McKinsey & Company

Healthcare Systems and Services Practice

Implications for value-based payment programs: Weathering COVID-19

Healthcare stakeholders are seeking ways to reward quality and value. As providers continue to manage COVID-19, value-based payment programs may provide support.

Julius Bruch, Adi Kumar, and Christa Moss

June 2020

COVID-19 has created an exogenous shock to the healthcare system, including a major disturbance of traditional utilization patterns and provider finances. Payers, providers, and state and federal governments had been embarking on a journey to transform the US healthcare payment system from one that rewards volume to one that rewards quality and value. Under value-based payment (VBP) programs, payers reward providers for reducing healthcare costs while maintaining or improving quality. Through a COVID-19 lens, VBP programs can support providers in times of uncertainty, such as by providing capitated incomes.

Less than 3 percent of payments are fully capitated, according to the latest Catalyst for Payment Reform scorecard.[1] Moreover, while COVID-19 has further unearthed some clear shortcomings of fee-for-service payment models,[2] it has also created meaningful cracks in the typical VBP accounting systems and payer-provider relationships. For example, providers in VBP arrangements, while fighting the pandemic, may be exposed to attribution losses, missed outcome metrics, missed savings targets, and struggles with reporting requirements. Therefore, most providers' 2020 performance under VBP programs cannot be fairly assessed in the way the programs were initially designed.

As a result, the regulatory environment has already begun to adapt by easing the burden on providers. The Centers for Medicare & Medicaid Services (CMS) announced it will amend its quality reporting requirements through the end of the second quarter 2020 and intends to prorate any losses incurred by Medicare Accountable Care Organizations (ACOs) in 2020 for the duration of the public health emergency.[3]

Still, providers are indicating concern and may seek to leave VBP programs unless additional actions are taken. In a recent survey,[4] 56 percent of ACOs with negative risk said they were at least "somewhat likely" to leave the program due to COVID-19. Thus, payers and providers face a critical choice about how to proceed. Potential options to consider are:

1. Bolt on additional safeguards to maintain (or grow) participation and adapt current programs to fairly compensate (and where possible, further support) providers; or
2. Pause current programs this year and plan to rebuild with improvements.

Option 1

Bolt on additional safeguards to maintain (or grow) participation and adapt current programs to fairly compensate (and where possible, further support) providers

As payers look to adapt program design, they might consider three tactical areas to maintain program goals, better support providers, and ensure continued participation. These actions may inform how payers assess and revise their VBP program designs.

- Strive for technical accuracy—make tactical changes to program design to ensure appropriate performance measurement, given the shock to healthcare system utilization and payment trends
- Ease provider burden—mitigate additional operational and resource requirements to support providers while they are focusing on the most critical actions amid the pandemic
- Adapt timing of payments to support providers—consider pulling forward rewards or delaying penalties

[1] "National scorecard on commercial payment reform 2.0," Catalyst for Payment Reform, 2019, catalyze.org.
[2] Medicare Learning Network, "Medicare fee-for-service (FFS) response to the public health emergency on the Coronavirus (COVID-19)," CMS, June 1, 2020, cms.gov.
[3] "CMS announces relief for clinicians, providers, hospitals and facilities participating in quality reporting programs in response to COVID-19," CMS, March 22, 2020, cms.gov.
[4] LaPointe J, "Over half of at-risk ACOs may quit MSSP to avoid COVID-19 losses," Revcycle Intelligence, April 14, 2020, revcycleintelligence.com.

Strive for technical accuracy

Orchestrators of innovative arrangements, including policy leaders and payers, may want to consider adjusting VBP programs to focus on what outcome improvements providers can control, rather than changes driven by or reliant on COVID-19. In practice, payers may need to make a series of adjustments to the technical elements of VBP programs:

— *Attribution*: In programs that define attribution by minimum activity levels, consider freezing attribution from a pre-COVID-19 era. Extend the window for determining activity, including telehealth visits in attribution methodologies, or alternative adjustments. These changes are especially relevant if the program makes payments on a per-member basis.

— *Quality metrics*: COVID-19 has reduced utilization.[5] While overutilization metrics (such as emergency department utilization) will likely perform well, others (for example, screening, vaccination, follow-up) will likely perform poorly. Consider excluding the time horizon affected by COVID-19 in the calculation of metrics, or resetting the threshold to adjust for its impact.

— *Risk adjustment*: The decrease in utilization—and coupled lack of access to recent diagnosis information—may make populations seem artificially less risky. Consider the time period affected by COVID-19 as an outlier and ensure appropriate lookback to pre-COVID-19 era care to determine risk.

— *Cost benchmarks*: This time of reduced utilization may be followed by a "surge" as routine care recommences. For 2020 performance, consider extending performance periods to balance impact of utilization patterns or comparing cost growth across regional (or national) peers in resetting benchmarks.

Ease provider burden

Providers have often expressed frustration by technical or reporting requirements.[6] In a COVID-19 era, healthcare stakeholders could consider easing or stopping these requirements. One example is payers adjusting (or pausing) reporting requirements for the current performance period. Providers are often tasked with submitting different reporting criteria for each value-based payment arrangement, which can be an operational burden. In addition to CMS amending reporting requirements for 2020, other payers, such as Centene, Blue Cross and Blue Shield of New Mexico, and Blue Cross and Blue Shield of North Carolina,[7] have given providers access to special grants and credits.

Adapt timing of payments to support providers

Value-based payment models may span multiple payments, including upfront, per member per month payments—either as a capitated amount to cover potential services rendered or a care coordination payment to support additional activities, as well as shared savings or risk payments delivered retrospectively based on performance. Timing of these payments may vary based on program design.

Opportunities to adjust timing of payments and better support providers include:

— Pausing or waiving any negative reconciliation payments that may be occurring now based on 2019 performance—in some cases, these are obtained through a withhold on current payments. Pausing or waiving will ensure that providers receive full payment for services rendered in the pandemic.

---

5 Cox C, Kamal R, and McDermott D, "How have healthcare utilization and spending changed so far during the coronavirus pandemic?" Peterson-KFF Health System Tracker, May 29, 2020, healthsystemtracker.org.

6 "Regulatory overload: Assessing the regulatory burden on health systems, hospitals and post-acute care providers," American Hospital Association, October 2017, aha.org.

7 "Health insurance providers respond to coronavirus (COVID-19)," AHIP, May 29, 2020, ahip.org.

— Accelerating shared savings payments—in many cases, payments do not occur until months after the performance period has ended based on the desire for nearly complete claims information prior to determining incentives. Payers can assess performance earlier, pay shared savings, and ensure payments are reconciled based on additional claims run-out.

— Accelerate per-member payments—rather than continuing on a monthly cadence, payers can pull forward payments to help providers solve the immediate cash flow issues given reduced utilization during the pandemic. For example, Blue Cross Blue Shield of Massachusetts is accelerating some payments for its Alternative Quality Contract (AQC) that would have been made in late 2020 or early 2021 to assist providers with the financial pressures associated with the COVID-19 public health emergency.[8]

Keeping programs running and bolting on additional safeguards does come with its own risks. It is not trivial to ensure accuracy for the analytics. It may be even harder to convince providers that the program has been adjusted sufficiently to shield them from adverse consequences. As a result, providers may still leave programs.

Option 2

Pause current programs this year and plan to rebuild with improvements

If making the technical adaptations and tactical changes above seems technically difficult for payers or is contractually not possible, pausing or ending VBP programs is an option. Some contracts contain *force majeure* clauses allowing payers to excuse performance during the current measurement period in the face of COVID-19.[9] This pause could be followed up by the development of revised programs addressing provider concerns and seen as an opportunity to reimagine the future of value-based care. Key risks of this approach include undermining care quality for members during this time of crisis, potentially harming relationships with providers expecting incentive payments or care management fees given economic hardships, and ultimately sending out the signal that value-based payment works during good times only.

The potential approaches to address VBP programs, given the circumstances of COVID-19, illustrate two options to consider. While adjusting the program and bolting on safeguards is not without its challenges, it is an option that keeps providers engaged and maintains the collaborative payer-provider relationship often found in successful VBP arrangements.

Pausing programs, comparatively, is an option that is easier to communicate and may enable a "reboot" of VBP programs down the line. Regardless of the route taken, the following overarching steps could be considered:

— *Adopt and communicate changes quickly to provide clarity, allay provider concerns, and enable continued investments in VBP*: Clear communication will be key to alleviate provider concerns and prevent a wave of providers leaving VBP programs.

— *Recognize VBP program members as partners*: VBP program members have demonstrated their willingness to take on risk by partnering with payers to improve the care they provide. Whether it be access to credits, grants, accelerated payments, or access to infrastructure, such as telemedicine platforms—consider rewarding this group as members of a select community.

[8] "Health insurance providers respond to coronavirus (COVID-19)," AHIP, May 29, 2020, ahip.org.
[9] Selby J and Mitchell GR, "Value-based payment arrangements during the COVID-19 pandemic," Epstein Becker & Green, March 30, 2020, healthlawadvisor.com.

— *Encourage positive trends facilitated by the current situation*: Amid the tremendous toll of COVID-19 on patients and providers, some small bright spots have emerged, including greater adoption of telehealth[10] and greater use of home health. Decrease in emergency room use in 2020 should be further examined. Trends that increase quality and decrease costs should be maintained in VBP programs in the long term.

Finally, leaders managing VBP programs will encounter additional operational implications. Team capabilities and priorities may need to be reconsidered in order to address any technical adjustments or the pausing of the program. Analysis and data requirements may change in response. Leaders should also consider what needs to be in place, in addition to value-based payment, in order to provide high quality and efficient care to patients, for example, through network management or care management.

While COVID-19 sent an unprecedented shock to the healthcare system, leaders can now seize the opportunity to reimagine payment systems that—if managed correctly—create efficiency and provide high-quality care to patients.

[10] Bestsennyy O, Gilbert G, Harris A, and Rost J, "Telehealth: A quarter-trillion-dollar post-COVID-19 reality?" McKinsey & Company, May 29, 2020, McKinsey.com.

Julius Bruch (Julius_Bruch@mckinsey.com) is a consultant in McKinsey's New York office. **Adi Kumar** (Adi_Kumar@mckinsey.com) is a partner in the Washington, DC, office. **Christa Moss** is an alumna from the Cleveland office.

This article was edited by Elizabeth Newman, an executive editor in the Chicago office.