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A risky prescription: Part D risk sharing arrangements

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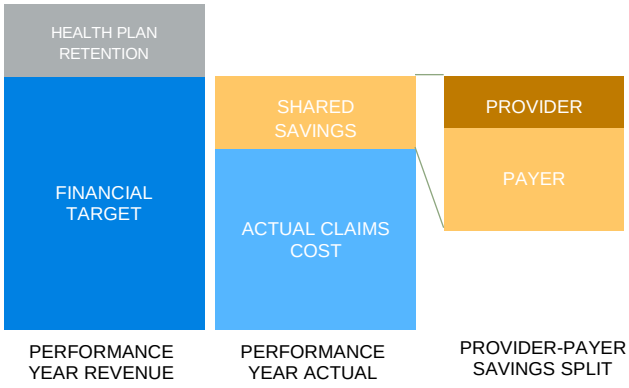
A current trend in payer-provider contracting is the incorporation of shared risk, where the cost of care for a health plan's members is shared by both a traditional payer (typically a health plan) and a physician group, hospital, or other provider organization. This is a departure from typical payer-provider contracting known as fee-for-service (FFS), which involves payers reimbursing providers for each individual service. Risk-sharing contracts have long existed in various forms under the broad umbrella of capitation, but newer approaches such as shared savings (i.e., an upside-only risk arrangement) and shared risk (both upside and downside risk) are becoming increasingly common in all health insurance markets, including Medicare Advantage.

For many shared risk arrangements, a financial "target" for the performance year is defined, often expressed as a percent of revenue or a per member per month (PMPM) claim cost for the members for whom the provider shares risk with the health plan (the at-risk population). Although financial targets differ, common methods include projections from a previous period (e.g., a trend may be applied to the prior year's claim costs), specified medical loss ratios (e.g., claims divided by revenue), or target trends (e.g., the cost trend for the provider's patients may be compared to that of a "control group" population).

In shared risk contracts, providers are typically rewarded based on their ability to "move the needle" on the cost and quality of healthcare services provided to their patients. Therefore, a provider's success under the contract is based on the "savings" generated, by achieving costs that are lower than the financial target.

The figure below provides an illustrative example of a shared risk model. In this model:

- A financial target is set as a percentage of health plan revenue.
- The performance year's actual costs for the population are compared to the target, to determine the aggregate savings or losses.
- Depending on the specific contract terms, a share of the "savings" (the difference between target and actual costs) accrued to the health plan is shared with providers. Under two-sided risk models, providers will share both the savings and the losses.



In Medicare Advantage shared risk arrangements, the financial target for most agreements is based on a percentage of the plan sponsor's Medicare Advantage Part C (medical benefit including supplemental benefits) revenue for the at-risk population. As these contracts become more sophisticated and prevalent, both sides are seeking to expand the set of services covered under them, sometimes including prescription drugs (Part D). In this article, we will discuss some of the most important considerations for Medicare Advantage risk-sharing arrangements that include Part D drug coverage.

Medicare Advantage and Part D

In essence, a Medicare Advantage plan is a complex risk-sharing arrangement between the Centers for Medicare and Medicaid Services (CMS) and Medicare Advantage plan sponsors. Each year, plan sponsors submit bids to CMS for each benefit plan to be offered. These bids become the foundation for the revenue paid to each plan sponsor, which is then financially responsible for its own performance (including cost overruns beyond projections and gains for better-than-expected results).

Because bids are submitted well in advance of a contract year, and because many of the bid-specific components are outside of the control of a plan sponsor or provider (e.g., the CMS benchmark revenue for a given county), it is very important that providers in risk-sharing arrangements understand the Medicare Advantage revenue stream and keep abreast of changes that may impact the providers' financial target[1]. It is also important for providers to have insight into the bid strategies, competitive standing, and financial health of plan sponsors. Changes in a plan sponsor's star rating, membership, benefits, competitive position, and other factors can significantly impact whether the risk-sharing contract's financial target is reasonable or achievable for the provider.

The inclusion of Part D in Medicare Advantage risk-sharing arrangements adds another layer of complexity due to the many Part D revenue components and other factors that differ from Part C risk-sharing.

Overview of Part D revenue[2]

The Part D revenue stream encompasses several components, including the following:

REVENUE COMPONENT	INITIAL PAYER	ULTIMATE PAYER	TRUE-UP	DESCRIPTION
DIRECT SUBSIDY	CMS	CMS	RECONCILED FOR FINAL RISK SCORES	This is the baseline payment from CMS to the plan sponsor, adjusted for members' Part D risk scores. These payments are made prospectively based on estimated risk scores, with a later true-up to account for late submissions of risk score data.
MEMBER PREMIUM	MEMBER	N/A	N/A	Member premium is divided into two parts (basic and supplemental) and determined by the Part D bid submission process. The Basic portion covers the cost of Defined Standard Part D coverage in excess of the direct subsidy. The supplemental portion covers the cost of any benefits above and beyond the Defined Standard plan, such as reduced cost sharing, elimination of the deductible, coverage of the "doughnut hole" or gap, etc. It is common for Part D plans coupled with Medicare Advantage plans to reduce one or both components of the member premium using offsets from the Medicare Advantage payments from CMS.
MEMBER COST SHARING	MEMBER	N/A	N/A	Member cost sharing varies between four phases of the Part D benefit. The Defined Standard Part D benefit has a deductible, a benefit maximum called the initial coverage limit (ICL), a "doughnut hole" or gap before catastrophic coverage starts, and finally catastrophic coverage for members with very high costs. Member cost sharing is determined at the point of sale, and is collected immediately by the pharmacy and paid to the plan.
LOW INCOME COST-SHARING SUBSIDY (LICS)	CMS	CMS	RECONCILED FOR ACTUAL COST SHARING	Low income members have some or all of the member cost sharing paid for by CMS, including prescriptions filled in the coverage gap and catastrophic phases. The plan sponsor is paid a prospective payment to cover reduced cost sharing based on their filed Part D bids. Any difference between the prospective payment and actual LICS amounts paid by the plan sponsor is ultimately reconciled, so that CMS effectively pays for the reduced cost sharing for these members in full.

[1] Moody, S and Hiemenz, K. (January 12, 2017). Providers should do annual check-ups on Medicare Advantage risk-sharing contracts. Milliman White Paper. Retrieved November 14, 2017, from http://us.milliman.com/insight/2017/Providers-should-do-annual-check-ups-on-Medicare-Advantage-risk-sharing-contracts

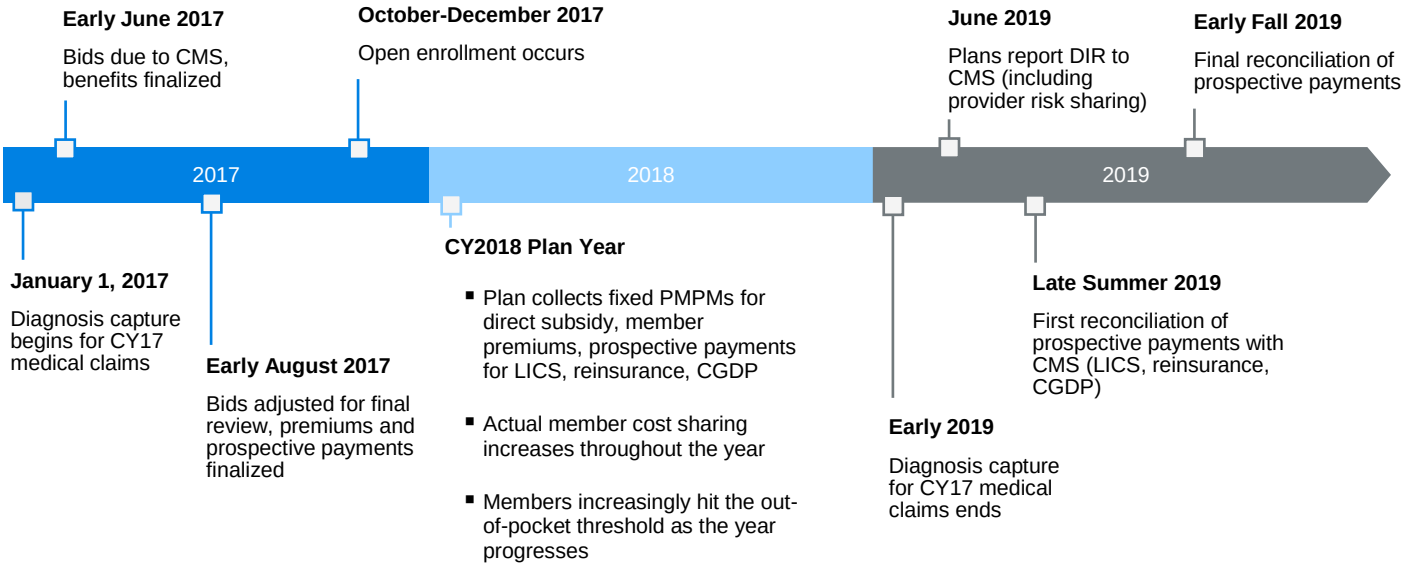
[2] See also MedPac's Part D payment basics primer: http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_17_partd_final86a411adfa9c665e80adff00009edf9c.pdf?sfvrsn=0

REVENUE COMPONENT	INITIAL PAYER	ULTIMATE PAYER	TRUE-UP	DESCRIPTION
LOW INCOME PREMIUM SUBSIDY AMOUNT (LIPSA)	CMS	N/A	N/A	Low income members also have some or all of their monthly premium paid for by CMS. CMS sets a maximum premium subsidy amount by region (low income benchmark or LIB), and the plan sponsor is paid the lesser of the LIB and the basic premium filed in their Part D bids.
FEDERAL REINSURANCE	CMS	CMS	RECONCILED FOR ACTUAL COST SHARING	Once members' out-of-pocket costs reach the catastrophic phase of coverage[3], CMS pays 80% of the net cost of further prescriptions. CMS makes prospective payments to the plan sponsor for this coverage, based on estimates in the filed Part D bids. Any difference between the prospective payment and actual reinsurance amount paid by the plan sponsor is ultimately reconciled, so that CMS ultimately pays the plan sponsor the actual amounts for these claims.
CMS RISK CORRIDOR	N/A	CMS	BASED ON FINAL SUBMITTED RESULTS	Part D has a built-in risk-sharing arrangement between the plan sponsor and CMS. Generally, the plan is responsible for the first 5% of gains or losses, with CMS taking an increasing portion of gains or losses (up to 80%) beyond the first 5% gain or loss. This calculation is based on actual experience compared to the drug cost and administrative cost ratios assumed in the Part D bids. Additionally, the aggregate risk share is calculated for the Part D basic benefit only, and separately for each plan.
COVERAGE GAP DISCOUNT PROGRAM (CGDP)	CMS	MANUFACTURERS	COSTS SHIFTED FROM CMS TO MANUFACTURERS BASED ON ACTUAL GAP COVERAGE	Non-low income members receive a 50% discount on brand-name drugs in the coverage gap. CMS makes a prospective payment to plan sponsors for this coverage based on estimates in the filed bids. Any difference between the prospective payment and actual discounts paid by the plan sponsor at point of sale on behalf of the manufacturers is reconciled in full with pharmaceutical manufacturers. The pharmaceutical manufacturers ultimately pay the plan sponsor the actual amount for these claims, with CMS taking back the prospective payments as the manufacturers pay the plan sponsor for the discounts.
REBATES	MANUFACTURERS	N/A	N/A	Rebates are any price concessions paid by drug manufacturers and pharmacies to pharmacy benefit managers (PBMs) following the sale of a drug. They are often specific to a drug and contingent on that drug's preferred placement on a PBM's formulary. Per CMS guidelines, rebates are passed through from PBM to plan sponsor.

[3] $5,000 in CY 2018.

Timeline

In addition to containing many components, the Part D revenue stream also has a long and complex timeline, as illustrated in the following table:



Complexities of including Part D in risk-sharing arrangements

While many Medicare Advantage plans have risk-sharing arrangements with providers that cover medical (Part C) benefits, the arrangements have historically excluded Part D, partially due to the added complexity this brings to the contracting process. However, the dynamics of risk-sharing arrangements are changing and Medicare Advantage risk-sharing arrangements are increasingly including Part D.

Careful consideration is required to determine which elements should be included, and how they should be incorporated into a shared risk contract. In particular, plan sponsors and providers will need to consider the following factors:

CMS risk corridor: As described previously, the risk-sharing program between CMS and plan sponsors has varying levels of risk sharing (e.g., 0%, 50%, and 80%), depending on the relationship of actual plan costs to bid targets. This calculation is done at the benefit plan level, whereas a risk-sharing arrangement between a plan sponsor and provider may include entire benefit plans or a subset of membership in one or more benefit plans. Plan sponsors and providers will need to consider questions such as the following:

- To what extent is the CMS settlement impacted by providers other than the providers with the risk contract?
- Does the risk-sharing contract include or exclude the CMS risk corridor settlement? If the settlement is included, how does that impact the timing of the determination of shared savings or losses? To what extent does the Part D risk sharing arrangement impact the plan sponsor's CMS risk corridor settlement?
- Does the contract need to stipulate how to allocate settlement amounts in the risk corridor calculation for a subset population?
- How is the gain/loss for a plan allocated across different at-risk populations?

CGDP, LICS, and federal reinsurance subsidies: As indicated in the table above, the CGDP, LICS and federal reinsurance components are "pass through" items that are ultimately reconciled with CMS and the manufacturers. The plan sponsor is therefore not at risk for these revenue components. Providers and plan sponsors will need to consider such questions as the following:

- Should the CGDP, LICS and federal reinsurance subsidies be included in the risk-sharing arrangement?
- If these components are to be included, how will the revenue and claims experience be allocated among the population subsets? For example, if a provider group has a disproportionate share of claimants with high Part D costs, the

results of the provider group-specific reinsurance settlement will be different from the settlement for the overall plan.

DIR reporting: Risk-sharing arrangements require (potentially significant) additional administrative efforts for the plan sponsor's reporting to CMS. If payments to providers are expected to differ from the actual cost of providing the Part D benefit, then the plan sponsor is required to report the difference as Direct and Indirect Remuneration (DIR) in their annual bid developments. Because DIR is shared with the government based on the amount of federal reinsurance, a plan does not retain the full gain or loss from the provider in the bid. This creates challenges in the bid, particularly if the risk-sharing arrangement is based on a percentage of revenue.

The timing of the DIR reporting also presents administrative challenges. The plan sponsor would also need to include the impact of the risk-sharing in the annual DIR reporting, which happens in June following the end of the plan year, as shown in the timeline above. Therefore, the plan sponsor's reporting of DIR and the CMS Part D settlement process may take place before the plan sponsor settlement with providers – which could complicate the plan sponsor's submission of the DIR amounts to CMS.

Interactions with Part C risk-sharing: Some arrangements may incorporate both Part C and Part D under a single contract. Considerations for how Part C risk sharing impacts Part D, include the following:

- When setting the targets for risk-sharing, it may not be appropriate to use the same loss ratio target for Parts C and D. For example, populations may have high pharmacy costs but low medical costs, or vice versa, and the loss ratios may differ for the two components. This situation may be exacerbated by including or excluding certain revenue components (e.g., federal reinsurance or LICS) as part of the loss ratio calculation.
- Is the settlement of a risk-sharing contract done in aggregate for Part C and Part D combined, or are they settled separately?
- If the contract is settled in aggregate, how is the settlement allocated between both parts? How does that allocation impact the existing Part D risk-sharing mechanism with CMS?

Manufacturer and pharmacy rebates: Manufacturer and pharmacy rebate revenue presents many complicating factors because unlike other revenue streams, rebates are not tracked at the member level by CMS. Additionally, rebate revenue can vary dramatically by plan sponsor. Providers should consider the following questions regarding rebates:

- Have rebates been included in calculation of the target amount? Are they treated as claim offsets or as revenue?
- If rebates are considered revenue, are rebates shared with providers at the same percentage as other revenue or passed through to providers?
- Given that rebates are often paid in aggregate (across contracts or plans), how will rebates be allocated to members covered in the risk-sharing arrangement?
- Rebates from both manufacturers and pharmacies can be subject to separate risk-sharing arrangements (such as those based on volume or a generic dispensing rate). In what order are the various risk-sharing contracts settled, and do any of them present conflicting interests? For example, a manufacturer may give a higher rebate for a larger volume of a more expensive drug. Will the shared risk arrangement with the provider take into account these larger rebates?
- How will the portion of rebates shared with the federal government be applied to the provider's share of rebates?

Differences between filed bids and financial target: The appropriate financial target for a risk-sharing arrangement may differ from the filed bids. Providers should consider the following questions when settling on the financial target:

- How will sequestration be handled? Payments from CMS (including the Part C capitation, Part D direct subsidy, and rebates allocated from Part C to buy down the Part D premium) are reduced for sequestration.
- Will the Health Insurer Provider Fee be included as a revenue offset? On what year will the insurer fee be based?
- How will multiple risk-sharing arrangements for different provider groups within the same plan interact and impact the financial target for each provider group?

A prescription for success

Given the complicating factors listed above, why would plan sponsors and providers want to engage in a Part D risk-sharing arrangement? For the same reason as any other risk-sharing contract: providers can influence member behavior, and risk-sharing aligns cost and quality incentives between plan sponsors and providers. Further incentive is provided by the recent MACRA legislation, which encourages providers to engage in risk-sharing arrangements with private payers, including Medicare Advantage plan sponsors.[4]

With the ongoing rise in the proportion of healthcare costs attributable to pharmacy services, many Medicare Advantage plan sponsors see risk-sharing as a means of mitigating rising

[4] Kunkel, C. et al (February 21, 2017). MACRA and Medicare Advantage plans: Synergies and potential opportunities. Milliman White Paper. Retrieved November 14, 2017, from http://www.milliman.com/insight/2017/MACRA-and-Medicare-Advantage-plans-Synergies-and-potential-opportunities

pharmacy claim costs. Sharing the risk on these claims rewards providers who prescribe thoughtfully by allowing them to also benefit directly from improved outcomes.

Nevertheless, there are numerous conceptual and technical issues that participants in a risk-sharing arrangement that includes Part D will need to consider. Conceptually, Part D is already a risk-sharing arrangement between the plan sponsor and CMS, so the plan sponsor's risk is already lessened via the risk corridor. Further, even as pharmacy costs increase, the total contribution to the cost of care is still much lower than for medical services. From a technical perspective, the administrative complexity of accounting for the many moving parts in the Part D program should not be underestimated. Equitable risk-sharing arrangements that include Part D can be constructed, but both plan sponsors and providers must fully understand how each revenue stream will impact their arrangements. All parties should enter arrangements fully aware of their respective responsibilities, both financial and administrative.

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