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Post-Pandemic Partnerships, p.16
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### ON THE COVER

**Bill Wulf, MD**

The APG Chair-Elect shares how Central Ohio Primary Care pivoted to telehealth—overnight.

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### Other Notes

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From the President
A MESSAGE FROM DON CRANE, PRESIDENT AND CEO
AMERICA’S PHYSICIAN GROUPS

Members and friends,

When the ball dropped and we rang in the year 2020, few could imagine the world as it is today. As I write this in late July, there are 16.5 million confirmed cases of the novel coronavirus around the world, with 4.3 million cases here in the United States. We've seen countries shut down their borders, states close virtually all businesses, and cities come to a complete standstill. The sickness and death, the economic devastation, the stress—all brought about by COVID-19. Very few of us have ever experienced anything like this before.

Like many other organizations, America’s Physician Groups was not immune to COVID-19. Our highest priorities are the health, safety, and well-being of the APG community. With that in mind, we made the very difficult decision to cancel our Annual Conference 2020.

As the severity of COVID-19 became more evident, physicians rolled up their sleeves and got to work, putting their own health at risk to meet the care needs of the patients and communities they serve. Many of our physician group members—in a week or less—transformed their practices from virtually all in-patient visits to virtually all telehealth. Our members are finding new and innovative ways to serve—from remote monitoring to virtual yoga. As one APG member said, “We're doing whatever it takes to keep our patients healthy.”

Your commitment to care hasn't changed under these trying circumstances. And our commitment to providing you with the leadership, advocacy, and educational resources you need remains as strong as ever. Here is what we are doing on behalf of our members and others in the value-based care movement:

• We are hard at work in Washington, advocating to ensure physician organizations receive the resources they need to keep their doors open and continue providing care to patients.

• Through our website, webinars, and other materials, we are educating our members on how to qualify for and access vital resources in legislation like the CARES Act. We are providing information on changes to health policies and regulations that matter to your practice.

• While we support our members’ fight against COVID-19, we also remain focused on driving the evolution and transformation of healthcare delivery throughout the nation.

There is no question that millions of Americans are rightfully hurting and fearful of an uncertain future. I take solace in a quote from Mahatma Gandhi: “The future depends on what we do in the present.” I couldn't be prouder to be part of an organization whose members are serving on the front lines of this healthcare crisis. Working together, we will answer this global health threat. And we will come out stronger for it.

As to the future, I hope you will join us for our Colloquium 2020, which will be held as a virtual event November 17-19. The theme is a timely one: “Answering the Call: Value-Based Care in Public Health.” For today, however, I hope you stay safe and healthy.

As always, stay tuned and stay in touch. ☝️

Don Crane,
America’s Physician Groups
President and CEO
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August 19
Emerging Insights of COVID-19 on Healthcare Delivery
August 20
Racism – A Public Health Crisis in America
August 27
Reimagining the Physician Role to Serve Seniors in the Wake of a Crisis
(Offered by naviHealth)
September 28
Medical Group Pharmacy Trends and Drug Pipeline
(Offered by Ventegra)

PUBLIC RELATIONS/MARKETING COMMITTEE
Tuesday, September 1

GENERAL MEMBERSHIP/HUMAN RESOURCES COMMITTEE
Wednesday, September 2

NORTHEAST REGIONAL MEETING
Tuesday, September 15

NORTHERN CALIFORNIA REGIONAL MEETING
Wednesday, September 16

NORTHWEST REGIONAL MEETING
Thursday, September 24

SAN DIEGO REGIONAL MEETING
Tuesday, September 29

PEDIATRICS COMMITTEE
Wednesday, September 30

SOUTHEAST REGIONAL MEETING
Tuesday, October 6

MIDWEST REGIONAL MEETING
Tuesday, October 6

SOUTHWEST REGIONAL MEETING
Tuesday, October 13

INLAND EMPIRE REGIONAL MEETING
Thursday, October 15

MOUNTAIN REGIONAL MEETING
Thursday, October 15

CONTRACTS COMMITTEE
Thursday, November 12

For information on all APG events, visit www.apg.org.

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COLLOQUIUM 2020

November 17 - 19, 2020

ANSWERING THE CALL: VALUE-BASED CARE IN PUBLIC HEALTH EMERGENCIES

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The nationwide response to the COVID-19 pandemic continues. Congress and the administration have passed a series of bills and regulations offering financial relief and support for various industries impacted by COVID-19 and the resulting halt to commerce across the country.

America’s Physician Groups has been extremely active in advocating on behalf of our membership for financial relief and assistance during this pandemic. We have also been very active in ensuring that alternative payment models, Medicare Advantage (MA), and other risk-bearing arrangements are preserved during this public health emergency—so that the move from volume to value-based care can continue its momentum.

MSSP ADVOCACY

APG, along with eight other healthcare organizations, sent a letter to Seema Verma, Administrator of the Centers for Medicare & Medicaid Services (CMS). The letter provided recommendations in response to policy and regulatory revisions related to the COVID-19 public health emergency.

The letter’s recommendations focused on ensuring that the Medicare Shared Savings Program (MSSP) remains sustainable for accountable care organizations (ACOs) and physician groups that are on the front lines of COVID-19.

“Every day, ACOs and physician groups are among the millions of healthcare ‘heroes’ providing care to the communities they serve,” wrote Don Crane, President and CEO of APG. “We urge CMS to provide them with the resources they need to continue that care.”

FUTURE OF APMs WEBINAR

Brad Smith, Deputy Administrator and Director for the Center for Medicare and Medicaid Innovation (CMMI), joined APG’s recent webinar—co-hosted by CareJourney—on the Future of APMs. Valinda Rutledge, Senior Vice President of Federal Affairs at APG, and Aneesh Chopra, President of CareJourney, gave presentations on:

- What risk-based care will look like as the pandemic continues
- The future state of risk-based models in a post-COVID-19 world
- The value offered by staying in risk-based models during COVID-19

Deputy Administrator Smith reiterated his agency’s commitment to risk-based models while speaking with attendees. He offered continued support and collaboration from CMMI in pursuit of the models’ viability.

TELEHEALTH RECOMMENDATIONS

APG also met with CMS leadership to advocate that audio-only telehealth services qualify for risk-adjustment payments. In April, CMS announced

“Throughout the COVID-19 pandemic, APG has been focused on ensuring that physicians have a stable stream of financial assistance.”
that organizations—including those in Medicare Advantage (MA)—that submit diagnoses for risk-adjusted payment can now submit diagnoses from telehealth visits for risk adjustment. However, CMS insisted that payment eligibility only extended to audio-video visits.

APG sent a letter advocating for extending eligibility for MA risk-adjustment payment to audio-only telehealth services during COVID-19. The letter recommended that CMS count diagnoses obtained from audio-only telehealth services for MA risk adjustment and offered suggestions on the guardrails given by CMS—analyzing the obstacles they present for physicians in providing care.

The letter also highlighted discrepancies in payment for audio-only telehealth visits compared with audio-visual visits. APG continues to advocate on this issue and the extension of adequate payment for audio-only telehealth services.

COMMENTS: INTERIM FINAL RULE

APG filed comments to CMS on the agency’s April interim final rule. The rule offered regulations addressing a variety of issues resulting from the COVID-19 pandemic. APG outlined a host of recommendations in response to the rule, including:

• Expansion of eligible providers for reimbursement for telehealth
• Reimbursement for physicians for audio-only telehealth services for MA risk adjustment
• Lifting restrictions on e-health and virtual check-ins that require providers to track possible follow-up visits and reconcile any follow-up interactions
• Clarity on the types of services that may be available to patients on homebound status during the public health emergency
• Incentives to keep healthcare organizations enrolled in alternative payment models
• Pay-for-reporting for all quality measures in 2020 and 2021

Considering the increased importance of telehealth, the letter addressed to Senate Finance made the case for making these changes permanent.

APG also submitted letters to Sens. Jeanne Shaheen (D-N.H.) and Michael Bennet (D-Colo.), as well as five additional Senate offices, in support of their recently introduced Medicare Accelerated and Advance Payments Improvement Act. This legislation provides physician groups on the front lines of COVID-19 with the financial resources they need to continue providing care to the communities they serve. Key components include:

• Authorizing CMS to offer partial forgiveness for the loans provided by the accelerated and advance payment programs
• Lowering the amount withheld from Medicare service claims from 100% to a much more manageable 25%
• Lowering the applicable interest rate of repayment to 2%

IN CONCLUSION

Throughout the COVID-19 pandemic, APG has been focused on ensuring that physicians have a stable stream of financial assistance—while also advocating that Congress, the U.S. Department of Health & Human Services, CMS, and other federal agencies work to alleviate near-term financial concerns so that physicians may concentrate on providing care.

APG is committed to transforming our healthcare system toward one focused on value-based care and improved population health, quality, and patient experience. APG will advocate for additional financial relief as debate in Washington continues.
In March 2020, as the COVID-19 pandemic hit California, Yamilett Medrano jumped into the deep end of the pool.

“Yami” Medrano graduated from the University of Southern California’s Master of Health Administration Program in 2017. She then began working for Loma Linda University Health—first as Telehealth Program Manager and then as Program Director for Digital Health. Her job: implement and develop telehealth adoption among Loma Linda physician networks throughout Southern California’s “Inland Empire.” Loma Linda is a big system, with a network of over 1,000 providers.

The job was going slowly and steadily with the usual issues—health plan reluctance to incent telehealth adoption and physician confusion over dozens of conflicting standards and billing processes. During the first part of 2020, though, newly enacted California legislation was accelerating telehealth adoption. This was in anticipation of a January 1, 2021, mandate for health insurers to cover telehealth services and pay providers in parity with in-person visits. But the challenging environment was still impeding adoption.

The COVID-19 pandemic changed everything.

AN OVERNIGHT CHANGE

The Inland Empire, like the rest of the country, suddenly experienced an overnight drop in patient visits. Physicians scrambled to keep their offices open, scrounging for personal protective equipment (PPE). Public officials cautioned people to avoid elective healthcare, and patients stayed home. Loma Linda University Health, like other systems across the nation, had to implement telehealth capabilities almost overnight.

Since Medrano was the only full-time employee in the Digital Health department, she was tasked with developing expertise and partnering with leaders across the organization to prepare the standards, billing, and technology aspects for implementation.

Prior to the pandemic, the system was averaging five to 10 video visits per day. In a matter of 72 hours, the number of video visits was increased to include all physician-based and hospital-based clinics. By March 17, all clinics had been instructed to convert visits to telephone or video.

At the late April peak, the network was averaging 53% of overall outpatient visits completed via video, about 21% via telephone, and another 26% in person. E-visits increased volume, but only reached about 1% of overall visits. Primary care areas (i.e., family medicine, general medicine, and pediatrics) achieved as high as 90% to 95% of total visits completed virtually. These encompassed video, telephone, and e-visits.
Since the pandemic began, 651 providers have seen patients via video, and 127 clinic locations have offered video visits. This does not include additional hospital and skilled nursing facility (SNF) video visits.

A FOUNDATION FOR SUCCESS

Like other integrated systems that had embarked on adopting telehealth prior to COVID-19, Loma Linda’s earlier preparations provided a foundation for rapid adoption across its provider network.

The previous integration of the electronic health record (EHR) solution, Epic, included MyChart video visits and provided a stable platform for provider adoption that was connected to the existing patient record system. Loma Linda had also contracted with Vidyo to provide secure, accessible telehealth access to patients across the internet.

After the Centers for Medicare & Medicaid Services (CMS) issued a HIPAA waiver, Zoom was also introduced into clinical workflows. Zoom soon accounted for 20% of all video visits. The other 80% were completed using MyChart or other physician-preferred video options. Medrano attributes the rapid deployment to the availability of the EHR-integrated video platform and the huge team effort that helped Loma Linda respond and transition care successfully.

In a matter of days and weeks, Loma Linda also had to create patient-facing education—including flyers, FAQs, tips and tricks, and a dedicated webpage. Its marketing team rushed to place billboards throughout the community advertising virtual care. “We continue to revise and strategize how we educate and communicate with patients, physicians, and staff,” she says.

The time crunch was just the first hurdle. Loma Linda University Health was also challenged with connectivity issues and network infrastructure problems. Audio difficulties arose from time to time. Medrano identified a need for a secondary, non-integrated video solution such as Zoom or Doximity for patients who did not have a patient portal or did not want to join via MyChart.

WILL TELEHEALTH STICK?

How did the doctors and patients feel about this transition? A surprising number of physicians that had previously been resistant to telehealth realized that the video visit format was comfortable for both them and their patients. Physicians can learn a lot about a patient’s environment and background through video visits.

Patients like the experience as well. Medrano reports that surveys indicate that patients appreciate the convenience and feel as if they have more time to ask questions and speak with their physician.

Will telehealth stick? By early May, the network began to add back more in-person visits and procedures/surgeries into its utilization volume. Loma Linda University Health is still averaging 30%-50% of its patient visit volume (it varies across specialties) through telehealth video visits. Medrano estimates that the network will reach a level of 20% to 30% virtual patient visits over the long term. Both patients and physicians have learned to appreciate the convenience and access provided by telehealth.

Was the effort worth it? Definitely, says Medrano. The quick effort to deploy telehealth solutions across the entire network was a professionally rewarding experience, bringing a profound sense of accomplishment. An early advocate for telehealth, she also participates in the California Telehealth Policy Coalition—a stakeholder group that circulates best practice resources and advocates for greater adoption of this form of care delivery. The future will bring greater understanding of the areas in which video visits can be offered, and where they cannot.

Postscript: Medrano’s time at USC included courses taught by Bill Barcellona, an adjunct professor at USC. He is very proud of Medrano’s work ethic, commitment, and skills, and he looks forward to her future accomplishments.
Prior to March of this year, Central Ohio Primary Care (COPC) did not provide telehealth visits. In preparation for a slow launch of video visits in 2020, we increased our broadband capabilities in early 2020. Fortuitously, an upgrade from eClinicalWorks (eCW) in January improved our ability to deliver a satisfactory video visit.

The plan was to pilot telehealth mid-year with a slow launch in the third quarter. Then, COVID-19 came along.

**IT AND TELEHEALTH RESPONSE**

In response to the emerging pandemic—and in accordance with directives from the state of Ohio's Department of Health—we asked our physicians to limit in-person visits to emergencies or those deemed clinically necessary. We instructed our physicians that no wellness exams be performed in person, for patients of any age, beginning March 23.

In just one week, starting March 17, the COPC Information Services Department enabled 380 providers to perform video visits. In the six weeks between March 23 and May 8, our staff web-enabled over 16,000 patients who had not previously been accessing our portal, thus enabling an upcoming video visit for these individuals. Our physicians used eCW, Updox, and (rarely) FaceTime technology for video visits.

Patient volumes were maintained at a 65% level compared with 2019, and 65% of all visits were done by video during the six weeks following March 23. COPC care management staff reached out to nearly 4,000 high-risk patients to meet both social and medical needs. These patients were identified based on age, chronic conditions, past emergency room utilization, and on whether they lived alone.

If needed, care management staff went to the patient's home with an iPad to facilitate a video visit with a physician. During this time, an after-hours video visit system enabled over 500 video visits during evenings and weekends. Our triage system found that nearly half of these patients required a visit within four hours, and all were done via video.

These visits were "picked-up" by waiting physicians within one minute of being placed in a queue by an after-hours call center nurse. As of June 18, COPC had completed over 90,000 video visits this year. Despite now seeing patients in person, we continue to use video for more than 20% of our over 3,500 daily visits.

**SURVEYS SAY...TELEHEALTH IS HERE TO STAY**

We surveyed over 8,000 patients following their video visit, as well as our primary care physicians. We found that:

- 98% of patients were either satisfied or highly satisfied with their video visit.
- Only 36% of patients said they would prefer their next visit be in-person.

“The plan was to pilot telehealth mid-year with a slow launch in the third quarter. Then, COVID-19 came along.”
• 90% of physicians planned to continue telehealth as part of their practice.
• 97% of physicians were either confident or extremely confident in their ability to provide telehealth.

Continued telehealth services will require adequate reimbursement from commercial and government payers, as well as employer support. A video visit performed by a patient’s PCP within the health record is clearly the most desirable and clinically efficient telehealth service available. There are surely many visits that can and should be provided via video.

LOOKING BACK

It is a shame that it took a pandemic to move us to telehealth. In retrospect, I believe we as primary care physicians began abdicating some of our responsibility years ago—when we turned our phones to an answering service at 5 p.m. each weekday and on weekends.

Our recorded message would first instruct patients to hang up and call 911 or go to the emergency room if there was an emergency. Next we provided a long list of services we could not, or would not, provide after hours. Finally, we asked the patient to leave a message and returned the call sometime later.

This abdication led to the need for urgent care facilities, overuse of emergency departments, and the advent of remote telehealth services provided outside of the patient’s longitudinal record. We have often allowed and even encouraged others to care for our patients outside of the limited hours we set for our clinics.

Fortunately, the nationwide expansion of value-based contracting and the progressive movement to full-risk contracting will accelerate the recognition that we as primary care physicians will be expected to assume an expanded responsibility for our patients’ care.

Bill Wulf, MD, is CEO of Central Ohio Primary Care (COPC) and Chair-Elect of America’s Physician Groups.

Central Ohio Primary Care (COPC) is an independent, physician-owned primary care organization with 435 physicians in 77 locations. Ancillary services include a high-complexity laboratory, radiology, cardiovascular testing, and six urgent care facilities. COPC utilizes eClinicalWorks and cares for 25% of the population in Central Ohio.

All COPC commercial contracts include a per-member, per-month prepayment used for care management and education programs, as well as year-end shared savings. COPC is a CPC+ participant for 35,000 Medicare fee-for-service lives and is in a joint venture with agilon health in prepaid, full-risk arrangements for 33,000 Medicare Advantage lives.
The realities of the COVID-19 pandemic reveal an urgent need for healthcare providers and payers to work together for the benefit of both patients and frontline physicians. Infected patients require fast, unfettered access to testing and treatment. Overwhelmed physicians and their staff must clear the way to treat urgent patients, while upholding care for their patients struggling with chronic illnesses and ongoing treatment needs.

As global attention naturally turns toward the crisis at hand, it is important that stakeholders across the healthcare industry do not lose sight of the role that payer-provider partnerships will play not only today, but moving forward. The good news is our industry was moving in this direction even before COVID-19.

In a 2019 SPH Analytics survey of more than 80 providers and health plans, 94% of respondents said they believe collaboration between payers and providers is now a key determinant of success. Partnerships within the healthcare ecosystem we’re building today will become the foundation for more sustainable business models that put patients at the center of care, offer efficiency to overburdened healthcare teams, and work toward reducing unnecessary spending—all ingredients for effective healthcare resilience in the future.

Last year, Alignment Healthcare formed partnerships with two of California’s largest regional systems: Sutter Health, based in Sacramento, and PIH Health in Whittier. As the benefits of our partnerships have become more obvious during the pandemic, we have learned that these relationships work best when our goals are aligned and our partnerships meet the needs of every patient in the ecosystem. While many factors contribute to a successful partnership, we have discovered that three overarching tenets are critical.

**TENET 1: SIMPLIFY PATIENT ACCESS TO CARE**

As community hospitals across the country quickly pivoted to address faster testing and urgent care for coronavirus cases, we saw a concerted effort to reschedule routine physician visits and non-urgent or voluntary medical procedures. It made sense, too: Hospitals were right to preserve capacity for incoming COVID-19 patients.

Necessity becomes the mother of faster adoption. While staying home has been the recommended strategy for flattening the curve and avoiding infection, we cannot ignore the importance of general healthcare and the ongoing monitoring and treatment for chronic illnesses. In response, we’ve seen a dramatic spike in the adoption of telehealth solutions. This year, the U.S. telehealth market is expected to reach around $10 billion, with 80% year-over-year growth due to the COVID-19 pandemic, according to an Arizton report. And for good reason. As TechRepublic recently reported, “Online appointments give doctors greater
flexibility, and with flexibility being one of the key factors in preventing burnout, that perk is incredibly beneficial for the provider’s state of mind."³

A foundation for our partnerships with Sutter and PIH is Alignment Healthcare’s ACCESS On-Demand Concierge program. This service empowers Alignment Health Plan members to access a national network of U.S. board-certified physicians by phone or video 24 hours a day, seven days a week. This makes it easy for our members to honor shelter-in-place orders without delaying a diagnosis, treatment, or changes in prescriptions. It also allows doctors to focus first and foremost on their highest-priority patients.

TENET 2: PROVIDE FLEXIBLE SUPPORT FOR STRESSED PHYSICIANS AND THEIR TEAMS

Before COVID-19, physicians already balanced limited time with increasing patient loads. As this new pandemic schedule intensifies, digital solutions that automate manual tasks, provide a more comprehensive picture of patient health, and allow physicians to invest more time in critical cases will become invaluable.

A foundation for Alignment’s provider partnerships is AVA™, our proprietary data analytics and technology command center. AVA hosts our Alignment Healthcare Patient 360, which gives physicians a snapshot of a member’s health and treatment history so they can facilitate care coordination and close gaps in care. It keeps providers engaged with their patients’ care even if they cannot see them physically. It also simplifies access to additional care that may be needed.

Alignment Healthcare has also worked to supplement physicians’ telehealth backlog—now a growing reality—with Alignment’s network of doctors. We do this via our Care Anywhere program, a targeted high-risk program focused on the delivery of in-home care. Our clinical team, in coordination with a member’s primary care physician, provides members 24/7 access to a doctor and data-driven in-home care solutions.

TENET 3: ALIGN INCENTIVES TOWARD A MORE SUSTAINABLE BUSINESS MODEL THAT CENTERS THE ECOSYSTEM AROUND BETTER PATIENT OUTCOMES

Unfortunately, the traditional healthcare landscape often puts payers and providers at odds around misaligned incentives in the patient interaction. According to a 2017 Deloitte report, “Value-based care encourages providers and health plans to align their interests, allowing payers to more easily lower the cost trajectory of healthcare costs and offering providers the tools to help effectively deliver quality care."⁴

Tightly aligned incentives for patients, providers, and payers are a key foundation for our provider partnerships. First and foremost, patients must have the best possible outcomes—or they will take their business elsewhere. Meanwhile, providers need accurate, complete interoperable patient data and help with ongoing consumer engagement. Payers need the highest-quality care for their members, with an eye toward staying efficient with resources and cutting out waste.

In just one example, as the payer in California, we implemented a proactive educational communications campaign that engaged nearly 100% of our members through email, SMS text, phone calls, telephonic town halls, and direct mail, advising them on how to protect themselves from COVID-19 and stay at home. We believe this aggressive member engagement effort contributed to lives saved.

While the pandemic and all of its social, economic, and health impacts have yet to play out, the payer-provider partnerships we are codifying now will be part of the future of driving value across the healthcare chain for the patient, the doctor, and the greater good—no matter what comes next. ○

Dawn Maroney is President for Alignment Healthcare, a Medicare Advantage company focused on providing population health management services to health systems and provider groups across the country.

References


How Will COVID-19 Impact Business Insurance Premiums?

BY BRAD AYRES

Given the climate of great uncertainty created by the COVID-19 pandemic, how will business insurance premiums be affected? To help answer this question for the America's Physician Groups member community, I will share some of the recent trends influencing insurance rates and provide guidance on what can be expected with premiums in your upcoming renewals. (And please, don't shoot the messenger—I come in peace.)

FACTORS IMPACTING RATES

Insurance rates are primarily driven by empirical data but are influenced by risk-projection models. Risk is inextricably tied to uncertainty. In this unique time of global health, social, and financial uncertainty, insurance premiums are increasing, coverage is tightening, and deductible levels are rising for several lines of insurance.

Insurance underwriters are guided by actuaries. These actuaries are supported by teams of financial and business analysts that use technology to evaluate and determine a given organization's risk. They take into account one to three years of historic empirical "experience" data, exposure across coverage categories, and the firm's financial strength, coupled with industry guidance.

AREAS OF ANTICIPATED PREMIUM INCREASES

We are seeing the greatest rate increases in employment practices liability (EPL), followed by directors and officers (D&O) and errors and omissions (E&O) insurance. Other lines—including cyber and crime, as well as property and casualty (P&C)—are showing lower unilateral increases in comparison. Stop loss and employee benefits insurance rates appear to be less directly impacted by the pandemic at this point.

CONTRIBUTING FACTORS

Layoffs and Furloughs:

Since the economic impacts of the pandemic hit our industry late in the first quarter, carriers have seen wrongful termination claims spike. This is due to the widespread furloughs and layoffs many healthcare delivery organizations have had to make. The carriers must account for this increase in wrongful termination claims in their risk models, and it is now reflected in higher premiums for EPL and E&O insurance.

Working From Home:

Although deemed “essential,” most health delivery organizations have pivoted to having their employees work primarily from home. This dramatic change has introduced new risks.
I don’t believe any healthcare executive would have predicted in January that his or her entire team would operate remotely from their homes—let alone complete such a transition in under a few weeks. The technologies that were rapidly deployed, the remote management and accountability processes established in such short order, were impressive. It’s been a remarkable feat to witness the robust changes, particularly in claims operations, where teams traditionally worked in office settings.

But the speed of this change has also created cyber-crime risks not anticipated before the pandemic. Healthcare operations are now being run from a widely distributed work environment of home settings, rather than being managed within the heavily fortified corporate infrastructure. New security vulnerabilities include:

- Personal equipment being used for professional use
- Multi-factor authentication (MFA) often not utilized using shared home computers
- Company VPNs established on compromised personal equipment

This presents criminals with opportunities, and the attacks are growing in sophistication and zeal. Ransomware and phishing schemes increase during high-anxiety periods as more people fall prey to fear and hope-based campaigns.

A recent Beazley report showed a 25% increase in ransomware attacks in the first quarter this year over the prior quarter. The report states, “During the pandemic, attackers are taking advantage of the fact that many employees have been working from home, without the technical protections that their corporate networks often provide.”

**Return to Work:**

When things stabilize, a robust “return to work” strategy will be important to protect the health of your employees and your business from avoidable workers’ compensation claims. Litigation driven by employees feeling unsafe to return to work due to the threat of workplace COVID-19 infections is contributing to premium increases.

Recommendations from leading health agencies are advising employers to become workplace health gatekeepers to ensure office safety. While this seems like a necessary step given the crisis we face, such practices threaten to infringe on longstanding personal health privacy rights in the name of new models of workplace safety procedures. Your insurance broker

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### COVID-Related Impact on Premiums for Risk-Bearing Organizations

**Q3-20 Through Q1-21 Renewals**

<table>
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<tr>
<th>Insurance</th>
<th>Anticipated Premium Impact</th>
<th>Coverage Change Trends</th>
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<tr>
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<tr>
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</tr>
<tr>
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<td></td>
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</table>
should have resources to support your human resources department with carrier-recommended tools to help you balance this fragile dilemma.

Expect insurance premium increases with D&O, E&O, and EPL as we travel down uncharted paths littered with HR land mines this year.

**Medical Spend Projected Increases:**
The financial effects of the COVID-19-related critical care cases ripple through the entire healthcare ecosystem. There’s also concern about an increase in hospitalizations coinciding with the flu season this fall. With such widespread speculation of the financial impact on both public and private entities, underwriters are more risk-averse. This is reflected in increased rates, higher deductibles, lower caps, and more carve-outs written into the policies.

We’ve also seen stop-loss insurance carriers increasingly engage with clients to develop specific risk mitigation strategies to help prepare and manage the rise of high-cost exposure. The shared incentive to manage costs is driving many carriers to extend analytic tools and clinical resources to clients.

**Shift From Commercial to Medicaid:**
Millions of former commercially insured members are now on Medicaid. This is due to the highest volume of initial filing for unemployment assistance since the Great Depression. For physicians, this shift has meant reductions in contract rates and fee-for-service reimbursements.³

When significant decreases in physician compensation transpire, an increase in claims fraud traditionally follows. Investing in a leading claims fraud/waste/abuse solution to protect your business will not only protect you during this anticipated trend, but help control stop-loss premium increases in the years ahead.

**ADDITIONAL RENEWAL DOCUMENTATION**
You can expect more stringent financial reporting and reserve requirements. Carriers are requiring additional financial documentation and tightening financial solvency standards. They are also looking for compliance adherence language pertaining to return-to-work procedures and office health safety (OSHA) protocols. These updated protocols for each state are available at osha.gov/stateplans/.

**WHAT YOU CAN DO**
When possible, ensure your broker incorporates an “experience refund” to your premiums. This provision will benefit you if the insurer’s loss experience is less than projected. Build in more time during your renewal to account for the additional supporting documentation that carriers are now requesting.

Make sure you are receiving multiple carrier bids. The rate variation from carrier to carrier can be 15% to 50% for certain coverage lines. The rate disparity is heightened during times of great uncertainty. If you have not received multiple carrier bids in the past, you may have paid hundreds of thousands of dollars more on insurance than necessary. Multiple bids are more important than ever.

**SILVER LININGS**
The COVID-19 pandemic is a global tragedy of incalculable measure. Amidst the great loss, the crisis has sharpened us and inspired heroic healthcare leadership and innovation. I believe the courageous decisions made in streamlining workflows, empowering individuals, trusting remote employees, widely incorporating telehealth technologies, and proactively engaging patients will lead to permanent changes. Some of these remarkable innovations were highlighted by New West Physicians and Vancouver Clinic in a recent APG webinar.⁴

I am hopeful these efforts and breakthroughs will lead to lower insurance premiums the following policy year as you demonstrate improved outcomes even in a time of crisis. In the meantime, the broker community is here to advocate for you and help ensure you have the necessary insurance protection to weather the storms ahead.

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Without a threatening letter from a regulatory agency or an external investigation from a large client, it can be difficult for a healthcare vendor or provider to justify developing a compliance program. Today’s consensus is that limited financial and human resources would be better served for market growth or another revenue-generating initiative.

However, the sooner a healthcare organization emphasizes operational compliance, the more likely it is to avoid costly issues down the road. Early compliance can also serve as a potential growth opportunity—and even a competitive advantage in a market saturated with vendors and providers.

As the Centers for Medicare & Medicaid Services (CMS) and state health departments continue to prioritize compliance audits for the largest healthcare organizations, vendors and providers will be best prepared to enter into agreements with these organizations if—prior to contracting—they are able to demonstrate:

1. Knowledge of the potential partner’s regulatory environment
2. Operational compliance to the larger organization’s policies
3. A culture of high ethical and professional standards
4. A solution to reduce or eliminate government-issued sanctions for the larger organization

By highlighting an organization’s operational excellence and its understanding of the regulatory environment and operational requirements, an internal compliance review with a potential partner conducted prior to the statement of work will separate a vendor from its peers.

WHAT IS HEALTHCARE COMPLIANCE?

Although every healthcare organization must follow state corporate laws, healthcare compliance is something different. Healthcare compliance specifically defines the operational requirements and/or benchmarks that must be met in delivering healthcare to consumers.

For example, if an organization is determining whether a network provider’s proposed treatment is approved or denied, the response time, member and provider communications, and the appeal process are all documented in a regulation or contract with a government agency. These determination requirements are just one example of the numerous compliance obligations healthcare organizations must fulfill.

Until 2010, healthcare organizations were not required to document their compliance to their governing authority. However, with the implementation of the Patient Protection and Affordable Care Act (ACA) in 2010, compliance programs became mandatory for all healthcare organizations participating in government business programs. Specifically, the ACA requires that healthcare providers establish compliance programs to participate in Medicare, Medicaid, or the Children’s Health Insurance Program (CHIP).

The ACA, combined with stringent federal and state regulations, places such restrictive regulatory requirements on healthcare organizations that they have very little leeway to implement initiatives that would separate them from their competitors in terms of strategic growth, improved delivery, cost-saving reductions, or performance benchmarks.

Everything—including billing, defining adequate provider networks, advertising, member mailings, addressing member grievances, and even communicating with a member—is codified in a regulation or in a contract that the organization has with the governing municipality.
Despite all these requirements, many healthcare organizations still operate without a compliance program—and do not even conduct an audit to gauge their compliance.

By developing an effective compliance program, a healthcare vendor or provider is broadcasting to its employees, consumers, and potential partners that it conducts itself in an ethical manner and in conformance with all state and federal laws. In addition, a simple documented compliance program helps reduce the submission of fraudulent claims, the chances of insurance billing audits and unethical business conduct, and conflicts of interest in everyday practice and vendor arrangements. Employees also develop a better understanding of compliance expectations, as well as how to respond to and report a problem.

**MONITORING COMPLIANCE BEGINS WITH THE MCO**

In most federal and state jurisdictions, the managed care organization (MCO) is responsible for policing the delivery of healthcare to its consumers. Specifically, CMS and many state regulators require an MCO to monitor and ensure the compliance not only of its directly contracted entities (first tier) but also the organizations that contract with those first-tier entities.

In fact, during CMS and state department of health audits, MCOs will be subject to compliance findings or corrective action if there is a lack of oversight of first-tier, downstream, and related entities, or if one of those entities violates a regulation.1

A vendor or provider to an MCO that does not understand the law or fails to demonstrate evidence of compliance is not a sufficient excuse for violations. For this reason, it is common for MCOs to require an annual attestation from their vendors and providers to ensure they are following applicable compliance program requirements.

If vendors or providers fail to submit satisfactory documentation or fail to satisfy compliance program requirements, the MCO may issue a corrective action or carry out other contractual remedies (e.g., sanctions or contract termination).

**DEMONSTRATING COMPLIANCE TO A POTENTIAL PARTNER**

Given MCOs’ heightened scrutiny of their contractors, demonstrating knowledge of and adherence to a potential partner’s regulatory requirements should be part of the business development plan and included in every vendor or provider’s marketing pitch.

Because vendors and providers are also responsible for complying with all Medicare and state public health regulations, “best-in-class” vendors and providers should, as part of their compliance program, maintain policies and procedures that cover all the requirements outlined in the relevant regulations. They also must adopt or acknowledge an MCO’s code of conduct or have their own code of conduct with the same elements, including a fraud, waste, and abuse (FWA) plan.

Startup vendors often fail to fully review the regulatory environment of a potential client. They may propose a product or solution that either needs modifications to meet the regulatory requirements of the larger organization or, in the worst-case scenario, try to sell a noncompliant solution.

For example, a vendor that has developed a monetary incentive program for members to enroll in a specific Medicaid MCO may be in violation of the jurisdiction’s Medicaid marketing and solicitation rules. For a vendor to market its product without a full understanding of its operational limitations in a specific regulatory environment would certainly result in potential clients/partners questioning that vendor’s credibility.

By contrast, a compliance program that includes a preemptive compliance review will confirm that the organization or provider is meeting the relevant requirements in the applicable jurisdiction. The purpose of documenting and completing such a review is to fully assess the vendor’s or provider’s capacity to manage and perform services in accordance with state and federal laws, rules, and regulations, accreditation organization standards, and the requirements of their potential partners.

The solution or product that the vendor or provider offers to a potential client should not only achieve cost savings through improved delivery, but it also could be marketed as achieving cost savings by reducing sanctions or potential sanctions for the client. For example, the obvious pitch for a vendor that offers a telemedicine platform is that the telemedicine solution will result in lower administrative costs, increased encounters with providers, and lower costs of care. However, the most resourceful leaders will also understand that their product can assist the MCO in achieving its CMS and state regulatory requirements around network adequacy, access, and availability, and provider directory accuracy.

Government agencies have issued numerous findings to MCOs for not meeting network requirements, subjecting them to millions of dollars in CMS and state sanctions. For certain MCOs, a product/solution that can reduce government-issued sanctions may be the most appealing reason to contract with a vendor.

**WHAT IS A PREEMPTIVE COMPLIANCE REVIEW?**

At the highest level, a preemptive compliance review assures the potential partner that a vendor or provider can document a compliance program that ensures the organization is: continued on page 29
Do Oversight Programs Have a Measurable ROI?

BY RUSS FOSTER AND SHEILA STEPHENS

It's no surprise that healthcare leaders are concerned and challenged by the current environment and the ever-increasing focus on regulatory changes, surveillance, and enforcement. These concerns are evident in findings from a study by North Carolina State University and Protiviti in the fall of 2019.

The study included 1,063 board members and C-Suite executives from around the globe, who shared their concerns regarding the immediate future (prior to COVID-19). Participants identified the following as among their major concerns:

- Ever-present threats related to cyber security
- Increasing market disruptions
- Increased regulatory control and scrutiny

These concerns foretell the changing business environment and potential for unwelcome surprises—the reality that organizations face risks that can adversely impact their reputation and bottom line overnight. Consequently, it is increasingly important that organizations develop mechanisms to quickly and proactively identify and mitigate risk.

Study participants from healthcare had additional concerns, including an upswing of what appears to be a rise of professional whistleblowers and a resulting anticipated upswing in provider audits. Another concern is the increasing collaboration among various government agencies as they launch joint efforts to combat fraud. These agencies include the Office of Inspector General, the Centers for Medicare & Medicaid Services (CMS), Office of Civil Rights, and the Department of Justice.1

Added to their concerns is the belief that regulatory bodies are exercising more scrutiny and imposing more frequent enforcement actions—including fines and civil money penalties for failure to ensure compliant activities, as well as fines and take-backs for fraud, waste, and abuse violations.

In response to these challenges and scrutiny, health plans and provider groups have enhanced their oversight and internal audit processes. As a result, they have experienced an increase in the cost of doing business. While some increased costs—such as staffing for oversight programs and payments for fines and penalties—are clear and direct, there are also increased indirect costs, such as directors and officers insurance premium increases. All of this supports the fact that oversight is part of the cost of doing business in today’s highly regulated environment.

WHY INVEST IN OVERSIGHT PROGRAMS?

It is important to note that even with the most stringent oversight program, an organization can still experience a noncompliant event that places the organization at undue risk. In these circumstances, the benefits of a comprehensive oversight program include early detection, immediate intervention to mitigate or negate impact, and immediate remediation.

We recognize there is cost associated with operationalizing a comprehensive oversight program. However, we believe there is an associated and significant positive return on
investment (ROI). Oversight programs can and do reduce and mitigate risk situations—as well as the associated potential enforcement actions, including sanctions, suspension of enrollment, fines, and monetary penalties.

These programs should not simply be construed as the normal cost of doing business. Rather, they are an investment in your organization and the people who staff the operations. They can save your organization much more than the cost to operate them.

Oversight programs are founded on knowing the applicable regulations, ensuring internal and delegate compliant operations, and conducting ongoing monitoring and audits. These activities are essential to prevention, early detection, and mitigation. A health plan may give a delegate the authority to act on its behalf, but the organization remains accountable.

Continuous oversight monitoring is critical to ensuring compliant practices at both the plan and delegate level. Investing in compliance will enhance the ability to identify and correct suspicious or noncompliant activity in a timely manner—which can avoid or mitigate enforcement action.

We believe that comprehensive oversight programs that include fraud, waste, and abuse auditing are extremely cost-effective when administered diligently. The return on investment can be evidenced in avoidance of enforcement actions and related costs.

THE COST OF NONCOMPLIANCE

For example, in 2019 a dozen health plans in California experienced enforcement action by the California Department of Managed Health Care (DMHC), including fines of $1.9 million, all related to a single medical group. DMHC was alerted to problems within the medical group by an internal whistleblower, which prompted an in-depth investigation.

DMHC’s findings included delayed care for costly services, illegal economic profiling—which restricted access to certain specialist providers—and falsified audit documents. Upon taking the enforcement action, DMHC underscored that under California law, health plans are ultimately responsible for delegated functions and the compliance of delegates.²

The fines were not the only costs the plans incurred. The DMHC ordered the plans to terminate their respective contracts with the medical group and to conduct outreach to enrollees to assess and rectify any access issues. The costs related to terminating a medical group agreement and transitioning all assigned members either back to the plan or to another group are not insignificant. The outreach efforts to contact enrollees resulted in additional costs to the plans in terms of staff time and productivity. Further, the plans experienced ongoing costs related to corrective actions and regulatory communications and reporting.

In addition to these tangible direct costs and loss of projected revenue, there are intangible costs associated with this type of situation. These include costs related to organizational image, enrollee satisfaction, and provider relations.

Another example from California: In 2017, DMHC levied a $5 million fine on a plan for systemic grievance system violations.³

Meanwhile, for plans with a CMS contract, regulatory compliance goes beyond state requirements and includes the various federal regulations that apply to Medicare Advantage and Part D products. CMS enforcement actions related to Part C and Part D can vary from immediate suspension of enrollment and marketing to civil money penalties. All of these are costly to the organization.

In 2016, CMS notified a major health plan that it was imposing a civil money penalty in the amount of $2.5 million for over 50 of the plan’s Medicare Advantage-Prescription Drug (MA-PD) and Prescription Drug Plan (PDP) contracts. The penalty was due to findings that the plan failed to comply with Medicare requirements related to Part D formulary, benefit administration, and coverage determinations, appeals, and grievances. CMS also found the failures were systemic and resulted in enrollees inappropriately experiencing delayed or denied access to benefits and/or increased out-of-pocket costs.⁴

In 2017, CMS fined a major health plan $1.2 million for 11 of the plan’s MA-PDs and PDPs—also finding the failures to be systemic and adversely affecting (or likely adversely affecting) enrollees. CMS further decreed the enrollees experienced, or likely experienced, delayed or denied access to covered benefits, increased out-of-pocket costs, and/or inadequate grievance or appeal rights.⁵

CMS’ efforts to ensure plan compliance are further evidenced by anti-fraud activities. For example, during fiscal year 2018, the federal government won or negotiated over $2.3 billion in healthcare fraud judgments and settlements, and it attained additional administrative impositions in healthcare fraud cases and proceedings.

As a result of these efforts, as well as those of preceding years, $2.3 billion was returned to the federal government or paid to private persons. Of this $2.3 billion, the Medicare Trust Funds received transfers of approximately $1.2 billion during this period, while $232 million in federal Medicaid money was transferred separately to the Treasury.⁶

continued on next page
GOING BEYOND WRITTEN DOCUMENTS

Comprehensive oversight programs—and supporting operational policies and procedures that promulgate and articulate applicable regulations—can be effective tools to ensure internal and delegate compliance and avoid the types of enforcement actions outlined in the examples above.

But oversight programs must not just be written documents. Instead, they must be operational living documents that provide value to the organization.

Successful delegate oversight processes require:

• Pre-delegation, including evaluation and implementation activities
• Performance monitoring, including:
  o Ongoing review of performance indicators
  o Communicating routinely with delegates
  o Focused reviews
  o Corrective action plans as warranted
• Annual evaluation, including the assessment of program and contract standards and performance compliance

The value and ROI are created each time a suspicious or noncompliant activity is identified and corrected in a timely manner—avoiding or mitigating an adverse finding or enforcement action.

In asking whether oversight programs have a measurable ROI, we highlight the findings from a 2011 study conducted by the Ponemon Institute. This study included 46 multinational organizations across a number of industries, including healthcare, that are required to comply with privacy and data protection laws, regulations, and policies to protect individuals’ sensitive and confidential information.

The study found that the average cost of compliance was a third of the cost of noncompliance. Investment in compliance also helped organizations avoid business disruption, decreased productivity, penalties, and other legal and non-legal settlements. The findings clearly support the premise that the cost of noncompliance can be more expensive than investing in compliance activities.7

Therefore, the real question becomes: How much could it cost your organization if you do not invest in compliance and related oversight activities? The direct costs can be staggering, and there are indirect costs, too.

Noncompliance leaves your organization at risk for:

• License and contract revocations
• Business disruptions
• Poor patient care
• Erosion of trust
• A damaged reputation

THE BOTTOM LINE

It comes down to where you assign the cost of doing business. You can roll the dice and not invest in a comprehensive oversight program—and hope you will not experience any compliance breaches, adverse regulatory findings, civil money penalties, or other enforcement actions. Or, you can choose a proactive strategy to implement and support an effective oversight program. Either way, there is a cost of doing business.

Yes, oversight programs are a cost of doing business—but they also have a measurable ROI. We believe the evidence shows that organizations that make monetary and talent investments in comprehensive oversight programs actually save money, as well as create an operational safety net.

The bottom line, based on our experience, is that it may be far less costly to invest in compliance and related oversight than to risk noncompliance. A comprehensive oversight program—designed to detect potential problems early on—is the most cost-effective strategy and a solid investment for any organization.

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Endnotes

2DMHC Fines 12 Health Plans $1.9 Million for Improperly Denying Care to Enrollees, DMHC Help Center, December 18, 2019.
3DMHC Fines Health Plan $5 Million for Systemic Grievance System Violations, DMHC Help Center, November 15, 2017.
7The True Cost of Compliance: A Benchmark Study of Multinational Organizations, Research Report, Ponemon Institute, LLC, January 2011.
Preemptive Compliance...continued from page 25

- Operating in accordance with applicable laws and regulations
- Creating a culture of honesty and integrity
- Meeting high ethical and professional standards
- Preventing fraud and abuse and other compliance issues
- Detecting compliance issues at earlier stages
- Assuring prompt corrective action
- Creating a culture of ethical and compliance behavior
- Building employee trust and confidence

According to CMS, a good compliance program consists of seven core elements:

1. Written policies and procedures to promote the organization’s commitment to compliance
2. A compliance officer responsible for monitoring compliance efforts and enforcing practice standards
3. Reporting systems that encourage individuals to make complaints regarding compliance items without fear of retaliation
4. Formal education and training programs for all levels of employees
5. Ongoing auditing and monitoring of systems
6. Policies to enforce standards of conduct
7. Corrective action when vulnerabilities are identified

Healthcare organizations should promote a culture of compliance at all levels. Moreover, having an effective compliance program is an ongoing process. It is not a static document. It’s proactive and responsive, and it changes with the needs of the organization.

HIPAA, HITRUST, AND CYBERSECURITY

As the Health Insurance Portability and Accountability Act of 1996 (HIPAA) goes into full effect, and cybersecurity breaches become even more prevalent, large healthcare entities are requiring potential vendors (and in some cases even providers) to become Health Information Trust Alliance (HITRUST) compliant or certified. There is no question that every healthcare organization that stores or exchanges protected health information or other sensitive information with a vendor or business associate must ensure that information is appropriately and effectively safeguarded.

In the past, healthcare organizations either signed business associate agreements or verbally committed to their partners that they were HIPAA-compliant and had adequate information security controls in place. In addition, some organizations may have provided compliance reports or signed attestations to demonstrate compliance.

The challenge with this sort of vendor monitoring is that a healthcare organization cannot be “certified” as HIPAA-compliant. As an alternative, organizations have had to use an internal resource to perform a self-assessment against the HIPAA requirements or hire an external assessor to perform an independent assessment.

In 2007, a consortium of healthcare organizations came together and formed the HITRUST Alliance, a nonprofit focused on making information protection a core pillar of healthcare information systems and exchanges. HITRUST was created to address challenges such as concern over breaches, numerous and sometimes inconsistent requirements and standards, compliance issues, and the growing risk and liability associated with information security in the healthcare industry.

An increasing number of healthcare organizations, including Anthem, Health Care Services Corp., Highmark, Humana, and UnitedHealth Group now require their vendors to obtain HITRUST certification as a means of demonstrating effective security and privacy practices aligned with the requirements of the healthcare industry. HITRUST estimates that approximately 7,500 currently contracted organizations will need to become HITRUST-certified within the next two years.

Today, for most vendors and providers intending to contract with a large healthcare organization, obtaining HITRUST certification is an essential component of business development. However, it should not be confused with assuring a partner that a vendor or provider is meeting federal and state operational requirements.

CONCLUSION

The early development of a compliance program—including a preemptive compliance review—is something vendors and providers should strongly consider. Such a program can protect them from a make-or-break compliance inquiry down the road.

But a compliance program also enables a vendor or provider to demonstrate that it understands the potential partner’s regulatory environment and that its offered services can reduce compliance sanctions for the larger organization. That will distinguish the vendor or provider as “best in class.” It is a growth strategy that should not be ignored.

Justin Frazer is Director, Regulatory Compliance, Healthcare Consulting Group, Mazars USA LLP.

References

For more details, qualifications, and guidelines on these entities, see Medicare Managed Care Manual Chapter 21, Compliance Program Guidelines; Prescription Drug Benefit Manual Chapter 9, Compliance Program Guidelines.
Solar Helps Fortune 500 Companies Save Money

Data from the Solar Energy Industries Association's (SEIA) annual Solar Means Business report shows that major U.S. corporations, including Kaiser Permanente, are investing in solar and renewable energy at an incredible rate. It's easy to see why. Solar energy is a cost-effective way for businesses to generate the electricity they need for many applications. For example, U.S. healthcare is an energy-intensive industry, and healthcare buildings are getting larger to meet the growing needs of the population.

![Electric Energy Cost per Square Foot](image)

**SOLAR COSTS HAVE FALLEN 63%**

More businesses are also becoming socially driven and are adopting the triple bottom line approach—people, planet, and profits—that goes beyond measuring financial results to considering a company's effects on community health, sustainability, and enhanced reputation.

With solar costs dropping 63% in the last 10 years, corporate customers have been able to increase the size of their solar photovoltaic (PV) systems. This has had a meaningful impact on corporate climate goals, with commercial solar PV systems offsetting 7.5 million metric tons of CO2 annually. This is the equivalent of taking 1.6 million cars off the road each year.

![Price by System Size](image)
BOTTOM-LINE BENEFITS

As soon as your solar system is activated, you start saving money that would otherwise be spent on electric bills—while protecting your facility from utility price increases. Depending on your location and how you choose to finance solar, you can lock in low electricity rates and possibly eliminate your entire electric bill.

Think about your bottom-line benefits in healthcare. Savings on electric bills can be used in operations efficiency. Remember, you are guaranteed utility hikes each year. The longer you wait to switch to solar, the more it will cost you.

Check with your accountant for depreciation and the federal investment tax credit (ITC), which is 26% in 2020, drops to 22% in 2021, and is only 10% after 2021. If your organization is tax-exempt, you cannot directly take advantage of the ITC. However, you can work with financial partners to establish a power purchase agreement (PPA). This is a contract in which another party owns the solar system and takes advantage of the tax benefits, while you enjoy the energy savings with no upfront costs.

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**Top 10 Rankings**

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SEIA’s 2018 Solar Means Business report. This chart shows the 10 largest commercial solar installations.

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The most expensive decision you can make about solar is to do nothing. To learn more about how solar energy can benefit your healthcare business, contact Valerie Okunami, Commercial Energy Advisor, at 916-761-1853.
The historical growth of HMO products has resulted in the growth and expansion of delegation—not only of financial risk, but also of administrative responsibilities. In order to manage financial risk while providing high-quality patient care, physician organizations developed the systems, tools, and resources needed to successfully perform these additional administrative functions and care management activities.

The growth of this delegated model is often attributed with the success of capitated, or value-based, care. In recent years, a number of organizations, including the Integrated Healthcare Association (IHA) in California, have provided supporting evidence that HMOs and delegated physician organizations demonstrate better quality and lower costs.

As illustrated in IHA’s July 2016 Regional Health Care Cost & Quality Atlas Fact Sheet, HMOs consistently outperform commercial PPOs on both clinical quality and cost measures. In addition, Medicare Advantage (MA) plans typically outperform Medicare fee-for-service on both clinical quality and cost measures.

PHYSICIAN ORGANIZATIONS AND DELEGATION

The evolution of the delegated model is based on the premise that a provider entity is best equipped to manage the care of its patients. The model has become common in many states, with provider organizations delegated for everything from a few to several administrative services.

As more health plans delegate to provider organizations, it promotes the ability of providers to achieve the quadruple aim: improving the health of populations, enhancing the patient experience of care, reducing the per-capita cost of health, and improving the lives of healthcare providers. Assuming delegation for administrative services, along with financial risk, is fundamental to being able to control the total dollars—while managing and delivering care to patients.

WHAT IS DELEGATION?

The National Committee for Quality Assurance (NCQA) defines delegation as a formal process by which an organization gives another entity the authority to perform certain functions on its behalf. Although an organization may delegate the authority to perform a function, it may not delegate the responsibility for ensuring that the function is performed appropriately.

Health plans hold the license or certificate to function as health plans in the state in which they provide services. Therefore, the plans retain the ultimate responsibility and accountability for ensuring delegated functions are performed appropriately.

However, delegation has many advantages for both the health plan and the provider organization. This is why so many plans delegate as many administrative functions as possible to contracted provider organizations. The terms and mutual responsibilities are typically detailed in an agreement between the plan and the provider organization.

QUESTIONS TO ASK

For provider organizations, the value of becoming a delegated entity is in the increased control in key functional areas, including medical decision-making, dollars and claims payment, and provider network decisions.

The key is to understand the requirements related to delegation and assess internal capacity to successfully provide these services. Some organizations take as many of the administrative functions as possible from the health plan to
create a competitive edge, while enhancing their level of control. However, there are a few questions to ask before accepting delegation, including:

- Is your organization financially ready to become a delegated entity or to expand delegated functions?
- Does your organization have the expertise to provide such services and to ensure compliance for delegated functions?
- Does your organization have the necessary information systems, data collection, and analysis capabilities to monitor and report delegated functions?
- Does your organization have established internal audit and oversight capabilities?
- Has your organization conducted a value-based risk analysis to determine the pros and cons of accepting delegation?

IMPACT OF DELEGATION

Once your organization has agreed to accept delegation and a detailed delegation agreement has been negotiated, it is important to understand the role and impact of delegation throughout the organization. Here are some areas to consider.

GOVERNANCE STRUCTURE

The provider organization needs to have a board of directors that wants to take on the roles that come with delegation. Leadership needs to support the cost and infrastructure it will take to perform the administrative services the organization is contracted to provide.

The board and leadership team need to be committed to improving their knowledge and understanding of managed care principles and compliance requirements through continuing education and training, continuous quality improvement, and introduction and adoption of best practices. This will enable the organization to successfully operate in an efficient and cost-effective manner and in full compliance with all rules, regulations, and guidelines.

FINANCIAL CONSIDERATIONS

Taking on delegated administrative services enhances the financial risk of the organization. The organization’s financial viability in a delegated model is a critical factor in the decision to accept delegation. Additionally, the organization must be prepared to monitor and reconcile membership and payments received from the health plan to ensure accurate accounting of dollars paid.

CLAIMS MANAGEMENT

A provider organization must be able to process all types of claims for which it has financial risk. It will need to be prepared to support the necessary infrastructure—including policies and procedures, competent claims staff, configuration, provider dispute resolution processes, and recovery, as well as a claims payment system that is sufficiently expansive to accommodate all types of claims and data retrieval.

CREDENTIALING

The organization must have and maintain the ability to credential and recredential all types of providers, including physicians, nonphysicians, ancillary providers, and facilities. Further, it must monitor and continuously update its provider network and have processes in place to monitor, track, and report sanctioned and excluded providers.

MEDICAL MANAGEMENT

Medical management is a broad term that may include utilization management and medical decision-making related to pre-service requests, concurrent review, and post-service requests. The term may also include case management, care coordination, and population health management.

All of these require expert clinical staff who can administer the authorization processes, as well as other programs designed to manage risk and coordinate care and services. Some or all parts of medical management may be delegated. The detailed delegation agreement is vital to ensuring a complete understanding of what is delegated and what is not.

DATA ANALYTICS

Data is critical to the success of managing a risk population. Most delegation agreements have specific reporting requirements, so it is important to evaluate your data collection and reporting capabilities. It is also essential that the organization monitor performance and compliance with contractual obligations.

Detailed member information is essential for population health management, for proactively managing care and services, and for better identifying and managing risk. Basic data collection and analysis requirements include:

- An organized system to collect and report uniform data. This can be as simple as an Excel spreadsheet or as sophisticated as a registry.

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Choosing an MSO: 10 Factors to Consider

BY RUSS FOSTER AND SHEILA STEPHENS

Selecting a management services organization (MSO) is not a process to short-cut. The potential adverse impact related to making the wrong decision is too great. The selection process should occur in much the same way as any other major purchase decision—that is, driven by your needs.

Simply put, MSOs provide administrative services on behalf of providers and their respective entities. Our focus for this article is on full-service MSOs that serve medical groups and independent practice associations (IPAs) that contract with health plans and accept delegation for one or more administrative functions and related responsibilities (as set forth in delegation agreements and health plan contracts).

Based on our experience, organizations should consider 10 core factors in selecting the right MSO:

1. Business focus or type of MSO
2. Specific services needed
3. Reputation, performance, and relationships with health plans/payers
4. Ownership affiliation
5. Administrative capacity and financial viability
6. Transition timeline
7. Contract terms and conditions
8. MSO fees and other costs
9. Control
10. Oversight and monitoring

This article does not include a detailed legal or technical review of MSO ownership structures, corporate practice of medicine statutes, and other state statutes that may relate to MSOs and physician relationships. Before entering into a relationship with an MSO, we strongly advise a medical group or IPA to seek legal advice from a knowledgeable legal source—including developing and reviewing any agreement prior to execution.

1. BUSINESS FOCUS OR TYPE OF MSO

MSOs come in many shapes and sizes and offer varying levels of functionality, expertise, and experience. Some areas to consider include:

- **Product lines.** An MSO that does not administer Medicaid products may not be a good fit for a purchaser that is heavily contracted for Medicaid products.

- **Geographic location.** An MSO that primarily focuses on Medicaid may initially sound perfect for a large medical group that serves only Medicaid. However, if the MSO is in a different state than the medical group, it may not be sufficiently familiar with the unique aspects of Medicaid in that different state. This may be particularly important in heavily regulated states with significant focus on Medicaid managed care.

- **Cultural or ethnic aspects.** These may be important if your medical group or IPA serves a particular cultural or ethnic population. In that case, it is prudent to determine if the MSO currently serves similar medical groups or IPAs.
The initial step is to identify the MSO options that most closely align with your organization's operational need in terms of expertise associated with product lines—and to the extent possible, satisfy any cultural or ethnicity needs. In some cases, it may be best that the MSO operate within a reasonable distance of your service area or location.

2. SPECIFIC SERVICES NEEDED

The needs of your medical group or IPA will vary depending on your size and capabilities. This will ultimately determine the type and size of MSO needed.

In the marketplace today, a significant number of small risk-bearing medical groups and IPAs have no administrative infrastructure or staff and must outsource all delegated functions to an affiliated or independent MSO.

Some mid- to large-sized medical groups and IPAs have a certain level of administrative capacity, but continue to outsource core functions like IT, claims and capitation processing and payment, credentialing, and reporting functions.

You may also have unique needs or interests that require specific MSO capabilities, such as population health management, data management, and value-based contracting expertise. Some MSOs have invested heavily in IT and other support systems and staffing to manage changes in payment models (including value-based models within a clinically integrated system), and they are well-positioned to provide resources that a smaller organization could not otherwise afford.

MSO services can be obtained in numerous configurations, from purchasing a single service, such as IT/claims processing, to acquiring a full range of services. These may include:

- Quality improvement activities
- Utilization management activities
- Case management
- Population health management
- Enrollment and eligibility verification
- Accounting and auditing
- Revenue reconciliation
- Claims processing
- Credentialing
- Provider relations and contracting
- Education and training
- Practice management
- Coding/billing/revenue cycle and reconciliation
- Information systems/EHR, data analytics, reporting, and benchmarking
- Vendor, equipment, and facilities contracting
- Human resources and benefits management
- Payroll
- Compliance and risk management

3. REPUTATION, PERFORMANCE, AND RELATIONSHIPS WITH HEALTH PLANS/PAYERS

Not all MSOs offer comparable levels of quality, service, or expertise. When considering a potential MSO, you should:

- Communicate with other entities currently served by that MSO to evaluate the level of satisfaction and performance. Verifying the MSO’s reputation within the industry may provide valuable insight that otherwise may not be available until it is too late.
- Interview key department managers and supervisors, in addition to C-suite executives.
- Consider questioning the contracting health plans to see if there are any concerns regarding an MSO’s business ethics, competency, or confidence.
- Adopt a “buyer beware” perspective if the MSO is new, with very limited experience. MSOs need significant membership volume to sustain their operations and to recruit experienced staff. A lack of resources can have a significant impact on quality and compliance.

Equally important is the relationship that an MSO has with key health plans in your service area. Historically, many small- to mid-sized medical groups and IPAs have had limited interface with senior-level health plan personnel, especially those that oversee the contract negotiation process. Partnering with an MSO that has a longstanding and/or positive relationship with health plans will:

1. Enhance access to health plan contracts that may not otherwise be made available to the medical group/IPA
2. Expedite the timeline for negotiating and executing contract documents
3. Streamline the initial due diligence review and subsequent annual audit process
4. Provide a more direct communication venue in the event that administrative, operational, clinical, or financial issues arise (which they invariably will)

That being said, it is imperative that your medical group/IPA drives the decision-making process on the health plan contract terms. You want to ensure that the MSO’s business goals (increased lives and related management fees) do not supersede those of your organization—including financial profitability on each and every health plan agreement (increased lives adding increased profits to the bottom line).

Knowing an MSO’s reputation, performance, and relationships with health plans/payers is essential. Contracted health

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plans—and often the state—will hold you, the purchaser, accountable for all delegated functions. This is a significant distinction and one that could adversely impact your health plan contracts if the MSO’s reputation, performance, or relationships do not meet expectations or standards or are noncompliant.

Remember, when you contract an MSO for delegated functions such as claims processing and utilization management, you are allowing the MSO to make decisions that impact your relationships, as well as your finances.

4. OWNERSHIP AFFILIATION

It’s not uncommon for MSO ownership to include venture capital, private equity, health systems, and/or other high-net worth individuals. In some cases, the business interests of these owners and their demands on the MSO for return on investment could result in potential conflicts of interest (i.e., competitors gaining access to your providers and data) or other contract terms, including pricing that could be outside of market norms.

Linking your business strategies to the MSO selection and MSO ownership will help to determine if the MSO is a good fit—aligning with your mission, values, and business goals. This will also help determine if the MSO is willing to adopt your organization’s mission, values, and business strategies and integrate them operationally into the services you wish them to provide.

Ensuring a good fit means you must be knowledgeable about the MSO’s ownership and structure.

5. ADMINISTRATIVE CAPACITY AND FINANCIAL VIABILITY

One of the most important considerations is whether the MSO has the administrative capacity and financial viability to serve your needs. Ultimately, the MSO will conduct business on your behalf. Therefore, you need to validate its ability and capacity to do this.

A common complaint is the absence of experienced MSO staff in key departments, such as claims, utilization management, case management, contracting, and finance and accounting. Mistakes made in these departments can be the difference between gains and losses, compliance or noncompliance, and solvency and insolvency.

Some MSOs may contract with an offshore subcontractor for certain services. This is an important factor to know, as both health plan contracts and their upstream agreements with government-funded programs require—at the very least—acknowledgement and attestations related to the use of offshore subcontractors.

You should conduct a thorough due diligence of the potential MSO to better understand its administrative capacity and financial stability. This due diligence should include assessing:

- Organizational structure
- Staffing and staff expertise and experience
- Supervision and oversight
- Performance monitoring
- Policies and procedures
- Recent audit results
- Functional area specifics—such as configuration in support of claims payment, and clinical criteria sets employed in utilization management decisions and consistency of application

The due diligence assessment must include a review of the MSO’s financial viability, including a review of the MSOs’ audited financial statements, if available. Currently, MSOs are largely unregulated, which can result in them operating with very little cash reserves to help offset a bad month, quarter, or year. A well-run MSO, like any other business, will be able to demonstrate they have enough reserves to cover any contingency. MSOs that are losing money, or whose profits are being upstreamed to investors or parent organizations, will have difficulty assuring their financial viability.

The MSO’s administrative capacity should also include communications and reporting. This is important because agreements with contracted health plans hold the purchaser accountable for delegated services, including timely notifications and reporting.

For example, for health plan contracts that include Medicare Advantage products, it is essential the MSO has the capability to collect and report Part C and Part D data on behalf of the purchaser. In some states, such as California, the purchaser may be considered a risk-bearing organization (RBO) and be required to submit timely financial reports to the state. The MSO must be capable of preparing and submitting such documents on the purchaser’s behalf.

6. TIMELINE FOR TRANSITION

In most cases, a reasonable transition period is around four to six months. It can be accomplished faster if all parties are motivated and working toward a common goal. However, all too often, the outgoing MSO is not motivated to work cooperatively with the incoming MSO. This creates significant transition issues in uploading critical eligibility, benefit tables, claims and authorization records, contracts, and other core documents.

Timing considerations also include developing and implementing a formal communication, notification, and
transition plan and timeline. The potential MSO might be a perfect fit in other respects. But if you absolutely need a three-month transition period, and the MSO is not able to transition before nine months, that gap may be the deciding factor.

7. CONTRACT TERMS AND CONDITIONS

Read the contract from cover to cover! As they say, the devil’s in the details, and that is certainly the case with MSO agreements. There should be a formal administrative services agreement (ASA) in place—sometimes referred to as a management services agreement (MSA).

It is critical that you are intimately familiar with all terms and conditions. Every agreement should include a detailed list of services to be provided and excluded and key deliverables and timeframes, limitations and exceptions, MSO responsibilities, purchaser’s responsibilities, and dispute terms. Other significant terms include termination for cause, termination without cause, regulatory requirements (including recordkeeping requirements), and overall compliance, such as state- or CMS-specific regulatory requirements.

The ASA must be developed and structured to ensure the MSO does not exercise any undue control over the medical group or IPA, become too involved with its affairs, or overstep into clinical practice. All of these could create legal issues related to the corporate practice of medicine laws. This underscores the need for expert legal review of the ASA.

Understanding just how far the MSO is willing to go to meet your organization’s needs—as well as having a clearly articulated ASA that has been developed or reviewed by expert legal counsel—will help you avoid serious conflicts down the road, including litigation.

8. MSO FEES AND OTHER COSTS

You must evaluate the administrative fees charged by the MSO to see if they are reasonable and at fair market value. The cost consideration is twofold:

1. Outsourcing to an MSO should not cost you significantly more than providing the services in house. One of the primary reasons for outsourcing is to reduce administrative costs.

You may still need to engage the MSO to provide certain services excluded from the stated fees. In this scenario, the aggregate cost of MSO services could be significantly higher than the negotiated rate the MSO is quoting for covered services. Some MSOs like to unbundle, while others offer all-inclusive pricing.

2. It is important to obtain competitive and fair market terms to ensure the entity remains in safe harbor as it relates to any anti-kickback, Stark, or corporate practice of medicine statutes. This is an area where you are strongly advised to seek legal advice from a knowledgeable legal source, who can advise regarding regulatory risks. Additionally, it is highly recommended that you obtain a fair market value opinion from a knowledgeable CPA or healthcare consultant before entering a rate discussion with a prospective MSO.

MSOs will also often charge a setup fee for onboarding a new client, and there could be penalty provisions for early termination. Again, expert legal review of the ASA and its financial terms is strongly advised to ensure safe harbor related to both duties and fees.

9. CONTROL

Yes, control. Even though you want to outsource one or more administrative functions to the MSO, it is critical that you retain control. What this means is the MSO must be required to administer functions contracted through the ASA in accordance with your entity’s health plan contracts, policies and procedures, and provider agreements, as well as all applicable regulatory requirements. The physician organization that holds the contract with the health plan is the entity that must remain in control.

While the MSO must have general internal controls in place, its ability and willingness to accommodate the unique needs of your medical group or IPA is an essential factor in selecting the best MSO.

For example, you may have several different contract templates for primary care physicians, along with different scopes of service, fee schedules, and payment methodologies. In this scenario, it is critical to validate that the MSO is capable and has necessary controls in place to pay like providers based on different fee schedules or payment methodologies.

You should expect the MSO to provide frequent and timely reports regarding paid, denied, delayed, modified, and disputed claims as part of the control process. Inadequate controls can be costly financially and politically, and they can have contractual and regulatory consequences.

Another example relates to medical necessity decisions and ensuring the MSO has controls in place to follow your approved and adopted practice protocols or guidelines. This is an important point of control. The MSO must not usurp the policies that support the foundation for the delivery of medical care as established by the purchaser or its providers. The MSO must follow the medical guidance of the purchaser—as outlined in the purchaser’s respective policies, procedures, protocols, and guidelines—to ensure that physicians retain the ultimate responsibility over patient care.

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To do otherwise may place the medical group or IPA and the MSO in conflict with regulatory bodies. For example, the Medical Board of California has determined that certain decisions remain in the realm of physician expertise, and these decisions and activities can be made by a physician who consults with the MSO, but not by the MSO alone.¹

10. OVERSIGHT AND MONITORING

The MSO, under the ASA, is accountable to the purchaser. It is the purchaser that holds the contracts with health plan partners, so it is the entity held accountable for ensuring full regulatory compliance. Therefore, the purchaser must be prepared to conduct oversight of all delegated functions.

This is not as simple as it may sound. Oversight is a two-way street that requires open, transparent communication and cooperation between the two parties. Along with expertise and capacity, the MSO should promote your ability to readily oversee its activities. This is a key factor in the selection process. The MSO must be capable and committed to providing transparent communications regarding performance and accuracy of reports to ensure compliance on behalf of your medical group or IPA.

All too often, we see purchasers who abdicate to the MSO—and MSOs that attempt to unduly control the business in favor of the MSO and not the purchaser. Clear and transparent communications—along with frequent and thorough oversight of the MSO through ongoing monitoring, auditing, and compliance reviews—are essential to ensuring that the terms and intent of the ASA, as well as regulatory compliance, are met.

CONCLUSION

The decision to contract administrative services to an MSO or to change from one MSO to another is a major one that requires time and due diligence efforts. Selecting an MSO requires many considerations. It is essential the purchaser not short-cut the process. To do so could easily result in an adverse or costly outcome.

Asking all the right questions and conducting an exploratory due diligence assessment will yield a best-fit relationship that is supported by mutual goals, clear expectations, cost-effective processes, and mutual benefit—without the MSO exercising undue control.

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Endnotes

¹ Medical Board of California’s Corporate Practice of Medicine guide; http://www.mbc.ca.gov/Licensees/Corporate_Practice.aspx

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- The ability to evaluate specified outcomes related to a given subset of the membership
- Knowing how the data relates to the business strategy

CONTRACTING

The provider organization is responsible for ensuring its provider network addresses all services identified in the risk agreement. Contracts with your providers must address all compliance requirements, as well as any specific requirements associated with delegation. A critical success factor is to fully understand the contract with the health plan, along with any additional delegation documents.

COMPLIANCE

Accepting delegation means that the organization has agreed to meet all applicable regulations that govern the products related to the delegated services—as well as all associated contractual obligations. It is essential that the organization is committed at all levels to ensuring compliance with all services.

Compliance considerations include state and federal regulations; HIPAA; fraud, waste, and abuse; and training and education, along with associated documentation. Accepting delegation is a major commitment. It’s critical to have an internal team that understands the regulations and obligations.

WHY AGREE TO DELEGATION?

The major reason to accept delegation is to increase the organization’s control over decision-making. Taking only financial risk allows a provider organization to contract competively, as well as possibly expand revenue from payers, but it does not provide the structure needed to manage its dollars or its membership.

Delegation of administrative services provides the basis for decision-making, fiscal management, and network management. It’s that basis that encourages the provider organization to be creative and innovative in how it manages its patient population—and how its network providers are paid. ○

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