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Practical Physician Solutions to Thrive in a Post-COVID-19 World

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Background

Much has been written about the dramatic impact that COVID-19 has had on health systems across the country. The triangulation of unanticipated COVID-19 cost, lost revenue from the mass cancellation of elective procedures, and a precipitous decline in investment income has created a financial gap that the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), Federal Emergency Management Agency (FEMA), and other subsidies will not fill.

These same factors have had a dramatic impact on both employed and independent medical groups across the country. Accordingly, we see six key physician macro-trends on the horizon for health system executives and medical group leaders:

1. A significant decline in reimbursement cross-subsidization opportunities (e.g., less commercial business to cover government payer losses) will result in continued revenue degradation.
2. Capital will be much more difficult to secure as health system margin gaps increase, challenging the ability to continue to make seven-to-nine figure investments in their medical groups.
3. Most regions will experience greater market turbulence through the combining of expanded telemedicine with undercapitalized independent medical groups, creating opportunities for new competitors to enter traditional markets.
4. An increased need to enhance alignment with independent physicians, which will be key as many health systems rely on independents for 40% to 50% or more of their case volumes and revenue.
5. Demand for immediate ROI from alignment efforts with key physicians as both health system and physician practices face financial challenges, shortening the runway to financial impact on both sides of the negotiating table.
6. Best-in-class digital health solutions will be a necessity and not a luxury as patient demands increase for more consumer-centric services, when and where consumers want them at a price that is both transparent and affordable.

As dramatic as these impacts may seem, two of them pose the greatest concern for both employed and independent physicians: revenue degradation, and the threat created by digital health that could make this problem worse.

Revenue degradation

Revenue degradation is caused by the simultaneous combination of volume decline and payer mix erosion. While only time will tell the ultimate impact of COVID-19 on utilization rates for physician encounters, we are reminded that the uninsured and underinsured use healthcare at a rate that is approximately one-third that of a commercially insured population. On top of that, Medicare utilization during COVID-19 has declined by 40% to 50%. Given this circumstantial evidence, we find it difficult to see physician group volumes returning to "normal" any time soon.

Yes, there are some who have seen volumes come back as states have reopened, but volumes only tell half of the story. As unemployment rates continue to increase, we are seeing the number of uninsured and underinsured in the U.S. rise to levels unseen since the Great Depression. This will result in a decrease in commercial payer mix for both independent and employed medical groups, which will cause the revenue line to diminish even if volumes return to pre-COVID levels.

Using Medical Group Management Association median data as a guide, we project that a 1% decline in commercial payer mix could mean as much as a 1.5% decline in top-line revenue. To put this into perspective, for a typical employed medical group of 500 physicians with commercial rates at 130% of Medicare, a loss of three percentage points of commercial payer mix could mean as much as $10 million in revenue decline.

Digital health

While much has been written about the tectonic shift to telehealth and digital health, most have ignored the negative reimbursement impact and competitive threat that now faces many health systems as a result. Both governmental and commercial payers have suspended the historical barriers that limited telehealth and digital health (e.g., reimbursement rates, geographic restrictions, and privacy and security standards) to help consumers receive the care they need. Many medical groups pivoted overnight to virtual visits in response to state shutdown orders.

Over the long term, we believe that virtual care is here to stay, and 30% to 50% of office visits may continue in digital platforms. However, given the fact that over $1 trillion has been added to the national debt and states have become more challenged to balance budgets, we do not expect reimbursement rates for digital visits to remain at pre-COVID face-to-face levels. This likely normalization of rates to somewhere between current and historical rates will further contribute to revenue degradation for medical groups.

In addition to the decline in rates, technology tears down barriers to entry, bringing the threat of new competition to markets large and small. As large systems continue to look to grow volumes, the usual and potentially new disruptors will see this as an opportunity to enter a fragmented healthcare industry that remains ripe for disruption. Digital health adoption leads to new potential opportunities for centralization of services and market entry strategies that weren't historically possible, so consider digital relationships to expand your provider networks. Alternatively, as health systems traditionally lag in digital capabilities, strategic partnerships with progressive organizations such as Amazon, Optum, and others may become a viable alternative for independent physician practices looking to rapidly scale capabilities. They also present opportunities for employers looking for alternatives to lower healthcare spend to prevent annual double-digit premium increases, which have become the norm.

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Implications for physician enterprises

Taken as a whole, we see the quality and quantity of physician revenue at serious risk for the foreseeable future. As a result of the factors above, we are perhaps more bearish on medical group short-term recovery than industry wisdom might currently indicate.

Health systems subsidize their employed medical groups, often in excess of $200,000 per physician, and factors that drive this investment — such as productivity, throughput, and overhead — are well known. What's often forgotten is that employed group investment is only the tip of the iceberg when it comes to health system physician investment — expense of hospital-based physicians (e.g., hospitalists, anesthesiologists, Emergency Department physicians), professional service agreements (PSAs) for specialists, and other arrangements all represent physician investments beyond the employed group. The impact of revenue degradation and digital health will likely increase negative returns on employed and independent physician alignment efforts if historical approaches are not modified to adjust for current realities.

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The preponderance of evidence suggests that health system and medical group leaders shouldn't stand pat and assume that revenue, volumes, and current relationships with market physicians will be maintained without decisive moves implemented with rigor and pace. There will be winners and losers, and markets will be disrupted. The question is what side of the post-COVID-19 storyline organizations will land on. As mentioned, physician relationships — employed, contracted, and independent — will be critical for health systems to restore, redesign, and revitalize efforts to achieve budgetary target commitment.

Reinventing Ambulatory & Physician Enterprise Post-COVID-19

How to grow and optimize physician investments in a post-pandemic world

Strategic Network Planning

- Comprehensive Provider Development Planning
- CIN/ACO Development
- Ambulatory Facility Planning
- New Revenue Model Creation
- Independent Provider Development
- Primary Care Model Innovation
- Digital Platform Development

Operational Optimization

- Comprehensive Assessment of Employed Group Performance
- Balance Productivity, Compensation & Funds Flow
- Programs to Maximize Quality & Cost (TCOC, HCC, RAF)
- Ambulatory Facility Consolidation
- Referral Management to Improve Continuity of Care
- Differentiated Patient Experience

Solutions to improve access and achieve growth

Solutions to create new models of care and shift to digital

Solutions to manage risk and gain access to new revenue models

Create true system physician alignment strategy vs. one-off 'bad' deals

The next-generation ambulatory and physician network will be the chassis for health system revenue and margin growth. Traditionally, network development meant an employed physician recruiting plan, PSA development for those physicians who wanted "employment lite," and a rush to form clinically integrated networks and accountable care organizations (ACOs) to take on risk.

But too often these strategies were not deliberately matched to market need, nor integrated at the system level into a synergistic plan to achieve system growth objectives. Hospital or market leaders made their own decisions without consistency in structure or a unifying vision. With reduced access to capital, and shrinking margins, systems will need to extract maximum value from physician investments. This will require a single plan, unified key performance indicators, centralized approaches to scale investments, and truly aligned compensation models.

Invest in digital care models to expand market reach and recapture volumes while "rightsizing" footprints to coincide with this new delivery model

If COVID-19 proved one thing, it's that models of care — the notion of providing care at the "right place, right time, by the right provider at the right cost" — are subject to change. Nowhere is this more apparent than in primary care where, prior to COVID-19, less than 5% of all care was provided via digital means. While COVID-19 experiences differed widely by system and specialty, most agree movement of 30% or more of physician encounters is likely, with such specialties as endocrinology and dermatology settling at a much higher rate. Moving forward, this service will need to meet escalating consumer demands for 24/7 access, price transparency, and care navigation that seamlessly connects with the entire care delivery system — not simply a single encounter on an iPad.

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There are, however, two important addendums to the transition to digital worth noting.

First, the transition to digital will have a profound impact on real estate and facility solutions. Any decisions in this regard must account for such items as the expansion of access points, capture of consolidation opportunities, and the impact of remote work environments and social distancing requirements on facility needs.

Second, telemedicine will become a factor in Centers for Medicare & Medicaid Services (CMS) and other payers' determination of network adequacy as they recognize the potential cost savings that could result.

At the end of the day, market-leading systems will find ways to use their telemedicine platform as the way to decrease cost and drive growth.

Optimize medical group operations and compensation arrangements to increase efficiencies and enhance margin

The concept of the high-performing medical group — one that is operationally efficient and fiscally in line with established metrics, and links productivity and compensation — matters now more than ever due to the limited availability of cash and capital. The creation of management service organizations to develop best-in-class capabilities, while moving costs from fixed to variable, will support these optimization efforts while creating additional alignment opportunities with market physicians.

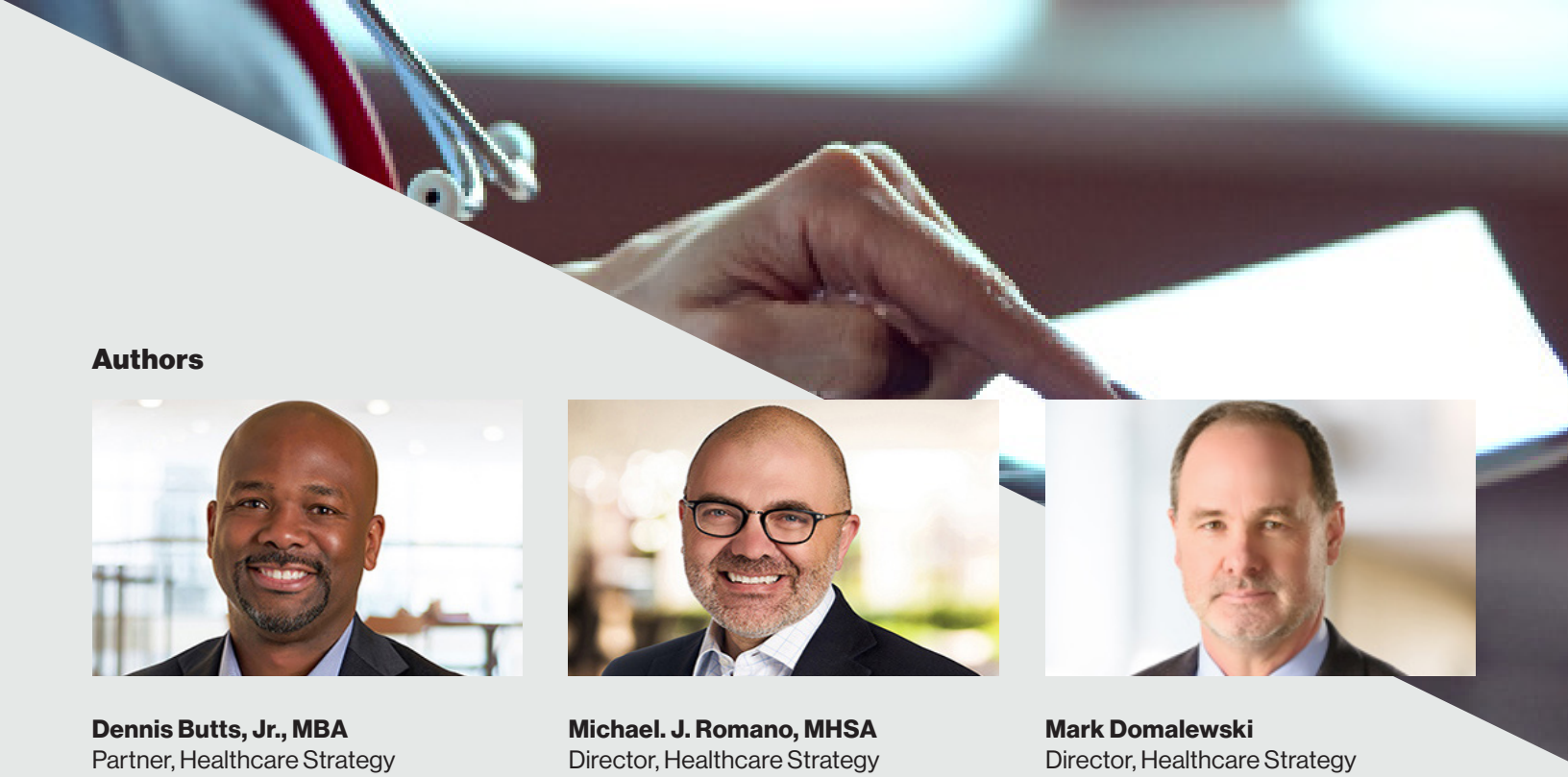
The current crisis may embolden us to make changes in our compensation plans that are necessary for future success. As we get beyond COVID-19, we will consider new compensation arrangements for these various providers. The degree to which productivity will continue to drive employed and contracted physician relationships will be a key question. Furthermore, while most PSAs turned out to be good insultation from economic downturns, we have learned that the long-term success of those partners is also important.

The right compensation approach will also ensure that patient satisfaction, quality of care, access, clinical cost management — and not just productivity — will all be encouraged and rewarded.

Develop capabilities to assume risk and create new and more resilient revenue models

As a result of COVID-19, more than $1 trillion was added to the national debt. Recent comments by CMS, the American Hospital Association, and the National Association of ACOs have validated a desire to continue to push value-based payment methodologies. Instead of backing off, now is the time for providers to develop the capabilities to assume more risk and support value-based care. Those physician groups with heavier percentages of revenue in capitated arrangements have been shielded from revenue declines though this period, and therefore, building capability will be a requirement as CMS doubles down on risk.

To successfully navigate this course, systems will need to create a runway to these arrangements through rapid capability development, resulting in care variation reduction, in-network care retention, targeted total cost of care reductions, improved outcomes, and Hierarchical Condition Category risk scores that are aligned with the managed population's true risk profile. Owning the premium dollar allowed payer profits to increase during the pandemic. Creating more resiliency for medical groups will be tied to gaining greater access to the premium dollar through enhanced payment models.



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