Guidehouse

Healthcare

Strategic Payer and Provider Partnerships Post-COVID-19

Achieving Financial Alignment With Fee-for-Value Models

Executive Summary

While the first wave of COVID-19 had an immediate economic impact on hospitals and health systems (and waves two and three are poised to increase those financial pressures), payers will face a further delayed, but also unavoidable financial effect. As the underlying cause for this financial instability is exposed, moving forward, both entities will need to consider partnership models to financially align on sophisticated strategies to achieve success in a new post-COVID-19 reality.

For providers, the pandemic's impact on canceled or postponed elective procedures resulted in a 40%-70% reduction in inpatient visits compared to the previous year. By the end of 2020, the American Hospital Association projects the financial toll of COVID-19 on health systems will reach $323 billion. The reduction in services rendered, billed using the traditional fee-for-service (FFS) model, represents 80% of the financial loss incurred.[1]

On the other hand, payers have been able to defer the pandemic's immediate financial impact as they continue collecting premium dollars based on pre-pandemic utilization levels from members and government programs (Medicare Advantage and managed Medicaid). Reduced claims payments for the same cancelled and now further postponed services also provided a temporary shield.[2] The second and third wave of the pandemic might only prolong that effect as patients could continue to delay seeking preventative and chronic condition care. However, as patients do return for care, payers will begin to face two challenges in the coming months and years:

1. Delayed procedures for chronic patients requiring treatment, resulting in worsening of conditions and further complications; thereby increasing patient costs and payers' share in their cost of care.
2. The imbalance of premiums collected to medical expenses paid, requiring payers to either issue rebates to members per Affordable Care Act regulations or reinvest in the provider community that has been impacted most by the pandemic.

Premera Blue Cross, for instance, has already set aside premium paybacks by allocating $25 million in discounts to members in the coming months. Similar relief planning is being seen by the other carriers. The Kaiser Family Foundation estimated that payers could face rebates amounting to $2.7 billion, and although there is still uncertainty, health plans should be profitable this year.[3]

1. "New AHA Report Finds Losses Deepen for Hospitals and Health Systems Due to COVID-19," American Hospital Association, June 24, 2020, https://www.aha.org/issue-brief/2020-06-30-new-aha-report-finds-losses-deepen-hospitals-and-health-systems-due-covid-19.
2. "Health insurers speed MLR rebates through premium discounts," Modern Healthcare, May 20, 2020, https://www.modernhealthcare.com/insurance/health-insurers-speed-mlr-rebates-through-premium-discounts.
3. "Mich. health plan profits dropped in Q1; experts project rosy year ahead with more rebates," Modern Healthcare, July 04, 2020, https://www.modernhealthcare.com/insurance/mich-health-plan-profits-dropped-q1-experts-project-rosy-year-ahead-more-rebates.

The sharp decrease in the utilization of services and resulting financial disruption reveals the risk of relying on FFS as an organization's primary book of business. Although the recent news of efficacious vaccine trials seems optimistic for patient outcomes, a vaccine would not resolve the reliance on FFS and economic problems it created. With both sides needing to find stability, especially as winter poses further pandemic and therefore economic challenges, the opportunity for risk-based payer-provider partnerships is ripe.

The Fee-for-Value Solution — Shared Savings, Capitation, and Joint Ventures

Capitalizing on the trends that have been catalyzed by the pandemic and forming partnerships that are based on a fee-for-value (FFV), rather than a FFS model, can lead to financial integration, stability, and success.[4] While there are providers currently in FFV arrangements and assuming some financial risk, the majority of those existing FFV contracts are based on pay-for-performance (P4P) models, where payment is triggered when providers meet certain targets. P4P distributes some funds from a payer to a provider; however, it essentially has done very little to protect against the significant losses providers have incurred in 2020.

Moving to more progressive FFV arrangements — or value-based partnership models — could allow both players to maintain stronger financial positions despite the pandemic and evolve away from the costly and inefficient FFS model. According to Dr. Tunde Sotunde, president and CEO of Blue Cross Blue Shield of North Carolina, "Collaborating with the primary care community has never been more important as this pandemic unfolds. Finding new ways for [providers] to embrace and succeed in value-based care is an important step to better, simpler, and more affordable healthcare for our members."[5]

There are a range of FFV arrangements that allow payers to meet providers where they are and ascend toward growing levels of risk in order to methodically achieve success, including shared savings, capitation, and joint ventures (Figure 1). While adoption of FFV contracts in each model has plateaued in recent years (Figure 2), it is widely recognized that risk-based payment is the future of payer-provider partnership models, as they promote the financial and operational integration of the two entities.

Figure 1: Fee-for-Value Risk Spectrum

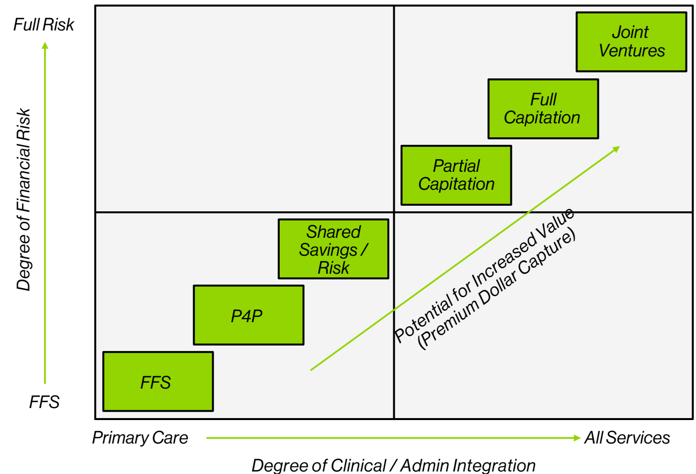
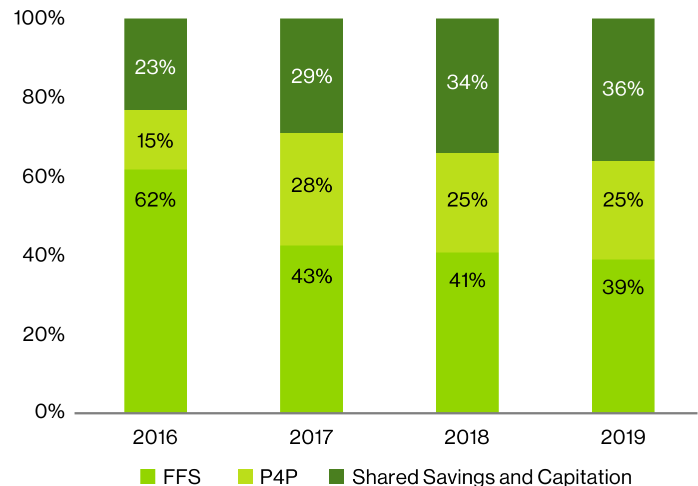


Figure 2: Adoption of Value-based Contracts 2016-2019



Source: HCP-LAN 2016-2019

4. "Impact of COVID-19 on Payer-Provider Collaboration," Guidehouse, May 27, 2020, https://guidehouse.com/insights/healthcare/2020/covid-19/impact-of-covid19-on-payer-provider-collaboration.
5. "Payers Continue to Expand Value-Based Contracting Despite COVID-19," Health Payer Intelligence, June 30, 2020, https://healthpayerintelligence.com/news/payers-continue-to-expand-value-based-contracting-despite-covid-19.

Shared Savings

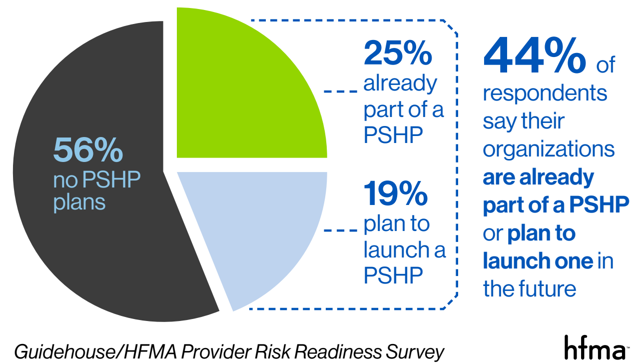
In this type of arrangement, actual medical expense is compared with a predetermined target and savings may be distributed based on a provider's clinical and financial performance; downside arrangements also include a distribution from the provider to the plan to the degree actual expense is worse than expected.

Partial and Full Capitation

In a capitated arrangement, per member per month payments are made by payers to providers to cover the total cost of care for a defined patient population. This predetermined payment allows payers to budget and maintain a constant medical payment expenditure, shifting the financial risk for the population to the provider; providers successful at managing the cost of care can garner first-dollar margin as traditionally realized by payers.

Joint Ventures

A joint venture represents the most integrated partnership model in which the payer and provider each have equity ownership in the insurance product. While the construct of a joint venture model can vary significantly between payer and provider partners, the most common type is a provider-sponsored health plan (PSHP), where the parent (i.e., majority owner) of the insurance product is a provider. Providers that have strong performance, significant market presence, and a trusted, well-performing payer have pursued this model to not only capture the financial benefit but also increase the level of patients through a co-branded, differentiated market product. Multiple joint ventures have emerged in recent years across all payer lines of business, with notable partnerships including Blue Cross Blue Shield of Rhode Island with Lifespan in the marketplace, Security Health Plan with both Mayo Clinic and Marshfield Clinic Health System for employers, and WellCare with UNC Health Alliance in the Medicare Advantage line of business and Horizon Blue Cross Blue Shield of New Jersey with Braven Health.



Providers that already have a majority of their book of business in capitated arrangements, for example, accredit the capitation revenue for allowing them to stay afloat during COVID-19. In response to what his practice faced during the early months of the pandemic, Dr. Fuad Sheriff, in Amherst, N.Y., cited that the revenue from capitation accounted for 60% of his practice's income.[6]

Figure 4 illustrates a high-level example of various partnership arrangements and the resulting provider financial funds, accounting for the 50% decrease in medical expenses as a result of COVID-19.

Figure 4: Illustrative Provider Reimbursement Scenarios

	FFS	Shared Savings	Full Capitation
2019 Provider Reimbursement	$10.0M	$10.0M	$10.0M
2020 Provider Reimbursement (COVID-19 Impact)	$5.0M	$5.0M	n/a
Shared Savings Distribution	n/a	50%	n/a
Shared Savings Recoup	n/a	$2.5M	n/a
2020 Total Reimbursement	$5.0M	$7.5M	$10.0M
COVID-19 Provider Payment Impact	**($5.0M)**	**($2.5M)**	**$0**

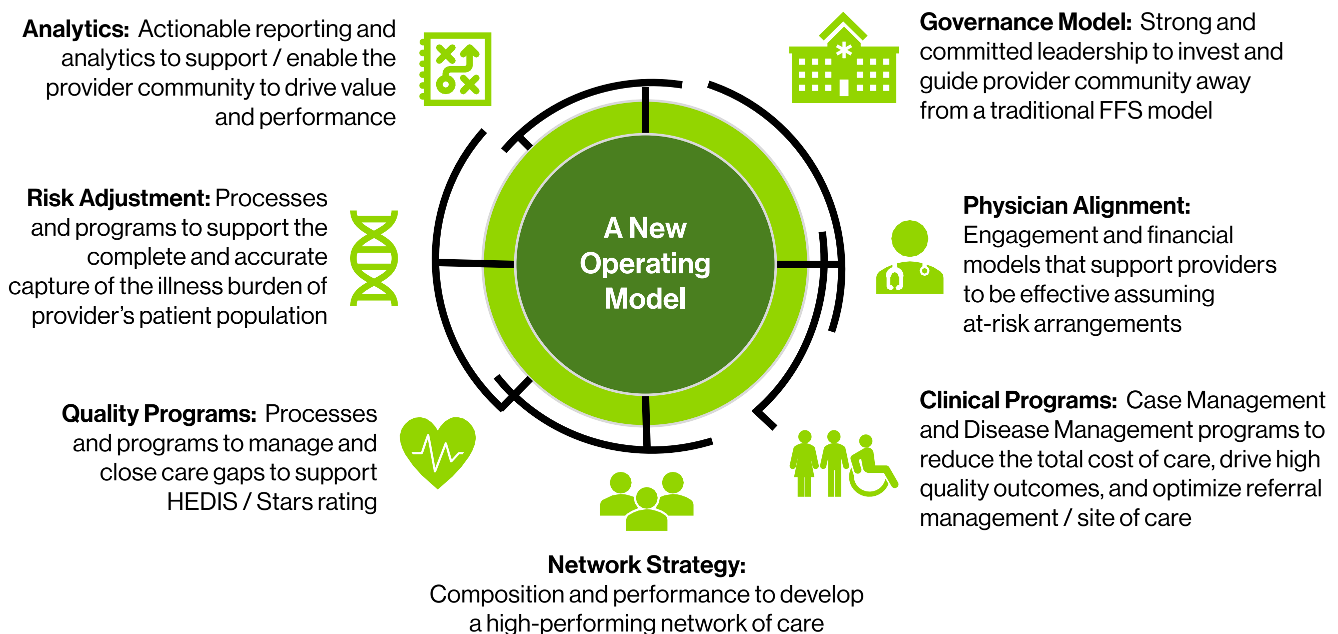
6. Shelby Livingston, "COVID-19 may end up boosting value-based payment," Modern Healthcare, June 13, 2020, https://www.modernhealthcare.com/insurance/covid-19-may-end-up-boosting-value-based-payment.

A Risk-Based Operating Model

Both commercial and government payers are projected to continue to move providers into more aggressive risk-based contracts to stem the increases in healthcare spend while maintaining the quality of care being provided.

To be successful in any of these arrangements, providers will need to create and bolster their internal operating capabilities. The sophistication and scalability of capabilities providers must possess will differ by arrangement, and as they enter more aggressive risk-based contracts and strategic partnerships. Figure 5 provides an overview of these capabilities.

Figure 5: Provider At-Risk Operating Model



Additionally, payers and providers need to have a bi-directional, strategic relationship to achieve the most value from their contractual arrangements. As a result, payers will also need to modify their operating model to become a better partner to their provider community, key operational elements can include, but are not limited to:

- **Contracting:** Process that is fair, transparent, and repeatable
- **Data and Reporting:** Timely sharing of actionable data, insights, and performance
- **Internal Administrative:** Payment configuration to support varying FFV arrangements
- **External Administrative:** Programs to mitigate administrative burden imposed on providers
- **Financial Operations:** Process to perform financial reconciliation of FFV arrangements

Implementing any one of these arrangements requires a symbiotic payer-provider partnership. An in-depth assessment of both the provider's and payer's internal and external capabilities should be used as a road map to guide each entity on their collective journey as they enter and invest in FFV arrangements.

Strong Payer and Provider Partnerships for Future Financial Success

When strategically aligned, FFV payer-provider partnerships will bolster greater financial success and stability. This would allow both entities to weather not only major disturbances in medical utilization, such as the COVID-19 pandemic, but also work proactively to reduce the growing medical expenditures that continue to consume the healthcare system.

Yet in a recent Healthcare Intelligence publication, 38% of providers said they do not communicate at all with public payers and 32% said they do not communicate with private payers at all.[7] Lack of trust and limited communication leads to a misalignment in value-based care goals, limiting the success of these initiatives. Only 6% of providers felt fully aligned with their public payers and 5% feel the same about their private payers. Meanwhile, 14% of public payers felt fully aligned with small physician groups and none felt fully aligned with large physician groups or hospitals. Clearly these numbers must improve for these partnership to be successfully developed.

COVID-19 is another tragic example that proves FFS models are not sustainable. The provider-payer FFV arrangements that have fared well are those that were able to focus on combining their strengths and building bidirectional capabilities to support a mutually beneficial, evolving partnership. To ensure mutual sustainability, financial engineering and enterprise collaboration must continue to evolve in a more synergistic way.

7. Emily Sokol, "Value Based Care Stunted by Misaligned Payer-Provider Relationship," HealthPayer Intelligence, September 28, 2020, https://healthpayerintelligence.com/news/value-based-care-stunted-by-misaligned-payer-provider-relationship.

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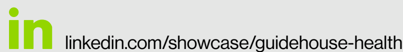

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