COPE HEALTH SOLUTIONS

Webinar Q&A

Maximizing Medicare Revenue Through Payment Models

November 18, 2021

1. How we can continue to improve performance under the MSSP and in the BPCI-A program

There are many ways to improve performance in the MSSP and BPCI-A programs:

a. Development and optimization of clinical pathways, care coordination and post-acute network management are crucial to the BPCI-A program and are important to continually improve with the MSSP population as well.
   i. For elective surgeries a thorough pre-operative assessment and patient engagement plan are critical. Work with the patient to get their chronic conditions under control – weight, blood sugar, or engaged in pre-operative physical therapy. These have a huge impact on surgical outcomes and recovery. Post-operative planning should also be coordinated between the primary physician, hospital or surgical center and post-acute network.
b. For organizations involved in both MSSP and BPCI-A, the resultant improved performance for the MSSP population should also generate a positive impact to the BPCI-A due to better managed care and surgical interventions being performed at the right time.
c. Engagement with attributed members, specifically with their primary care provider and care team is also a key aspect, both to improve member experience and also to improve adherence and referral management. PCPs and their care team should understand the SDoH, medical risk factors and unique care needs of their attributed beneficiaries in order to provide appropriate acuity of care in the most efficient facility and the appropriate time.
d. High performing MSSP ACOs should consider taking more risk through a more advanced MSSP track or through Medicare Direct Contracting or Medicare Advantage risk arrangements to increase access to premium dollar revenue.

2. Our organization belongs to an ACO? Can you comment on that?

The Medicare ACO program is an opportunity for providers to take on risk and generate greater revenues through improved outcomes within the Medicare population. The ACO programs offer a glide path for organizations to develop the capabilities and expertise necessary to successfully manage risk.

a. Key considerations if you're in an ACO:
   i. What does Medicare Advantage look like in your market have you gone through the analyses to determine whether the opportunities are better through MSSP versus Medicare Advantage?
   ii. What is the portion of your population that are dual eligible? Have you assessed the options for DSNP or related risk arrangements for duals, including PACE, versus the ACO program and MDC?
   iii. Are you part of another ACO? If so, do you have over 5000 attributed members yourself? What value does the larger ACO provide to your organization, providers and attributed members? Have you developed or are you developing your own population health management infrastructure?
   iv. How are you performing as an MSSP ACO or as part of a larger ACO? Are you ready to transition to a higher level or risk within the ACO program, through Medicare Direct Contracting or through Medicare Advantage risk arrangements?
b. Critical success factors for ACOs:
   i. Ability to influence practice transformation and referral behavior of PCPs.

ii. Alignment of the ACO governance, incentives, network, data and population health management activities with other value based payment arrangements including not only Medicare Advantage risk arrangements but those for all other lines of business.
iii. Ability to adequately capture and stratify the risk of the individual beneficiaries of the ACO (inclusive of HCCs, SDoH and other contributing risk factors) and design individual care plans for those beneficiaries.

3. **Will the impacts of COVID-19 and a new Administration at CMS change the trajectory of the trends seen in Medicare currently, and if so, how?**
    a. CMS has been consistently encouraging and creating programs to transition providers into value based payments across multiple administrations from both political parties. Many states have also worked through federal waivers and state programs to encourage both payers and providers to move into value based payment arrangements. We do not expect that to change.
    b. Lessons from the pandemic could shift more providers towards value-based payments as a means to "de-risk" and generate consistent cash flows, ironically.
    c. Covid-19 brought more focus on the need to address social determinants of health (SDoH) and ensure equitable access to appropriate care and providers are best incentivized and able to flow funds as needed to address SDoH gap closure through value based payment arrangements, particularly capitation.
    d. Providers in capitated arrangements did not experience the cash flow constraints during Covid-19 that hit many organizations operating with primarily FFS reimbursement.

4. **Is there a best program to grow Medicare revenue?**
    a. Each organization, the populations they serve and the dynamics of the market(s) they are in are unique. It is important to take into consideration:
        i. Your provider network and ability to grow it. What is your makeup of primary care versus specialty care? Are your specialists high performers from a total cost of care as well as quality perspective? What is the mix of your attributed or potentially attributed membership in terms of Medicare FFS, MA, dual eligible, DSNP and PACE.
    b. Understanding your organization's capabilities, the population you serve – and that you want to serve with growth, and the dynamics of the markets you are in and want to grow into will help with understanding the program that's the best fit for you at this time. Depending on your organization it is likely that a combination of strategies across MSSP or MDC, Medicare Advantage risk arrangements.
    c. Typically the more financial risk you share with the payer (CMS or insurance carrier) allows you to share in more of the savings and drive revenues.
    d. MDC compared to MSSP:

Medicare Direct Contracting vs. ACO

	Medicare Direct Contracting Global & Professional Models	Shared Savings ACO
Program Overview	A new program released in November 2019 built upon the NGACO program, with appeal to more organization types and sizes ready for capitation and two-sided risk	The Shared Savings Program began in 2012 with Tracks 1 and 2. Tracks 3 and 1+ were later added in 2016 and 2018. They have since been restructured into the BASIC and ENHANCED Tracks under the Pathways to Success program restructure
Minimum Beneficiary Size	• Standard Model: 5,000 beneficiaries • New Entrant Model: 1,000 with glide path to 5,000 by PY4 • High Risk Model: 250 with glide path to 1,400 by PY5	5,000 Beneficiaries
Capitation	Capitation is required, either professional or global. Mandatory for participant providers, but optional for preferred providers in the direct contracting entity (DCE)	No capitation option
Shared Savings or Loss	First dollar savings or loss with risk corridors and optional stop-loss insurance. Includes discount withhold and quality withhold • Professional: 50% • Global: 100%	First dollar savings once minimum savings rate (1% MSR) is met or exceeded. First dollar loss after Minimum Loss Rate (1% MLR) rate is met or exceeded. • BASIC Track: Savings Glide path of 40% to 50% savings based on quality performance, not to exceed 10% of updated benchmark; Losses for risk/reward models at 30% with caps • ENHANCED Track: 75% based on quality performance, not to exceed 20% of updated benchmark; loss rate of 40% to 75%, not to exceed 15% of updated benchmark
Quality Measures	14 quality measures proposed, 10 of which are CAHPS measures – Pay for Reporting (P4R) during PY1 and Pay for Performance (P4P) thereafter Includes additional bonus pool for High Performers beginning in PY2	23 quality measures with Pay for Reporting to Pay for Performance (P4P) progression
Beneficiary Alignment	Prospective claims-based and voluntary alignment with new Prospective Plus alignment option	Choice of prospective assignment or preliminary prospective assignment with retrospective reconciliation. Voluntary alignment

5. **Does it make sense to take risk across multiple payers/Medicare programs?**
    a. Depending on your specific situation, as per number 4 above it is likely important, although in some smaller markets there may not be adequate beneficiaries eligible for numerous programs to make a focus beyond one or maybe two programs worthwhile.
    b. For the right organizations and situations it can be beneficial to take risk across multiple payers and even multiple CMS programs, such as the example above of MSSP and BPCI-A.
    c. It's important to assess the market, current payers and payers that may be entering or interested in entering the market in order to select 1-3 priority partner payers with which to build not only MA but other lines of business as well.

d. When working with priority partner payers considerations may include not only how risk arrangements are structured but also potential opportunities for joint ventures and/or co-branded MA products.
e. When taking risk across multiple payers, align incentives and contractual mechanics as much as possible between various arrangements; i.e. incorporate the same quality metrics and risk adjustment methodology.
f. Another key consideration is to work to align the level of risk, and if possible KPIs such as quality program metrics, across all MA payers when taking global risk. Your risk pool is all the members under any global arrangement instead of a subset with a single payer. Aligning risk across your key payers allows you to expand your revenue opportunity and reduce catastrophic risk by expanding the risk pool more quickly.