

# Keeping up with COVID-19

## Webinar Series

### Q&A

May 7, 2020

## COVID-19 Pandemic Accelerates the U.S. Transition to Value-Based Care

### Q. How does COVID-19 change the outlook for risk-based arrangements?

**A.** At face value, the outlook is pretty bad for 2020 as COVID-19 expenses are going to exceed allowances. On the other hand, CMS is making substantial accommodations and commercial payors are following regulatory and social pressure to do likewise. For example, many payors offer full coverage, without a copay, for COVID-19 testing.

My position is that these actions demonstrate that we have the capability to bend the cost-curve if sufficient motivation moves the market, in this case health care providers and pharma. Simply stated, health care in the United States does not have to be as expensive as it currently is. Having said that, I recognize that this challenge has been considered as far back as the Social Security Act of 1935 but we, the American people, have not developed an appetite to adequately solve it... yet.

### Q. What strategies should providers pursue to respond to payors who are using reduced copays as incentives to encourage beneficiaries to use national telehealth providers rather than their local providers?

**A.** One strategy, which I would consider gut instinct, would be to highlight telemedicine's downsides, including the inability to conduct physical examinations, which can affect patient care; the inability to obtain essential blood work; the inability to console patients when giving bad news; etc. But after further consideration, this was the strategy employed by retailers against Amazon and streaming services.

Rather than focus on how bad the alternative is, reflect on what you could do better. Identify your unique strengths and advantages and lead with those. I believe I gave an example, contrasting a 5-star restaurant versus fast food; contrasting said restaurant against door dash would be instructive.

### Q. What specific trends do you predict with provider-based full-risk population solutions?

**A.** Greater shared responsibility between providers, patients and payors. Providers will be more cognizant of the value of a considered service, payors will pay for valuable care with fewer "denial games" and patients will become partners in shared risk.

For example, if a patient is non-compliant, their primary care provider will be empowered to do more than get frustrated. Said provider could schedule a meeting between all three parties – patient, provider and payor – in which they discuss the need for compliance, the potential health risks and increased costs of continued irresponsibility and the very real threat that a future meeting may result in a non-compliant penalty where said patient (including employees!) are required to pay a "care crisis" fee atop of the standard premium.

Health care is going to become more sensitive to an individual's personal efforts to maintain homeostasis and general wellness. This is not about comorbidities; this is about compliance.

### Q. What specifically do you predict will occur with full parity between virtual and in-person care?

**A.** In my opinion, there will never be parity between virtual and in-person care, at least not with current technologies. Just as there is not full parity between an in-person meeting and Zoom. Teleconferencing, email and phone calls go a long way for business operations and communication expediency. But as the idiom goes, "more deals are closed on the golf course than in the boardroom."

If a personal touch is valuable for business, it is certainly valuable for excellent health care. Nevertheless, after the final analysis, many aspects of care will change soon, for example, registration, preventative care checkups, mental health services, speech and audio therapies.

**Q. Should hospitals rebill claims with the new DRG weights to receive additional reimbursement?**

**A.** CMS recently repurposed the cost-saving modifier for COVID-19 as it pertains to testing-related services performed between March 18, 2020 until the TBD end of this Public Health Emergency. More specifically, if you bill Medicare for these Part B services you should use the CS modifier and I would suggest rebilling those claims where applicable.

**Q. How long will insurance payors pay full reimbursement for telehealth visits?**

**A.** For as long as they must. Meaning for as long as there is social and regulatory pressure to do it, they will. But, needless to say, it cannot remain free forever. Prudent organizations will incorporate telehealth as part of their care options and define a defensible cost model.

**With providers going out of business, further reducing access to care, what will be the VBC trends?**

**A.** There will be greater reliance on Nurse Practitioners and Physician Assistants. We're already doing this in rural and other critical access areas where NPs and PAs have been authorized to perform services traditionally reserved for Medical Doctors. The net result of this will be a realization that you don't need to be a doctor to perform a strep test.

More specifically, 28 states allow nurse practitioners to practice independently<sup>1</sup>, without physician oversight where they can open their own practices, prescribe controlled substances, and practice to the extent of their training. Physician assistants, on the other hand, require physician supervision but the level of necessary supervision varies by state; some even by telephone accessibility.

**Q. In many areas, there are more specialists than primary doctors, so it can be difficult to locate a primary doctor. What do you foresee the future to look like?**

**A.** My prediction is that within the next 20 years one won't have to be a doctor to practice medicine. Primary care will become a shared responsibility between patients and their respective health community. There will be doctors, do not doubt that, but they will primarily be an escalation point for when preventative care is not succeeding or for those with greater care needs.

Between now and then, as stated earlier, NPs and PAs will take on more of the primary care burden.



**Sources**

1 <https://www.beckershospitalreview.com/hospital-physician-relationships/28-states-with-full-practice-authority-for-nps.html>

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**Q. What are your thoughts regarding the CMS mandate to publish costs of specified services for the public; do patient consumers understand the value of the information and its value when they're using their deductible dollars?**

**A.** A significant component to our price and cost issues are that we, consumers, often don't know what we're getting into when it comes to health care. In a way, this is akin to the "if you have to ask, you can't afford it" model. While this may be palatable for a luxury experience, health care can no longer be considered a civil luxury.

If we're going to empower consumers to take greater ownership of their health and wellness, we need to make the services easier to consume. Price transparency, in my opinion, is a great step forward.

**Q. Do you think that the pandemic will change those with conditions that put them at greater risk to catch the virus [and] will change their attitude towards preventative care?**

**A.** My current understanding is that reactions have been mixed. People with compromised immune systems are taking this "more seriously" whereas the elderly, though also recognizing the need for caution, are not as zealously cautious to wear masks and confine themselves. I do not have significant data on this, I am speaking from anecdotal experiences and a few news stories; take it with a healthy grain of salt.

Regardless of nuance for a moment, yes, I do think that things will change somewhat and that we will all expand our normal standard of safety to one degree or another.

**Q. How will value-based care work when the local hospital bought up all of the physician practices within the local region? How will we be able to "shop" for the best price?**

**A.** My answer of "drive to where they have competition" was a poor response that didn't convey my true sentiment... "Find a way to make them compete" is what I was aiming for.

Health care is highly regulated and there is a limit to how expensive a monopoly health network can become. But even still, I am bothered by the prospects of health care being even moderately more expensive than necessary. Having said that, I am encouraged by the recent advances in price transparency and the greater recognition that consumers have choices.

Alternative payment models and value-based care practices can – and will! – be stood up in any market that has a substantial population density. Enterprising physicians (and/or NPs!) will bring costs down.