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Health Care on the Other Side: Changing Payer-Provider Relationships in a Post-COVID-19 Landscape

Hospitals, physician practices, and other provider organizations are dealing with unprecedented challenges in the present public health emergency following the spread of the novel coronavirus (COVID-19) pandemic. Providers can expect to continue feeling the impact of COVID-19 long after the public health crisis abates. Given that payers control a significant portion of providers' revenue, the financial pressure on providers and successful navigation of the post-pandemic environment will require providers to reset their relationship with payers.

In the pre-pandemic world, providers operated in a landscape characterized by steady and growing patient volumes, broad health insurance coverage, and generally adequate reimbursement. This landscape allowed providers to implement value-based payment models with insurers and other payers. COVID-19 has fundamentally disrupted this landscape. Providers must now look to adapt their payer relationships accordingly. This joint publication of Jones Day's lawyers and BDO outlines some of the current trends providers are facing with respect to their payer relationships, and offers insight on strategies for providers when working with payers in navigating their post-COVID-19 relationships.

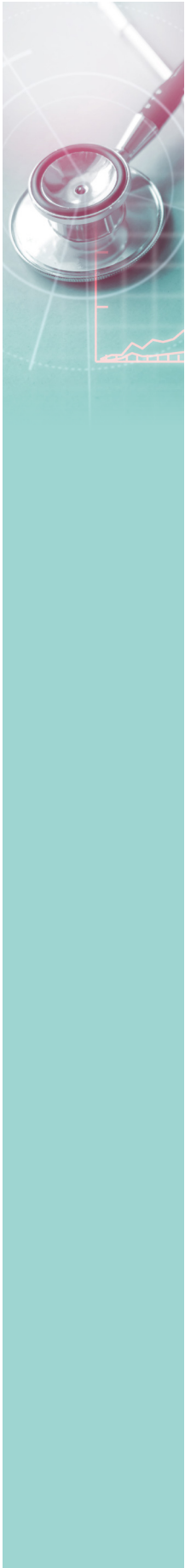


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CURRENT TRENDS OF PAYER-PROVIDER RELATIONS DURING THE COVID-19 PANDEMIC

The current trends in the health care landscape will determine what new payer–provider relationships will look like moving forward. The following are among the most significant trends that are impacting the payer–provider relationship:

Increased Financial Challenges from Lower Patient Volumes and Revenue

In order to preserve resources to deal with COVID-19 patients, hospitals and other providers paused non-emergent elective services. Though hospitals and certain physician practices are experiencing a near-term uptick in COVID-related patient cases, and the current restrictions on elective procedures will eventually be curtailed, the cancellation of elective procedures and outpatient services has significantly reduced the volume and associated revenue for many providers. The impact on providers varies depending on whether a provider is for-profit or not-for-profit, large or small, rural or metropolitan, as well as based on case-mix and historic specialty. The revenue loss will be especially acute for hospitals, physician groups, and post-acute providers.

Invalid Actuarial Assumptions and Financial Modeling

The actuarial assumptions and financial modeling around utilization and unit price that payers and providers relied upon in formulating reimbursement methodologies and rates may no longer be valid or credible as a result of the disruption caused by the pandemic. These actuarial assumptions are critical for a percent of premium, capitation, and value-based care incentive arrangements. Similarly, the unprecedented shift in patient and service mix has rendered previously negotiated unit prices insufficient for most providers' post-pandemic budget needs. Payers and providers alike recognize that the disruption in actuarial and other assumptions that are the foundation of current payer contracts warrant changes in contract pricing structures, reimbursement methodologies, and contractual terms.

Disrupted Value-Based Care in Pay-for-Performance Models

The pandemic has disrupted providers' ability to manage proactive quality improvement programs, including the CMS Medicare Shared Savings Program (MSSP), bundled payment programs, and similar value-based care programs. These

programs contain clinical or administrative initiatives tied to performance metrics, some of which may carry financial implications. Because of the disruption from COVID-19, providers may not be able to achieve performance, and comparisons to prior-period performance as a metric have become less credible. Providers' inability to satisfy performance metrics will adversely impact value-based compensation.

Given the lag between performance and payout, the financial consequences may not be immediately obvious and will likely show up on financial reports later. Providers may feel this impact across multiple years, as many value-based care agreements are multi-year, with considerable revenue and reimbursement tied to year-over-year performance improvement.

Increased Retroactive Disenrollment Among Patients

The full extent of the pandemic's impact on employment has yet to be seen. It is already apparent, however, that as more people lose their jobs, the percentage of the population covered by health insurance will fluctuate greatly. For some patients, their coverage may change multiple times within a plan year or shift from employer-based coverage to coverage through Medicare, Medicaid, or the Affordable Care Act's health insurance marketplaces. These market factors likely affect patients' payer mix and lead to increased retroactive adjustments to claims, eligibility, capitation, and incentive earnings. For example, monthly capitated payments are retroactively adjusted for changes in membership, with some changes going back 90 or more days. Even the fee-for-service arrangements will not be completely immune from the impact of retroactive disenrollment as payers may seek to recover claims paid for patients who were retrospectively determined to be ineligible for coverage. When retroactive changes to membership occur, providers lose revenue they otherwise anticipate retaining.



STRATEGIES FOR THE POST-COVID-19 PAYER-PROVIDER RELATIONSHIP

Payer contracts represent most providers' largest revenue and volume sources, and these contracts will continue to be eminently important in the post-COVID world. As providers assess changes in their operational landscape and plan for economic recovery, providers would be well-served by being proactive in understanding and implementing their payer contracting options. Below are a number of strategies that are worthy of providers' consideration:

Collaborate with Payers on Financial Relief Solutions and Additional Funding Sources

A number of payers have offered accelerated or advance payment programs for providers. While not all payers have formal programs, many of them are willing to work with their providers to craft a customized, provider-specific relief plan. Feasible options will be partly determined by the type of provider entity and the type of payer contract held by the provider, and could be in the form of future premiums, incentive accruals or estimates, current accounts receivable, or zero- or low-interest loans.

Providers may also consider other potential sources of financing by leveraging provider organizations (ACOs, CINs, MSOs, and others). Many ACOs and CINs have already had agreements in place with payers for shared savings or other value-based arrangements. They are in an ideal position to secure accelerated payments or advances from payers on behalf of their participating providers. Seeking new or maintaining existing affiliations with risk-bearing provider networks could also be a way for providers to seek additional revenue stability and obtain access to a more stable patient base. A further advantage of the ACO participating in the MSSP is the ACO's ability to utilize Stark Law and Anti-Kickback Statute waivers providing immunity from prosecution under these law. These MSSP ACO waivers will survive the end of the public health emergency and can be used to create pro-Triple Aim incentive payments beyond current regulatory limits.

Restructure Payer Contracts

Providers may consider using this opportunity to open their payer contracts for renewal negotiations to secure needed cash flow and reset pricing. When a negotiation makes sense

for a provider, the provider should focus on addressing radically changing health care economics, optimizing reimbursement, and securing appropriate contractual protections.

Simply seeking rate increases is likely to be a shortsighted and unsuccessful strategy. Rather, providers should consider how their current reimbursement model might be reevaluated in the context of their payer contracts. For example, in light of the impact of the pandemic on the industry, providers should ask whether a fee-for-service arrangement is still right for their organizations or whether providers should explore alternative reimbursement methodologies, such as a greater mix of capitation, percentage of premium or other models. These methodologies may not only offer cash flow stability on a short-term and longer-term basis but also may mitigate against risk relating to significant shift of patient mix and services. Such an evolution in reimbursement will necessarily impact other contractual provisions such as term, termination, audit rights, prompt pay and offset, and similar provisions.

Diversify Services Through Telehealth and Other Remote Care Services

The COVID-19 pandemic has put telehealth and other remote care services (e.g., medical homes and remote care management) in the limelight. Stakeholders are predicting that a widespread adoption of telehealth and remote care services by patients and payers is now inevitable. Many payers have also been more willing to reimburse telehealth and remote care services. As providers consider requesting payers to add telehealth and remote care to their payer contracts, they must have a solid understanding of the economics of such services, including market rates for payer reimbursement and

typical provider margins. To successfully implement these alternative remote care services, providers should strategically turn their existing telemedicine and remote care capabilities into full virtual health workflows and engage and activate their patient base to leverage virtual health options.

Limit Risk Related to Future Retroactive Disenrollment

The trend toward greater retroactive disenrollment could especially impact capitated and other risk-bearing providers in addition to fee-for-service arrangements. Given that such retroactive adjustments are likely to exceed normal levels and could result in severe provider financial stress, providers should seek to limit their risk related to future retroactive disenrollment, to the extent permitted by law, such as by limiting lookback periods, clawback rights, and other similar repayment terms.

Reassess Nonpayment Contract Terms

Looking ahead, the pandemic has highlighted the need for providers to build in contractual protections for pandemic and other national and local emergency events (floods, hurricanes, and the like). These events materially and adversely impact cost, access to services, and patient volumes. The structure of these provisions will depend on the overall economic model of the payer-provider relationship. By way of example, current *force majeure* clauses may not be designed to excuse performance temporarily or even permanently in response to this pandemic or other emergency events. Therefore, providers will need to analyze their contractual rights and obligations under each payer contract with respect to these emergency situations.

Prepare for Challenging Negotiations with Payers

Payers and providers are likely to have significantly different views on what contractual modifications should be implemented to address the providers' needs during the post-pandemic recovery. Accordingly, the industry is primed for a round of contentious contract renegotiations—many off renewal cycle—as health systems, hospitals, and physician groups attempt to adapt to new financial realities.



KEY TAKEAWAYS

1. COVID-19 has disrupted the sense of normalcy in health care delivery, and its disruptive impact on the payment and delivery system will be felt for the foreseeable future. The relationship between payers and providers must be redefined in the post-pandemic health care industry.
2. The current trends affecting health care operations associated with COVID-19, particularly those impacting providers' current relationships with payers, are providing actionable insight into how the relationship between payers and providers must evolve.
3. Providers must decisively define a forward-looking strategy that identifies and plans for a payer contracting "reboot" that includes restructuring their payer contracts and reimbursement models in the post-pandemic landscape.

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