EXECUTIVE INTERVIEW SERIES

The Impact of COVID-19 on Payer-Provider Collaboration

Q&A with Bill Van Antwerp and Nate Akers, Guidehouse

How do you believe COVID-19 will impact payer-provider collaboration moving forward?

Akers: As with other areas of healthcare and the overall economy, we anticipate sustained long-term impacts on payer-provider collaboration resulting from COVID-19.

In the short term, we know that hospitals and health systems are experiencing material decreases in revenue. This is primarily due to utilization drops ranging from 50% to 90%, with rural hospitals experiencing the most significant utilization impacts. Providers that took capitation payments are maintaining more consistent cash flows, and health systems that built and own their own health plan are sustaining stronger financial positions. Furthermore, providers with medical loss ratio (MLR)-based shared savings arrangements are expecting higher than normal shared savings revenues with commercial payers.

For payers, MLRs are drastically under forecast. This is largely being met with payers searching for ways to shift these surplus dollars back through the primary care system to ensure wellness and other quality-related efforts can be realized despite the drop in normal utilization.

All of this points to the need for payers to focus on aligning more closely with providers. If they don't, they run the risk of enhancing the business case for providers to get closer to the premium dollar through vehicles like provider-sponsored health plans or direct contracting with employers.

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Van Antwerp: In addition to the financial implications, payers and providers will need to better align and collaborate coming out of this pandemic to ensure market preparedness for the next COVID-19 wave or pandemic. If they do not, policymakers will take that effort out of their hands, and we believe this will reduce efficiencies and the quality of care provided to the communities they serve.

We also see this as an opportunity for providers and payers to engage in a partnership dialogue outside of any contract discussions. Current circumstances allow leaders to take more risk to force change that normally would be quickly questioned. It's a chance to build a foundation of trust and to support the community together, instead of eyeing short-term financial gains. This includes developing new care and reimbursement models and driving increased transparency and true interoperability.

5 Areas for Post-Pandemic Payer-Provider Collaboration

- Synchronize and optimize the member's digital journey throughout the care continuum.
- Ensure more thoughtful and efficient administrative avenues to care are implemented to minimize administrative costs.
- Create new reimbursement models that achieve consistent payment to providers, reward efficient care delivery, and mitigate controls for unwarranted care.
- Partner on a single stream of clinical knowledge in a community to avoid conflict of information for how to react to or treat an illness in that community.
- Create a joint policy agenda and strategy to ensure the government's policy response doesn't result in financial and administrative controls that hamper local healthcare response to the next COVID-19 wave or pandemic.

What should payers be thinking about and preparing for as the risk around COVID-19 subsides and we enter a new reality?

Akers: We recently partnered with HFMA on a survey of 174 provider executives, and 68% predict their organizations will be using telehealth at least five times more than they did pre-pandemic. We agree that telehealth is here to stay, and payers will need to be ready for it to make up an exponentially larger portion of cost of care than it did before the crisis.

Payers will also have to prepare for an elongated economic downturn that really puts pressure on the commercial line of business for most of them.

With this new reality, payers should keep the following in mind:

1. Are we ready to engage providers with the payment models they are willing to accept going forward? Do we have the tools to support them through this journey?
2. Is our digital strategy sound and still relevant in the new normal? Have we carefully thought out the member experience of navigating this new virtual health engagement platform?
3. Are we mitigating the risk to future top-line revenues driven by risk adjustment and quality bonuses in an environment where members have limited access to care?
4. Do we have an optimized telehealth platform that includes processes to appropriately document the burden of illness for our patients?
5. Are we diversifying our portfolio and making up for loss of revenue on our commercial business through our other lines of business, primarily Medicare Advantage?
6. How will we serve the needs of the unemployed and underemployed impacted by a depressed economy? How can we directly support our members through waived cost sharing and social determinants of health investments?

These are questions that need to be answered now and planned for and invested in over the long term.

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How have payers’ digital strategies changed since the onset of the pandemic, and how will they evolve to best serve members?

Van Antwerp: Many of our clients have invested significantly in digital tools to better serve their members. Although healthcare’s digital capabilities are maturing at an industry level, we still trail other industries. The pandemic magnifies the need for payers and providers to fully embrace digital, specifically member engagement and analytics, and move from approaching digital as a set of tools to a true mindset. This shift requires leadership capabilities around digital that are mature and nimble, which is what the crisis will demand moving forward.

Members will come out of this experience with a different perspective on the entire care delivery system. Payers will need to enhance their digital tools for members, including symptom checkers supported by predictive analytics and artificial intelligence. Virtual health will be considered standard with the expectation that a significant amount of provider visits will take place via phone or video call. Interactive technology tools will emerge as the dominant methods for members to interact with the healthcare system.

We believe payers need to assess the initiatives they’ve been pursuing on the digital front and address the following considerations:

1. Will their digital strategy be relevant in the new normal?
2. What will drive value in the new reality as they build a framework for understanding the return on investment and total impact on their customers?
3. Do they have the capacity and infrastructure for digital care delivery to become the standard of care?
4. How will they adjust their provider contracts to effectively support stakeholders?
5. What measures will they put in place to measure and report on quality using telehealth?

The latest tool in the battle against COVID-19 involves adding contact tracing to their current testing efforts. There will be intense debates over privacy rights and varying points of view on the effectiveness of these approaches at this stage of the pandemic.

What does the future hold for value-based and risk-based programs in this new reality?

Akers: We believe there are two camps in the "new normal." One will see a shift to more consistent payment models and away from fee-for-service. The other will feel the need to fight for increased fee-for-service payment schedules. Which method organizations end up following will be determined by individual market factors, such as competitiveness of market.

In the short-term, payers will need to have a plan to manage existing programs with respect to both their own and providers' financial picture. Having an accurate projection of MLR impacts given challenges in the current environment will be necessary. These projections allow payers to either advance payment based on likely financial outcomes on current programs — which will go a long way in supporting provider partners now — or provide direct-to-member benefits or cost-sharing relief.

Van Antwerp: As we look longer term, we believe providers will be more likely to embrace risk-based reimbursement in the form of capitation or global payments, but less interested in traditional shared savings and risk models that are more abundant today. The shift toward more capitation-like models with risk corridors will give providers a more consistent revenue stream in case of a second COVID-19 wave or surges, or if another crisis occurs in the future that significantly reduces their fee-for-service revenue.

With this in mind, payers must ensure their value-based care capabilities are ready for this shift. A close look at key capabilities related to attribution, financial and quality performance measurement, data sharing and reporting, and financial settlement is required, and investments should be made to close any existing gaps.

Moreover, with more capitation or global payments, the need for financial controls and downstream reinsurance protections are required to protect both payers and providers. Finally, there is a continued need to integrate member benefits and member engagement into these programs to ensure incentives are aligned across all the involved parties.

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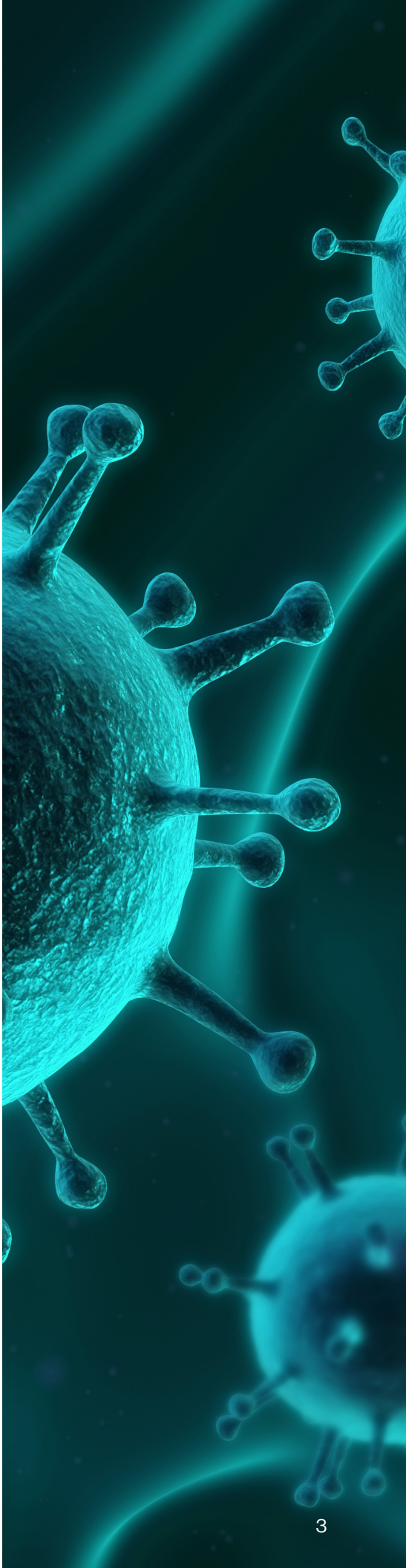

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