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It took a pandemic: the implications of COVID-19 experiences for value-based care

October 2020

Introduction

As COVID-19 unfolded and health systems' patient volumes plummeted, we were often asked, "What will value-based care look like when we come out of this? How will our experience with COVID-19 reshape future value-based care models?" Those are great questions, and we worked with many organizations—Sg2® clients, Vizient® members and others—to help answer them.

Providers participating in this research varied widely with regard to size—ranging from a community hospital with just over 100 beds to a health system with over 20,000—location, experience levels and other characteristics (Figure 1). This variation gave us a diverse cross-section of viewpoints.

This report summarizes what we learned and adds our perspective on value-based care and the implications of COVID-19. While none of us can predict the future (especially during an election year), the pandemic has definitely fanned the flames of value-based care. Where do we go from here?

83%

of health systems interviewed believe the shift to value-based care will accelerate as a result of the pandemic.

At the height of the pandemic, value-based care wasn't a priority. Health systems made difficult decisions to furlough or repurpose population health and value-based care staff members as priorities shifted. The federal government was unusually silent about how it would handle its alternative payment model (APM) programs such as the Medicare Shared Savings Program or Bundled Payments for Care Improvement Advanced. Health systems dug in and reverted to what comforts them during chaos, the one thing they know well—fee-for-service (FFS) reimbursement and bringing volumes back to "normal."

Yet as the presumably safer FFS structure started to be rebuilt, many health system leaders realized the inherent risk in a reimbursement system dependent on patient volumes that may not always be there. As COVID-19 shifted the balance of power to those holding the medical risk, it became clear that the future of value-based care will be tied to the willingness of payers to propel us further and the boldness of providers who will accept and manage risk in new ways. Either way, FFS will likely remain with us as our system evolves, but it may start to go the way of the typewriter as new methodologies and shifting accountability bring much-needed creative destruction to our path to value in health care delivery.

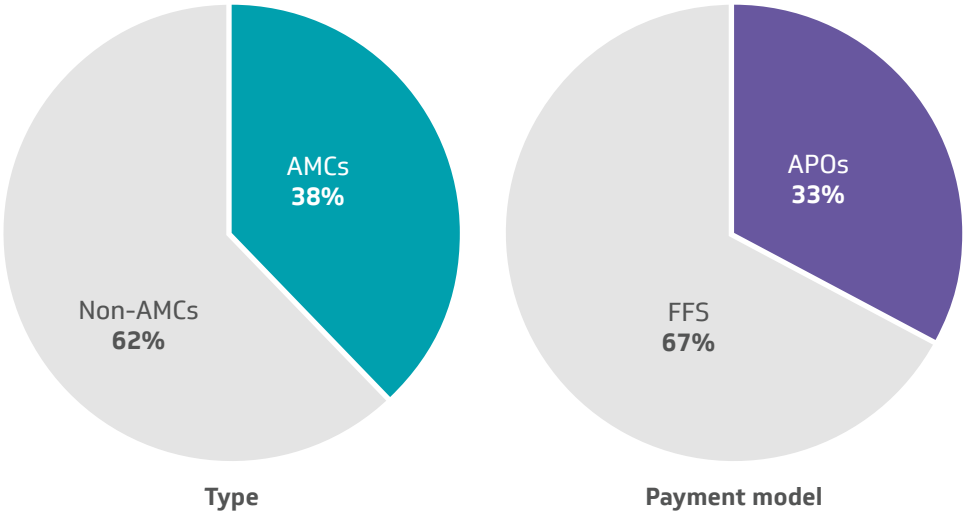
Pre-pandemic

Before the pandemic, the road to value was long and often divided. Critics pointed to decades-old challenges (such as perceived incentives to limit care or lack of data) as proof of its imminent failure, while proponents claimed that it was the single most effective solution to the ever-rising health care costs facing our nation.

There is no doubt that movement toward value has taken hold across the country for the past decade. But despite a flurry of activity and significant progress, the reality is that most health systems and providers have entered APMs without taking on any meaningful downside risk. Acceleration of value-based care models without accountability is more akin to a simulation exercise than to an intentional and transformational shift. Unfortunately, in addition to carrying little provider risk, the vast majority of APMs are still tied to an underlying FFS architecture (Figure 2). How can we fix the system if our solutions are built on the same broken chassis?

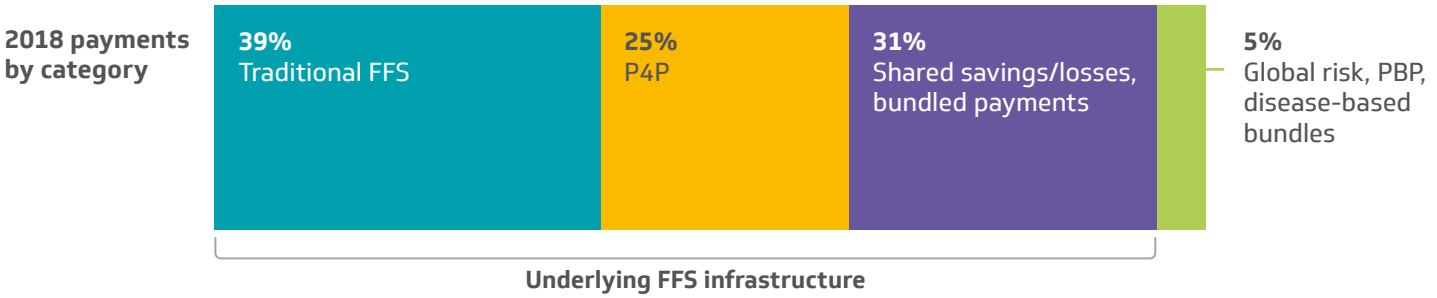
How can we fix the system if our solutions are built on the broken chassis of fee-for-service?

Figure 1. Selected characteristics[a] of project participants



[a] APOs include those using advanced risk-bearing payment models, such as provider sponsored health plans or global budget models. FFS organizations were mostly in the early stages of advanced payment models, with few or no capitation or population-based payments.
Abbreviations: AMC = academic medical center; APO = alternative payment organization; FFS = fee for service.

Figure 2. Pre-pandemic state of value-based care



Source: Sg2.
Abbreviations: FFS = fee for service; P4P = pay for performance; PBP = population-based payment.

Implications of the pandemic

Table 1 summarizes several themes that arose in our talks with organizations around the country about the implications of COVID-19 for value-based care. The text that follows discusses our perspectives on these trends.

Table 1. Implications of COVID-19 for value-based care

Category	Themes
System of care	• System of care innovations happened at a rapid pace. From virtual health to skilled nursing at home, health delivery systems advanced years in a matter of months. • Existing population health infrastructure and expertise provided valuable tools that enabled providers to more effectively manage during the pandemic.
Finance, payer strategy and coverage churn	• Organizations primarily reimbursed via FFS faced greater financial challenges than their more diversified value-based reimbursement peers; those under FFS were also more reliant on government subsidies. • Doubling down on cost optimization was a primary strategy to sustain operations as FFS revenues dried up. • Payers, whether large national carriers or PSHPs, were the beneficiaries of the significant utilization downturn. • While most health systems expect a material change in insurance coverage enrollment and therefore payer mix, very few have been affected at this time because of factors such as employers imposing furloughs rather than layoffs.
Physician alignment	• There was significant variation in perspectives on the impact on physician alignment; responses ranged from "our market has very few independents" to "this may be the factor to force independents to rethink their independence." • Most organizations kept employed physicians' and providers' salaries whole, even though most receive wRVU-based compensation; they recognize the need for compensation to evolve along with value-based models. • "Heightened concern" is the best way to describe health systems' view on physician enablement companies and payers acquiring physician groups.
Future innovation, interest and investment	• Perspectives on capitation and other prospective revenue models have quickly become much more positive, and not just primary care or professional capitation. • Direct-to-employer arrangements are on most organizations' radar as they prepare for coverage churn and increasing competition for commercially insured patients. • Investment strategies for system of care assets, while mostly intact, are being reenvisioned in light of the push toward providing care virtually or at homes and other less-acute sites that has been prompted by the pandemic.

Abbreviations: FFS = fee for service; PSHP = provider-sponsored health plan; wRVU = work relative value unit.

System of care

Many health systems faced staggering financial losses as often-more-profitable elective cases were stopped and demand for certain health care services remained tepid even after reopening. At Vizient and Sg2, we project a 19% reduction in inpatient volume nationally in 2020. We also expect that volume will never fully recover, remaining 1% below current levels in 2024 and 2029 (Table 2).

We have covered the effects of inpatient shifts for years; this is a primary way that health systems achieve savings in APMs. However, what is new in the post-pandemic world is that the same (or even more draconian) changes are seen at other sites of care; virtual and home care are the only two models that show volume growth at five years. These changes are likely to happen with or without payment model changes, and vary by market.

The changes driven by COVID-19 are well aligned with tactics for successful value-based care operations and have the potential to reduce the total cost of care.

Many of these care delivery changes will shift the national direction of the health care industry, although some may be stifled by organizational desire to go back to what is familiar. Mayo Clinic CEO Gianrico Farrugia, MD, has been a vocal supporter of actively maintaining virtual health services by "deliberately countering backsliding into a mostly in-person care model"[1]; managing in a value-based environment will require this type of innovative persistence.

The pandemic has dictated numerous additional changes to the existing care delivery system, including increasing delivery of services at home and other ambulatory opportunities, decreasing unnecessary emergency department utilization, and providing coordinated, team-based care. These shifts parallel ongoing efforts by the Centers for Medicare & Medicaid Services such as eliminating the inpatient-only list and implementing site-neutral payments, changes that are inspiring further discussions about service distribution and appropriate site of care. Although the future for the revenue side of value-based care remains to be seen, the changes driven by COVID-19 are well aligned with tactics for successful value-based care operations and have the potential to reduce the total cost of care over the long term. Capturing the financial upside in a system of care that has been pushed to innovate faster than expected requires bold new thinking.

Table 2. Volume for 2019 and forecasts through 2029, by site of care

Site of care	2019 volume (millions)	Forecast increase/decrease (%)		
		1-year	5-year	10-year
Emergency department	106	−25	−9	−8
Inpatient	30	−19	−1	−1
Hospital outpatient/ambulatory surgery center	553	−25	−3	6
Skilled nursing facility	3.2	−27	−12	−3
Urgent/retail care	9.3	−52	−29	−26
Office/clinic	2,700	−41	−16	−12
Virtual evaluation and management visit	342	36	37	43
Home	413	−8	6	15

Source: Sg2.

Finance, payer strategy and coverage churn

The pandemic showed us clearly that FFS-based providers simply cannot survive significant deterioration in health care utilization. As elective procedures were stopped, FFS-based health systems resorted to internal cost management and government subsidies as their primary source of stability. At the same time, delivery system changes that would normally have taken years occurred in weeks or months, to the detriment of many health systems' bottom lines. And the balance of power between payer and provider shifted dramatically, with major payers showing escalating profits throughout the height of the pandemic (Table 3). Likewise, health systems with provider-sponsored health plans (PSHPs) or advanced risk-bearing performed significantly better than their FFS organization peers.

These shifts, coupled with ongoing financial pressures, will continue to push organizations to find ways to control costs and assess how they define risk.

Pursuing a diversified portfolio of risk-based products encourages value-based behavior and protects providers from volatile swings in volume.

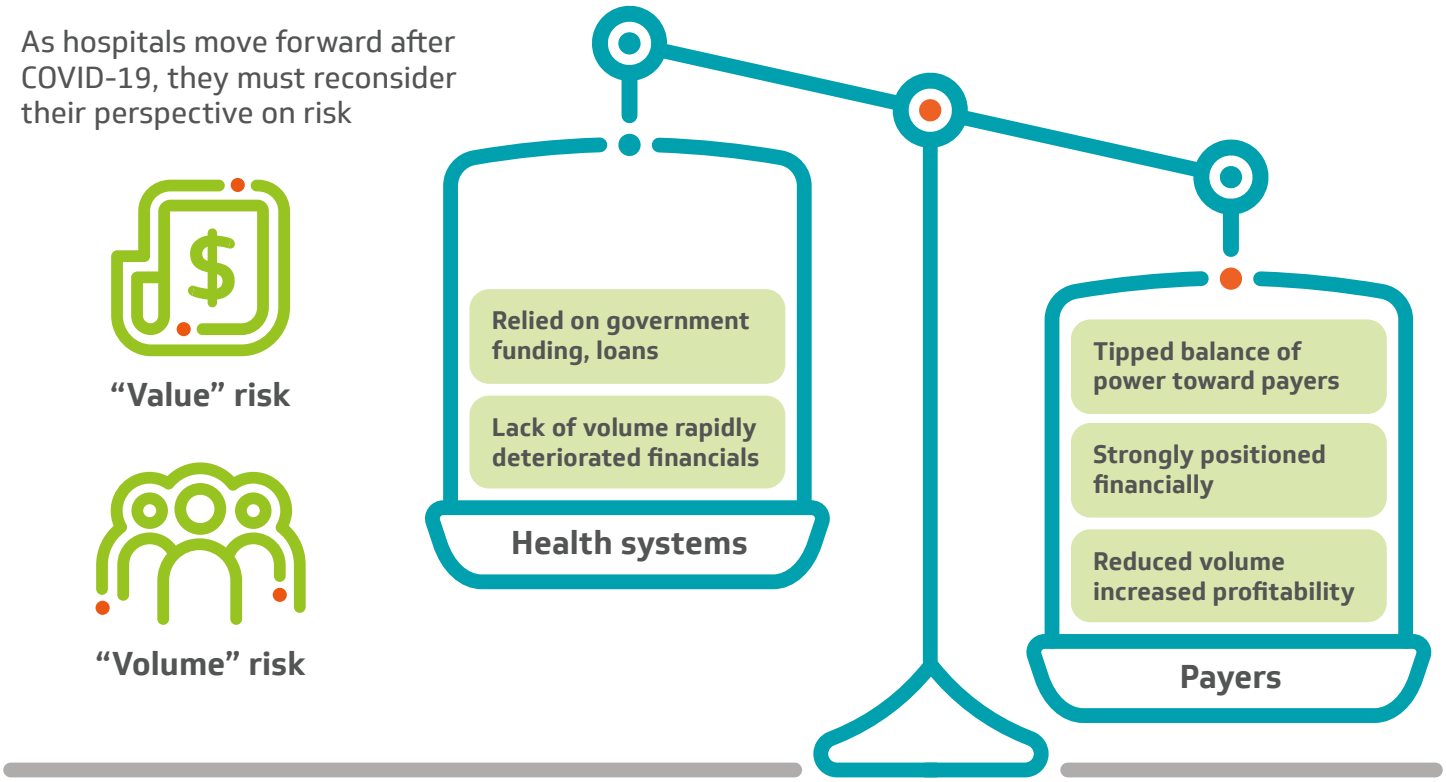
All of this is not to say that every health system should jump fully into risk tomorrow. Actuarially, many believe that the pendulum will swing the other way, as patients who have put off health care services return, potentially with more advanced and complicated conditions. However, the pandemic cast light on the riskiness of having all of your eggs in an FFS basket (Figure 3). Pursuing a diversified portfolio of risk-based products, preferably some that include capitation, population-based payments, full or partial premium or other prospective revenue, encourages value-based behavior and protects providers from volatile swings in volume.

Table 3. Financial performance of major national insurers

Insurer	Net income, Q2 2020 ($ billions)	Change from Q2 2019 (%)	Percentage point change in medical loss ratio
Anthem	2.3	99.8	−8.8
Centene	1.2	144.3	−4.6
CIGNA	1.8	24.8	−11.1
CVS Health	3.0	54.6	−13.7
Humana	1.8	94.5	−8.0
UnitedHealth	6.7	97.8	−12.9

Source: *Modern Healthcare*.[2]

Figure 3. Redefining risk



Source: Sg2.

Now is the time for payers and providers to partner and innovate. Look beyond traditional Medicare FFS opportunities; commercial, direct-to-employer, Medicare Advantage and Medicaid must all be considered and carefully balanced, particularly given expected coverage churn and exposure of health equity challenges. We've seen promising news recently of major systems succeeding in payer partnerships, such as UNC Health Alliance's success with Blue Cross and Blue Shield of North Carolina, which netted $17.5 million in revenue for UNC for 2019,[3] or new value-based arrangements coming on the heels of the pandemic such as the arrangement between Allina Health and Blue Cross and Blue Shield of Minnesota,[4] or the cobranding agreement between Cleveland Clinic and Aetna.[5] Medicare has also been extremely active since the beginning of the pandemic, pushing forward with direct contracting (which includes prospective revenue in the form of capitation), announcing future mandatory bundled payments, and releasing new mandatory models for end-stage renal disease and radiation oncology to begin January 2021, with other models expected to be released later. The momentum must continue, and it must include models that are not entirely reliant on FFS.

Physician alignment

Private equity firms, payers and provider enablers (such as Agilon and Privia) are all interested in changing the model, delivering on the value equation and benefiting from the inefficiencies they can drive out of the system in their risk-based models. Health systems must be nimbler with their employed physician enterprises, clinically integrated networks (CINs) and other alignment structures in order to compete. Primary care redesign that is thoughtful and creative can be a game-changer. The lack of true integration either through employment or through CINs and other vehicles must be resolved to support advances in payment models, acceptance of risk and associated site-of-care shifts.

Competitors for physicians are changing quickly and sometimes under health systems' radar. For example, OptumCare's acquisition of physician practices is occurring quietly as its financial status is strengthened by the pandemic: "Over the course of the quarter, the Company accelerated the growth of its employed and affiliated physicians at OptumCare."[6] And novel health insurer Oscar introduced its virtual primary care model, including no-cost labs conducted in the patient's home in connection with virtual care.[7]

Health systems must use the available physician alignment tools and models to establish more enduring partnerships with physicians and help drive innovation to allow providers to compete, capture share and manage in a value-based environment. While CINs and accountable care organizations (ACOs) were a useful tool during the pandemic, in order to remain useful physician alignment tools in the future they must enable health systems to manage the total cost of care.

Future innovation, interest and investment

The ubiquitous failure of FFS will, and should, encourage organizations to explore value-based care that moves away from that infrastructure. As many providers pointed out, capitation is a critical place to start and we can expect to see something of a resurgence. UnitedHealth Group recently released results of a study that assessed the quality performance of primary care practices across the country, concluding that primary care providers with capitated arrangements performed better than those without.[8] This makes today's capitation different from the older version that was not tied to quality. Payers are clearly seeing the value in capitation—as an example, Blue Cross and Blue Shield of North Carolina has already implemented a new program, targeted at primary care physicians, that is designed around a capitated model with obligation to value.[9]

The failure of fee-for-service should encourage organizations to explore value-based care that moves away from that infrastructure.

Our FFS system also distracts us from focusing on public health, health equity and community resource partnerships in support of improving social determinants of health. These issues were bubbling to the surface before the pandemic and now, more than ever, will require a deliberate approach as part of the long-term vision for value.

As with the opportunity to transform payer arrangements, the pandemic may force often-discussed direct-to-employer arrangements back into the limelight. At a time when there are expected to be fewer commercially insured patients, employers are looking for differentiators and ways to reduce costs. All signals point to a renewed focus on health systems working with employers in novel ways.

Summary and takeaways

The pandemic exposed the riskiness of FFS: redefine organizational perspective on risk and diversify payer portfolios

We know that only part of the U.S. health care cost problem is related to utilization and intensity of services. However, we also know that FFS incentivizes the wrong behavior. The pandemic allowed us to see just how risky an entirely FFS system can be. Not every organization needs to take on full risk, as in a Kaiser-type integrated care and coverage model, but the evolution of the overall payment structure is a necessity.

It is an election year, so we could see policy changes that affect health care reimbursement and APMs, but significant deviations from value-based care models are not expected from either candidate. Expect more population-based payments and/or capitation; the Centers for Medicare & Medicaid Services is exploring these options in several of its new models (Direct Contracting and Primary Care First). Prospective revenue-based APMs beyond those in traditional Medicare (commercial, Medicare Advantage, Medicaid managed care organizations) pursued through other payer-provider partnerships will be important, as will direct-to-employer arrangements. And keep an eye on disease-based care bundles, which will likely be part of our future. Health systems should renew their value-based care planning to incorporate diversification of payment models and further refine their payer strategies at a time when payers are better positioned and in many cases, more open to these conversations.

The future of value-based care will be tied to the willingness of payers to propel us further and the boldness of providers who will accept and manage risk in new ways.

Internal cost optimization is a no-regrets move to consider now, regardless of payment model

Internal costs—is there a perfect answer? Probably not, but there are better performers and for organizations that are not among them, now is the time to make changes. Regardless of whether reimbursement is FFS, capitation or global budget, the most important no-regrets move is to get costs in order. That starts with fully understanding those costs, knowing where there is margin and what is subsidized (or cross-subsidized), and sometimes making tough decisions. It isn't flashy or fancy, but it is practical and responsible—make it a priority, since there's no knowing what type of disruption will be next.

Don't regress in system of care evolution: site-of-care dispersion is going to happen, so plan accordingly

The pandemic has created an environment in which innovation and acceleration of care delivery redesign is not only supported, but essential. The successful implementation of historically underutilized tools such as virtual health care has shifted organizational mindset from "can it actually work?" to "this is a feasible tool." In many ways, COVID-19 has uncovered both the benefits of these progressive solutions and the barriers to their use. Determine where these innovations can be most effectively deployed to provide the best outcomes for patients and providers alike. Ultimately, these care delivery changes are aligned with value-based efforts to reduce the total cost of care and improve outcomes. As reimbursements shift away from volume and toward value, these efforts will be integral to financial success.

Reframing strategic issues to include questions such as "how many patient lives do we need to manage given current assets?" is an important step and makes the patient population the focus of the strategy. Carefully modeling the financial impact of site-of-care shifts against projected APM performance and methodologies allows health systems to clearly understand financial implications and provides opportunities to prioritize value-based care, rather than stifling innovation.

Community partnerships, health equity and public health must be at the forefront of value-based care strategy

COVID-19 put extreme stresses on the health care system from both a financial and resource perspective. Health care disparities across different geographic regions and demographics have been exposed and are demanding to be addressed. Although the pandemic experience was universal for providers in many ways, the recovery and response are leading to more divergence than ever before between those who are prepared for the next evolutionary step of health care and those who are struggling to survive.

In order to succeed in value-based care, health systems of the future will need to view their public health role in a different light; community resources will become a large part of the system of care; and health equity will not be ignored. Stable, prospective revenue streams such as those available via certain value-based arrangements can help systems obtain a return on their investments in social programs and partnerships.

Physician alignment or physician employment? Both and more

The physician landscape is as complicated and competitive as ever. As the pandemic pushes the system toward value, success will require engaged, aligned and properly incentivized physicians. For some, that will mean optimizing the employed physician enterprise. For others, it will mean expanding use of physician alignment tools to partner with independent physicians. Consolidation and provider hesitation have allowed for new competitors in the form of private equity firms, physician enablers and even payers, which now have greater financial means than ever before. The time is now for health systems that are leading CINs, ACOs, bundled payment models and similar efforts to find a formula for success that will improve the stickiness of these models with physicians and other providers.

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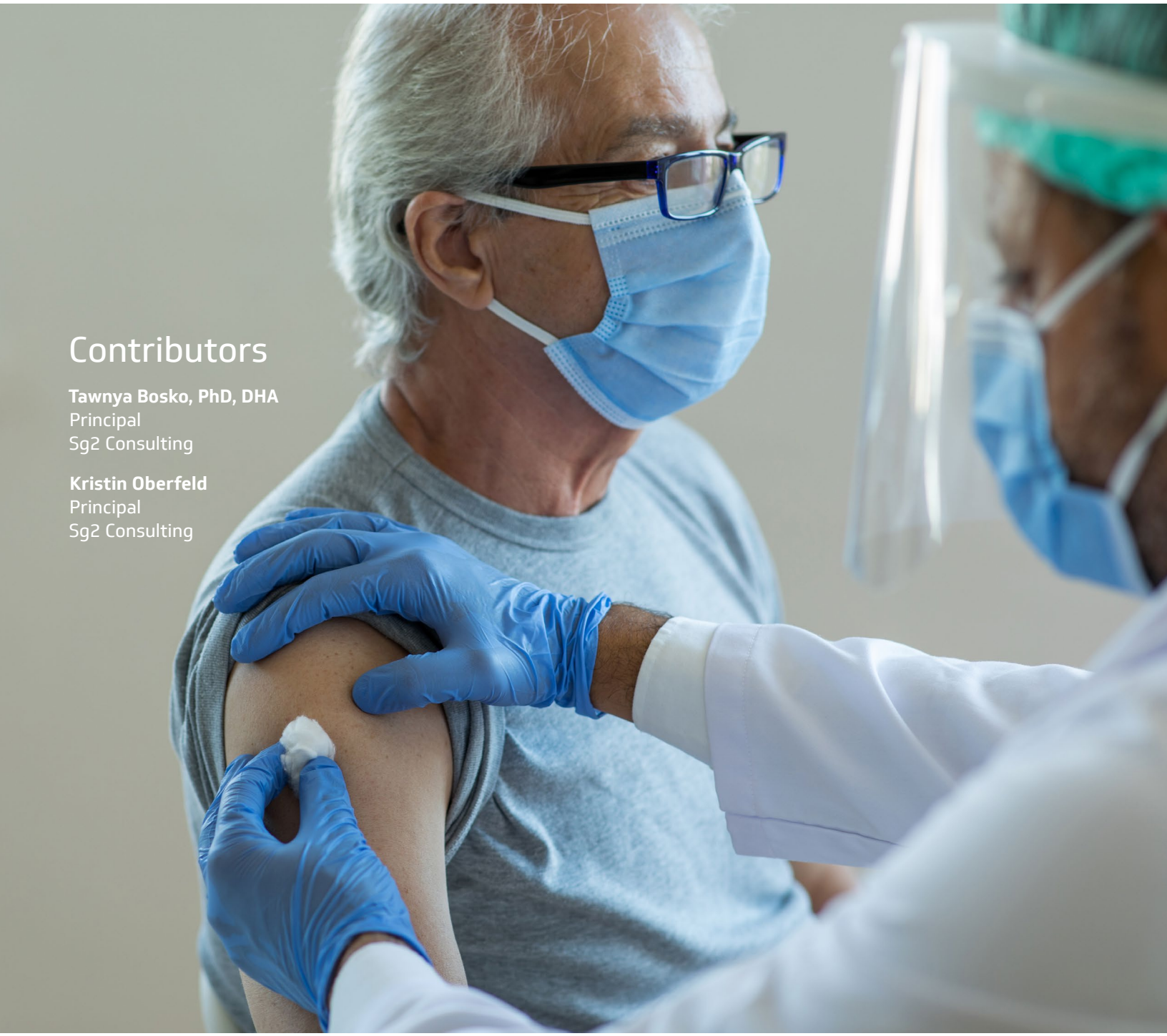

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