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The New Normal: How Will Providers and Payors Adapt?

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>
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> **Founding Dean Emeritus, Jefferson College of Population Health**

Webinar Summary, June 24, 2020

Within a few short months, the COVID-19 pandemic has successfully pushed back and altered many of the structural barriers that had previously slowed the widespread investment of our nation's health systems in digital medicine. In an effort to educate and inform on the potential path that lays ahead for many providers, administrators, and medical professionals, AMGA hosted a special free-flowing virtual discussion titled "The New Normal: How Will Providers and Payors Adapt?"

Moderated by DocASAP Co-founder and CEO Puneet Maheshwari and featuring industry heavyweights and prognosticators David Nash, M.D., M.B.A., founding dean emeritus, Jefferson College of Population Health, and Kumar Saurabh, chief financial officer, employer and individual, UnitedHealthcare, the conversation centered around three prevalent macro trends facing the greater healthcare industry in the wake of the coronavirus:

- Contact-free care delivery and the adoption of telemedicine
- The democratization of data and patient empowerment
- The state of value-based care and what it will take for it to succeed

Each of these topics were meant to be examined in the context of their implications for payors and providers, population health, and regulatory considerations.

"This is a very unique time," Maheshwari explained in his opening statement. "We are right now at a cusp where the new normal is getting defined."

Contact-Free Care Delivery

Maheshwari kicked off the discussion with an alarming statistic, citing recent research that found that roughly $250 billion of current U.S. healthcare spending could be potentially virtualized. Whether you want to call it contactless care delivery, telehealth, etc., Saurabh asserted that "its moment has come."

Noting the very evident uptick across the board in telemedicine usage, Saurabh explained he looks at the trend across two major dimensions: consumer engagement and how the provider practices inside his or her office. “The core thing that we are trying to really figure out is, is it a permanent shift? Is this a fundamental restructuring of how some physician groups might practice medicine? And right now, we are still in hypothesis generation mode, and the world keeps changing.”

Thus far, Maheshwari has recognized some emerging payor/provider collaborations that are accelerating the move, from burgeoning technology investment to different payment models. From the consumer perspective, Maheshwari adds that contact-free care delivery could really represent a fundamental shift in a patient’s willingness to engage with providers and their care.

Taking the mic from Saurabh, Nash quickly borrowed a popular refrain from his boss at Jefferson, Dr. Stephen Klasko, who has asked over the years why we even still call it “telemedicine.” People don’t saying they’re going to “telebank,” so why should we continue to refer to telemedicine as its own separate activity? It is quickly becoming part of the same care continuum, with far greater opportunities for engagement and the ability of reaching those populations of patients that were hardly given the attention they rightly deserved.

“To really connect with the community and for the community to connect with us as the providers in this situation, you can’t improve the health of the population unless they’re engaged with you as well,” said Nash. “So I prefer to just think of it as all part of digital health and being in constant contact with patients. And then to mass customize that information, that’s the wave of the future. Many providers are anxious to ‘get back to business’ and rev up the utilization engine. I really don’t accept that notion. I understand where it comes from. Is the system that got us to this point the same system that’s going to take us into the future? They are going to be two very different systems.

“From a population health perspective, I think we’re going to be dealing with populations that we never really paid any attention to before, and we’re going to be able to have a much broader, deeper, and enduring impact on these populations using the tools of digital health. What we need is some better measures of whether this technology is really working. Who’s doing a great job? Who’s doing a mediocre job and why? And then close the feedback loop to the people running the systems so they can continuously improve the outcome.”

Maheshwari acknowledged that any conversation about contactless care delivery would be incomplete if there wasn’t at least some examination of the role of the government and regulatory oversight. While the services now made available for telehealth have greatly expanded since the pandemic began, Maheshwari asked the panel what else they would like to see from Congress.

“With the role of the government, we go into philosophy now,” joked Saurabh. “From my perspective, we have been slow from a regulative perspective to figure out how to fix it. I think both payors and providers have been generally supportive of this notion of telemedicine. To me, it could represent a fundamental shift in the business model of medicine, and I think that’s a good thing for the industry and could help costs in this country. I also think when we think about CMS [the Centers for Medicare and Medicaid Services], a lot of what CMS does is focused on Medicare, and I think unfortunately we have made that the standard for what is allowed and what’s possible in the country. They are the single largest payer, and if you’re a doctor or a physician, it’s difficult to change your behavior if the single largest payer is going to behave differently.

"Having said that, I do feel the genie is out of a bottle. I'm sure there are different perspectives on that, but practically, I just don't see how we go backwards, especially with the uncertainty that continues to pervade from a COVID-19 perspective. What payers and providers ought to be doing here is really figuring out how to make this change sustainable, what continues to improve the care delivery parameters that we all care about."

Nash agreed wholeheartedly with this particular assessment, adding that the coronavirus managed to break through the regulatory logjam, resulting in more transformation in 90 days than in the previous nine years. "Nothing like an emergency and a burning platform to create social change," he quipped.

As Nash sees it, the regulatory shift is going to go further, bending towards a change in home health, moving beyond just simple home care with acute care and chronic care becoming part of the equation.

"Companies that are already doing this, they are all part of this movement to get care out from the super expensive four walls of the hospital, where everything has to be cross-subsidized, and get it into the home, where it's safer, fewer errors, there's less opportunity for infection, fewer falls, and all the rest," said Nash. "This is just the beginning. It's great that CMS figured it out in time in an emergency, but I think the fundamentals are all pointing toward this. Not just a primary care doctor doing his visits online, I think it's an absolute paradigm shift out of the hospital and doing it all remotely."

Democratizing Data

To preface the next topic, Maheshwari pointed out that one of the foundational puzzle pieces for giving contact-free care delivery its true paradigm-shifting potential is the accurate, free-flowing exchange of data. Previously siloed for many years, available toolkits and processes found in data mining, artificial intelligence, and machine learning have completely altered and transformed the ways patients can be given the care they need. The real question Maheshwari posed to Nash and Saurabh is: How far can such technological utilization go from where we are now?

Nash's vision looks beyond the standard electronic health record—a product that was designed for billing—towards something new, an existential "2.0" update where patient data starts to be not only collected but analyzed. "We've got to go from EHRs to registries to artificial intelligence, and I'm pretty confident we are deeply along this road," he said. "This progressive use of the data is like blood flow in a physiologic system. But data by itself, without actionable information, is not usable. So we've got to get from the data actionable information."

Building off Nash's comments, Saurabh argued that if true data democratization becomes a reality, the act of collecting cannot be an end in itself. There needs to be a genuine thought process about the why of it all. "I sort of start at the other end of the whole thing, which is the question around what are we fundamentally trying to solve?" he explained. "We all want to reduce healthcare costs. We want better quality, but we're sort of really getting down one level deep."

From Saurabh's point of view, despite having such an abundance of evidence-based medicine, there continues to be huge variation in the actual type of care that's delivered at the local market level. "That alignment on the problem you're trying to solve is something we need to spend more time on," he said. "And I think if we can do that, you'll find that people naturally come together. We get very excited about connecting sources of data but are not always being really clear about why we are trying to do that."

Once again turning to the role of government in this transformative data-sharing, Nash feels that the only thing it needs to do is mandate interoperability,

continue to refine the online language, and then just stay out of everybody's way. Unfortunately, Nash explained, the current administration has actually walked back a number of interoperability initiatives during the pandemic, which isn't helping in the current state of the industry. "A lot more could be done to mandate interoperability, which would go a long way toward making the data flow smoother with fewer restrictions and with fewer breakages," he said.

Value-Based Care

Because no discussion on the greater trends of the American health industry would be complete without the topic of value-base care, the final point of conversation turned to this shift in payment models. Maheshwari wondered where it is ultimately going to go.

Saurabh advocated a need for acceleration. "Unfortunately, as much as we talk about value-based payments, we are fairly incremental in how we execute on them," he said. "This idea of moving toward a shared responsibility around the patient between payors and providers, this notion of moving to real risk is more often than not a nice headline."

Saurabh argues that incentives alone are insufficient, that payors and providers need come together and build a shared infrastructure or leverage an existing infrastructure to invest in the capabilities around managing risk as an entity. "If there was a moment in time that really underlines how flawed fee-for-service is, I think that moment in time is now," he added. "We don't really have a choice but to accelerate the transition to value-based care. But it needs to be real. It needs to have infrastructure associated with it, and we need to be able to link it to actual things that drive physician behavior, as opposed to this notion that we'll create incentives and the world will turn around them."

Nash concurred with his colleague, stating, "I hope that the burning platform of the last 90 days is the death knell for fee-for-service and private practice. We've been talking about this now for a decade, and once again raise your hand if you think the system that brought us to the precipice is the same system we need to get us out of the hole. From my perspective, we are inexorably further down the road than ever before, and the whole notion of, 'Come back and we'll restart the utilization engine and everything will be fine with more heads in the beds,' it's just not true. It might be a short-term economic solution, but it doesn't create health." Nash predicts that in the wake of the coronavirus, there's no turning back in the movement to value-based care.

Managing Costs

Considering these macro trends and their implications for key stakeholders, Maheshwari asked his panelists to offer a final thought on what needs to be accomplished among payors and providers to make a "blue sky picture" future.

For Saurabh and Nash both, there first needs to be a consensus on the industry's biggest problem, which is the fact that it is just too expensive. Healthcare costs should not be more than a family's mortgage. While the building blocks for something better, something transformational are there, Saurabh and Nash argue that there needs to be a willingness and execution from both the payor and provider.

Going a bit further in the assessment, Nash predict two inexorable trends. The first is what he calls the emergence of the "pay-vider," new joint ventures between the traditional for-profit payors and provider organizations, "because providers need to learn how to deal with risk, and payors are experts at managing risk." The second observation stems from the fact that the for-profit managed care industry has developed a massive cash war chest as a result of the unanticipated decrease in medical spend thanks to COVID-19. Nash predicts that providers are going to use that cash to help create and capitalized these new relationships with payors.

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