

How does COVID-19 impact risk-based contracting?

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Over the last decade, providers' annual revenue has been increasingly tied to alternative payment models (APMs). Providers are taking on additional financial risk through a variety of types of risk-based contracts across a variety of payers (Medicare, Medicaid, employer groups, and commercial insurance plans). 36% of total U.S. healthcare payments were tied to APMs in 2018, a steady increase from 23% three years prior.¹

While providers have started to take on various types of risk through APMs, there are important factors for provider organizations to consider before taking on risk for the total cost of care. These factors include the ability to manage the total cost of care, overall risk tolerance, and attributed member group size.² Some challenges associated with these factors have led to providers not taking on additional risk.

COVID-19 had significant impacts on healthcare providers in 2020, with many provider systems seeing decreases in revenue. These losses have been large enough that the U.S. Department of Health and Human Services (HHS) has provided about \$100 billion³ of financial relief to providers as of December 23. While this is certainly a large amount, it does not fully cover providers' lost revenue due to COVID-19.

An interesting effect of COVID-19 is that many of the providers who have taken on the most risk through APMs have been most protected from the revenue declines due to deferred and canceled care during 2020. For example, a provider operating under global capitation would have had a steady revenue stream during the pandemic, and while it is at risk for managing the care of its members, it has seen the financial protections that these risk arrangements can provide. Providers should not enter risk-sharing arrangements in hopes of pandemic-like events to trigger savings, but there are certainly protections to be had with risk-sharing arrangements.

As we move into 2021 and hopefully out of the COVID-19 pandemic, it will be interesting to see the impact on the trends of APMs. It is possible that more providers will find value in taking on more risk, given the protection that it provided to some during the pandemic.

Status quo: What does the APM market look like?

While there is a wide range of payment models, in this article we treat all contracts that are not traditional fee-for-service (FFS)⁴ as APMs. These models pay provider groups and hospitals based on some measure of the value of care and quality provided and shift one or more types of risk from the insurer to the providers:

- **Utilization risk:** Risk that members will use more or fewer services than anticipated.
- **Population risk:** Risk that the underlying demographics and morbidity of the population will shift. This impacts utilization risk and can be explicitly reflected in population risk scores.
- **Performance risk:** Risk for providing adequate and efficient care for members, based on their conditions and needs.
- **Pricing risk:** Risk of having appropriate price levels in any payment arrangement.

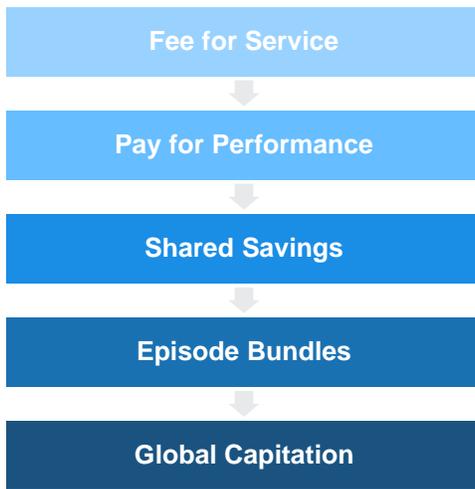
¹ HCP-LAN 2018 APM Measurement Effort. 2018 Measurement Report. Retrieved January 5, 2021, from <https://hcp-lan.org/2018-apm-measurement/>, and HCP-LAN 2019 APM Measurement Effort. Retrieved January 5, 2021, from <https://hcp-lan.org/apm-measurement-effort/>

² HFMA (June 24, 2019). 3 details for healthcare providers to know before taking on risk. Retrieved December 24, 2020, from <https://www.hfma.org/topics/news/2019/06/3-details-for-healthcare-providers-to-know-before-taking-on-risk.html>.

³ CDC. HHS Provider Relief Fund. Retrieved December 28, 2020, from <https://data.cdc.gov/Administrative/HHS-Provider-Relief-Fund/kh8y-3es6>.

⁴ We also note the existence of contracts such as "Pay for Reporting" or "Pay for Quality." Note that "Pay for Reporting" in particular may be intended to serve as a bridge toward "Pay for Performance" when there is a lack of valid baseline data, as opposed to being an end in and of itself.

FIGURE 1: EXAMPLES OF THE RISK PATH FOR PROVIDERS (LOW TO HIGH RISK)



Fee-for-service contracts with bonuses for quality or value are at the low-risk end of the risk path; for instance, “pay for performance” models. These models do not typically carry any downside risk, but they can be used as an initial step along the path to risk for providers.

Shared savings models fall in the middle of the risk path. Some of these models involve upside risk only, while others carry both upside and downside risk. Often these models are set up to allow providers a glide path to taking on more risk as the upside and downside risks increase over time.

Episode-based bundled payments are another notable form of APM. An example of this would be a provider receiving a single payment to cover the care for a member throughout a pregnancy, or having a single rate set to cover all the providers who care for a member who is having a hip replacement. This model has been advanced by the Centers for Medicare and Medicaid Services (CMS) as part of its Innovation Center.

Global capitation models are an example of an APM where providers take on most risk. Providers are typically paid a flat per member per month (PMPM) amount for attributed members in advance. Another example of an APM with high provider risk is a fully integrated finance and delivery system, such as a joint venture between a provider group and a health plan.

The COVID-19 effect on provider payment dynamics

COVID-19 has had, and will continue to have, many effects on provider revenue and expenses, primarily relating to utilization risk and population risk. We focus on a few key effects below:

DECLINE IN UTILIZATION DURING PANDEMIC

Beginning in March 2020, utilization declined for many health services. Milliman has estimated that, in the commercial market, medical (nonpharmaceutical) costs declined approximately 14% in March, 41% in April, and 23% in May, compared to 2019.⁵ Additionally, the American Hospital Association (AHA) published early estimates that the lost revenue for hospitals and health systems due to COVID-19 was an average of \$50.7 billion per month from March to June.⁶ This overall decline in utilization and revenue occurred despite COVID-19 infections themselves driving additional care needs, as well as the increase in services such as telemedicine. However, we note that provider revenues have gradually been trending back toward pre-COVID-19 levels.⁷

This overall decline in utilization has complicated the relationship between plans and providers in a number of ways. Aside from the decrease in cash flow for most providers, the reduction in care due to COVID-19 may trigger medical loss ratio (MLR) rebates that the carriers must pay to the federal government (for Medicare Advantage) or members (for commercial plans). This disconnect between provider losses and plan gains may create an added incentive to move toward risk.

RETURN OF DEFERRED CARE: WILL IT RETURN, AND IF SO WHEN AND BY HOW MUCH?

An additional consideration for providers is what will happen to any care that gets deferred during the pandemic. Some care was truly deferred and will “return” (previously deferred care subsequently being fulfilled). Some care will have no “return” (for example, because the medical issue was avoided, because it is no longer relevant to the patient, or because the service has been replaced by telemedicine). Some care may result in increases to member morbidity and require more care and expenses than if it had been delivered normally in the first place.

⁵ Mulhern, Dan (November 2020). Impact of COVID-19 on Commercial Health Trends Through May 2020. Milliman Insight. Retrieved December 28, 2020 from <https://www.milliman.com/en/insight/impact-of-covid19-on-commercial-health-trends-through-may-2020>.

⁶ AHA (May 2020). Hospitals and Health Systems Face Unprecedented Financial Pressures Due to COVID-19. Retrieved December 28, 2020, from <https://www.aha.org/guidesreports/2020-05-05-hospitals-and-health-systems-face-unprecedented-financial-pressures-due>.

⁷ Mehrotra, A. et al. (October 15, 2020). The Impact of the COVID-19 Pandemic on Outpatient Care: Visits Return to Prepandemic Levels, but Not for All Providers and Patients. Commonwealth Fund. Retrieved December 28, 2020, from <https://www.commonwealthfund.org/publications/2020/oct/impact-covid-19-pandemic-outpatient-care-visits-return-prepandemic-levels>.

While the impacts of this will likely vary by market and service line, preliminary CMS estimates for the Medicare market are an overall 12% reduction in care in 2020, and a 2% increase in care for 2021.⁸

It is also possible that there are material long-term healthcare cost and utilization impacts for patients who are infected with COVID-19. In particular, a subset of the COVID-19 population is experiencing substantial longer-term health impacts due to COVID-19, and it is possible that many of these impacts will become chronic or even worsen over time.

RISK SCORE IMPACTS

For providers who do or may soon accept risk through an APM, an important consideration is the impact of care reductions on risk scores and associated revenue targets. Milliman recently presented a paper on the potential impact of COVID-19 on Medicare Advantage (MA) plan revenues and risk scores, with potential Part C risk score impacts ranging from 0.8% reductions in scenarios with fewer excluded services, and up to 9.0% reductions in scenarios with very heavy service exclusions.⁹ Non-Medicare markets will have different populations and (often) different risk score and revenue models, but we think this is a useful framework around which to consider potential impacts even outside of Medicare Advantage Part D (MAPD) plans.

Another relevant issue is that, for MAPD, CMS will provide additional flexibility around telehealth-based diagnoses in risk score calculations. Providers in the MA space can reasonably expect to receive additional revenue for this adjustment, but providers in other markets may need to negotiate around this issue. This may be particularly important where risk scores are prospective, as revenue targets in 2021 and beyond may be artificially dampened due to care reductions, particularly if telehealth and resulting codes are excluded from the calculations.

Overall impact: COVID-19 and provider payment models

Among the various forms of APMs, we consider the financial impact of the utilization decline, the return of deferred care, and risk scores for three specific APMs that would typically apply across the entire spectrum of care: fee-for-service (FFS), shared savings, and global capitation. The table in Figure 2 summarizes at a high level how providers in each type of payment arrangement are likely impacted by COVID-19 in each of these three areas.

FIGURE 2: IMPACT OF PAYMENT ARRANGEMENTS AND UTILIZATION

	DECLINE IN UTILIZATION	RETURN OF DEFERRED CARE	RISK SCORE
Fee-For-Service	Negative Impact	Positive Impact	N/A
Shared Savings	Impact Varies	Impact Varies	Impact Varies
Global Capitation	Positive Impact	Negative Impact	Impact Varies

We explore the impact of COVID-19 on each of these payment models in more detail below.

FEE-FOR-SERVICE

FFS providers are substantially exposed to the financial impacts of the pandemic largely due to the fact that their cash flows are directly tied to the level of utilization. As utilization declined in spring 2020, providers suffered losses in revenue. In some cases, they likely began to treat members for COVID-19 but those additional services were relatively small compared to the utilization decline.

However, if some of the care that was deferred in 2020 returns in 2021 and later, FFS providers could see an increase in revenue—particularly if there is an increase in the acuity of the care required for these returning services. Even with the return of care, it is unlikely to fully offset losses seen from the initial decline in utilization.

As these types of arrangements do not typically consider member risk, the impact of the pandemic on FFS risk scores is not relevant to providers' financial situations under these arrangements.

Providers in FFS arrangements had very clear cash flow impacts during the pandemic. This decline of revenues due to COVID-19, as well as the potential for future revenue increases, will be important factors for providers as they review their current payment arrangements and potentially consider taking on more risk in these arrangements.

SHARED SAVINGS

Because shared savings arrangements are often settled after the completion of a performance year, the drop in utilization can result in negative cash flow impacts to providers. However, despite the cash flow timing issues, providers in these arrangements may still receive shared savings payments and

⁸ CMS (November 12, 2020). November 2020 Actuarial User Group Call. Retrieved December 28, 2020, from <https://www.cms.gov/files/document/user-group-call-agenda-2020-11-12.pdf>.

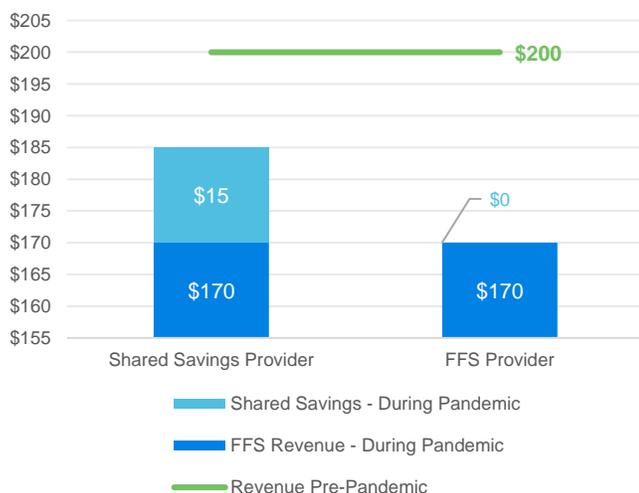
⁹ Pipich, R.J., Cross, K., & Bell, D. (October 20, 2020). How Far Will Medicare Advantage 2021 Revenue and Risk Scores Drop if Seniors Stop Going to the Doctor? Milliman Insight. Retrieved December 28, 2020, from <https://www.milliman.com/en/insight/How-far-will-Medicare-Advantage-2021-revenue-and-risk-scores-drop>.

have their losses dampened due to these arrangements. Additional revenue from treating COVID-19 patients dampens the negative cash flows.

It is also possible that carriers will seek to rebase the benchmark for 2020 prior to calculating any shared savings. Any rebasing will likely result in a lower benchmark and reduce any shared savings paid to a provider. It is unlikely that the shared savings from these arrangements will fully compensate for the decline in utilization during the pandemic, but the exact offset will vary greatly depending on the specific parameters of the shared savings arrangement.

Consider a simple example of a provider organization that has a 50% upside shared savings. If COVID-19 results in a 15% decline in utilization in 2020 and the benchmark is not rebased, then the provider's shared savings arrangement will only result in a 7.5% shared savings on total cost of care compared to a 15% decline in direct revenue. Providers who furnish most of the care for an average patient (such as an integrated health system comprising primary care, specialty care, and facility care) will directly bear much higher losses from declining utilization. Those providers will be unlikely to recover all of their COVID-19 losses through shared savings. If the benchmark is rebased to account for some of the impact of COVID-19, then the shared savings would likely be an even smaller percentage. Such a shared savings is certainly nontrivial, but it will likely not come close to matching the revenue decline.

FIGURE 3: SHARED SAVINGS EXAMPLE (PMPM BASIS)



While we consider a shared savings example above, it is possible that providers also had downside risk built into their risk-sharing arrangements. Although we do not expect it to be common, it is possible that providers may be required to pay shared losses, particularly if the benchmark gets rebased to

account for the decline in utilization associated with COVID-19. Providers should also consider the potential for rebasing revenue targets for future years, which will need to be negotiated. It is particularly important for providers to understand the assumptions going into the benchmarking process given today's complex environment.

The potential return of deferred care presents an additional risk. On the one hand, the return of this care would result in additional provider revenue. However, depending on the new benchmarks and the amount of returning care, providers could be at risk for shared losses.

Risk scores will be important for providers whose benchmarks are set as a function of risk scores (either directly, or via a percentage of revenue when plan revenue depends on risk scores, which is common in MAPD). Providers in relationships where risk scores are set concurrently could see this as the mechanism to adjust 2020 benchmarks for COVID-19; this could make it especially important for providers to accurately and appropriately code for members they see, and make sure they see all members over the course of the year. Additionally, for prospective risk scores, similar imperatives occur, just with the revenue streams delayed (i.e., 2020 claims would inform 2021 risk scores and resulting revenue).

GLOBAL CAPITATION

Global capitation arrangements are examples of where providers take on full risk for the care of members as they are paid a fixed amount per attributed member in advance. These types of arrangements have offered more protection as utilization declined during the pandemic compared to FFS and shared savings. With global capitation, providers have continued to receive steady cash flows despite members having fewer visits and services. In the context of the pandemic, a downside risk that these providers face is largely related to the treatment of members with COVID-19. As noted above, these downside risks generally have had smaller dollar impacts to providers than the impact of declining utilization, although the absolute impact of COVID-19 treatment is expected to vary depending on the provider type and location. There may also be long-term effects on these patients that may result in additional care being required in the future.

The existence of capitation can provide substantial relief to providers who would otherwise experience substantial declines in revenue due to COVID-19. However, we note that, as with shared savings, commercial and other payers may negotiate shifts in the global capitation payment for future years (as, from the payer perspective, some reductions in care were due to COVID-19 not provider efficiency). This could materially reduce the ability of capitation to make up for provider revenue losses.

The eventual return of deferred care and impacts on risk scores could further adversely affect providers in capitation arrangements. It will be important for providers to monitor their ongoing experience as well as engage in the process of setting benchmarks to ensure that they meet the needs of both providers and their payer partners.

Additionally, it may be particularly important for providers in these arrangements to consider the impacts on risk scores, as in many cases the revenue amounts providers are paid tie directly to risk scores. As discussed above, it is likely that COVID-19 will result in lowered risk scores where substantial amounts of care are deferred. This is particularly relevant given the lack of a direct COVID-19 adjustment to risk scores (for instance, CMS's risk score model does not have a COVID-19 coefficient, so only any resulting comorbidities of COVID-19 would be flagged for additional revenue).

What's next

It is unclear how COVID-19 will impact providers' appetite to enter into APMs. The trends prior to COVID-19 indicated that providers have been slowly transitioning to taking on additional risk through them. As discussed, a wide range of APMs exists for providers to choose from and each one tends to be unique.

Given the impact of COVID-19 on providers in various payment arrangements, it will be interesting to see whether providers accelerate the trend of moving toward taking on more risk in APMs. Providers with the largest revenue declines due to COVID-19 may now look toward payment alternatives that can help provide steadier cash flows.

However, as noted above, different APM arrangements will have materially different impacts on the ability of providers to recover from COVID-19-induced losses, and each will have different imperatives in terms of provider engagement and monitoring. As providers consider APMs as solutions to today's problems, they will need to answer questions such as: Will this arrangement offer protection from revenue drops due to lower utilization? What risks do we face from deferred or canceled care? What impact will COVID-19 have on risk score-based APMs?

In an already complex world of alternative payment models, COVID-19 has added new complexities for providers to carefully consider going forward.



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