Ask the Experts: Financial Sustainability Post-Covid-19

The Covid-19 public health crisis has had a substantial financial, economic, mental and physical health impact in the U.S. and around the world. Health systems and hospitals have had to increase hospital capacity, stop elective surgeries and adjust their workflows significantly to deal with the shifting needs of the community and patients serve. Outpatient and ambulatory volumes dwindled during stay-at-home orders.

Coming out of the initial Covid-19 crisis period, hospitals and health systems need to identify rapidly and act on targeted opportunities to improve revenue now, for 2021 and beyond. In this article, COPE Health Solutions has asked a few experts to provide actionable revenue maximization strategies and recommendations for hospitals, health systems and medical groups.

We interviewed some of COPE Health Solutions Advisory Board members, Board members and leadership for their thoughts.

C. Duane Dauner is an Executive Advisor for COPE Health Solutions and served as President/CEO of the California Hospital Association, the statewide leader representing the interests of nearly 400 hospitals and health systems in California from 1985-2017. Mr. Dauner also serves on COPE Health Solutions Advisory Board.

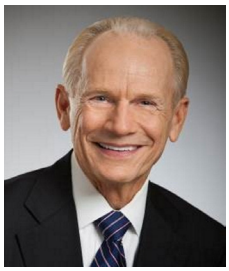
Joel Perlman is an Executive Advisor for COPE Health Solutions and served as the Executive Vice President, CFO of the Montefiore Health System, Montefiore Medicine. In 2016 after 28 years as CFO, he retired and has stayed as Senior Adviser to the CEO. Mr. Perlman is also a Board Member of COPE Health Solutions.

Ram Raju, MD is an Executive Advisor for COPE Health Solutions and is the Senior Vice President and Community Health Investment Officer at Northwell Health. At Northwell Health, he is responsible for promoting, sustaining and advancing an environment that supports equity and diversity, while helping the health system eliminate health disparities. Dr. Raju also serves on COPE Health Solutions Advisory Board.

Allen Miller is a Principal and CEO of COPE Health Solutions, a leading national health care consultancy focused on helping payers and providers accelerate sustainable population health management and drive value-based care transformation.

Q: With the disruptions made to care models and standard workflows, what are some strategies to maximize reimbursement today and in the next six months under existing health plan contracts?

Dauner: It is important to make people feel safe to come back to providers' locations and receive care. The best communicator of safety is a doctor, someone who is visible in the community, who can communicate that patients' safety is important, and providers are committed to keeping them safe when they get care. Telehealth services have been crucial during this crisis, and it will be important to negotiate contractual payment extensions for the telehealth services that were put in place by the Centers for Medicare & Medicaid Services (CMS) and other payers.



C. Duane Dauner
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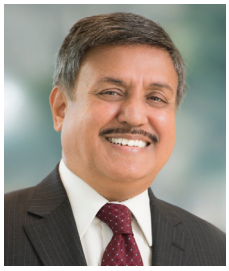

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"Coming out of the initial Covid-19 crisis period, hospitals and health systems need to identify rapidly and act on targeted opportunities to improve revenue now, for 2021 and beyond."

Raju: Hospitals need to think about increasing volume for patients coming in and consider other reimbursement options in the future to make up for the loss in revenue and increase in costs. Telemedicine has caught on, and it is important to leverage the reimbursement available for these services. Telemedicine will continue to move forward in the future, and the winners will need to invest wisely in technology and embrace the shift in the avenues of care it provides.

Perlman: An immediate step is to ensure that your organization receives all available Covid-19 disaster relief funding. It is also essential to maintain complete documentation supporting relief funding in an auditable format. Looking ahead, many health systems and other provider organizations will experience an increase in utilization and revenue as providers resume more normal operations, and patients who deferred accessing care during the pandemic return.

Some provider organizations will likely extend hours and/or days of operations to meet temporary patient demand spikes. We have witnessed a significant increase in telehealth services during the pandemic. Telehealth, virtual and remote monitoring services will likely continue to grow exponentially. This will require health care organizations to have the appropriate information technology infrastructure and effective relationships with vendors offering enhanced technology solutions to provide high quality, cost effective and consumer-centric care. Ultimately, the value of telehealth will be enhanced by well-informed reimbursement policies, effective interoperability, data sharing and well-designed care management workflows.

Miller: If you haven't already, create a simple table for all of your health plan, MSSP ACO and any other payer arrangements, enabling quick and easy comparison of quality metrics, shared savings requirements and other key revenue levers. Ensure your initiatives to close quality care gaps are targeted such that activities undertaken will provide maximum ROI on the quality metrics across your agreements with the most upside opportunity. If you are in any value-based payment (VBP) arrangements and have access to claims data, it is important to leverage that data and engage closely with your physicians and attributed patients to reduce leakage. This will ensure any needed procedures are proactively scheduled and undertaken within your own network of physicians and facilities as patients go back to accessing care and screenings.

Q. How would you recommend providers and payers think about quality metrics and payments, as well as risk score coding for the remainder of 2020 and going into 2021?

Dauner: Standard quality metrics have been impacted by the crisis. Many quality reporting guidelines have been waived, and exceptions were made during the crisis. However, these waivers will expire when the emergency period ends or soon after. This does not mean that things will go back to normal, and there is still a potential for additional surges of Covid-19 and hotspots that will likely emerge.

Some quality scores may have increased in some areas of the country during this crisis. Utilization was down with fewer patients receiving care while there has been heightened sensitivity to safety precautions to ensure patients and staff are safe (e.g.,consistent hand washing has increased), allowing for more focused attention to patient care and safety.

Raju: Bad quality costs a lot of money. From a doctor's perspective, there has been little money in quality; most revenue has been earned through procedures and visits. Physicians' reputations have been based on outcomes metrics rather than quality measures. There needs to be a shift in quality program structure to focus on patient based outcomes because that is best for patients, providers and payers. For example, if a doctor does a limb surgery, he or she is focused on the outcome metric percentage, such as limbs saved, which does not account for long-term patient based outcomes such as the patient's ability to use their limbs after surgery. Payers will need to incentivize more for these quality measures in the future.

Perlman: The best way to continuously deliver high quality care and improve customer experience is for payers and providers to work collaboratively to construct contracts that are durable and benefit both parties. Contracts should reflect incentives that are aligned around evidence-based quality, outcomes and best practices. Contracts ideally would have longer terms, eliminate provisions that can undermine the VBP arrangements (e.g., rebasing), and serve to benefit all stakeholders (patient, provider and payer/purchaser). Additionally, as we have come to understand the impact of social determinants of health (SDOH) on a person's health status, cost of care and quality of life, community-based services should be tightly integrated into care management models; including appropriate severity measures and VBP incentives. The Covid-19 crisis has tragically exposed the inequities in our health care system and must be addressed through improved access and quality of care for vulnerable communities and patient populations. However, improvements in patient care and overall community health status will take years to be fully realized, and all stakeholders should be committed to programs, funding approaches and contracts with a longitudinal view in mind. Implementing effective SDOH initiatives will benefit society, the economy and will produce an ROI for all those engaged. Community-based organizations (CBOs) must be included as aligned partners to bring about meaningful change and advance the goal of health care equity.

Miller: Healthcare Effectiveness Data and Information Set (HEDIS) care gaps are likely not on track, and providers will need to catch up on screenings, immunizations and other key interventions to both improve quality and protect the health of patients. As mentioned earlier, this will also give you a leg up on identifying procedures and diagnostics needed and ensuring those are scheduled and undertaken within your network. It will also be important to focus on accurate coding, including analyses to uncover likely missed coding based on prescriptions and other available data. Doing this will position providers for more revenue through VBP agreements in 2021 and beyond. The providers who are adept at coding for risk scores, hitting quality targets and achieving savings on MLR are better partners for payers and more likely to succeed in building additional membership with the higher market share payers.

Q. What considerations should be taken into account today when developing and negotiating future contracts with payers?

Dauner: It will be important to negotiate contractual adjustments during extraordinary circumstances, such as this pandemic. Extending telehealth codes and rates into future contracts also will be important. Lastly, risk contracting failed in the 1980s, but many of the past flaws have been solved with technology, knowledge and systems, thereby creating an opportunity now to enter into risk arrangements.

Raju: We have to start to pay not only based on medical risk, but social risk as well. Patients who are sent home from the hospital often end up coming right back because they face socioeconomic barriers that have not been addressed. Consistently using ICD-10 z codes will be essential for this to be successful as the z codes provide a methodology to include SDOH in risk scoring and risk stratification. This will help identify both the ROI on addressing underlying SDOH issues and the patients to prioritize for non-medical support services. However, this requires payers to start reimbursing for these services to incentivize providers to consistently use these codes or take more financial risk and directly gain the value themselves from the financial benefits of providing SDOH services to close both socioeconomic barriers and care gaps.

Perlman: The crisis has profoundly demonstrated that we remain far removed from an optimal health care system. Going forward, we must commit to working collaboratively to develop durable long-term contracts that are fair, measurable, and evidence-based and adaptive to unforeseen developments such as Covid-19. This will be essential to encourage more providers and payers to engage in robust VBP arrangements. With shared goals, transparency and accountability, contracts can be designed to measure and reward quality, outcomes, reduce per capita costs and fully deliver on the promise of Triple Aim.

Miller: Providers in the right risk agreements will come out far ahead of their peers both in typical circumstances and during a disaster such as the Covid-19 pandemic, when significant volumes of care are put on hold and fee-for-service (FFS) payments grind to a halt. We're seeing more providers interested in VBP arrangements and capitation, at least starting with primary care capitation. If it's possible to gain access to capitation, consider beginning with primary care capitation with a reasonable quality incentive and shared savings program for the total cost of care. Be sure to get access to the historical claims data for new VBP agreements. Be clear about what parts of the administration of risk you want to own, such as complex care management, credentialing, utilization management (UM), etc. and ensure you have the necessary internal capabilities and the delegation of these functions through your payer agreements.

Q. What do you think the future is for VBP contracts? How will Covid-19 accelerate or slow the transition to VBP?

Dauner: If there is a silver lining coming from this pandemic, it is that it has accelerated the use of telehealth and other technologies that some had been reluctant to use before the pandemic. Covid-19 has opened several flood gates, and we will see more risk and VBP arrangements using such technologies. It is likely that we will take steps toward VBP for these telehealth and other remote care services, starting with FFS, followed by incentives on both sides to move into global risk and capitated arrangements over time.

Raju: VBP is not going to slow down, but the value it brings will need to be redefined. Covid-19 will impact negotiations in the future as health systems and hospitals will not only have to think about creating value for the patient, but also plan for the future. Being prepared for any potential emergencies will be very important, which will require a reserve of money and resources, and someone will need to be responsible to pay for it (e.g., government, payers, etc.). One approach to developing the reserve is to structure it similarly to medical education expenses as these expenses are built into the reimbursement structure.

Perlman: In the near term many health systems/other provider organizations are focused on Covid-19 recovery priorities — clinical, operational and financial — that may temper rapid transition to VBP arrangements. During the crisis, utilization of typical health care services has significantly declined. This has resulted in large declines in revenue for providers. Conversely, many health plans have benefited financially from the decline in medical spend. As demand grows in the coming months, FFS payments will help providers to recover Covid-19 related lost revenues. Longer term, the imperatives to lower per capita healthcare costs, market forces and payment reform policies will continue to drive the transition from FFS to VBP.

For VBP to fulfill its potential, payers and providers must commit to enduring partnerships which align their financial interests long term. Durable, well-designed VBP arrangements should focus on "perpetual gainsharing." This requires that contracts be designed to reward continuous improvements in quality, patient experience and cost effective care. ACOs/IPAs must enfranchise all stakeholders and tailor incentives to all provider sectors in the network (acute care, primary and specialty physicians, ambulatory, telehealth and virtual care service providers, sub-acute and community based providers). There are a number of forces disrupting the traditional health care delivery model including medical and technology advances, consumer expectations, new and diverse market entrants. These forces make it all the more important that traditional providers embrace VBP arrangements and share in the financial benefits and gains realized from innovation, long-term.

Miller: If you look at the Centers for Medicare and Medicaid Innovation (CMMI) Medicare Direct Contracting program, you'll find that CMMI has actually done a pretty good job of taking lessons learned from capitation over the years in California and other markets. They have created a useful roadmap for providers considering what is needed to succeed in full risk, what to seek delegation for and how capitation works. Not everyone will be ready to jump into Medicare Direct Contracting or full risk; however this is clearly where health care is going from a payment perspective, and you will see more payers coming to the table with more aggressive VBP offerings,

pressuring providers to step up. In the immediate term, providers can focus on improving quality and risk scores, so that when they enter into agreements with greater premium risk they will benefit from the added premium dollar generated through quality and risk adjustment. For these contracts to be successful, heath plans will need to be transparent with data and premium and providers will need to come to the table with transparency on their non-premium subsidies such as Disproportionate Share Hospital (DSH) and 340b in order to enable development of risk agreements that maximize all dollars for the benefit of all parties, including patients.

Q. How should health systems and payers prepare for and ensure financial success with a growing Medicaid population?

Dauner: Medicaid programs pay less than most payers, creating downward pressures on revenue streams to health systems and hospitals. There is an incentive to demonstrate to Medicaid payers the value of telehealth and remote health monitoring that will allow providers to deliver appropriate services at a lower cost. It will be important to evaluate the Medicaid population to determine their likelihood of using these services and categorize them into three groups: technologically savvy, comfortable with technology and not capable or willing to use technology. A targeted VBP strategy can be established based on this information. For example, you may want to contract at-risk for the technology savvy group and then down the road develop a shared risk contract for the comfortable with technology group while keeping FFS for those who are not capable or willing to use technology.

Raju: This is very simple in that there is only two ways to fix this: get more in reimbursement and revenue or cut expenses. For the Medicaid population, there really is limited opportunity to get more revenue, so will need to focus on cutting costs for these patients. It will be important to reduce emergency department and inpatient visits and increase access to resources outside of the hospital and into the community like primary care, home care and care management. This also includes addressing SDOH because if these resources are not available, length of stay increases. There should be more social workers than doctors to help address patients' SDOH needs.

Perlman: Typically, higher commercial payment rates, have compensated for lower Medicaid and Medicare reimbursement. The higher the commercial payer mix a provider organization has usually translate into better financial performance and long-term financial health. As Covid-19 has led to high levels of unemployment, most health systems will experience a growth in their Medicaid payer mix for some period, leading to greater financial challenges. This makes it ever more important to focus on working efficiently to lower the cost of care, and enhancing quality. Innovation, technology, elimination of avoidable administrative burdens and reduction in inefficient variances in care practice will contribute to the financial well-being of provider organizations. Additionally, needed changes in reimbursement policy will be important for the long-term viability of safety net and rural providers. Engagement in well-designed Medicaid VBP arrangements should benefit provider organizations with large or growing Medicaid patient populations.

Miller: First, ask yourself if you have the right provider network and other key capabilities to be successful in Medicaid. Some questions include:

- Do you have federally qualified health centers (FQHCs) or rural health clinics (RHCs) in rural areas in your network?
- Do you have high percentage Medicaid clinics that are not FQHCs or RHCs, including those with a teaching mission that would benefit from being classified as FQHC look-alikes?
- Do you have a strategy to both improve access to primary and specialty care, including through e-consult and telehealth, for Medicaid while working to channel hospitalizations into hospitals with access to both Medicaid DSH and 340b?
- Have you created a network of CBOs with defined value-add services to impact SDOH challenges for your Medicaid population, and are those CBOs well aligned with your FQHC, RHC and other PCP network?
- Do you have the right care model, including non-licensed to licensed staffing ratios to ensure high impact care management with a strong ROI?

- Have you developed the ability to monitor and manage patients, including those positive for exposed to Covid-19 and the chronically ill, in order to alleviate stress in ED and reduce avoidable admissions?
- Do you have low acuity respite care set up to enable transitional care for homeless patients post-discharge?

Medicaid is very well designed for success in premium risk arrangements, and these should be aggressively explored with health plans assuming you can answer positively to some or all of the questions above. Medicaid numbers will increase dramatically going into 2021 as states get newly eligible members enrolled so now is the time to ensure you are prepared with a successful Medicaid strategy.

Q. How will the upcoming election impact health care and how potential future Covid-19 surges are managed?

Dauner: This is far more complex than a presidential election. Who wins the U.S. Senate, House, state and local government offices will play a significant role in shaping the future of health care. The election and who wins can influence health care in various ways, but this is not the only avenue to make changes and how we react to future surges. Preparation needs to start now for potential future pandemics and other disasters. It doesn't matter who the president is if the citizens don't play their part and abide by the public health guidelines.

Raju: The plans and topics discussed during the election and what actually happens are two very different things. Covid-19 created a huge problem and now there will have to be a focus on public health, technology and data. There was not a focus on public health in the past, and it impacted our ability to react to the public health emergency.

Perlman: It will take a concerted, sustained effort of all stakeholders including governments, payers, providers and consumers, to address what is challenging today's health care system (e.g. disparities in care, high costs, misaligned incentives and the risks of future crises). Effective policy which improves access, quality and affordability of health care for all should be informed by research and medical advances, innovation, evidence-based practices and by health care and public health experts irrespective of the political party in power. The Covid-19 pandemic has exposed our shortcomings and should catalyze actions that will advance the goals of health equity, improved community health status, quality of care, public health preparedness and fiscal responsibility.

Miller: This election will be important for many reasons. That said, there are some absolute trends in health care that are not going to change regardless of who wins the presidency, governorships or federal and state legislatures. A focus on reducing total cost of care, improving quality outcomes, improving both patient and provider satisfaction and addressing underlying SDOH will be engrained in health care policies consistently. CMS and the states have been moving toward more Medicare Advantage and VBP; more downside risk and quality requirements attached to Medicare FFS Medicaid managed care and value-based payment, primary care and behavioral health integration; and movement from fragmented dual eligible Medicare and Medicaid programs to more PACE, dual eligible alignment pilots and DSNP plans. FQHC and RHCs have also been consistent bi-partisan winners. Our recommendation is to focus strategy around the consistent macro trends and avoid being pulled off course by the short-term distractions.

COPE Health Solutions sincerely thanks Mr. Dauner, Mr. Perlman and Dr. Raju for sharing their thoughts. For more information on how the current Covid-19 epidemic impacts FFS and VBP strategies, please contact Allen Miller at (310) 386-5812 or amiller@copehealthsolutions.com.