Advisory Board

ISSUE 1 | Spring 2021

Executive Insights

A round-up of research for health care leaders

FEATURED

STRATEGY

Projecting volume recovery through H1 of 2021

pg 22

DIGITAL HEALTH

A primer on virtual-first health plan products

pg 33

POLICY

We predicted big cuts to Medicaid payments after Covid-19. Here's why we've changed our minds.

pg 46

PANDEMIC

Good? Bad? Ugly? We've updated our take on what's next for the epidemic.

pg 54

DIGITAL HEALTH

Amazon Care is coming to all 50 states—with the potential to disrupt patient-physician relationships

pg 69

IN THIS EDITION

Letter from the editor

It has been a year. Where to begin.

Welcome to the inaugural issue of Advisory Board's Executive Insights—in what I hope will become a quarterly journal for executives across the health care industry. Herein we have collected all of our research, insights, and opinion pieces aimed specifically at health care leaders and published online across the first quarter of 2021.

For most of the past 12 months, our industry has found itself reacting, adapting, and hoping that life will return to what we remember at some point just around the corner. But it hasn't turned out that way. It's trite to say that the pandemic has irrevocably altered nearly everything we accepted as normal—but I don't think that has it quite right. The pandemic—and indeed much of the past several years—has very painfully revealed that many of the assumptions we held as true and unchanging simply weren't. Here are just a few from our industry: Telework results in poor productivity and engagement. Digital health will never take hold as a viable alternative to in-person visits. Physicians will never practice differently without different financial incentives being thrown at them. Patients may want to be treated with home-based care, but few will ever provide it. All, as it turns out, untrue.

In this issue—and in those to come—we want to show you not how to go back to normal (whatever that was), but rather what's coming. We've examined how behavioral health will have to permanently change to adapt to a society largely kept isolated from one another for a year. We're looking at the future of digital health and how Big Tech plans to disrupt it and private health plans intend to pay for it. And we model out future volume recovery for providers—under a variety of vaccination scenarios.

I should point out that everything you read here has already been published online. Some time ago, Advisory Board altered its publishing schedule such that ideas are now published as soon as they are written, and not long after they've been formulated and vetted. Executives no longer have to wait for a member event or the newest book to hear our take on any of the major topics facing the industry.

But sometimes it's handy to have it all in one place. We, of course, welcome any and all feedback—effusive endorsement, savage criticism, we value it all. If you have any questions, comments, or ideas for future topics, please feel free to contact me. I hope to see you all again very, very soon—either in person at an upcoming Advisory Board event, or in my (mostly) weekly webcast, Stay Up to Date. And if you haven't subscribed to our podcast, Radio Advisory, hosted by my longtime colleague, Rachel Woods, please do so. It's been growing by leaps and bounds. If you're not registered and you'd like to be, we've helpfully included instructions how on page 88.

So those are the main things. How are you all?

Christopher Kerns

EXECUTIVE EDITOR AND VICE PRESIDENT

Featured contributors

Heather Bell
bellh@advisory.com

Manasi Kapoor
kapoorma@advisory.com

Amanda Berra
berraa@advisory.com

Christopher Kerns
kernsc@advisory.com

Megan Director
directorm@advisory.com

Madeleine Langr
langrm@advisory.com

Yulan Egan
egany@advisory.com

John League
leaguej@advisory.com

Colin Gelbaugh
gelbaugc@advisory.com

Regina Lohr
lohrr@advisory.com

Brandi Greenberg
greenbeb@advisory.com

Ben Umansky
umanskyb@advisory.com

Sarah Hostetter
hostetts@advisory.com

Rachel Woods
woodsr@advisory.com

In this edition

POLICY

Navigating Biden's first 100 days

How a narrow majority can reshape health care

By Heather Bell

JANUARY 20, 2021

The first 100 days of a president's term often serve as a litmus test for how the president will govern and what policies the new administration will prioritize for the duration of the term. But when President Joe Biden is sworn into office on January 20th, his administration will face unprecedented challenges—a global pandemic, a recovering economy, and political unrest—that will dominate his administration's initial agenda.

Health care leaders must be prepared for policy changes that are inherent when a new party assumes office, particularly as they continue to battle the real-world effects of caring for patients during the Covid-19 pandemic. This briefing breaks down four key questions to watch, including the health care policies the Biden administration could prioritize in the first 100 days—and what to watch beyond that time period.

This article was originally published online on January 20, 2021. To see the original article with all citations, please go to: **advisory.com/Biden-Harris/first100days.**

How we got here

The 2020 elections led to Democratic control of the White House and the House of Representatives. The Senate is split 50-50, with vice president Kamala Harris serving as the tie-breaking vote. Although Democrats lack the 60 Senate votes required to overcome a filibuster, Democratic control of the White House and Congress gives the party a new freedom to enact Joe Biden's agenda.

But that freedom will be tempered by the fact that Biden is taking office amid a global pandemic that has placed enormous pressure on the United States' economy and health care system, as well as an increasingly uncertain political climate. When the Senate resumes, it will begin a second impeachment trial for President Donald Trump, due to the violent events on January 6th at the U.S. Capitol. This means that the Biden administration and the Democratic-controlled Congress will have little bandwidth to address health care not related to Covid-19 in the first 100 days of the new administration.

50 of 100
Senate Democrats

221 of 435
House Democrats

Here are four key issues to watch:

01 Who are the key players in health care?

02 What mechanisms will drive policy changes?

03 What health care topics will be prioritized?

04 What to watch for beyond the first 100 days?

Who are the key players in health care?

In the leadup to inauguration, President Biden announced several cabinet nominees, but many important health care nominations remain unknown. He has, however, announced special appointments related to Covid-19. Listed below are the health care nominations Biden has announced—and a few others to watch for.

Xavier Becerra, HHS Secretary

Becerra has served as California's attorney general since 2017. Becerra led the Democratic state attorney generals' defense in California v. Texas, which seeks to strike down the Affordable Care Act, and spent 24 years representing California in the U.S. House of Representatives. While there, he was a member of the House Ways and Means Committee's subcommittee on health, and he voted to enact the ACA. Becerra will need to be confirmed by the Senate.

Chiquita Brooks-LaSure, CMS Administrator

Brooks-LaSure is a managing director at Manatt Health. She began her career as a program examiner and lead Medicaid analyst at the Office of Management and Budget. She worked as a Democratic staffer for the House Ways and Means Committee, led Biden's HHS review team, and held positions at HHS and CMS under the Obama administration. Brooks-LaSure will need to be confirmed by the Senate.

Rochelle Walensky, CDC Director

In the leadup to inauguration, President Biden announced several cabinet nominees, but many important health care nominations remain unknown. He has, however, announced special appointments related to Covid-19. Listed below are the health care nominations Biden has announced—and a few others to watch for. Walensky is chief of infectious diseases at Massachusetts General Hospital, a professor at Harvard Medical School, and an expert on HIV and AIDS. Walensky will not need to be confirmed by the Senate, meaning she can immediately step into the role.

Elizabeth Fowler, Center for Medicare and Medicaid Innovation Director

Fowler has served as EVP for programs at the Commonwealth Fund, and on the National Economic Council as a special assistant to former President Barack Obama on health care and economic policy. Fowler also worked on ACA implementation efforts while serving in a role at HHS. Fowler's position does not require Senate confirmation.

Neera Tanden, Office of Management and Budget Director

Tanden currently is president and CEO of the Center for American Progress. She served as senior advisor for health reform at HHS under former President Barack Obama, where she developed policies and provisions included in the Affordable Care Act. Tanden's position requires Senate confirmation.

Anthony Fauci, Chief Medical Advisor

Fauci, who became the Trump administration's key public-facing expert on the response to the Covid-19 pandemic, will continue to serve as the director of NIAID. But Biden also is elevating Fauci's role, asking him to serve as his chief medical advisor and to join his Covid-19 response team. Fauci's position does not require Senate confirmation.

Vivek Murthy, U.S. Surgeon

General Murthy will be returning to the surgeon general role, which he held from 2014 to 2017. During that time, he focused on preventive care and reducing the stigma surrounding mental health care. He also oversaw the publication of a landmark report on substance use disorders and warned against e-cigarettes. Biden has asked Murthy to co-chair his coronavirus task force, which will most likely be his focus for his first months on the job. Murthy's role requires Senate confirmation.

Jeffrey Zients, Covid-19 Czar

Zients, currently a co-chair of Biden's transition team, co-founded the nonprofit Urban Alliance with his wife and serves as board chair. Zients responsible for fixing the ACA exchange website in 2013 and is now tasked with fixing the federal government's response to the Covid-19 pandemic. Zients' position does not require Senate confirmation.

David Kessler, coronavirus task force co-chair

Kessler, a pediatrician and lawyer, led the FDA under presidents George H. W. Bush and Bill Clinton. Kessler will work closely with Gen. Gustave F. Perna, who will continue as COO of the coronavirus task force that the Trump administration called Operation Warp Speed. This position does not need to be confirmed by the Senate.

Marcella Nunez-Smith, coronavirus task force co-chair

Nunez-Smith is an associate professor of internal medicine, public health, and management at Yale School of Medicine. Nunez-Smith's research at Yale focuses on promoting health and health care equity for marginalized populations. She has served as an advisor to the Biden-Harris campaign. Nunez-Smith's position does not require Senate confirmation.

Other health care roles to watch

The focus on the new coronavirus task force has left several health care posts unfilled. These posts will play key roles in shaping the Biden administration's approach Medicare payments, value-based payment models, drug and medical device approvals, including approving a Covid-19 vaccine, and medical research.

Four health care positions to watch:

- Administrator of the Centers for Medicare & Medicaid Services
- Commissioner of the Food & Drug Administration
- Director of the National Institutes of Health
- Director of the Centers for Medicare & Medicaid Services

What mechanisms drive policy changes?

Incoming administrations have several mechanisms at hand to make health care policy changes at the executive and legislative level. But some mechanisms take more time and party unity than others. The table below details the mechanisms the Biden administration can use to halt or roll back Trump-era policies and implement new policies.

EXECUTIVE BRANCH	
Executive orders	Presidents have historically assumed the authority to issue orders directed at government agencies to help manage and guide the operations of the federal government. Executive orders are considered legally binding so long as they are supported by congressional statute or the Constitution. Executive orders are subject to judicial review, may not be used to repeal or amend a statute, and cannot direct the government to act in contradiction to the law. Executive orders are typically used to determine how legislation is executed and to what extent legislation is enforced.
Public health emergency	The Public Health Service Act gives the HHS Secretary the authority to declare a public health emergency when certain conditions are met. The declaration allows the secretary to waive or modify certain Medicare, Medicaid, CHIP, and HIPAA requirements; make temporary appointments to respond to the emergency; declare an emergency under the Federal Food, Drug, and Cosmetic Act allowing the emergency use authorization of unapproved or approved drugs, devices, or biological products; adjust Medicare Part B reimbursement. The current public health emergency has been in place since Jan. 31, 2020.
Regulatory postponement	The president can halt any rule from the previous administration that has not been finalized or taken effect as of Jan. 20, 2021. Rules that have been finalized for more than 60 days must go through the rule making process to be withdrawn.
CMS waiver oversight	CMS can decline to renew previously submitted Medicaid waivers or reject future waivers. CMS also reserves the right to withdraw approved waivers. However, this authority has never been used before and states can challenge a waiver withdrawal.
Rule making process	Federal agencies can propose new rules or terminate or amend existing rules through the rule making process. Most rules follow the same process: an agency submits the rule to the Office of Management and Budget, then the rule (if approved) is then published to collect public comment. The agency must publish and review the commentary before issuing a final rule. The process can be lengthy, which is a key reason the Trump administration finalized several rules by November 20th, making them ineligible for regulatory postponement.

LEGISLATIVE BRANCH	
Congressional Review Act	The CRA gives Congress the ability to invalidate federal agency rules published in the previous 60 legislative days. A CRA resolution bypasses the normal cloture process that requires a 60-vote threshold and can pass by a simple majority. CRA bars the issuing agency from considering anything similar in the future. CRAs are subject to presidential veto, as such they are most commonly used when a new administration takes office.
Budget reconciliation	Budget reconciliation is a legislative process created to enable the Senate to quickly pass bills related to spending, revenue, or deficit reduction. Bills passed under reconciliation are not subject to filibuster and can be passed by a simple majority vote. But the process generally is limited to three times a year—one bill for each subject—unless Congress approves more than one budget resolution in a single year. Provisions of reconciliation that do not affect spending or revenues can be blocked via the Byrd Rule, though the Senate can vote to waive the Byrd Rule with a three-fifths vote.
Bipartisan legislation	Biden and centrist Democrats could work across the aisle on pressing coronavirus relief issues and other bipartisan topics to quickly pass legislation and skip the reconciliation process.
Filibuster abolition	Legislation that is subjected to Senate filibuster requires 60 votes to overcome. Although some Democrats have floated the idea of eliminating the filibuster, doing so would have long-standing repercussions. Doing so would allow whichever party holds a simple majority of 51 votes to pass legislation.

Three health care topics Biden could prioritize

While past administrations have been able to use their first 100 days to set the policy tone of their time in office, the Biden administration will need to dedicate significant time and resources out of the gate toward combating the Covid-19. The 117th Congress, meanwhile, will likely focus on relief packages related to Covid-19 and will have to dedicate time to the impeachment proceedings.

The result is that the Biden administration will have little bandwidth to address health care priorities unrelated to Covid-19 in the first 100 days of office. In the following pages, we'll outline the three health care topics we expect the Biden administration will address in the first 100 days.

01

POLICY

Responding to Covid-19

02

POLICY

Protecting health insurance coverage

03

POLICY

Advancing health equity

Responding to Covid-19

01

As discussed, the response to Covid-19 is likely to take up a considerable portion of the Biden administration's time and resources at the beginning of his term. The table below details the executive and legislative actions the Biden administration and Congress could take in the first 100 days.

PUBLIC HEALTH	DESCRIPTION	MECHANISM FOR CHANGE
National mask mandate	On day one, Biden is expected to issue an executive order requiring masks in federal properties and during interstate travel. Health care leaders have urged states to adopt mask mandates to reduce community spread, but not all states have done so. Biden may try to incentivize or work with states to encourage them to issue mask mandates.	*Executive or legislative* Legal experts say it's unlikely a national mandate would survive a legal challenge. Instead, Biden could direct the CDC to issue strong guidance encouraging mask use outside of areas where the federal government has jurisdiction and work with states to implement mandates. Legal experts also say Biden could ask Congress to pass a mandate under the commerce power or to include incentives for mask use in an upcoming relief package.
National social distancing guidance	Federal guidelines encouraging Americans to remain socially distant expired on April 30. Since then, states have taken different approaches to reopening, with many rolling back stay-at-home orders. Biden could quickly issue more stringent federal guidelines on social distancing. The goal of such guidance would be to slow community spread.	*Executive* The Biden administration has the authority to issue new guidance. But such guidance is not legally binding at the federal level.
Halt process to leave the World Health Organization and restore funding	The Trump administration in July began the process to formally withdraw the United States from the WHO over concerns about the organization's handling of the new coronavirus, and its handling of China. That process is set to be complete in July 2021. Several public health experts spoke out against the move, saying it hurt the United States' position as global health care leader.	*Executive* The Biden administration can reverse the Trump administration's move to withdraw the United States from WHO. Biden has said he plans to reverse that process on day one of his presidency.

SUPPLY CHAIN	DESCRIPTION	MECHANISM FOR CHANGE
National vaccine campaign	Biden has set a goal to vaccinate 100 million people during his first 100 days of office. He laid out a national vaccination program that relies in part on community vaccination centers and mobile vaccination units. Biden also has said he will use the Defense Production Act to increase production of Covid-19 vaccines and vaccine supplies.	*Executive and legislative* Biden's administration under the PHE can appoint new leaders and launch new programs targeting the epidemic. However, Biden needs Congress to approve the funding for the national vaccination program.
Expand Covid-19 testing	Biden's Covid-19 plan calls for expanding access to testing and ensuring tests are available at no-cost to individuals.	*Executive and legislative* The Biden administration has broad authority under the PHE to address the epidemic. However, any funding will need to be approved by Congress.
CMS establish a diagnosis code for Covid-19 for claims data	Biden is expected to call on CMS to create a Covid-19 ICD-10 code to be used on an emergency basis.	*Executive* CMS under the PHE can issue new Medicare billing codes.
COVID-19 RELIEF		
Pass and sign a $1.9 trillion "American Rescue Plan" by January 30	Biden has laid out a wide-ranging Covid relief package that includes additional stimulus checks for individuals and funding for many of his coronavirus-related programs, including $20 billion to expand vaccination distribution, $50 billion for testing, and relief for state and local governments, which they can use to cover Medicaid expenses. While Biden's original plan does not include Provider Relief Fund updates, Democrats may be able to leverage their majority to put that funding back on the table.	*Legislative* Both Biden and congressional Democrats have indicated that they will start by trying to negotiate a bipartisan package; if that fails, Democrats could pivot to budget reconciliation.
Extend Medicare regulations tied to public health emergency	The Public Health Emergency is tied to several Medicare-related measures that are renewed every time the PHE is renewed. These include Medicare reimbursement for Covid-related discharges, loosened restrictions on post-acute care facilities, telehealth reimbursement, and more.	*Executive* The HHS secretary can renew the PHE as long as conditions are met.
CMS establish a diagnosis code for Covid-19 for claims data	Private insurance measures that are tied to the PHE are renewed every time the PHE is renewed. This includes enhanced coverage and cost-sharing waivers for Covid-19 tests and vaccines.	*Executive* The HHS secretary can renew the PHE as long as conditions are met.

Protecting health insurance coverage

Increasing access to health insurance is a top priority for the Biden administration. But while larger policy goals like a public option are likely outside the scope of the first 100 days, there are several actions related to Medicaid and the private insurance industry that the Biden administration could reasonably take.

MEDICAID	DESCRIPTION	MECHANISM FOR CHANGE
Halt Medicaid work requirements	The Trump administration approved 12 Medicaid waivers—including four that are facing legal challenges—allowing states to implement work requirements. Seven states have pending waivers. Rolling back these waivers is expected to be a big priority for the Biden administration.	*Executive and judicial* MS can issue new guidance rescinding the 2018 State Medicaid Director Letter allowing states to implement Medicaid work requirements and reject any pending waiver. Approved waivers are trickier. The Supreme Court is set to weigh in on the legality of the Medicaid waiver approvals in Arkansas and New Hampshire. If the Court upholds the waivers, CMS can decline to renew previously submitted Medicaid waivers, or reject future waivers; it reserves the right to withdraw approved waivers. However, this authority has never been used before and states can challenge a waiver withdrawal.
Halt Medicaid "block grant" requirements	CMS recently approved a first-of-its-kind Medicaid Block grant waiver for Tennessee under which the state agrees to try and keep Medicaid spending below a certain target. If the state stays under the target it can keep roughly half of any federal savings and use that money in other state funded priorities. If it exceeds the target, expenses, with some exceptions, come out of the state's budget.	*Executive* CMS can issue new guidance rescinding 2020 State Medicaid Directors Letter allowing states implement either a block grant funding model or a per capita cap model for certain Medicaid beneficiaries. CMS can decline to renew previously submitted Medicaid waivers, or reject future waivers; it reserves the right to withdraw approved waivers. However, this authority has never been used before and states can challenge a waiver withdrawal.
Increasing FMAP	The Families First Coronavirus Response Act increased the federal Medicaid match rate by 6.2 percentage points through the end of the quarter in which the PHE expires. Biden's relief proposal would change the FMAP to 100% for Medicaid vaccine administration costs.	*Legislative* Both Biden and congressional Democrats have indicated that they will start by trying to negotiate a bipartisan relief package; if that fails, Democrats could pivot to budget reconciliation.

PRIVATE INSURANCE	DESCRIPTION	MECHANISM FOR CHANGE
Reinstate funding for ACA navigation and advertising and extend enrollment season back original 90-day length	The Trump administration cut funding for the exchanges' open enrollment in 2018 by $26 million to just $10 million. The administration also reduced the original 90-day open enrollment period to 42 days.	*Executive* HHS could propose a new rule that would reinstate the original open enrollment period window and restore funding.
Unwind short-term health plans and revised standards for Association Health Plans	Trump issued a 2017 executive order that directs federal agencies to consider changes that would loosen federal requirements on association health plans and short-term health plans, which do not have to comply with the ACA's essential health benefits.	*Executive* Biden can rescind that executive order and HHS can issue new rules restricting federal requirements on association health plans and short-term health plans.
Open an individual market special enrollment period	Millions of people have lost health insurance as a result of the new coronavirus pandemic and some experts have called on the federal government to issue a special enrollment period so those individuals can access subsidies health plans.	*Executive* HHS under the PHE can launch a special open enrollment period.
Lower premiums and increase subsidies for people purchasing health insurance on the individual market	Biden's Covid relief and stimulus proposal would increase premium tax credits so that all exchange enrollees will never pay more than 8.5% of their income for coverage.	*Legislative and executive* Congress would need to approve additional funds to increase subsidies and HHS would then need to issue new rules outlining eligibility requirements. Both Biden and congressional Democrats have indicated that they will start by trying to negotiate a bipartisan package; if that fails, Democrats could pivot to budget reconciliation.
REPRODUCTIVE CARE		
Rescind "global gag rule," also known as the Mexico City Policy, that bars foreign NGOs that receive U.S. global health funding from providing abortion-related services	Trump signed an executive order to enact the global gag rule shortly after taking office in January 2017. The administration later expanded the policy to include all global health funding, instead of just funding related to family planning.	*Executive* Biden can rescind the global gag rule via an executive order. This would follow the precedent set by former Democratic presidents.

Advancing health equity

The novel coronavirus put a spotlight on health care inequities in 2020, and Biden has made it clear that addressing health inequities will be a key focus for his administration. While systemic changes will likely take longer than the initial 100 days to address, there are several Trump-era regulations Biden's administration could quickly rescind.

HEALTH CARE PROTECTIONS	DESCRIPTION	MECHANISM FOR CHANGE
Restore and expand protections for transgender individuals when receiving health care	Trump administration in 2020 issued regulations that rolled back an Obama-era rule defining gender identify as protected from sex discrimination; the new rule could have allow ed insurers and providers to refuse covering and providing services tied to gender transition but w as blocked by federal courts.	*Executive* Biden's administration can issue new regulations that restore Obama-era regulations barring providers from discriminating against patients on the basis of gender identity, sex-stereotyping, and sexual orientation.
Restore requirements that health care providers post information in numerous languages and have translation services available	Trump in 2020 issues a rule that rolled back the Obama-era regulations requiring most health care providers to post information in 15 languages and have translation services available to patients.	*Executive* Biden's administration can issue new regulations that restore Obama-era regulations requiring most health care providers to post information in 15 languages and have translation services available to patients.
Reverse Department of Homeland Security rule restricting poor immigrants' access to public benefits like Medicaid	DHS in 2019 issued a final rule that allow s federal officials to consider whether immigrants are receiving or are likely to receive Medicaid or other public benefits when reviewing their residency applications.	*Executive* DHS under Biden can issue new rules that no longer tie a person's immigration status or application for permanent residency to their likelihood of receiving Medicaid, SNAP benefits, or other federal assistance.
HEALTH CARE DISPARITIES		
Reducing the U.S. maternal mortality rate	The U.S. has one of the highest maternal mortality rates when compared with other developed nations, and black women have maternal mortality rates that are nearly triple those of non-Hispanic white women. Biden has touted California's Maternal Quality Care Collaborative and plans to roll this program out nationwide.	*Executive and legislative* California's program is funded in part by CDC's Perinatal Quality Collaboratives and the agency could work with states to implement similar programs. But any new national program would likely require an act of Congress, which could take longer given Congress' busy calendar.

What to watch for beyond the first 100 days

01 Coverage expansion

Expanding access to ACA-compliant health coverage was a pillar of Biden's presidential campaign. Looking ahead we could see Biden and Democrats work on legislation to create a public option or provide incentives for states that have not yet done so to expand Medicaid under the ACA.

QUESTIONS TO CONSIDER

- Will Democrats get rid of the filibuster, and if they do, can they convince all 50 Democratic senators to get on board with public option or reducing the eligibility age?
- Can Democrats convince any Republican Senators to get on board with additional coverage expansions?

02 Medicare Trust Fund stabilization

Shoring up the Medicare Trust Fund is something the Biden administration will need to address as current estimates project it could become insolvent by 2024. There are several ways policymakers and lawmakers can approach this, including provider reimbursement cuts or tax increases; increased borrowing; reducing Medicare drug spending lowering Medicare eligibility age (potentially requires 60 votes); or increasing participation in value-based care.

- Will Democrats prioritize increasing revenue (e.g., tax increases or increased borrowing) or reducing spending?
- Will efforts to reduce spending focus on medical spending or drug spending?

03 Anti-trust actions

The Trump administration focused anti-trust efforts on intra-market horizontal consolidation. In addition, FTC in 2019 began evaluating the effects that certificates of public advantage (COPAs) have on health care access, innovation, prices, and quality.

- Will anti-trust efforts remain focused on horizontal integration, or will the Biden administration take a closer look at vertical integration?
- How will Covid-induced financial pressure influence anti-trust scrutiny?

04 Future of the ACA

The Supreme Court this spring is set to rule in a case that seeks to strike down the Affordable Care Act. While many legal scholars believe the Court will uphold the law, Democrats have options that could ensure the law's survival.

- Will Democrats wait for a decision, or act preemptively?
- If the courts strike down the ACA, will Biden move forward with Obamacare 2.0 or will Congress seek to save the ACA by adding a severability clause or a $1 tax penalty for remaining uninsured?

Parting thoughts

Biden's first 100 days will be anything but ordinary. Biden is expected to issue several executive orders during his first few days in office that address the coronavirus pandemic, but his administration will also have opportunities to make changes beyond the pandemic.

The first 100 days often set the tone for a president's governing style and policy agenda, but health care leaders should not be misled by Biden's first 100 days. While big ticket items to reduce the uninsured rate and stabilize the Medicare Trust Fund are unlikely to surface early in Biden's presidential term, they remain key priorities for the president and could gain traction when the United States is no longer in the throws of the new coronavirus epidemic.

Health care leaders should prepare for the following near- and long-term changes:

- **Near term:** A lot more federal money is likely to be channeled into health care, with more federal control over the Covid-19 vaccine rollout
- **Medium term:** If the ACA gets overturned, Democrats will get the ultimate "do over" to implement health care reform with 10 years of lessons learned
- **Long term:** Democrats will have a much freer hand to stabilize Medicare's finance, which could manifest in some combination of price cuts, tax increases, and value-based reimbursement changes

PANDEMIC

Will clinical trial innovation outlast Covid-19?

Only if these 7 conditions are met.

By Pamela Divack & Manasi Kapoor

JANUARY 22, 2021

In 2020, life sciences manufacturers, providers, researchers, and other health care stakeholders renewed their interest and investment in clinical trial innovation. Spurred by limitations of Covid-19 shutdowns, many organizations had to quickly adapt and introduce telehealth, e-consent, direct-to-patient drug shipping, and remote monitoring to support ongoing trials. And clinical trial innovation companies, such as Science 37, VirTrial, and Medable, saw an explosion in interest and demand from their life sciences partners.

While these innovations were great to see, solutions like decentralized or virtual trials are not new. In fact, clinical trials have long been an area ripe for disruption. The challenges and inefficiencies with clinical research are well known; clinical trials are expensive, burdensome for patients and caregivers, and often fail to recruit a diverse set of trial participants. Life sciences companies have experimented with incorporating elements of virtual or decentralized trials into existing trial designs, but most efforts to innovate have been fragmented or have occurred on an ad-hoc basis.

This article was originally published online on January 22, 2021. To see the original article with all citations, please go to: **advisory.com/PostCovidClinicalTrials.**

What the health care industry must do to accelerate clinical trial innovation

01

Academic medical centers and providers become active proponents of virtual and decentralized clinical trials.

In the past year, life sciences companies and contract research organizations (CROs) have committed to advancing clinical trial innovation. Notably, the newly formed Decentralized Trials and Research Alliance (DTRA)—which aims to make clinical trial participation widely accessible by advancing policies, research practices and new technologies in decentralized trials—already has more than 50 members spanning life sciences companies and CROs.

In 2021, academic medical centers (AMCs) and providers must also embrace clinical trial innovation. Today, providers have expressed interest in decentralized and virtual trials, but it has not been top-of-mind—especially as they navigate other Covid-19 challenges. However, providers have already realized many benefits of decentralized trials throughout the pandemic. For example, many cancer trials were successful after having to quickly adapt decentralized protocols during the pandemic.

Decentralized and virtual trials will become increasingly important to AMCs and providers, especially for emerging pipeline treatments, such as gene therapy and rare disease drugs. Studies for these products will require providers and researchers to follow up with a small number of dispersed patients over a long period of time. Remote patient monitoring, telehealth, and other decentralized tools will be essential for trial continuation and success in the long term.

02

Advancements in digital data collection improve the validity and usefulness of digital endpoints used in decentralized and virtual clinical trials.

Over the last few years, life sciences companies and researchers have experimented with using wearable devices and digital tools to collect data during clinical trials. For example, Apple and Stanford Health's Heart Study used the Apple Watch to monitor and detect Atrial Fibrillation. Novartis launched the FocalView app to allow researchers to track ophthalmology disease progression using data collected from patients' smartphones. The Digital Medicine Society even created a Library of Digital Endpoints to crowdsource the number and kinds of digital endpoints used in clinical trials.

Despite the momentum toward digital data collection, few stakeholders have embraced a standard framework through which they can assess and validate digitally collected endpoints. However, many efforts are underway to regulate digital data collection and endpoint selection. For example, the Clinical Trials Transformation Initiative has developed a series of frameworks and pathways for developing novel endpoints from digital health technologies to improve clinical trials.

These frameworks are a key first step in advancing industry-wide clinical trial innovation. In 2021, researchers, trial sponsors, and regulatory groups must align on a standard framework to ensure the quality, consistency, and reliability of data generated through digital trials. This will enable industry leaders to embrace new types of data collection and to gain confidence generating evidence through innovative clinical trial designs.

03

FDA and regulatory agencies develop guidelines that encourage post-pandemic clinical trial innovation.

At the beginning of the pandemic, FDA issued new guidance for conducting clinical trials during Covid-19. This guidance allowed for flexibility in trial conduct during the pandemic and led to increased use of telehealth, e-consent, remote monitoring, and other tools for decentralized and virtual clinical trials.

FDA has already shown early signs of openness towards clinical trial innovation, and the agency recently published a guidance document on the conduct of complex innovative trial designs, such as master protocols. Next, FDA must capture lessons learned from decentralized and virtual trial design during the pandemic and establish guidelines that encourage their widespread use in the future.

04

The health care industry addresses technology disparities that currently mitigate remote trial accessibility.

Decentralized and virtual clinical trials can expand care to underserved populations, improve diversity and inclusion in trials, and advance health equity. And many industry leaders have already committed to improving diversity and inclusion in clinical trials. However, disparities over access to technology used in decentralized and virtual trials mitigate the potential for these goals to succeed.

In 2021, researchers, providers, life sciences companies, and other industry stakeholders must prioritize addressing underlying causes of trial participation disparities—such as insufficient access to the internet, technology, and transportation. This will enable clinical trial innovations to succeed and improve accessibility and health equity for all.

What life sciences companies must do to accelerate clinical trial innovation

05

Life sciences companies begin incorporating elements of virtual and decentralized trials into their existing clinical trials.

Clinical trials do not have to be entirely virtual or decentralized to be successful. Incremental changes or additions to existing trials, like virtual check-in visits, e-consent, direct-to-patient drug shipping, or remote patient monitoring, can add value to patients and providers and improve their experience with trials—without completely changing existing protocols.

By starting to innovate within their existing trial designs and testing new technology, life sciences companies can begin to gain comfort with decentralized and virtual trial and identify innovations that have the most impact.

06

Life sciences companies invest in proof-of-concept decentralized and virtual trials to build confidence in their applicability and use.

Launching a fully virtual or decentralized trial for a new drug or intervention may be risky for life sciences companies' pivotal, pre-launch clinical trials. However, life sciences companies can begin to invest in lower-stakes, proof-of-concept decentralized and virtual trials for Phase IV studies or utilize trial innovations to measure the efficacy of non-drug solutions—such as beyond the pill services or digital health apps.

Proof-of-concept studies can help life sciences leaders build comfort with new processes and protocols for data collection and patient communications and anticipate future roadblocks and obstacles in trial innovation. They can also help life sciences' provider and researcher partners acclimate to different kinds of virtual data collection and trial designs.

07

Medical affairs, market access, HEOR, commercial, and regulatory colleagues within life sciences companies work together to overcome internal roadblocks to trial innovation.

Company siloes have traditionally hindered clinical trial innovation and adoption of new trial designs. However, Covid-19 has demonstrated how internal siloes within life sciences companies can work together to innovate trials and overcome internal barriers.

At the beginning of the pandemic, some life sciences companies set up cross-functional SWAT teams to implement components of decentralized and virtual trials into trials impacted by the pandemic. Now, they are turning those SWAT teams into a formalized function,recognizing that different siloes within a life sciences organization can contribute to, and benefit from, clinical trial innovation.

For example, medical affairs and HEOR teams can identify post-launch evidence needs to inform endpoint selection and trial design and advance Phase IV/real-world evidence studies. Research and development (R&D) can utilize clinical trial innovation to improve the patient and provider experience in pre-launch clinical trials, increase diversity and representation in trials, and collect digital endpoints and patient-reported outcomes to strengthen regulatory submissions. And key accounts, commercial, and market access colleagues can use evidence generated in trials to strengthen relationships with key customers.

STRATEGY

Projecting volume recovery through H1 of 2021

By Colin Gelbaugh

JANUARY 26, 2021

Volume performance for the first half of the year is likely to remain suppressed compared to 2019 levels for most services. However, an accelerated vaccine rollout and concerted recovery strategies by providers could result in a more favorable outlook. Read on to understand how volumes will trend for the first half of 2021 and the top factors impacting volume recovery that you can inflect.

This article was originally published online on January 26, 2021. To see the original article with all citations, please go to: **advisory.com/2021VolumeRecovery.**

Outlook for H1 of 2021

We modeled three likely paths forward for Covid-19 case and hospitalization growth—optimistic, most likely, and pessimistic scenarios. Based on our models, providers can expect national volumes in the following ranges for H1 of 2021.

	January	February	March	April	May	June
Inpatient admissions	94%–95%	95%–96%	93%–97%	92%–96%	91%–95%	91%–93%
Inpatient surgeries	86%–88%	84%–89%	79%–96%	84%–103%	89%–102%	93%–103%
Outpatient surgeries	94%–96%	92%–98%	87%–101%	92%–101%	98%–102%	100%–102%
Outpatient visits	96%–97%	96%–97%	96%–97%	97%–99%	97%–99%	97%–99%

Inpatient admissions are expected to remain close to baseline throughout Q1 in all three scenarios because of a large number of Covid-19 admissions. Inpatient days will likely exceed 2019 levels due to lengthy hospital stays among Covid-19 admissions and higher-acuity non-Covid-19 patients who have complicating factors from delaying care. Throughout Q2, the number of Covid-19 admissions will steadily decrease as the vaccine is administered to those most likely to have adverse consequences from infection. Volume will remain suppressed long-term due to sustained reductions in ED visits which can be the admission source for as much of 80% of inpatient volume.

Inpatient surgeries are highly correlated with the trajectory of Covid-19 hospitalizations as they are the first services to be postponed to preserve staff and space for Covid-19 patients. In all three scenarios, there will be some level of elective inpatient surgery postponements through Q1 (ranging from 4% to 21% reductions nationally compared to baseline). In the pessimistic scenario, postponements will continue through June. In the optimistic scenario, postponements will continue through March. In the most likely scenario, postponements will continue to an extent through May. A portion of these surgeries will be recovered later in the year, driving surgical volume temporarily above 2019 baseline levels.

Outpatient surgeries will also be postponed to preserve staff for inpatient units, but to a lesser extent than inpatient surgeries (4.5% reduction in the most likely scenario by the end of Q1). Providers must contend with the extended time needed to accommodate Covid-19 cleaning and safety protocols and decreased demand from consumers due to safety or financial reasons. In the optimistic and most likely scenarios, outpatient surgeries will outperform 2019 levels by the end of Q2 due to strong organic growth and from performing rescheduled services that were postponed earlier in the year.

Outpatient visits will not be subject to the same level of volatility as other services due to Covid-19 surges. By now, providers have managed to install operating procedures to accommodate patients safely with only slight reductions in throughput and efficiency. The larger impacts will be site of care shifts, namely to virtual options, which now constitute 19% of total visits and also deferrals of care among those sensitive to costs or concerned about Covid-19 exposure.

What you can do to speed volume recovery

Our Covid-19 models and volume forecasts have been built around average performance at the national level. However, we expect a large degree of variability based on local community characteristics, government policies, consumer behaviors, and organizational recovery strategies. A speedier recovery may be achieved if providers outperform across the following factors:

01

Frequency and duration of elective surgery postponements. Some states have more stringent thresholds where mandatory elective service cancellation policies go into effect (and some don't have regulations at all). Additionally, some state regulations only apply to inpatient elective surgeries and not outpatient surgeries. An updated list of policy orders is maintained here. Regardless of the policy confines, providers should closely monitor data trends and make cancellation decisions on a rolling basis based on real-time capacity and staffing needs to limit the duration of necessary cancellations.

02

Vaccine distribution and uptake. As of late January, 23 million doses of vaccine have been administered across the U.S. There will likely be wider variability in the vaccination rate over time across regions based on access to distribution sites and consumer perception of the vaccine. Providers can inflect local vaccination rates by establishing accessible vaccination sites and creating a robust communications plan that is targeted toward the most vulnerable and those that are most hesitant to receive a vaccine, including conservatives, individuals aged 30-49, rural residents, and Black adults. Some patients may be motivated by a direct recommendation from their personal physician.

03

Limits to efficiency and throughput. Added cleaning and safety protocols may extend procedure and visit times by 15% or more. Providers that can streamline new operating procedures and extend weekend and evening hours will be able to compensate for longer turnaround times and decreased efficiency.

04

Extent of care deferrals and site of service shifts. Consumers are deferring care for both safety and financial reasons. Most providers have already installed additional safety precautions in their facilities and started to offer virtual options when able, but those that communicate and enforce the safety measures most important to consumers will be more successful at increasing comfort with seeking in-person care. Additionally, communities with more unemployment and insurance loss may need to offer special accommodations such as payment plans to avoid deferrals of care for financial reasons.

05

Recovery of backlogged services. It's not a given that providers will recover all elective surgeries that were postponed, even with well-established prioritization criteria for performing these surgeries. Providers with fewer workforce, bed, and operating room constraints will be able to address the surgical backlog sooner. Consumers may ultimately decide to switch to providers that can schedule them sooner, demonstrate better safety and cleaning protocols, lower their out-of-pocket costs, allow family to accompany them, or offer a less burdensome scheduling process.

DIGITAL HEALTH

How to advance telehealth with evidence—not assumptions

By John League

FEBRUARY 12, 2021

Many health care leaders seem to view Covid-19 as exceptional, not transformational. That is, it's a bump in the road. They believe that once the Covid-19 pandemic has been contained, we can go back to how we did things before—especially for telehealth.

Now, I don't mean to suggest that health care should sustain every stopgap measure and regulatory flexibility from the public health emergency. But telehealth adoption has been beholden to a lot of largely untested assumptions about use, cost, and quality. We've learned a lot as an industry over the past year about how to deliver care outside of traditional in-person interactions between clinicians and patients.

This article was originally published online on February 12, 2021. To see the original article with all citations, please go to: **advisory.com/AdvanceTelehealth.**

The question is: How do we know what to sustain beyond the pandemic? The answer: Evidence.

We have more data on telehealth than ever before—which extends far beyond the lockdown-driven, virtual-care-only days of April-May 2020—and more federal dollars to study that data. Across the final six months of 2020, virtual visits in the U.S. consistently made up 15% to 20% of all visits on a weekly basis, a baseline that was not correlated with spikes in Covid-19 infection or hospitalizations. That steady utilization can provide the data we need to inform decisions about how to deploy telehealth going forward.

Unfortunately, I see two obstacles to making constructive use of this hard-earned evidence. The first is simply ignoring it because it may not align with entrenched, pre-pandemic perspective on telehealth. The second is holding telehealth to a higher standard than other modes of care delivery. I am especially worried because I see these obstacles not only at individual provider organizations but also in recent meetings of the **Medicare Payment Advisory Commission** (MedPAC).

Health care can't ignore 2020 data

MedPAC can have an outsized influence on the future of telehealth. As an independent advisor to Congress on Medicare, MedPAC's recommendations have far-reaching impact on what all payers, including both government and private health plans, will prioritize and reimburse. So, it is disappointing that some MedPAC commissioners and staff seem to be stuck on pre-pandemic assumptions about telehealth.

In each of the three most recent public MedPAC meetings, commissioners and staff consistently assert that virtual care "should" cost or "probably" costs less for providers to offer. There's no evidence given for this, but in a staff presentation at the commission's January 2021 meeting, it was listed first among reasons that **CMS** should reimburse for telehealth at lower rates than in-person care. Another orthodox but largely unproven assumption rounds out those reasons: That payment parity will "distort prices" as clinicians steer patients to virtual instead of in-person visits.

I want to be clear: Reimbursement parity alone will not make telehealth valuable for patients. At the same time, denying parity without looking at actual data on cost, use, and downstream affects of upstream telehealth doesn't help patients, either. We can't continue to be satisfied with assumptions about what works and what doesn't.

Some health systems have already shared data that debunks long-held assumptions that telehealth would surely increase use and ultimately cost more than in-person care. For example, **Stanford Health's** utilization data indicates that telehealth has been a substitute for in-person visits, not simply an add-on service.

If your organization is unsure about what data to collect or analyze—or what to do with it once you have it—I have a suggestion. The **Alliance for Connected Care** has an open call for telehealth data. It's asking providers to submit data on recent telehealth use to answer questions on utilization, no-show rates, post-discharge care coordination, skilled nursing facility transfers, and imaging. This is a strong first step in understanding how telehealth is being used and its impact on care.

Telehealth is different, but the standard of care is not

If that evidence is to guide our industry to constructive choices about telehealth, we can't hold telehealth to an unnecessarily higher standard. The prevailing approach to something new in health care tends to be that if it isn't demonstrably better than what we already know or do, then we won't change.

You can see that in the adoption of tele-behavioral health. Even before Covid-19, clinical research consistently indicated that tele-behavioral health was comparable in quality and outcomes to in-person behavioral health. Still, most behavioral health providers resisted connecting with patients virtually. In January 2020, only about 3% of all psychiatry visits were virtual. The perceived limitations of virtual platforms (including difficulty reading body language and making eye contact) outweighed the potential benefits (including patient convenience, provider visibility into a patient's home, and increased ability for patients to terminate a session) for most providers, even though the quality of care was the same.

But just because telehealth can't do everything, that doesn't mean it can't do anything—which behavioral health providers seem to have realized in 2020. In December 2020, virtual visits accounted for two-thirds of all psychiatry visits.

Unequal standards for dealing with fraud, waste, and abuse (FWA) also undermine a consistent, location-agnostic standard of care. Both MedPAC presentations and media headlines consistently have tarred "telehealth companies" as participants in unnecessary orders for durable medical equipment, genetic tests, and prescriptions. This is simply unfair. There is no evidence that vendors who provide legitimate telehealth services were involved in any of these abuses. And one of the proposed remedies—requiring in-person visits to order specific kinds of testing and medical equipment—is willfully blind to the fact that, unfortunately, FWA occur throughout Medicare.

Clinicians have made heroic efforts to integrate telehealth into practice. The Taskforce on Telehealth Policy put it best...

> "We should trust clinicians providing telehealth services to triage patients needing a higher level of care or in-patient care, as we do in other care settings."

STRATEGY

Why system innovation strategies fall into the service line disconnect—and how to fix it

By Amanda Berra & Megan Director

FEBRUARY 16, 2021

Welcome to "Field Report," a series where Advisory Board experts weigh in on what they are hearing from health care organizations across the country. In this edition, Amanda Berra, who has studied health systems' work formalizing innovation strategy, talks with Megan Director, who works with service line leaders nationwide on strategy and business development. The goal: Shed some light on why system-level strategy goals often feel disconnected from the front lines of care.

In the first of this two-part series, Director quizzed me on exactly what innovation strategy means, in concrete terms, not buzzwords. In this second part, I found out what Director knows about "the service line disconnect"—and why it is getting in the way of health system success when it comes to not just innovation strategy, but a wide range of ambitious system goals.

This article was originally published online on February 16, 2021. To see the original article with all citations, please go to: **advisory.com/field-report/SystemInnovation.**

Q&A with Amanda Berra (AB) and Megan Director (MD)

AB When last we talked, your questions about what is happening in innovation strategy at the system level with innovation were all premised on the idea that there is a gap between that activity, and what service line leaders are doing, thinking, and know about in their day-to-day closer to the front lines of care delivery. Can you explain more about this? What does the disconnect consist of, and why is it there?

MD Well, in general, service line leaders are not often brought into executive strategy decisions, even if it is about things that impact their day-to-day. For example, when CMS first put heart failure readmissions penalties into place, and system executives realized it could hit their bottom line, they started developing readmissions reduction task forces. But CV teams had already been working on this. So, you started to see a duplication in efforts because the system-level leaders were thinking about their system strategic plan, but not aligning it with the existing strategic plan of the service lines, and not bringing them into the relevant conversations.

AB Why do you think service line leaders were not invited to those conversations?

MD Maybe because traditionally the service line leader used to be thought of as more of a clinical and operations role, and not as much strategy. Over the years, these leaders have become more strategic in nature as service lines are becoming more important to the health system. But the leaders themselves still don't always have a seat at the table.

This "service line disconnect" shows up in a lot of areas, including growth and business development, care variation reduction work, and of course, innovation. It's why innovation has been thought of as happening at the system level without connecting the dots to what service lines are already doing to innovate care models to meet their own strategic goals.

AB OK, let's be very concrete about this. In a typical service line, is there a service line strategic plan? And if yes, how does it relate to the system-wide strategic plan?

MD Yes, there should be service line strategic plans in place at every system. In fact, that's part of how we define, within Advisory Board research, what needs to exist in order to call something "a service line"—there needs to be (1) that strategic plan, (2) dedicated leadership, and (3) some authority over budget to even qualify. But when it comes to service line strategic plans, we often see a disconnect between the plan for the system and how it cascades down to the clinical service lines.

AB Is part of the problem you're highlighting the fact that the plan tends to cascade DOWN, versus cascading UP (if you can overlook the metaphor problems with that)?

MD In a way, yes. Because ideally, it should be a combination of both. System strategy leaders need to set the goals and general direction for their service lines, but they should be incorporating bottom-up intel gathering from the service line level to do so.

I would recommend three phases. First, strategy leaders should engage service line leaders on challenges, opportunities, and priorities. From there, the executives and planning team can define system-wide goals for the service line. And in that third phase, the planning team should be partnering with service lines to cascade system

goals into meaningful service line opportunities. Then the service lines are responsible for building the plans to actually execute on these goals and objectives.

But that process often doesn't happen. It's too often top-down, and the service lines are left to figure it out on their own.

As for innovation, whether it's in the official system strategic plan or not, service line leaders may not know about it, or factor it into what they think of as their main concern, which is how they can solve problems—usually by getting scrappy and figuring out how they are going evolve, with or without system input.

AB In the spirit of scrappiness, you said something interesting a second ago about how service line leaders are already innovating. Can you explain how, if at all, service line leaders are thinking about emerging technology for hitting the goals that they know they have for the service line? I'm not talking about traditional clinical tech, like imaging or implantable devices—more, the types of tech that a system innovation strategy would be working to pull in, like consumer-facing digital solutions, AI, and things like that. Where does that show up in system service line leaders' work?

MD In service lines, innovation has traditionally been about widgets and gadgets—like medical devices that we use in procedures. Service line leaders had to evaluate new tech in a reactive way, because their physicians or vendors would bring it to their desk, and they had to figure out whether or not to invest in that new patient care innovation.

But when it comes to digital tools and apps, often service line leaders don't feel empowered because that kind of contracting seems like a system-level decision.

Consider EHRs. Service line leaders have limited influence here. The system selects and forms partnerships with EHR vendors, telemedicine platforms, maybe startups that are developing new digital tech.

But excluding service line leaders is a big loss for the system because those leaders understand operationally how that solution will (or won't) work with physicians and workflows, and also whether and how it will help achieve service line goals. It's a sniff test for will this thing that sounds good actually work in practice—and is it something we need? If you don't get that perspective, you can really miss out on very valuable information about what is worth pursuing or not.

AB That's actually something we saw in the innovation research too. The programs we ended up profiling had staff that viewed talking with service line and other operational-leader type stakeholders as a core part of their role. I'm talking hours and hours every month in meetings with clinical leaders, asking them "what problems do you have" and talking about where and how emerging tech might help, and also sharing with them "here are some possibilities and new tech and new partnerships we are thinking about" and getting their feedback. It's obvious that that's a better way for a system innovation team to be an asset to the system.

But my concern as I'm hearing you, is that what many of these innovation leaders told me they do all day, doesn't sound like it's common in your experience working with service line leaders. They say they're not having conversations like that. What gives?

MD I don't know. But I will tell you that in the service line strategy planning workshops I have been doing lately, where we bring together service line leaders and strategy leaders, you can see a lot of untapped potential. The service line leaders are coming up with fantastic ideas when they are told, as part of the exercise, to think hypothetically and outside the box about how strategy problems in the service line could be solved, and what solutions they would recommend for the stakeholders they work with. For example, we often do a stakeholder analysis for patients, physicians, and payers in the market. During this, the service line leaders are coming up with digital technology, portals, innovative solutions to meet the needs of multiple stakeholders, because service line leaders have that uniquely broad perspective based on where they sit. At the end of the workshop, the strategy leader ends up taking away a lot of these ideas as a short list of the higher value opportunities to leverage tech for service line goals.

It's all great—but, it's clear to me that these people have not had these conversations in other forums yet. The service line leaders are saying things like, "Why don't we have x to help with patient journey, or help with patient outreach" while the strategy leaders are asking, "Why is this the first time we are thinking about this?"

AB Well, one thing I notice about what you're saying is that it is the STRATEGY leader getting pulled into these conversations, not the INNOVATION leader. So, maybe we're looking at the market reality that there are still plenty of systems that do not have a dedicated innovation team yet. And even if there is a team, it may not yet be plugged into all these stakeholder conversations.

MD Agreed.

AB OK, different question. It makes sense to say, "System-level executives should deal service line leaders in to find opportunities." But, in theory, one of the benefits of doing innovation centrally, at the system level, is that you can spot things that would apply across service lines—so that the system doesn't end up with a lot of fragmentation and a billion little pilots and different apps and no unified platform.

Knowing that you're personally deepest in CV, but you also spend a lot of time talking "pan service lines," what do you think about that and innovation? When you hear service line leaders talking about opportunities to use emerging tech, does it seem like things that would span across all the major clinical service lines? Or does it sound like CV needs CV things, and cancer care needs cancer care things, or what?

MD Great question. This gets back to the earlier issue about why there might be a discontent between system-level initiatives and service-line realities. It used to be that transformative catalysts for care innovation were external pushes, especially new Medicare requirements, often in disease-specific ways. Think mandatory episodic bundles that started with orthopedic procedures. Now we are seeing them in oncology. As a result, these teams are thinking in their own worlds about how to manage complex or chronic patients across the continuum of care, and so innovation happened in a siloed way.

But really, it doesn't matter what the disease state is—there are common things you can do to better manage these patient populations, and probably huge opportunities to solve larger programs. That means siloed problem solving is not the right answer.

So innovation leaders would do well to bring the service line leaders together to talk about these issues; there are common problems they could find that would span clinical areas. Especially with goals like engagement and patient management across the continuum, or managing patients at home. Yes, there are nuances in what you do or say to that patient, but the concept and strategies for reducing readmissions or managing complex patients will be the same, so there should be a lot of opportunity.

Now to be clear, you don't need every service line leader in every innovation discussion, that isn't feasible. But you need a forum for service line leaders to gather together and share ideas and prioritize challenges, because that is where you will find the most scale for innovations to invest in.

AB Let's throw in the venture capitalist's favorite question—with your pan service line view, what kinds of problems would you bet on, as areas that are ripe for tech to solve—or, specific tech that you hear enthusiasm about among service line leaders?

MD A lot of what is popping is patient activation and engagement, and increasing access to patients across the continuum to better manage overall care. On the front end, getting patients in the door. With Covid-19, it's about patients being hesitant to come in and programs need better ways to communicate with them to let them know how to approach a visit, where to get the care why they should be coming in. But, it's not just a Covid-19 issue, this will be around long after the pandemic is hopefully behind us. Think how many patients are not getting screenings like mammography or CV if they are at risk.

Systems need better ways to engage with patients, or prospective patients, at scale to risk-stratify, triage, identify, and invite patients in the door. If you can be the best at doing that in your market that is how you will get patients in. A lot of folks are talking about that.

AB Is it the system that needs to have that interface—an app, I guess? Or is it primary care? I feel like there's been a lot written about how some hospital and system apps are not well used—and it almost seems like the primary care practice, or maybe a medical specialist, is the one who needs to have that ongoing relationship.

MD Agreed—ultimately for many hospitals and systems, they're still predominantly about sick care. On the well care end, it's those general practitioners or others who have a longitudinal relationship with patients who make more sense as a 'front door' of ongoing communication and care.

AB Takeaway for innovation strategists and service line leaders alike being: Consider your primary care referral channels, and what their digital relationship with patients is like!

DIGITAL HEALTH

A primer on virtual-first health plan products

By Tabiya Ahmed

FEBRUARY 22, 2021

THE IDEA

Virtual primary care products use telehealth as the central tool for managing a member's care, rather than only as an on-demand acute care option. In the virtual primary care models emerging, a patient typically sees a primary care provider remotely via video and the clinician can direct next steps that incorporate health plan information such as cost sharing or referral quality data.

THE PROMISE

Virtual primary care products use technology to deliver primary care in a way that is accessible, convenient, and cost effective to both members and health plans. If utilized optimally, virtual primary care can substitute for unnecessary in-person visits or influence downstream care at a reduced cost to the ecosystem.

WHY NOW

The Covid-19 pandemic has accelerated the adoption of telehealth nationwide. However, even before Covid-19, health plans were expanding virtual options in order to appeal to cost-conscious, technologically savvy consumers. The pandemic led many consumers to try virtual visits for the first time. Many of those consumers have reacted positively to the experience, so health plans are using this opportunity to experiment with virtual primary care products.

REALITY CHECK

Structuring products around a core virtual primary care service seems to be an ideal next step in guiding cost-effective care delivery. But health plans must consider how their broader provider network will react to the plan steering patients to virtual care. This also involves balancing consumer expectations for the low-cost virtual care available through vendors with local providers' needs for sufficient reimbursement.

This article was originally published online on February 22, 2021. To see the original article with all citations, please go to: **advisory.com/VirtualFirstPlans.**

KEY COMPONENTS OF VIRTUAL PRIMARY CARE

Common member incentives

Lower premiums

No cost sharing for virtual primary care

Lower cost sharing for follow-up care, prescriptions, labs, specialists etc referred by virtual service

24/7 access to dedicated virtual services

Common provider capabilities

Has access to previous visits and medical records

Can diagnose, prescribe, and counsel

If needed, can provide downstream referral

Can follow up through another virtual visit

What is it?

Virtual primary care products move telehealth beyond episodic and urgent care to address primary care needs, integrated behavioral health care, and chronic condition management. Major virtual primary care products on the market feature several components. These include an interoperable digital telehealth platform that is accessible via patient login, a care team featuring a central primary care provider who can evaluate, diagnose and prescribe medications; and access to downstream care such as follow-up visits, lab tests and imaging.

Most virtual primary care products in the market in 2021 utilize an external vendor such as 98point6 or Doctor On Demand to deliver the virtual care, but many plans intend to eventually include their traditional provider network. A key difference between current virtual primary care products is how they control downstream care through referrals. Some virtual primary care products, such as "virtual first," require a member to have a virtual visit before getting a referral for any downstream care. This puts health plans in control of steerage, as members are receiving referrals to the plan's most preferred providers within the network.

Why is it useful?

Virtual primary care products...

- Expand access to members who may not use in-person services
- Allow health plans to steer members to low-cost, high-quality sites of care
- Provide alternatives to costly emergency room and urgent care

Most health plans that have invested in virtual primary care products cite purchaser pressure and market competitiveness as two major reasons for doing so. And after creating a virtual primary care product, many plans find that their members appreciate the ease of access and positive consumer experience.

Virtual primary care products can be a way for plans to engage with young, healthy members by providing low cost, preventive visits. Virtual visits are also an option for frequent check-ins with members with more complex conditions.

Plans note that these virtual primary care products can help patients become more informed consumers. Virtual primary care has the potential to help health plans control costs. This could be through steerage (having "HMO-style" referral rules) or influence on care decisions (providing cost incentives for members).

Why now?

Telehealth is playing an ever-increasing role in care delivery. Covid-19 has tested the health care system's flexibility and resilience in many ways and has forced organizations to adapt. Health plans responded quickly to the pandemic by making virtual visits more accessible. Some actions plans took included:

- Lowering or eliminating out-of-pocket costs
- Extending coverage for virtual visits to more members
- Advertising the benefits of virtual visits
- Incentivizing providers through reimbursement parity and loosened regulations

Advisory Board's 2020 Consumer Preferences Survey of 3,500 consumers across different lines of business found that most members first heard about virtual visits because of the Covid-19 pandemic. The response was generally positive, as 52% of survey respondents said that they would use a virtual visit in the future instead of an in-person visit.

Health plans can capitalize on this newfound interest in virtual care by encouraging sustained use of this technology. In addition, the pandemic and resulting increase in unemployment rates have led more cost-conscious consumers to the individual market. These consumers are more likely to experiment with a less traditional plan in exchange for lower up-front costs. As one plan leader put it, this is a way for plans to "disrupt their own business model."

91%

Of members learned about virtual visits because of Covid-19

45%

Of members who have had a virtual visit had their first virtual visit due to the Covid-19 pandemic

Early adopters

WHO'S DOING WHAT

Humana

Health plan covering 5 million lives

Doctor On Demand

Telemedicine company

Humana implemented a virtual primary care product through their partnership with Doctor On Demand called On Hand. The plan gives patients access to a dedicated virtual primary care provider, through Humana or Doctor On Demand's network

STRATEGY 1

Integrating network into third party app

On Hand, Humana's offering with Doctor On Demand, was the first major commitment into virtual primary care. It became available in 2020 to Humana's self-funded plans in eligible regions and is marketed as a low-cost alternative to Humana's other plans. Its premiums are about half the cost of Humana's most popular purchased plan. On Hand members can access care through Doctor On Demand's Synapse platform. One notable feature of this platform is that it allowed Humana to integrate its existing provider network with Doctor on Demand's network. This enables consumers to continue long-term relationships with their current providers, while also broadening access to a new pool of providers through Doctor On Demand's network. If needed, referrals for in-person care downstream are sent to in-network Humana providers.

Humana's "On-hand" virtual product

VIRTUAL ACCESS TO SERVICES

Virtual PCP

Members can use current provider or get assigned dedicated PCP from Doctor On Demand

Medical device kit

Member is given digital blood pressure cuff, thermometer, and log

LOWER COSTS

Affordable coverage

$0 copays for video visits; $5 copays for lab tests and prescriptions

Downstream navigation

Doctor On Demand's "smart referrals" feature ensures all referrals remain in-network

WHO'S DOING WHAT

Premera Blue Cross

Health plan covering 2 million lives

98point6

Telemedicine company

Premera's partnership with 98point6 uses the combination of a pre-appointment AI assistant and dedicated 98point6 provider to administer a member's long-term care. The care is primarily provided through in-app text messaging.

STRATEGY 2

Utilizing vendor-only network

Premera's newest low-premium virtual care product, Premera NOW, is accessible to employers in the Washington market for the first time in 2020. Members access the virtual visit through their Premera NOW app, which operates on the 98point6 platform. What makes this product unique is its technology-first component.

At the start of the visit, an automated assistant, rather than an actual provider, gathers information on symptoms and if needed, collects photos. Then an assigned 98point6 provider reviews the case and provides diagnosis and treatment over in-app text messaging. The product uses 98point6 providers for the virtual component but allows for in-network follow-up for in-person care through referrals. The virtual care component is 100% covered and aims to get consumers to always start their care through their app. In all issues besides emergent care, the member knows to use the app as their "one stop shop." This funneling of members through a virtual platform allows the plan to steer members to more efficient sites of care while also allowing members the ability to make an informed decision on the quality of the provider they choose.

SIMILAR ADOPTER

Utilizing vendor-only network

Priority Health, a health plan in Michigan, is partnering with Doctor On Demand to offer a virtual primary care plan to families living in the plan's "My Priority" service areas in 2021. Members who enroll in the MyPriority Telehealth PCP plan receive an assigned PCP through Doctor On Demand. This provider, who can deliver services for primary care, urgent care, behavioral health, and chronic or preventive care conducts all appointments virtually. If the member needs in-person care, their virtual provider can provide a referral to a high-quality, low-cost provider in the Priority Health HMO network, staying true to that plan design. A care coordinator can help members choose and schedule a visit with the referred provider. Fitting within the traditional plan HMO structure, this plan leverages the virtual component to encourage utilization among those without a PCP or those who want to avoid in-person care.

> "With more and more people realizing that telehealth can be a safe and convenient option for certain types of care, we knew that now was the right time to launch this innovative plan option."
>
> Carrie Kincaid, VP Individual Markets
> Priority Health

WHO'S DOING WHAT

Alignment Healthcare

Medicare Advantage Plan covering 50,000 lives

Alignment Healthcare's Medicare Advantage plan focuses on providing concierge services to their senior population. It offers a virtual plan that builds on their ACCESS On Demand platform.

STRATEGY 3

Building on health plan platform

Alignment Healthcare has launched a Virtual Medicare Advantage plan aimed at providing personalized, accessible care to its senior members. The plan utilizes the payer's own ACCESS On-Demand Concierge platform. It features access to providers 24/7 and a dedicated concierge team that provides two-way consumer engagement—by servicing inbound calls and actively reaching out to patients. What makes Alignment successful is the Alignment Virtual Application (AVA), which pulls real-time data from a member's care journey including prescriptions, facility admissions and treatments. This allows the dedicated clinician to have the most up-to-date information and prevent them from duplicating any procedures or treatments.

Every member opting into this plan receives a high-touch onboarding process that designates an assistant to enrollees so they can become familiar with their benefits. In addition, if members do not have the technology required to participate in this plan, Alignment will provide it for them. Providers in the Alignment network are also not restricted to virtual visits but can provide in-person or at-home care if deemed necessary.

> "The design of the program will be centered around primary care services and specialty services—not just on demand services, but primary care through a concierge platform."

Dawn Maroney, President of Consumer Markets, Alignment Healthcare

SIMILAR ADOPTER

Building on health plan platform

Oscar Health, a pioneer in the tech-driven health insurance arena, launched a virtual primary care product in Texas and has plans to expand to other markets through 2021. The insurer builds on its Oscar Care offerings, utilizing the Oscar Medical Group providers to deliver personalized longitudinal primary care to members. There is no cost to the member for virtual visits and initial specialist referrals prescribed by an Oscar provider giving the payer more control of downstream care. Oscar also provides members with kits to monitor their vital signs, as well as access to in-home lab draws, greatly reducing the need for in-person visits overall. Oscar's virtual primary care offering is another tool in their suite of low-cost, technology-reliant health plan products. This plan greatly reduces member cost sharing—in most cases the member pays nothing. At the same time, it allows Oscar to control a member's initial care interaction and routes them to the most efficient option downstream.

> "Americans consistently cite cost, quality and convenience as their biggest struggles with the health care system—our new offering solves for all of them."
>
> Mario Schlosser, CEO and Cofounder
> Oscar Health

Should you pursue this idea?

The number of virtual visits grew exponentially last year. But many health plan leaders are waiting to see if that trend will continue after the Covid-19 pandemic subsides. Your organization might benefit from virtual primary care now if you...

- Have a targeted membership that you want to engage
- Have either a strong internal technology platform or the ability to partner with a third party
- Have a network with a wide range of provider options that vary in cost and quality
- Have room for negotiation with in-network providers
- Are in markets where competitors are flexing their telehealth benefits and consumers are responding positively
- Are committed to utilization of primary and preventive care

PROS	CONS
✓ More control over referrals and downstream care	✗ Members and providers will need high-touch onboarding
✓ Can attract additional cost-conscious member segments to enroll	✗ Members may have to switch providers if provider is not participating in product
✓ Can remain competitive and innovative among purchasers	✗ Providers may be unhappy having to compete with a vendor network

What we're keeping an eye out for

The Covid-19 pandemic has thrust telehealth into the forefront of care delivery. Health plan leaders are looking at how to capitalize on this interest, expanding the use of virtual visits to a wholly virtual primary care product. But the future of telehealth depends on continued interest from consumers and providers, as well as potential changes to government regulations.

Things that affect the calculus:

- Introduction of value-based arrangements into the telehealth benefit
- Telehealth payment parity and reimbursement regulation
- Desire for providers to want to provide virtual care through third-party platforms

As payers and providers return to normal negotiations, the virtual-first design of providing care through designated telehealth platforms will likely continue. For example, **Harvard Pilgrim Health** announced a partnership with Doctor On Demand to expand their virtual primary care offerings this year. **Kaiser Permanente** also introduced a 2021 virtual-first option: Virtual Plus.

As of now, plan leaders that we have spoken with mentioned that many providers see these virtual primary care products as a threat to their business. Therefore, plans who choose not to integrate their traditional network with third-party vendors will have to think strategically about carving out roles for each provider type and guaranteeing a level of volume through referrals.

However, we're also watching for more launches like **UnitedHealthcare's** virtual primary care policy, which allows eligible members to establish a virtual relationship with their current doctor and receive primary care and preventive visits at no cost to the member.

PANDEMIC

3 big mistakes in your Covid-19 vaccine strategy (and how to fix them)

By Rachel Woods and Allyson Paiewonsky

FEBRUARY 24, 2021

Health systems have had no shortage of challenges over the last year—and now, they face the added challenge of an increasingly complex vaccine rollout, one that requires ongoing coordination with a wide variety of external stakeholders, from public health agencies, to pharmaceutical companies, to tech companies, and more.

But without a clear roadmap for how these stakeholders should work together, the vaccine rollout may continue to falter—especially now, as vaccine supply ramps up and states broaden vaccine eligibility. To help provider organizations scale up and avoid the missteps that plagued the start of the rollout, we've outlined below the three biggest mistakes that providers can't afford to make—and strategies to avoid them.

This article was originally published online on February 24, 2021. To see the original article with all citations, please go to: **advisory.com/covid-19/VaccineStratMistakes.**

MISTAKE
01

A fragmented communication strategy

Anyone who has tried to get a Covid-19 vaccine (or knows someone who has) understands that the process has been chaotic at best. Every patient seems to have a story of spending hours online or on the phone, talking to what feels like every industry stakeholder to get answers on when and where they should get their vaccine—and if providers aren't careful, this frustration will result in patients breaking what little loyalties they had to their health system or physicians.

On the flip side, this crisis presents an opportunity for health systems to be the source of truth for the community, engage patients in new ways, and reach out to new consumers. Health care leaders must lean in and own the communication, because if providers can't help prospective patients get the information they need, patients will ultimately turn to the entities that can.

The good news is that there are simple steps leaders can take now to be a guiding force in the market. Think about the digital front door first by updating website banners, FAQ pages, and marketing materials to clarify vaccine prioritization, estimate timelines, and share logistics. Refresh these pages as often as needed to ensure patients and family members know they're reading the latest available information.

In addition, make sure you're clearly communicating your organizations' approach to administering unused and potentially expiring doses, as "waitlist" and "unused dose" policies are increasingly becoming a source of confusion and perceived inequity nationwide. This level of transparency will be particularly important as more states broaden the number of people eligible for vaccination appointments. Acting as the source of truth will require coordination with other health care and community partners to streamline messaging across the region and target media campaigns that combat confusion, distrust, and misinformation.

MISTAKE
02

Tapping an already overburdened workforce for Covid-19 vaccination

Shortages of PPE and medical equipment have been an ongoing problem throughout the pandemic. And with the rapidly expanding vaccine rollout, new shortages are likely in the coming months—this time, the supply of vaccinators. Leaders must think proactively to ensure that the supply of vaccinators doesn't become yet another bottleneck—even as they continue to protect an already overburdened workforce.

Health systems can't rely on the nurses on the frontlines of Covid-19 treatment to also be on the frontline of Covid-19 vaccination. Instead, they should expand capacity by looking beyond typical staffing pools.

But not just anyone can be a vaccinator. Vaccinator eligibility and training requirements vary state by state. Leaders should learn their state's guidelines to get as creative as possible with who gets tapped as vaccinators. Depending on state regulations, health systems should find, train, and deploy students, community pharmacists, other clinicians, retirees, and volunteers to deliver vaccines. The goal here is to effectively train and deploy vaccinators without creating major workforce gaps elsewhere in the system or further fueling burnout.

MISTAKE
03

Not planning for how vaccination will affect inequities

While recent research shows that Americans as a whole are increasingly positive about getting a Covid-19 vaccine, that enthusiasm is not consistent across racial and ethnic groups. In some communities, a lack of confidence in the Covid-19 vaccine stems largely from a legacy of medical abuse and discrimination—a legitimate distrust that poses a unique hurdle to equitable vaccine distribution, as the communities disproportionately affected by the pandemic are still the most hesitant to get vaccinated.

To address this distrust, provider organizations must understand the cultural nuances of their patient population so as to identify which members of their communities are less trusting of medical institutions and more likely to avoid vaccination. With this patient population in mind, develop a targeted communication strategy that addresses the root causes for vaccination mistrust and skepticism. Ensure that this communication strategy is accessible by translating all vaccination information into the languages spoken by members of your patient population.

That said, while provider organizations can play a distinct role here, you can't mitigate vaccine disparities on your own. Taking a community-centered approach to equitable vaccination will require working with grassroots organizations and faith-based leaders to reach those most disconnected from the health care system. Leaders should coordinate with community-based organizations and tap into a variety of spokespeople, including community health workers, religious leaders, pharmacists, and educators to spread information about the vaccine, build trust, and address access barriers.

POLICY

We predicted big cuts to Medicaid payments after Covid-19.

Here's why we've changed our minds.

By Yulan Egan

MARCH 3, 2021

Last spring, as the Covid-19 pandemic gained steam, our research team took a look at how the pandemic would impact the major U.S. purchasers of health care services: employers, health plans, Medicaid, and Medicare. Despite the upheaval in health care delivery, our analysis predicted relative financial stability for payers. Declines in utilization meant that health care was poised to be a relative bright spot in employer budgets for the year. Health plans similarly expected costs to go down, and most of the big national plans were confident that they were diversified enough to weather potential shifts in payer mix. And while the federal government was spending billions of dollars on Covid-19 relief, its ability to engage in deficit spending meant Medicare could likely remain untouched.

This article was originally published online on March 3, 2021. To see the original article with all citations, please go to: **advisory.com/2021MedicaidOutlook.**

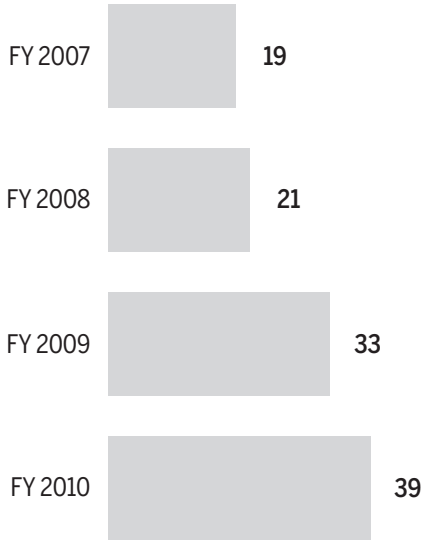
The outlook for Medicaid was different. Like other payers, we expected Medicaid programs to see temporary declines in spending due to canceled or delayed procedures. But on the flipside, we thought Medicaid enrollment growth (due to employment losses) would drive costs up. We also expected states to take a big hit on the revenue side of the equation due to their reliance on tax revenues. Unlike the federal government, most states are constitutionally obligated to balance their budgets, meaning they don't have the flexibility to finance deficits like the federal government.

For all those reasons, we believed states would face immediate and unavoidable pressure to cut Medicaid spending—and that pressure would drive most states to resort to provider rate cuts. We also felt on firm footing in making that prediction because we had a historical proxy: the 2008–2009 recession. In the aftermath of that economic decline, most states either cut or froze provider reimbursement rates.

As is often the case in health care, it will be a while yet before we have a clear and comprehensive data set to understand exactly what Medicaid programs did across 2020 and into 2021. But we increasingly believe our original projection painted far too negative a picture.

MOST STATES CUT PROVIDER RATES DURING LAST RECESSION

States reporting at least one provider rate cut or freeze



Why—and how—has our perspective shifted?

There's clearly been economic fallout from the pandemic, but the nature of that fallout has played out in some surprising ways. While there is considerable variability state by state, here's what we've observed, on average, when it comes to some of the most common sources of state revenue:

1. **Income taxes: Smaller-than-expected decline.** The revenue from income taxes has decreased. But the concentration of job losses in lower-wage workers—and the relatively rapid return of (some) employment—has made this decline smaller than originally expected. A strong stock market has also sustained tax revenue associated with capital gains.
2. **Sales taxes: Smaller-than-expected decline.** State revenue from sales taxes dipped sharply in the early stages of the pandemic. But 2020's strong start before the pandemic and a rebound later in the year due to online sales meant that overall declines for the year were smaller than anticipated.
3. **Property taxes: Relatively stable.** Most state governments rely less heavily on property tax revenue than local governments. But those states that do largely saw stable—if not increased—revenues due the surprising strength of the housing market nationwide.
4. **Corporate taxes: Significant decline, as expected.** Businesses—particularly small ones—struggled significantly during the pandemic. Unsurprisingly, corporate tax revenues declined substantially. But those revenues make up a relatively small portion of state and local revenues in comparison to income, sales, and property taxes.

So, on average, states experienced smaller revenue declines than we originally expected. States also received aid from the federal government, including enhanced funding for Medicaid in the form of enhanced Federal Medical Assistance Percentages (FMAP). Overall, we expect the effect on Medicaid programs to be smaller than we originally feared. And with Congress poised (as of this writing) to funnel more support to states for 2021 and the Biden administration reportedly planning to maintain the Public Health Emergency (and the associated FMAP bump) for the duration of this year as well, we are cautiously optimistic that we're on track for a similar story in 2021.

Let's be clear: we're not saying that the outlook for Medicaid is rosy. States have long struggled to balance their budgets. And as a growing share of the budget in many states, Medicaid is a clear target for cuts. However, the Covid-19 pandemic hasn't been a cataclysmic event for Medicaid in the way we originally feared.

We should also note that there is significant state-by-state variability in the dynamics described above. Some states experienced much sharper declines in income and sales tax revenues than others. But we believe pressure to constrain Medicaid spending in most states is a medium- to long-term pressure, not a near-term one. And that has important implications for how states will approach Medicaid across the next year or two.

What should we expect from Medicaid moving forward?

Here's what we're watching:

01 **Income taxes: Smaller-than-expected decline.** The revenue from income taxes has decreased. But the concentration of job losses in lower-wage workers—and the relatively rapid return of (some) employment—has made this decline smaller than originally expected. A strong stock market has also sustained tax revenue associated with capital gains.

02 **Sales taxes: Smaller-than-expected decline.** State revenue from sales taxes dipped sharply in the early stages of the pandemic. But 2020's strong start before the pandemic and a rebound later in the year due to online sales meant that overall declines for the year were smaller than anticipated.

03 **Property taxes: Relatively stable.** Most state governments rely less heavily on property tax revenue than local governments. But those states that do largely saw stable—if not increased—revenues due the surprising strength of the housing market nationwide.

POLICY

The No Surprises Act cheat sheet

How the new surprise-billing law is poised to upend payer-provider negotiations.

By Heather Bell

MARCH 4, 2021

Key Takeaways

01 Congress passed the No Surprises Act in December 2020 to mitigate patients' exposure to surprise medical bills and require insurers and providers to resolve payment disputes for out-of-network care independently or use a new arbitration process.

02 The federal law achieves the primary goal of surprise billing legislation: patients will be held harmless once the new law becomes effective on January 1, 2022.

03 While the federal law will create a clear process for resolving out-of-network payment disputes, it raises broader pricing, contracting, and billing questions for providers and insurers.

This article was originally published online on March 4, 2021. To see the original article with all citations, please go to: **advisory.com/NoSurprisesAct.**

What is it?

Surprise billing occurs when a patient unwittingly receives care from an out-of-network provider and is responsible for all or a large portion of the cost. This can occur when patients are unable to choose an in-network facility or provider because they are receiving emergency care or scheduled care and their care team includes an out-of-network ancillary provider.

Surprise billing is not new; it is a result of preferred provider networks that create differential benefits and prices between in-network and out-of-network providers. Thirty-two states had surprise billing laws as of 2020, but those protections vary by state and exclude more than 100 million Americans nationwide who receive their health insurance through federally regulated self-funded plans.

Growing media attention and public outcry made surprise billing a priority for Congress. In 2019, Congress nearly passed legislation to address surprise billing, but progress stalled in part because policymakers disagreed about how to resolve payment disputes for out-of-network care. Hospital and provider groups advocated for a baseball-style arbitration process, while insurers favored a benchmark payment standard. In December 2020, Congress reached a last minute compromise and passed the No Surprises Act as part of the Consolidated Appropriations Act, 2021.

The law, which takes effect on January 1, 2022, resolves two underlying drivers of surprise bills. First, the law requires insurers to reclassify specific out-of-network care as in-network when determining a patient's financial obligations, resolving instances in which insurers set higher cost-sharing requirements for out-of-network versus in-network care. Second, the law prohibits providers from billing patients for more than in-network cost-sharing for most out-of-network care, resolving instances in which providers directly bill patients when insurers do not cover their full price, a practice known as balance billing.

How does it work?

The No Surprises Act is designed to protect commercially insured patients from surprise bills, including those enrolled in individual, group fully funded, and group self-funded plans. The law does this by prohibiting providers from billing patients for more than in-network cost-sharing amounts for most out-of-network care that previously led to surprise bills and requiring insurers to classify such care as in network when determining a patient's financial obligations.

Services that cannot be balance billed

The law protects patients from receiving surprise bills under most scenarios in which surprise billing generally occurs:

- All out-of-network emergency care, including certain post-stabilization care
- Ancillary services delivered by an out-of-network provider at an in-network facility related to anesthesiology, emergency care, laboratory, neonatology, pathology, and radiology, as well as services provided by assistant surgeons, hospitalists, and intensivists
- Out-of-network air ambulance transportation that would have been covered if the air ambulance was in-network
- Non-emergency care delivered by an out-of-network provider at an in-network facility without obtaining patient consent 72 hours in advance

Services that can be balance billed

The law includes a notable exception for ground ambulance transportation: patients who are transported to a facility by an out-of-network ground ambulance can still receive a balance bill from the ambulance provider. One study based on data from a large national insurance plan estimated 79% of ground ambulances providers used for emergencies were out-of-network.

The law also outlines specific criteria that, if met, permits certain out-of-network providers to balance bill patients for non-emergency services. However, this does not apply to the ancillary services listed on the previous page.

Eligible out-of-network providers may balance bill if the patient consents to receiving the care. To obtain consent, the provider must give the patient a written notice at least 72 hours before the date of service clearly explaining that the provider is out-of-network, consent is optional, and the patient can choose to seek care from an in-network provider, as well as any information on prior authorization. In addition, the notice must include an estimate of the amount the patient would be charged. The patient must sign and date the notice.

Payment for services that cannot be balance billed

Beyond eliminating most balance billing, the law also aims to keep patients out of payment disputes by creating a new process for insurers and providers to reach an agreement on the final payment amount for out-of-network care. The new approach can stretch up to several months.

Initial payment

The law requires insurers to make an initial payment or submit a denial of payment to the provider within 30 days of the service. The law does not set a minimum payment amount and sunsets the Affordable Care Act's so-called "greatest of three" rule (The greatest of three rule refers to the minimum floor set for what health plans must pay for out-of-network emergency care).

Independent dispute resolution and arbitration processes

At this point, either the out-of-network provider or the insurer can trigger a new independent dispute resolution (IDR), which begins with a 30-day open negotiation period. If the parties do not reach a payment agreement, either one can initiate the law's formal arbitration process. Providers and insurers also have the option to combine several payment disputes into one arbitration proceeding.

The process gives both parties three days to select a certified, third-party arbitrator; if they do not, HHS will appoint one within six days. Once an arbitrator is chosen, the provider and insurer each have 10 days to submit a final payment offer, as well as any additional information for the arbitrator to review. The arbitrator then has 30 days to select one of the two offers. When making these decisions, the law encourages arbitrators to consider several factors, including:

- The insurer's 2019 median in-network rate for similar services in that geographic area, adjusted based on inflation
- Demonstrations of good faith efforts to reach an agreement
- Contracted rates between the insurer and provider for the previous four years
- Both parties' market share
- Patient acuity
- The provider's level of training, experience, and quality, or the facility's teaching status, case mix, and scope of services

Arbitrators are not allowed to consider the provider's billed charges, Medicare rates, or Medicaid rates. Once the arbitrator selects the final payment amount, the insurer has 30 days to make the payment, and the losing party must pay the administrative costs for the arbitration process.

Why does it matter?

THE NO SURPRISES ACT CREATES NEW STRATEGIC IMPLICATIONS FOR PROVIDERS AND INSURERS.

- **Bargaining powers may shift in contract negotiations.** The ability to balance bill patients historically has given providers leverage in contract negotiations with insurers. In removing that tool, the law adds new complexities to contract negotiations and could shift the balance of power. Insurers likely will face less financial risk from providers being out-of-network, which could allow them to negotiate lower prices—although insurers will still have to contend with selling products that exclude specific providers. The arbitration process (which providers advocated for) also introduces a new degree of uncertainty for insurers and providers, which could encourage them to complete contracting negotiations.
- **The law may create downward pricing pressure—but the extent is unclear.** The law's ultimate impact on pricing is uncertain because shifts in bargaining power will not materialize immediately or uniformly nationwide—plus in some cases, existing state law will supersede this new federal law, preempting additional change. That said, similar pieces of legislation enacted at the state level offer some insight. After New York implemented a ban on surprise billing, providers experienced a 13% average reduction in payments. But individual arbitration awards remained high as the law directed arbitrators to consider the 80th percentile of providers' charges, which differs from the new federal law. Ultimately, the law's impact on networks, provider payments, and bargaining dynamics will be influenced by the specific details that will emerge across 2021 through HHS' regulatory process.
- **Providers and insurers may benefit from improved patient financial experience.** The No Surprises Act will reduce surprise bills and improve the consumer experience for commercially insured patients—a positive for patients, but also for providers and insurers. In general, delivering a positive financial experience yields a tangible return on investment for providers, as satisfied patients are more likely to return to the hospital, recommend the hospital, and pay their bill in full. Insurers also stand to benefit from fewer surprise bills, as polling data show that many patients blame insurers for their surprise bills. But challenges remain. Patients who receive non-emergency services may consent to balance billing and as noted above, are subject to additional exceptions for ancillary services.

THE NO SURPRISES ACT ALSO CREATES NEW PRACTICAL IMPLICATIONS FOR PROVIDERS AND INSURERS. THEY WILL NEED TO:

- **Adjust billing and communication strategies.** Providers and insurers will need to adjust their billing systems and processes to account for the new requirements. For example, leaders need to ensure that eligible bills only include patients' in-network cost-sharing obligations for services that cannot be balance billed. For the specific services that are eligible for balance billing, leaders must build a process for obtaining consent for out-of-network care that complies with the new law. They must also prepare to clearly communicate the implications of out-of-network care to patients.
- **Prepare for the new arbitration process.** Except in states where existing surprise billing laws supersede the No Surprises Act, providers and insurers will need to prepare for the new dispute resolution and arbitration model. For example, leaders will need to assign staff to manage the process, design a method for determining their final offer amounts, and refine their arbitration strategy as they gain experience and see arbitration results over time.
- **Conduct a cost-benefit analysis of when to pursue arbitration.** The new arbitration model establishes a formal and structured process for resolving payment disputes between providers and insurers, but it can also result in payment delays and administrative costs. The legislation requires the losing party to pay the administrative costs of arbitration to deter excessive use. Additionally, the initiating party is prohibited from instigating arbitration for the same service with the same stakeholder for 90 days. As a result, stakeholders will need to evaluate the best cases for arbitration.

What is the implementation process?

While the No Surprises Act outlines specific parameters that providers, insurers, and arbitrators must follow, HHS will need to develop detailed regulations to implement the law. Because the law takes effect on January 1, 2022, HHS will need to issue proposed and final rules in 2021. The federal rulemaking process requires HHS to publish a proposed rule and collect public comment for at least 60 days before finalizing regulations.

Those regulations could ultimately shape the law's impact on network strategy, payments amounts, and any changes in bargaining power. Health care leaders should watch to see:

- What criteria arbitrators will need to meet for certification
- The methodology insurers will use to determine the qualifying payment amount for emergency services
- The geographic regions that insurers use to calculate median in-network rates
- How HHS will select an arbitrator if parties do not reach a decision
- If HHS expands the list of specialties that are prohibited from balance billing patients for care delivered by out-of-network clinicians at in-network facilities
- If HHS alters the list of advanced diagnostic lab tests that qualify for balance billing under the law
- Whether HHS will offer arbitrators guidance on how to use the law's list of factors they can consider

In addition, the law requires HHS, in consultation with the Departments of Labor and Treasury, to develop guidance surrounding the notice and consent requirements. That guidance is due by July 1, 2021.

Conversations you should be having

01 Evaluate your current exposure: audit billing data to identify the extent of surprise billing at your organization.

02 Examine the local regulatory environment: review any existing surprise billing laws in your state, as the federal law defers to state precedent in certain scenarios.

03 Determine your patient communication strategy: prepare to inform patients of their consumer rights and improve price transparency.

04 Prepare for negotiation and arbitration: identify any changes in bargaining strength to prepare for provider-insurer contract negotiations and prepare for the new dispute resolution process and arbitration model.

05 Consider your feedback options: provide public comment on forthcoming rules or defer to trade organizations to represent your perspective.

These conversations might reveal that your organization is largely unaffected or that the organization should prepare for possible externalities.

PANDEMIC

Good? Bad? Ugly? We've updated our take on what's next for the epidemic.

By Brandi Greenberg

MARCH 5, 2021

Let's try this again. Last month, I explored one of the most common questions of 2020 (and 2021): "When will life get back to 'normal'?"

While I couldn't suggest a specific date when normality will return, I used my background researching the health care industry to identify three distinct scenarios—the "good," the "bad," and the "ugly"—and offered probabilities for each one based on the best available data I had at the time. But a lot has changed in four weeks. We've seen promising new data about vaccine efficacy; we've seen more viral variants take hold; and just last week, we saw a third vaccine receive FDA authorization for use in the United States.

So, it's time to revisit those original scenarios and the assumed probabilities of each. As I noted in February, even though I embrace the fluidity of these predictions, I still think there's value in "gut checking" where we are now and where we could end up later this year—and considering how health care stakeholders should prepare.

This article was originally published online on March 5, 2021. To see the original article with all citations, please go to: **advisory.com/covid-19/GoodBadUgly.**

The 'good' scenario: America achieves herd immunity by summer, primarily via vaccinations

As I mentioned last month, we must first acknowledge a painful truth—there is no "good" outcome in a pandemic that has already killed more than 510,000 Americans and has exacerbated severe health disparities.

Yet in the last few weeks, we've seen vaccination rates go up, case rates come down, as well as several new deals that will expand vaccine manufacturing capacity. These trends all make me increasingly optimistic that a "good" future could be awaiting us—at least in the United States, where I'm most familiar with the state of affairs.

There are a few reasons to think this scenario is likely. First, our supply of vaccines is rapidly expanding. In fact, Biden just announced that the United States will have enough vaccines for every American by the end of May, rather than the end of July, as originally promised. How have we made such strides so quickly? FDA just last week authorized Johnson & Johnson's (J&J) single-shot vaccine; the company said it can deliver an additional 20 million doses in the United States by the end of March, and 100 million doses by the end of June. It's unclear to what degree J&J's newly announced manufacturing partnership with Merck will impact domestic supply, but it's safe to say it will likely help. In addition, Pfizer said it can increase supply of its vaccine from 4-5 million doses per week to 13 million doses per week by mid-March, and Moderna said it can double its supplies to provide more than 40 million doses per month by April.

Second, the pace at which we're getting shots into arms is accelerating. 78.6 million vaccines have already been administered in the United States–at a rate of 1.94 million doses per day. Governments, providers, and pharmacies are improving their supply chain logistics and coordination efforts to more efficiently and seamlessly roll out the vaccines. In addition, states are quickly moving through different phases of prioritization and eligibility. For example, New York, California, and Washington D.C. now are administering vaccines to people with underlying conditions and comorbidities. And several are prioritizing teachers and child-care workers, in the hopes of accelerating timelines to resume in-person teaching. Additionally, new supply chain advances will help expand access and ease storage requirements. For example, Pfizer's vaccine can now be stored at normal freezer temperatures for five days, and J&J's vaccine can be stored at normal refrigerator temperatures for at least three months. Importantly, the Biden administration, local municipalities, and provider organizations have expanded efforts to improve access to vaccines for underserved communities and launched targeted campaigns to combat vaccine distrust—hopefully leading to more equitable vaccination rates nationwide.

Third, we're also learning more about the vaccines that give me additional confidence in their safety and their efficacy. New data from Israel and the United Kingdom provide the first real-world evidence confirming that Pfizer's vaccine is nearly as effective in the real-world as it was in clinical trials. Data also shows that Pfizer's vaccine is 75% efficacious after one dose, and people who already had Covid-19 might only need one dose. While it's too early to know whether this will cause governments to update their prioritization criteria or recommended dosing protocols, the new data nevertheless should build confidence that these vaccines are safe and effective.

We're also learning that even if new coronavirus variants are able to infect vaccinated patients, our existing vaccines still seem to prevent Covid-19 from turning deadly. As the New York Times has reported, of the 75,000 patients who received the five major vaccine candidates in clinical trials—including studies in the United States, United Kingdom, Brazil, and South Africa—not a single one has died from Covid-19.

Fourth, new vaccines are likely coming. We've seen promising—if incomplete—data from Novavax, AstraZeneca, and CureVac/GSK on their vaccine candidates, which (like J&J's vaccine) are easier to distribute than Pfizer's and Moderna's mRNA-based vaccines.

Fifth, the grim truth is that more people are acquiring some degree of natural immunity (if limited) from coronavirus infections. So far 28 million Americans have tested positive for the virus, and some experts believe multiple times as many were infected without a confirmatory test. Nobody knows exactly how long their immunity will last, but they're a growing population with at least some protection.

Finally, spring is coming, and cases are already starting to decline from the winter surges. This seasonal effect, when combined with rising vaccination rates, could cause infections to plummet. That, in turn, would reduce hospital and ICU occupancy rates, which would help providers deliver top-quality care to each patient, further reducing death rates.

This increasingly optimistic scenario is reflected in updated projections by the well-regarded Institute for Health Metrics and Evaluation. It projects that daily deaths will decline from their peaks by about 90% by June.

For all of these reasons, here's my updated thinking about the likelihood of a "good" scenario.

- **What defines a "good" scenario?** To my mind, a "good" scenario means death rates decline by 90% or more by summer and that herd immunity—perhaps with help from continued masking or social distancing—prevents a major surge in deaths next winter. Outbreaks could still emerge among undervaccinated populations or geographies, but these flare-ups would be far smaller than this winter's epidemic.
- **What are the odds?** This, I think, is more likely than many people believe. I'd now put the odds at 65%, notably higher than I estimated last month.
- **How can health care stakeholders prepare?** If the U.S. health care system is flooded with newly authorized coronavirus vaccines, our core challenge will be getting those vaccines into people's arms quickly. Our Covid-19 Vaccine Scenario Planning Guide can help you do that. You'll also need to address vaccine misinformation, as well as meaningfully engage with communities who have deep-seated, and historically well-deserved, mistrust of the health care system. Here's Advisory Board's take on five common vaccine concerns—and how to overcome them.

The 'bad' scenario: America achieves herd immunity in late 2021, in large part due to new infections

America is likely to achieve herd immunity in 2021. The difference between a "good" and a "bad" future is largely about how we get there and how long it takes.

Specifically, in a "bad" scenario, tens of millions of additional Americans will gain immunity the hard way: by contracting Covid-19, with all the morbidity and mortality risks that entails. Of course, we still don't know how long that type of immunity will last, especially as new viral variants take hold.

Why could this happen?

On the vaccine front, it's easy to imagine why progress could stall. Perhaps new data reveals existing vaccines (and boosters) are less effective than expected against new variants. Vaccine uptake may stall out too soon, with 30+% of the adult population holding out against getting a shot. Either option leaves a sizable portion of the country still prone to new infection, hospitalization, or death. And we could also learn that vaccine or infection-induced immunity may be short lived.

Perhaps new data halts—or even reverses—the authorization of pending vaccine candidates. Or perhaps Moderna, Pfizer, or J&J, encounter major manufacturing problems, or no vaccine is ever authorized for children or pregnant people. While some clinical trials involving pregnant people are in the works, vaccine trials for teens and children are moving slower than anticipated. Since children make up about a quarter of the population, and we know they can transmit the virus, further delays in child/teen eligibility could definitely slow our pace toward herd immunity.

These risks are all possible. But if there's a reason for optimism, it's that the number and variety of vaccine candidates under development—as well as the number of companies helping out with manufacturing and distribution—creates resilience against any single failure. In other words, for America's vaccination strategy to fall apart, multiple things likely would have to go wrong.

A separate—and to my mind bigger—concern is that the coronavirus could spread more rapidly than previously projected. This is, in fact, already happening, as more infectious variants that originated in the United Kingdom, Brazil, and South Africa, California, and New York are spreading across the United States. Just this week, Houston became the first American city to record cases of every major Covid-19 variant, and experts are projecting a potential surge this month related to the variant originating in the United Kingdom. And as I mentioned above, without approved vaccines for children (and parent willingness to have their children vaccinated), the virus could continue spreading and mutating faster than our vaccination programs can keep up.

Worryingly, this spread in variants could coincide with governments and individuals prematurely relaxing preventative measures like social distancing and masking as vaccination rates increase and the weather warms up. Already we've seen Texas and Mississippi lift masking requirements and capacity constraints. Since we still don't know enough about how the vaccines impact transmission, this could lead to an uptick in the spread of the virus.

If these new variants spread faster than vaccinations can occur, then 2021 could be a very difficult year. Further, if the coronavirus becomes more infectious, it would become harder and harder for the United States to achieve herd immunity, since the virus would remain capable of spreading, even with fewer vulnerable targets.

This is the possibility triggering lots of conversation and speculation among my peer group, and it makes the "bad" scenario feel frighteningly plausible, even if it's still unlikely.

- **What defines a "bad" scenario?** I'd consider a "bad" outcome to mean: (1) Coronavirus variants drive a new surge in U.S. cases this spring, and we experience infection and death rates that markedly exceed their January peaks; and/or (2) a significant portion of the public remains unvaccinated by fall, and Covid-19 surges as the weather cools.
- **What are the odds?** I'd estimate a 15% chance—lower than my estimate from last month, for the reasons I've outlined. (I'd put higher odds on what we might call a "mixed-bad" scenario, where certain populations receive the vaccine more slowly, leading some communities—especially historically disadvantaged ones—to experience a "bad" future even as others see "good" outcomes.)
- **How can health care stakeholders prepare?** This scenario implies high ICU occupancy rates across the next few months, plus the possibility of significant surges next winter. To keep hospital beds available for those who most need them, it will be critical to embrace telehealth, adapt to digital health's "next normal," and ramp up hospital-at-home care.

The 'ugly' scenario: Vaccines falter, and America doesn't achieve herd immunity in 2021

The defining characteristic of an "ugly" scenario is that America fails to achieve herd immunity in 2021. This could occur if existing vaccines and boosters don't effectively protect against new coronavirus variants, or if the immunity conveyed by infections or vaccinations fades quickly. (We're already seeing signs of this risk in South Africa, where a new variant is reinfecting people who've already had the coronavirus.)

Even if the existing vaccines and boosters do work well enough to protect against new variants, the global supply is still insufficient, and we're nowhere close to having global herd immunity. In this analysis we've focused on when life will return to normal in the United States, but the reality is that the wellbeing of other countries directly impacts ours. The longer Covid-19 goes unchecked in developing nations, the greater the opportunity exists for newer, more potent variants to develop—potentially ones that are resistant to current vaccines. And as long as our borders are open, those variants will make it into the United States. Not only will this directly impact people who aren't vaccinated for a range of reasons (e.g., immunocompromised patients, children, pregnant people), but the industry will be continuously playing catch up to develop effective boosters for those already vaccinated.

In this scenario, 2021—and even 2022—could look a lot like 2020.

We could see new rounds of stay-at-home orders and lockdowns, more stringent than any put into place since April 2020. The U.S. economy, which so far has been buoyed by hopes of a rapid bounce-back from the epidemic, could crater. A slim Democratic majority in Congress may struggle to pass relief packages, amplifying the suffering. The failure of early vaccines could lead to a resurgence of vaccine skepticism.

Further, there's suggestive evidence that some of the new coronavirus variants might cause more severe symptoms, which could further overwhelm hospitals and ICUs and cause hundreds of thousands of new deaths. And many people, after years of arranging their lives around an epidemic, could simply give up on social distancing, driving even more infections.

In this scenario, the coronavirus could even become an endemic human disease—the sort of durable, deadly pathogen that wealthy nations haven't dealt with since the middle of the 20th century.

Eventually, our institutions would adapt, and we'd get better at both preventing spread and treating people who become infected. But make no mistake: This is a grim future to imagine.

- **What defines an "ugly" scenario?** We'll know we're in an "ugly" future if we find it's impossible to achieve herd immunity with current vaccines—whether because our vaccines don't protect against new variants or vaccine-induced immunity fades more quickly than we can vaccinate the public.
- **What are the odds?** It's difficult to say, since the risk depends on impossible-to-know variables such as how quickly variants evolve and whether they develop vaccine resistance. My best guess, however, is 20%—higher than my estimate from last month. Ultimately, if things don't go well, they're likely to go downhill in a very significant way.
- **How can health care stakeholders prepare?** Because an "ugly" scenario could take so many forms, the best way to prepare is to increase your organization's overall resilience. Get ready to boost your surge capacity. Ensure you're ready to meet PPE needs. And make sure you can recognize, and address emotional distress in your staff.

We will live in the future we build

One final thought. For most of this post, I've framed Covid-19's course as something that will happen to us. The world will hand us a good, bad, or ugly future, and it'll be up to us to respond accordingly.

But as anyone who knows me will attest, I'm inherently an optimist at heart. And my optimism comes from a belief in human ingenuity and resilience—and a choice to focus on the things we can control. As people who work in the health care industry—and as members of a shared human community—we absolutely have a role in shaping our future. So I'll close with the same sentiment as I shared one month ago: if we do everything we can to ramp up vaccinations, to engage and overcome vaccine hesitancy, to recognize and contain the spread of Covid-19, and to make social distancing and mask-wearing easier and more acceptable in our communities, we can nudge the course of the epidemic in a more hopeful direction.

A "good" outcome isn't guaranteed, but it's a real possibility—and it's at least partly in our control. We all just need to do our part to bring it about.

POLICY

How will the Biden administration alter health policy?

3 takeaways from health care executives

By Ben Umansky

MARCH 6, 2021

Since the presidential and Congressional elections concluded, Advisory Board has been working with leaders across the industry to prepare for a new era of health policy. As expert partner, I've had the opportunity to speak virtually with executives about their hopes and fears for the Biden era, including through our invitation-only 2021 Health Policy Executive Briefings over the past month. Reflecting back on those briefings and my private conversations with a range of executives, I'm struck by three observations that offer a glimpse into health care leaders' mindsets in the early days of the new administration.

This article was originally published online on March 6, 2021. To see the original article with all citations, please go to: **advisory.com/Biden-Harris/PolicyLandscape.**

OBSERVATION 1

Executives are serious about understanding political and policy realities, not just hypotheticals.

It isn't always easy to get on a CEO's calendar—even for Advisory Board. So, when I saw dozens of C-suite executives not only sign up for our virtual discussions, but also show up on time and stay engaged through the whole session, I knew they weren't popping in just for fun. There's a real sense that health care could be on the verge of major change, and leaders know they need to be up to speed on the issues.

But the mood is not one of agitation, excitement, panic, or dramatics. Overwhelmingly, the leaders who joined the virtual sessions and who I've spoken to separately are calmly and professionally assessing the situation and preparing for likely eventualities. I can't help but compare it to the mood when former President Barack Obama began pushing for the Affordable Care Act, or when President Trump sought to repeal and (perhaps) replace it. For many reasons, and for better or worse, the dawn of the Biden administration seems a slower, calmer, and more deliberate time. Credit is due to those executives who aren't jumping to conclusions or getting distracted by what-ifs, especially when managing the pandemic and vaccine rollout rightfully demands their fullest attention.

OBSERVATION 2

There's a much wider issue set facing real-world health care leaders than what's in the media spotlight.

One reason for the more measured approach may be that Democrats' razor-thin majority in the Senate means ambitious policy proposals such as a public option or even Medicare for All have little to no practical likelihood for now. Executives need to understand why the budget reconciliation process isn't a silver bullet for Democrats and why eliminating the filibuster, while not impossible, is probably a bridge too far for many Senate moderates.

But none of that means there won't be plenty of policy changes coming. Our conversations with executives covered everything from prescription drug spending (plenty of political agreement on the problems, but less on the solutions) to price transparency (a Trump-era priority likely to remain prominent in the Biden era) to antitrust policy (a huge wild card for executives often competing at break-neck pace in the race for scale). These are issues that depend on administrative rulemaking, legal challenges, executive appointments, and other mechanisms of policy that don't necessarily grab headlines the way massive legislative battles do.

Momentum for that roll-up-your-sleeves policymaking will build just as the novelty of a new administration wears off. Executives will need to find ways to maintain diligent focus—or deputize trusted partners to keep them up to speed.

OBSERVATION 3

State-level dynamics will matter as much or more than what happens in Washington, D.C.

Our virtual sessions, which included leaders from all across the country, made clear once again how much depends on state-level policy. For example, while the Biden administration will have national influence over Medicaid policy through CMS' waiver authority and other tools, the Chief Strategy Officer of a prominent Florida health system was rightly far more focused on the posture of Florida's Republican-led state government when we discussed the possibility of coverage expansion under the Affordable Care Act.

Indeed, almost every policy issue of national prominence has a state-level dynamic: Lawmakers in Colorado and Washington have dipped their toes into the public option space. The future of telemedicine depends in part on licensure decisions. Site-of-care shifts move faster or slower depending on local Certificate of Need laws. Every executive who began a comment with, "In [my state]..." reminds all of us why we should be thinking outside the Beltway.

POLICY

The 689-page, $1.9T coronavirus relief bill—simplified

By Heather Bell

MARCH 10, 2021

The House on Wednesday voted 220-211, largely along party lines, to approve President Biden's $1.9 trillion American Rescue Plan Act, providing financial relief to small businesses and households impacted by the coronavirus epidemic.

Congressional Democrats passed the bill via budget reconciliation, which allows them to pass legislation on a simple majority vote and without Republican support. The Senate last week voted 51–50, along party lines, to approve the package with Vice President Kamala Harris casting the tie-breaking vote. Rep. Jared Golden (D-Maine) joined all Republicans in the House in voting against the measure.

This article was originally published online on March 10, 2021. To see the original article with all citations, please go to: **advisory.com/Biden-Harris/StimulusBill.**

While the latest Morning Consult poll found 76% of Americans supported the bill—including nearly 60% of Republican voters who said they either "strongly" or "somewhat" support the package—congressional Republicans have balked at the overall size of the package and the impact on the growing national debt. At the start of the relief package negotiations, a group of Senate Republicans offered an alternative $600 billion proposal. Though Biden signaled he was open to negotiations, Democrats ultimately stuck with the $1.9 trillion cost.

Unlike past Covid-19 relief packages, such as the Cares Act, the health care industry is not the primary benefactor—but that doesn't mean the industry will not feel the effects of the bill. Next I outline four ways the American Rescue Plan could affect the health care industry in the short- and long-term.

01

More money in consumers' pockets could mean more doctor visits and paid medical bills

The American Rescue Plan will provide $1,400 stimulus checks to millions of Americans with annual incomes up to $75,000, with check amounts fully phased out for those with annual incomes of $80,000 and higher. The measure also extends the $300 weekly unemployment insurance through Sept. 6, provides full coverage of COBRA insurance premiums through September for those who were laid off amid the pandemic, and increases the child tax credit.

Each of these provisions translates to more money in many Americans' pockets. A recent Pew Research survey found 66% of low-income adults said they planned to use most of their stimulus funds on short-term items like bills or other essential needs. Meanwhile, a separate survey conducted at the end of 2020 found 66% of consumers were concerned about paying their medical expenses in 2021. The additional stimulus checks and unemployment insurance extension is likely to help at least some consumers pay needed medical bills.

02

No additional PRF funds means providers must double down on recovering patient volumes

Provider groups made three big asks of Congress as they negotiated this bill: Include an additional $35 billion for the Provider Relief Fund (PRF), extend the moratorium on the 2% Medicare payment cuts set to expire on March 31, and delay the looming 4% Medicare cuts called for under the PAYGO rules. The American Rescue Plan does not include any of these asks, at least not in full.

While the bill does not include a boost to PRF funds, the Senate did add $8.5 billion to help rural providers or suppliers cover health care expenses and lost revenues related to the pandemic. Eligible providers or suppliers must apply for the funding and provide documentation of their Covid-related expenses and revenue losses. One notable change is the Senate ultimately removed a requirement for parent organizations to pass all of the funding on to the rural provider. The bill also provides $500 million in grant funding for Department of Agriculture to award to eligible entities, including rural hospitals, to help cover pandemic-related expenses. In addition, the bill restores the wage index "rural floor" for hospitals in states considered all urban beginning Oct. 1, 2021 (currently this applies to Delaware, New Jersey, and Rhode Island), and ensures ambulance providers are fully reimbursed when Covid-19 prevents them from transporting a Medicare beneficiary to an approved location. But the bill does not include any additional funding for the PRF—and it's not entirely clear that more funding was needed.

The latest data—and our own conversations with hospital executives—suggest that hospitals are OK for the near term. The Cares Act provided grants and loans to hospitals when they needed it most—and those funds, coupled with the winter surge in Covid-19 cases that filled hospital beds, appears to have staved off any immediate solvency crisis for providers. The extra costs and relatively meager reimbursement for Covid-19 patients have certainly eroded margins—even with the extra volumes—and the Cares Act money was almost certainly necessary to keep providers in the black. But most CFOs report that loans are getting repaid, and that they expect volume growth in 2021 to at least partially restore profitability.

And while the exact amount remains uncertain (AHA previously said $4.4 billion was left in PRF, but other estimates have placed that number higher), the PRF still has funds available for hospitals that are in need so it's not too surprising that lawmakers were unwilling to divert funds from other needed areas (rural hospitals, schools, states, and vaccine and testing efforts to name a few) to put more money into PRF.

But the long-term picture looks different. Future profitability will be determined by hospitals' ability to recover patient volumes for scheduled care. The latest data indicate hospitals could lose up to $122 billion in 2021 if vaccine distribution wanes and hospitals do not recover patient volumes lost amid the pandemic. And this figure does not include the sequester cuts that are set to take effect March 31 or the 4% Medicare cut under PAYGO rules that the Congressional Budget Office (CBO) said would be triggered in 2022. That means hospitals, physicians, and other Medicare providers would receive lower reimbursement at a time when they are still recovering from the pandemic. It's worth noting, though, that Congress does have time to act to stave off those cuts, and a bipartisan group of lawmakers recently said there is bipartisan support to tackle that issue after Congress passed the Covid-19 relief package.

03

More people could gain coverage via the ACA's exchanges and Medicaid expansion

The legislation also takes initial steps toward the coverage expansions Biden campaigned on, making notable updates to the Affordable Care Act that temporarily address what some public health experts have labeled the ACA's affordability problem and offer holdout states a financial incentive to expand their Medicaid programs.

First, the bill eliminates the so-called "subsidy cliff" that prevents individuals with annual incomes over 400% of the federal poverty level (FPL) from qualifying for subsidies to offset the cost of purchasing coverage on the ACA's exchanges. Under the bill, people above 400% FPL will qualify for subsidies and their premium costs will be capped at 8.5% of their incomes for two years. The bill also fully subsidizes coverage for people with annual incomes up to 150% FPL for two years. CBO projected the provision would cost $4.5 billion over the 2021–2030 period and lead to 1.3 million fewer uninsured people in 2022.

The changes are being lauded as a win for consumers who will have access to more affordable coverage, providers who benefit from a lower uninsured rate, and insurers who are likely to see a temporary increase in enrollees for 2021 and 2022. But it's important to remember that these provisions are temporary—the funding to cover the additional subsidies is allocated for two years—and Congress will need to take additional action to keep those coverage expansions in place.

The bill also includes a carrot for the 12 remaining states that have not expanded Medicaid under the ACA. Currently, the government pays 90% of states' expansion costs for the first three years. Under the bill, the government would still cover 90% of those costs, but it also would provide a 5% FMAP bump for the states' non-expansion population if they choose to expand their Medicaid programs under the ACA. But it's not yet clear if states will take the carrot. Governors in states that have not expanded their Medicaid programs continue to face political hurdles regarding the ACA. But many of those governors are likely to feel increased pressure to expand Medicaid coverage from both a budget standpoint and local advocacy groups. Already this year, we've seen ballot initiatives to expand Medicaid in at least four states.

04

Cap on drugmakers' Medicaid rebates will expire in 2024

One interesting provision that has largely flown under the radar will eliminate the cap on Medicaid inflation rebates in 2024. Under current law, Medicaid requires drugmakers to pay a rebate for brand-name and generic drugs, as well as an inflation rebate penalty for drugs whose prices rise faster than inflation. The ACA capped the maximum total rebate, meaning the sum of both the basic rebate and the inflation rebate, at 100% of the drug's average manufacturer price.

However, the American Rescue Plan removes the 100% cap, opening up the potential for drugmakers to pay rebates that exceed the price of their drugs. This scenario is only possible if a drug's price increases faster than inflation, but in such cases, the total rebate that the drugmaker must pay to a state Medicaid program could total more than the drug's average manufacturer price.

MACPAC recommended this change back in 2019, noting that it would save states money and act as a disincentive for steep price increases. CBO last month projected the change would reduce federal Medicaid spending by $15.9 billion over 10 years. However, some experts have noted that the change could prompt drug manufacturers to simply set higher prices for new drugs or adopt other cost shifting mechanisms.

Another key component is which drugs will be affected by the change. In 2019, MACPAC noted that 18.5% of brand-name drugs hit the 100% rebate cap during the fourth quarter of 2015. While the rule change is likely to affect drugs like insulin that have seen steep price increases in recent years, it may also curtail price increases for lower-cost generics that have lower margin for drugmakers to begin with.

PANDEMIC

Are you a vaccine 'hunter,' 'shopper,' or 'avoider'?

These 3 emerging groups are making it hard to vaccinate equitably

By Rachel Woods & Brandi Greenberg

MARCH 12, 2021

The state of Covid-19 vaccinations is rapidly evolving, and sometimes it can feel like the health care industry has found itself in a game of "whack-a-mole." Leaders knock down one challenge, only for another to appear just out of reach.

As we have said before, there are plenty of logistical and operational barriers to vaccinating the globe, none of which have gotten any easier. The latest dilemma isn't about syringes or nursing capacity—it's about the lengths some people are going to in pursuit of that hard-to-obtain shot, and the challenges those extra efforts create for health officials trying hard to enable equitable access, especially among economically disadvantaged communities.

This article was originally published online on March 12, 2021. To see the original article with all citations, please go to: **advisory.com/covid-19/VaccineEquity.**

What we've been tracking: Vaccine hunters and immunization tourists

For the last several months, vaccine demand has far outstripped supply and overwhelmed existing administrative infrastructure here in the United States. As a result, registration websites routinely crash or require continuous refresh, people line up early each morning in hope of nabbing an unclaimed dose at the end of the day, and some even travel across state lines to capitalize on more favorable prioritization policies (e.g., smokers traveling to New Jersey).

Despite the handful of well-publicized stories about intentionally deceptive behavior—such as people posing as grandparents or paying the elderly to claim them as a caregiver (which even made it into the cold open of SNL)—most of today's vaccine hunters aren't doing anything unethical. They are working within the rules of a system ripe for arbitrage—but it's a system that also disproportionately favors those with time, technology, transportation, and tremendous flexibility. By and large, successful hunters can navigate multiple complicated registration sites, dedicate time to refreshing appointment pages on their laptops with high-speed internet connections, and step away from their white-collared jobs on a dime if they secure a coveted appointment or learn of a site likely to have extra doses at the end of the day. They might not be boarding a private jet, but they do tend to be more affluent, and they do tend to be white.

Technology-based aggregators are stepping in to streamline the "hunting process." New websites match leftover doses to people willing to offer their arm at a moment's notice while still prioritizing vulnerable populations. While this is still a technological solution, vaccine matchers like Dr. B are working to remove some of the more annoying barriers to vaccine access—the time it takes to search and refresh—instead routing people to opportunities closer to home.

All of this means that health systems and public health leaders must work that much harder to rebalance the scales and bolster access for historically marginalized and underserved communities. As we learned from our recent podcast conversation with Parkland Health executives, leaders must work proactively to reduce inequities by adopting a data-driven process for identifying the most vulnerable. Then, they must pair that data-driven outreach with a combination of online and in-person registration, door-to-door vaccination campaigns, mobile vaccination sites, and a triage process that redirects patients to vaccination sites during regular medical appointments.

With vaccine supply expanding rapidly, and with three effective vaccines now available in the U.S., we're likely to see fewer hunters over time. President Biden projects that the United States will have enough doses to vaccinate all American adults by the end of May. But between now and then, we're likely to see more examples of a new kind of consumer behavior: vaccine shopping.

The latest challenge: Vaccine shoppers

Vaccine shoppers aren't interested in just any dose; they are interested in getting the vaccine that they perceive to be the best. To be clear, our guidance (and the CDC's guidance) is for eligible adults to take any Covid-19 immunization available. But consumers are starting to call around to determine which manufacturers' shots are available at different locations, and they're starting to express preferences for one vaccine over another.

To be fair, there are some legitimate reasons for vaccine shopping. If someone is terrified of needles or has transportation constraints, Johnson & Johnson's single-dose option may make more sense. If someone may be allergic to ingredients in one manufacturer's vaccine, then it's great that we

now have two other options. But too much shopping for one vaccine over another—especially if those shoppers are vocal about their perceptions of one product's superiority—can exacerbate both perceived and actual inequities. Moreover, if public opinion starts to skew perceptions that one vaccine is superior or inferior, then we risk increased hesitancy and mistrust, especially among people of color.

So far, most states have prioritized the most vulnerable people for Covid-19 vaccination. But as supply ramps up, public health officials and health system leaders may start to prioritize certain vaccines for specific populations. For example, there's already widespread talk of prioritizing Johnson & Johnson's easily transported, single-dose vaccine for vulnerable populations already struggling with access. Those who live far away from vaccination sites, lack easy access to transportation, or have other constraints that may make it difficult for them to follow up for a second dose may all truly benefit from easier access to a "one and done" vaccination.

However, we cannot acknowledge these advantages without placing them in historical and sociological context. Many of the potential beneficiaries mentioned above are also people of color—and if there's even a hint that the one-dose option is in any way inferior to the two-dose mRNA options, some may hesitate to take what's offered to them, concerned that this may be one more example (over hundreds of years) of the medical system prioritizing white lives over their own. Every health care leader and public official must continue to reinforce the message that no vaccine is superior to the others, and that all protect very well against severe disease, hospitalization, and death.

The future challenge: Vaccine avoiders

As supplies continue to increase, vaccine hesitancy and distrust have the potential to create yet another dilemma.

The Biden administration's promise of sufficient supply by May doesn't guarantee anything close to herd immunity—these projections don't account for the number of American adults who still aren't ready to get vaccinated. As of late February, Kaiser Family Foundation estimated that as many as 44% of American adults are still hesitant (22%) or unwilling (22%). If we don't make significant progress in lowering that number, we may soon find ourselves with the opposite problem from what we face today: too much supply, and not enough people who want a shot (or two). Before demand starts to dip, providers and public health officials must ramp up their proactive outreach and their efforts to build trust, particularly among communities of color.

While we're unlikely to reduce vaccine hesitancy to zero, there's much that health care leaders can do to empathetically listen, engage, and educate people in order to ensure demand keeps up with supply—and increase our chances of hitting something close to herd immunity this summer.

DIGITAL HEALTH

Amazon Care is coming to all 50 states

With the potential to disrupt patient-physician relationships

By Yulan Egan, John League & Sarah Hostetter

MARCH 18, 2021

In recent weeks, many across the industry have picked up on cues suggesting that Amazon was quietly preparing to expand its care delivery arm, Amazon Care. Launched about a year and a half ago, Amazon Care currently offers a combination of virtual care and house calls. To date, those services have only been available to Amazon employees in Washington State. But yesterday, Amazon formally revealed plans to expand those services in 2021. That plan includes three distinct elements.

01 As of yesterday, Amazon Care is available to other employers in Washington State.

02 Starting this summer, Amazon Care's virtual services will become available to Amazon employees and other employers in all 50 states.

03 Amazon Care's in-person services will become available in "major cities" across the country "in the coming months." The announcement mentions Washington, D.C. and Baltimore as two initial targets.

This article was originally published online on March 18, 2021. To see the original article with all citations, please go to: **advisory.com/AmazonCareExpansion.**

Our initial take

Amazon's brand cachet has the potential to disintermediate existing patient-provider relationships. During the pandemic, most virtual visits were delivered by traditional care providers like hospitals and physician groups. Patients largely relied on virtual channels to connect with their existing care providers. But as plans and providers work to figure out what their long-term stance toward telehealth will be, there may be an opening for non-traditional players to gain a deeper foothold in the market. Amazon's brand and existing consumer relationships could prove to be an advantage over traditional provider groups, health plans, and pure play telehealth platforms.

Amazon is betting big on home-based care. Amazon has been experimenting with a variety of tools for improving employee health and well-being. In addition to piloting Amazon Care, they have partnered with Crossover Health since July of 2020 to offer Amazon employees in three markets both virtual and in-person care, the latter of which is delivered at 17 bricks-and-mortar Crossover "Neighborhood Health Centers." Crossover Health recently announced an expansion of this partnership to include two additional markets, with a continued focus on Amazon employees. But the much smaller scale of this expansion indicates that Amazon either has increased confidence in the growth potential of home-based services, or at least that the company perceives a need to move more quickly in the home-based care space.

This will accelerate the commoditization of virtual visits. Based on yesterday's announcement, it appears that Amazon Care's initial priority will be in selling virtual care services to other large employers, rather than launching a large-scale, consumer-facing virtual care platform. But it's not hard to envision that a direct-to-consumer virtual care platform might be a next step. The ability to offer a virtual visit is not going to be a differentiator for providers or plans in a world where a certain number of Amazon Care visits are included with a Prime membership. Depending on how tightly Amazon plans to integrate this service with Alexa's capabilities, this move could even commoditize some remote patient monitoring functions as well.

This could be Amazon's most directly competitive move into the health care space yet. Three years ago, as Amazon was just beginning its foray into health care, we sat down to brainstorm what health care "identities" the technology giant might adopt. At that time, most of Amazon's near-term bets appeared to be either collaborative in nature (e.g., partnering with health systems to streamline logistics) or modestly competitive plays in the pharmacy space (e.g., the PillPack acquisition). We identified care delivery—and specifically primary care delivery—as the most ambitious and directly competitive play the company was likely to make, but also noted that this strategy was unlikely to materialize in the short-term. The Covid-19 pandemic has almost certainly accelerates that timeline. Amazon Care was initially launched as a pilot before the pandemic began, but it's hard to envision a scenario in which the company could or would expand its services so rapidly without the incredible surge in demand for telehealth services brought on by the pandemic.

The potential of Amazon Care is clear—but its success is far from certain. Here are three things we think will dictate the size of its impact.

Will Amazon Care remain a business-to-business offering, or will it eventually become a direct-to-consumer model?

As of December 2020, Amazon reportedly employs about 1.3M people. They are a large employer, to be sure, but this number still represents only a very small portion of the commercially insured market, and an even smaller portion of the U.S. population. The move to sell the platform to other employers will drastically increase Amazon Care's potential impact—but that impact is still likely to occur unevenly across the country, with Amazon Care being a much bigger competitive in some markets than in others, based on employer uptake.

A direct-to-consumer play could prove to be a true driver of discontinuous growth nationwide, especially if integrated as part of the Amazon Prime membership program (recent data suggests that nearly a third of Americans have an Amazon Prime membership today).

How deeply will Amazon Care integrate itself with existing, local care delivery networks?

For all of virtual care's potential, it's not realistic to expect 100% of care—even primary care—to be delivered virtually. And while it appears Amazon Care will include house calls as well in certain markets, its clinicians will still inevitably bear responsibility for referring patients to specialists and other care providers in many cases.

Amazon Care's early marketing materials lead with a clear focus on ease, primarily centered on accessibility and convenience. There is little indication of how Amazon plans to handle integration of patient health records and referrals, which are critical elements of the patient experience as well—and an important reason why many patients have preferred to use virtual care to connect with their own care teams, rather than relying on national telehealth platforms.

How will Amazon make Amazon Care sticky—and how much of that "stickiness" is aimed at health care services specifically?

The Amazon ecosystem is designed to frictionlessly reinforce a consumer's relationship with Amazon. All of the various elements of Prime, Alexa, Video, Whole Foods, etc. are built to keep customers in Amazon channels.

Amazon will ostensibly do the same thing with Amazon Care, but it's not clear how much of the strategy will be to direct Amazon Care customers to non-health care channels like Video or Prime, versus health care-specific channels like PillPack. Which channels Amazon priorities will provide important cues as to how much Amazon Care is a health care strategy as opposed to a retail strategy designed to drive virtual foot traffic to the broader suite of Amazon offerings.

PANDEMIC

3 ways to help your clinicians heal after a year of Covid-19

By Madeleine Langr

MARCH 18, 2021

This March marks a year since Covid-19 patients first entered U.S. hospitals. With vaccine rollout underway, many are looking forward to a year with fewer Covid-19 cases and a return to some aspects of our pre-Covid lives.

But even as we look ahead, the impact of this crisis will be felt long after vaccines roll out. Clinical workers put themselves at risk as they stood on the frontlines of care delivery during a global pandemic—and many continue to do so today. The physical stress and emotional burden staff took on is immense, and for many, this is just the start of processing the toll of the last year.

As leaders, one of the most important steps you can take for your team is to invest in the time and resources to support recovery.

Recently, 10 Advisory Board experts met to discuss how health care leaders can acknowledge the collective trauma of the last year and bolster the support required for recovery. Here's our guidance for how you can help your team start to heal during—and after—this crisis.

This article was originally published online on March 18, 2021. To see the original article with all citations, please go to: **advisory.com/covid-19/WorkforceRecovery.**

Laying the foundation: Start with safety

Before addressing recovery, every leader must commit to ensuring staff feel, and are, safe at work. Absent a safe work environment, recovery efforts will not only fall short, but may do more harm than good.

For the past year, staff put their health at risk to care for Covid-19 patients—at times without proper PPE. Now is the time to rebuild trust and ensure everyone feels safe at work.

As leaders, one of the best ways you can do that is transparently communicating about the steps you're keeping to keep your team safe. Then, solicit input from staff to understand whether they have safety concerns and how you can address those head-on.

Three steps to prioritize workforce recovery

1. **Immediate:** Make support services opt-out (if you haven't already). Many organizations have seen low utilization of emotional support initiatives, even across the last year. This is due to the "I'm fine" culture in health care, where clinicians often rely on individual coping mechanisms over organization-led support services. On top of that, many staff experienced information overload as new support options were rolled out in the heat of the pandemic. They may not have a comprehensive understanding of what options are at their disposal or felt they had the capacity to use them. As you roll out recovery initiatives or renew your commitment to existing supports, make them opt-out and couple that with a system-wide awareness campaign to drive utilization.
2. **Near term:** Assess your support services for breadth, depth, and accessibility to meet your staff's individual and collective needs. Healing won't look the same for everybody. Identify what your staff need physically and emotionally for their recovery, and make sure your organization has a wide selection of accessible options to meet them where they are. Ask for staff input, and use that information to tailor and prioritize the recovery efforts that will be most impactful. Consider auditing the support you've put in place across the last year to decide what to continue, stop, or double-down on.
3. **Long term:** Commit to workforce recovery as a top 2021 priority. Most organizations are, and should be, focused on getting back to a healthy bottom line, but don't let recovery fall in strategic importance. The C-suite must make strategic and financial tradeoffs to prioritize recovery. This will require intentionally reinvesting time and energy from other important initiatives, such as engagement or technology rollouts, into recovery. We've already seen an exodus of clinical staff during the pandemic. If your clinicians can't recover from the last year, you risk losing more staff, which will hurt the bottom line, patient safety, and engagement down the road.

Planning for an end state, not an end date

At this one-year marker, it's an important moment to commemorate the sacrifices clinicians have made over the last year and commit to investing in a comprehensive workforce recovery strategy. Although the crisis is far from over, there are steps you can take now to ensure everyone feels safe at work, help clinicians unpack their experiences, and proactively bolster support over the long haul.

POLICY

The 5 biggest challenges awaiting HHS Secretary Xavier Becerra

By Heather Bell

MARCH 19, 2021

After 56 days without a confirmed leader, HHS has a new secretary. The Senate on Thursday voted 50-49 to confirm Xavier Becerra as the next HHS secretary.

As the final vote suggests, Becerra's road to confirmation wasn't smooth. While leading insurer and provider groups came out in favor of Becerra (PhRMA has remained silent on the nomination), others—including many congressional Republicans—have raised concerns about his lack of hands-on health care experience, particularly during the Covid-19 crisis.

But it's worth noting that while the United States is in the midst of one of the worst public health crises it's seen in recent history (and greatly needed a head of HHS), only three past HHS secretaries had medical training. It's far more common for HHS secretaries to have political and management experience. And Becerra is largely being viewed as political operative for the department, as opposed to an HHS secretary coming in with his own set of policy agenda items. In fact, one thing his confirmation hearings made clear is that Becerra is committed to carrying out President Biden's health care agenda.

This article was originally published online on March 19, 2021. To see the original article with all citations, please go to: **advisory.com/weekly-line/HHSchallenges.**

5 health policy challenges facing Becerra

01

Seeing the United States through the end of Covid-19 pandemic—and beyond

While the United States is not out of the woods, there are increasing signs that the immediate Covid-19 crisis may wane throughout 2021 as more people get vaccinated and develop natural immunity. This means Becerra will need to see the country through the end of public health emergency.

That's no simple task. Under the Biden administration, HHS and its related agencies play a leading role in many areas, including:

- Coordinating vaccination distribution (and in the near term will need to work with states to meet President Biden's new goal of opening Covid-19 vaccinations to the general public by May 1)
- Approving and authorizing new Covid-19 treatments and therapies
- Distributing and managing the health care-related funds included in the Cares Act, Consolidated Appropriations Act, and the latest American Rescue Plan
- Collecting loan repayments granted to providers through the stimulus packages above

Becerra also will be tasked with lifting the public health emergency declaration—a decision that will impact provider reimbursement rates, insurer coverage requirements, telehealth reimbursement, and more. While some of those changes will require congressional action, others will fall to HHS and its related agencies. That is because many of the reimbursement and regulatory changes that went into effect to help the health care systems respond to the pandemic are tied to the public health emergency declaration. When that declaration is lifted, HHS and its related agencies will need to shepherd the industry into a new normal.

02

Reducing the uninsured population

In 2019, an estimated 30 million U.S. residents were uninsured—and reducing that number is one of the Biden administration's top health care priorities. Throughout Becerra's confirmation hearings, there was a lot of focus on his past support for single-payer proposals as a way to achieve universal health coverage. But, as Becerra told Senate committee members, he will support Biden's policy agenda—and Biden has been steadfast in his preference for a public option health plan and building on the ACA.

We've already seen Congress take steps to temporarily expand subsidies to purchase exchange coverage and entice states to expand their Medicaid programs under the ACA. Becerra and HHS' agencies will be responsible for implementing those changes—including convincing holdout states to expand Medicaid under the ACA—and measure their success in reducing the uninsured rate. For instance, we could see HHS and CMS use the Medicaid waiver program to allow states to modify their programs in ways that makes Medicaid expansion more appealing, although the Biden administration has already signaled it will not allow Medicaid work requirements to continue.

HHS and CMS also could allow states to use the Section 1332 waiver authority to test new approaches to coverage, such as public options or even single-payer systems. A handful of states are exploring public option or Medicaid buy-in programs, and Washington state this year launched its own public option plan, called Cascade Care. There appears to be little political appetite (at least at the moment) for a federal public option. But if Congress were to pass such a measure, Becerra would be responsible for implementing it—and could use his political background to help such a plan cross the finish line.

03

Making health care more affordable

Rapidly rising health care costs are a concern for policymakers and consumers. At the start of the pandemic, nearly half of U.S. adults ages 19 to 64 were underinsured and vulnerable to high medical bills. Nearly a quarter of adults in this age group had difficulties paying medical bills, 21% did not fill a prescription because of cost, and 21% skipped recommended care because of cost. And it's not just consumers who have a health care affordability problem. The Medicare Trust Fund is currently projected to be depleted in 2026, and some recent projections put the insolvency date at 2024.

This means health care prices, and health care spending more broadly, will be a priority for Becerra. There are several ways the Becerra and the Biden administration can approach affordability. For example, HHS could build on or adjust Trump-era price transparency rules. CMS is expected to continue the U.S. health system's shift to value-based payment models, placing an emphasis on increasing provider participation. But we've already seen CMS review or delay several Trump-era payment models, including the Primary Care First model, the Geographic Direct Contracting model, and the Kidney Care Choices model. It will be interesting to see what new models come out of CMMI under the Biden administration.

Given the looming Medicare insolvency, it's also likely that we could see CMS lower provider reimbursement rates in ways such as targeting certain specialties and continuing the shift toward outpatient and home-based care, with additional site-neutral payment cuts.

Drug prices are another area ripe for congressional and regulatory action. Lawmakers on both sides of aisle have signaled their support for passing legislation to lower consumers' out-of-pocket drug costs. On the regulatory side, we could see HHS reform or modify existing programs. Drug rebates have been a hot topic in recent years, and Becerra has suggested that rebates would be a key area of focus for HHS. The department is currently reviewing several Trump-era policies, including the administration's Drug Pricing Rebate rule, which Becerra has called "rushed." During his senate confirmation hearings, Becerra told lawmakers that patients should not be caught in the middle between pharmacy benefit managers and drugmakers and that HHS would "make sure no one is trying to game the system."

HHS will also be tasked with implementing the American Rescue Plan's temporary subsidy expansion, which some public health experts have praised for addressing the ACA's affordability problem. The changes are expected to be available to consumers purchasing plans on the federal exchange on April 1. It will be interesting to see how the increased subsidies impact both the uninsured rate and consumers' health care cost concerns, and whether Congress down the road will look to extend or make the new changes permanent.

04

Addressing health inequities in the US health care system

The fact that health care inequities appear fourth on this list doesn't mean it is a lower priority item. It's just the opposite. Each of the above challenges presents an opportunity to reduce health care inequities and should be addressed through a lens of doing so. For example, research has consistently shown the ACA's Medicaid expansion reduced racial and ethnic disparities in health coverage and access to care.

But progress has largely stalled. The latest CDC report on life expectancy showed an overall decline of one year in 2020. But the decline was three years for Black Americans and a two-year decline for Latino Americans. CDC data also shows that Black women are more than twice as likely to die during pregnancy or after childbirth as white women, and minority groups have lower Covid-19 vaccination rates than whites.

Biden has made inequity a priority for his administration, appointing Marcella Nunez-Smith to serve as the White House's first presidential adviser focused on combating racism and racial disparities in health care. But HHS under Becerra will need to develop the actual policies to address health care disparities and close existing gaps. One possibility is that HHS will focus its efforts is data collection and reporting among Medicare and Medicaid providers. Another potential area of focus, which we'll explore in more detail below, is identifying ways to reduce the uninsured population.

05

Overhaul CMS star ratings programs and other policy priorities

CMS' star ratings programs have been a point of contention for industry stakeholders since their inception. But a recent New York Times investigation and a California lawsuit accursing a nursing home chain of gaming the star ratings system are likely to put this issue front and center for Becerra, who was still serving as California AG when the suit was filed. While it's too early to say exactly how Becerra and CMS would approach the star ratings programs, the latest news suggests the agency may revisit those programs and seek to implement broader reforms.

In addition to the above, it will be interesting to see how Becerra approaches several other policy areas. These include environmental health policy, which was a key focus for Becerra as California AG; antitrust activity (while this largely falls to other agencies, Becerra is likely to bring his background on anti-competitive behavior to how he approaches health care transparency and other policies); and reforming the 340B program, which Becerra has said he will work to strengthen.

POLICY

The Biden admin extended the special open enrollment period.

Here are 4 questions to watch.

By Heather Bell

MARCH 26, 2021

HHS on Tuesday extended the federal exchange's special open-enrollment period until Aug. 15.

The special open-enrollment period launched Feb. 15 in the 36 states that use the federal exchange to help people who lost their coverage due to the Covid-19 pandemic. The extension gives consumers an additional three months to change or sign up for new health plans in light of subsidy increases included in the recently enacted American Rescue Plan. Some state-run exchanges also have extended their open enrollment periods into August, and at least two—California and Maryland—will allow residents to purchase exchange coverage throughout 2021.

This article was originally published online on March 26, 2021. To see the original article with all citations, please go to: **advisory.com/weekly-line/SpecialOpenEnrollment.**

In any other year, we'd likely see insurers raising alarms over prolonged open-enrollment periods, as it opens the potential for people to wait to purchase coverage until they are sick, resulting in sicker risk pools. Past data also suggests individual market enrollees who purchase coverage during a special open enrollment period have higher care costs. But this is not your typical year. The health care industry is still navigating the pandemic, and insurers are not playing by the typical rules related to risk pools and adverse selection. As such, America's Health Insurance Plans and insurers have largely welcomed the special open enrollment period and the new consumers they could bring.

The general uncertainty around the pandemic and the prolonged special open enrollment periods raise key questions about the marketplace.

01

How will the Biden administration's exchange-related actions affect enrollment?

While CMS under President Trump focused on reducing federal spending on exchange subsidies, the Biden administration is doubling down on the Affordable Care Act (ACA) exchanges to reduce the uninsured population. The recently enacted American Rescue Plan fills existing gaps in exchange coverage affordability by temporarily expanding subsidies to those with annual incomes above 400% of the federal poverty level (FPL) if their premium costs are greater than 8.5% of their income. In addition, under the law, those with incomes from 100% to 150% of FPL are now eligible for fully subsidized coverage if they purchase a benchmark silver plan.

But what does all of this mean for enrollment? The Kaiser Family Foundation estimates that 1.4 million uninsured people are newly eligible for a subsidized exchange plan. The Congressional Budget Office (CBO) estimated that the subsidy changes would prompt 1.7 million people to purchase exchange coverage in 2022, including 1.3 million previously uninsured individuals. That would be a significant increase on the 8.3 million people who selected a federal exchange plan for the 2021 coverage year, although it would still be below peak enrollment numbers seen in 2016 and 2017. But CBO's numbers do not take into account the fact that HHS is dedicating at least $50 million to promote the special enrollment period and $2.3 million to so-called navigators who help consumers sign up for exchange plans.

Industry analysts have long said that some of the estimated 57% of uninsured people who qualify for financial assistance under the ACA do not know they are eligible. The additional outreach could help fill some of those gaps. During the first two weeks of the special open enrollment period, 206,236 people signed up for new exchange plans, and we'll be watching to see how enrollment numbers progress.

02

How will a longer special open enrollment period affect insurer risk pools?

While a boost in enrollment is positive, having a lot of new, previously uninsured people coming in mid-year makes risk adjustment harder because insurers will need to account for any conditions they may have with little information or provider documentation. That's why insurers will be interested to know who these new enrollees are and how they will affect risk pools.

Insurers aim to enroll a mix of sick and health members to control premium costs (healthy members who use less coverage offset the cost of the sicker members who require more costly care). Prior to the Affordable Care Act, insurers were able to achieve this balance by denying coverage to those with preexisting conditions or raising costs for those individuals. In a post-ACA world, insurers cannot deny coverage to sick applicants and, therefore, have less control over their risk pools. The ACA put in place some forcing mechanisms to help address that concern, including a fixed open enrollment period to prevent people from signing up for exchange plans when they are sick and need coverage, and a financial penalty for those who remain uninsured, which was essentially eliminated under the Trump administration.

There is some initial good news for insurer risk pools. Preliminary data from state-run exchanges suggest that younger enrollees, who are typically considered to be healthier, are enrolling in coverage during the special open enrollment periods. But time will tell if insurers' 2021 risk pools are balanced or trend sicker or healthier.

03

What does the special open enrollment period mean for 2022 cost sharing?

One of the main arguments in favor of limited open enrollment periods is to ensure that insurance actuaries have reliable data to make cost projections for the next year's premium rates. Having a prolonged open enrollment period makes that trickier. As we noted above, a large influx in members midway through the year will make risk adjustment harder. But that is not the only complication; actuarial values do not hold their value throughout the year, meaning consumers who purchase coverage effective June 1 will have half the time to reach their deductible as those who purchased coverage effective January 1. That has implications for the data insurance actuaries will use to make cost sharing determinations for 2022.

04

How could the special open enrollment period affect the overall market?

For the past three years, the ACA's exchange marketplace has remained relatively stable. Premiums for the lowest-price silver plans declined from 2018 to 2020, while exchange plan competition has grown. This is all good news, and the fact that insurers are returning to the exchanges signals that the markets are expected to remain relatively stable. But it's likely the industry could see the effects from the pandemic and the prolonged open enrollment periods extend into 2022.

One thing is certain, the Biden administration is committed to shoring the ACA and the exchanges up. We'll be watching throughout the year to determine how the Covid-19 pandemic and special open-enrollment period impact the exchange and individual marketplace.

STRATEGY

How to succeed at infusion and still embrace lower costs

By Gina Lohr & Elle Choi

MARCH 26, 2021

The infusion care landscape has changed dramatically in the past few years, and it is still changing. As spending on provider-administered medications continues to rise, health plans and employers are implementing new requirements to lower costs. Common requirements include site-of-care policies, which mandate that patients receive care from non-hospital infusion providers when safe and appropriate, and specialty pharmacy sourcing (i.e., white bagging) policies, which compel providers to source medications from a designated specialty pharmacy instead of their typical supply chain partners.

These requirements have added to the contentious relationships between stakeholders involved in infusion care. And while each stakeholder may have a share in the blame for rising drug spend, each stakeholder also can have a role to play in creating a future where patients receive infusion care in the right setting for the right price.

To further cross-sector understanding and foster a collaborative dialogue, Advisory Board recently convened a panel of experts representing the employer, health plan, health system, and private practice provider perspectives on the changing landscape of infusion care.

This article was originally published online on March 26, 2021. To see the original article with all citations, please go to: **advisory.com/2021InfusionCareOutlook.**

INSIGHT 1

Health plans and providers need to enhance their communication strategies to reduce fragmentation of care for patients.

The current status quo for infusion patients includes frequent communication breakdowns around where patients can receive care. Patients are unsure of where they should go to receive infusions, and providers are unable to provide answers. This results in added stress for the patient and sometimes even delays in care. Ultimately, in patients' eyes, these breakdowns make the provider, health plan, and even the employer look incompetent.

One reason for these breakdowns is poor communication between providers and health plans. Communication between these two parties is often channeled through the provider's managed care team. The infusion care team and other providers may be left out of the loop when health plans change their coverage policies. It's common for providers to first learn that they are no longer allowed to administer a patient's medication when their patients show them their notification letter and ask questions about how they will receive their infusions.

In situations where a patient's health plan requires a site-of-care shift, providers want to ensure the patient feels informed and safe during the transition. But providers are in a difficult position without the ability to coordinate directly with the health plan. Providers can either tell the patient to call the health plan for answers or assume this responsibility on the patient's behalf. Providers and their staff spend countless hours calling health plan 1-800 numbers to identify alternative infusion providers in the patient's network and geographic location.

Health plans are beginning to acknowledge these challenges. To facilitate closer collaboration, Ortiz noted that Cigna is implementing a "hands-on" site-of-care policy. Cigna's program involves case managers who work with both patients and their prescribers to select treatment locations, submit referrals to new sites of care, and ensure new providers receive patients' orders. Case managers also leave a direct phone line with the patient and prescriber to offer support and answer questions during the transition.

Beyond this patient-specific coordination, providers have expressed eagerness to have more open lines of communication with health plans. They see opportunities to provide feedback on plan changes and collaborate on improving patient experience. Once all stakeholders know when and how policies are changing and who to call when they have questions, the system will be less likely to experience breakdowns.

INSIGHT 2

Improving price transparency can help lower care costs. One of the most straightforward strategies is to educate providers and patients about drug costs and their down-stream cost impacts.

Providers often don't know the costs of the medications they prescribe or how the costs will impact their patients. Amerine explained that when sharing cost insight with providers, it helps to include both the cost of treatment and associated downstream costs such as for labs or other supportive agents, which contribute to the total cost of treatment with that drug. Her research found that providers don't realize that although one drug may have a higher price tag, it may have lower overall costs.

Panelists suggested that when providers have cost information available, they will take it into account. UNC Health is helping providers act on transparent cost data by including dollar signs next to treatment options in its electronic health record system. This allows its providers to have point-of-care insight into the financial impact on the patient. Ortiz shared that Cigna is taking a similar approach to support physician decisions by highlighting medications with the greatest clinical value in its prior authorization portal.

Price transparency also matters to patients. There is a misperception that insured cancer patients are not cost-sensitive because they quickly reach their out-of-pocket maximum following a cancer diagnosis. In working closely with employers, Ladd has found that it's not this straightforward. She explained that "once employees understand the association between medical expenses and salaries, there is a lot more motivation for them to engage on health care costs."

INSIGHT 3

There is widespread interest in value-based care models as an opportunity to align incentives across patients, payers, and providers. However, these models have proven challenging to implement.

The US Oncology Network, a national network of independent community oncology providers, has been a leader in using value-based solutions to demonstrate aligned priorities between providers, health plans, and employers. Currently, 50% of its practices are engaged in contracts with two-sided risk. This incentivizes providers to lower costs while supporting improved patient outcomes. For example, the network has enrolled more than 100,000 patients in Medicare's Oncology Care Model and generated $122 million in cumulative Medicare savings. Wilfong noted that many employers are pursuing strategies, such as white-bagging, that function as "band-aids" but don't address the underlying issue of cost the way a value-based care approach does.

However, panelists highlighted several challenges to implementing value-based care solutions—especially for oncology. Given the relative rarity of any given cancer diagnosis, it's difficult for a provider to capture enough patients covered by one insurance company to demonstrate outcomes. This is further complicated by an unpredictable patient mix, given that seemingly subtle differences in cancer type can lead to dramatic variation in treatment costs. For example, employers might assume that a bundle for early-stage breast cancer might be an effective place to start. However, for a provider, the cost difference between treating hormone-based breast cancer and HER2 positive cancer can mean meeting cost goals or being underwater. In addition, solutions need to have built-in flexibility to adapt to the changing drug pipeline.

Despite the challenges, employers are still interested in pursuing value-based care models. Carrum Health and Memorial Sloan Kettering recently announced a partnership on direct-to-employer contracting for cancer care, which guarantees the total cost of care for breast or thyroid cancer for up to two years. As part of this agreement, employers will have the option to select from various bundles. For instance, one bundle will cover two years of in-person treatment for metastatic breast cancer and thyroid cancer, while other bundles will cover remote diagnosis, treatment planning, and care guidance for patients with other cancers.

The way forward

While there are still many challenges to address in infusion care, the panelists demonstrated an eagerness to tackle them head-on. Many organizations are working to identify solutions. However, this session revealed that no one stakeholder can unilaterally ensure a high-quality infusion care experience and outcomes. To achieve this goal, stakeholders must improve their communication and be open to collaboration. Ultimately, panelists conveyed optimism that this is possible and hope that it will be possible to reshape infusion care processes and reimbursement in a way that ensures patients receive the right care, in the right setting, at the right cost.

PANDEMIC

A year into the pandemic, here's how behavioral health care is changing—for the worse and for the better

By Clare Wirth & Darby Sullivan

MARCH 29, 2021

When the Covid-19 pandemic and economic downturn hit, the need for behavioral health care intensified. Last year brought a dangerous combination of economic insecurity, fewer opportunities for meaningful social interactions, reduced functioning of community services, national trauma from racist violence, and general dread about the existential threat of a global pandemic. As of February 2021, 39% of Americans reported symptoms of anxiety or depression. That's almost four times higher than in 2019—and it almost certainly fails to capture the actual size of the need.

There's no way to sugarcoat the fact that the challenges are great and, in many ways, getting worse. But there is some good news. Behavioral health care has breached the national consciousness, and some industry stakeholders are making new steps toward lasting solutions.

Here's the latest on how Covid-19 is impacting behavioral health care—for the worse and for the better—and what we're paying close attention to in the coming months.

This article was originally published online on March 29, 2021. To see the original article with all citations, please go to: **advisory.com/2021BehavioralHealthOutlook.**

How Covid-19 is impacting demand for behavioral health care

FOR THE WORSE...

The behavioral health crisis is not going to subside when Covid-19 does.

A McKinsey analysis shows a potential 50% increase in the prevalence of behavioral health conditions in 2021 due to Covid-19, which they note is likely an underestimate. Data also shows higher rates of anxiety, depression, binge drinking, difficulty sleeping, irregular eating, and worsening chronic conditions.

Over 81,000 people died from drug overdose in the 12-month period ending in June 2020, a 20% increase over the year prior and the highest ever recorded in the U.S. Elevated deaths of despair (those related to suicide, alcohol, and drugs) are likely to continue due to the lingering economic impact of Covid-19.

This "second pandemic" is inherently a health equity crisis—particularly for those who sit at the intersection of racial and economic marginalization.

According to new survey data from the Kaiser Family Foundation, essential workers, communities of color (especially Black and Latino adults), adults in households with job loss, and young adults all reported symptoms of behavioral health conditions at higher rates compared to their counterparts. In addition, children's mental health-related ED visits accounted to a significantly higher proportion of pediatric ED visits in April through October 2020 than in 2019.

FOR THE BETTER...

There are early signs that (some) stigma is dissipating.

Unlike most other specialties, need and demand are not interchangeable in behavioral health. Even when services are available and affordable, patients can be reluctant due to deeply engrained cultural norms. Thus, reducing stigma can unlock demand for lower-acuity behavioral health services before patients become acute and require costly, intensive services.

During the Covid-19 crisis, more people are assessing if they need support and seeking help when they do. Mental Health America reported a 93% increase in people using their online anxiety screenings and a 62% increase in people using their depression screens in 2020 over 2019. Also, according to a recent Optum survey of about 1,200 commercial, Medicare, and Medicaid patients, about half of respondents received more behavioral health support in 2020 than before. There's also anecdotal evidence we're having more conversations about our mental health.

But we promised cautious optimism for a reason. There is not yet enough data to definitively conclude that behavioral health stigma has declined during the Covid-19 pandemic, or by how much. In reality, certain conditions (such as substance use disorders) are more likely to remain stigmatized than others (such as depression and anxiety). In addition, not all demographic groups are starting from the same place. Receiving mental health treatment is more stigmatized in certain populations, such as Asian American and Pacific Islanders (AAPI) and Black communities.

How Covid-19 is impacting supply of behavioral health care

FOR THE WORSE...

The underlying incentives (and lack of incentives) to provide behavioral health care haven't changed.

There's a strong business case that behavioral health care reduces the total cost of care and improves patient outcomes. But it's not a revenue growth engine for health systems because payers generally don't provide adequate reimbursement. And the capacity of traditional behavioral health providers is diminishing amid the current economic crisis. More than half of traditional behavioral health providers have had to close programs, and nearly two-thirds have had to cancel or reschedule appointments, or turn away patients entirely.

Ultimately, patients pay the price. Many don't receive the care they need. And if they do, many end up paying out of pocket.

Structural barriers to supply persist.

Telehealth can extend the reach of the current workforce only so far. The psychiatrist shortage is worsening as the bulk of current providers prepares to retire. The industry has gotten creative by creating specialized psychiatric nursing and APP roles, and upskilling social workers to try to fill the gap. But recent improvements disproportionately benefit patients with low-acuity needs.

PCPs are maxed out, or close to it. Plans and provider organizations have often turned to busy PCPs to handle some of the lowest acuity behavioral health needs. Before Covid-19, half of all behavioral health conditions were treated in primary care. And PCPs said even more patients started coming to them with behavioral health concerns during the pandemic, according to a recent Advisory Board survey (full report coming soon).

But PCPs are already overloaded—half report being burnt out. Our survey found only 20% receive incentives for behavioral health screening, 21% receive ongoing training in this area, 25% have embedded behavioral health staff, and 30% receive on-demand expertise to address patients' behavioral health needs.

FOR THE BETTER...

High utilization of tele-behavioral health services and sizeable investments in behavioral health startups show promise for addressing certain needs.

Covid-19 has validated the potential for scaled access to low-acuity interventions, as evidenced by consistently high demand for telehealth and the continued emergence of well-funded start-ups. Tele-behavioral health use has held at peak Covid-19 levels. About 66% of psychiatry visits are still virtual. In contrast, other specialties have plateaued with around 15% to 20% of visits occurring virtually. Also, in 2020, $2.4 billion was invested in U.S.-based digital health start-ups that address behavioral health needs.

But with all advancements in telehealth there's a potential to deepen disparities. While telehealth can dramatically increase access to care, many patients face barriers that prevent them from using virtual options. Also, new companies don't cover the full range of behavioral health needs. For example, startups focused on substance use disorder and developmental disorders have not garnered anywhere near the same level of investment as companies focused on other behavioral health needs.

Employers are sizing up their own responsibilities.

About half of U.S. workers report struggling with mental health issues. The bulk of employers are responding—surveys show they intend to expand access to behavioral health and well-being services in 2021. And employer-focused start-ups such as Lyra Health and Modern Health are priming to support. They scored $75 million and $35 million deals, respectively, in H1 2020.

What we're watching

Behavioral health is at a pivot point in the U.S. Here are some questions we'll be watching this year:

- **Patient demand:** How will patient needs evolve during recovery from the pandemic? How will that manifest over time (absenteeism, PTSD symptoms, etc.)? How long will recovery take?
- **Stigma:** Will the prevalence of behavioral health needs significantly—and quantifiably—reduce stigma?
- **Provider role:** How will the role of providers evolve as employers and direct-to-consumer vendors fill unresolved gaps in behavioral health access?
- **Vendor consolidation:** Will vendors partner with one another to provide a continuum of care?
- **Medical-behavioral care integration:** Will vendors integrate their efforts with provider organizations or remain siloed? Would integration be sustainable for providers?
- **Long-term changes:** Ultimately, will Covid-19 catalyze long-term transformation of the U.S. health system's incentives and capacity to address pervasive behavioral health needs?

There is so much information out there—news, opinions, ideas, you name it. Who has time to sift through and figure out what to do? That's where we come in. Each week, host and seasoned researcher, Rachel Woods, talks with industry experts to break down the issues on your mind and offer recommendations on what to do next.

Listen and subscribe at **radioadvisory.advisory.com**

"Stay Up to Date" is a new discussion series where Advisory Board experts talk you through the latest issues facing the health care industry and provide answers to your most pressing questions. In just an hour each week, we'll make sense of the latest problems, so you can focus on solutions.

Watch now at **advisory.com/StayUpToDate**

What are today's 10 biggest stories in health care? To find out, Advisory Board's experts dive into 1,000+ news clips every morning across industry, national, and local outlines, and we sum it all up in our most popular email newsletter, the Daily Briefing.

Subscribe now at **advisory.com/dailybriefing**

CREDITS

EXECUTIVE EDITOR

Christopher Kerns

MANAGING EDITOR

Yulan Egan

DESIGNER

Stefanie Kuchta

CONTRIBUTING AUTHORS

Tabiya Ahmed

Heather Bell

Amanda Berra

Elle Choi

Megan Director

Pamela Divack

Colin Gelbaugh

Brandi Greenberg

Sarah Hostetter

Manasi Kapoor

Madeleine Langr

John League

Regina Lohr

Allyson Paiewonsky

Darby Sullivan

Ben Umansky

Rachel Woods

Clare Wirth

LEGAL CAVEAT

WF4345014

Advisory Board helps leaders and future leaders in the health care industry work smarter and faster by providing provocative insights, actionable strategies, and practical tools to support execution.

With more than 40 years of experience, a team of 200+ experts, and a network of 4,500+ member organizations, we spend more time researching the now and predicting the next than anyone else in the health care industry.

We know that together we can change the business of health care for the better. **Join us by visiting advisory.com.**