



Five Healthcare Trends in 2020: Your Cheat Sheet

In 2020, our nation's healthcare delivery and payment environment will continue its multi-year evolution. While some key trends will continue and expand, 2020 also brings new trends that will have a significant impact on healthcare providers across the continuum.

The top five trends to watch in 2020 are:

1. Consolidation
2. System Disruptors
3. Consumerism
4. Growth in Medicare Advantage
5. New Post-Acute Models



Healthcare Consolidation



The continued – and growing – trend toward integrated production, including non-traditional partners, helps define an age of major transformation across the healthcare industry. **While mergers and acquisitions**

between hospitals, health systems and physician practices may be waning, consolidation among unlikely partners has accelerated. These types of relationships include the ongoing integration between CVS and Aetna and the announced deal between Walmart and Amedysis.

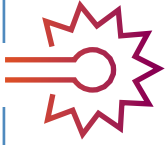
Why It Matters:

Greater consolidation and integration across the healthcare system has the potential to play a vital role in improving patient treatment as traditional silos of care are broken down. These new partnerships are emerging in a value-based healthcare environment as they help reduce inefficiencies in care and improve care coordination for patients. While the intention is that these new organizations will improve clinical outcomes and clinical decision support for patients post-discharge, there are still risks that monopolistic entities retain the benefits of scale and efficiency rather than passing along reduced healthcare costs to consumers. In 2020, it will be important to watch for some controls in the forms of new regulation to ensure the benefits go to the consumer. In fact, in November 2019, the Medicare Payment Advisory Commission (MedPAC), under the direction of Congress, began an initial investigation as to the effects of hospital mergers and healthcare provider consolidation.

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Healthcare System Disruptors



A rapidly growing trend is the rise of “disruptors” within healthcare – these are outside sources that have not traditionally been tied to healthcare, but are seeking to radically reform the system.

One of the most notable disruptors is Haven, the non-profit stemming from the joint venture between Amazon, Berkshire Hathaway, and J. P. Morgan, which is aimed at improving the healthcare for their collective 1.2 million employees. Another disruptor to the status quo is Best Buy and their expansion into home healthcare, with the intent on enabling seniors to “age in place” through the use of technological wearable devices, remote monitoring tools and, eventually, new care coordination

services. These are just two examples of organizations seeking to address the nation’s healthcare challenges with innovative solutions.¹

Why It Matters:

First off, it is important to recognize that these healthcare disruptors are all new and non-traditional participants in the healthcare marketplace. **They are leading a trend to interrupt and dislocate the status quo and forge new pathways to improve healthcare services in America. By nature they will upend the healthcare industry, but the timing and exact impact is unknown.**



Consumerism



The concept of consumerism is that patients are taking ownership of care decisions based upon costs, their understanding of the full scope of options available to them based on research and trustworthy sources of information, and leveraging their use of technologies.

Within this trend, consumers are increasingly searching for the best value at the lowest cost that is the most convenient to their lives. In response, healthcare providers have been asked to respond with more price transparency and demonstrated quality outcomes.

Additionally, new technologies – such as wearable devices – provide consumers new ways to engage in their own healthy living and in managing certain conditions. **This is important because research demonstrates that increasing a patient’s participation in their care plan is associated with improved healthcare outcomes and reduced healthcare costs.²**

Why It Matters:

With more than 80% of consumers researching their healthcare options online and the increased reliance on the reputation of a hospital, physician or provider before making healthcare decisions, costs and publicly-reported quality scores are increasingly important. This elevates the need for all health settings and health professionals to manage their online reputation, to ensure the highest quality outcomes that are reported on sites such as Medicare compare and to increase transparency in terms of the patient’s out-of-pocket costs.

The Centers for Medicare and Medicaid Services (CMS) has proposed – but not finalized – new price transparency measures where all hospitals will have to “publish the prices they negotiate with payers for standard services and items” in order to help educate patients as to costs. However, the “shoppable prices” that CMS has proposed be made available will have little context for patients, and will not provide relevant data such as expected out-of-pocket costs.

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Growth in Medicare Advantage

Enrollment in Medicare Advantage (MA) plans has more than doubled over the past 20 years—growing from 18% in 1999 to 36.7% in 2019.³ The Congressional Budget Office (CBO) projects that the share of beneficiaries enrolled in Medicare Advantage plans will rise to about 47 percent by 2029.¹

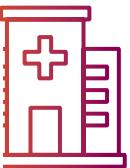
More and more Americans are choosing to enroll in Medicare Advantage rather than traditional Medicare because of the perceived convenience and additional benefits touted by the managed care organizations. However, providers are increasingly finding that MA plans are discounting or ignoring physician decisions for the best and most clinically appropriate level of care for patients. Rather, plans are focusing on cost over optimal patient outcomes.

Why It Matters:

With health services and setting-specific care being denied by MA plans, patients, their families and physicians are increasingly appealing the plan's decisions. However, the appeals process can lead to delays in patients receiving the most appropriate care and significant additional administrative burden for physicians and care providers. Congressional leaders are taking notice, and in an initial effort to improve the Medicare Advantage appeals process, they have introduced the Improving Seniors' Timely Access to Care Act (HR 3107). The legislation would reduce provider administrative burdens and increase transparency surrounding the use of prior authorization in MA, enable "real time" decisions by the plans, and seeks beneficiary protections based on evidence-based medical guidelines to ensure continuity during a course of treatment.

Expect more Congressional activity and pressure from hospitals and health systems throughout 2020 to protect patient access to high-quality care in a timely manner.

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New Post-Acute Models

In 2020, both Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs) will undergo significant overhauls to their Medicare payment systems. In October 2019, SNFs began a new system known as the

Patient Driven Payment Model (PDPM) and in January 2020, HHAs will undergo a reform to a new system known as Patient Driven Groupings Model (PDGM). Under both PDPM and PDGM, rehabilitative therapies are no longer the driver for Medicare payments; rather, Medicare payments are tied to the complexity of patient needs rather than the volume of services delivered.

However, providers must be mindful that CMS expects the same, or better, outcomes for patients under this new payment model.

Why It Matters:

In the early stages of PDPM, many SNF operators responded with layoffs or significant changes to the employment of qualified physical and occupational therapists and speech language pathologists. **Despite the fact that therapies will not be a driver of reimbursement levels under the new models, they will still be essential to drive quality care and patient outcomes.** In fact, therapies have been shown to have a huge impact on reducing lengths of stay and readmission rates, and improving functional outcomes and quality of life.

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How Kindred Can Help

How Kindred Can Help

We specialize in the treatment and rehabilitation of the post-intensive care and complex medical patients requiring continued intensive care, including specialized rehabilitation, in an acute hospital setting.

Our interdisciplinary team of skilled and specialty clinicians in our long-term acute care hospitals can be the right partner for you for your patients who have been in an ICU or critical care unit or who are chronically ill and at the greatest risk for hospital readmission.

With daily physician oversight, ICU/CCU-level staffing and specially trained interdisciplinary teams, we work to improve outcomes, reduce costly readmissions and help patients transition to a lower level of care.

Additionally, Kindred remains an advocate to help shape new health policies as Congress and the Administration seek to establish value-based healthcare payments and delivery reforms.

If you have a critically ill patient in need of care after a hospital stay, call a Kindred Clinical Liaison for a patient assessment. Our experts will help you determine the most appropriate care setting for your patient's next stage of treatment. If you are unsure of who your Kindred representative is, please visit us online at www.kindredhospitals.com to find our hospital nearest you.

References

1. Bryant, Bailey, "Best Buy, Amazon and Walmart Leading Retail's Race into Home-Based Care," homehealthcarenews.com, September 29, 2019, <https://homehealthcarenews.com/2019/09/best-buy-amazon-and-walmart-leading-retails-race-into-home-based-care/>
2. Coulter A, Ellins J. *Effectiveness of strategies for informing, educating, and involving patients*. *BMJ*. 2007; 335(7609):24–7.
3. *Kaiser Family Foundation: Medicare Advantage*, June 2019, <https://www.kff.org/medicare/fact-sheet/medicare-advantage/>



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