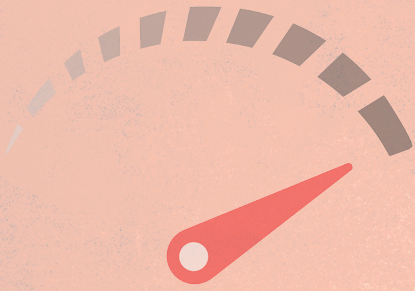


Risk Adjustment Never Sleeps



New RA Realities in *the Coronavirus Pandemic*

by Will Stabler

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Executive Summary

The COVID-19 pandemic has sent a tsunami through every industry on the planet, and those of us who work in the business of risk adjustment (RA) are not immune from its effects. Surviving this pandemic means toughing it out, but truly thriving through it is all about finding opportunities and re-imagining how we operate while we are living in a bleak new environment for doing so.

In this whitepaper I will look at the COVID-19 pandemic from the standpoint of its effects on the business of risk adjustment and the professionals working in this novel RA landscape. I will also consider changes that are already happening in the broader risk adjustment world in both the government and business sectors because of the pandemic, highlighting opportunities in where things are heading.



Where Are the Challenges and Potential Opportunities in the New Reality?

“From what we have seen so far, the only thing certain about COVID-19 is uncertainty. MA organizations and providers alike need to plan for today’s reality to be the new normal.”

What do we do now? What are the challenges and potential opportunities COVID-19 is already bringing to the RA business? In this whitepaper, I will explore the role of telehealth and look into opportunities of operational efficiencies, education and critical activities in pursuing maximum return, to include building more electronic retrieval capacity and EMR integration.

What happens when the team is completely back to work. Will it ever be? The lockdown will eventually end and all the pieces of the healthcare system will fall back into place, but likely not into the same space as they were before. Both health plans and providers will need to try to anticipate some of the changes so they are prepared to launch with all elements of people, process, and technology ready to go.

How do we navigate “pseudo normalcy” and what does that look like in risk adjustment? Eventually, pressure will ease on healthcare systems, and member outreach and support will need to begin to ramp up. How do we facilitate this contact with enhanced telehealth and online options? More information will need to be integrated into provider EMRs to facilitate these relationships. Also, the pandemic has the potential to greatly worsen the impact of social determinants of health (SDoH) as more and more people experience social isolation/loneliness, food insecurity and housing instability.

So, SDoH may need to be considered more broadly in medical management.

People with chronic disease will likely be much sicker after months of being told they can’t see their caregiver and not being properly monitored for their conditions. Care gaps that had been previously identified will remain unaddressed, so EMRs will need to be enhanced to facilitate better tracking. Ramping back up again will necessitate retrieving as many records as possible that might require in-person scanning in case “ramping down” again becomes necessary.

What do we do from here until 2020 year-end? From what we have seen so far, the only thing certain about COVID-19 is uncertainty. MA organizations and providers alike need to plan for today’s reality to be the new normal, so we need to adjust our mix of tactics. Procrastination on reporting is no longer an option.

Health plan/provider partnerships will be more important than ever in easing the burden of regulatory reporting requirements, improving care quality, and reducing costs. This will be our opportunity to strengthen them. This will also be the time to advocate with CMS to not only ensure that greater acceptance of telehealth becomes permanent, but also to encourage other approaches and models, including automatic revalidation of long-term conditions that do not go away.



The Coronavirus Pandemic Gives Telehealth a Big Shot in the Arm

On April 10, the Centers for Medicaid and Medicare Services (CMS) sent a letter to all “Medicare Advantage, Cost, PACE and Demonstration Organizations” that has been a long time in coming titled, “Applicability of diagnoses from telehealth services for risk adjustment.” The letter starts: “The 2019 Coronavirus Disease (COVID-19) pandemic has resulted in an urgency to expand the use of virtual care to reduce the risk of spreading the virus; CMS is stating that Medicare Advantage (MA) organizations and other organizations that submit diagnoses for risk adjusted payment are able to submit diagnoses for risk adjustment that are from telehealth visits when those visits meet all criteria for risk adjustment eligibility, which include being from an allowable inpatient, outpatient or professional service, and from a face-to-face encounter.”

Flash forward to summer 2020. Thanks to COVID-19, telehealth is apparently here to stay, if the current head of the Centers for Medicare and Medicaid Services (CMS) has a say in it.

“I can’t imagine going back,” said CMS Administrator Seema Verma at a STAT virtual event in early June. “People recognize the value of this, so it seems like it would not be a good thing to force our beneficiaries to go back to in-person visits” (Ross, 2020, June 9).

Indeed, in the pandemic environment, 89% of patients who have used telehealth say they were satisfied with the experience, according to a new national survey from the Alliance of Community Health Plans and the Academy of Managed Care Pharmacy. On the other hand, 42% percent of people say they are uncomfortable going to a hospital for treatment and 39% say they plan to delay future care. Also, while 58% of respondents view their physician as their most trusted source for information on the coronavirus, only 31% of them say they feel comfortable actually visiting the doctor’s office (ACHP/ACMP, 2020).

According to the results of another new survey of 1,800 patients nationwide from Doctor.com, 50% of respondents have used telehealth during the past three months. Of those, 83% say they will likely keep using telehealth even after the end of the pandemic. Three-quarters of respondents said

they would take telehealth appointments with a doctor they already had a relationship with. Also, more than half (55%) said they would take remote visits with a new doctor. Good news can also be gleaned from the survey in wellness regimens, care for chronic illness, and continuity of care, as 91% of respondents said they believe having care via telehealth would help them adhere to both appointments and medication regimens (Kitchen, 2020).

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I can’t imagine going back. People recognize the value of this, so it seems like it would not be a good thing to force our beneficiaries to go back to in-person visits.

-Seema Verma

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Based on this guidance for telehealth use, we in Medicare Advantage and risk adjustment need to keep up vigorous support and advocacy for the use of telehealth through in-home assessments or provider office leads. Urge provider offices that might not have previously established a capability to consider identifying a telehealth capability vendor that can be made available for their offices. Develop provider education on telehealth coding and documentation requirements. Consider

modifying provider incentives to encourage the use of this modality in assessing and managing patients.

Other ways to support provider networks in using telehealth include:

- Providing education about requirements of telehealth visits
- Providing sourcing options for those providers, typically smaller, that do not have telehealth capability
- Introducing temporary incentives to encourage telehealth visits, particularly in conjunction with Annual Wellness Visits (AWVs). This is a great modality for focused conversation about annual health and wellness planning and confirmation of long-term conditions.
- Identifying members and patients requiring support via telehealth for outreach.
- Supporting provider outreach through tools, scripting, and best practices. Layer in scheduling support for those providers that cannot address that on their own.
- Conducting outreach to members about telehealth options to ensure they are primed when providers conduct outreach.

The Coronavirus Pandemic Gives Telehealth a Big Shot in the Arm, continued...

This lockdown period is the prime time to take advantage of new telehealth opportunities that have been created by the pandemic in closing emerging care gaps that are likely being created by the crisis and resultant restrictions on access to care.

Where provider networks are not able to use telehealth, layer in telehealth in-home assessments for members. There can and should also be linkages with care management support as well as battery of assessments related to SDoH that provide referral points.

Expanding the Role of Telehealth

To help gain wider acceptance of telehealth, providers and health plans need to work together to improve our efficacy in capturing and recapturing Hierarchical Condition Categories (HCCs) through this modality. For many HCCs, we will need to innovate modifications to the telehealth visits to ensure we improve that efficacy.

This is particularly important with new patients. For example, in chronic obstructive pulmonary disease (COPD), heart arrhythmias, and coagulation defects, to name a few, we can recapture through modified telehealth visits for existing patients because we have the supporting lab work/monitoring data in the health record/EMR. Initially capturing those HCCs for new patients in a telehealth environment during a pandemic is another story, because that background monitoring and lab data is a challenge to collect. Creating solutions for these issues should be a priority once we begin to open up after the lockdown, especially if we need to go back to “stay at home” orders in the future. And we can start working on that now.

Providers and plans can utilize telehealth capabilities to facilitate Annual Wellness Visits (AWV) with members. In some ways AWVs are uniquely suited for telehealth visits. The focus is on care planning and confirmation of status of existing conditions that do not require new tests or diagnoses. To facilitate telehealth AWVs, plans should: 1) provide member incentives for completing AWVs (cost sharing for AWVs is already \$0); 2) introduce new or additional provider incentives for telehealth AWVs; and 3) activate members

about benefits of visits while addressing lingering doubts about the technology and interaction.

Another issue we need to solve related to telehealth on a societal/legislative level is broadband Internet access, which is a social determinant of health in the telehealth arena. According to Pew Research, in 2019, 73% percent of U.S. adults had high-speed broadband internet access at home. Among all age groups of adults except for those over 65, this ranges from 77% to 79%, but for those over 65, broadband access at home was at 59%, so there is a disparity there in the Medicare Advantage population (Pew Research, 2019).

Still, the same study shows that 73% of those over 65 use the internet, so a greater percentage of that age group is apparently able to access the Internet somewhere. Also, 91% of those over 65 reported having cellphones, but only 53% reported having smartphones. Similar disparities also occur among racial and socioeconomic lines.

For the highest risk populations with the greatest need, plans might consider very targeted distribution of internet enabled devices to facilitate telehealth interactions with providers and plan care teams.

Teleworking for Better Partnerships

Again, our industry should work during this time to ensure telehealth/telework becomes a permanent feature of our healthcare system, and not only for patient-care visits and reimbursement. It also has a role in a new, broader definition of telehealth on the operational side that helps us with member engagement and education, and also with one of my pet projects—improving health plan/provider partnerships.

You can imagine that if we can get key people from health plans and provider organizations together periodically—say, on Skype or Zoom—to work on things like synchronizing the timing of data collection, or improving EMR accuracy, we will be creating an entirely new way of thinking of “telehealth.” We’re working toward improving care for people and keeping their costs down, right? There are millions more people in the world lately who are getting quite a bit more adept at “telecollaboration,” including me and my colleagues. Let’s take advantage of that.



Putting a New Spark in the Conversation Over Assuming More Risk

As of the end of May, diagnostic testing was down 60% across the nation and the number of people who sought care in the hospital was down about 55%. Many providers drastically reduced elective surgeries. This resulted in huge losses in the fee-for-service environment, and a worry that a complete recovery from this situation will never occur, which has put a new spark in the conversation about value-based care. Two respected authorities on both sides of the political spectrum recently discussed value-based care in the era of COVID-19.

In a Health Evolution virtual Executive Briefing in early June, Andy Slavitt, former acting CMS Administrator in the Obama Administration, and now Chairman and founder of the non-profit United States of Care, said the COVID-19 pandemic may be an opportunity for moving toward value-based care, and away from fee-for-service. A theme throughout the forum was considering the advantages of value-based care for driving sustainability in a post-COVID world of declining revenues (Health Evolution, 2010).

“We ought to pledge to come out of this as a healthcare system better than we entered it,” Slavitt said. While he acknowledged that value-based care is not perfect, he asserted that it is better positioned than fee-for-service in providing services around the needs of patients and how they live, citing issues of equity, prevention, bringing care to where it is most needed, and building healthcare system resilience.

“None of this can happen if we don’t have a resilient healthcare system,” Slavitt said. “None of this can happen if we don’t have a healthcare system driven by value-based payments. That will really enable this.”

Slavitt said providers need to be incentivized to take care of patient populations and the sick, so they can practice in the way they prefer and base their decisions on resources and the needs of the patient population. That means taking on risk.

Adam Boehler, former director of CMS’s Center for Medicare and Medicaid Innovation in the Trump Administration, and now CEO of U.S. International Development Finance Corporation, was also featured in the forum.

“One area that has not been negatively impacted in the healthcare system throughout all of this has been risk-based organizations—anybody taking real risks,” Boehler said. He added that if he were in a fee-for-service health system in this environment, he would be concerned about whether electives would ever come back up to 100 percent of where they were before the pandemic.

Boehler added, “Now might be an opportunity for a health system to say, ‘If I enter into full risk or 50-up, 50-down, I’m in a much better situation than continuing with fee for service.’”

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-Adam Boehler

“I don’t know how long it’s going to take for things to go back like they were pre-COVID,” said Boehler. “I do know that if you’re in a risk-based environment, taking risk from the government and others, that won’t matter as much, because you’ll be aligned better. This might be the impetus, because on one hand, now as a health system, you have a pretty big negative if you continue in the same vein, and maybe there are unknowns on the

risk-based side, but better an unknown than a guaranteed negative, in my opinion.”

On the other hand, the journey toward value-based care is predicated on trust among payers and providers, and that trust was on shaky ground before the pandemic hit. A just-released study by Xtelligent titled, “Provider Perceptions of Value-based Care” found that a good number of providers have little trust with private and public payers, with 16% of specialty care physicians reporting they have no trust in private payers and 11% reporting no trust in public payers. At the same time, 32% reported they had no communication with their private payers and 38% had no communication with their public payers. (Sokol, 2020, May 8)

Because communication is the major issue in trust, it is likely that disrupted communications during the lockdown has the potential to further erode that trust, so health plans need to be mindful of that and continue to reach out to providers using the technological communications tools at our disposal. Also, both payers and physicians must be very cognizant of their language in communication. Both need to reinforce shared goals and cooperation in serving their members/patients.



The Perils and Possibilities in Venturing Back Out

Somewhere around the end of April, the lockdown, stay at home, safer at home—or whatever you call it—began to ease up a bit in certain regions of the country. On the front lines of that process were hospitals, physicians and other providers, who began gradually allowing some elective surgeries and non-emergency visits.

As family practice physicians, hospitals and outpatient care centers start seeing more patients in-person for conditions other than COVID-19, member/patient outreach and support, I dare say, will be more critical for both providers and plans than it has ever been. Care gaps have been widened and exacerbated by the pandemic shutdown, and they will need to be urgently addressed. The effects of chronic care needs that have gone unmet for several months will become apparent.

Both healthcare provider organizations and us in Medicare Advantage and risk adjustment in general (Managed Medicaid/HIX-ACA) have an urgent mission in common: increasing patient/member engagement through outreach and support. This seems like a good time for us to work together.

A Focus on Outreach and the Point of Care

Physicians and other providers, and payers in this time need to lock in the capacity to conduct outreach and complete individual health assessments on a prioritized set of members to address whole-patient needs on risk, quality, and medical management. In preparation for opening up, providers and plans should be identifying and prioritizing groups of patients/members for outreach to schedule visits. They should know who in their patient/member population needs expedited care the most after months of being locked out of the healthcare system for non-urgent care.

MA organizations and other plans should be supporting member health needs through various methods, including member outreach messaging, appointment scheduling, adjusting cost sharing particularly related to primary care, outpatient behavioral health, and telehealth in any form. They also should be adding incentive models or adjusting existing

ones to encourage appropriate clinical interactions to improve the management of their health. Members, particularly Medicare Advantage, but also ACA and Medicaid, need to be supported and encouraged to utilize different models of care.

This is where provider engagement comes in—a need that has been thrust upon us during the past three months or so. Well before the COVID-19 Pandemic struck, I wrote an article titled, [“Risk Adjustment’s Future Lies at the Point of Care.”](#) In that article, I made the point that providing value-based care was no longer an option because of the explosive growth of costs throughout the healthcare system, and creating value-based arrangements between providers and payers would be key to providing it.

The following are some of the goals of effective provider engagement in risk adjustment that I outlined:

- helping to facilitate accurate diagnosis and management of member conditions
- supporting the physician’s capture and CMS-compliant documentation of patients’ chronic conditions
- increasing the accuracy of medical record documentation
- addressing HEDIS measures that impact Star ratings at the point of care

“Provider engagement is the starting point for improvement in risk adjustment processes, no matter your business perspective,” I wrote. “For health plans, there is no longer a question of how interconnected all the data we use in clinical quality, healthcare improvement, disease management, wellness and risk adjustment has become.”

I also pointed out that at their core, physicians are scientists, so you can get them excited and engaged when you can show them data demonstrating measurable clinical and financial progress. That is, if you can manage to do it without adding to their already overly burdensome clinical documentation duties. This is where an interoperable EMR in widespread use comes in.



Healthcare IT Interoperability and the Coronavirus Pandemic

One would assume that if the explosion in telemedicine continues, a natural extension would have to be a more rapid advancement of interoperability in EMRs and other healthcare information technology, but also digital transformation in healthcare overall. There are early signs that this is happening.

Even though all large health providers are seeing a steep decline in revenue as a result of COVID-19, there is one place they apparently will not be cutting back on investment for the future—automation and technology. In a new survey from Black Book, 84% of hospitals and 79% of large physician practices confirmed that they have performed audits on the current status of their digital transformation over the past few months (i.e., during the pandemic crisis). In those audits, 93% of those respondents said they identified missing capabilities, redundant technology, or conflicting systems (Lagasse, 2020, June 9).

The most interesting finding to me in this survey is that even in this tough financial environment, only 12% of CFOs of those organizations plan to cut or defer spending on digital transformation of their financial systems. Also, the survey found that the highest-rated solutions for meeting the current challenges are empowering virtual health (87%) and initiating highly positive patient experiences (73%).

These two issues are critical to the provider/health plan partnerships we need during the pandemic response, and these solutions sound a lot like value-based care. None of it will happen without the digital transformation.

Anyone who has been following me over the past few years knows that healthcare IT interoperability is a passion and a sticking point for me. In the summary of the [last in a series of seven articles](#) on healthcare IT interoperability I wrote these hopeful words:

“Interoperability should eventually take us to a place where patients and providers are enabled to work as a team toward preventive medicine and value-based care. This is a place where patients have access to their full medical records, and are working in decision-making partnerships with their

healthcare providers. When we get there, everyone in the healthcare system can make best use of that patient-generated data, which is predicted to be so valuable in the future. We’re going to get there.”

I said that because at the time, it looked like we were on the way there. So, you can imagine it was disappointing in mid-April to see CMS delaying compliance with interoperability requirements that were set to take effect on Jan. 1, 2021. According to the rule, by that date, the 125 million or so patients/members in Medicare Advantage plans, Medicaid, the Children’s Health Insurance Program, and Affordable Care Act exchange plans were supposed to be provided with free access to all of their personal health data through standardized application programming interfaces (API). In other words, full access via interoperable EMRs. That has been put off now at least July 1 of next year, at a time when that kind of access could have come in very handy for everyone involved, from the providers to the payers to, especially, the patients/members.

Perhaps more unfortunate, in my view, is that when the pandemic hit, the Cures Act final rule was not already fully implemented, with all patients/members having universal access to an interoperable medical record. Imagine if it had been. Patients would have electronic access to all of their medical and claims data. From a public health standpoint, patients would have been able to contribute their data toward a more rapid understanding of what COVID-19 is doing in the population and what the most effective treatments are.

One of our main goals in this new telehealth and telecollaboration reality should be to greatly enhance the EMR for optimal tracking, and convert as much interaction and reporting to digital means as possible, especially if we have to eventually go back into lockdown. However, as we peek out into this new world of telehealth and teleworking, we have to concede that we are still stuck to some degree in our old telephonic and paper-based reality. We need to move away from that.

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Healthcare IT Interoperability and the Coronavirus Pandemic, continued...

If we want our world to remain open, we need to ensure that the healthcare system does not become overloaded again. According to a plan laid out this month by the Association of State and Territorial Health Officials, besides testing and public compliance with mitigation guidelines, the key element in the ability to open and remain open is “the ability of the public health and healthcare system to quickly contain future outbreaks and associated healthcare surges. (Fraser, et. al, 2020) ”

That will require a strong system of contact tracing, which will be instrumental in containing localized outbreaks of the virus before they become unmanageable and send us back into our homes. This consists of three elements:

Identifying contacts—

Once we confirm a person is infected, we identify as many people as we can who had close contact with that infected person.

Outreach—Once the contacts are identified, these people need to be informed of their status and educated on what they need to do next, which includes self-quarantining to prevent spreading the infection further.

Monitoring and follow-up—Physicians and other health providers will need to monitor these contacts for symptoms and ensure that proper measures are taken to prevent spread of infection. They also need to identify the people who might be at highest risk should they contract the virus.

Healthcare providers are vital in supporting areas 1 and 3 of this effort, especially that last one, and they need the right technological tools to help them do that. These times present an opportunity for providers and payers to strive to create various solutions for integrating information into provider EMRs to address care gaps and COVID-19 pandemic monitoring/follow-up at the same time. A robust EMR, coupled with telehealth and emerging remote monitoring tools and wearables could make the effort much safer and more seamless.

There could be another big side benefit to the process of perfecting a technological solution to the monitoring and follow-up aspects of contact tracing. Remember our problem of capturing HCCs in the telehealth environment for certain conditions in new patients? How do we figure out how to develop and connect apps to the EMR and other patient data systems to improve COVID-19 screening, triage and monitoring,

thus addressing both issues at the same time? The pandemic is challenging us to answer that question.

The COVID-19 Pandemic is unmasking our interoperability problem in health care. There has never been a time when it was so critical for public health officials and healthcare providers to be able to easily share a wide range of standardized health information on people.

There has also never been a time, arguably, when we needed to have an easily accessible picture of the entire patient, their underlying health conditions and where care gaps lie. Now is the time for health care to catch up and finally solve the interoperability issue.

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Risk Adjustment Never Sleeps: Successfully Navigating Our New Reality

What are our priorities through the end of 2020? How can very recent, significant changes in our world wrought by the Coronavirus Pandemic guide how we move forward?

First, let's look at the financial picture. Recently, we were given a peek at what the COVID-19 Pandemic may cost U.S. health insurers. According to a report conducted by Wakeley Consulting Group for America's Health Insurance Plans (AHIP), the costs for insurers in 2020 and 2021 could be anywhere from \$56 billion to \$556 billion (Cohen, Whittall & Murray, 2020).

The study was based on 255 million people insured through commercial, Medicaid and Medicare Advantage managed care plans. These numbers depend on the percentage of people who are ultimately infected, with a range of 20% to 60% of the population.

So, before we move on, we have to consider the resources we have going forward, because that will dictate what we are able to do operationally. Because there has been very little medical expense during the lockdown, many health plans are giving back premiums or are considering doing so. For example, in early May United Healthcare committed \$1.5 billion to premium rebates and other concessions, and in the beginning of June Anthem committed to \$2.5 billion.

Medicare Advantage organizations and other health plans need to decide now how much, if anything, they can afford to give back in premium rebates, and how much that will impact operations going forward in 2020. With that in mind, we need to consider that, just as in every given year, 2020 only has 12 months, and we are beginning to get indications that 2021 could be as bleak as this year. So, even though we remain hopeful for better days ahead, we cannot afford to be complacent.

Beyond the financial situation, we also need to consider the current state of the COVID crisis. In its recent study, titled, "Reopening the U.S. Healthcare System: Tracking the Pandemic, Reopening Readiness, and Health Services Utilization," the IQVIA Institute for Human Data Science found that, "While the United States has passed a modeled peak number of active cases in late May, significant numbers of active cases persist." Among other findings, "Based on new active cases reported, 177 million people—55% of the population—live in States that are rebounding or have not peaked" (IQVIA, 2020).

All indications are that we may see widespread COVID-19 outbreaks in the fall, and if not, there will certainly be pockets in different regions of the country through the end of the

year. So, health plans, physicians and other providers, and patients/members need to plan for the worst-case scenario—another shutdown in their own region or nationally.

We also need to look at how the pandemic shutdown may have affected people's health. Nearly half (48%) of people in a new survey by Kaiser Family Foundation said a member of their household has skipped or delayed medical care due to the COVID-19 outbreak. Among them, 11% said the person's condition worsened as a result. Of those who have postponed care, about 32% said they would seek care in the next three months and 10% plan to do so in the next four months to a year (Hamel, et. al, 2020).

According to the IQVIA Study, two noteworthy things happened that have a huge effect on closing care gaps:

"Elective procedures nearly ceased during the depths of the COVID 19 shutdown in April but have mostly recovered through the week of May 22, particularly orthopedic procedures, while colonoscopies/sigmoidoscopies are still at levels 40% below the baseline. Oncology visits have rebounded while new diagnoses lag and lab diagnostics remain about 40% below baseline levels nationally.

"Total new starts for medicines since March 6th are down 34% cumulatively through May 29th, with 80 million fewer new prescriptions filled compared to baseline" (IQVIA, 2020).

Moving Forward

Again, there are some bright spots for the future, but we are still in the thick of this. So, both providers and health plans need to pull as many people back into care so we can close care gaps while we can and make up for some of the financial losses during the shutdown. At the same time, we need to be advocating for progress in value-based care, telehealth, and healthcare information technology more broadly.

In an article I wrote in early 2019 on consumerism and value-based care titled, [Healthcare Consumerism and the Move Toward Wellness](#), I pointed out one of the major impediments to the move toward VBC and true consumerism:

"The implication is that the model we are moving toward will be highly focused on the patient as an involved player. The evidence of that evolution should be a rising wave of consumerism as the transformation takes place, and we are seeing some of that already. But the reality so far is that this move is largely being accomplished without much involve-

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Successfully Navigating Our New Reality, continued...

ment from the consumer, making it look more like the paternalistic model that has always been a hallmark of the U.S. healthcare system.”

I believe that has changed. The consumer has been thrown into the deep end of the pool by the coronavirus. This has been shown in consumers quickly embracing telehealth. They have been given something they want, and they will likely be demanding more.

Medicare Advantage and other health plans, along with small provider organizations, need to take a cue from these major providers I mentioned above and not cut back on investments in digital transformation, no matter how much it hurts in the short term. This could open up opportunities for partnerships that can streamline operations for both types of organizations and help them together develop a new definition of value-based care in our “new world.” Perhaps we should call it “value-focused” care.

What to do With Our Time and Resources?

To recap, every minute that our area is not a hotspot overwhelmed with COVID-19 cases, we need to be laser-focused on our priorities:

- Prepare for the worst for the winter and possibly truncated 2021 (financially and health-wise).
- Do the most you can do within your own four walls without exposing yourself and your staff.
- If you are a health plan, work with your provider; if you are provider, work with your health plan.
- Stress the importance of virtual visits in closing gaps.
- Work with CMS and others to continue to advocate for telehealth, inclusion of IHAs, interoperability.
- Continually ensure you are finding and serving the sickest of the sick.
- Continually ensure we are using our data most efficiently in aggressive member/patient outreach.

Now more than ever, physicians and health plans need to team up to bring patients/members with chronic conditions quickly back onboard into a care regimen and get as much necessary face-to-care while they can (including diagnostics), so they can be set up to be better managed by telehealth.

Hand-in-hand with that effort is aggressively expanding patient/member outreach in order to identify care gaps. For that we need to stratify our data on patients/members. Those who are the sickest, with unaddressed conditions, have not been getting better through the lockdown because of the lack of temporally contiguous chronic care—health plans must help guide and optimize the use of these data sets.

For example, if our physicians and other providers only have July through December to see patients in person and get them into diagnostics, it makes sense to see diabetics. If those patients/members have not been coming into the doctors’ office for care at all for three months, they are likely to be in much worse condition than before the stay-at-home orders. Also, cancers, heart failure, kidney failure, liver disease, pulmonary problems, and many other conditions did not go away and need to be addressed.

Regionally, providers and health plans need to be aggressive with the time they have through the end of the year. At the same time, because of the urgency and time restraints, you may be tempted to consider canceling vacations or going to a seven-day work week, but don’t forget your greatest asset—your people. Everyone is exhausted and burned out from the response to the Coronavirus Pandemic, and that needs to be taken into account in any plan for moving forward.

Providers and health plans must not lose sight of our second mission during these times, which is making sure we do not lose the many things we have gained from the pandemic.

What We Have Gained, You Say?

You heard me right, and our gains may turn out to be significant, so we need to push hard in advocating for them. Let’s look at where we have been driving, or where we are possibly being driven. Like nearly every other industry, health care is reeling from the effects of the coronavirus lockdowns, and is trying to determine a path forward.

The coronavirus may be dictating that path to a large degree, but in some ways, that may not be a bad thing. Remember, back in the old days (a.k.a., last year) when one of the things that made us tremble the most in any business was disruptive innovation? You had two choices with disruptive innovation—you either feared and resisted it, or you threw out your arms and embraced it. I can say with confidence that there has never been a bigger disruptive influence on innovation in the business of risk adjustment than COVID-19.

Back in the “old days” of the twenty-teens, I and many of us in this business cried out for universal access to interoperable EMRs, pushed for telehealth adoption/acceptance, and tried to advance the concept of assuming risk in the interest of advancing value-based care. In all cases we ran into seemingly insurmountable barriers. In these new days, we seem to have found an unlikely ally. The Coronavirus Pandemic is not just giving us a gentle prod toward those directions—it is on our tails with a bullhorn and out in front of us with a bulldozer, plowing that road.

- Will Stabler

About Will Stabler



Will Stabler leads Advantasure's Risk Adjustment and Quality solutions growth, an integral element of the company's product suite. He is primarily responsible for new client development. His focus is on technology-enabled information/business/healthcare services and software with deep experience with providers, health plans and other risk-bearing entities. And is a sought after thought leader and as such delivers keynotes, crafts commentary and often participates in industry panels and roundtables.

In prior roles, and for most of his career, Will was responsible for multinational new business development across an array of industries. He has extensive experience partnering with C-Suite peers and boards of directors across the entire range of the corporate life cycle from start-ups to middle market companies to billion-dollar multinationals. He has been responsible for P&L, market strategy development, and client solution planning for various regional, national and multinational markets and served as President, CEO and other CXO roles.

Will was raised in a family of physicians; he grew up coding procedures and learning the business of medicine and was formerly a certified coder. He was also part of the first wave of electronic claim processing and built a medical billing & consulting firm that assisted practices with building new facilities, CMS audits, billing, claims, human resource administration and general practice management.

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