Incentives Aligned: Value-based contracting and strategies for Medicare patients

Milliman

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Structuring Medicare Advantage value-based contracts to align incentives

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Overview

From a provider perspective, Medicare Advantage (MA) shared risk agreements often have greater upside potential than commercial agreements

- Opportunity to increase premium payments from CMS is significant advantage
- Revenue per member per month (PMPM) for MA members is significantly higher than commercial members

Appropriately structured MA value-based contracts can be a win-win for both payer and provider

The ideal value-based contract is a platform for collaboration

Risk coding

Provider-payer alignment

- Risk scores are critical to MA plans. It is difficult to have competitive products if coding lags competitors
- Largest potential opportunity to generate savings and may significantly reduce deficit risk
- Provider can enhance CMS revenue and generate savings for the same underlying claims risk
- Most MA plans invest considerable resources to ensure coding information is complete and accurate, and usually work collaboratively with providers to ensure this happens

Moody's Aligned Incentive Rating

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Quality improvement

Provider-payer alignment

- Impact on star rating is also significant to MA plans
- MA plans usually collaborate with providers to improve star ratings
- Providers view it as an additional revenue stream to incent and reward additional quality improvement efforts, as well as contribute toward the additional costs of those efforts

Provider-payer friction

- Quality gates can often diminish alignment of incentives
- Be wary of how Stars cutpoints are set, particularly the timing, and its perception with providers
- Incentive needs to be reflective of current performance and effort required

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Medical management

Provider-payer alignment

- Reducing utilization also improves performance under MA shared risk agreements
- Lower utilization also benefits MA plans, who may be willing to collaborate to achieve savings or make investments in provider infrastructure
  - Care management fees commonly paid to providers

Provider-payer friction

- Impact to provider may be tapered by lost FFS revenues
- May require significant infrastructure investments to achieve and keep savings
  - Data onboarding and population health analytics can be particularly intensive
  - MA plans increasingly reluctant to maintain initial levels of care management / infrastructure payments

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Risk transfer

Provider-payer alignment

- Most agreements have a well structured transition to downside risk, reflecting population size considerations and establishing a track record of success prior to taking on risk
- Appropriate transfer of risk only for factors which providers can impact
- Clear definition of the costs and revenues included and excluded from the MLR calculation

Provider-payer friction

- Major negotiation angst from lack of perceived equity in the balance of risk and reward
  - MLR targets that don’t reflect historic performance or MLR targets based on bid MLRs (remember bid MLR bakes in anticipated coding and medical trend improvement)
- Contracts that don’t address potential adverse impacts of regulatory actions or changes
- Costs included in the MLR calculation which may be ambiguous or black box calculations

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Part D

Provider-payer alignment

- Much less negative impact on provider revenues than cutting medical cost, except for hospital owned pharmacies
- Much smaller component of total cost of care than medical
- Provider controls prescribing for the most part

Provider-payer friction

- 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 uncertain – its pricing/ insurance risk providers should not take
- Regulatory uncertainty
- Data availability and exchange not always the best
- Can be conflict between financial incentives and clinical best practice, thanks to rebates
- Plan would still share risk with CMS absent Part D risk sharing

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Market share growth

Provider-payer alignment

- Risk-based contracts often conduit to volume growth for providers and market growth / new market entry for MA plans
  - Leakage for attributed members often exceeds 50% in MA populations
  - “Flipping” original Medicare members using network providers to MA may be attractive to providers as well as the MA plan
- If not at capacity, potential positive impact to provider often exceeds near-term medical management impact
- Integrated care should enhance medical management outcomes for MA plans

Provider-payer friction

- PPO plans are increasingly more popular but limit opportunity for provider to effectively manage leakage
- MA plans are usually indifferent to leakage

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Alternatives to Medicare Advantage

The Medicare fee-for-service landscape

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What's happening in the Medicare FFS program?

A general environment of uncertainty

Continued downward price pressure

Increased incentives to participate in alternative payment models

Instability related to COVID-19

The Center for Medicare and Medicaid Innovation

Created by the Affordable Care Act

http://innovation.cms.gov

What is an alternative payment model (value-based model)?

A value-based payment model is any model that ties payment to the value of the services provided to members, instead of just the quantity of services (an 'alternative' to fee-for-service).

Examples of value-based (or 'alternative') payment models

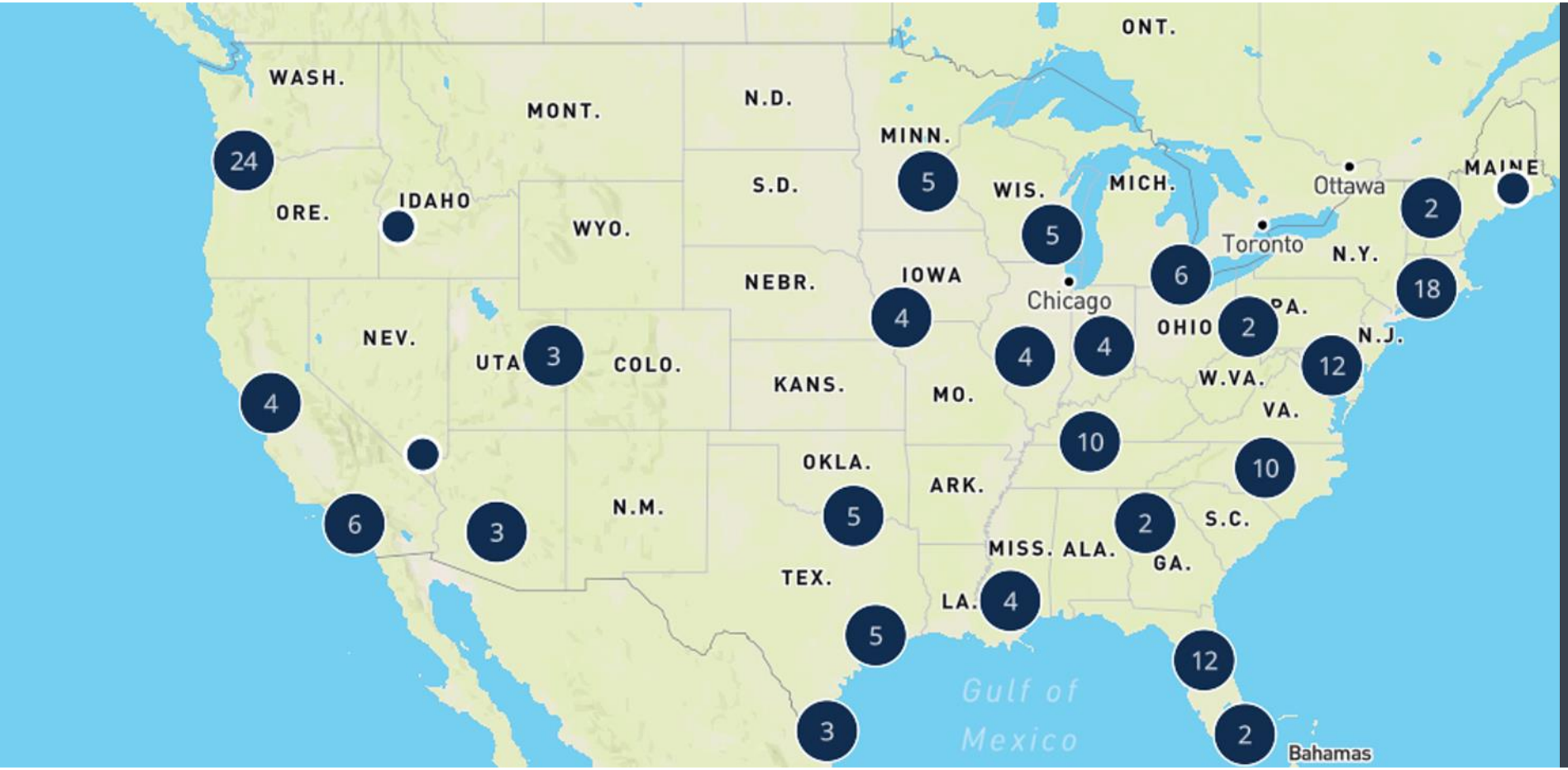
Accountable Care Organizations (ACOs)

Episode-based payments

Pay-for-performance

Patient-centered medical homes

Medicare FFS ACOs are ubiquitous

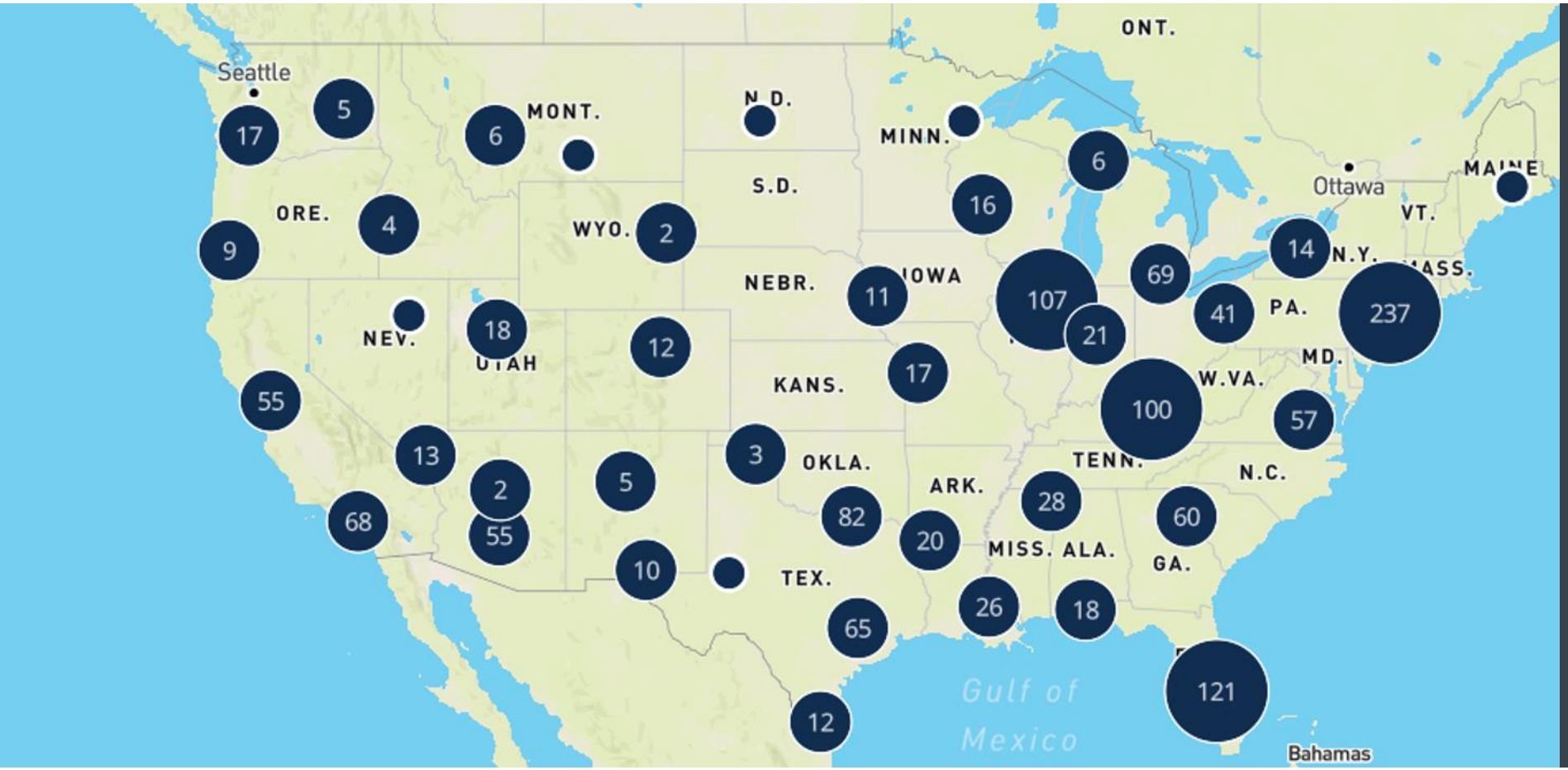


Many types, including:

- Pioneer ACO Model
- Next Generation ACO Model
- Medicare Shared Savings Program
- Direct Contracting
- Specialty ACOs (for example, ESRD)

Source: https://innovation.cms.gov/innovation-models/map#category=accountable-care

Episode-based payment models are even more ubiquitous



Many types, including:

- Bundled Payments for Care Improvement Advanced
- Comprehensive Care for Joint Replacement
- Oncology Care Model

Source: https://innovation.cms.gov/innovation-models/map#category=episode-based-payment-initiatives

Why would providers engage in Medicare FFS APMs?

A variety of reasons – and the motivation may influence the type of APM

1

Maintain a steady source of revenue

From low risk (*Comprehensive Primary Care*) to higher risk (*ACO programs*)

2

Share in savings from efficiencies created

From narrow (*Bundled Payments*) to broad (*ACO programs*)

3

Comply with the Quality Payment Program (MACRA), and get financial bonuses or reduce penalties

Becoming a 'Qualifying APM Participant'

4

Develop capabilities for the future

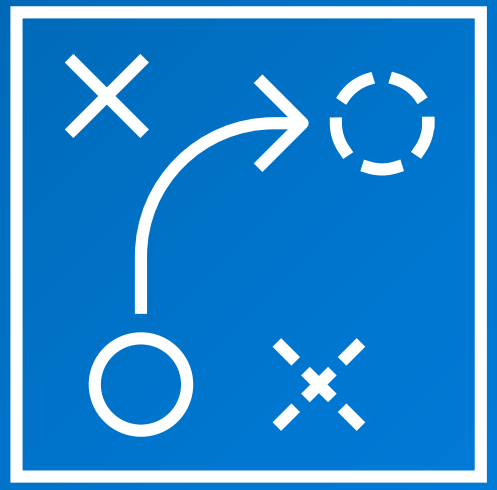
APMs across the spectrum

5

Align financial and quality of care incentives among providers

Often motivated by one of the above

Provider strategies for Medicare populations



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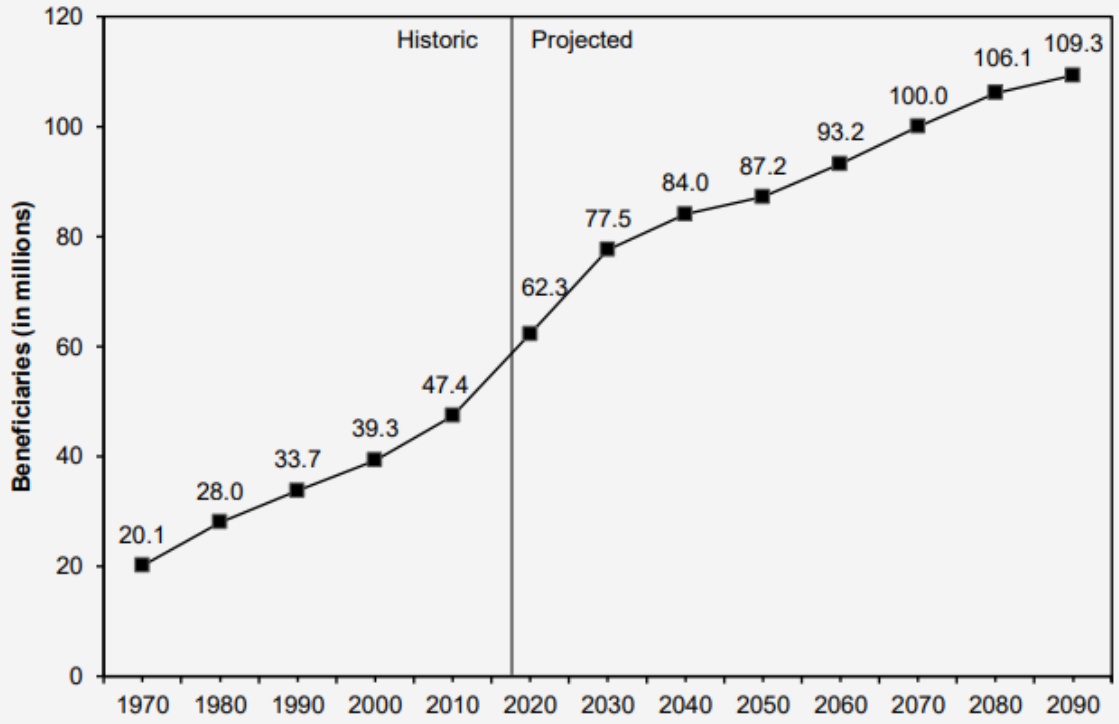
Why develop a Medicare strategy?

- Medicare population – fastest growing segment of the population
- Medicare is an ever-increasing portion of the provider's payer mix
- Medicare Advantage is not a zero-sum game – coordinated efforts increase the size of the pie for all stakeholders
- Many providers are dealing with tight margins, need to capitalize on cost and revenue opportunities
- MACRA – creates new urgency around providers entering into advanced alternative payment models in order to maximize incentive revenue
- Capitalize on enterprise population health efforts



Note: Enrollment numbers are based on Part A enrollment only. Beneficiaries enrolled only in Part B are not included. The potential effects of the COVID-19 pandemic are not reflected in these projections.

Source: The annual report of the Boards of Trustees of the Medicare trust funds 2020.

The most aggressive strategies

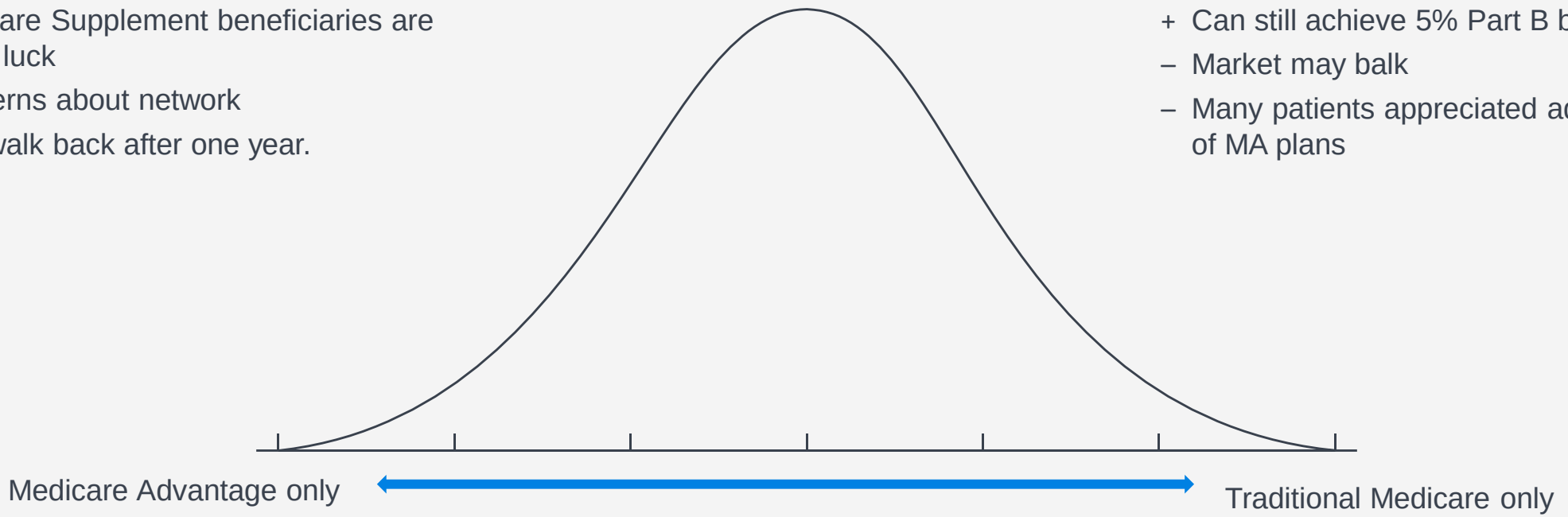
Some providers are going all-in on either Medicare Advantage or traditional Medicare

MA only strategy

+ Revenue potential
+ Simple
– Market may balk
– Medicare Supplement beneficiaries are out of luck
– Concerns about network
– May walk back after one year.

Traditional Medicare only

+ Streamline operations
+ No contracting with payers
+ No denials
+ Can still achieve 5% Part B bonus
– Market may balk
– Many patients appreciated added value of MA plans

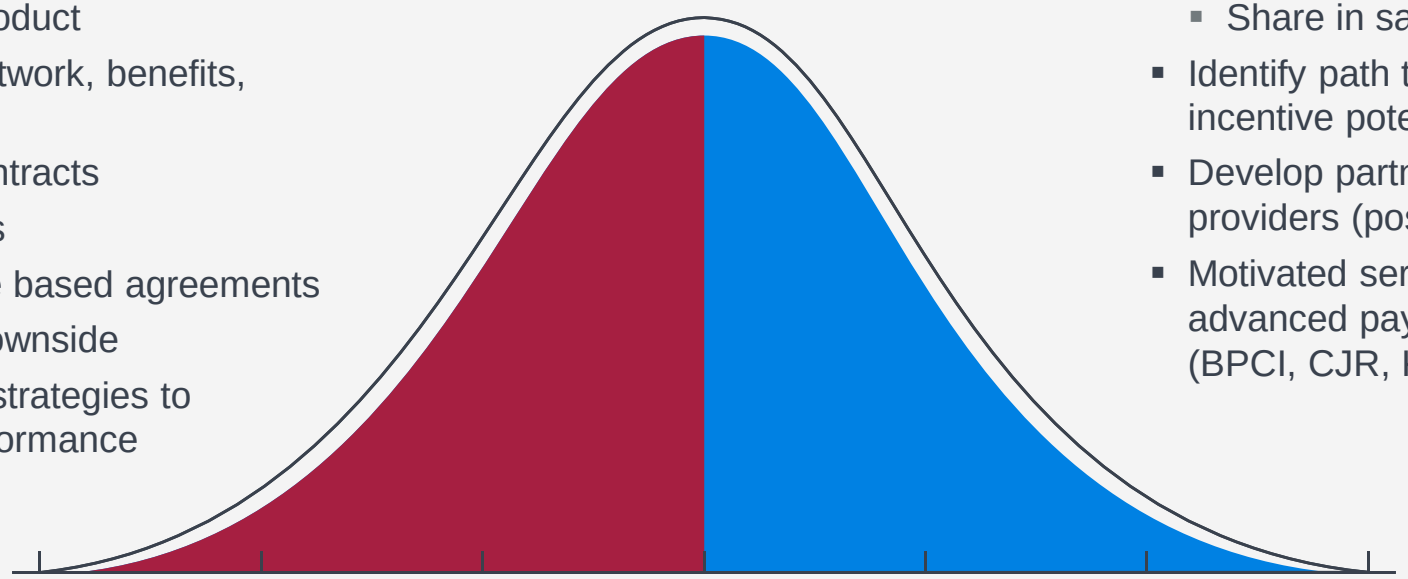


What about everyone else???

Most providers will have robust MA and traditional Medicare populations

Embrace Medicare Advantage

- Consider provider sponsored health plan (partner with MSO, TPA, vendor)
  - Difficult but possible
- Consider co-branded product
  - Provider has say in network, benefits, advertising etc.
- Consider limiting MA contracts
  - Pick preferred partners
- Create meaningful value based agreements
  - Material upside and downside
- Develop organizational strategies to support the product performance



Medicare Advantage only

Traditional Medicare only

Embrace Traditional Medicare

- Consider path to risk (MSSP, Direct Contracting, bundles, etc.)
  - Capitalize on work already being done
  - Share in savings
- Identify path to maximize MACRA incentive potential
- Develop partnerships with other providers (post-acute)
- Motivated service lines can embark on advanced payment models on their own (BPCI, CJR, Kidney Care First)

Common tactics to maximize performance

1

Risk adjustment efforts

- Provider education
- Data conveyance
- Chart reviews

2

Patient attachment / attribution

- Outreach for PCP visits/AWVs
- Clinical care gap outreach
- Home visits

3

Site of service initiatives

- Need to be strategic

4

Care model improvements – length of stay initiatives, discharge planning, post discharge follow-up

5

Specialty pharmacy initiatives (biosimilars, preferred pharmacy)

6

Network management efforts

How can health plans and providers partner?

1

Coordinate efforts

- Outreach works best coming from the doctor's office.

2

Health plans can share data

- Timely, accurate, actionable, consistent
- Patient specific – suspect conditions, care gaps, annual wellness visit lists, etc.
- Transparent costs/financials

3

Fit into each other's processes

- For example, health plan may need to embed resources at provider's office to do chart reviews

4

Streamline information for members and providers

- Socialize supplemental benefits (meals, companionship benefits, transportation, etc.)

5

Simplify financial terms

- Perform settlements timely and provide frequent reporting
- Provide timely quality data
- Financial targets and incentives should be super easy to understand or will likely get lost in translation.

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Thank you

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