



# How value-based care became vital for survival



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The COVID-19 pandemic forced health care providers nationwide to adopt clinical practices that aligned with value-based care (VBC). The VBC payment philosophy, where health care providers are paid based on patient outcomes rather than volume of services performed, has been growing in popularity for more than a decade. However, because most revenue comes from fee-for-service lines of business, COVID-19 is a financial disaster for many doctors, hospitals and health systems.

But not all. Organizations that had significant stake in VBC saw financial gains that are hastening the move to value.

“The pandemic absolutely accelerated our desire to get into more types of value-based arrangements,” said Aric Coffman, CEO of the Everett (Wash.) Clinic. Their patient panel is about 10% risk-based payment models but approaching about 30% of total revenue. “That [VBC] part of the business actually performed well during the nadir of the pandemic.”

### An adjusting market

Most provider organizations have had experience with value-based contracts and managing population health. Some participate in value-based programs offered by the Centers for Medicare & Medicaid Services (CMS). Others contract with commercial payers. Some physicians simply absorb risk under the Medicare Access and CHIP Reauthorization Act (MACRA) body of regulations. But the COVID-19 pandemic forced providers to adopt certain value-oriented practices to manage through the pandemic.

As the health care market adjusts to the pandemic and prepares for a post-COVID future, health care leaders must decide whether to accelerate their embrace of value-based care.

“In the early days of the pandemic, somebody said to me that public health is just population health management in crisis mode,” said Erik Johnson, vice president of value-based care at Optum Advisory Services. “And I think that’s a very true statement. Population health management is foundational to value-based care success, and providers are getting a lot of reps in right now in the things that they would need to do in a value-based arrangement.”

COVID-19 caused providers and payers to transform their operations virtually overnight. Provider leaders encouraged their clinical teams to find less expensive and invasive ways to keep their patients healthy, with primary care being the first line of defense. Physician practices worked to stay engaged with their patient panels, particularly their at-risk and chronic patients. Combine this focus with government mandates taking



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high-margin, elective procedures off the table, providers found themselves in a de facto state of managing population health. These and other practices embraced during the pandemic lockdowns could be leveraged in pursuit of value.

## Reconfigured delivery models

One of the most stunning transformations obliged by the pandemic was the speed with which the country embraced telehealth. A study published in May 2020 indicated that one health system saw the percentage of telehealth visits increase from less than 1% pre-pandemic to 70% of their total visits.

While virtual visits subsided as lockdowns started easing, they remained higher than pre-pandemic levels.<sup>3</sup> And there was additional evidence that attitudes about telehealth were evolving. In 2018, only 30% of clinicians wanted to actively engage virtually with patients, versus 55% in 2020. And only 20% of 2020 clinicians were against virtual engagement, while 40% of clinicians in 2018 opposed virtual or digital interactions.<sup>4</sup>

Payers paved the way for telehealth acceptance. The Coronavirus Preparedness and Response Supplemental Appropriation Act and the Coronavirus Aid, Relief and Economic Security (CARES) Act both made it possible for Medicare to cover telehealth visits. The CARES Act also allowed Federally Qualified Health Centers and Rural Health Clinics to receive Medicare payments for telehealth services. The act also lifted some restrictions on home health, home dialysis and hospice.<sup>5</sup> Executive orders enabled Medicare to pay for more than 80 additional services not enumerated by the CARES Act.<sup>6</sup> And as of this writing, Congress is considering multiple bills that would make some of the above changes permanent.<sup>7</sup>

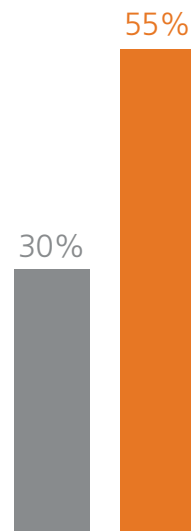
Commercial payers have followed suit. In an American Medical Association (AMA) analysis of 31 regional and national health insurers, the AMA found 24 had made telehealth parity part of their payment policy, while 28 payers had made telehealth a covered benefit for their members. Twelve of the insurers used CMS to determine which telehealth services they would cover.<sup>8</sup>

“Insurance companies knew that members would be very, very leery about getting in-person care,” said Jane Kim, director at Optum Advisory Services. “So they addressed that by really leveraging telehealth.”

Beyond the new affinity with telehealth, the pandemic is helping payers and providers align in important ways. “Payers and providers are focused on the same thing,” said Johnson. “And that is proactively engaging with the sickest people in the community to use primary care as a means to mitigate any further deterioration in their health.”

## The fee-for-service bust

Still, the pandemic’s consequences for health care providers are dire. The American Hospital Association estimates hospitals lost \$200 billion between March and June 2020.<sup>9</sup> Disrupted cash flow has led to tens of thousands of health care workers either being furloughed or laid off.<sup>10</sup> Hospitals aren’t the only providers under financial stress due to the pandemic. Specialty physicians, especially pediatricians, pulmonologists and surgical specialists, also suffered steep declines in patient visits.<sup>11</sup>



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Beyond layoffs, the pandemic forced health care organizations into a different operating model. In addition to telehealth for some primary care, telehealth tools made it possible for some health care professionals to work from home. And the work-from-home genie likely won't go back in the health care bottle.

"Without question, we'll be working much of our workforce from home going forward," Coffman said. He estimates up to one half of support staff at the Everett Clinic could be working from home, while as much as one-third of his clinical workforce could be working remotely.

Another pandemic result likely to linger is the low demand for elective procedures or non-emergent care. Nearly half of Americans said they avoided care because of the pandemic.<sup>12</sup> The number of reported heart attacks and strokes plummeted, presumably because sufferers were afraid of infection.<sup>13</sup> Some people who needed care went without out of fear. Others realized they could live with whatever malady they had.<sup>14</sup> And a percentage of those will decide they do not need them going forward. Still more will go without because they have lost their insurance.

As a result, hospitals are likely to continue to struggle. While hospitals have been working for years to decrease costs for improved margins, the pandemic blew a hole in their cash flow. At least in the short term, hospital leaders will look to negotiate rate increases, which could also cause insurance rates to rise.

### The value-based care boom

While providers that relied on fee-for-service payments struggled, the pandemic led to a financial windfall for those providers who had aggressively pursued risk-based contracts.

Organizations working under value-based contracts prior to the pandemic were already incentivized to focus more on primary care. Capitated providers fared especially well. Providers that accepted downside risk — where they would stand to lose money if their cost of care went above predefined levels — also fared well because their higher-than-average shared savings rates. Organizations working under upside risk contracts — where they would stand to gain when costs were kept low but not lose when costs were high — still had solid balance sheets. But they may not have done as well as their more at-risk counterparts.

Payers are the ultimate risk-bearing health care entity. They had great financials through the first half of 2020 if judging purely by medical loss ratios (MLR).

"Targets for medical loss ratios are above 80%, but actual MLRs came in for the first half of the year at about 70% across the industry," said Jay Hazelrigs, vice president of provider actuarial services at Optum. In many instances, payers who do not hit their MLR thresholds will need to write rebate checks to their members.

"The bigger issue they're worried about is they could have a horrible back half of the year," Hazelrigs said. "Payers are very cognizant of the possibility that people who should have been getting care all along, didn't. Now they're going to come back into the health care system a lot sicker."

Providers that have oriented themselves toward risk-based payment models are positioned for growth, either by increasing market share or by acquiring other organizations.

“Health system leaders are realizing that, had they been more involved in value-based care contracts, they would be talking less about losses and potential layoffs,” Hazelrigs said. “Their conversation would be more about how they could grow, potentially through acquisitions.”

Large physician groups are a type of provider best positioned for growth. These groups, with their sophisticated administrative regimes and their large patient panels, are likely to maintain a strong financial position. That is especially true of groups that have aggressively grown their risk-based portfolio.

Smaller health systems with a strong regional presence will also be incentivized to move more quickly down the value-based road. They typically serve large populations needed to manage clinical and financial risk. Larger multistate health systems, on the other hand, may struggle to gain a foothold under value because they may not have a strong enough population footprint within any one market.

Medicare and Medicaid will continue to increase their rolls as the population ages and as unemployment remains an issue. Medicare Advantage (MA) is also poised for growth because of lower consumer costs. But MA will have its issues.

“It’s going to be really pure luck if MA plans make money in 2021, because they’re really just guessing at what their premium rates should be,” Johnson said. “Payers will have so little data on which to base their bids because they will not have seen enough volume to get accurate HCC coding and accurate RAF scores.”

Increasing costs in the latter half of 2020 and decreasing commercial insurance pools could make 2021 a difficult year for all payers. But there are still opportunities for growth in the payer market.

“The government is drowning in debt and they’re placing a premium on insurers who manage risk well,” Kim said. “I think this is where the deployment of digitally and tech-enabled care models that manage to that total-cost-of-care pressure makes sense. And that’s where delegated risk models for Medicare and Medicaid will be attractive.”

## A risk for all: Patient engagement

Value-based care works best when patients are motivated to proactively manage their own health. But in a post-COVID-19 world, providers and payers need to do even more to engage patients. Patients who need to be seen by their physicians need to trust that seeing their doctor will not result in a COVID-19 infection.

“Consumers have to be taught what is safe, and the burden is on health systems and physicians to reach out to them,” Johnson said. “They need to communicate they’re open for business and why they decided it was safe to open.”

Convenience can also enhance patient engagement. Telehealth will continue to play a critical role in making it simpler and easier for patients to see their doctors. Physician groups found that video visits were not only a low-cost way to connect with patients, they could see more patients on a given day.

But beyond video visits, telehealth can facilitate faster, more secure communication between patient and provider. And providers can incorporate some of the same

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protocols and smart-device tools for other functions; for instance, to schedule appointments or to offer online check-in. Payers and risk-bearing providers have also been sending remote monitoring kits and home test kits (diabetes tests, for instance) to high-risk patients to help them do disease management remotely.

“Right now, patients encounter a lot of friction,” Johnson said. “In most cases, patients need to call to make an appointment and check calendars and fill out paperwork. All that stuff needs to get stripped out.”

Providers and payers could further reduce friction by sharing data so they can better identify and stratify those high-risk patients. “I think that’s an opportunity for payers to subsidize value-based behavior among patients through that type of engagement,” Johnson said.

As for the medium- to low-risk populations, the most effective organization to engage these types of consumers may be the employer. Employers’ interests are aligned with value-based systems; employers want to help their employees stay healthy and avoid absenteeism and undue health care costs.

## Vital for survival

Payer and provider organizations will likely be challenged by the clinical and financial impacts of the COVID-19 pandemic for years to come. How should payers and providers proceed as they navigate these new waters?



### Invest in value

As procedures continue to be moved out of acute care environments and into outpatient surgical centers and clinics, health care organizations need to increase their ambulatory footprint. Expect significant activity in mergers and acquisitions within the next 18 months.

As for acute care, Johnson said, “Hospitals have got to stop building new capacity. They won’t be able to use it. There’s no demand for it. We’re woefully inadequate in rural markets, but in general, we don’t need more hospital beds.”



### Engage patients better

Any health care organization, regardless of type, will benefit from better engaging with patients. The trend of consumerism in health care — favoring consumer convenience and giving patients and their families tools to help them make better decisions — is a concept whose time has come.<sup>15</sup>

“There needs to be some investment made in understanding what works with high-risk and the polychronic patients,” Johnson said. “There’s an answer and I would be spending some time on finding it. Because if I can do that successfully, not only have I enhanced my ability to manage risk with the riskiest people, but I’m going to generate loyalty and keep that life in my ecosystem for a long time.”

## Four critical lessons from COVID-19

- Invest in value
- Engage patients better
- Advocate for regulatory change
- Create provider and payer partnerships



### Advocate for changing regulations

COVID-19 will be part of our present for the near future. It will bring with it some unintended consequences, but many of its effects can be predicted. The more our regulatory regime can be adjusted for it, the better we can operate. Some such changes in regulation include:

- **Mandating site-neutral payments from CMS:** Value-based care relies on incentives that lower cost while improving quality. Since site-neutral payments would encourage one payment rate no matter the facility, doctors would schedule procedures where costs are kept low and quality high. Site-neutral payments are already standard for things like physical therapy within skilled nursing facilities and home health. It's time to start advocating for similar policies for outpatient procedures.
- **Easing licensure restrictions:** Value-based care becomes more productive when everyone operates at the top of their license. That will be even more important as the stresses of the pandemic push more clinicians toward retirement. Allowing advanced nurse practitioners and physician assistants to do what physicians are often required to do can help physicians focus their efforts where they are needed most.
- **Open the way for telehealth:** As smartphones and broadband have become ubiquitous and as secure online communication has become more affordable, telehealth has grown in popularity. Regulations have lagged, and it took a pandemic to open the regulatory doors. It is important that those doors stay open post-pandemic.

"Telehealth helps providers manage their patients at home in a way they didn't see before. The benefits are much more obvious to them now," Johnson said.

While payment parity is a function of the pandemic, its permanence is up for debate. "Patients love it, and providers love it. But payers are concerned that telehealth may be used more as an add-on rather than a substitution," Hazelrigs said. "If we can just get the funding right, telehealth is a pretty big win."



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### Create opportunities for provider and payer partnerships

Value-based care success is more likely when payers and providers partner to share data, expand their capacity, or both. Johnson points to Canopy Health, an organization that created an independent physician association (IPA) in northern California using the physician networks of three health insurers.

"Their goal is to own covered lives by reducing friction and making it convenient for their members to access care. But they didn't have the bandwidth to go out and build a network," Johnson said.

## Navigating forward

Payer and provider organizations will likely be challenged by the clinical and financial impacts of the COVID-19 pandemic for years to come. How should payers and providers proceed as they navigate these new waters?

If the demand for care will not get back to where it was before the pandemic, then the fee-for-service payment model will be one of COVID-19's casualties. Telehealth, remote monitoring and less expensive sites of care likely are a permanent fixture in health care. It is an environment where risk-based payment models will thrive. And it is a model that is getting a dry run during the pandemic.

While working in some type of risk-based contract is the norm for many providers, Johnson said, "at some point, it will occur to them that they can't get through these oscillating waves of boom and bust with a fee-for-service model. They'll see that shared risk is a way to smooth out their cash flows.

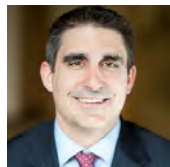
"The work they're doing is good and proactive. And the only way they get paid for it is if they take on risk."

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