COVID-19 Impact on Health Service Delivery

MODERATOR: SUDHA SHENOY, FSA, MAAA, CERA
PRESENTERS: ERIK JOHNSON, BA, MBA
           KATHERINE HEMPSTEAD, PHD
           STEPHANIE ENZMINGER, FSA, MAAA

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COVID-19 Impact on Health Service Delivery

ERIK JOHNSON
The Post-COVID Era for Health Systems
Some Principles for Pacing and Priorities

COVID-19
+ stay informed

• July 2020
Complex questions that demand simultaneous answers

**What do we do about what’s happening now?**
- Responding effectively to the initial surge in the COVID-19 pandemic

  **Timeline:** February – May 2020
  **Major objectives**
  - Maximize supply
  - Accommodate demand
  - Reduce spread
  **Key challenges**
  - Supply constraints
  - Predicting and accommodating demand
  - Reducing speed

**How do we get to a ‘new normal’?**
- Establishing cadence for the gradual reopening and repositioning of services while maintaining pandemic readiness/response

  **Timeline:** May/June 2020 -- beyond
  **Major objectives**
  - Prioritize pent-up demand
  - Increase testing available
  - Establishing new “system-ness”
  - Maximize access to/generation of testing and surveillance data
  **Key challenges**
  - What/when services/facilities to re-open
  - Quantifying financial impact on system of initial surge
  - Access to capital
  - Sufficient staffing and supplies
  - Identifying key partners

**When is the next surge going to hit our market?**
- Preparing for the second surge in the pandemic and establishing a permanent footing for hot spot response

  **Timeline:** April 2020 - 2021
  **Major objectives**
  - Predict and manage hot spots
  - Sustain business/clinical operations
  - Containment and public health coordination
  - Staying open while accommodating new surge demand
  **Key challenges**
  - PPE and testing supplies in sufficient volume
  - Staffing sustainability
  - Local/county level surveillance data
Ten assumptions to keep in mind on the other side of the initial surge

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<tr>
<td><strong>1</strong></td>
<td>There will not be a vaccine for 12-18 months.</td>
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<td><strong>2</strong></td>
<td>There will be ongoing cases and local hot spots arising for the foreseeable future.</td>
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<td><strong>3</strong></td>
<td>Localized surges and hot-spotting will accompany the gradual re-opening of the economy</td>
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<td><strong>4</strong></td>
<td>Even after the gradual re-opening, a recession is likely to be prolonged</td>
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<td><strong>5</strong></td>
<td>There will be a polyglot of policy responses at the Federal, State, and local level requiring adaptation</td>
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<td><strong>6</strong></td>
<td>Telehealth will be an expectation and a need-to-have in the months and years ahead</td>
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<td><strong>7</strong></td>
<td>Markets that had initial success with social distancing/shelter in place will have less herd immunity in the immediate aftermath</td>
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<td><strong>8</strong></td>
<td>Payer mix will veer sharply toward exchange and Medicaid-based coverage</td>
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<td><strong>9</strong></td>
<td>Not all service lines will be brought back online simultaneously</td>
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<td><strong>10</strong></td>
<td>Despite pent-up demand, consumer response may lag as confidence needs to rebuild</td>
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A new financial model in post-COVID-19 era

Endemic Scenario Projections
Development of 3-5 deterministic scenarios based on quartile outcomes of Monte Carlo Simulation.

Impact on Care
Scenario driven modeling tool providing estimates of financial impact with the ability to inform future strategies and tactics.

Payer Shift Projections
Providing estimates of payer mix shifts to inform future financial implications.

Financial Model Projections
Scenario 1
Scenario 2
Scenario 3
Scenario 4

Employer
Sponsored
Medicaid
ACA
Uninsured
All Other

Before COVID-19
After COVID-19

7%
8%
9%
4%
2%
3%
6%
4%
10%
12%
20%
70%
11%
10%
5%
10%
10%
15%
17%
28%
75%
15%
14%
9%
14%
14%
21%

Surveillance Capabilities
Multiple metrics to be monitored and interpreted to identify changes in Covid-19 patterns, which will continually inform our integrated capability inputs.
This is going to be both a slope and an intercept challenge

Preparing for new inpatient economics

The Mirage of Rapid Volume Recovery
- While health systems continue to work through the backlog created by a three-month shutdown, a lot of volume has permanently disappeared
- Summer volume not indicative of autumn volume
- Inpatient cases may be up in near-term, but ER volumes remain depressed

Will Demand Patterns Ever Recover?
- Slope of demand very much in debate; patient self-care over the last three months may have altered view of how to use the health care system
- Drop in both the slope and intercept will spell a new future for inpatient economics and spur a migration to value-based care
Preparing for a gradual, sequenced launch

- Model/assess where the market is in recovery
  - Assess pace of recovery to determine likelihood of sustained second surge or isolated hot-spotting in a market
  - Demand/facilitate greater testing for confirmed cases and antibody presence
  - Herd immunity likely inversely proportional to success of initial stay-in-place policies at state/local level

- Prioritize resumption of activities
  - Rank order service lines by most urgent/non-COVID pent-up demand (e.g., cancer surgeries) for initial opening
  - Ensure reliable supply chain of PPE as well as appropriate mix of clinical staffing in place
  - Set cadence of service line re-starts according to emergent/urgent (PPD), planned (3-6 months), cosmetic, and secondary-surge capacity

- Do not go alone
  - Collaborate with delivery chain partners to ensure that referrals can be fulfilled and system can accommodate sufficient volume
  - Key partners include SNF (for Medicare acute and chronic), specialty pharmacies, labs, and physician/hospital collaborations
  - Coordinate with public health agencies to monitor test reporting

- Public health is part of the job
  - Initial surge exposed gaps in public-private sharing of information around testing, asset allocation, and testing results
  - Increased importance around public health collaboration as initial surge exposed socio-economic health disparities
  - As coverage shifts to exchange and Medicaid, emphasis on social determinants will only heighten

- A new financial model for the enterprise
  - Gradual phase-in of service lines/urgent demand will require detailed financial projections to manage variable costs
  - Need for scenario modeling around consumer reluctance to re-enter the health care ecosystem for elective/cosmetic procedures
  - Telehealth represents an opportunity for improved throughput; impact on productivity for practices requires modeling
COVID-19 has triggered dynamics favoring VBC adoption

Volume-based business models are at risk in many markets

Delivery model is shifting to embrace VBC trends

Solvency crisis likely to trigger consolidation

- Trend toward self-care during the pandemic suggests volume will drop and become less reliable, particularly in a pre-vaccine world
- Cash flow disruptions in a fee-for-service model have proven dire – requiring greater predictability
- Shift in payer mix for 2020-2021 will result in much lower fee-for-service rates for the same amount of care
- Rapid shift to telehealth makes extension of primary care/patient engagement easier and more efficient
- Accelerated shift to low-cost sites of care, avoidance of ED will reward systems with significant ambulatory footprints
- Home-based care/aging in place will demand a focus on preventive care and social determinants
- Value-based care demands scale – in ability to provide care and aggregate populations
- Liquidity crisis – leading a solvency crisis – likely to trigger a spike in acquisitions, allowing systems to get bigger and expand their footprints
- Such acquisitions likely to lead to vertical integration that can support provider-sponsored plans
Taking risk has taken on a new imperative

Moving toward Disrupter status can involve aggressive move to total-cost-of-care, capitated contracts. In the post-COVID-19. Such contracts, while entailing substantial actuarial risk, can move providers toward more stable cash flows, reward early coordinated surveillance efforts to intervene in potential secondary infection surges, and reward widespread adoption of new delivery models – including telehealth and site-of-service optimization – that accelerate primary and preventive care to attributed/enrolled populations.
Building a patient-centric health management ecosystem

- Patient experience
- Population health management
- Continuity of care
- Health analytics
COVID-19 & PHYSICIAN PRACTICES

KATHERINE HEMPSTEAD
Visits: Rebound, but plateau

The number of visits to ambulatory practices had declined nearly 60 percent by early April. Since that time, the numbers have rebounded substantially, though the rebound may be beginning to plateau.
Medicare has recovered the most

Since the nadir of visits in late March, there has been a substantial rebound in visits among people covered by Medicare. The rebound among people covered by Medicaid has lagged.
Differences by specialty

In the past week, visits to some clinical specialties, such as dermatology and rheumatology, have returned to their baseline rates. The cumulative decline in visits from the start of the pandemic is greatest among pediatricians, pulmonologists, and several surgical specialties.
Impact of Telehealth

Initially, as in-person visits dropped, telemedicine visits increased rapidly. Since that peak in mid-April, telemedicine use has begun to decline, though it remains substantially higher than prior to the pandemic. We present telemedicine use in different ways in the following two graphs.

The decline among in-person visits is steeper than the decline among visits of any type (telemedicine and in-person). The gap between the two lines is driven by the use of telemedicine.
Telehealth visits have plateaued
Job losses and gains

Since February: 1.6m health care jobs lost 43% re-gained so far
Economic impact of COVID

• Study – (Basu et al, Health Affairs) - microsimulation of revenue impact
• 4 kinds of practices
• Findings:
  • Average loss $67,000 per MD in 2020
  • Nationally - @220,000 practices - @ $15b – smaller practices hit harder
  • Worse outcomes if telemedicine parity is reversed
  • CARES payments not sufficient
• Recommendations:
  • Future: reforms that encourage transition to capitation
  • NOW: make small capitated payments to PCPs
Value Based Payment improved COVID response

Recommendation: Promote transition to VBP
Policy issues

• Financial assistance
  • Federal response
  • State Medicaid programs

• Value Based Payment
  • CMS demonstrations

• Telehealth
  • Temporary federal waiver
  • State variation
  • Parity question
  • OOP cost waivers
Will financial vulnerability accelerate ongoing trends toward consolidation and/or “retailization” of PCP?

Walgreens/Village MD
“Re-imagined primary care delivery”
Will build 500-700 clinics over next 5 years
“Neighborhood Health Destinations”
“PCP is supported with data and analytic tools to enable full risk taking.”
Will compete with CVS Health Care Hub, etc.
Not everyone is a fan

A well-functioning system for delivering primary care is essential for keeping people healthy. How best to structure and staff that system are topics of ongoing debate. For decades, primary care physicians and the model of the physician-owned practice remained the de facto way to bring essential diagnostic and treatment services, chronic disease management, and prevention and wellness to patients. That’s changed over the past couple decades as primary care physician shortages, and the rise of specialty medicine, retail health care, and the modern quality movement with its hyper focus on cookbook medicine have conspired to undermine a physician-centric primary care delivery system.

A new narrative now focuses less on the central role of the primary care physician and more on the roles of technology, non-physician staff, standardization, and corporate medicine in getting primary care to people on time and at lower cost.

Timothy Hoff, STAT July 13, 2020
COVID-19 Impact on Health Service Delivery - Long Term Care

STEPHANIE ENTZMINGER
COVID-19 Impact on Post-Acute and LTC Facilities

- How did we find ourselves here?
- What’s happening now?
- What does the future hold?
The Perfect Storm for Post-Acute Care

- COVID ICU discharges require lengthy rehab
- Skilled Nursing Facility residents generally have greater COVID-19 risk
- Limited benefits (e.g. sick pay) for staff

Vulnerable Populations in Long-Term Care Facilities

COVID-19 Cases and Deaths in LTC Facilities as a Share of Total, by State

Source: Kaiser Family Foundation, accessed 7/11/2020
Which Long-Term Care Facilities Are Affected?


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<tr>
<th>Location</th>
<th>Without COVID-19</th>
<th>With COVID-19</th>
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<tbody>
<tr>
<td>Urban</td>
<td></td>
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<tr>
<td>Rural</td>
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<table>
<thead>
<tr>
<th>Medicaid Share</th>
<th>Without COVID-19</th>
<th>With COVID-19</th>
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<tr>
<td>Low (≤ 85%)</td>
<td></td>
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<tr>
<td>High (&gt; 85%)</td>
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## Evolution of Federal Guidance

<table>
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<th>Month</th>
<th>Events</th>
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| March | • Recommended visitor restrictions, cancellation of group activities  
       • Postponed routine inspections |
| April | • Recommended separate facilities for COVID-positive patients  
       • Full PPE required for care of all residents if transmission occurs |
| May   | • Mandated reporting of nursing home cases and deaths  
       • Reopening guidance issued |
| June  | • Ended data submission waivers  
       • Medicare to cover diagnostic testing for Nursing Home residents consistent with CDC guidance |
| July  | • Announced additional support for facilities with infection control issues |

Source: CMS Newsroom
Variations in State Guidance

State Guidance on Staff Screening in Assisted Living Facilities

- **Require**
- **Recommend**
- **No guidance**

Source: Kaiser Family Foundation, accessed 7/11/2020
The Balance Sheet

• Cancellation of inpatient procedures affects Medicare revenue
• Recovering COVID patients require beds
• Increased overhead for PPE and infection control
• Limited government assistance

Where Have the Claims Gone?

Source: Barnett et al. (2020) “Mortality, Admissions, and Patient Census at SNFs in 3 US Cities During the COVID-19 Pandemic”.

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The number of weekly facility admissions per 1000 SNF residents for the Cleveland, Detroit, and New York City metropolitan areas is shown in the graphs. The data is presented for the years 2019 and 2020.
Next Steps: Short-Term

• Surveillance testing
• PPE
• Sick leave for staff
• Infection control protocols
• Resident morale
Next Steps: Long-Term

• Relationships with hospital systems
• Alternative payment models
• Aging in place
  • PACE
  • HCBS Waivers
• Support for LTC workforce
Questions?
Speaker Bios
Sudha Shenoy, FSA, MAAA, CERA

She has over 25 years of actuarial expertise various actuarial positions across payers, providers as well as general health care consulting.

Her clients have included provider groups, state governments and the Center for Medicare and Medicaid Services (CMS).

Her experience covers all lines of business including Medicaid rate setting, ACOs, Medicare bid review & audit, value-based purchasing, provider risk contracting and reimbursement modeling.

Sudha is a fellow of the Society of Actuaries (SOA), Member of the Academy of Actuaries and a Chartered Enterprise Risk Analyst. She is an active volunteer on many SOA projects and is currently serving on the SOA Health Section Council. She has served on the Board of Directors of the SOA.
Erik Johnson, BA, MBA

• Erik is a **VP and National Practice Lead for Value Based Care, Optum Insight**
• He has broad experience in designing population health strategies for a broad array of providers. At Optum, he leads clients through the process of developing new value-based care strategies and operating models that rely on the sharing of risk between payers and health systems and the design and development of post-acute care networks
• In addition, Erik has extensive experience working with the **National Health Service (NHS) in the United Kingdom** as the NHS transitions its operating model toward one that is based on integrated care models and Triple Aim objectives
• He was most recently **Senior Vice President at Avalere Health**, where he ran its Healthcare Networks consulting practice and oversaw new product development
• Prior to joining Avalere, Erik Johnson was a **Managing Director with Manatt Health Solutions**
• He previously spent five years at the **Advisory Board Company** as Managing Director for its health IT and hospital finance research practices
• Erik has an **BA with honors and distinction from Stanford University and an MBA from the Stanford Graduate School of Business**
Katherine Hempstead, PhD

Katherine Hempstead is a Senior Policy Adviser at the Robert Wood Johnson Foundation. She works on health care issues, mostly those related to health insurance, costs, and access to care. In her work in the policy unit, she seeks to inform policy discussions at the federal and state level by making data and analyses widely available.

Hempstead joined the Robert Wood Johnson Foundation in 2011. Prior to that, she was the Director of the Center for Health Statistics in the New Jersey Department of Health.

Hempstead received a PhD in Demography and History from the University of Pennsylvania, where she also received a bachelor’s degree in history and economics.

She was a post-doctoral fellow at Princeton University’s Office of Population Research at the Woodrow Wilson School.

She frequently speaks and writes about health insurance and other health care topics.

She is also an active researcher and has authored numerous articles in the peer reviewed literature.
Stephanie Entzminger, FSA, MAAA

- Stephanie Entzminger, Consulting Actuary, Axene Health Partners
- She joined Axene Health Partners in 2018 and serves clients with her expertise in Long-Term Care
- She also provides a wide variety of actuarial services including provider contracting, health care analytics, strategic planning, IBNR estimation, dispute resolution etc.
- Stephanie assisted in the development of the AHP COVID-19 Planning Resource Model and has been active in recent COVID-19-related research and projects
- Stephanie previously worked in an insurance setting for Continental LTC, Inc. as a pricing actuary for their Long-Term Care business
- She has also worked in a consultant setting for Towers Watson in their defined benefit pension group
- She is a Fellow of the Society of Actuaries as well as a Member of the American Academy of Actuaries
- She currently serves on the Section Council for the Social Insurance and Public Finance Section of the Society of Actuaries
- Stephanie earned a Bachelor of Science in applied mathematics from Loyola Marymount University in Los Angeles, as well as a Master of Arts in mathematics with a concentration in actuarial science from the University of Texas in Austin