Know your worth – Contracting in Medicare value-based programs

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Medicare Advantage Value-Based Payments Risk Terms and Modeling, and the influence of Operational Capabilities

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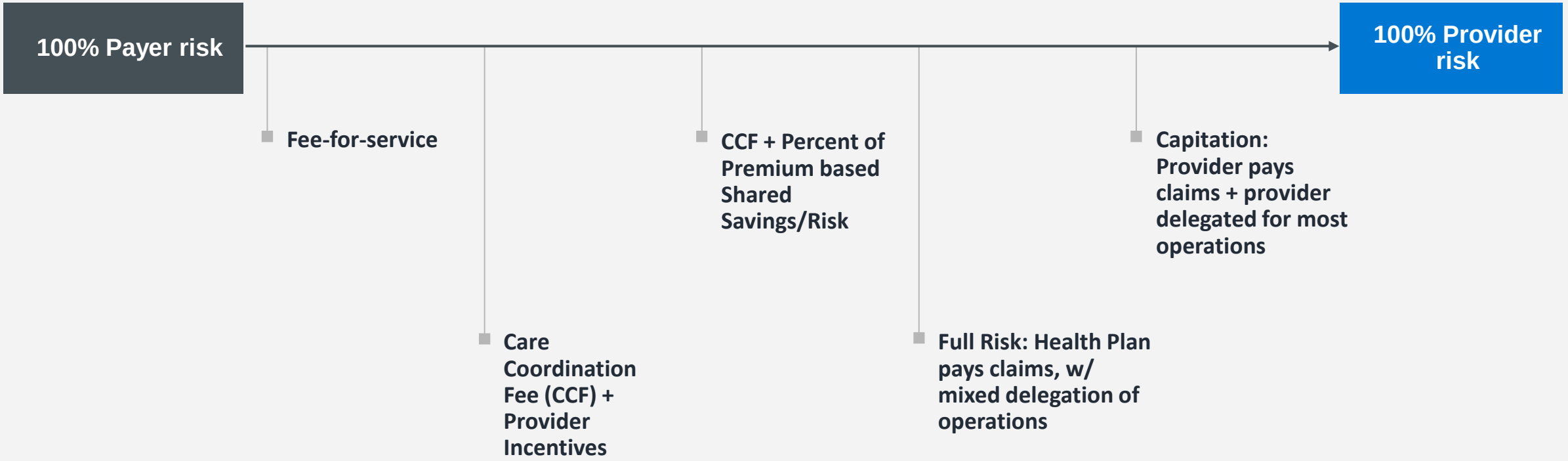
MA risk continuum



Medicare Advantage risk sharing common contract terms/provisions

Contract negotiations involve many moving parts and terms. Providers and health plans are all at a different VBP readiness level. Developing a risk arrangement that is a win-win is possible with flexibility in the terms and path-to-risk.

- **General**
  - Length of contract term
  - **Membership thresholds to move to risk**
- **Fees / payment types**
  - **Care Coordination Fee (CCF)**
  - Infrastructure payments
  - **Percent of Premium (POP) target**
- **Quality-based incentives**
  - Quality Gate
  - Surplus / Deficit adjustments
  - PMPM quality bonus payments

- **Risk sharing terms**
  - **Shared Savings and Risk %**
  - **Definition of revenue**
  - **Division of Financial Responsibility (DoFR) / Carve-outs**
  - Caps on savings / losses
  - What is included in Medical Cost that is not claims payment
  - **Part D**
  - **Stop loss (PIP Regulations)**
- **Data exchange**
  - Claims, MMR, Authorizations

- **Other terms**
  - **Provider engagement in Benefit decisions**
  - **Plan Design inclusions / exclusions (SNP plans, Part B Buydown, MA Only)**
  - Specific members or conditions included/excluded
  - **Operational responsibilities**
  - Member assignment
  - **Material Change Language**

Medicare Advantage contract evaluation

With all the varying terms and considerations there is no one-size-fits-all solution. Payers and providers must partner in evaluating the contract terms.

- **Data exchange between health plan and provider is critical but challenging**
  - The provider needs data to understand the population being considered under the contract terms
  - The health plan is limited as to what they can share, but may be able to provide claims and revenue data
  - The provider may need help ingesting the data, categorizing, identifying data issues, and translating to a consumable data source
  - The data will be historical, and not always a good predictor of the future
  - Depending on the population, the provider may need to research expense volatility using other populations or larger datasets
- **Developing financial models to evaluated the risk and scenario testing the assumptions to measure the range of results can help a provider determine:**
  - Which contract terms are most impactful to results
  - Whether they can mitigate the risk or improve performance such that the contract is appropriate for their financial situation
- **Understanding the provider's operational capabilities and factoring these capabilities into the scenario testing is essential**
  - Taking a realistic approach to evaluating operational capabilities and the investment required to improve capabilities will benefit the provider and health plan

Medicare Advantage risk sharing operations considerations

The financial commitment by providers to operate a VBP should be aligned with the risk terms and financial potential for the provider. There is a broad spectrum of operations a provider could take on through the life of the risk contract. The list below is not a comprehensive list of all operations functions a provider may perform.

Clinical and Claims Operations

- Care / Utilization Management
- Claims payment
- STARs and Risk Adjustment
- EMR integration / connectivity
- Data ingestion and analytics

Member Communication and Growth

- Sales / Marketing
- Broker outreach
- Member retention
- Member outreach for onboarding, annual wellness visits, care management, etc.

Provider / Network Development

- Provider credentialing
- Provider outreach
- Performance based subcontracts with Specialists
- MSB subcontracting and management

Health plan and provider operations are very complex. As providers take on more risk, these complex worlds collide. For VBP models to be successful for the health plan, providers, and members, the health plan and provider must collaborate.

Common concerns - Provider

Providers that are at the beginning stages of value-based payment models will have different concerns and expectations than providers that have been in risk bearing contracts for many years. Payers and providers must be flexible in how they work together to arrive at the win-win outcome.

Financial

- Contract terms and financial calculation is too complex, making it difficult to understand the risk
- Difficult to monitor performance due to IBNR, assignment changes, accrued risk score, etc
- Big step to move into downside risk
- Impact of annual changes from CMS
- Impact of benefit design
- Administrative costs are too high

Operations

- Consistency / reconciliation of data feeds
- Division of Financial Responsibility (DoFR) is inconsistent with practice patterns
- Part D / Rx specific issues (e.g., rebates and cashflows)
- Risk adjustment model processes, timing and complexity

Common concerns - Payer

Like Providers, Payers will have concerns as providers move towards the global risk end of the value-based payment model spectrum and take on more operations responsibility.

- **Financial viability of provider losses**
- **Selection bias (e.g., only successful providers sign up and/or continue)**
- **Achieving a meaningful portion of the patient panel**
- **Savings driven by random fluctuation**
- **Member experience from provider role in:**
  - Operations delegation
  - Claims payment / rerouting
  - Member outreach
  - Customer service

Partnership and Collaboration

All the challenges highlighted can be solved and value-based payment models can be successful for the health plan, providers, and members.

The most critical success factor is Partnership and Collaboration

Specialty risk sharing considerations

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Overview of Chronic Kidney Disease

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Chronic Kidney Disease

Disease Progression & Treatment

Chronic Kidney Disease (CKD)

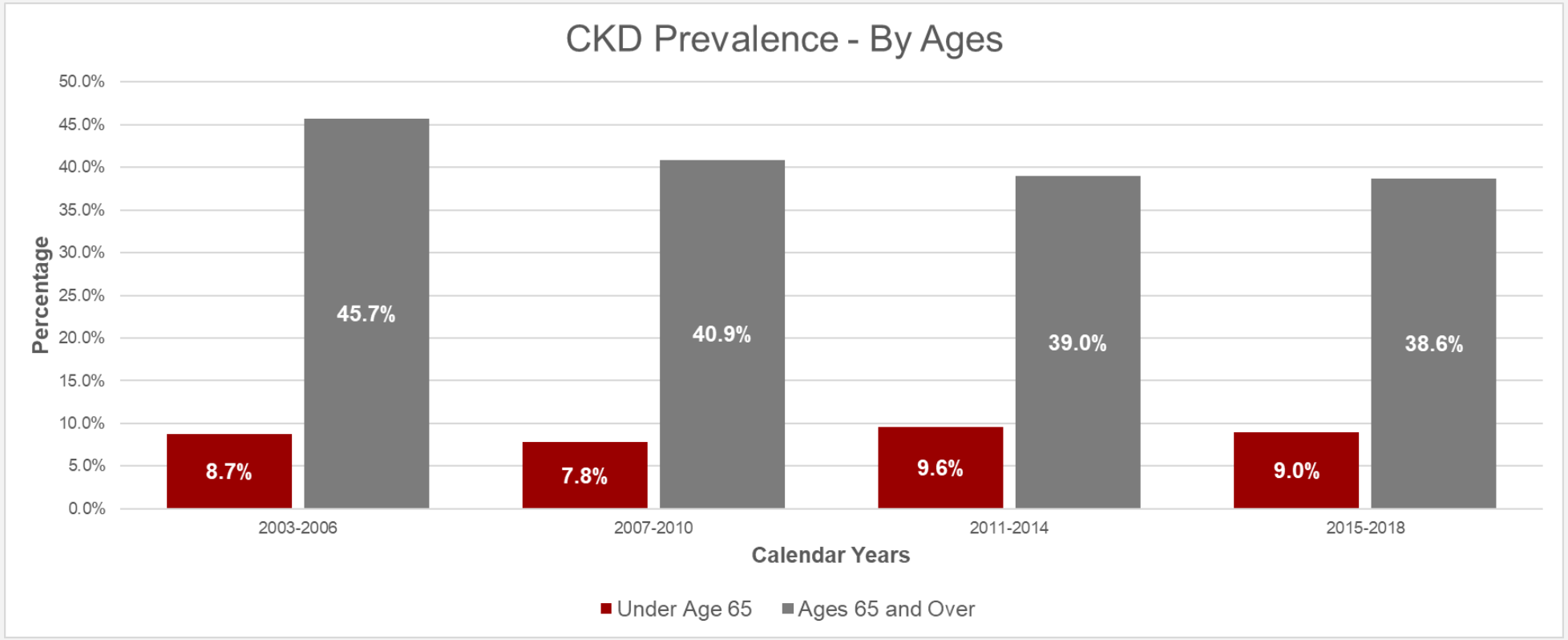
- **Kidney Function**
- **CKD Stages 1 – 5**

End-Stage Renal Disease (ESRD)

- **Dialysis Treatment**
- **Kidney Transplant**

CKD Patients

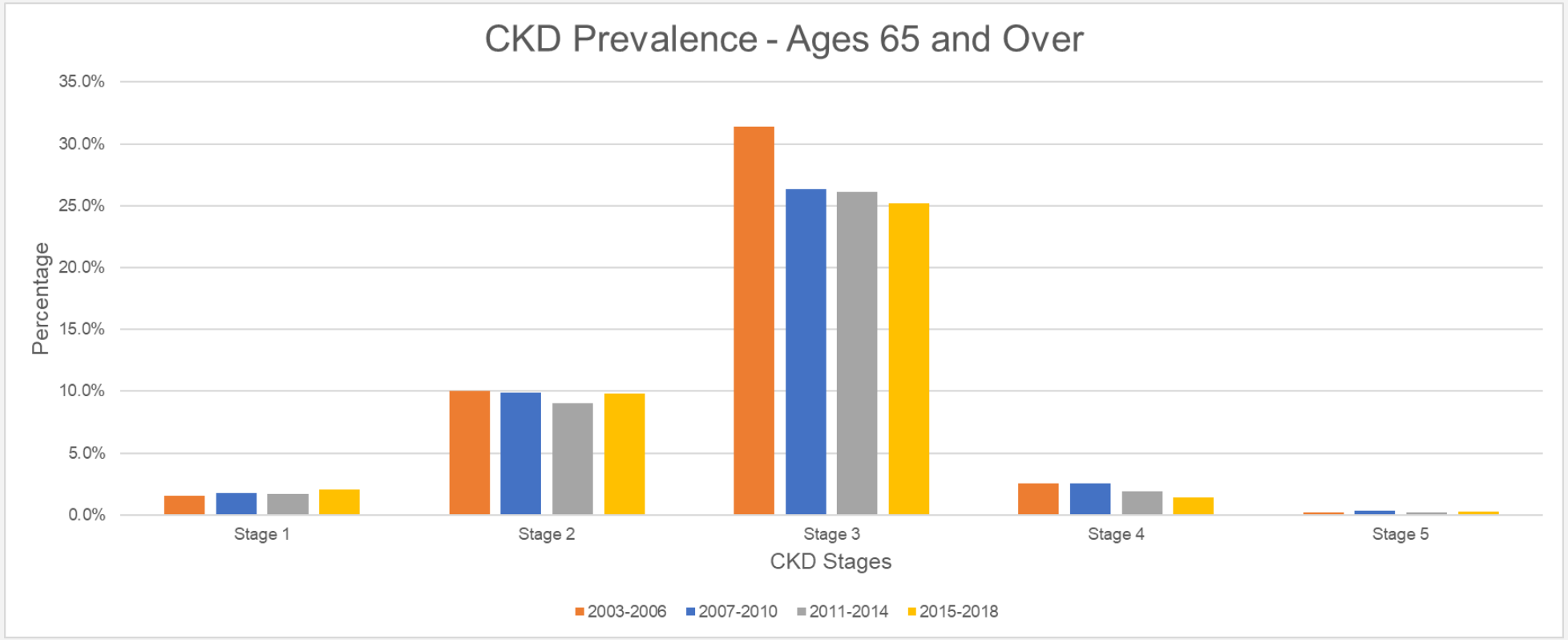
Condition Prevalence – Under Age 65, Ages 65 and Over



Data source: National Health and Nutrition Examination Survey (NHANES)

CKD Patients

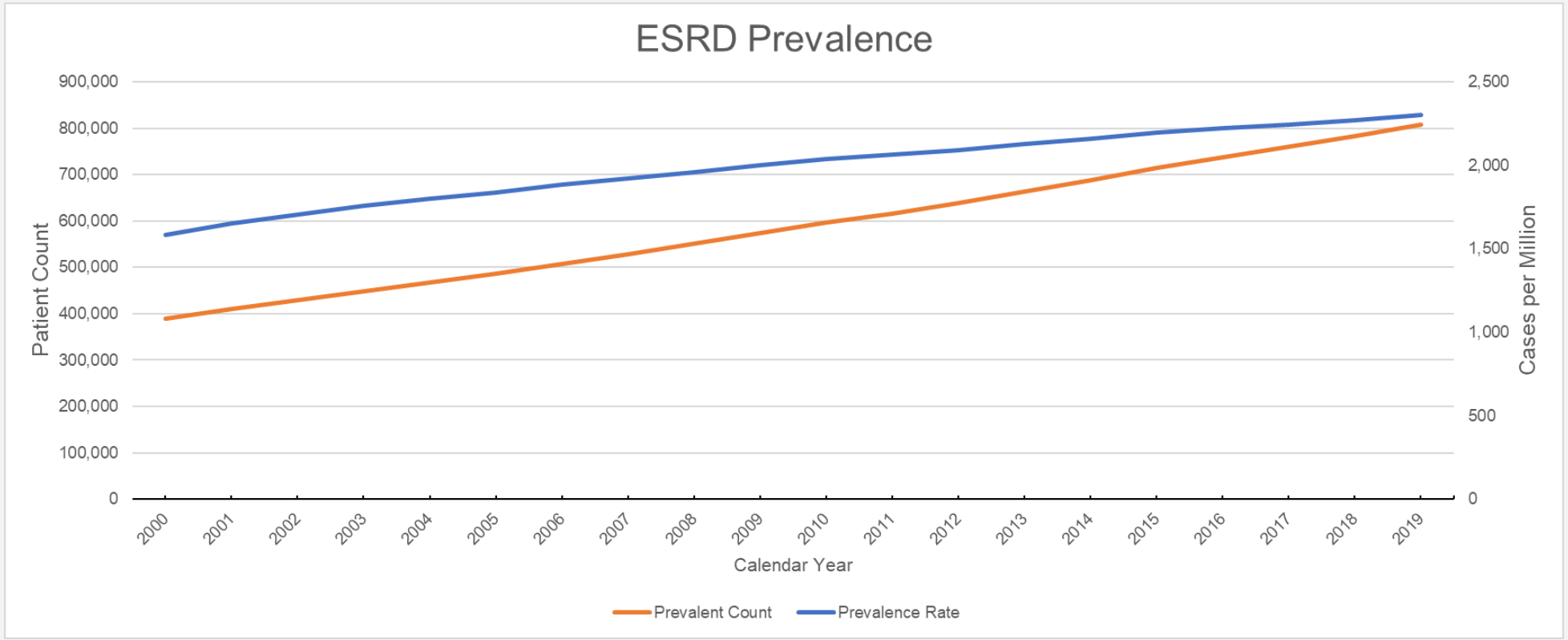
Condition Prevalence by CKD Stage – Ages 65 and Over



Data source: National Health and Nutrition Examination Survey (NHANES)

ESRD Patients

Condition Prevalence – Overall

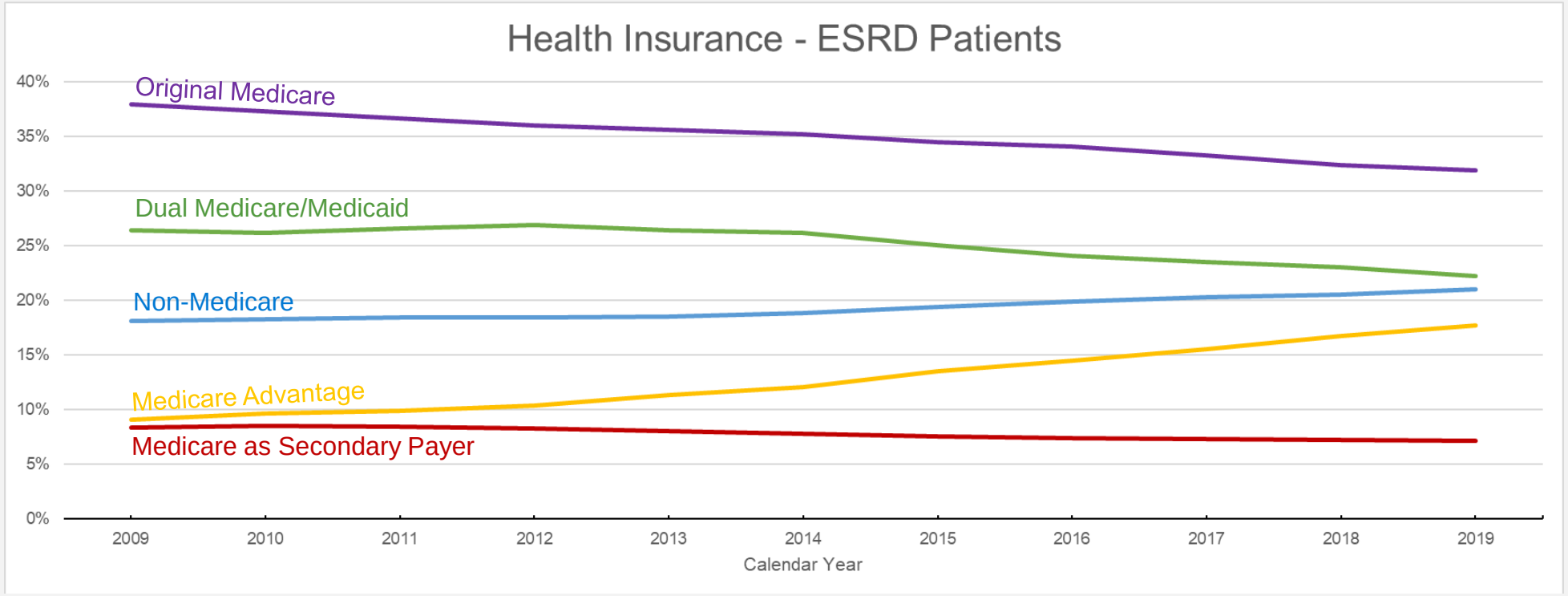


Data Source: United States Renal Data System (USRDS) – 2021 Annual Report

* Prevalence rate adjusted to 2015 patient mix

ESRD Patients

Health Insurance Coverage



Data Source: United States Renal Data System (USRDS) – 2021 Annual Report

Patient Costs

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Medical Total Cost of Care

2019 Allowed PMPM by CKD/ESRD Stage and Line of Business

Line of Business	CKD Stage 3	CKD Stage 4	CKD Stage 5	ESRD
Commercial LG[1]	$2,447	$4,240	$8,604	$15,238
Medicare FFS[2]	$2,691	$3,684	$5,192	$8,624
Managed Medicaid[1]	$698	$948	$1,243	$4,532

1 Sourced from Milliman's CHSD

2 Sourced from CMS Medicare FFS 5% sample

Payment Models

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CMS Innovation Center Payment Models

Kidney Care

End-Stage Renal Disease Treatment Choices (ETC)

Meant to encourage home dialysis and transplantation over in-center hemodialysis for beneficiaries with ESRD

Payment adjustment for the ESRD Prospective Payment System for participating ESRD facilities and to the monthly capitation payment for participating nephrologists managing beneficiaries with ESRD

Applies to select Medicare claims with dates from January 1, 2021 through June 30, 2027

https://www.cms.gov/newsroom/fact-sheets/end-stage-renal-disease-treatment-choices-etc-model-fact-sheet

https://innovation.cms.gov/innovation-models/kidney-care-choices-kcc-model

Kidney Care Choices (KCC) Model

Meant to encourage care that delays the need for dialysis for beneficiaries with CKD stage 4 or 5 and encourages kidney transplantation

Monthly capitation payment adjusted for health outcomes and utilization or shared savings for total cost and quality of care for attributed beneficiaries

Model performance period began on January 1, 2022, and will continue through December 31, 2026

Kidney Care Choices (KCC) Model

Accountable Care Model Overview

CMS innovation model for medicare beneficiaries with CKD stages 4 and 5, beneficiaries with ESRD receiving maintenance dialysis, and beneficiaries who were aligned to a KCF practice or kidney contracting entity (KCE) that then receive a kidney transplant.

Aims to delay the need for dialysis and encourage kidney transplantation

2022 is the first performance year for the model

Patients with kidney disease tend to follow the most expensive path, with little prevention of disease progression and an unplanned start to in-center hemodialysis treatment.

By increasing education and understanding of the kidney disease process, aligned beneficiaries may be better prepared to actively participate in shared decision making for their care.

KCEs are required to include nephrologists or nephrology practices and transplant providers, while dialysis facilities and other providers and suppliers are optional participants in KCEs.

Kidney Care First (KCF) Option

Comprehensive Kidney Care Contracting (CKCC) Graduated Option

CKCC Professional Option

CKCC Global Option

Comprehensive Kidney Care Contracting (CKCC)

Risk options

Graduated Level 1

- No downside
- Up to 40% upside up to 10% improvement against benchmark
- Truncation (reinsurance not necessary)
- Minimum savings rate

Graduated Level 2

- Up to 30% downside
- Up to 50% upside
  - 1st 5%:30% down / 50% up
  - Next 5%: 20% down / 35% up
  - Next 5%: 10% down / 15% up
  - Remainder: 5% down/up
- Reinsurance offered by CMS
- 2.5% quality withhold

Professional

- Up to 50% downside/upside
  - 1st 5%: 50% down/up
  - Next 5%: 35% down/up
  - Next 5%: 15% down/up
  - Remainder: 5% down/up
- Reinsurance offered by CMS
- 5% quality withhold

Global

- Up to full risk
  - 1st 5%: 100% down/up
  - Next 5%: 50% down/up
  - Next 5%: 25% down/up
  - Remainder: 10% down/up
- Reinsurance offered by CMS
- 5% quality withhold

CKCC KCE participation agreement

www.qualityforum.org/Publications/2015/12/Renal_Measures_Final_Report.aspx

Comprehensive Kidney Care Contracting (CKCC)

Program considerations

Growth

- Ramping up management for the entire cohort immediately
- Minimum beneficiary counts

Management

- Managing total cost of care and administering surveys to patients they may not be used to receiving from their nephrologists such as PHQ-9 and PAM

Benchmark

- The target benchmarks are not finalized until after the performance year ends and are subject to retrospective trend and risk score adjustments

Expertise

- Complicated and often unclear provisions (too many options), relatively new model (few experts), and volatile populations (10%+ death, ineligibility, and dealignment rate)

Data

- Inaccuracies in data from CMS, delays in getting corrected data, emerging historical CKCC-managed data to rely on for projections, difficult to understand and work with CCLF files, and material stoploss impacts

Alignment

- Difficult to get a perfect picture of which beneficiaries are aligned to the KCE until settlement is released – “one touch” rule (must see nephrologist), in KCE service area, and prospective to retrospective dealignment

What's next for CMMI kidney models?

Comprehensive ESRD Care (CEC) Model
Oct 2015 – Mar 2020

Kidney Care Choices (KCC) Model
Jan 2022 – Dec 2026

New model or reprise of previous model?

Part D in Provider Risk Contracts

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Include or Exclude Part D?

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Case for Inclusion

- Much smaller component of total cost of care than medical
- Much less negative impact on provider revenues than cutting medical cost, except maybe for hospital owned pharmacies
- Part D may have lower bid MLRs (higher allocation of non-benefit expenses relative to net plan liability than on Part C)
- Provider controls prescribing for the most part

Case for Exclusion

- Provider does not control many of the elements that materially impact Part D utilization and / or cost such as drug prices, drug rebates, formulary, benefit design
- Drug price trends are uncertain, and this is pricing / insurance risk providers should not take
- Less opportunity from risk coding improvement than on Part C
- Part D benefit design significantly limits opportunity for providers to substantially manage the net plan liability (limited ROI)
- Data availability and exchange not always the best (rebates can often be particularly opaque)
- Impact of manufacture rebates can create conflict between financial incentives and clinical best practice
- Plan would still share risk with CMS absent Part D risk sharing
- Regulatory uncertainty and change e.g., the Inflation Reduction Act (IRA)

Inflation Reduction Act Impacts on Risk Sharing

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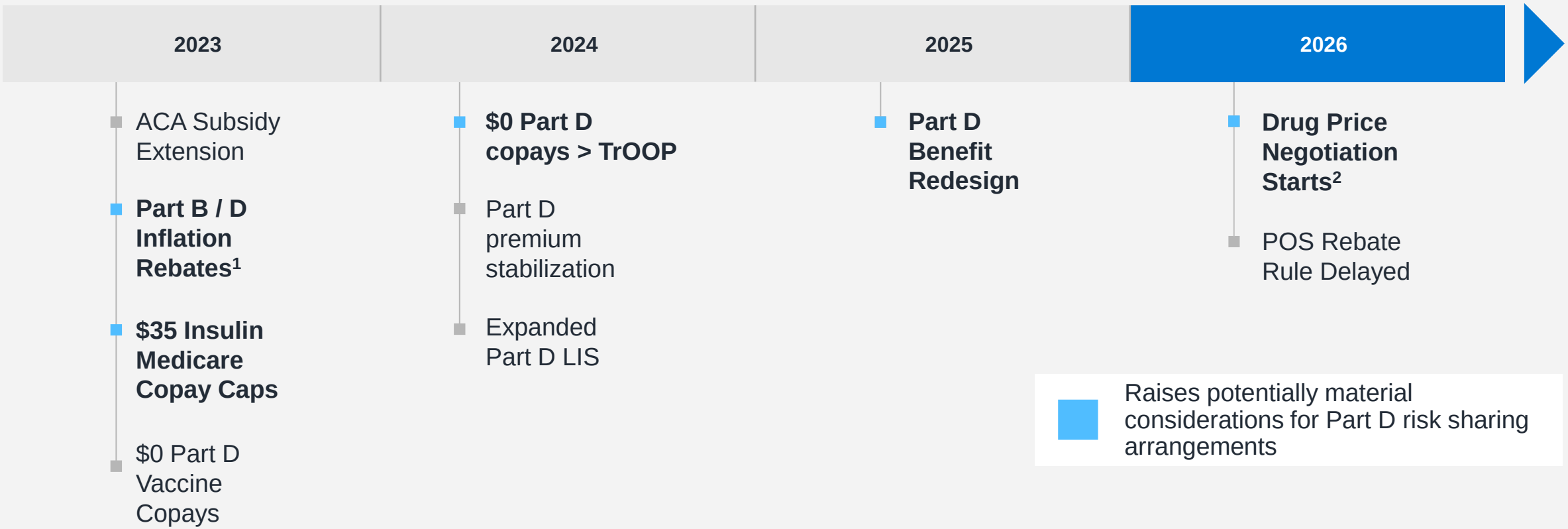
IRA: Major Changes and Timeline*



*For more details, refer to: https://www.milliman.com/-/media/milliman/pdfs/2022-articles/8-17-22_weathering-the-reform-storm.ashx
[1] Part D inflation rebates apply starting Q4 2022, Part B applies starting Q1 2023 [2] Part D drug price negotiation starts for 2026, Part B drug price negotiation starts in 2028

2023 Defined Standard Benefit

		Deductible	Initial Coverage Limit (ICL)	Coverage Gap	Catastrophic
		Gross Drug Cost **$505**	*Gross Drug Cost* **$4,660**	*True Out-of-Pocket* **$7,400**	
Applicable Drugs	**MEMBER**	100%	25%	25%	5%
	PLAN SPONSOR		75%	5%	15%
	PHARMACEUTICAL MANUFACTURER			70%	
	FEDERAL GOVERNMENT				80%
Non-Applicable Drugs		*Same as applicable*		25% 75%	Same as applicable

Part D Benefit Redesign (2025+)

Inflation Reduction Act Part D Benefit*

Members
Pharma Manufacturers
Plan Sponsors
Federal Government

Deductible Phase	Standard Coverage Phase		Post-threshold Phase	
	Non-Applicable	Applicable	Non-Applicable	Applicable
100% Member Coinsurance	75% Plan Liability	65% Plan Liability	60% Plan Liability	60% Plan Liability
		10% Manufacturer Liability		20% Manufacturer Liability
	25% Member Coinsurance	25% Member Coinsurance	40% Federal Reinsurance	20% Federal Reinsurance
Deductible			MOOP ($2,000 in 2025)	

*Manufacturer Discount Program will be phased in through 2031 for income & “specified” / “specified small” manufacturer definitions. Does not apply to drugs selected for price negotiation.

Potential Impact on Part C Value-Based Contracts

I don’t take risk on Part D, so this doesn’t impact me, right?

Not Necessarily!

Part D pricing is interconnected with Part C bids:

- Part C rebate dollars can be used (and often are used) to buy down Part D premiums
- If Part D premiums increase, it puts pressure on Part C benefits and pricing to either create additional rebates or cut back on benefits and/or increase Part C premiums

Aligning Incentives and Opportunities

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Platform for Collaboration

Appropriate transfer of risk only for factors providers can manage

E.g., Focus incentives on Part D Stars metrics such as medication adherence

Protection from insurance risk while incentivizing higher performance

E.g., Upside only on Part D

Mitigate potential adverse impacts of regulatory changes

E.g., Contract review clauses in the event of material regulatory changes

Timely and open sharing of data and information

E.g., Part D rebates, PDE data, bid pricing and benefit strategy

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Q&A

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Thank you

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