EXECUTIVE BRIEFING PREVIEW

16 Things CEOs Need to Know in 2021

Advisory Board

In a year when the public and political spotlight was already focused squarely on health care, the Covid-19 pandemic has intensified the level of scrutiny on the industry. While sentiment toward the industry has largely improved, the outbreak has also prompted conversations about the structural shortcomings of the current system. Although the issues of coverage and affordability remain at the forefront, Covid-19 has introduced a new dimension—resilience—to the discussion as well.

This executive briefing examines the emerging focus on resilience by breaking down how purchaser motivations are (and aren't) shifting—and how the core structural elements of the delivery system must evolve as a result of the Covid-19 pandemic.

This preview contains the first eight of our 16 top insights about the state of the health care industry in the wake of the Covid-19 pandemic. Members of select Research programs[1] have access to the full briefing.

For more information, please contact us at **programinquiries@advisory.com** or visit **advisory.com/memberships**.

1) Health Care Advisory Board (Strategy for hospitals and health systems), Health Care Industry Committee (for health care professional service companies), Clinical Innovators Council (for life sciences firms), Health Care IT Forum (for digital health companies), and Health Plan Advisory Council (for health plans).

16 things CEOs need to know in 2021

AVAILABLE IN PREVIEW

01 The need to improve the industry's durability has not eliminated the mandate to deliver on affordability. True resilience delivers on both ambitions.

02 Despite a near-term focus on providing financial relief, neither Medicare nor Medicaid are backing off from efforts to control future spending growth.

03 Employers will increasingly seek savings by accelerating physician-led efforts to steer patients to lower-cost care settings.

04 While the pandemic has introduced new complexities for value-based care, both public and private payers remain committed to payment reform.

05 Fear that the pandemic will prompt increased consolidation is driving purchasers to more strategically align with independent physicians.

06 While most physician practices would prefer to align with other independent groups, many more are ultimately likely to seek acquisition by private equity firms or health plans.

07 Following a short-term slowdown, hospital M&A is likely to accelerate—but the bar for proving value has increased for both participants and regulators alike.

08 Covid-19 presents a unique—but likely fleeting—opportunity for health systems to demonstrate the value of scale.

AVAILABLE WITH MEMBERSHIP

09 Enthusiastic projections about home-based care hinge primarily on growing patient preference, overlooking the complex interplay of factors that influence site-of-care shifts.

10 A growing and widespread web of alliances between plans, pharmacies, and ambulatory providers is poised to shift pharmaceutical-reliant services out of the hospital setting.

11 Practical, regulatory, and reimbursement barriers will continue to constrain home-based senior care, despite clear patient preference to "age in place."

12 With telehealth unlikely to return to pre-pandemic lows, the industry must ensure virtual care is used to confront (not exacerbate) unaffordability and inequity.

13 The pandemic has forced hospitals to grapple publicly with three major weaknesses: supply chain shortages, capacity management constraints, and workforce burnout.

14 Greater transparency—and tighter cross-industry alignment—will be even more critical to improving supply chain resilience than larger stockpiles.

15 While low hospital occupancy has long been viewed as a sign of the industry's inefficiency, the pandemic will shift fixed-cost restructuring efforts away from the inpatient space.

16 Given the immense burden borne by frontline clinicians, executives must reaffirm their commitment to investing in their clinical workforces.

01

The need to improve the industry's durability has not eliminated the mandate to deliver on affordability. True resilience delivers on both ambitions.

At both the individual and organizational levels, the health care industry took extraordinary action to battle Covid-19. But the pandemic has also exposed many of the industry's shortcomings. In some cases, the most remarkable stories from the front lines—for example, the extreme lengths providers went to in order to secure PPE—also underscore the industry's biggest weaknesses. Shortages of supplies, staff, cash reserves, and (to a lesser extent) bed capacity, all highlighted the fragility of the U.S. health care system, both in its ability to withstand sudden surges as well as precipitous drop-offs in demand.

Improving the industry's ability to withstand such shocks would be straightforward with unlimited resourcing. With additional funding, the health care industry could assemble massive stockpiles of critical supplies, staff large numbers of empty beds, and maintain huge cash reserves.

But such strategies would stand in direct conflict with recent efforts to improve health care affordability. Our opinion at Advisory Board is that affordability is itself a necessary element of resilience.

An industry that is not financially sustainable in the best of times won't be able to weather a shock or crisis (Figure 1.1).

> Investing in more durability seemingly requires compromising affordability, and a middle ground meets neither goal.
>
> **Can the industry satisfy both aims?**

Advisory Board's view is that true resilience lies not in brute strength and massive reserves, but in the ability to respond and pivot quickly in times of crisis. Defined in these terms, resilience includes at least four key elements.

Efficient use of resources is the first core tenet of resilience—and is integral to the industry's ability to deliver on the growing mandate for affordability. However, an industry that runs leanly must also have structures in place that make it flexible. As demands on the industry shift (sometimes suddenly), it must be able to respond accordingly. Agility is also critical. An industry that is flexible but slow to move is unlikely to successfully weather a sudden shock or crisis.

Finally, we would also argue that the industry cannot truly be resilient unless it is built on a foundation of health equity. A system that benefits only some patients and leaves others more vulnerable is one that amplifies the impact of shocks—the opposite of resilience (Figure 1.2).

While this newfound focus on resilience does not reflect a shift away from affordability, it could stand to change the way in which health care purchasers pursue affordability.

FIGURE 1.1: **HOW CAN HEALTH CARE BECOME MORE DURABLE WITHOUT SACRIFICING AFFORDABILITY?**

Goal: The health care delivery system has the raw strength and capacity to meet demand during surges and to survive during droughts.

Essential components of durability:

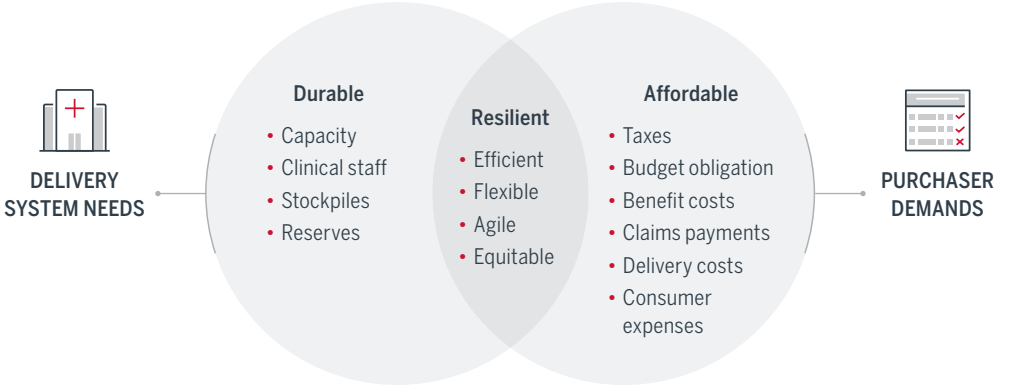
- Health system capacity
- Stockpiles of critical supplies and drugs
- Clinical staff
- Solvent reserves

Goal: Health care expenses are manageable enough that no one segment of the industry cannot pay its share to keep the industry moving—even after a shock.

Essential components of affordability:

- Public taxes
- Government budget obligations
- Employer benefit costs
- Insurer claims payments
- Provider delivery costs
- Consumer expenses

FIGURE 1.2: **RESILIENCY LIES IN EFFICIENT, FLEXIBLE, AGILE, AND EQUITABLE STRATEGIES**



02

Despite a near-term focus on providing financial relief, neither Medicare nor Medicaid are backing off from efforts to control future spending growth.

Before the Covid-19 pandemic began, policymakers on both sides of the aisle were signaling a growing openness to pricing controls. Hospitals and pharmaceutical manufacturers found themselves common targets in proposals at the federal and state levels. In the wake of Covid-19, such conversations have largely halted as the government has worked to bolster providers and fund the race for a vaccine.

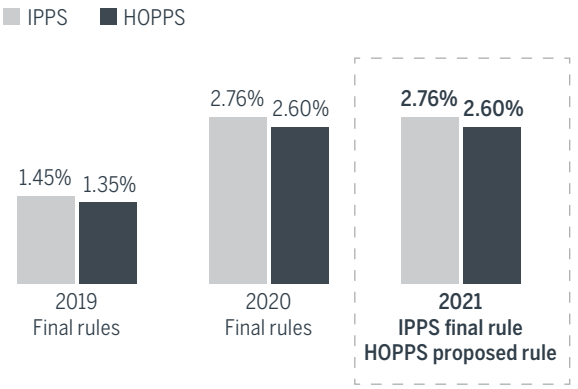
This doesn't mean that CMS is pivoting away from efforts to control spending. In fact, policymakers have continued to emphasize their focus on other spending control levers like site-of-care shifts and value-based care programs. Moreover, the looming insolvency of the Medicare Hospital Insurance Trust Fund is likely to prompt Congressional action in the coming years. Historically, provider rate cuts have been a consistent component of legislative changes designed to bolster the trust fund (Figure 2.1).

While price cuts in Medicare are likely in the coming years, Medicaid programs are expected to feel even more immediate urgency to control spending. With the majority of states required to balance their budgets, legislators and administrators will be forced to look for immediate savings opportunities.

Federal aid for state Medicaid programs prohibits states from disenrolling Medicaid beneficiaries, reducing Medicaid benefits, or increasing beneficiary cost-sharing, leaving states with few options for managing Medicaid spending. Absent additional federal funding, most states will likely resort to Medicaid reimbursement cuts to balance their budgets (Figure 2.2). Such cuts were common during the Great Recession—and Medicaid directors already expect even deeper cuts this time around.

FIGURE 2.1: **MEDICARE PRICE GROWTH STEADY, CMS CONTINUES TO PURSUE OTHER COST-SAVINGS LEVERS**

IPPS[1] and HOPPS[2] payment rate increases...



...while other cost-saving options move forward

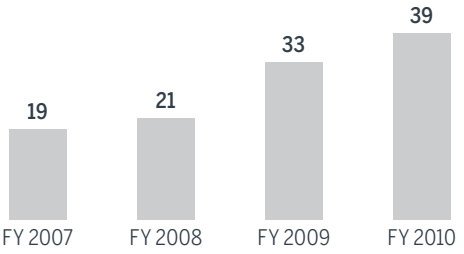
Site-of-care shifts

Value-based care programs

1) Inpatient Prospective Payment System.
2) Hospital Outpatient Prospective Payment System.

FIGURE 2.2: **MAJORITY OF MEDICAID PROGRAMS TURNED TO PRICE CUTS DURING LAST RECESSION**

States reporting at least one provider rate cut or freeze



> [The looming crisis facing Medicaid programs] is going to be the '09 recession on steroids. It's going to hit hard, and it's going to hit fast."
>
> **Matt Salo**
> Executive Director, National Association of Medicaid Directors

03

Employers will increasingly seek savings by accelerating physician-led efforts to steer patients to lower-cost care settings.

While Medicaid seems poised to follow a similar trajectory to that observed during the Great Recession, employers are pursuing a very different set of strategies this time around. A decade ago, employers' primary strategy to cut health spending was to shift costs onto employees (Figure 3.1).

Despite the acute financial pressure facing many employers, Advisory Board does not expect most employers to pursue cost-shifting today. Heavy reliance on high-deductible health plans across the past decade means that many employers have reached the limit of what their employees are willing to bear. The optics of cutting health care benefits during a pandemic are also poor. Perhaps most importantly, many employers have found that health care costs are trending under budget for this year due to the immense number of employees that canceled non-urgent procedures during the first half of 2020. Finally, the sheer magnitude of the financial pressure facing many employers means that those seeking near-term savings will likely resort to layoffs, rather than trying to wring modest savings out of their health care costs.

Employers will still look to control health spending across the long term. However, such strategies are unlikely to be notably altered by the pandemic.

Before the pandemic began, employers were coalescing around steerage-focused strategies. Whether through concierge navigation services, Center of Excellence networks, reference pricing, or second opinion services, employers were experimenting with a variety of ways to shift employees to lower-cost (and potentially higher-quality) providers and care settings. In fact, perhaps one of the most important impacts of high-deductible health plans has been to increase consumer willingness to tolerate these types of steerage strategies, so long as it minimizes their out-of-pocket exposure (Figure 3.2).

FIGURE 3.1: **COMMON EMPLOYER BENEFIT CHANGES POST-2008 RECESSION**

Percentage of employers indicating they were likely or very likely to make or keep changes after economy recovers in 2009

n=329 human resources professionals

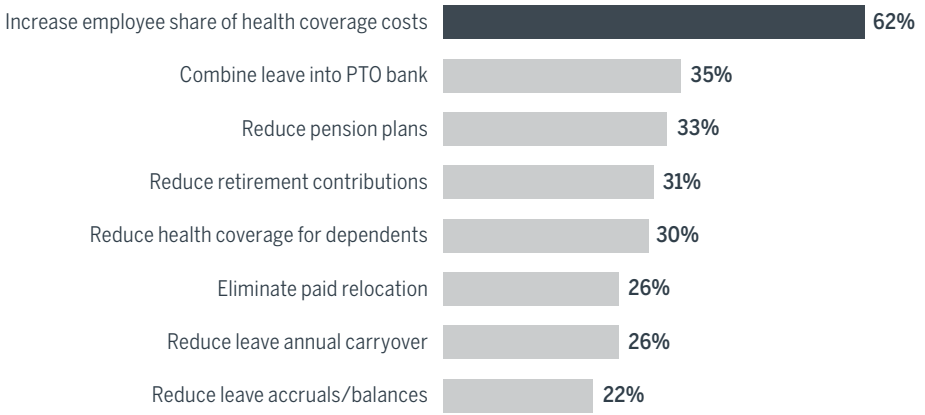
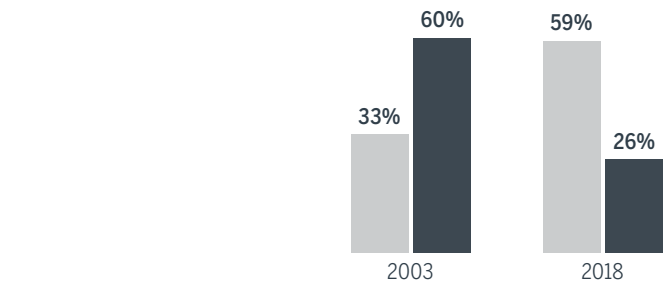


FIGURE 3.2: **COST SHARING INCREASED ACCEPTANCE OF MANAGED CARE**

Percentage of people who report cost- or coverage-related features as the most important aspects in a health plan

n=1,407 adults ages 18–64 with employer-sponsored insurance



04

While the pandemic has introduced new complexities for value-based care, both public and private payers remain committed to payment reform.

Across all payer segments—both public and private—the pandemic has raised questions about the future of value-based care and risk-based contracting.

Covid-19 has undoubtedly slowed the progress of Medicare risk models. New value-based programs that were slated to launch in 2020—like the Direct Contracting model and Primary Care First model—are now delayed until 2021 (although critically, CMS has not canceled these programs). CMS also announced that it will not accept new applicants to the Medicare Shared Savings Program for 2021. At the same time, CMS has introduced several flexibilities designed to keep participation levels in current programs steady. For example, they have granted ACO participants more time to transition out of upside-only models and agreed to waive any losses incurred in downside risk models for the duration of the public health emergency.

Many private payers have similarly updated contract terms to grant risk-bearing providers flexibility for 2020. Some health plans even hope to accelerate adoption of value-based care models, particularly among independent physician practices that may see newfound value in the steady revenue streams offered by capitated contracts.

For example, Blue Cross and Blue Shield (BCBS) of North Carolina is offering independent physicians in its market financial support and revenue stabilization through 2021. In return, participating physicians must join the plan's ACO program and commit to maintaining their independence for the duration of the program.

CASE PROFILE

BCBS of North Carolina accelerated payment program

Financial stabilization

Distribute payments until the end of 2021 to "true up" revenue to what an average practice earned in 2019

Transition to value-based care

Require practices to commit to join a Blue Premier ACO by January 1, 2021

Eligibility for capitation

Offer practices a primary care capitation model that will start in 2022 (PCPs are not required to join at this time)

Requirements to participate in the program

1. Provide care delivery and care coordination activities
2. Commit to join the pathway to value-based care
3. Maintain independent status for the duration of the program

05

Fear that the pandemic will prompt increased consolidation is driving purchasers to more strategically align with independent physicians.

Efforts to stabilize physician revenue come as many practices—especially small primary care and single-specialty groups—face immense financial pressure due to Covid-19. The pandemic will undoubtedly push a number of these practices to seek shelter with a larger partner who can provide immediate financial support, as well as protection during future crises.

The range of potential capital partners a practice may consider has expanded significantly in recent years (Figure 5.1). Where physicians once had to choose between a larger practice and a health system, physicians today may also consider partnering with a national practice firm, a health plan, or a private equity investor.

Purchasers and legislators are increasingly making their preferences known. Many of these stakeholders have expressed their concerns over the role that hospital employment of physicians may play in driving up prices, as well as the role that private equity investors have played in exacerbating surprise out-of-network bills.

For example, in the wake of the pandemic, the Pacific Business Group on Health (a coalition of private and public employers based on the West Coast) sent a letter to the California legislature requesting that the state help stabilize the economics of independent primary care practices—and establish a moratorium on hospital-led M&A for the next year.

> "These monthly payments would serve as a lifeline to primary-care providers who have suffered a serious loss of revenue during the COVID pandemic and, as a result, would otherwise be forced to close their practices or be acquired by large health systems."
>
> **Bill Kramer**
> Executive Director for Health Policy at the Pacific Business Group on Health

FIGURE 5.1: **POTENTIAL STRATEGIC PARTNERS FOR ESTABLISHED PHYSICIAN PRACTICES**

Potential partner	Attractive factors	Deterring factors	Common target specialties	
Other physician practices	Like-minded, similar to status quo	Likely only large groups have enough capital to acquire	Single and multi-specialty groups	Typical physician preference
Enablement partner	Independence, long-term sustainability, burnout mitigation	Partial business model change, limited short-term cash support	Small, independent primary care practices	New suitors
Health plan	Long-term sustainability, burnout mitigation	Lose independence, partial business model change	Independent primary care practices	
Private equity investor	Rapid cash infusion, remain independent	Aggressive growth targets, limited control over future owners, range of business model change	Orthopedics, gastroenterology, women's health, urology	
Health system	Stability with employment, existing delivery infrastructure	Lose independence, uncertain revenue stability due to Covid-19	Primary care practices, new physician graduates	No slam dunk

CASE PROFILE

Requests from Pacific Business Group on Health to California legislature

Require health insurers to distribute $2.5B in prospective payments to independent PCPs

Expand opportunities for primary care practices to transition to value-based care models that increase investment in primary care

Mandate that hospitals and health systems forgo M&A deals with other providers for 12 months in order to receive CARES Act funding

06

While most physician practices would prefer to align with other independent groups, many more are ultimately likely to seek acquisition by private equity firms or health plans.

If possible, most physician groups would likely prefer to maintain their independence by aligning with a larger practice. While the number of independent practices has continued to decline, recent years have also seen the growth of physician disruptors like ChenMed, Aledade, and Privia—all of whom purport to offer a physician-led alternative to hospital employment or private equity (PE) investment.

Many of these players operate models that center on risk-based contracts and value-based care. As a result, they have successfully weathered the first few months of the Covid-19 pandemic. However, their singular focus on value-based care models also means that they are extremely selective in the physicians they partner with. Despite continued growth, they also remain relatively small players in a limited number of markets.

For physicians who choose to forgo independence, health systems have long been a natural partner. In recent years, however, a growing number of physicians—particularly those who have chosen to remain independent to this point—have expressed hesitations about seeking hospital employment, due largely to concerns about loss of autonomy. Those who do not want to seek employment with a health system are likely to find themselves with two viable options: private equity firms and health plans.

Because of the sudden nature of the economic downturn, many private equity groups found themselves with plenty of liquid funds or "dry powder" to spend. Practice finances are expected to continue to deteriorate in the coming months, as it has become clear that a complete volume recovery is unlikely and as federal support winds down. PE activity is likely to accelerate as practice valuations decrease and as travel restrictions start to ease.

Health plans have also emerged from early stages of the pandemic in a position of relative financial strength. This will provide players like Humana and Optum[1] with additional opportunity to accelerate physician alignment strategies that have been underway for a few years. Of particular note is the recent entry of several Blues plans into the physician space as well; most notably, Blue Cross Blue Shield (BCBS) of California's acquisition of Brown & Toland, a large physician group on Northern California (Figure 6.1).

1) Advisory Board is a subsidiary of Optum. All Advisory Board research, expert perspectives, and recommendations remain independent.

CASE PROFILE

Aledade emphasizes value proposition to physicians

Aledade, Inc. procured shipments of PPE for over 500 physician practices in its ACOs, including:

282K
Surgical masks

29K
Face shields

119K
KN95 respirators

348K
Medical gloves

"It looks like there will be no new ACOs in 2021. But you can add practices to existing ACOs. We @AledadeACO have 38 of them. And we will take every last independent primary care practice who wants something better for their patients, for their practices, and for society."

Farzad Mostashari, CEO, Aledade, Inc.
Twitter, 4/30/2020

CASE PROFILE

ChenMed openly recruits and expands

25% expansion
with 15 new locations planned for 2020, as of June 2020

"Find a like-minded physician-led and run practice that's big enough and stable enough to help today and for the long term."

Christopher Chen, CEO, ChenMed
LinkedIn, 6/10/2020

FIGURE 6.1: **PLAN-PHYSICIAN ALIGNMENT MARCHES ON**

Humana

55+
Physician practices throughout the U.S.

- Establishes joint venture with PE firm Welsh, Carson, Anderson & Stowe to expand primary care centers for seniors with subsidiary Partners in Primary Care (47 locations)

Optum[1]

46,000+
Employed or contracted physicians

- Acquired DaVita Medical Group in 2019, which operates 300 clinics, 35 urgent-care centers, and six outpatient surgery centers throughout the U.S.

Blue Cross Blue Shield

14
BCBS plans investing in provider acquisition and/or alignment

- June 2019: BCBS of Minnesota enters a joint venture with North Memorial Health to co-own 20 outpatient clinics
- April 2020: Blue Shield of California's subsidiary Altais acquires Brown & Toland's 2,700 physicians

1) Advisory Board is a subsidiary of Optum. All Advisory Board research, expert perspectives, and recommendations remain independent.

07

Following a short-term slowdown, hospital M&A is likely to accelerate—but the bar for proving value has increased for both participants and regulators alike.

Hospitals and health systems face many of the same financial pressures as independent physician practices. While their size affords them some level of protection, many are anticipating heavy consolidation activity within the hospital sector as well.

Advisory Board expects that hospital M&A activity will slow temporarily due to a combination of limited bandwidth among executive teams and a desire to see how potential partners fare financially in the coming months. In the long run, however, M&A activity will likely accelerate (Figure 7.1).

The pandemic will almost certainly prompt an uptick in acquisitions of small community hospitals, many of which face extreme financial headwinds as a result of Covid-19. While regulators may fear the potential ramifications of such deals on pricing, they are also unlikely to prevent deals that will preserve access within a community.

The outlook for "mergers of equals" (whether financially motivated or strategically motivated) is less clear. While Advisory Board expects an uptick in deal announcements, it is not yet certain how regulators will look on such deals, and whether they will offer more—or less—leniency in the wake of the pandemic (Figure 7.2)

FIGURE 7.1: **M&A ACTIVITY TO SLOW TEMPORARILY BEFORE ACCELERATING**

Factors contributing to a near-term slowdown

Management teams actively redeploying resources and investing time to manage Covid-19 crisis

Reduced cash on hand as a result of delayed and canceled care

Organizations waiting for health care demand to stabilize before committing to mergers and acquisitions

Possible drivers of long-run M&A acceleration

Mounting financial challenges ("have-to" scenarios): Will financial pressure from Covid-19 force previously unwilling partners to seek shelter in scale?

New returns to scale ("want-to" scenarios): Will the emerging competitive landscape offer organizations new opportunities to find value in scale and achieve true "systemness"?

More regulatory freedom: Will regulators accept new (or old) arguments for the benefits of consolidation and permit M&A where they had not before?

FIGURE 7.2: **COVID-19 IMPACT ON M&A**

Covid-19 impact on M&A

- Deals are likely to accelerate as a result of the crisis
- Deals could be accelerated by Covid-19 under the right conditions:
  - Both parties see clear value in increasing scale
  - Value of consolidation is clear to regulatory stakeholders

08

Covid-19 presents a unique—but likely fleeting—opportunity for health systems to demonstrate the value of scale.

The regulatory outlook for hospital M&A will depend at least in part on health systems' ability to prove and articulate the value that scale has provided during the pandemic.

By and large, most health systems were able to demonstrate a remarkable amount of "systemness" in their Covid-19 responses. The pandemic required systems to make quick and centralized decisions, to flex supplies and staff across their organizations, and to quickly roll out new protocols and programs (such as telehealth) enterprise-wide (Figure 8.1).

While the pandemic has provided health systems with an opportunity to find new value in scale, the peri-Covid "recovery"period will also provide organizations with a unique opportunity to pursue evergreen (and in many cases, ever-elusive) systemness ambitions. As organizations bring services and staff back online, they may choose to establish new norms and structures. For example, they might rationalize service lines, sunset underperforming programs, reorganize governance and leadership structures, or outsource functions to third parties (Figure 8.2).

Many decisions will revolve around site of care. The recovery period provides opportunity for leaders to re-evaluate ratios of inpatient and outpatient capacity, shift services out of the hospital setting, and permanently expand telehealth and virtual care options.

FIGURE 8.1: **SOME SYSTEMS ABLE TO REAP REWARDS OF SYSTEMNESS (NOT JUST SCALE)**

OPERATIONAL ADVANTAGE

Novant Health

- 15 hospitals, 350+ practices in NC, SC, VA
- Built an interactive, real-time dashboard at the system, region, facility, and clinic levels to preempt supply shortages and shift resources across system
- As of June 2020, no Novant facility had experienced shortfalls in ventilators, PPE, or other resources

TRANSFORMATIONAL ADVANTAGE

UC San Diego Health

- Two-hospital academic system in San Diego, CA
- University engineers developed a monitoring platform for Covid-19 patients to recover at home using a wearable device and an app
- Monitoring platform is being tested by patients in a clinical trial at the health system

STRUCTURAL ADVANTAGE

NorthShore University HealthSystem

- Five hospitals, 140+ practices in Evanston, IL
- Transformed a single hospital campus into a dedicated Covid-19 treatment center for the system
- Allowed the system to triple its ICU surge capacity

CLINICAL ADVANTAGE

Montefiore Medical Center

- 11 hospitals in Bronx, NY
- Created a command center to enable critical care physicians to provide virtual support to staff across the system; enabled the system to manage with a 1:50 critical care physician ratio

FIGURE 8.2: **LEADING HEALTH SYSTEMS WILL USE THE RECOVERY PERIOD AS AN OPPORTUNITY**

1. **Reorganize governance and leadership structures:** Emergency response efforts highlight organizational structures that slow down decision-making and hinder coordination
2. **Make difficult decisions about outsourcing:** Financial pressure jump-starts conversations about which business functions to keep in-house and which can be outsourced to third parties
3. **Rationalize services across sites of care:** Evaluate which services to bring back and where; recovery period could be opportunity to sunset under-performing programs or shift settings
4. **Re-evaluate ratio of inpatient to outpatient capacity:** While more outpatient capacity is needed, health systems will be reluctant to downsize acute inpatient capacity
5. **Shift procedures out of the hospital (or hospital outpatient department) setting:** After clinging to hospital-based reimbursement, hospitals will confront which services can safely move to alternative sites of care
6. **Permanently expand telehealth and virtual options:** After being forced to use telehealth, consumers (and some physicians) will expect continued availability of virtual care services

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