Session 186: Evolving Value Based Programs and the Impacts on Provider Analytics & Reporting

2019 ANNUAL MEETING & EXHIBIT

Evolving Value Based Programs & Impacts on Provider Analytics

JOSHUA MCPHEE, ASA, MAAA

JEREMIAH REUTER, ASA, MAAA, MS

PATRICK COLBERT, FSA, MAAA

October 30, 2019

SOCIETY OF ACTUARIES®

SOCIETY OF ACTUARIES
Antitrust Compliance Guidelines

Active participation in the Society of Actuaries is an important aspect of membership. While the positive contributions of professional societies and associations are well-recognized and encouraged, association activities are vulnerable to close antitrust scrutiny. By their very nature, associations bring together industry competitors and other market participants.

The United States antitrust laws aim to protect consumers by preserving the free economy and prohibiting anti-competitive business practices; they promote competition. There are both state and federal antitrust laws, although state antitrust laws closely follow federal law. The Sherman Act, is the primary U.S. antitrust law pertaining to association activities. The Sherman Act prohibits every contract, combination or conspiracy that places an unreasonable restraint on trade. There are, however, some activities that are illegal under all circumstances, such as price fixing, market allocation and collusive bidding.

There is no safe harbor under the antitrust law for professional association activities. Therefore, association meeting participants should refrain from discussing any activity that could potentially be construed as having an anti-competitive effect. Discussions relating to product or service pricing, market allocations, membership restrictions, product standardization or other conditions on trade could arguably be perceived as a restraint on trade and may expose the SOA and its members to antitrust enforcement procedures.

While participating in all SOA in person meetings, webinars, teleconferences or side discussions, you should avoid discussing competitively sensitive information with competitors and follow these guidelines:

- Do not discuss prices for services or products or anything else that might affect prices
- Do not discuss what you or other entities plan to do in a particular geographic or product markets or with particular customers.
- Do not speak on behalf of the SOA or any of its committees unless specifically authorized to do so.
- Do leave a meeting where any anticompetitive pricing or market allocation discussion occurs.
- Do alert SOA staff and/or legal counsel to any concerning discussions
- Do consult with legal counsel before raising any matter or making a statement that may involve competitively sensitive information.

Adherence to these guidelines involves not only avoidance of antitrust violations, but avoidance of behavior which might be so construed. These guidelines only provide an overview of prohibited activities. SOA legal counsel reviews meeting agenda and materials as deemed appropriate and any discussion that departs from the formal agenda should be scrutinized carefully. Antitrust compliance is everyone's responsibility; however, please seek legal counsel if you have any questions or concerns.

Presentation Disclaimer

Presentations are intended for educational purposes only and do not replace independent professional judgment. Statements of fact and opinions expressed are those of the participants individually and, unless expressly stated to the contrary, are not the opinion or position of the Society of Actuaries, its cosponsors or its committees. The Society of Actuaries does not endorse or approve, and assumes no responsibility for, the content, accuracy or completeness of the information presented. Attendees should note that the sessions are audio-recorded and may be published in various media, including print, audio and video formats without further notice.

Introductions

Joshua McPhee is a Director with Evolent Health in Arlington, VA. At Evolent, Josh leads a team of actuaries helping provider organizations understand and succeed in value-based care arrangements. Recently, his focus has been on innovative, Medicare FFS models such as the Medicare Shared Savings Program and NGACO.

Previously, Josh worked as an actuary for a retiree benefits exchange.

Joshua is a member of the American Academy of Actuaries and an Associate of the Society of Actuaries. He graduated from the University of Toronto majoring in Actuarial Science and Statistics.

Joshua McPhee ASA, MAAA
Director, Actuarial Services

Evolent Health

jmcphee@evolenthealth.com

Jeremiah Reuter, ASA, MAAA, MS
Vice President
Provider Actuarial Services

Optum

M 262-352-7548
T 303-714-3873

Jeremiah.Reuter@Optum.com

Jeremiah is an actuary and vice president in the Provider Actuarial Services team at Optum. He has 19 years of experience in the health care actuarial field. His primary focus has been in the area of U.S. healthcare consulting for providers. He has worked with health care providers, health insurance plans, ACOs, Medicare Advantage plans, CMS and state and national regulatory agencies. Jeremiah also has an extensive background in international healthcare, having spent three years working with the National Health Service (NHS) in the UK as well as projects in Canada and Columbia.

Jeremiah currently advises provider organizations in identifying and managing risk, frequently serving in the role of Chief Actuary ACOs, CINs and provider risk-bearing entities. Jeremiah is also currently consulting with health plans and health care providers on the impact value based arrangements as they continue to expand their risk portfolios initiated by the Affordable Care Act (ACA) legislation.

He is a member of the American Academy of Actuaries and an Associate of the Society of Actuaries. Jeremiah graduated magna cum laude from Mayville State University with a double major in mathematics and physical science. He also holds a Master of Science degree in mathematics from the University of North Dakota.

Pat Colbert has over 12 years of actuarial experience that includes working with health plans and provider organizations.

Pat has been with Evolent Health since 2015. Pat is currently a Managing Director focused on supporting Medicaid MCOs in Florida and Texas. Pat also oversees actuarial services for a variety of ACOs participating in MSSP, NGACO, and private payer partnerships.

Before joining Evolent, Pat worked as an Analytic Manager focused on clinical program analytics at Tufts Health Plan and previously worked in the retirement line of business at Towers Watson.

Patrick Colbert, FSA, MAAA
Managing Director, Actuarial Services

Evolent Health

pcolbert@evolenthealth.com

Goals of Presentation

- Compare the strengths and weaknesses of various implementations of value-based care in a Medicare FFS context

- Identify key risks provider groups face when participating in value-based care and how these risks differ based on group characteristics

- To understand the analytics required for a provider to be successful under ACO and other value-based contracts

The Evolution of Value-Based Care

What is Value-Based Care?

Value-Based Care (VBC) aka Value-Based Payment (VBP) is part of a larger strategy to reform how we pay for health care

- Value-based programs support the triple aim:
  - Better care for individuals
  - Better health for populations
  - Lower cost

VBP focus on outcomes, not services provided

- Fee for **value** instead of fee for **service**

Quality is a component of provider reimbursement

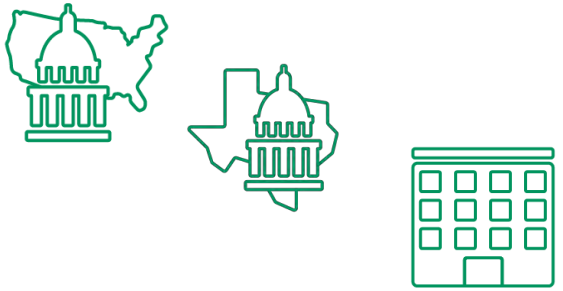
Models focus on **total cost of care** for a group or patients and/or cost for an episode (Bundled Payments, Oncology Care Model)

Designs emphasize evidence-based medicine & medically necessary spend

Source: https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/value-based-programs.html

VBP is not new, just continually evolving

- VBP is inclusive of federal, state, and private programs like:
  - Pay for Performance contracts
  - Hospital Readmission Reduction Programs
  - Fraud & Abuse enforcement activities
  - Quality payment programs



- Affordable Care Act helped advance newer forms of VBP
  - Accountable care organizations (ACOs)
  - Patient centered medical homes (PCMHs)
  - ACA established Center for Medicare & Medicaid Innovation (CMMI)
    - Established “for the purpose of testing innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care for those individuals who receive Medicare, Medicaid, or CHIP benefits”

https://innovation.cms.gov/About/

Drivers of Evolution

- CMS need to ensure long-term solvency of Medicare trust fund
  - Value-based care reallocates payment to highest **value** services
  - Reducing prices would not change incentives creating concern about not achieving long-term goals

- MACRA legislation effectively made increased VBP mandatory for most providers
  - Join Advanced Alternative Payment Model (APM)
  - or
  - Compete with peers through Merit-based Incentive Payment System (MIPS)

- MSSP Pathways to Success
  - Limits time in upside-only arrangements forcing move to two-sided arrangement
  - This challenges provider community to get more serious about participation in VBP

Themes in Evolution

More risk shifting to providers

Cascading across payers and lines of business

More complex models

- Models continue to evolve to address shortcomings of older arrangements
- Shift from historical comparisons or market comparisons to combinations
- Modifications to align incentives to address concerns of both payers and providers
- Models adjusted to keep efficient and inefficient systems in the game

Higher need for data sharing and analytics

- Limited levers require more/better data sharing and improved analytics to determine opportunities for savings

Movement away from Care Coordination Fees

- When fees do exist, they are increasingly put at risk / taken out of shared savings

Increased focus on including pharmacy costs

Shifting Risk to Providers

Payers have many motivations to offload risk

- RBC considerations
- De-risking the bottom line
- Predictable cash-flows
- Reduced medical expense to increase profit or gain competitive advantage

Providers can benefit from risk shift in VBP

- Predictable cash-flows
- (Theoretically) streamlined admin costs
- Feeling of contributing to the solution of health care cost crisis

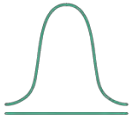
Providers are not experienced risk managers

- Limited appreciation for insurance risk and volatility

Themes in Model Design

Individual stop-loss

- Payers have been pushing to increase cap
- Providers concerned a few complex cases can erode value generated



Aggregate risk

- What level of caps on savings and losses are needed?

What portion of risk/reward is appropriate?

- Symmetrical upside/downside?
- Increasing risk over time?

Should target be based on historical spend or market/regional costs?

How often will targets be reset or rebased?

Model Standardization

- Payers often push standard deals across broad provider networks
  - When successful, this offers administrative savings and can create an appearance of fairness within the network
- Providers often claim unique circumstances warrant a custom model
  - Some are perceived differences, others create varying potential for success
    - System connections – IPA vs Health System

Panel sizes / consistency

    - Service offerings / specialty care

Risk profile

    - Demographics – Adults vs Pediatrics

Geography

  - Providers face different models across payers

Provider Challenges with Standardization

A single model will have difficulty providing the right incentives based on:

Efficiency

- Beating historical spend works for inefficient providers
  - Does it make sense to reward inefficient providers for improvement if they're still inefficient?
- Efficient providers face challenges reducing spend and prefer to compete against market
  - Will rewarding already efficient providers do enough to reduce total cost of care?

Scale

- Large integrated provider groups control significant share of total cost of care
- Small primary care only organizations face challenges affecting specialist & facility spend

Structure

- Systems with ties to facilities face conflicts on reducing revenue to generate value
- Connection to facility does provide financial backing in order to take on risk
- Whether or not to include specialist in ACOs is a highly debated topic

Difficulties in Medicare FFS Context

- Provisions of Medicare limit levers to reduce spend and generate value

Open network

- Medicare FFS is committed to beneficiary choice so risk-bearing providers cannot dictate which providers a beneficiary can or even *should* see

No utilization management

- ACOs - even those taking full risk- cannot deny services to a Medicare beneficiary

No control over payment

- This is changing somewhat with direct contracting

No benefit design

- Providers cannot alter plan design to address issues and generate value

- Other common concerns:

Foundation in beating historical spend with limited historical data

- Need transparency into detail behind what was wrong before in order to identify opportunities

Timing of payment

- ACOs begin to spend money several months before a performance year, but don't get paid until 9 months after the performance year

Selection Issues

- Market for VBP models can create selection issues that make aggregate statistics on model performance misleading
  - Do ACOs perform better over time or do poorly performing ACOs leave the program?
  - Options and ability to jump from option to option can amplify selection issues
- Sophisticated providers choose a model to receive the best compensation which may not derive most value for the payer
  - Particularly challenging in a world where VBP is still primarily voluntary
  - Many payers are working to address this by forcing some level of VBP
- One-size fits all approaches that don't address critical differences lead to a bad mix of participating providers
  - Lack of regional component and use of national trend in MSSP created challenges for efficient ACOs
  - Limits on risk adjustment force ACOs with acuity shifts out of the program
  - Same risk exposure forces those with smaller balance sheets to opt out

Improvement in Recent Models

- "Preferred Provider" concept helps bring specialists into the fold
  - This may help less integrated systems affect a larger portion of TME

- Expanded benefits
  - Two-sided models allow providers to tweak plan coverage
    - SNF Waiver
    - Telehealth Waiver
    - Beneficiary Incentives

- Adjustments to even playing field and improve mix of participants
  - Efficiency is being acknowledged as a differentiator
  - Risk limits adjusted for high-revenue vs low-revenue

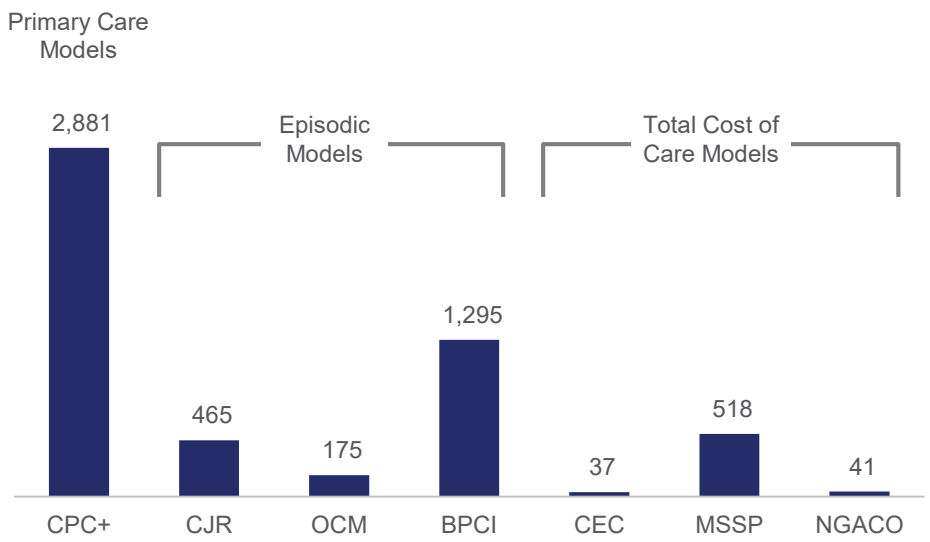
Value-Based Care: Medicare Lens

How are Medicare providers participating in Value-Based Care

Currently a **broad spectrum** of value-based care programs in the Medicare FFS environment – differences exist in both program characteristics and level of risk

Current APM Participants by Model

Participants, varies by program (i.e. practice, ACO)



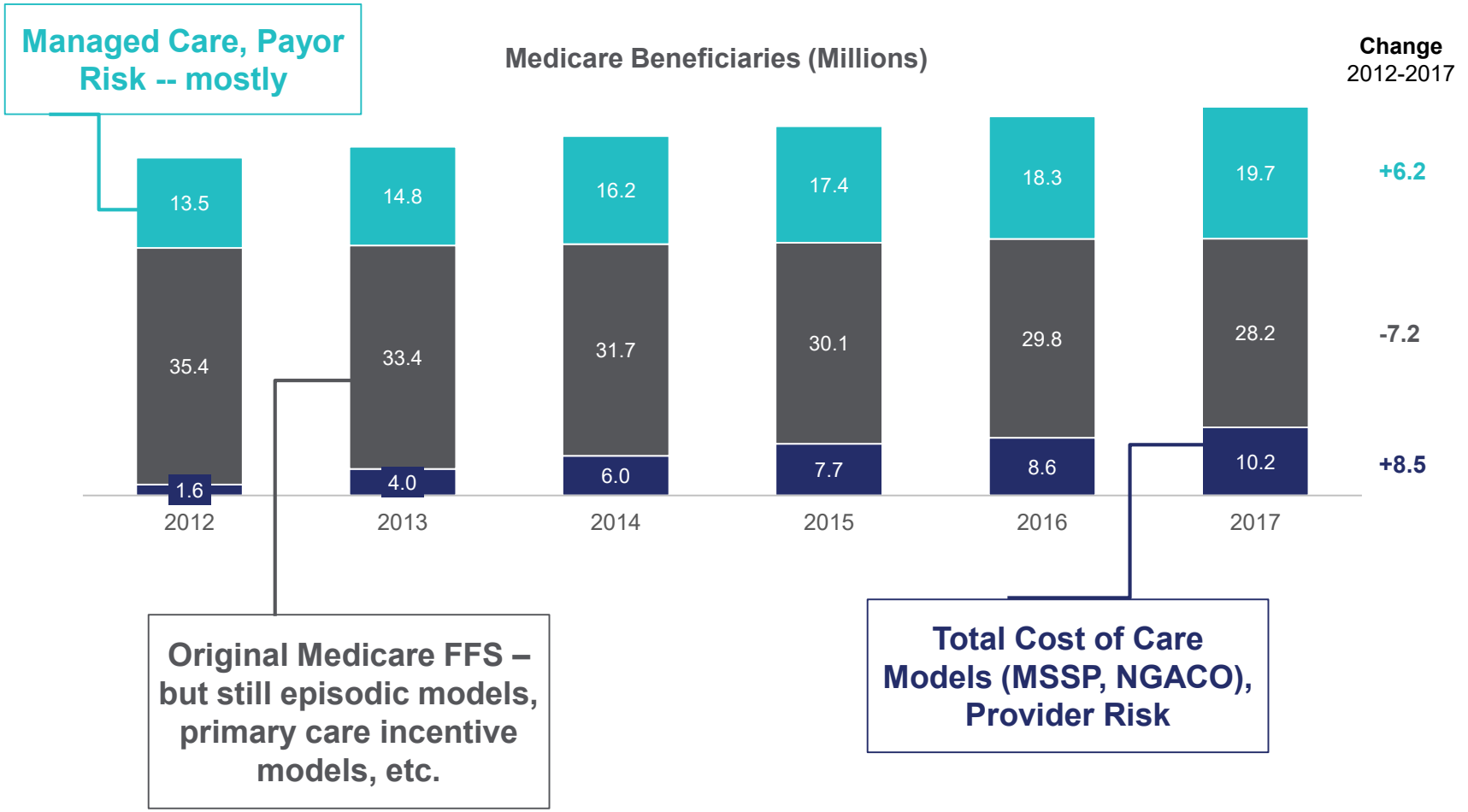
Change from 2017 to 2018

▲15K Clinicians participating in MIPS through APMs

▲80K Clinicians participating in Advanced APMs

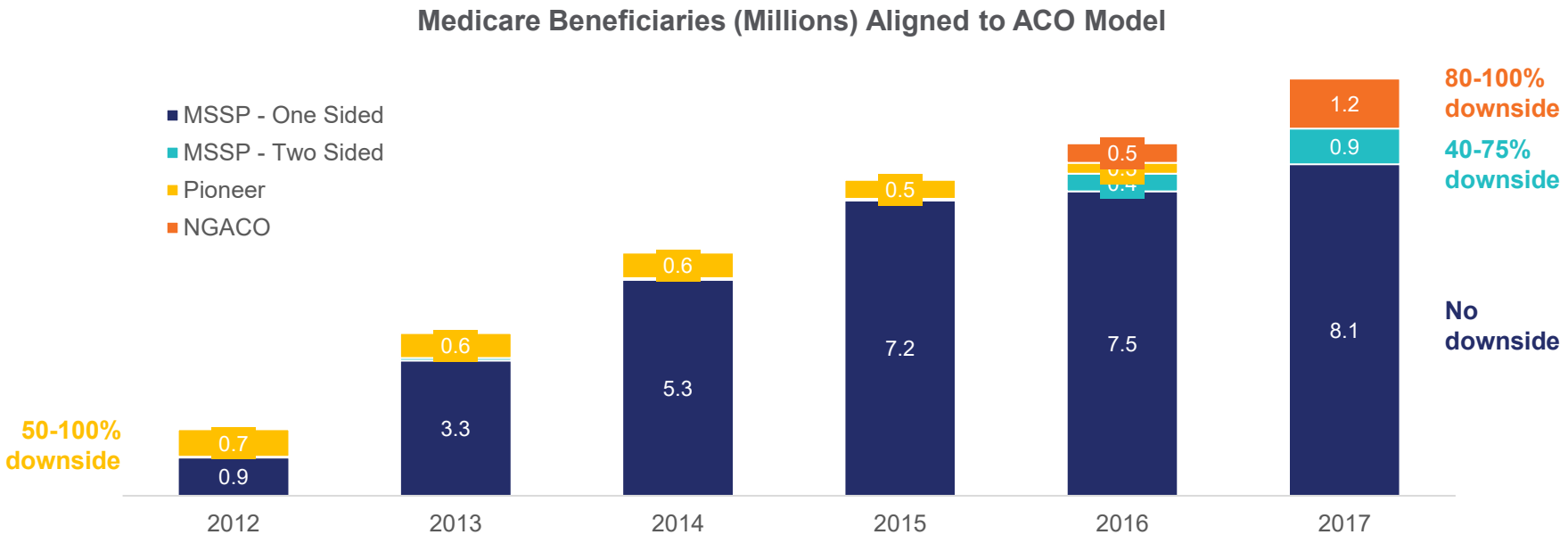
Source: CMS Quality Payment Program Participation in 2018: Results At-A-Glance

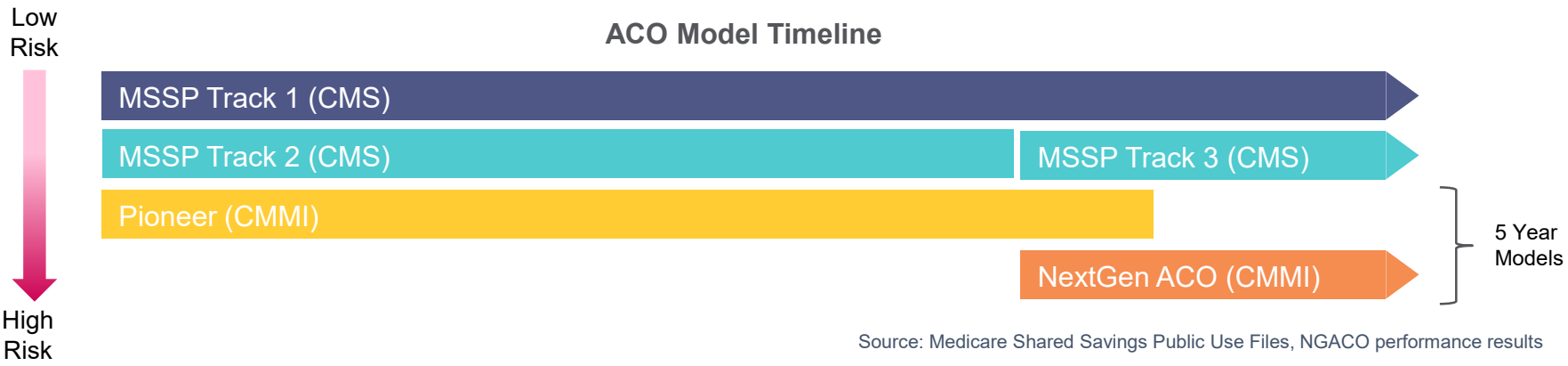
Participation in Medicare ACOs has increased over time



Source: Medicare Shared Savings Public Use Files, NGACO and Pioneer Performance Results, CY2020 Medicare Advantage Final Call Letter

Despite growth in ACO formation, moving to risk hasn't happened as quickly

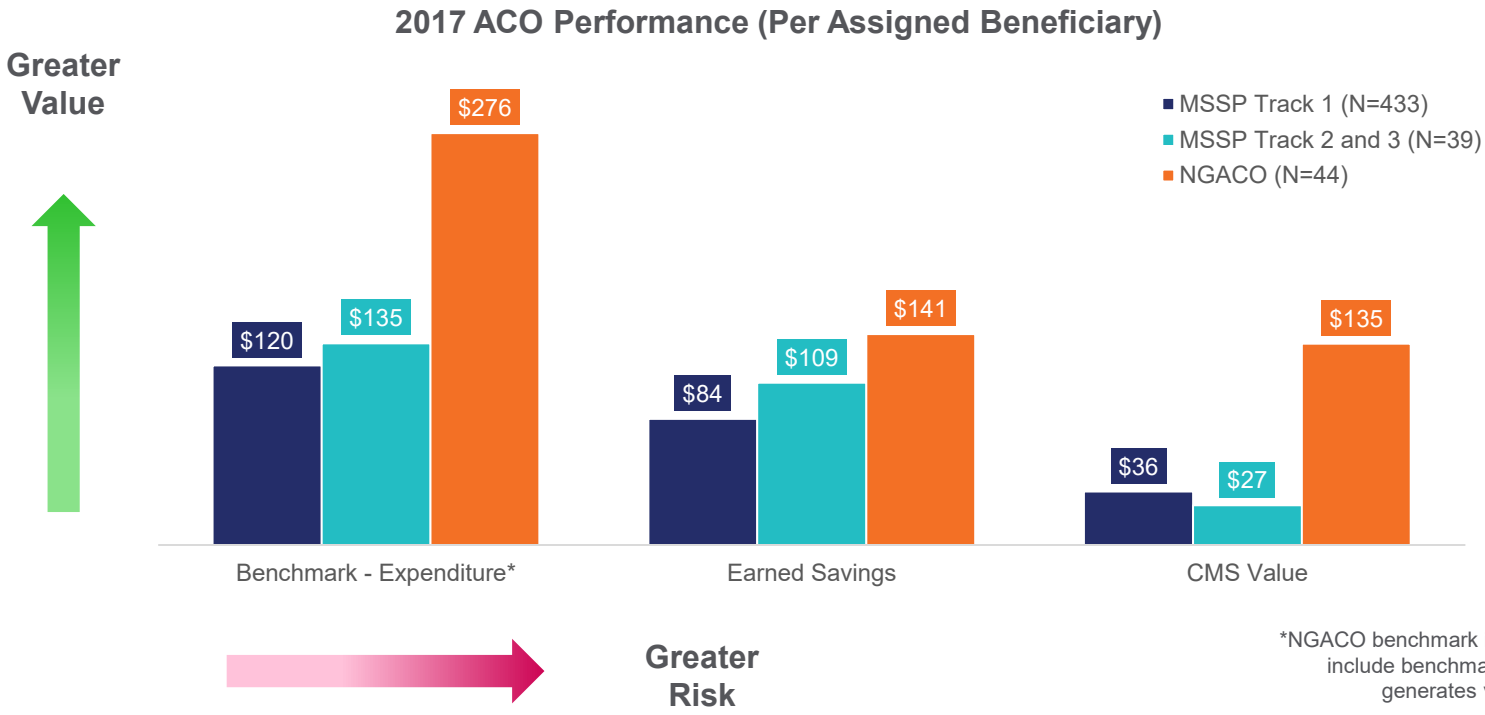




Source: Medicare Shared Savings Public Use Files, NGACO performance results

evolent HEALTH

In 2017, ACO models generated value for both providers and Medicare – more for 2-sided models



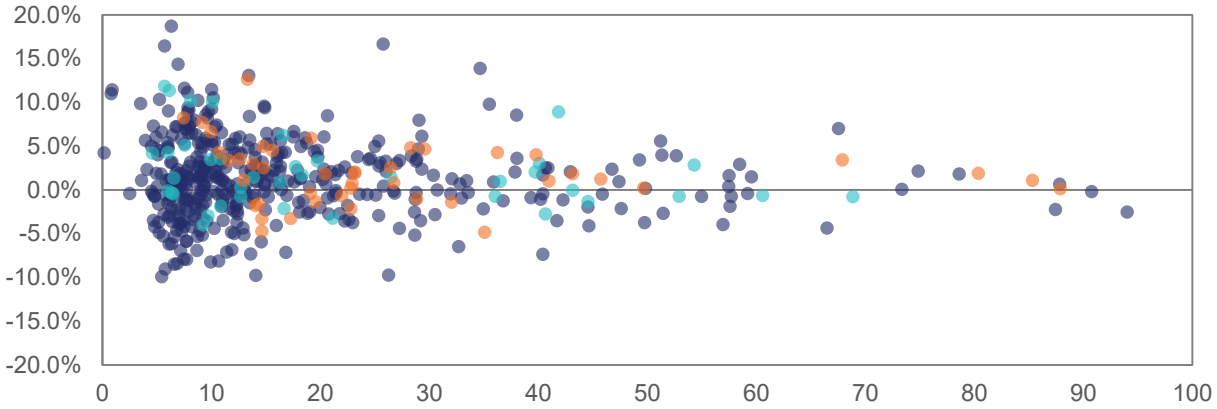
*NGACO benchmark is adjusted here to include benchmark discount, which generates value for Medicare

On average, ACOs in higher risk models generated more savings per beneficiary in 2017, potentially due to high-performing organizations favoring these models

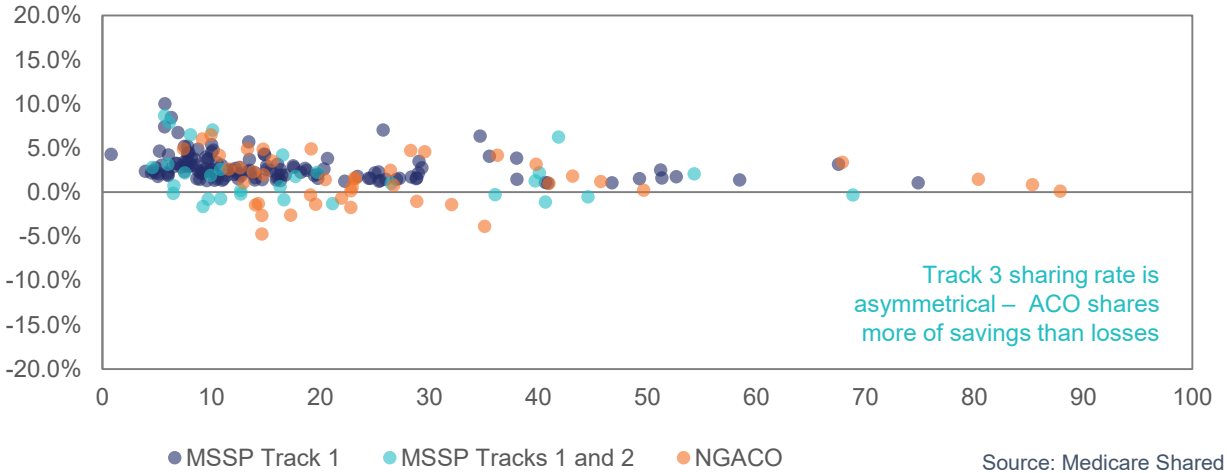
Source: Medicare Shared Savings Public Use Files, NGACO performance results

ACOs take on considerable financial risk in 2-sided total cost of care models

2017 **Benchmark – Expenditure** (% of Benchmark) by Number of Attributed Beneficiaries (000's)



2017 **Earned Savings** (% of Benchmark) by Number of Attributed Beneficiaries (000's)



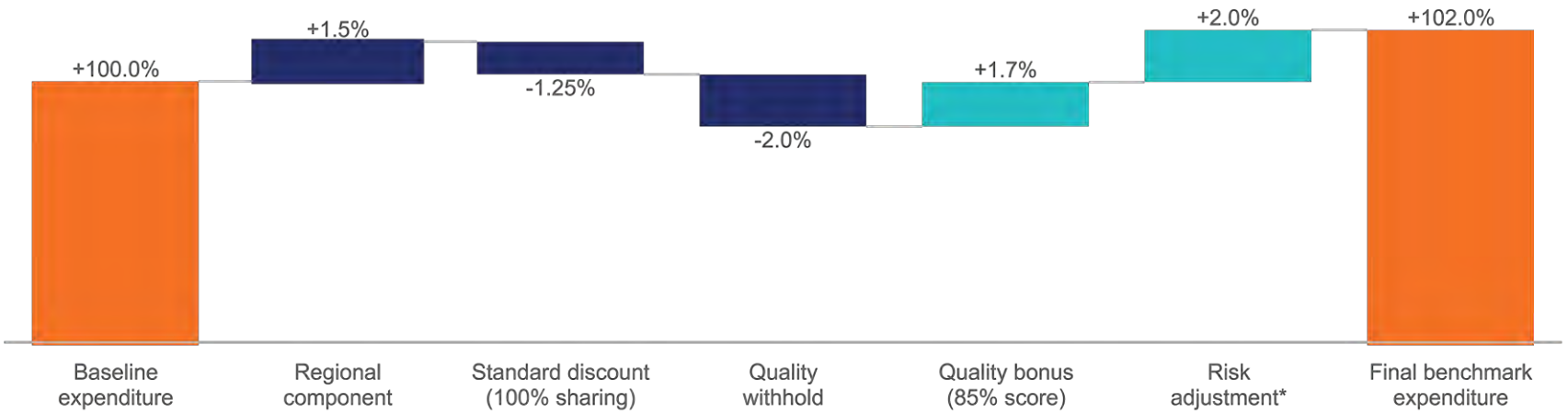
In 2017, **39%** of ACOs experienced gross losses, **27%** experienced gross losses exceeding 1% of benchmark and **6%** experienced gross losses exceeding 5% of benchmark.

Taking greater accountability for beneficiaries requires provider organizations to develop new capabilities.

Source: Medicare Shared Savings Public Use Files, NGACO performance results

In addition to operational considerations, understanding the benchmark is key for providers

Example Benchmark: 2019 NGACO Program



Baseline Expenditure	Regional Component	Discount	Quality	Risk Adjustment
• How many baseline years? • What is the weighting across baseline years? • Regional, national or other trend? • Does trend capture unit cost, utilization or both? • How are catastrophic claims handled?	• How is region defined? • Is the ACO rewarded for local efficiency or national efficiency? • Is the regional adjustment capped? • Is inefficiency treated differently from efficiency?	• Is a discount applied to benchmark? • What is the trade-off between discount and sharing rate? (i.e. is sharing rate high enough to offset lower benchmark)	• Does quality affect the benchmark? • If quality doesn't affect benchmark, does it affect the sharing rate?	• Is the benchmark adjusted for changes in risk from baseline? • Is a coding intensity adjustment applied to risk scores? • Is benchmark adjustment capped? • What risk score model is used?

As value-based models become more prevalent, focus on regional benchmarking increases

In VBC models, CMS seeks to **"encourage continuous improvements in operating efficiency over the long-run"**.

However, high-performing ACOs will lose credit for cost improvements as the baseline period is updated.

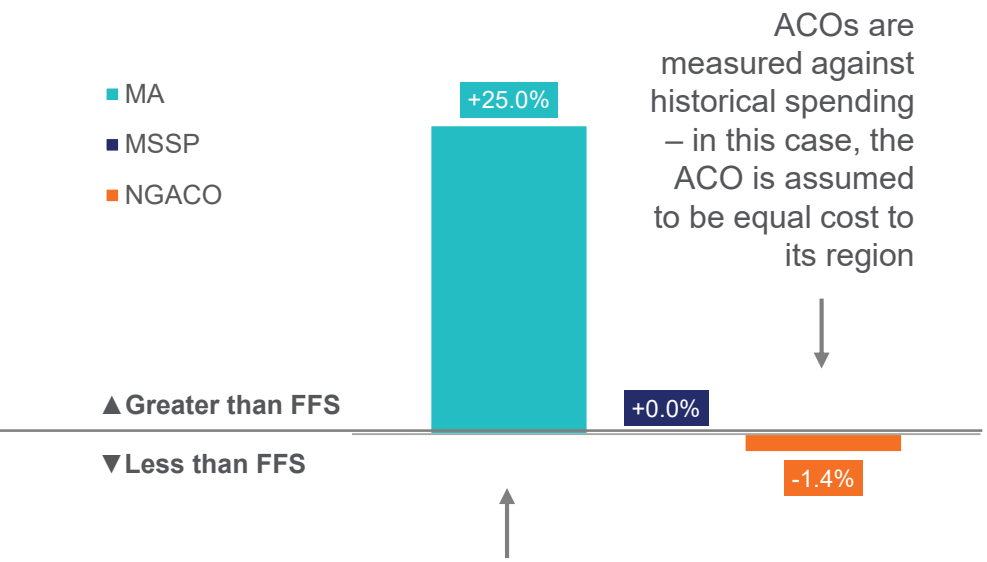
CMS has indicated that future models will have **"…prospective benchmarking that aligns with Medicare Advantage"**

Key Considerations for Provider Groups

- How is the region defined?
- Is the ACO rewarded for local efficiency or national efficiency?
- Is the regional adjustment capped?
- Is inefficiency treated differently from efficiency?

Regional benchmarking—a tale of two counties
Greene, Missouri

The chart below compares CMS benchmark relative to the FFS baseline for a Medicare Advantage plan, MSSP ACO and NGACO.



MA plans "bid" against their benchmark rate. If the bid is below the benchmark, a portion of the difference is returned to the MCO to provide additional member benefits. If the bid is above benchmark, a member premium is charged

Average cost ACO in low cost region

Because FFS costs in Greene, MO are low relative to the nation, CMS incentivizes MA plans with a 15% adjustment to the benchmark. Additionally, high quality plans can earn a "double bonus" of an additional 10%.

ACOs in low cost regions are not similarly incentivized. An MSSP ACO that is equal cost to its region—even if the region is very low cost nationally—will not receive any adjustment to its benchmark.

The NGACO program would also include a discount to help the program achieve its goal of Medicare savings.

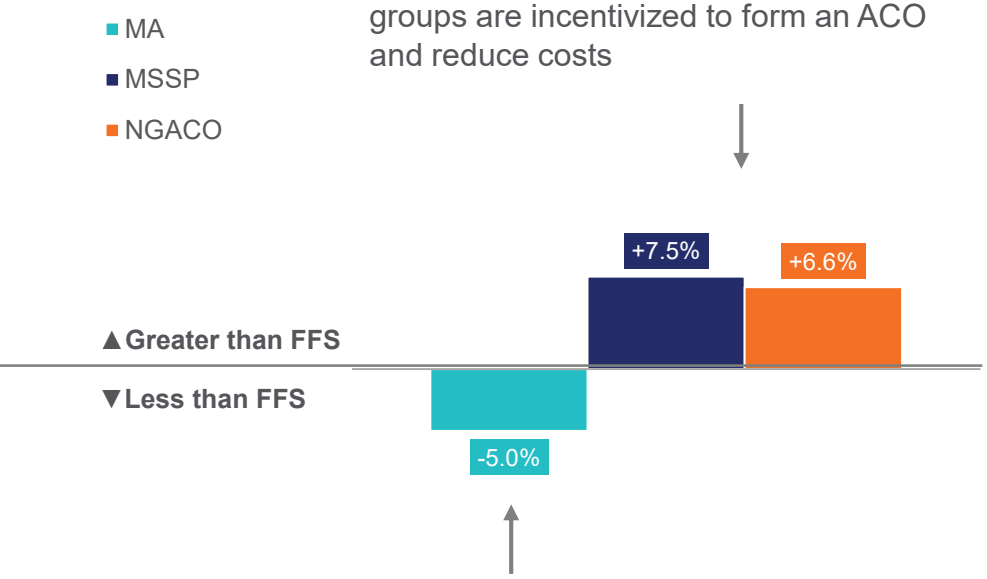
Assumptions

- ACO baseline cost is **100%** of the region
- Greene, MO is in lowest quartile of counties (+15% MA adj.) and is a double bonus county
- MA STAR rating of 4.5, ACO quality score of 90%
- MSSP in second agreement period (50/25% regional adj.)
- NGACO discount is 1.25% (100% sharing rate)
- No impact of risk adjustment

Source: 2020 Medicare Advantage Statutory Benchmark Calculation, MSSP "Pathways to Success" and NGACO PY4/5 Program Rules

Regional benchmarking—a tale of two counties
Lee, Florida

The chart below compares CMS benchmark relative to the FFS baseline for a Medicare Advantage plan, MSSP ACO and NGACO.



In high cost regions, MCO's must operate within a discounted FFS rate (assuming no quality bonus).

High cost ACO in high cost region

Managed care organizations participating in MA bid in all cases against their benchmark. Although high cost plans can charge a member premium if their bid is above the benchmark, it may make the plan uncompetitive relative to other plans.

ACOs have a unique financial opportunity to reduce costs since their "revenue" or benchmark is based on the ACO's historical spending.

CMS may still reduce the ACO's benchmark to account for the greater savings opportunity. Provider's should understand these adjustments in order to ensure they can achieve the cost reductions required to realize shared savings.

Assumptions

- ACO baseline cost is 110% of the region
- Lee, FL is in highest quartile of counties (-5% MA adj.)
- MA STAR rating of 3.0, ACO quality score of 70%
- MSSP in second agreement period (50/25% regional adj.)
- NGACO discount is 1.25% (100% sharing rate)
- No impact of risk adjustment

Source: 2020 Medicare Advantage Statutory Benchmark Calculation, MSSP "Pathways to Success" and NGACO PY4/5 Program Rules

Other considerations in navigating value-based care models

Demonstration Models vs Permanent Models

- CMMI models such as Pioneer and Next Generation ACO are demonstration models, designed to test innovative payment methods over a limited 5-year duration
- Demonstration models provide new opportunities for providers to innovate, but also create risks
- Mid-year program changes have occurred in the NGACO model, which had significant impact on the ACOs participating

Retrospective vs Prospective

- Retrospective benchmark methodologies are determined **after** the performance year ends, based on actual experience. Prospective methodologies estimate parameters **before** the performance year.
- For example, in MSSP the benchmark is trended using actual regional and national Medicare FFS trends in the performance year. In NGACO, trend assumption is known in advance but must be estimated
- Retrospective methodologies decrease visibility, but improves correlation between benchmark and costs

Model Overlap

- As the Medicare FFS space becomes more saturated with value-based care models, an important consideration for providers is the interaction between various models
- Medicare is prohibited from making payments to more than one organization for the same savings. For example, if an ACO-aligned beneficiary also participates in a bundle episode, the associated savings would accrue to both organizations

Third Party Vendors

- Third-party vendors can help accelerate the transition to value-based care with technology, care management, insurance or analytics and actuarial services
- Providers should be aware of cashflow considerations – vendors often must be paid during the year while shared savings is typically reconciled and paid much later

Direct Contracting and Primary Care First

New CMS Innovation Center Initiative Aims to Transform Primary Care

This is "the pivotal, hockey stick moment in paying for value in American healthcare."
-HHS Secretary Alex Azar

"…a clear sign that we are changing the status quo. This is a sweeping initiative that will shift a quarter of the country to outcomes-based payment."
-CMS Deputy Administrator for Innovation & Quality and CMMI Director Adam Boehler

CMMI Direct Contracting and Primary Care First models, announced on April 22, 2019, emphasize several key themes:

- Offering a **spectrum of primary care-focused payment incentives, flexibility and risk options up to full risk**
- Engaging a **wider array of organizations interested in taking on risk for populations**, i.e. not just ACOs but also organizations new to Medicare FFS (e.g. providers only in MA); Medicaid MCOs that want to take on risk for their full-benefit dually-eligible patients; and (for the DC Geographic PBP option) non-provider entities such as health plans, health technology companies, others
- Supporting an **optional focus on high-risk populations**, such as seriously ill patients, dually-eligible beneficiaries
- **Flexibility** to coordinate care and provide services targeted to patient needs including social determinants of health
- **Reduced administrative burden**, e.g., fewer measures focused more on outcomes than process
- **Attractive design features** based on prior CMMI model and private sector experience, e.g. prospective beneficiary alignment and voluntary alignment, moving to more regional/aligned benchmarking methodologies, waivers and benefit enhancements

Overview: Primary Care First Model

What is it?	• The Primary Care First model builds on the Comprehensive Primary Care Plus (CPC+) model as a regionally-based, multi-payer care and payment model to support primary care practices in care coordination and advanced primary care services. The model includes moderate downside risk with reduced administrative burden, increased transparency (sharing peer data) and an option to focus on complex/seriously ill patients.
How does it work?	• Primary Care First downside risk is capped at 10% of revenue (CMS says this is "offset" by admin savings from less revenue cycle activity) • Bonus adjustment of up to 50% of revenue based on performance, tied to risk-adjusted admissions measure • Will qualify for MACRA Quality Payment Program AAPM 5% bonus through 2024 if they meet definition of a "medical home" (as in CPC+; if part of an ACO, must meet QPP requirement to assume "more than nominal risk")
Who can participate?	• PCP practices and/or hospice and palliative providers located in selected geographic regions (18 CPC+ regions +8 new: AK, CA, DE, FL, ME, MA, NH, VA); aligned private payer partners (MA, commercial incl self-insured, Medicaid MCOs, State Medicaid agencies) • Medicare clinicians who provide hospice or palliative care services can either collaborate with Primary Care First PCPs or directly participate in the model through physician practices • Seriously Ill Population (SIP) applicants have option to take all SIP patients ID'd by CMS in their service area; participants can do only SIP if practice demonstrates sufficient network of other care orgs for bene long-term needs.
When and for how long does it run?	• Primary Care First is a five-year model with at least two cohorts slated to begin January 2021 • RFA and Solicitation for Payer Partnership coming spring 2019 for first cohort; start date January 2020 • More info: https://www.cms.gov/newsroom/fact-sheets/primary-care-first-foster-independence-reward-outcomes

Overview: New Direct Contracting Model

What is it?	Voluntary payment model for a broad range of organizations to test risk-sharing arrangements up to full risk & tied to quality for managing the health of a population of patients; Choices for payment, beneficiary attribution, benefit enhancements; Reduces admin burden and moves toward common payment benchmark/financial methodologies
How does it work?	**Three risk-sharing options:** 1. Professional PBP: lower-risk (50% savings/losses) with capitated, risk adjusted monthly payment for enhanced primary care services - 7% total cost of care (TCOC) 2. Global Population-Based Payment (PBP): Primary Care or Total Care Capitation, risk-adjusted monthly payment 3. Geographic PBP (CMS still finalizing, with RFI input): opportunity to take total-cost-of-care risk for all Medicare FFS beneficiaries in a defined region
Who can participate?	**Direct Contracting Entities (DCEs) can be:** • Primary-care focused providers under common corporate structure (Professional and Global PBP) • ACOs may participate in any of the 3 options • Orgs w/ MA risk contracts (voluntary alignment helps those previously ineligible due to low Medicare FFS volume) • MCOs serving full-benefit dual-eligible beneficiaries (can be DCE for dual population) • Geographic PBP not limited to providers; can be innovative orgs incl. health plans, tech companies, others that want to contract with providers and take on risk for a population in a defined geographic region.
When and for how long does it run?	• Initial Performance Year 0 (PY0) 2020 (optional, unless needed for alignment); Payments begin in PY1 (2021) • 5-Year model duration • DCE providers eligible for MACRA Quality Payment Program AAPM 5% bonus through 2024 (but not in PY0) • Requests for Applications (RFAs) *now anticipated Oct/Nov 2019* for Professional/Global; then Geographic PBP to follow: more detail on eligibility requirements/selection criteria, benchmark/payment methodology, waivers • *Non-binding LOIs were due August 2, 2019. CMMI says it received over 1,000 LOIs.* • More Information: https://www.cms.gov/newsroom/fact-sheets/direct-contracting

Direct Contracting: Benchmarking, Attribution & Cash Flow Options

	Design Element	Professional PBP	Global PBP	Geographic PBP[3]
Savings and Benchmark Methodology	Risk Sharing[1]	50% upside/downside	100% upside/downside	
	Risk Mitigation	Risk corridors and stop loss		TBD
	Beneficiary Alignment	1. Prospective alignment (claims based, +voluntary beneficiary alignment encouraged) 2. Prospective alignment "plus:" above +enhanced voluntary alignment: benes that align to a DCE added quarterly 3. Full-benefit duals aligned on basis of enrollment in participating Medicaid MCO; alignment to DCE through enhanced voluntary or claims-based alignment takes priority		
	Baseline Benchmark	Prospective; historical spending and MA-like regional expenditure adjustments (segmented by Aged & Disabled and ESRD)		One-year historic FFS spend in target region trended forward
	Discounts	None	Discount applied in Global PBP with potential for quality bonus	Negotiated
	Adjustments	Account for population risk and geographic price factors; potentially special adjustments for dually-eligible, complex chronic and seriously ill patients		None
	Trend	Historical baseline trended forward with US per capita cost growth		TBD
Cash Flow Options	Full risk + FFS claims processing			X
	Primary care capitation (7% TCOC)	X	X	
	Total care capitation[2]		X	X

[1] *Option for provisional reconciliation (select at start of PY) immediately following PY reflecting cost experience through first six months (with seasonality and claims run-out adjustments). CMS would distribute interim shared losses/savings, with final reconciliation taking place once full data are available.*
[2] *For services provided by participants + preferred providers*
[3] *Proposed, details not yet final*

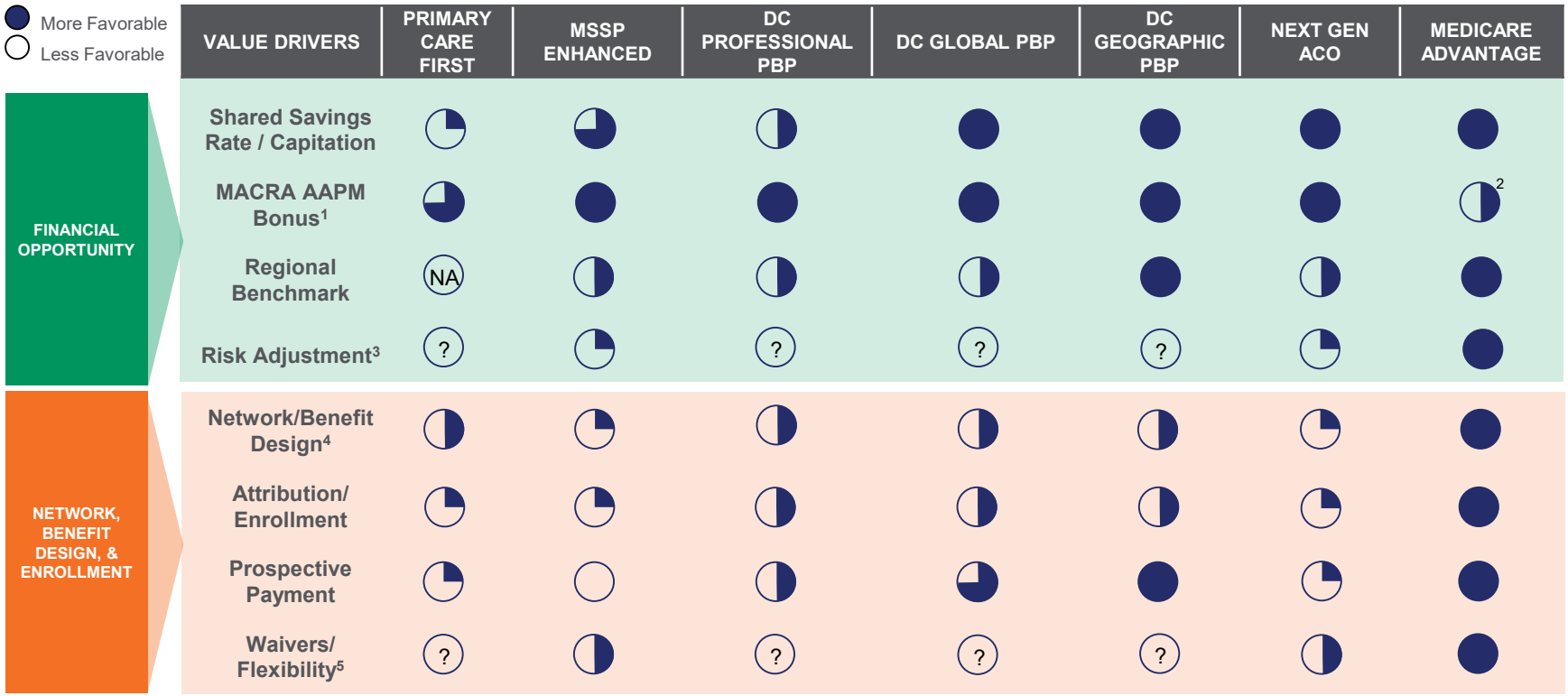
Direct Contracting: Eligibility and Beneficiary Target Populations

<table>
<tr><th colspan="2">Direct Contracting Entities</th><th colspan="2">Direct Contracting Beneficiaries</th></tr>
<tr><td colspan="2">Participating providers work through a “Direct Contracting Entity” (DCE). DCEs must have at least 5,000 attributed Medicare FFS beneficiaries[1]

Other DCE responsibilities include:
• Creating and managing participant and preferred provider lists
• Reporting quality measures to CMS (MIPS comparable, at least one outcome)
• Choosing the quality measures to report from a global list of categories</td><td colspan="2">Prospectively aligned to the DCE or voluntarily aligned during PY</td></tr>
<tr><th>Participants</th><th>Preferred Providers</th><th>High-Need Populations</th><th>Traditional Beneficiaries</th></tr>
<tr><td>• The core providers and suppliers of the DCE
• Used to align beneficiaries to DCE
• Responsible for reporting quality through the DCE</td><td>• Cannot be used to align beneficiaries
• Participate in certain downstream arrangements
• Certain benefit enhancements
• Contribute to DCE goals</td><td>• Medicare benes with complex chronic or serious illness
• Dually-eligible with complex needs (PACE-like population / approach)
• Dually-eligible enrolled in Medicaid managed care and Medicare FFS</td><td>• Patients enrolled in traditional Medicare FFS
• Model attribution overlap with MSSP or other FFS programs / CMMI models still TBD</td></tr>
<tr><td colspan="2">Geographic PBP is directed at innovative organizations (i.e. health plans, and healthcare technology companies) plus providers and supplier organizations. Details yet to be finalized, pending input through RFI. Estimated minimum attributed threshold = 75,000 beneficiaries</td><td colspan="2">During the Geographic PBP application process, CMS would assess the level of engagement and support from state Medicaid agencies to address potential for cost-shifting across Medicare and Medicaid, among other considerations.</td></tr>
</table>

[1] DCEs new to FFS are allowed a multi-year “on-ramp” to meet these requirements

At a Glance: Medicare Risk Across Key CMMI Models, MSSP and MA



[1] DCE providers will qualify for AAPM bonus. For PCF, they will if they meet the medical home definition; if they are rolled up in an ACO, they must meet the risk requirement.

[2] Starting in 2019, the MACRA "All-Payer Combination Option" allows Eligible Clinicians to become QPs through participation in a combination of AAPMs and Other Payer Advanced APMs

[3] Full risk adjustment details have not been released by CMS for Primary Cares Initiative models

[4] CMS exploring ways for DC entities to compete for beneficiaries but has not released details

[5] CMS yet to specify what waivers will be available to PCF and DC participants

Discussion

SOCIETY OF ACTUARIES®

Discussion: where does value-based care go from here?

- What role does Medicare Advantage and Medicaid play in value-based care?
- How will episodic models and total cost of care models evolve together? Which should take priority?
- What do changes in the Medicare space mean for commercial payers?
- How does the provider-payor relationship evolve? How is trust built?

Questions?

SOCIETY OF ACTUARIES®