MILLIMAN WHITE PAPER

Ten questions providers should be asking about their value-based contracts and the COVID-19 pandemic

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Over the last several years, healthcare providers have partnered with healthcare payers (e.g., health insurance companies, employers, and government entities) to establish value-based payment contracts in the spirit of better aligning incentives.

There are seemingly infinite variations of value-based contracts, but at their core they are all structured to reward providers for improving healthcare outcomes and/or reducing the cost of care. **But what happens when a global pandemic hits?**

Estimates of how the COVID-19 pandemic will financially impact the healthcare sector continue to evolve, but recent attempts to quantify the impact signal the likelihood that, for 2020, the reduction in spending associated with deferred care will outweigh in aggregate the increase in spending required to care for patients with COVID-19.[1] However, at an individual provider entity level, the change in spending will vary based on a multitude of factors such as geography, the nature of services provided, and the demographics of the population served. So what does this mean for the mutual financial responsibilities created through value-based contracts? **In short, for any given provider organization, the impact of COVID-19 on its value-based contracts will depend largely on certain actuarial, legal, and strategic aspects of each agreement.**

Defining and measuring value will be more challenging in this environment, but not impossible. In this paper, we will discuss 10 key questions that providers should be asking as they assess each of their value-based contracts[2] during this uncertain time.

1. What is the impact of COVID-19 on population expenditures?

This may be the most obvious consideration, but it is nonetheless critical. As mentioned earlier, COVID-19 is expected to drive a net decrease in healthcare spending in 2020. In many value-based contracts, the cost of providing care for the attributed population is likely to materialize below expectations (but not necessarily below the target—more on that later). However, value is defined in many contracts relative to reference populations' expenditures or changes in expenditures (trend). As such, it is critical to assess whether your organization's expenditures are impacted disproportionately to other populations (particularly populations your performance is measured against).[3]

2. How was the trend target established?

In many value-based contracts, targeted spending is based on historical costs for a population, adjusted for cost trends between the historical period and the measurement period. Broadly speaking, there are two ways to establish the cost trend adjustment:

1. **Prospective (absolute):** Trends are established in advance of the measurement period based on pricing targets or some other mutually agreed-upon objective.
2. **Retrospective (relative):** Trends are determined after the end of the measurement period based on observed spending in a comparable population, such as the payer's entire block of business in a geographic area or an external trend indicator.

Contracts with prospective trend targets have the greatest chance of payouts, because those trend targets likely did not consider the impact of COVID-19 at the time they were established. In many cases, this could lead to shared savings for providers due to depressed utilization. Contracts with retrospective trends will differ because the cost trend in the comparison population will reflect the impact of COVID-19. In these situations, providers should consider how COVID-19 (both direct costs and deferral of care) is likely to affect their attributed population **relative to peers**. The Medicare Shared Savings Program (MSSP) uses a retrospective trend, which

[1] Rogers, H.M., Mills, C. & Kramer, M.J. (April 23, 2020). Estimating the Impact of COVID-19 on Healthcare Costs in 2020: Key Factors of the Cost Trajectory. Milliman White Paper. Retrieved May 6, 2020, from https://us.milliman.com/en/insight/Estimating-the-impact-of-COVID19-on-healthcare-costs-in-2020.

[2] Our primary focus will be on value-based contracts that pertain to the total cost of care for a population. While many of the principles will apply to episodic and bundled value-based contracts, the full coverage of those arrangements is beyond the scope of this paper.

[3] Craff, M. et al. (April 21, 2020). Frameworks and Considerations for COVID-19-related Analyses. Milliman MedInsight White Paper. Retrieved May 6, 2020, from https://us.milliman.com/en/insight/Frameworks-and-considerations-for-COVID19-related-analyses.

means that benchmarks should be reasonably close to actual costs in aggregate,[4] although individual accountable care organizations (ACOs) can still expect to see material variance in their results if they are affected disproportionately relative to the broader Medicare fee-for-service (FFS) population.

3. What type of risk adjuster is used?

Risk adjustment is commonly used for value-based contracts (especially those focused on managing the total cost of care) in order to account for relative differences in the morbidity of a provider's attributed population to the populations used to establish the cost target. In understanding the nature of the risk adjustment applied, providers should be aware of two fundamental aspects of the risk adjustment methodology's design:

1. The type of data required, including combinations of the following:
   - Demographic information
   - Medical claims data
   - Prescription drug claims data
   - Other indicators, such as flags for institutionalized members or for those enrolled in a specific disease management program
2. The time period "predicted" or "explained":
   - A prospective model will predict the morbidity for a future time period
   - A retrospective (concurrent) model will explain a time period that has already occurred

If the risk adjustment model relies on medical claims data only, the disruption of medical services due to the COVID-19 pandemic will likely have the effect of understating the true morbidity of the attributed population. Risk adjustment models that incorporate prescription drug data may exhibit more stability assuming that members are able to maintain their prescription drug regimens through the pandemic. Retrospective models applied to 2020 performance years will produce distorted results because those models rely on 2020 claims data. Prospective models applied to 2020 performance years were based on 2019 claims data and will not be impacted by the pandemic[5]; however, prospective models applied to 2021 performance years will experience the same distortion as retrospective models applied to 2020 performance years.

COMMON APPLICATIONS OF PROSPECTIVE TREND TARGETS

Prospective trend targets are often used for lines of business where the payer is at risk, such as Medicare Advantage products and fully insured commercial products. Payers submit their pricing expectations for these products via rate filings and bid submissions several months in advance of contract periods. Once submitted and approved, payers are typically unable to adjust their pricing assumptions and may have to wait up to one year to revise their rates. For example, 2020 Medicare Advantage bids were submitted on June 3, 2019, and the next opportunity to revise rates will be for the 2021 contract period (with a bid submission deadline of June 1, 2020). By aligning the value-based contract trend target with their pricing expectations, payers are reducing the volatility in the actual-to-expected financial performance.

4. How is attribution determined?

In value-based contracts, the provider is typically only at risk for cost and quality measures for a subset of the payers' members. The process of determining which members providers are held accountable for is called "attribution."[6] In general, there are three approaches:

1. **Prospective**: Members are identified prior to the start of the measurement period based on experience during a historical time period.[7] This means the provider may be at risk for some members who did not actually receive care with the provider during the measurement period.
2. **Retrospective (or concurrent)**: Members are identified after the end of the measurement period based on experience during the measurement period.
3. **All-inclusive**: In some agreements, the provider may agree to cover any members that meet some basic criteria, such as residing in a particular geographic area or enrolling in a specific product.

Similar to the risk adjustment models described above, attribution models that rely on 2020 claims data will be distorted. Additionally, all-inclusive approaches will be impacted by economic factors, such as unemployment rates, which could lead to differences in the mix of enrollment across product lines. Lastly, the ability of providers to transition many of their evaluation and management (E&M) services to telehealth will be critical to stabilizing attribution during this period (if the attribution methodology uses telehealth visits).

[4] On April 30, CMS modified the MSSP to exclude costs related to episodes of care for COVID-19 treatment. However, it has not made any other changes to the underlying benchmarking methodology.

[5] While the data collection period may not be impacted, the predictive power of prospective models may be impacted.

[6] CMS also uses the terms "assignment" or "alignment," and for purposes of this paper we will consider them synonymous with "attribution."

[7] In some agreements, the provider may agree to cover any members in a certain area. This method shares similarities with a prospective attribution algorithm in that there is no guarantee that patients will visit the at-risk provider organization during the year.

5. What are the quality measures?

One of the fundamental aspects of value-based payment models is the ability for quality of care and/or patient outcomes to influence financial performance. Quality can be measured in myriad different ways, including claims-based measurements, electronic health record reporting, patient surveys, and other operational measures (such as data exchange requirements between both parties). During the COVID-19 health emergency, many of these measures may be difficult (and, perhaps, undesirable) for providers to achieve, because they often require in-person activities. Providers and payers should work together to assess the quality measures and scoring methodologies included in their value-based contracts and determine whether modifications are needed.

6. How will 2020 expenditures factor in to establishing future targets?

Although this question does not affect results for the current performance period, it is an important consideration for future years. In many contracts, the historical base period used to set the target is "updated" or "rebased" on a regular basis, sometimes once per year. This means that, at some point in the future, 2020 will be the base period for setting a future target. This will be problematic, assuming costs in 2020 do indeed deviate materially from expectations. In general, the best course of action will be to avoid using 2020 (at least the first half of 2020) as a baseline for benchmarking future costs because it is unlikely to be predictive of future spending patterns.

7. What types of modifications may be appropriate for our value-based contracts?

For nongovernmental contracts, providers and payers likely have a lot of latitude to adjust terms and conditions, assuming it is mutually agreeable to both parties. Although we have identified a number of contract provisions that may be under stress given the shock to the healthcare system, many of these areas could be easily addressed by making adjustments to the existing methodology. For example, quality metrics that are counterproductive to care needed during a pandemic could be removed. Or a risk corridor could be introduced, or lowered if already in place, to better pool catastrophic risk. Despite a changing and uncertain environment, both parties are likely to benefit if an agreement that aligns incentives remains in place.

8. What are the termination provisions for both sides?

Value-based contracts with the Centers for Medicare and Medicaid Services (CMS) have standardized provisions for termination. While it's reasonable to expect value-based contracts in the private sector have similar provisions, there is likely wide variation in how the terms are structured. Because termination provisions may define deadlines in relation to the start or end of the baseline period and/or each performance year, providers should review each contract to confirm the applicable time periods and determine key deadlines.

9. Was participation in the value-based contract associated with payment rate concessions?

There are often multiple motivations for payers and providers to participate in value-based contracts. In addition to advancing the Triple Aim of improving quality, reducing costs, and improving the patient experience, partnerships could also be motivated by increased access to resources such as population health management expertise or enhanced data sharing. Less obvious, though, is the motivation to increase market share for one or both parties. Payers having difficulties entering new markets may approach providers to request favorable payment rate agreements that would enable the payers to lower premiums and, in turn, increase membership. In exchange, providers may be offered some form of exclusivity in narrow networks designed to encourage members to use services within a delivery system through member cost-sharing strategies. Motivated providers will weigh payment rate concessions against their strategic objectives and the economic viability of the risks and rewards presented by the value-based contract.

By executing a value-based contract in tandem with payment rate reductions, the payer and provider are establishing a long-term partnership that evolves beyond the adversarial roles often displayed during FFS contract negotiations. When making decisions pertaining to the value-based contract, providers should be mindful of contingencies that may not be present in the contract itself.

10. What should we know about MLR requirements and risk corridors for insurers?

In general, minimum loss ratio (MLR) requirements are intended to ensure that payers spend a minimum amount of revenue on medical care and healthcare quality improvement. In the event that spending does not meet the requirement, a payer would be required to pay rebates. Similarly, many state Medicaid programs are implementing risk corridors in response to COVID-19, which trigger payments either to or from a payer if actual claims costs deviate materially from the amounts assumed in the managed care capitation rates. While seemingly straightforward on the surface, the underlying details are more complex. MLR and risk corridor requirements vary by line of business and can differ from one payer to the next. Providers should be aware of the requirements and how they may affect payer decision making.

Readers interested in a comparison of MLR requirements for Medicaid compared to commercial and Medicare Advantage are encouraged to read Milliman's thought leadership on this topic (see the article "Medical loss ratio (MLR) in the 'Mega Reg'").[8]

Conclusion

CMS, through its Extreme and Uncontrollable Circumstances Policy, has already taken steps to relieve providers participating in advanced alternative payment models (APMs), and there are industry advocates appealing to CMS to suspend any financial penalties created by these value-based contracts.[9] CMS has the ability to modify the terms of them in an efficient and uniform manner due to the standardized nature of their value-based contracts; providers are presented with choices to help align the contract with their tolerances for risk, but the terms of the contract are not negotiable. In the private sector, however, the value-based contracts executed between providers and commercial insurers, Medicare Advantage (MA) issuers, self-insured employers, and Medicaid managed care organizations (MCOs) are highly negotiated and customized. By exploring these questions for their value-based contracts, providers will be better prepared to engage with their payer partners to navigate difficult decisions brought about by the COVID-19 pandemic.

CONSIDERATIONS FOR EPISODIC MODELS

Payers typically think about healthcare spending on a per capita basis, and indeed, many value-based contracts measure costs in this way (often referred to as "total cost of care" models). However, providers often participate in episodic models where spending is measured over defined episodes that are triggered by a particular event, such as a surgery or a course of treatment. In these situations, the effects of COVID-19 may be quite different from those anticipated for per capita models and largely dependent on the exact nature of episode definitions. Narrowly defined episodes may be more resilient to the effects of deferred care or COVID-19 treatment, while broadly defined episodes may have more exposure to the broader pandemic effects (both deferred care and COVID-19 treatment). That being said, even narrowly defined episodes may experience changes in average episode risk profile due to the deferral of less emergency care (especially procedure-based episodes, as they are often associated with the elective procedures we expect to be delayed and/or reduced in number).

[8] Brostowitz, J., Jones, S.O., & McCulla, I.M. (June 27, 2016). Medical Loss Ratio (MLR) in the "Mega Reg." Milliman Research Report. Retrieved May 6, 2020, from https://us.milliman.com/en/insight/medical-loss-ratio-mlr-in-the-mega-reg.

[9] MedPAC (April 13, 2020). Re: Allowing ACO providers to focus on COVID-19 rather than shared savings. Retrieved May 6, 2020, from http://medpac.gov/docs/default-source/comment-letters/04132020_allowing_aco_providers_to_focus_on_covid_comment_sec.pdf?sfvrsn=0.

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