Session 64PD, Risk-Sharing Arrangements in Medicare Advantage

Presenters:
Adam J. Barnhart, FSA, MAAA
Hillary H. Millican, FSA, MAAA
Simon J. Moody, FSA, MAAA
Session 64PD – Risk-Sharing Arrangements in Medicare Advantage

Simon Moody, FSA, MAAA
Principal and Consulting Actuary

Hillary Millican, FSA, MAAA
Consulting Actuary

Adam Barnhart, FSA, MAAA
Consulting Actuary

26 JUNE 2018
This presentation is intended for the sole benefit of the attendees of the 2018 SOA Health Meeting session entitled “Risk-Sharing Arrangements in Medicare Advantage” as presented on June 26, 2018, and should not be distributed, in whole or in part, to any external party without the prior written permission of Milliman. We do not intend this information to benefit or create a legal liability to any third party, even if we permit the distribution of this information to such third party.

This presentation is designed to discuss trends and considerations for risk-sharing arrangements in Medicare Advantage. This information may not be appropriate, and should not be used, for other purposes.

Simon Moody, Hillary Millican, and Adam Barnhart are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses discussed in this presentation.

In preparing this information, we relied on information provided by CMS and accepted it without audit. Results and conclusions in this presentation may not be appropriate if this information is not accurate.
To Participate, look for Polls in the SOA Event App or visit health.cnf.io in your browser.

Find The Polls Feature Under More In The Event App

Type health.cnf.io In Your Browser

Choose your session

Respond to Polls when they appear
Poll: Given a chance, which of the following supernatural powers would you most like to possess?
Given a chance, which of the following supernatural powers would you most like to possess?

- Read other peoples’ minds: 30%
- See through objects: 0%
- Be able to accurately predict the future: 68%
- Change your appearance: 2%
Poll: What best describes the area of the health industry you work in?
What best describes the area of the health industry you work in?

- Private Health Plan Insurer: 60%
- Federal or State Government: 6%
- Healthcare Provider: 11%
- Consulting Firm: 23%
- Academia: 0%
- SOA: 0%
- Other: 0%
Agenda

- Introduction
- Provider Perspective
  - Driving Forces for Risk Sharing in MA
  - Provider Considerations for Deal Structures
  - Percent of Premium Cost Target Setting
  - Quality and Other Incentives
- Part D in Risk Sharing Agreements
  - Structure Options
  - Challenges
  - Health Plan and Provider Perspectives
- Related Parties
- Recap
What are risk-sharing arrangements?

- Provider has set metrics to achieve, and if they do so they get a financial reward.
- Commonly, 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.
- The “savings” (the difference between target and actual costs) accrued to the health plan is shared with providers.
The Provider Perspective
Driving Forces
Building on the Medicare ACO Momentum

Significant growth in Medicare ACOs

![Graph showing growth in Medicare ACOs](image)

![Map showing assigned beneficiary population by county](image)

![Pie chart showing contract types](image)
Revenue Enhancement

Commercial populations are shrinking; Medicare is growing

- Volume play – the Medicare population is growing, and Medicare Advantage (MA) is growing faster than traditional Medicare
  - Joint Ventures
  - Own your own health plan
  - Co-branded products
  - Provider Specific Plans

- Coding opportunity
  - Don’t have to reduce utilization (revenue) to generate savings
  - Many plans will support and contribute to coding improvement initiatives

- Many MA agreements include payments that are not at risk or have minimum risk
  - Some quality performance or efficiency metrics are additional PMPM payments
  - Contributions to care management and clinical integration
Push from Medicare Advantage Plans

- Natural extension from commercial shared savings / shared risk reimbursement agreements for many carriers
- Well-structured MA risk-based reimbursement contracts can provide significant competitive advantages for MA plans
  - Improved Stars and quality metrics
  - Risk score enhancement
  - Utilization management and lower costs
- Full risk capitation reduces risk based capital requirement
Poll: Will MACRA incent more providers to take downside risk on MA?
Will MACRA incent more providers to take downside risk on MA?

- Yes, providers will be sure to chase that 5% bonus: 19%
- No, providers do not like taking risk: 23%
- Not sure, could go either way: 56%
- What's MACRA: 2%
MACRA and the Quality Payment Program

Advanced APM track has potential advantages over MIPS

<table>
<thead>
<tr>
<th>Payment Years</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
<th>2024</th>
<th>2025</th>
<th>2026</th>
<th>2027</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current programs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meaningful use (max penalty)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-2.0%</td>
<td>-3.0%</td>
<td>-4.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PQRS reporting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-2.0%</td>
<td>-2.0%</td>
<td>-2.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Value modifier</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+/-2%</td>
<td>+/-4%</td>
<td>+/-4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Changes due to MACRA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Annual updates in physician payment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+0.5%</td>
<td>+0.5%</td>
<td>+0.5%</td>
<td>+0.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Merit-based Incentive Payment System (MIPS)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measurement period</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+/-4%*</td>
<td>+/-5%*</td>
<td>+/-7%*</td>
<td>+/-9%*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impacted providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare physicians, PA, NP, CNS, CRNA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Medicare physicians and practitioners who independently bill CMS with a NPI and meet volume thresholds</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Qualifying Alternative Payment Model (APM) participants (QPs)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measurement period</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+5%</td>
<td>+5%</td>
<td>+5%</td>
<td>+5%</td>
<td>+5%</td>
<td>+5%</td>
<td>+5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impacted providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Medicare physicians and practitioners who independently bill CMS with a NPI and meet volume thresholds</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* The multiplier on these adjustments can be up to 3x to ensure budget neutrality
MACRA and the QPP (cont.)
Advanced APM track: Qualifying Participant Thresholds

- MA is considered an ‘Other Payer’ in the current qualifying participant formula

<table>
<thead>
<tr>
<th>Patient Count Method</th>
<th>Medicare Option</th>
<th>All-Payer Combination Option (must meet both Medicare FFS and all patients)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medicare FFS (partial)</td>
<td>Medicare FFS (qualified)</td>
</tr>
<tr>
<td>Payment Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2019-20</td>
<td>10%</td>
<td>20%</td>
</tr>
<tr>
<td>2021-22</td>
<td>25%</td>
<td>35%</td>
</tr>
<tr>
<td>2023+</td>
<td>35%</td>
<td>50%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payment Amount Method</th>
<th>Medicare Option</th>
<th>All-Payer Combination Option (must meet both Medicare FFS and all patients)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medicare FFS (partial)</td>
<td>Medicare FFS (qualified)</td>
</tr>
<tr>
<td>Payment Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2019-20</td>
<td>20%</td>
<td>25%</td>
</tr>
<tr>
<td>2021-22</td>
<td>40%</td>
<td>50%</td>
</tr>
<tr>
<td>2023+</td>
<td>50%</td>
<td>75%</td>
</tr>
</tbody>
</table>
Provider Considerations for Deal Structures
Special Medicare Advantage Considerations

- Opportunity to increase premium revenues through enhanced risk scores and Star ratings has significant impacts on contract structures
- High degree of regulation over MA bid process provides consistent platform for negotiations with different carriers
- Must monitor impact of MA processes on plan’s revenues
- Reasonable to have upside only risk for two or three years at start of initial contract, with two sided risk following the initial transition period
- Need to consider who is included and excluded e.g., SNPs, EGWPs, PDPs
- Reporting from carriers for MA agreements is typically significantly better than their reporting for commercial agreements
Cost Target Methodology

- Most common to use percentage of total premium as basis for cost targets
- Included services typically based on services included in bid
- Carve-outs are less common under these agreements and are often limited to Rx and/or additional benefits not provided by most health systems (optometry, dental, OTC drugs, etc.)
- Carrier will often include certain administrative costs which may or may not qualify as “medical costs” under Medical Loss Ratio (MLR) rules
- Providers will typically look to exclude other incentive payments from medical costs used as basis for settlement
Percentage of Premium Cost Target Setting
Percent of Premium Considerations

- Generally, providers have greater risk for factors which they cannot influence if percentage of premium cost targets are used.
- MA percentage of premium risk models have some mitigating factors which may make them more attractive.
- It is important to carefully review the adequacy of the percentage of premiums used to develop cost targets under these arrangements.
- It is also important to monitor annual changes which may affect the premium revenues.
- Cost target developed for each product grouping based on contracted percentage of premium.
- MA shared risk “MLR” targets usually range between 83% and 88% of premium revenues for individual products (but increasingly seeing lower proposed targets).
Other Considerations

- Risks for high cost members and uncontrollable, high cost events may be removed via reductions in PMPM revenues

- Must structure agreement to ensure cut-off period includes all material CMS revenue adjustments (typically up to 12 months)

- Must reduce risk of adverse adjustments to revenue resulting from actions of other providers identified by CMS or carrier audits
Quality and Other Incentives
MA Quality Overview

- MA quality measurements have significant differences from commercial quality structures.
- CMS provides additional revenue for higher quality via Star ratings.
- Most MA plans use measures included by CMS as part of Star rating process as the basis for their quality incentives.
- Immediate and delayed impacts of quality improvements.
Quality Adjustment Strategies

- Strategies to ensure reasonable quality structures are generally the same as those used for similar commercial structures

- Most negotiations focus on elements which determine the financial impact of quality performance
  - Quality gate structure
  - Surplus / deficit adjustments or separate PMPM bonus
  - Magnitude of adjustment / payment
  - Structure for determining amount of payment
  - Ability to influence components established by CMS is usually limited
  - Included measures
  - Definitions and thresholds
  - Weighting of measures
Other Potential Incentives and Payments

- Infrastructure payments
  - Fairly common to include some form of infrastructure support
  - May have to meet limited performance criteria to qualify
  - Payments typically range from $3.00 to $8.00 PMPM

- Targeted utilization incentives
  - Included to provide some focus on managing cost of care
  - Typically based on 1-5 measures with limited financial incentives
  - May include penalties if do not pass any of the measures

- Other incentives include payments for annual wellness visits, health assessments, coding seminar attendance, and other mutually beneficial activities
Part D in Risk Sharing Agreements
Structure Options and Challenges
Poll: Does your capitation agreement include Part D?
Does your capitation agreement include Part D?

- 19% I don't have a capitation agreement
- 19% Yes, my agreement includes Part D
- 21% No, my agreement does not include Part D
- 33% I work with multiple agreements, some of which include Part D and some do not
- 8% I'm not sure
3 Ways to Structure

1. Part C and D set to combined percentage of revenue
   - Adjust both the Part C and Part D BPTs
   - Iterative DIR in bid
   - Actual experience will be “trued up” to the capitation during the Part D settlement
3 Ways to Structure

2. Part D set to percentage of revenue
   - Iterative DIR in bid
   - Actual experience will be “trued up” to the capitation during the Part D settlement
3 Ways to Structure

3. Part D capitation equal to percent of revenue reflected in Part D bid

- Part D capitation = \( \frac{\text{Net drug costs less estimated direct and indirect remuneration}}{\text{Part D at-risk revenue times Part D risk score}} \)

- Target loss ratio “floats” each year

- No adjustment in bid

- “True up” the actual experience to the bid loss ratio during the Part D settlement

- Recommended option because it’s administratively simple (“true up” only occurs once)
Part D Challenges

- Timing of Part D settlements
- CMS Risk Corridor
- DIR Estimation and Reporting
- Interactions with Part C
- Provider Perspective
- Health Plan Perspective
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:
Reinsurance, LICS, and CGDP Subsidies

- “Pass through” items that are ultimately reconciled with CMS and the manufacturers.
- The plan sponsor is therefore not at risk for these revenue components.
- Arrangements should consider:
  - Should these subsidies be included in the risk-sharing arrangement?
  - If yes:
    - 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.
    - How will these be estimated prior to the final settlement?
  - Given the complexities, most agreements do not include these items.
Part D is already a risk-sharing arrangement between the plan sponsor and CMS
- The plan sponsor’s risk is already lessened via the risk corridor.

This calculation is done at the benefit plan level
- 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.

Risk sharing on plan profit
- Admin and profit excluded
- Incentive to bid close to actual
- If receiving risk sharing from CMS, a closer bid could have resulted in higher profit
CMS Risk Corridor

- Impact of settlement by providers other than the providers with the risk contract?
- 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?
Rebates and Other DIR

- Rebates are not tracked at the member level
- 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?
Rebates and Other DIR

- Pharmacy DIR
  - Payers may have separate risk sharing arrangements with pharmacies
  - These arrangements may or may not align with provider arrangement
  - Common arrangements include:
    - Volume based
    - GDR
    - Adherence
    - Quality
Rebates and Other DIR

- DIR Reporting
  - Risk-sharing arrangements require 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.
  - A plan does not retain the full gain or loss from the provider in the bid, but shares it with CMS. This creates challenges in the bid, particularly if the risk-sharing arrangement is based on a percentage of revenue.
  - Timing of the DIR reporting also presents administrative challenges.
Poll: Does a provider have enough control over Part D costs such that risk sharing on Part D makes sense?
Does a provider have enough control over Part D costs such that risk sharing on Part D makes sense?
Part D Interactions with Part C

- Is it 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.
- 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 the allocation between Part C and D impact the existing Part D risk-sharing mechanism with CMS?
Other Complexities Of Including Part D In Risk-sharing Arrangements

- 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?
Partial Capitation

- Examples:
  - Providers may only take risk on counties they serve
  - Providers may only take risk on members they serve
  - Providers only take risk on certain services
- Increases complexity of bid calculations and settlement
- Many provider Part D considerations still remain
Part D in Risk Sharing Agreements
Provider and Health Plan Perspectives
Provider Perspective

- Part D benefit design and high current generic use limits savings opportunity
- Formulary is outside of provider control, and typically designed to reduce unnecessary spend => further limits opportunity
- Increasing uncertainty in Part D e.g., pipeline drugs, utilization and inflation trends
- Rebates impact revenue, are outside of provider control, and are driven by total plan utilization which is influenced by prescribing practices of other providers
- Data/information exchange difficult (e.g., PDE files, rebate information, settlements)
Health Plan Perspective

- Lessens or eliminates risk corridor protection from CMS, particularly relevant if sharing risk with a provider owner (keeps the risk within the organization)
- Bid development and settlement is more complicated
- Sharing risk with provider brings on greater potential of discussing provider settlements during CMS audit
- If providers lose money, could damage health plan/provider relationship
<table>
<thead>
<tr>
<th>2017 Part D Settlement Scenarios</th>
<th>No Capitation</th>
<th>True Up to Capitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Total Direct and Indirect Remuneration (DIR)</td>
<td>$800,000</td>
<td>($133,333)</td>
</tr>
<tr>
<td>B. Adjusted DIR Dollars for Non-Covered Drugs</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>C. Adjusted DIR Dollars for Covered Drugs (DDIR)</td>
<td>$800,000</td>
<td>($133,333)</td>
</tr>
<tr>
<td>D. Reinsurance Subsidy Revenue (Zero if Non-CY EGWP)</td>
<td>$3,000,000</td>
<td>$3,000,000</td>
</tr>
<tr>
<td>E. DIR Ratio</td>
<td>0.313</td>
<td>0.313</td>
</tr>
<tr>
<td>F. Reinsurance DIR (Zero if Non-CY EGWP)</td>
<td>$250,000</td>
<td>($41,667)</td>
</tr>
<tr>
<td>G. Allowable Reinsurance (Zero if Non-CY EGWP)</td>
<td>$4,750,000</td>
<td>$5,041,667</td>
</tr>
<tr>
<td>H. Reinsurance Subsidy</td>
<td>$3,800,000</td>
<td>$4,033,333</td>
</tr>
<tr>
<td>I. Reinsurance Settlement Received from or (Refunded to) CMS</td>
<td>$800,000</td>
<td>$1,033,333</td>
</tr>
<tr>
<td>J. Low Income Cost Subsidy (LICS) Revenue</td>
<td>$800,000</td>
<td>$800,000</td>
</tr>
<tr>
<td>K. Actual Member Cost Sharing Covered by CMS</td>
<td>$850,000</td>
<td>$850,000</td>
</tr>
<tr>
<td>L. LICS Settlement Received from or (Refunded to) CMS</td>
<td>$50,000</td>
<td>$50,000</td>
</tr>
<tr>
<td>M. Basic Member Premium and Direct Subsidy Revenue</td>
<td>$6,000,000</td>
<td>$6,000,000</td>
</tr>
<tr>
<td>N. Administration Load and Profit Margin in Premium</td>
<td>15.00%</td>
<td>15.00%</td>
</tr>
<tr>
<td>O. Target Amount</td>
<td>$5,100,000</td>
<td>$5,100,000</td>
</tr>
<tr>
<td>P. Unadjusted Risk Corridor Costs (URCC)</td>
<td>$9,000,000</td>
<td>$9,000,000</td>
</tr>
<tr>
<td>Q. Induced Utilization Ratio</td>
<td>1.000</td>
<td>1.000</td>
</tr>
<tr>
<td>R. Adjusted Allowable Risk Corridor Costs (AARCC)</td>
<td>$4,400,000</td>
<td>$5,100,000</td>
</tr>
<tr>
<td>S. Profit / (Loss) Amount Used for Risk Sharing Calculation</td>
<td>$700,000</td>
<td>$0</td>
</tr>
<tr>
<td>T. Profit / (Loss) Amount as a Percent of Target Amount</td>
<td>13.73%</td>
<td>0.00%</td>
</tr>
<tr>
<td>U. Loss Sharing Received from or (Profit Sharing Refunded to) CMS</td>
<td>($279,500)</td>
<td>$0</td>
</tr>
<tr>
<td>V. Total 2016 Settlements Received from or (Refunded to) CMS</td>
<td>$570,500</td>
<td>$1,083,333</td>
</tr>
</tbody>
</table>

| Revenue | $6,000,000 | $6,000,000 |
| Net Claims | $4,400,000 | $5,100,000 |
| Loss Ratio | 73.3% | 85.0% |

Target Loss Ratio: N/A 85.0%

Change in Settlement Gain (Loss): $512,833
### Illustrative 2017 Part D Settlement Example

<table>
<thead>
<tr>
<th>Description</th>
<th>No Capitation</th>
<th>True Up to Capitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDCB $11,000,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GDCA $5,000,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2017 Part D Settlement Scenarios</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### A. Total Direct and Indirect Remuneration (DIR)

- No Capitation: $800,000
- True Up to Capitation: $2,266,667

#### B. Adjusted DIR Dollars for Non-Covered Drugs

- No Capitation: $0
- True Up to Capitation: $0

#### C. Adjusted DIR Dollars for Covered Drugs (DDIR)

- No Capitation: $800,000
- True Up to Capitation: $2,266,667

#### D. Reinsurance Subsidy Revenue (Zero if Non-CY EGWP)

- No Capitation: $3,000,000
- True Up to Capitation: $3,000,000

#### E. DIR Ratio

- No Capitation: 0.313
- True Up to Capitation: 0.313

#### F. Reinsurance DIR (Zero if Non-CY EGWP)

- No Capitation: $250,000
- True Up to Capitation: $708,333

#### G. Allowable Reinsurance (Zero if Non-CY EGWP)

- No Capitation: $4,750,000
- True Up to Capitation: $4,291,667

#### H. Reinsurance Subsidy

- No Capitation: $3,800,000
- True Up to Capitation: $3,433,333

#### I. Reinsurance Settlement Received from or (Refunded to) CMS

- No Capitation: $800,000
- True Up to Capitation: $433,333

#### J. Low Income Cost Subsidy (LICS) Revenue

- No Capitation: $800,000
- True Up to Capitation: $800,000

#### K. Actual Member Cost Sharing Covered by CMS

- No Capitation: $850,000
- True Up to Capitation: $850,000

#### L. LICS Settlement Received from or (Refunded to) CMS

- No Capitation: $50,000
- True Up to Capitation: $50,000

#### M. Basic Member Premium and Direct Subsidy Revenue

- No Capitation: $6,000,000
- True Up to Capitation: $6,000,000

#### N. Administration Load and Profit Margin in Premium

- No Capitation: 15.00%
- True Up to Capitation: 15.00%

#### O. Target Amount

- No Capitation: $5,100,000
- True Up to Capitation: $5,100,000

#### P. Unadjusted Risk Corridor Costs (URCC)

- No Capitation: $10,800,000
- True Up to Capitation: $10,800,000

#### Q. Induced Utilization Ratio

- No Capitation: 1.000
- True Up to Capitation: 1.000

#### R. Adjusted Allowable Risk Corridor Costs (AARCC)

- No Capitation: $6,200,000
- True Up to Capitation: $5,100,000

#### S. Profit / (Loss) Amount Used for Risk Sharing Calculation

- No Capitation: ($1,100,000)
- True Up to Capitation: $0

#### T. Profit / (Loss) Amount as a Percent of Target Amount

- No Capitation: -21.57%
- True Up to Capitation: 0.00%

#### U. Loss Sharing Received from or (Profit Sharing Refunded to) CMS

- No Capitation: $599,500
- True Up to Capitation: $0

#### V. Total 2016 Settlements Received from or (Refunded to) CMS

- No Capitation: $1,449,500
- True Up to Capitation: $483,333

- Revenue $6,000,000 $6,000,000
- Net Claims $6,200,000 $5,100,000
- Loss Ratio 103.3% 85.0%

- Target Loss Ratio N/A 85.0%

- Change in Settlement Gain (Loss) ($966,167)
Related Parties
Poll: Does your capitation agreement include a related party?
Does your capitation agreement include a related party?

- 19% I don’t have a capitation agreement
- 45% Yes, my agreement includes a related party
- 33% No, my agreement does not include a related party
- 2% What’s a related party?
### Related Parties

- For providers where the health plan and the provider share common ownership, need to consider related party requirements for medical service arrangements

<table>
<thead>
<tr>
<th>Method</th>
<th>Availability</th>
<th>Unrelated Party</th>
<th>Criteria</th>
<th>Net Medical in BPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Method 1 Actual Cost</td>
<td>Always available</td>
<td>N/A</td>
<td>• Support method</td>
<td>Actual cost of RP</td>
</tr>
<tr>
<td>Method 2 Market Comparison – through MAO</td>
<td>Alternative to Method 1</td>
<td>• Similar services • Medicare population • Bid’s service area</td>
<td>• Compare to contract with sufficient costs of services • Fees within 5% or $2 PMPM—whichever is greater</td>
<td>Fees paid by MAO</td>
</tr>
<tr>
<td>Method 2 Market Comparison – through Related Party</td>
<td>Alternative to Method 1</td>
<td>• MAO • Similar services • Medicare population • Attest to contract availability</td>
<td>• Compare to contract with sufficient costs of services • Fees within 5% or $2 PMPM—whichever is greater</td>
<td>Fees paid by MAO</td>
</tr>
<tr>
<td>Method 3 Comparable to FFS</td>
<td>Cannot satisfy Method 1</td>
<td>N/A</td>
<td>• Demonstrate Method 1 not possible • Fees within 5% of 100% FFS or $2 PMPM— whichever is greater</td>
<td>Fees paid by MAO</td>
</tr>
<tr>
<td>Method 4 FFS Proxy</td>
<td>Cannot satisfy Method 1, or Method 2, or Method 3</td>
<td>N/A</td>
<td>• Show Method 1, 2, or 3 not possible • Show fees NOT comparable to 100% FFS</td>
<td>100% FFS</td>
</tr>
</tbody>
</table>
Recap

- Risk arrangements are growing and here to stay
- More two-sided risk arrangements
- More emphasis on quality
- Commonly percentage of premium
- Care on increasing revenue
- EGWPs/PPOs often excluded
- Joint venture / cobranded products
  - Expertise, star rating, and membership
  - Narrow network as long as meet adequacy
- Including Part D more common, but has challenges
Thank you

Simon Moody
simon.moody@milliman.com

Hillary Millican
hillary.millican@milliman.com

Adam Barnhart
adam.barnhart@milliman.com