resources will be setting economic incentives that reward improved quality, reduced costs, and top patient service satisfaction. This is a “must do” initiative for any health system/hospital given greater transparency, and in some cases, payment tied to scores (e.g., HCAHPS surveys).

**3. Clinicians, sometimes as a group or in conjunction with a hospital partner, will adopt new care models.**

The new models will either target managing a population or treating episodes of care (resource consumption per case). Expect greater use of information technology (IT), including telemedicine, wireless devices, and population and utilization analytics. New models include those mentioned above (Trend #2) as well as global payments and mini PCMHs targeted to specific major chronic diseases.

**4. Health plans will continue to be very active in their strategic initiatives as they prepare for the health insurance exchanges.**

Expect health plans to use their tremendous reserves to buy other health plans, targeting those with Medicare and/or Medicaid lives, and diversify into other related businesses, including support services for population health management, acquiring provider systems, and even the retail healthcare business. Further, they will continue to partner with high “foot traffic” chains to offer their products and enroll/insure more people (e.g., Walmart, Costco, Rite Aid). Further, a small but growing opportunity that health plans will pursue is to partner with health systems on private label health plans. These plans can build on the system’s self-funded employees, narrow network products, as well as other employers’ self-funded plans.

**5. The push-pull on volume. Just as efforts to reduce readmissions and length-of-stay are achieving the desired results for purposes of succeeding in new payment models, there will be a need to replace this "unwanted" volume with "new" volume.**

Get ready for a tough fight for market share. Providers will work immediately on capturing the population base to support their "sunk cost" in inpatient facilities and resources. There will be an all-out effort to consolidate markets (hospital to hospital, medical group to medical group, medical groups/physicians to hospitals, and health plan to health plan) to capture more population to increase throughput, reduce costs, and restructure assets in a market with over capacity.

**6. Keep an eye on the government.**

With state budgets still reeling from the recession and a disappointingly slow economic recovery, state governments will need to find solutions to their problems, which include Medicaid expansion/flexibility, insurance exchanges, state employee costs (health and retirement), and infrastructure costs to manage all of the changes underway. Like the states, the federal government must deal with Medicaid expansion, federal employee costs, healthcare costs, insurance exchanges, as well as healthcare reform implementation and subsidies, Medicare beneficiary growth, and new care delivery models. Centers for Medicare & Medicaid Services (CMS) reports disappointing news with fewer bundled payment applicants (i.e., less cost savings to pay for healthcare reform) and ACOs with smaller enrollments than expected (although more of them) as well as long payback from the CMS Innovation grants.

**7. IT will continue to consume a greater portion of a health system's budget.**

Health systems must invest in order to be ready for healthcare reform's new delivery models and payment systems. The necessary investment includes those that should be completed now such as PACS, results reporting, EMRs for the inpatient and outpatient setting, and CPOE. In 2013 and 2014, the focus will be on data warehouse and health information exchanges in which to participate or interface, and finally moving to population analytics and web portals for patients and physicians.

**8. Difficult employer-employee relations are coming.**

As healthcare employers experience greater revenue pressure on their businesses, employees will see smaller salary increases and will pay a greater portion of their healthcare insurance premiums and co-pays. Staffing reductions will continue, especially in non-clinical areas. Expect labor strife, layoffs, reduced hours, outsourcing departments or services, more of management's compensation at risk, and finally more incentive compensation for employees, which will be targeted to metrics in cost, quality, and customer service.

**9. Consolidation of providers will continue as hospitals seek to gain scale, reduce costs, and capture a greater portion of the healthcare continuum.**

Health systems will focus on geographic markets where they can concentrate resources and better utilize assets. This may mean that in larger markets, a system may consolidate four acute care providers into three sites and convert the fourth to post-acute care services. Medical groups and IPAs will consolidate as well, given that many physician organizations will not have the capital to invest in the necessary infrastructure (e.g., IT, care models, protocols, human resources to manage the "new" delivery system). Many physician organizations are populated by baby boomers who are beginning to consider retirement and may be looking for a sale to monetize their life long investment in their practice.

**10. Employers will respond.**

Employers have seen double digit premium costs over the past few years. They have and will continue to pass this cost on to employees. However, moving forward, expect employers to provide more information about pricing and quality metrics (transparency). The days of high deductible PPO narrow network health plans are here to stay. Most hospitals are using their employees and dependents as the “new narrow network” delivery system, where the patient incurs fewer out-of-pocket costs if they use their hospital and physician network. Further, during labor negotiations, hospitals and non-hospital employers will trade wage increases for new creative health benefit design by dropping low value providers.