Risk Sharing Arrangements in an Ever-Changing MAPD World

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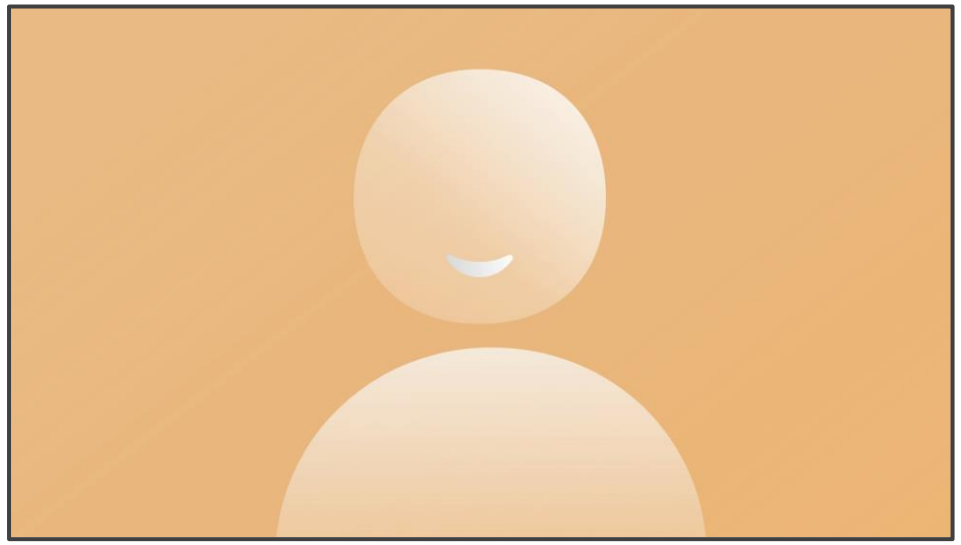
Presenters



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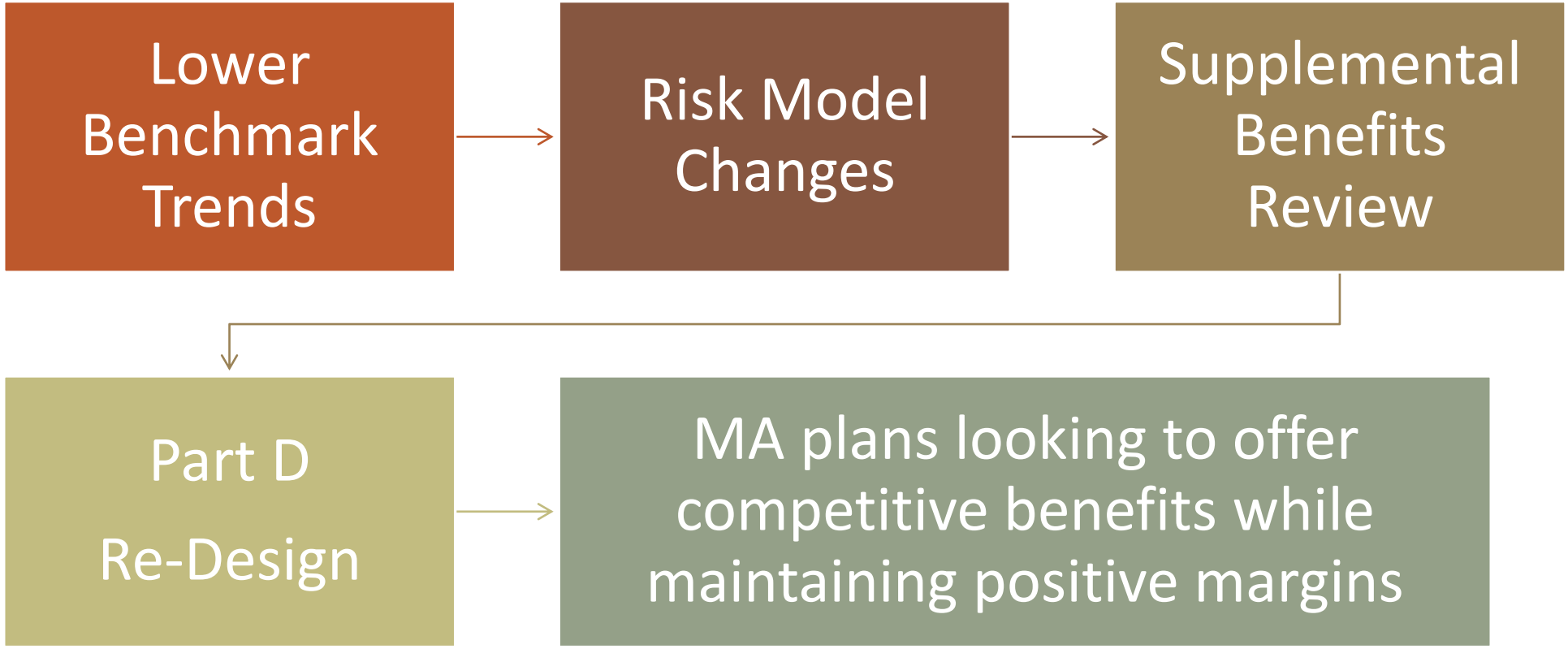
“With the passage of the Inflation Reduction Act in 2022, the MAPD program is due to undergo some of the biggest changes since the addition of Part D. In addition to the significant Part D IRA re-design, the Centers for Medicare and Medicaid Services (CMS) is moving forward with increased scrutiny on plan designs and supplemental plan benefit offerings, including for chronically ill (though SSBCI) and low-income (through VBID) Medicare beneficiaries. In the midst of it all, Medicare Advantage Organizations have put additional focus on maximizing and expanding on existing provider risk sharing arrangements to continue offering value to their members.”

- James Cooper

Overview

High Level Headwinds in Medicare Advantage



MAO Sustainability Efforts

Increased Revenue

- Risk Score Initiatives
- STAR ratings Initiatives
- Provider Incentives and Revenue Sharing

Reduced Claims Costs

- Medical Management
- VBID benefit flexibilities
- Provider Risk Sharing Contracts

Risk Deal Considerations from MAO Perspective

Global Cap

Limited Risk Sharing Arrangements

Part D Risk Sharing – Advantages and Disadvantages

High level of uncertainty heading into 2025

Larger share of claims at risk means greater savings and margin opportunities

CMS changing Understanding of Risk Sharing Revenue

Risk Sharing Allocation

To D or not to D

CMS Actuarial User-Group Guidance

04/10/2024

An MAO contract with a provider group includes provisions to incentivize performance on quality-of-care metrics…Per the MA BPT instructions, any payments earned for achievement of these measures would be considered provider incentive payments and therefore should be included as medical expenses in the MA BPT.

We believe it is not appropriate to allocate any portion of these expenses to the Part D BPT or DIR#10, because they do not have any impact on Part D drug cost and are typically paid to physician groups. Please confirm that this approach is appropriate.

Yes, it is appropriate to allocate the entire amount to the MA BPT

CMS Actuarial User-Group Guidance

04/16/2024

An MAO has a risk-sharing arrangement with medical providers which includes a single settlement based on a target medical loss ratio. The settlement is determined in aggregate, based on all benefit expenses and revenue under Medicare Parts C and D for beneficiaries that use the provider.

Is it appropriate to allocate the entire amount in the MA BPT since the payment is going to medical providers, not pharmacies?

Yes, it is appropriate to allocate the entire amount to the MA BPT

CMS Actuarial User-Group Guidance

04/25/2024

UGC Page 15 of the MA bid instructions states "it is not appropriate to provide risk protection for Part D through MA or vice versa." This section seems to suggest that some portion of costs should be allocated to Part D… Could you clarify what would be considered inappropriate risk protection between Part D and MA?

…regarding a risk-sharing arrangement between a Medicare Advantage Organization and medical providers. **CMS's response is that allocating the entire amount to the MA BPT is an appropriate allocation.** There may be other appropriate allocation methods. In making allocation determinations, plan sponsors should consider the services covered in the risk-sharing arrangement, the providers who provide those services, and the population that receive the services.

The original question used combined revenue … and benefit expense… as factors to calculate the settlement for a medical provider. **These factors determine the amount of the settlement… but do not necessarily determine the allocation of that settlement.**

CMS Actuarial User-Group Guidance

04/10/2024

Page 15 of the MA bid instructions pertaining to risk-sharing arrangements states, “the BPT must reflect the benefit costs in the service categories included in global capitation and risk-sharing contracts.” Please clarify the scope of the service categories included in the risk-sharing contract…

The most recent UGC response from contract year 2015 (cumulative index 1012) stated, “Allocate bonus payments to all MA service categories that are included in the calculation of the bonus.”… given OACT’s developing understanding of these arrangements, the actuary may (i) use the method above, **or (ii) determine that the allocation for your circumstance is more appropriately attributed (and then allocated) to a subset of the service categories…**

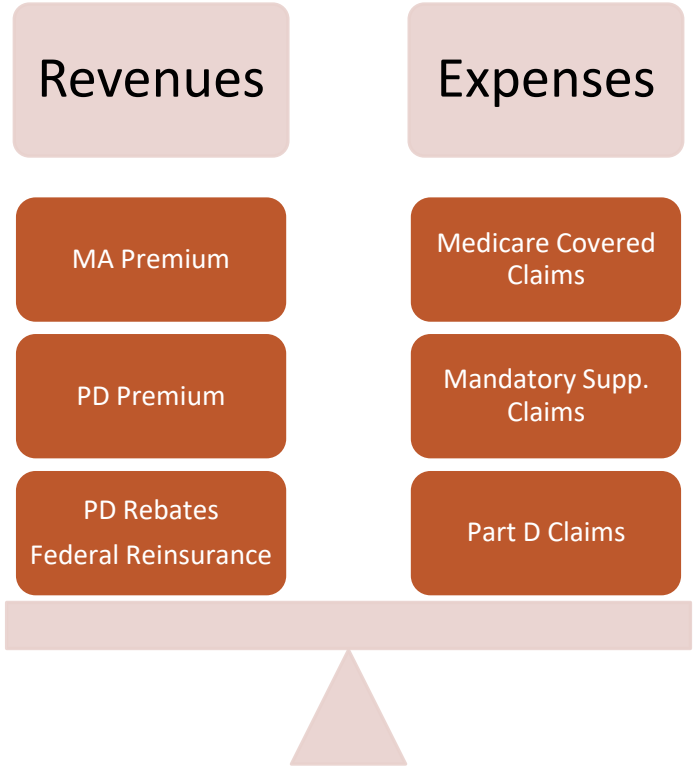
…OACT will continue to study this issue for CY2026.

Provider Risk Deal Prevalence

Historical Performance

How have risk deals in MA grown

Future Innovations



Provider Risk Sharing Overview

Medicare Advantage and Part D Risk Sharing 101

- Medicare Advantage Organization cedes some or all risk to contracted provider groups
- Common Risk Sharing Arrangements:
  - Plan cedes 85% of total MA revenue (including Part C rebates) and provider accepts all MA claims (including mandatory supplemental benefits)
    - Part C rebates used to buy down Part D premiums are generally excluded from revenue
  - Plan cedes 85% of total MAPD revenue and provider accepts all MAPD claims
    - Payers have the reputation of mishandling Part D revenue: uniformly spreading rebates, risk corridors, or federal reinsurance
  - Plan cedes 85% of bid revenue only, and provider accepts Medicare covered Part C claims only

V28 – Is It THAT Bad?

At-risk provider groups have incentives to code better than FFS groups, which is a double-edged sword when it comes to V28

While better coded groups will still have higher revenue than worse coded groups, better coded groups feel a higher revenue loss from the introduction of V28, when compared to other groups only taking FFS payments

VBC provider groups need higher gross margins than FFS groups, because VBC groups spend much more on: medical management, care coordination, and coding

V28 – Mitigation Efforts

Efforts to emphasize new V28 codes, difficult because many of the new codes are rare

Re-doubling efforts to ensure complete documentation of disease burden

Ensuring lives are receiving the appropriate risk model (ex: Dual, ESRD)

Cost Reduction Efforts – CCM, TCM, site of service, medication review

V28 Continued – Bid Mitigation (Hopefully)

Plans are able to control their margins via the annual bid process

Since Provider Groups do not file bids, providers are at the mercy of the payers' bid behavior

If payer's forecast material risk score losses in 2025, several things happen:

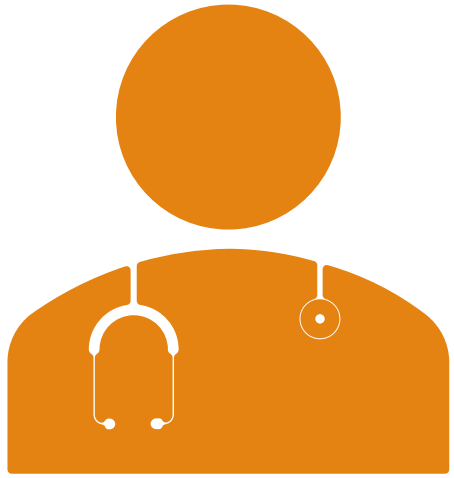
- Bid @1.0 goes up, reducing the revenue loss
- Lower benchmark produces lower rebates, reducing supplemental benefits
- At-risk provider groups enjoy 100% of the claims reduction, but only 85% of revenue reduction

Providers typically prefer lower mandatory supplemental benefits, because they are difficult for providers to control costs

For Flex card benefits or other similar "gift cards" provider groups feel this is a marketing expense that is being passed on to them

Part D Changes From Provider Perspective

- If the provider is accepting Part D risk, then the coding opportunity increases significantly (with the presumed much higher DS)
  - The Part D risk also increases materially, with less protection from federal reinsurance
- Plans not accepting Part D risk are generally happy, because the increased basic and supplemental premiums will need to be bought down with Part C rebates, which would have otherwise gone to mandatory supplemental benefits
    - Since rebates used to buy down Part D premiums will be excluded from revenue, the plan's total revenue will be reduced



Thanks.

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