OREGON HEALTH AUTHORITY'S TRANSFORMATION CENTER

SPRING 2021: VALUE-BASED PAYMENT WEBINAR SERIES

Session #3:

Learnings from COVID-19 and how they may impact the adoption of VBPs

May 19, 2021

WEBINAR SERIES OVERVIEW

- This is the third of a 5-part series focused on Value-Based Payment (VBP) for Providers.
- The objectives of this series include:
  - Provide an overview of VBP models as they apply to the Oregon landscape.
  - How VBP can support providers to improve patient outcomes through more comprehensive and flexible approaches to delivering healthcare services.
  - Enhance primary care, behavioral health and maternity care providers' readiness for VBP adoption.
- Sponsored by the Oregon Health Authority's Transformation Center in collaboration with Health Management Associates.
- 1.0 hour of CME is available through the American Academy of Family Practice, equivalent to AMA PRA Category 1 Credit™ toward the AMA Physician's Recognition Award. To receive the credit, you must complete the evaluation following-the session.

2021 Webinar Series, 12 – 1pm on:

- **March 17 (Recording available)**
- **April 21 (Recording available)**
- **May 19**
- **June 2**
- **June 16**

SPEAKERS AND DISCLOSURES

Faculty	Nature of Commercial Interest
 Jeanene Smith MD, MPH Presenter and Curriculum Adviser	Dr. Smith discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients. As a member of the American Academy of Family Practice (AAFP), she ensured the content met the AAFP CME requirements.
 Art Jones MD Presenter	Dr. Jones discloses that he is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients. He is also employed as Chief Medical Officer of Medical Home Network, a non-profit that supports Medical Home Network ACO and other safety net clinically integrated networks to transform care are under advanced alternative payment models.
 Janet Meyer Presenter	Ms. Meyer discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients.

TODAY'S AGENDA & LEARNING OBJECTIVES

Agenda:
Welcome and Introductions

Brief overview of COVID-19 impacts on healthcare payments.

Discussion of telehealth and other flexibilities under COVID-19 and potential continuation.

Discuss how successful patient-centered models of care that became widely used during the pandemic could be supported by VBP.

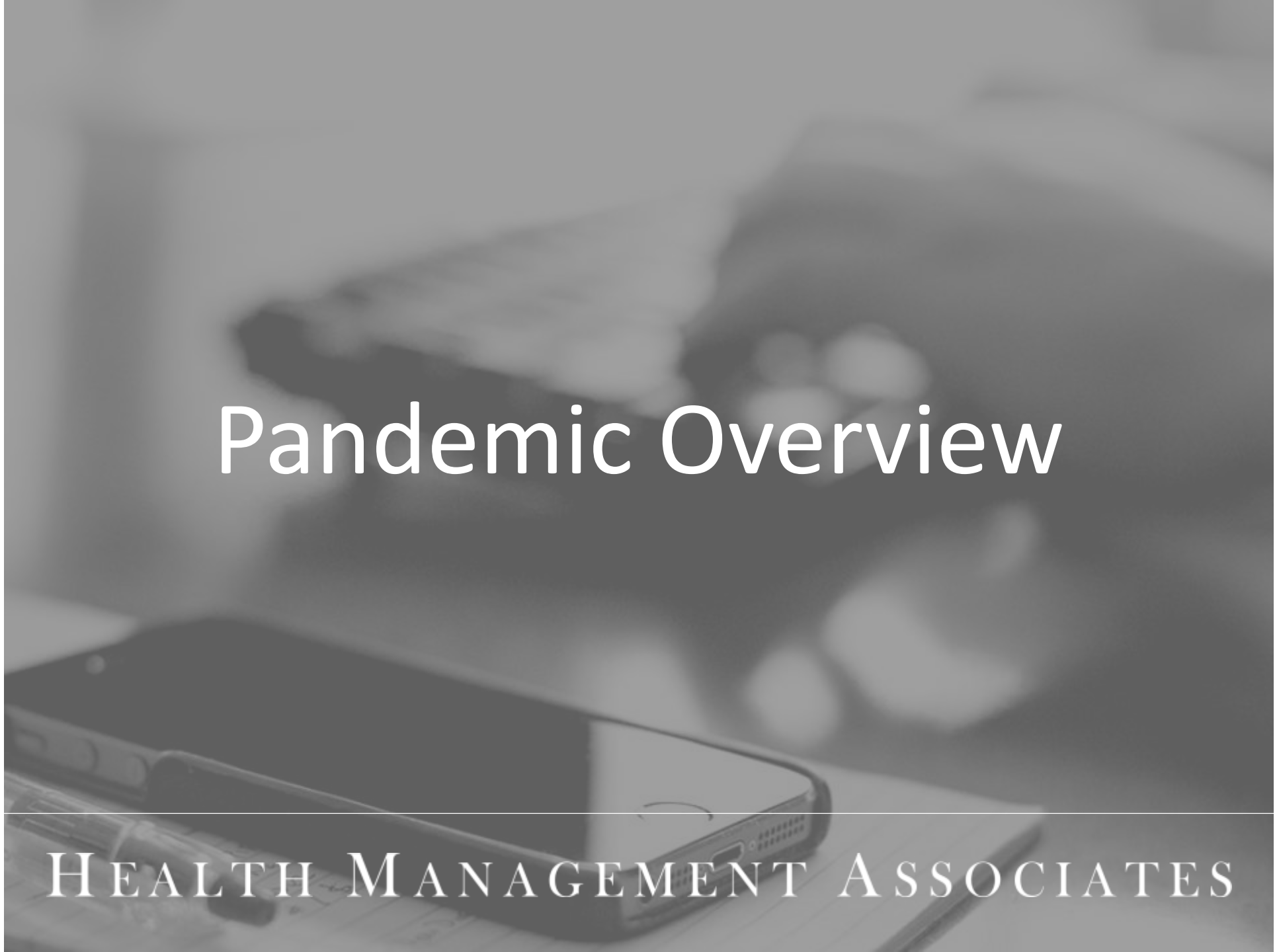
Examine how results from VBP can be impacted by how the methodologies address new telehealth flexibilities.

Q&A

Learning Objectives:

After this webinar, participants will be able to:

- Describe the importance of VBPs on health care during the COVID-19 pandemic.
- Identify 2-3 COVID-19 flexibilities that will continue, and an example of those which may end.
- Describe how moving to VBP may offer a route to continue successful patient-centered models of care developed during the pandemic.
- Identify the impact of the pandemic on VBP and the challenges and potential impacts on VBP in 2021 and beyond.



Pandemic Overview

HEALTH MANAGEMENT ASSOCIATES

Nearly every person and community in this country has been affected by the COVID-19 pandemic which has radically upended the norms of US politics, economy, culture, and race relations and reminded us of the fragility of life as we know it.

- Care was cancelled or deferred as patients weighed the risks and benefits of accessing health care services in-person.
- The American Hospital Association estimated hospitals and health systems lost $200 billion between March and June 2020.* In Oregon, the median hospital's operating margin fell to a minus 2.5% in January – March 2020 before rebounding to close the year with a $483 million surplus representing a 3.3% statewide operating margin. **
- As fee-for-service revenues from in-person visits dropped precipitously, some providers had little choice but to lay off staff while other staff resigned to care for their families, sought a safer employment environment, retired earlier than planned or became overwhelmed and burned out.
- Many of the providers who had taken the most "risk" in VBPs have been the most protected from revenue declines.

*https://www.aha.org/guidesreports/2020-05-05-hospitals-and-health-systems-face-unprecedented-financial-pressures-due

** OHA Hospital Financial & Utilization Dashboard

INTRODUCTION: COVID 19 RESPONSE

While some value-based payment programs were paused, others were modified by changing the quality gates and others were newly introduced.

- Telehealth payment rules were modified.
- Health care providers adapted, innovated and made an inspiring response in the time of crisis.
- The patient population quickly adapted to telehealth.
- For the 2020 and 2021 performance year, CMS implemented an Extreme and Uncontrollable Circumstances policy to allow clinicians, groups, and virtual groups to submit an application requesting reweighting of one or more Merit-based Incentive Payment System (MIPS) performance categories.

- The U.S. Department of Health and Human Services (HHS) provided approximately $100 billion of financial relief to providers in 2020.*

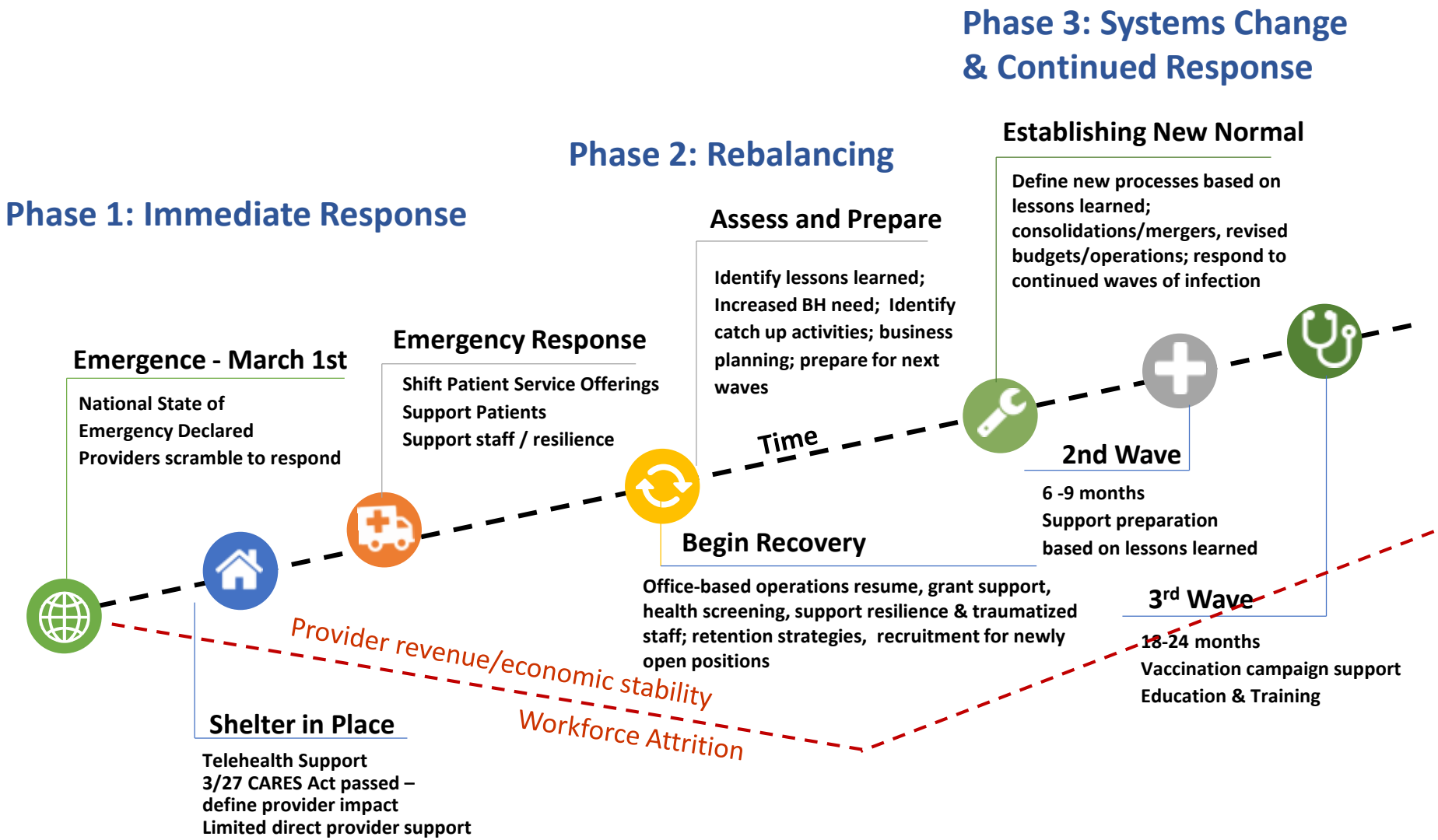
*https://data.cdc.gov/Administrative/HHS-Provider-Relief-Fund/kh8y-3es6

INTRODUCTION: COVID-19 OUTCOMES

- A May 2020 survey of Medicare Advantage beneficiaries found that 91% of those who had used telemedicine had a good experience and that 78% would use it again.*
- CMS estimates there was a 12% reduction in care in 2020.
- Medical loss ratios for some insurance plans dipped below the ACA mandated minimum triggering refunds to governmental payers, some employers and individuals.
- Prior to the pandemic, UnitedHealth Group study (August 2020) of 5 million enrollees found that primary care physicians paid under global capitation achieve key quality metrics at higher rates than those paid fee-for- service (FFS) using HEDIS metrics for preventive care and chronic conditions; outcomes for 2020 are pending.

*Morning Consult (2020), available at www.bettermedicarealliance.org/wp-content/ uploads/2020/06/BMA-Memo-CT-D23.pdf

COVID TRAJECTORY: DIFFERENT PHASES IN DIFFERENT PLACES



- Federal legislative and regulatory actions in 2020 increased temporary and permanent coverage of Medicare virtual care services and provided much needed support to the economy.

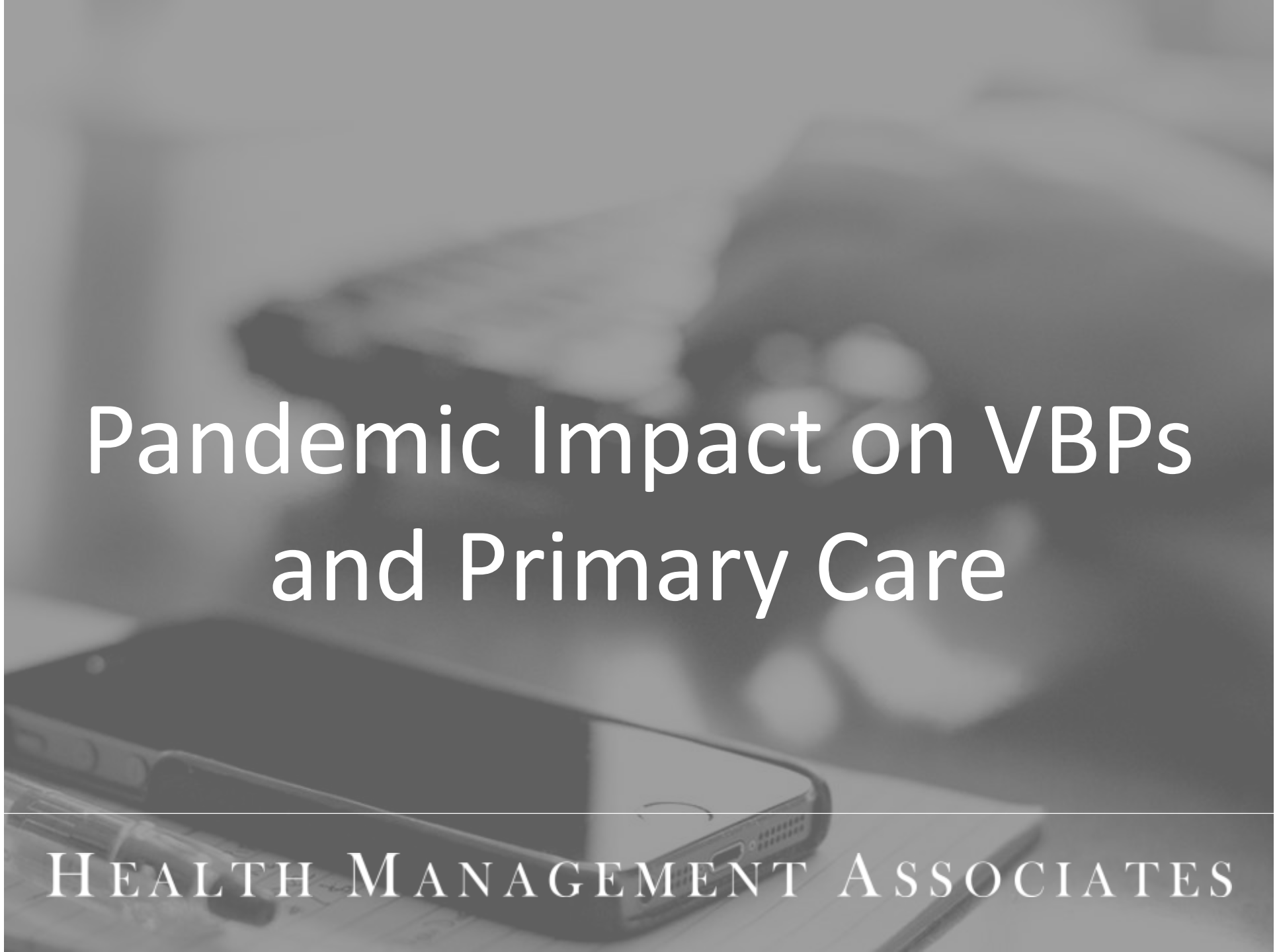
- States immediately began preparing for significant increases in Medicaid enrollment.

- CY 2021 Medicare Physician Fee Schedule Final Rule (November 2020):
  - Remote Patient Monitoring: Patient consent can be obtained at time of service; auxiliary office staff may provide services.
  - Virtual check-ins: New billing codes for audio-only specific services, new codes for new types of clinicians.
  - Incident-to billing: Physicians may provide direct supervision as long as they are immediately available by audio-only communication.
  - Nursing facilities: Telehealth services may be used for subsequent nursing facility services once every 14 days, rather than every 30 days.

- Omnibus Stimulus Package (December 2020/January 2021)

OREGON LANDSCAPE

- Federal legislation and regulation allowed for:
  - Expanded access to Medicaid,
  - Coverage for testing for COVID-19,
  - Increased the Medicaid Federal Medical Assistance Percentage (FMAP),
  - Expanded telehealth services during the emergency declaration,
  - Expanded definition of telehealth service providers,
  - Prohibited states from counting enhanced unemployment or stimulus check when determining Medicaid eligibility
  - Variety of "1135 waivers" (i.e., suspend FFS Prior Authorization (PA) requirements, extension of state fair hearing request timelines).
- Oregon submitted several State Plan Amendments to request flexibilities that could not be approved using other options. For example, RVU weights for telehealth/telemedicine were increased to make them comparable to face-to-face visits.
- CCO Quality Funds released to infuse resources to address critical areas of need.
  - Early release of 60% of the 2019 Quality Pool Fund ($98 million).
  - Suspension of the 2020 Quality Withhold during the emergency ($17 million/month).
- CCO VBP Roadmap requirements were modified so that Care Delivery Area VBPs now begin in 2022, and all are implemented by 2024.



Pandemic Impact on VBPs and Primary Care

HEALTH MANAGEMENT ASSOCIATES

WHICH SENTENCE BEST DESCRIBES YOUR PRACTICE?

1) We were NOT doing telehealth before COVID-19, and we had challenges getting started.

2) We were NOT doing telehealth before COVID-19, but we jumped in and implemented it quickly and smoothly.

3) We were doing a little telehealth before COVID-19, and this gave us an opportunity to expand.

4) We were doing a lot of telehealth before COVID-19, and we have expanded further.

CHALLENGES FACING PROVIDERS

By disrupting typical health care utilization patterns and requiring providers to quickly change how services are delivered, the pandemic has introduced a new set of challenges for VBP models.

Both payers and providers need to consider:

- Provider financial strain,
- Rapid changes in care delivery,
- Exacerbated health disparities,
- Technical challenges to the VBP programs – impact on cost projections and quality measures.

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Primary care practices are expected to lose $15 billion in 2020 after dramatic declines in both office visits and reimbursements during the COVID-19 pandemic.*

Telehealth can replace some of this through virtual and audio visits under current temporary emergency policies.

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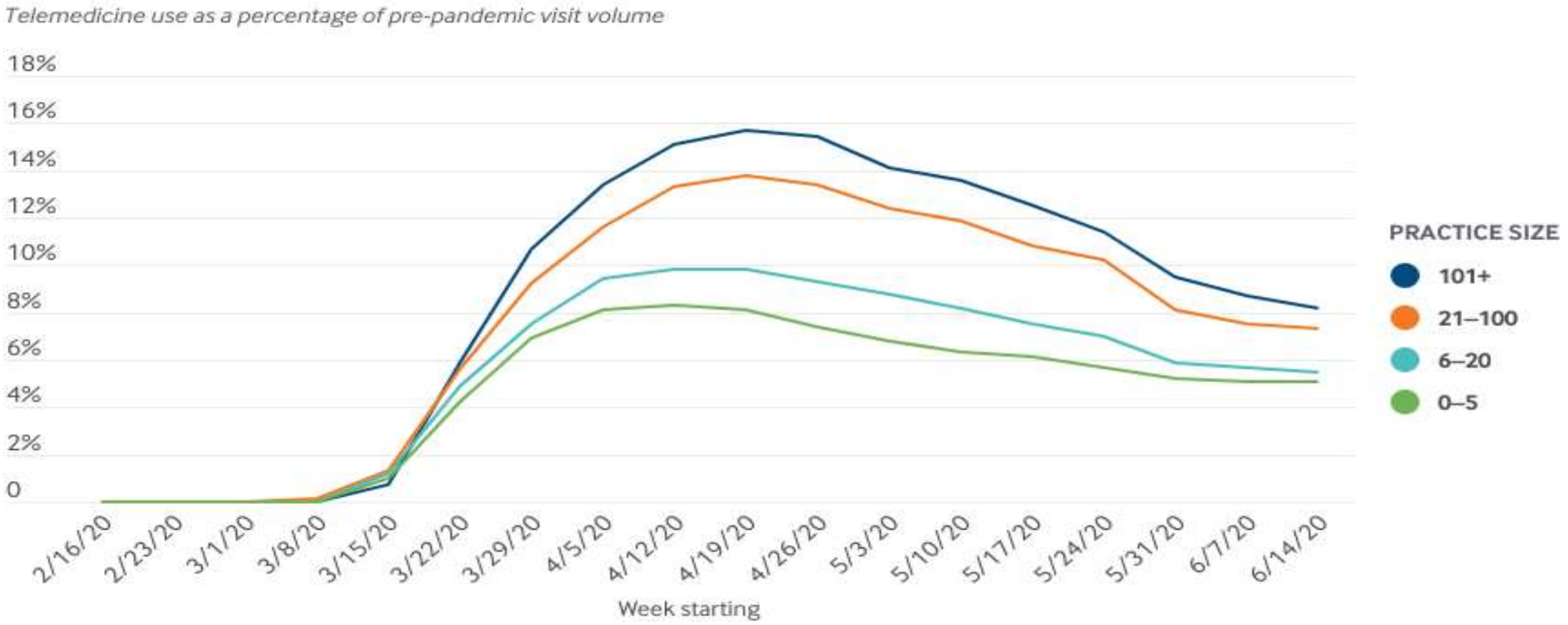
*Basu, S et al. “Primary Care Practice Finances in the United States Amid The COVID-19 Pandemic”. H. Affairs June 25, 2020; available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00794

RISE OF TELEHEALTH

- Some providers did more virtual visits in the first few weeks of the pandemic than they had done in an entire career and learned lessons certain to shift the future paradigm of care delivery.
- As the nation faced surges of COVID-19 through the year, practices had to adjust between offering safe in-person visits and ongoing demand for telehealth visits while keeping their staff healthy and practices financially viable.
- A recent Commonwealth Fund study found:
  - In April 2020, the number of all types of visits with ambulatory care practices declined by nearly 60% while telehealth visits rose rapidly.
  - In Spring 2020, telehealth was 12% of all visits, that rate fell somewhat in Fall 2020, but increased in late 2020 to just over 8% of visits nationally as new COVID-19 spikes emerged.
  - Larger practices were able to adapt to telehealth more quickly than smaller ones.

Weekly Telemedicine Visits as Fraction of Weekly Visits at Baseline, by Practice Size



Ateev Mehrota, Bill Wang, and Gregory Synder. *Telemedicine: What should the Post Pandemic Regulatory and Payment Landscape Look Like*? (Commonwealth Fund, Aug 2020; available at: https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/telemedicine-post-pandemic-regulation

RISE OF TELEMEDICINE

- Before the pandemic, use of telemedicine video visits was growing by 25% (Medicare) and 52% (Commercial) every year for the past decade but still a fraction of overall office visits.
- With COVID-19, many temporary policies were introduced to encourage telemedicine use and increase safety from the virus, with widespread rapid adoption.
- Systematic reviews consistently indicate that telemedicine is a safe and suitable alternative to traditional in-person models of care.
- Telemedicine has proven capable of improving access for underserved patient populations, especially those residing in rural areas.
- For certain medical conditions, telemedicine has demonstrated improved health outcomes with associated reductions in cost, but some studies have suggested its use may lead to unintended consequences such as increased health care utilization.
- Value-based payment models give providers the flexibility to use a package of telemedicine tools and in-person visits that are best suited for an individual patient's clinical scenario.

RISE OF TELEHEALTH- NEW PATIENT-CENTERED MODELS OF CARE

"Virtual endocrinology" providers have introduced continuous remote patient monitoring using internet-connected glucose monitors and smart phone apps.

- Insulin adjustment occurs through a variety of means, from automated feedback on apps to glucometers and text messages.
- A recent trial utilized cloud-based technologies incorporating patient self-tracking tools, shared decision-making interfaces, secure text messages, and virtual visits that demonstrated benefit. The telemedicine intervention group again achieved greater reduction in HgbA1c when compared with traditional controls over a three-month period (1.2% greater HgbA1c reduction).*
- These other forms of telehealth complicate the conversation about payment and regulations. While it seems feasible for an insurer to pay for a video visit, it is hard to envision paying a provider for each text message, portal exchange, or app use.
- These forms of telemedicine are better suited to value-based payment models rather than to fee-for-service.

*Hsu WC, Lau KH, Huang R, Ghiloni S, Le H, et al. 2016. Utilization of a cloud-based diabetes management program for insulin initiation and titration enables collaborative decision making
between healthcare providers and patients. Diabetes Technol. Ther. 18(2):59–67

RISE OF TELEHEALTH- NEW PATIENT-CENTERED MODELS OF CARE

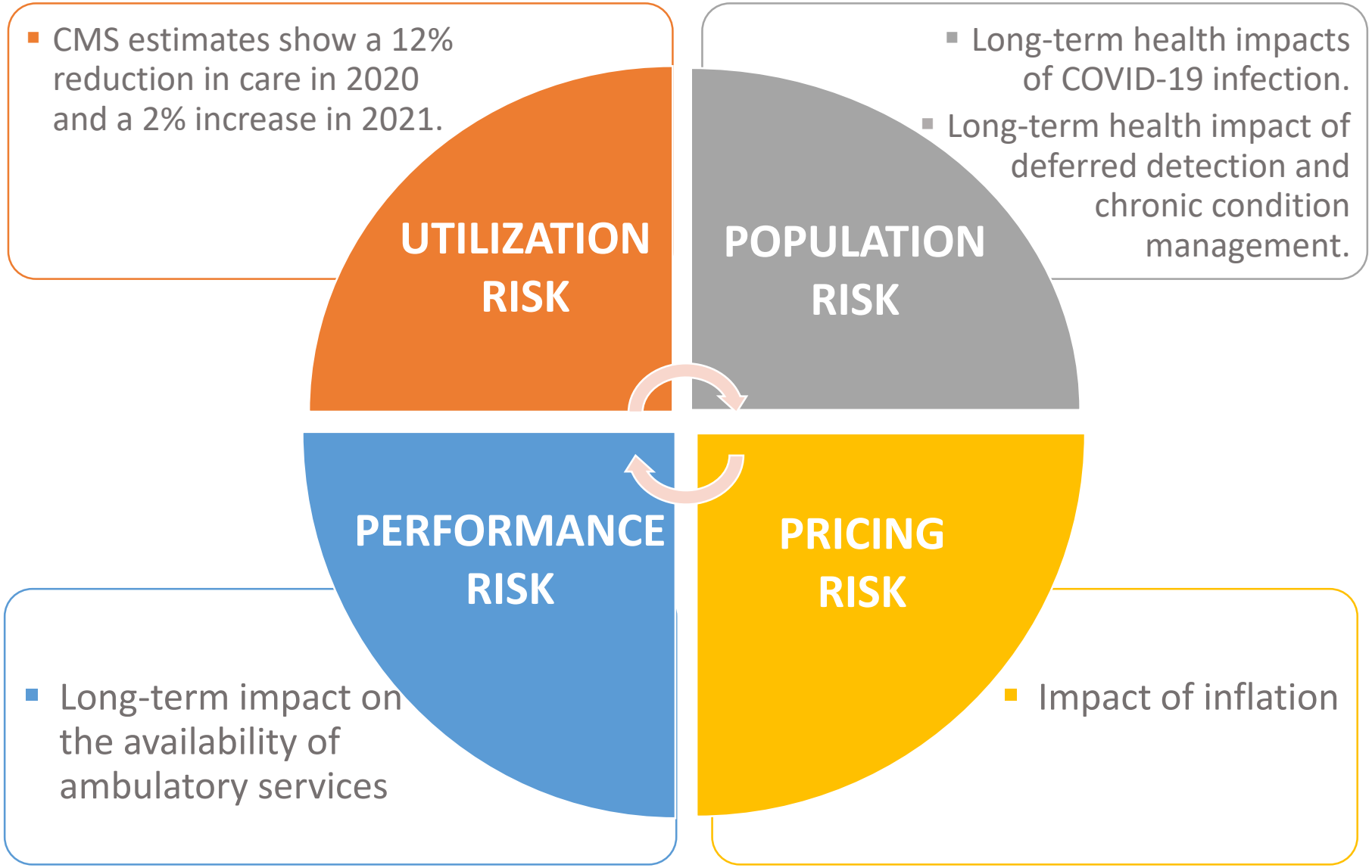
Telehealth interventions have also shown to be particularly useful for underserved and vulnerable diabetic patient populations.

- A good example of this is the IDEATel, a 5-year longitudinal study that recruited 1,665 patients residing in ethnically diverse and medically underserved areas in New York who were referred from their primary care providers.
  - Patients enrolled in the intervention group had a home telemedicine device capable of videoconferencing and glucose tracking, as well as providing patient access to clinical data and educational resources.
  - Over five years, this study found an additional HgbA1c reduction effect of 0.29% in the telemedicine intervention group when compared with usual care.*

- A recent study of vulnerable populations investigated the use of telemedicine to improve access for pediatric patients with type 1 diabetes in rural Wyoming. This study concluded that remote "telemedicine consultation proved noninferior to in-person annual visits" with comparable health outcomes and resulted in significantly less time missed from work/school.*

*Improving Access to Care: Telemedicine Across Medical Domains William Barbosa, Kina Zhou, Emma Waddell, Taylor Myers, E. Ray Dorsey. Annual Review of Public Health 2021 42:1, 463-481

POST-PANDEMIC FRAMEWORK FOR EVALUATING VALUE-BASED PAYMENT MODELS



TECHNICAL CONSIDERATIONS FOR POST-PANDEMIC VBP FRAMEWORK

- Impact on risk scores:
  - While audio-only telehealth services are often reimbursable, CMS requires services to be provided using an interactive audio and video communications systems that permits real-time interactive communication to have the diagnosis be eligible for risk adjustment purposes.
  - Estimates range from about a 1% reduction to risk scores (revenue) to a 9% reduction; scenarios that seem most plausible are centered around roughly a 3% reduction.
  - Depending on the payer, 2020 claims will determine either 2021 or 2022 risk scores.*

- Rebasing of shared savings benchmarks before paying 2020 savings.

- Rebasing of shared savings targets for future years.

*https://www.milliman.com/en/insight/How-far-will-Medicare-Advantage-2021-revenue-and-risk-scores-drop

PAYMENT STRATEGIES FOR TELEHEALTH

- LAN Category 1 Fee-for-service or pay-for-use model: payer bears the risk for low-value use of services.
- LAN Category 4 Per-member-per-month capitation: provider margin is very sensitive to small changes in utilization rate.
- LAN Category 2 Pay-for-performance: based on member experience but otherwise limited unless telehealth provider is also the PCP.
- LAN Category 2, 3 &/or 4: requires provider accountability for population health outcomes; limits payer risk.

2019 Primary Care Revenue

# of empaneled Medicaid Member Months in 2019

= PER MEMBER PER MONTH VBP RATE*

***Rate is inflated annually**

LESSONS LEARNED FROM THE PANDEMIC: RACIAL DISPARITIES AND INJUSTICE IMPACT ON VBP

- COVID-19 infections and deaths disproportionately impacted communities of color and furthers the priority for states, health care organizations and providers to directly address longstanding health disparities.
- VBP models can play key roles in directing, incentivizing, and providing the payment flexibilities required for this effort. Care should be taken so that historically marginalized groups are not inadvertently harmed.
- These models can hold providers financially accountable for reducing health disparities and/or implementing interventions that advance health equity.
    - Oregon's CCOs' performance measures are analyzed by race and ethnicity, though the state is not yet rewarding CCOs that demonstrate actual reductions in health disparities.
    - As CCOs are held more accountable for addressing disparities, provider VBPs will likely follow.
- VBP models can encourage the use of community health workers (CHWs) to provide community-based care and address health-related social needs. This workforce can:
    - Support success with new models of care that address patient-centered care needs, including addressing ongoing impacts of COVID-19 and social needs.
    - Support care coordination and outreach efforts across the patient population and start to address any gaps to reduce disparities.


What’s Next
HEALTH MANAGEMENT ASSOCIATES

- **System-wide: Key issues impacting all payers:**
  - Federal Public Health Emergency (PHE) will remain in place until 12/31/2021, but it could go longer.
  - Virtual care access disparities (income, race) will be a target of policymakers.
  - Audio-only virtual care services not likely to be made permanent coverage by most payers.
  - More states may require insurers to cover virtual care services.

- **Commercial insurers: Not likely to be leaders in telehealth expansion:**
  - Skeptical of the ability of telehealth to lower costs and fear patient/provider fraud.
  - Often limit telehealth coverage to basic medical and mental health services through a telehealth vendor.

- **Medicaid: Some states making temporary coverage permanent, following Medicare's lead:**
  - Spring/summer 2021 more States will begin to address permanent coverage policies and will realize they are not bound by the federal PHE.
  - States with significant budget concerns will place guardrails around expanded coverage (e.g., frequency limits, requirements for occasional in-person visits).

- **Medicare: Using its authority to expand coverage, but authority is limited:**
  - Congress must act to grant CMS authority to expand originating sites (urban and patients' home) and modalities (audio-only) once PHE is lifted.
  - Medicare Advantage plans have flexibility to cover more virtual care services and will in the years ahead.
  - Fraud risk and budget insecurity remain a concern of CMS/Congress.
  - Disease groups could be a pathway to expansion, with guardrails (e.g., mental health).
  - Communication Technology-Based Services (CTBSs) such as e-visits, virtual check-ins and telephone assessments will increase in use by provider practices and health systems.
  - Medicare's 2022 regulatory cycle will bring selected permanent expansions of virtual care service (e.g., Physician Fee Schedule, Medicare Advantage).
  - New pilot programs from the Centers for Medicare & Medicaid Innovation (CMMI) will likely include more expansive virtual care coverage.

- To shore up and strengthen essential roles and functions post pandemic, it will require:
  - + flexible funding structures that move beyond fee-for-service reimbursement,
  - + investment in technology and data capabilities that enable meaningful engagement with patients,
  - + and data-driven population health work.

RESOURCES

- Devoe, J and Bazemore, A. “Primary Care in the COVID-19 Pandemic: Essential, and Inspiring”. J Am Board Fam Med 2021;34:S1–S6. Available at https://pubmed.ncbi.nlm.nih.gov/33622807/.

- American Hospital Association (2020) “Hospitals and Health Systems Face Unprecedented Financial Pressures due to COVID-19” available at: https://www.aha.org/guidesreports/2020-05-05-hospitals-and-health-systems-face-unprecedented-financial-pressures-due.

- CARES Act Provider Relief Fund information available at: https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html#:~:text=CARES%20Act%20Provider%20Relief%20Fund%20The%20Provider%20Relief,on%20the%20front%20lines%20of%20the%20coronavirus%20response.

- Center for Medicare and Medicaid Services (CMS) Provider Telehealth Resources available at: https://telehealth.hhs.gov/providers/.

- UnitedHealth Group (August 2020) Survey “Physicians Provide Higher Quality Care Under Set Monthly Payments Instead of Being Paid Per Service” https://www.unitedhealthgroup.com/newsroom/2020/uhg-study-shows-higher-quality-care-under-set-monthly-payments-403552.html.

RESOURCES CONTINUED

- Basu, S et al. “Primary Care Practice Finances in the United States Amid The COVID-19 Pandemic”. H. Affairs June 25, 2020; available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00794.

- The Commonwealth Fund (Feb 2021) “The Impact of COVI-19 on Outpatient Visits in 2020: Visits Remained Stable, Despite a Late Surge in Cases” available at: https://www.commonwealthfund.org/publications/2021/feb/impact-covid-19-outpatient-visits-2020-visits-stable-despite-late-surge.

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- Center on Health Equity Action for System Transformation at Families USA (March 2019). “Accelerating Health Equity by Measuring and Paying for Results” available at: https://www.familiesusa.org/wp-content/uploads/2019/03/HEV_Data-Stratification_-Issue-Brief.pdf.

- Kangovi, S et al. “Evidence-based Community Health Worker Program Addresses Unmet Social Needs and Generates Positive Return on Investment”. H. Affairs 39, NO. 2 (2020) available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00981.

- The Playbook- Better Care for People with Complex Needs. “How Community Health Workers and Promotores Can Support Individuals with Complex Needs amid Covid-19” July 2020 available at: https://www.bettercareplaybook.org/sites/default/files/2020-07/Playbook-CHW-Webinar_07292020.pdf.

Q & A

Send your questions to the host via the Question function.

UPCOMING FROM THE OHA TRANSFORMATION CENTER

- Please complete the evaluation that will be sent out after the webinar.
- CME credit will be emailed to participants completing the evaluation.
- Slides, webinar recording will be available at: **https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Value-Based-Payment.aspx**
- Next session: **June 2, 2021, Noon to 1pm**

  Topic: Value-based payment for behavioral health providers: How do we keep from being left out?
- Follow-up questions?

  Contact: **OHAVBPQuestions@healthmanagement.com**