

# Eight key impacts of COVID-19 on MSSP ACOs

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During this time of uncertainty due to the COVID-19 pandemic, healthcare providers are fully engrossed in maintaining daily operations and ensuring continuity of care for their patients.

The crisis has also created many uncertainties for providers and Accountable Care Organizations (ACOs), which can seem overwhelming. It is not surprising that in this context, Medicare Shared Savings Program (MSSP) ACOs are particularly concerned about the potential for 2020 results to deteriorate due to COVID-19<sup>1</sup>.

In this white paper, we discuss eight key considerations for MSSP and other risk-sharing arrangements as they assess the impact of COVID-19:

1. **Risk exposure:** What is the downside risk exposure? Will contracts that historically produced gains continue to do so?
2. **Financial benchmark:** How will the financial benchmark or capitation payments reflect COVID-19?
3. **Expenditures:** How are expenditures expected to change for the specific population and services covered by the risk-sharing contract?
4. **Quality provisions:** How will potential reductions (or increases) in quality scores affect financial results?
5. **Attribution methodology:** How will reduced in-person office visits and potential increased telehealth visits affect patient attribution?
6. **Reporting:** How will claim payment and reporting be affected by COVID-19?
7. **Termination clauses and extreme circumstances contract adjustments:** What are the options for termination or contract adjustments if results deteriorate?
8. **Unintended consequences:** What are the potential unintended consequences of terminating a specific risk-sharing agreement?

## QUANTIFYING COVID-19 IMPACT

Milliman has quantified COVID-19 impacts to the medical system, including the effects of deferred and cancelled care in this linked [study](#).

While we discuss each of these items in relation to MSSP, these considerations can be applied to other types of provider risk-sharing programs.

Additionally, please note that the Medicare Payment Advisory Commission (MedPAC) recently wrote a letter to the Centers for Medicare and Medicaid Services (CMS)<sup>2</sup> recommending that CMS nullify the 2020 performance year for MSSP, among other recommendations.

<sup>1</sup> To see ACO survey results about ACO concerns, visit: <https://www.naacos.com/survey-shows-acos-concerns-about-the-effect-of-covid-19>

<sup>2</sup> To read the letter from MedPAC, visit: [http://medpac.gov/docs/default-source/comment-letters/04132020\\_allowing\\_aco\\_providers\\_to\\_focus\\_on\\_covid\\_comment\\_sec.pdf?sfvrsn=0](http://medpac.gov/docs/default-source/comment-letters/04132020_allowing_aco_providers_to_focus_on_covid_comment_sec.pdf?sfvrsn=0)

## Risk exposure

Under MSSP, the total risk exposure depends on the ACO's selected track, the benchmark, and potentially the ACO participant revenue. ACOs in Track 1 and the BASIC Levels A and B have no risk exposure since these are upside-only arrangements.

MSSP expresses the loss-sharing limit as the lower of a percentage of the benchmark and a percentage of ACO revenue under Medicare FFS. In general, it is fairly straightforward to calculate the total risk exposure for a given ACO.

However, understanding the likelihood and variability of loss levels is often more helpful. For example, what is the likelihood of a loss in excess of \$500,000? What is the likelihood of a \$1 million loss?

Because of COVID-19, there are several important items to consider when assessing the likelihood of significant losses:

- **COVID-19 and loss forgiveness:** CMS has indicated that the *extreme and uncontrollable circumstances policy* is in effect for all Medicare beneficiaries effective January 2020. Performance year 2020 shared losses will be prorated based on the portion of the year this policy is in effect. For example, if the *extreme and uncontrollable circumstances policy* continues through September, then 9/12ths of any 2020 shared losses would be forgiven under this policy.
- **PY2021:** Based on a recent study from the CBO<sup>3</sup>, there is a strong possibility that the PHE may be in place through a portion of 2021. This would result in a portion of the downside risk from 2021 being reduced/dampened.
- **Loss sharing rate:** The different MSSP tracks have different loss sharing rates, which can depend on the ACO's quality score. The potential impact of COVID-19 on an ACO's quality score is discussed further below.
- **Financial benchmark methodology:** The likelihood of losses will depend on many factors, including how the ACO's benchmark is developed. The potential effects of COVID-19 on an ACO's financial benchmark are discussed below.

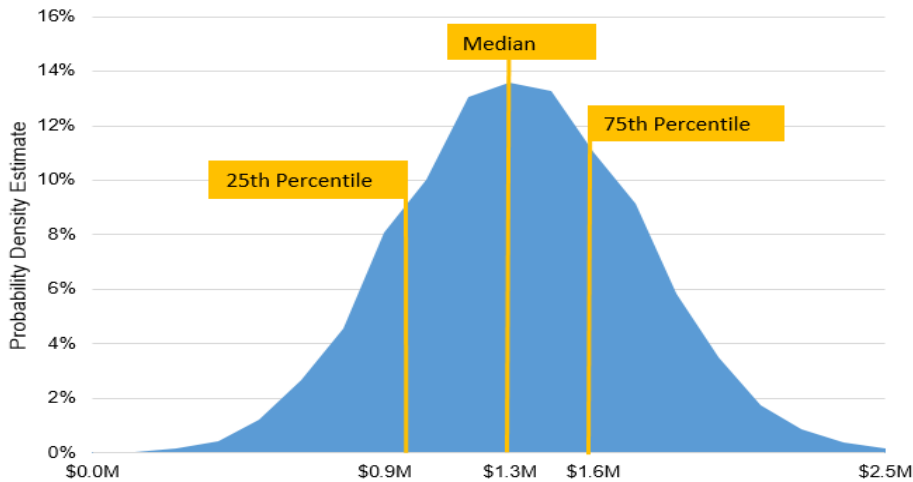
### USING SIMULATION TO ASSESS POTENTIAL SAVINGS/(LOSS) RESULTS

Point estimates are helpful for communicating best-estimate results. However, when estimating an ACO's risk-sharing potential gains and exposure to losses, many financial settlement variables are not known.

For example, for an MSSP ACO, the performance-year risk scores, expenditure trends, benchmark trends, and quality score will generally not be known until after the performance year is complete. However, these variables can be simulated based on the historical range of results for the ACO and the MSSP overall. Additionally, the settlement methodology, the number of assigned beneficiaries, the historical baseline expenditures and risk scores, and the ACO's track selection and risk-sharing parameters will generally be well understood. Combining these unknown random variables with the known amounts, ACOs can develop a picture of the potential range of financial settlement results. This information can then be used to make decisions about settlement accruals, reinsurance, focus areas (e.g. which variables drive settlement results), and renewal strategies. Figure 1 below shows an illustrative simulation of an ACO's performance-year savings/(loss) results.

<sup>3</sup> To see CBO study, visit: <https://www.cbo.gov/system/files/2020-04/HR6201.pdf>, p5

FIGURE 1: ILLUSTRATIVE DISTRIBUTION OF ACO'S POTENTIAL SAVINGS/(LOSS) RESULTS



## Financial benchmark

How COVID-19 will affect an ACO's MSSP financial benchmark depends on the ACO's region and ACO-specific circumstances, as well as the methodology applicable to the performance year. Quantifying the factors that contribute to an ACO's financial benchmark will inform the likelihood of gains or losses. CMS provides MSSP ACOs with the information needed to estimate the financial benchmark for each performance year. This information can be used as a starting point for evaluating the effects of COVID-19.

The degree to which an ACO's financial benchmark is negatively impacted by COVID-19 will depend primarily on the ACO's:

**Benchmark trend:** While Medicare FFS expenditures for 2020 (and potentially 2021) are likely to be out of step with historical spending, the regional and national trends used in the MSSP financial benchmark methodology are retrospective and will therefore include the effects of COVID-19. However, the cost of COVID-19 treatment will largely be excluded because beneficiaries' expenditures and eligibility during a COVID-19 episode of care are excluded from the benchmark (and ACO's experience), as specified in the CMS Interim Final Rule (scheduled to be published May 8, 2020).

CMS defines the COVID-19 episode of care as the months containing a COVID-19 related inpatient admission, and the month following the admission. Because of this, the deferred care associated with COVID-19, as well as outpatient costs (e.g. testing and consultations) not associated with an inpatient stay, will affect the benchmark trend.

For example, an ACO with benchmark trends largely based on the region will likely see similar benchmark and ACO expenditure trends, to the extent the ACO population's care deferral patterns are similar to the region. On the other hand, ACOs that have a significant portion of their benchmark trend set by the national trend may end up being more exposed to financial risk in the 2020 performance year depending on how their local care deferral (and social distancing) patterns compare to nationwide.

- **Beneficiary risk scores:** The CMS Hierarchical Condition Category (CMS-HCC) risk adjustment model used in MSSP to measure population changes for non-End-Stage Renal Disease beneficiaries is a prospective model. This means that diagnoses from a given year impact the risk score for the following year. Therefore, the COVID-19 pandemic **will not impact** an ACO's performance year 2020 risk scores. However, the risk scores for performance year 2021 **will be** based on claims and diagnosis data from 2020, and they are likely to be affected by the pandemic in a number of ways. Note that while the expenditures and eligibility associated with COVID-19 episodes of care will be excluded from MSSP settlement calculations, the diagnoses from these time periods will still impact 2021 risk scores for COVID-19 patients.

Outlined below are two ways COVID-19 could affect risk scores in 2021:

- **Risk score model:** As of the date of publication, there is no Hierarchical Condition Category specifically for COVID-19. CMS regularly updates the CMS-HCC risk adjustment model and could add a specific Hierarchical Condition Category for COVID-19.
- **Diagnosis capture:** COVID-19 has the potential to both increase and decrease diagnosis capture:
  - **Decrease:** Beneficiaries may forgo in-person visits with providers during the public health emergency, which reduces the opportunity to record diagnoses.
  - **Increase:** Patients infected with COVID-19 will likely seek additional care.
  - **Increase:** Expanded availability of telehealth services will increase the opportunity to record diagnoses.

Ultimately, an ACO's financial benchmark is based on the ACO's *relative* risk scores. Therefore, the degree to which an ACO's risk score increases or decreases *relative* to national averages will determine the effect of risk adjustment on the ACO's financial benchmark.

## Expenditures

The effect of COVID-19 on specific populations' healthcare costs are becoming better understood with each passing day. Evaluating the ACO's population and service area will help inform how COVID-19 treatment and testing, and the effect of deferred/cancelled care, could impact the ACO's expenditures. As mentioned above, understanding how the ACO-specific effect may be different from overall regional and national effects can help quantify the specific risks to the ACO.

Additionally, there are several recently enacted policies that will affect the net cost of COVID-19 for Medicare patients<sup>4</sup>:

- The exclusion of expenditures associated with a COVID-19 episode of care centered on inpatient treatment.
- Waiving of beneficiary cost sharing for COVID-19 testing and a visit that results in an order for COVID-19 testing.
- No additional deductible for quarantine in a hospital for patients who would have been otherwise discharged after an inpatient stay but are instead remaining in the hospital under quarantine.
- Effective April 1, 2020, a 20% increase to diagnosis-related group (DRG) weights for COVID-19 discharges, which directly affects Medicare FFS inpatient reimbursement.
- Effective May 1, 2020, a temporary suspension of sequestration through the end of 2020.

## Quality provisions

Because of the extreme and uncontrollable circumstances policy, MSSP ACOs are expected to have some quality requirements relief<sup>5</sup>. Specifically:

- For measures that the ACO is unable to report, the ACOs quality score will be set to the mean quality score for all MSSP ACOs.
- If the ACO is unable to completely and accurately report all quality measures, then CMS will use the highest of the ACO's quality score and the mean for all MSSP ACOs.
- CMS may take further action, so the final 2020 quality score methodology is not fully known at this time.

The potential for lower (or higher) quality scores can be incorporated into an analysis of an ACO's potential financial performance.

<sup>4</sup> For information on COVID-19 cost sharing requirements, see:

- Families First Act: <https://www.congress.gov/116/plaws/publ127/PLAW-116publ127.pdf>
- CMS - Coverage and Payment Related to COVID-19: <https://www.cms.gov/files/document/03052020-medicare-covid-19-fact-sheet.pdf>.

For information on Medicare reimbursement changes, see:

- CARES Act: <https://www.congress.gov/116/bills/s3548/BILLS-116s3548is.pdf>
- CMS guidance: <https://www.cms.gov/files/document/se20015.pdf>

<sup>5</sup> For more information, see the COVID-19 and ACOs Fact Sheet: <https://www.naacos.com/covid-19-and-acos-fact-sheet>

## Attribution methodology

MSSP uses claims-based attribution, supplemented by voluntary alignment. The claims-based attribution is primarily based on whether the ACO has the preponderance of a beneficiary's evaluation and management visits during the alignment period. For claims-based attribution there are two main considerations:

1. **Telehealth:** Beneficiaries may seek care in non-office settings, such as through telehealth. Telehealth coverage has been expanded significantly (via the removal of the geographic limitation) in response to COVID-19<sup>6</sup>.
  - ACOs with more robust telehealth capabilities may be able to effectively counteract the impact of decreased in-person visits.
  - The MSSP attribution methodology has been expanded to include telehealth CPT/HCPCS codes
2. **Forgoing in-person evaluation and management visits:** Beneficiaries may forgo care in 2020, leading to fewer attributed beneficiaries. Beneficiaries forgoing care are typically healthier, leaving less-healthy beneficiaries remaining in the attributed population, creating a selection bias.

MSSP ACOs should consider the pros and cons of retrospective and prospective assignment for 2021. For example, if an ACO believes using 2020 experience for prospective assignment may negatively impact performance year 2021 results, then retrospective assignment may be preferred<sup>7</sup>. In opting for retrospective assignment, the ACO has closer alignment between beneficiary attribution and expenditures during 2021, helping circumvent disruption due to the COVID-19 outbreak experienced in 2020 that would be included under prospective attribution.

## Reporting

The shift in utilization patterns and workforce limitations that many entities are experiencing may impact claims processing speed and claim payment patterns. Additionally, coding and payment system changes (e.g. the introduction of COVID-19 diagnosis codes, the 20% increase to DRG weights for COVID-19 admissions) may lead to delays in claim submission. The identification of COVID-19 episodes of care, and the corresponding impact on expenditures and eligibility (both for the ACO and the benchmark), could lead to further delays and higher-than-normal retroactivity for both expenditures and eligibility.

MSSP uses fixed completion factors based on historical experience to estimate ultimate expenditures as part of the quarterly reporting and the final settlement. Depending on the specific impact the COVID-19 pandemic has on a provider's claims reporting patterns, the historical completion factors may not be consistent with the actual reporting runout. For example, if the performance year claims are underreported relative to the experience period used to create the financial benchmark, then this could create "savings" under the MSSP settlement methodology.

However, the extent of the impact of COVID-19 disruptions will likely take a significant amount of time to know with any degree of certainty. This suggests that the interim reporting throughout performance year 2020 could be unreliable, and the ultimate 2020 results might come as more of a surprise (either favorable or unfavorable) for many ACOs. Claims processing issues could extend into post-2020 performance years, depending on the extent of the outbreak and how it affects the claim reporting processes for providers, Medicare administrative contractors (MACs), and CMS.

<sup>6</sup> For more information, see the Medicare Learning Network's Telehealth Booklet: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctstht.pdf>

<sup>7</sup> For more information on the impact of retrospective versus prospective attribution, see Milliman's issue brief: <https://milliman-cdn.azureedge.net/-/media/milliman/pdfs/articles/prospective-retrospective-assignment-mssp-beyond.ashx>

## Termination clauses and extreme circumstances contract adjustments

We have discussed the MSSP **extreme and uncontrollable circumstances policy** implications above.

### MSSP EXTREME AND UNCONTROLLABLE CIRCUMSTANCES POLICY AND COVID-19

The extreme and uncontrollable circumstances policy provides a mechanism for CMS to forgive shared losses and relax reporting requirements in the event of a natural disaster or Public Health Emergency (PHE).

CMS has the authority to determine:

- If an extreme and uncontrollable circumstance has occurred
- The affected areas
- The time period of the event
- The percentage of ACO's assigned beneficiaries residing in the affected areas<sup>8</sup>.

MSSP ACO's shared losses are then prorated based on the proportion of the ACO's beneficiaries and the performance year that is affected by the extreme and uncontrollable circumstance.

For the COVID-19 PHE, CMS has declared<sup>9</sup> that:

- 100 percent of assigned beneficiaries for all Shared Savings Program ACOs reside in an affected area and the total months affected by an extreme and uncontrollable circumstance will begin with [January 2020] and continue through the end of the current PHE.
- For PY 2020 financial reconciliation, [CMS] will reduce the amount of an ACO's shared losses by an amount determined by multiplying the shared losses by the percentage of the total months in the performance year affected by an extreme and uncontrollable circumstance, and the percentage of the ACO's assigned beneficiaries who reside in an area affected by an extreme and uncontrollable circumstance.
- If the COVID-19 PHE extends through all of CY 2020, all shared losses for PY 2020 will be mitigated for all ACOs participating in a performance-based risk track: including Track 2, the ENHANCED track, Levels C, D and E of the BASIC track, and the Track 1+ Model. At this time, the COVID-19 PHE has already covered four months (January through April 2020) meaning any shared losses an ACO incurs for PY 2020 will be reduced by at least one-third. Further, if the COVID-19 PHE extends for a large portion, if not all of the year, the existing extreme and uncontrollable circumstances policy under the Shared Savings Program would mitigate a significant portion of, if not all, shared losses an ACO may owe for PY 2020.

Note that CMS initially declared the PHE began March 2020 and later revised the start date to January 2020. As discussed in this whitepaper, CMS will exclude experience for COVID-19 episodes or care and has modified the MSSP quality reporting requirements for PY 2020.

MSSP ACOs also have the opportunity to withdraw at any point through June 30, 2020, without being held responsible for any shared losses for that performance year<sup>10</sup>. A notice of termination must be provided 30 days prior to termination, so effectively the deadline for making a decision is May 31, 2020. Withdrawing from MSSP may affect an ACO's track options upon reentry—potentially limiting an ACO to tracks with a higher level of downside risk. An ACO withdrawing after June 30 will be responsible for shared losses prorated for the portion of the year that it was participating in the program.

<sup>8</sup> Code of Federal Regulations 425.610: [https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=ae8e3622e8f0bcc868cf2e60afa879bf&mc=true&n=pt42.3.425&r=PART&ty=HTML#se42.3.425\\_1610](https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=ae8e3622e8f0bcc868cf2e60afa879bf&mc=true&n=pt42.3.425&r=PART&ty=HTML#se42.3.425_1610)

<sup>9</sup> Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency: <https://www.govinfo.gov/content/pkg/FR-2020-04-06/pdf/2020-06990.pdf>, page 19268

Medicare and Medicaid Programs, Basic Health Program, and Exchanges: Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program <https://www.federalregister.gov/documents/2020/05/08/2020-09608/medicare-and-medicare-programs-basic-health-program-and-exchanges-additional-policy-and-regulatory>

<sup>10</sup> To learn more, view the Department of Health and Human Services' Pathways to Success document (page 444): <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-27981.pdf>

## Unintended consequences

If an ACO terminates its MSSP contract, this may have unintended consequences. Examples include:

- **Delayed ability to reenter:** CMS has forgone the application cycle for January 2021. ACOs already participating in MSSP can voluntarily extend their contracts into 2021, but no new ACOs will be able to enter MSSP for a January 1, 2021, start date.
- **Rebasing:** Is the current benchmark favorable for the ACO? If the ACO terminates and then reenters MSSP, then the benchmark will likely be rebased, which could be unfavorable.
- **Missed opportunity for gains:** Understanding the net effect of COVID-19 on an ACO's settlement requires careful consideration of the different potential impacts, and it is still fraught with uncertainty. That said, MSSP is an asymmetrical model where an ACO's shared savings rate is often greater than the shared loss rate. Therefore, it is important to consider both the missed opportunity for gains in addition to the potential for losses.
- **Advanced Alternative Payment Model (APM) Qualifying Participant status<sup>11</sup>:** ACO participants that achieve qualifying participant (QP) status receive a 5% bonus on Part B professional revenue and are excluded from the Merit-Based Incentive Payment System (MIPS) and the associated reporting requirements. Additionally, starting in 2026, QPs will receive higher reimbursement under RBRVS than non-QPs.

## Conclusion

COVID-19 creates new risks for ACOs. However, quantifying how these risks may impact risk-sharing settlements is key to making informed decisions. Some ACOs may find that COVID-19 increases the potential for risk-sharing losses to unacceptable levels, while other ACOs may find that the potential for risk-sharing losses due to COVID-19 are mitigated by contract protections and the financial benchmark methodology. Reviewing contract provisions, compiling the relevant performance data, and quantifying the range of likely outcomes are critical first steps.

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<sup>11</sup> We note that the Patient Count and Payment Amount threshold requirements for becoming a QP are increasing in 2021. ACOs participating in Advanced APMs should review their Patient Count and Payment Amount scores and participant composition, to help ensure they meet the 2021 requirements.



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