COPE HEALTH SOLUTIONS

Webinar Q&A

Health Plans and Covid-19: Immediate Actions and Strategic Considerations

April 29, 2020

1. **What are your thoughts on the multi-organ effect of Covid-19 and the health plan infrastructure needed to manage this complex disease process?**

   As we learn more about the Covid-19 virus every day, it has become more apparent that it is a microvascular disease as much as it is a pulmonary process. While many of the mortalities seem related to the pulmonary process and the inability to oxygenate even while mechanically-ventilated, the most severe seem also associated with a cytokine storm or "run-away" immune system. However, those who recover from the pulmonary process as their immune system works to clear the virus are increasingly experiencing severe co-morbidities, including strokes and renal disease requiring dialysis.

   Health plans can build partnerships with dialysis providers and coordinate with stroke centers to help.

   Understanding what is happening clinically offers new opportunities to simplify Covid-19 related billing and payment for providers. Furthermore, keeping a good communication channel with provider partners on how treatments and screenings are evolving can offer insights for coverage and cost estimates going forward, and perhaps even ways to incentivize a coordinated response.

2. **Please explain the "file and use" issue.**

   Health plan filings in California related to health plan response to Covid-19, such as provider contract changes, administrative services agreement/vendor contract changes and marketing and advertising materials, will be considered "file and use" filings. That is, California health plans will not need to wait for California Department of Managed Health Care (DMHC) approval before implementing changes. However, health plans should consult their assigned reviewers via email regarding a telehealth proposal to use during the Covid-19 state of emergency. In addition, for any California health plan filings required by an Undertaking, if the plan wishes to seek an extension for the filing, the plan should consult with the plan's assigned reviewer in the Office of Plan Licensing.

   https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL%2020-015%20%20COVID-19%20Temporary%20Extension%20of%20Plan%20Deadlines.pdf?ver=2020-04-13-170810-493

   For other states, there will likely be similar considerations related to filings; it important to understand the way this is handled state by state.

3. **Can you confirm Medicare for telehealth will only pay for audio with video?**

   Yes, as of April 29th, Medicare only reimburses for telehealth when a provider uses an interactive audio and video telecommunications system that permits real-time communication.

Plans may wish to liberalize their own coverage policies versus following strictly fee-for-service Medicare framework. The Centers for Medicare and Medicaid Services (CMS) has given plans the broad ability to modify coverage during the pandemic.

4. Lloyd Dean wrote a piece about the "New Normal" post-Covid-19 impact on Social Determinants of Health (SDOH) and Health Disparities and Health Parity. What are your thoughts?

Health plans need to assess the specific social determinants they want to target, set an expectation and measurements on the anticipated changes, decide on the interventions they will use, and determine how they will measure the impact the interventions have on the total cost of care. The Covid-19 crisis has created additional barriers to health that extend beyond the boundaries of the poorest of communities. Provider networks services have been disrupted. Many patients, especially those in high-risk categories, may not be able to access services or carry out their treatment plans as services have been constricted and travel restricted.

As plans consider their strategy around SDOH, they should consider a three-pronged approach:

First, plans will need a strategy to support the community in addressing challenges through investments with a reasonable timeline for return on investment (ROI), targeting such investments in hotspots for vulnerable members, high incidence of chronic disease, and avoidable utilization. It requires insights to the drivers of these disparities specific to that community and collaborative partnerships with private and public community-based organizations (CBOs) to directly tackle these disparities and inequities. Care should be taken to select determinants that can be measured and correlated with well-defined interventions.

Second, plans need to consider how they select a network of contracted CBOs and the potential need to support them through investments in capacity building and infrastructure. Over time, they can be contracted, incentivized, and integrated into the care model. If the objective is to bring interventions intended to impact social determinants into the main stream, like effective evidence-based medical interventions, we will need to prove that they are effective and replicable. The CBOs responsible for implementing them will need to document the interventions, dates and outcomes, and the health plans will need to modify their systems to reimburse the CBOs and collect the data points needed to analyze the impact on quality and the total cost of patient care.

Third, to lower health care costs, plans should make care accessible and support upstream and post-acute care management efforts in the home and community through their provider contracting structure. Societal expectations have been changing and will continue to change to expect a more holistic care management model inclusive of CBOs. Health plans are often in the best position and have the most comprehensive information to help support and coordinate non-medical services such that services are well defined, consistently available and meet key quality metrics – just as with medical care. For example, home-based care management programs, remote patient monitoring and asynchronous communication platforms with their providers are all things patients will need and are interventions and services that improve outcomes, prevent avoidable acute episodes and conserve premium dollars.

We anticipate interventions that target SDOH will have an even more important role in health care post-Covid-19, particularly with tens of millions of people losing their jobs and becoming newly at risk for food, housing and other insecurity, transportation challenges, behavioral health crises, etc. This crisis is an opportunity for plans to refine their SDOH and CBO strategies and measure the effectiveness of interventions.

5. **Will the National Committee for Quality Assurance (NCQA) and Healthcare Effectiveness Data and Information Set (HEDIS) be adjusting benchmarks?**

   There has not been an official announcement regarding adjusting benchmarks, but we are seeing adjustments being made to specific quality programs due to the Covid-19 impacts to quality performance. CMS has eliminated requirements for the collection of HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data for 2020 for Medicare Advantage plans. As of April 29th, NCQA stated it did not intend to include Health Plan Ratings for Accreditation in 2020. State regulators may follow suit for Medicaid requirements for their individual quality programs so it is important to pay close attention to changes made so health plans can follow suit with their provider network.

6. **What role does "texting" apps have to increase effective communication between physicians and patients?**

   Texting apps can help provide real-time communication and engagement with providers and patients in a secure and HIPAA compliant manner. In many situations, texting apps can help enhance employee workflows, increase productivity and raise the standard of patient healthcare. The “on demand” features provided can help keep patients connected to their physicians and also help avoid unnecessary emergency room visits. We expect to see this trend grow post Covid-19. Some apps leverage bots and Covid-19 screening to automate some interactions, reducing staff burden and obviating need for in-person visits. These texting services can be part of a larger suite of remote monitoring and/or home-based care management services provided to members, particularly those at risk for Covid-19 complications.

   Some providers are making investments in these tools, accelerated now with the relaxed regulations around reimbursement for teleservices. Plans can decide to pay for these services going forward and reimburse virtual visits at equal or comparable rates to in-person visits, and provide reimbursement for asynchronous patient interactions. Under capitated arrangements, incentive alignment may be sufficient to support these provider efforts. Some health plans have invested in these tools themselves and provided them as a benefit as a differentiator.

7. **What should you do with providers in VBP that you know aren’t going to hit their metrics?**

   It is important to evaluate your VBP arrangements carefully and determine if providers will be at a disadvantage based on the Covid-19 impacts to utilization. Hold joint meetings with your providers to discuss things that can be done to help them better achieve quality metrics and if concessions can be made on cost targets to help keep providers motivated to continue risk-based agreements.

8. **I'd like to know how health plans at at-risk providers are going to handle the 2020 VBP arrangements and how to factor the unusual claims and clinical affects into future years' benchmarks. I'm also interested in quality program mitigation - on top of financial ones. Quality scores will suffer with the inability for members to get into their doctors office.**

   For 2020 VBP arrangements, health plans will need to examine the original budgets set for the year carefully and determine if concessions should be made based on the significant shift in volume and utilization of services. It may be too early to determine the impact of the 2020 on 2021 budgets, so careful financial modeling over the next few months can help better predict 2021, along with documenting key assumptions on future volumes and service mix.

   Quality scores will suffer so supporting providers with helping to close care gaps through telehealth visits and other member outreach measures will be important. Health plans should follow suit with what regulators are doing with quality measures to pass on the same concessions to their provider network *(refer to question 5 for more information)*.

9. **With the providers hurt by the inability to take visits, we expect them not to hit quality measures. Should we consider restructuring the quality metrics?**

   Providers will struggle to hit their quality measures due to the reduction of visits and encounters during the pandemic. CMS has waived the first six months of 2020 for the purposes of their Medicare quality programs and this is something health plans may consider doing as well. There can be considerations made around using 2020 as a “pay-for-reporting” year to help continue to incentive behavior changes with providers while still promoting overall quality performance.

10. **Which financial data metrics should be analyzed to arrive at a Covid-19 factor in a capitation rate?**

    Health plans should work to identify three categories of Covid-19 related utilization:
    1. Utilization and costs related to confirmed cases
    2. Utilization and encounters to rule out Covid-19
    3. The cost impacts of delay in care should be measured. This is the most complex Covid-19 impact to measure. This involves more than elective surgeries/procedures. Routine care, medication for chronic conditions and diagnostic procedures that created delays for conditions known to become more acute and more expensive to treat with delayed interventions should be collected and the estimated increased cost based on historical data should be quantified. Organizations that do not have the internal resources to complete this analysis should consider outsourcing it. Understanding the impact is important for rate setting and can lead to justifying investment for disaster response and preparedness.