CONSIDERATIONS FOR PROVIDERS ACCEPTING RISK ON MEDICARE PART D

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INTRODUCTION

WHAT IS PART D CAPITATION AND WHY WOULD A PROVIDER WANT TO ACCEPT IT?

What is Part D Capitation?

- A provider who is already taking medical risk on a given population can decide to also take risk on their prescription drug risk
- The provider then receives a **percentage of revenue from the payer** (member premium + CMS subsidies) and **becomes liable for their Rx claims**
- The provider is **profitable if net Rx claims are less than the revenue received from the payer (after accounting for any administrative costs** the provider incurs specifically associated with the arrangement)

Why Would a Provider Want to Accept Part D Risk?

- **A large payer who comprises a meaningful portion of their volume requires them** to take prescription drug risk if they want to receive medical capitation
- **The provider believes they can affect prescription drug claims** in a sufficiently meaningful way such that they can be profitable on the arrangement
- For an MAPD plan, excess government dollars (rebates) on the medical portion (Part C) of the benefit can be utilized to reduce members' Part D premium
    - It is common for providers to be frustrated by an increasing amount of "Part C rebate dollars" being allocated to buying down Part D premium and they decide the best route is to take capitation on all revenue

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QUESTIONS PROVIDERS MUST ANSWER

CONSIDERATIONS FOR PROVIDERS TAKING RISK ON MEDICARE PART D

1. IS THE POPULATION SUFFICIENTLY LARGE?

2. IS THERE A TRANSPARENT VIEW INTO THE PAYER'S PART D PRICING?

3. DOES THE PROVIDER UNDERSTAND THE LEVERS FOR PROFITABILITY IN PART D?

4. HOW DOES THE INFLATION REDUCTION ACT IMPACT A PART D CAPITATION ARRANGEMENT?

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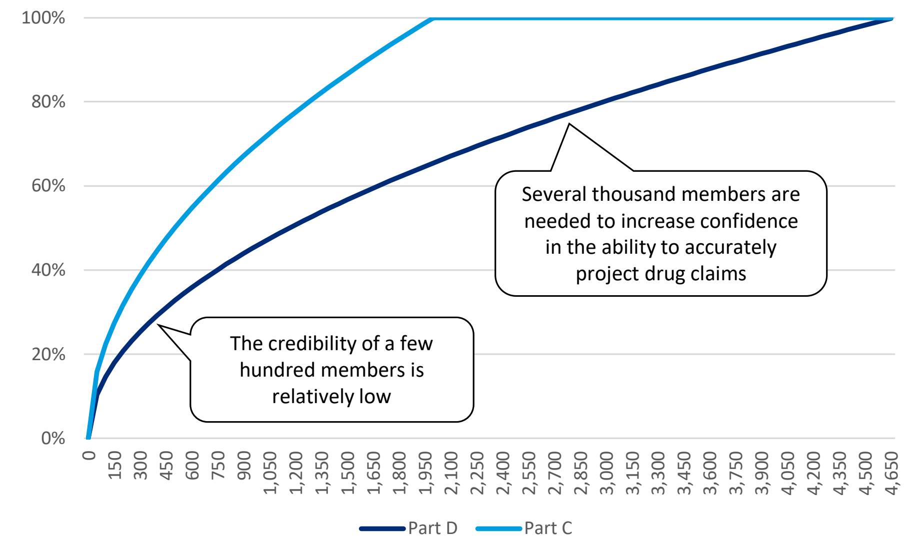
IS THE POPULATION STATISTICALLY CREDIBLE?

- CMS defines **full Part D credibility as 56,000 member months (or 4,667 average members)**
  - This does not mean a provider should automatically decline to participate with a population less than 4,667 members, but **the farther below that number that their population is, the more credibility risk they are exposing themselves to**
- This credibility value is so large due to the **high severity and low frequency of specialty medications**



Conclusion

If a provider group is receiving capitation on a meaningfully smaller population, it is possible that they do everything correct and still “lose” due to normal statistical variation in claims

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IS THE PAYER'S PRICING APPROPRIATE AND TRANSPARENT?

- Part D Revenue (member premium + CMS subsidies) is determined through the bid pricing process

- This pricing is reviewed for reasonability through the desk review and audit process, but **it is still possible that pricing contains aggressive assumptions** resulting in a potentially smaller-than-necessary revenue value

- It is uncommon for a payer to provide the full Bid Pricing Tool to a provider; however, it is **reasonable for a provider to ask for the following assumptions underlying the pricing that they are ultimately being paid based upon**:
  - Margin
  - Secular Drug Trend by Category
  - Additional trend assumptions such as: formulary savings, discount change, or population change
  - Does the provider's population comprise the entire plan being priced? (or are they a subset?)
    - This could result in **data and assumptions that are appropriate in the aggregate but not for the members specifically associated with the provider**

Conclusion

If a payers pricing is too aggressive, the provider isn't being set up for success in the Part D capitation arrangement

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DOES THE PROVIDER UNDERSTAND THE LEVERS OF PROFITABILITY IN PART D?

- Medicare Part D (and the prescription drug arena in general) contains financial nuances that make it more difficult to successfully compete in relative to Medicare Part C (and most medical products)
  - Manufacturers' rebates are going to be unknown to the provider and make up on average **roughly 30% of gross costs**;
    - This means a provider could believe they are prescribing a less expensive alternative, while in reality it is more expensive net of rebates
    - This also means that increasing generic fill rates doesn't necessarily have the magnitude of impact on cost that a provider might expect
  - Plan liability as a percentage of gross cost is relatively low (although increasing under IRA)
- CMS Subsidized revenue (risk-adjusted direct subsidy and Part C buydown dollars allocated to Part D) are a function of projected plan liability; **if a provider succeeds in reducing costs, this is likely to reduce future revenue**
- The protection of the risk corridors is largely eliminated under a Part D capitation arrangement due to the dynamics of the bids and the risk corridor calculation

Conclusion
The simplest and most effective way a provider can contain costs is by adhering to the health plan's formulary and utilization management criteria

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HOW DOES THE INFLATION REDUCTION ACT IMPACT PROVIDERS TAKING CAPITATION ON PART D?

- The Part D benefit redesign in 2025 contained in the Inflation Reduction Act results in a significant increase in Part D Plan liability, as well as a significant increase in risk-adjusted direct subsidy
  - This **increases the importance of accurate coding on members**, as the risk-adjusted revenue becomes a much larger piece of the puzzle
  - This also **provides additional incentive to properly manage claims** as the plan/provider is taking meaningful risk throughout the entirety of the benefit (as opposed to only moderate risk previously in the coverage gap and catastrophic phases
  - There will be increased pricing risk in 2025, as discussed on the prior slide as actuaries try to estimate impacts to utilization and liability stemming from the benefit redesign

Current Benefit Design for Brands				
Benefit Phase	**Government**	**Part D Plan**	**Member**	**Manufacturer**
Deductible	0%	0%	100%	0%
Initial Coverage	0%	75%	25%	0%
Coverage Gap	0%	5%	25%	70%
Catastrophic	80%	15%	5%	0%

Final *Inflation Reduction Act* Benefit Design for Brands				
Benefit Phase	**Government**	**Part D Plan**	**Member**	**Manufacturer[2]**
Deductible	0%	0%	100%	0%
Initial Coverage	0%	65%	25%	10%
Catastrophic[1]	20%	60%	0%	20%

1. The Catastrophic phase would begin after a $2,000 MOOP in 2025 under this new design
2. The new benefit design would extend the manufacturers' amount to LIS beneficiaries

Conclusion

Following the benefit redesign in 2025, Part D liability (and risk-adjusted revenue) will be meaningfully higher increasing the risk providers will be taking on under a capitation arrangement

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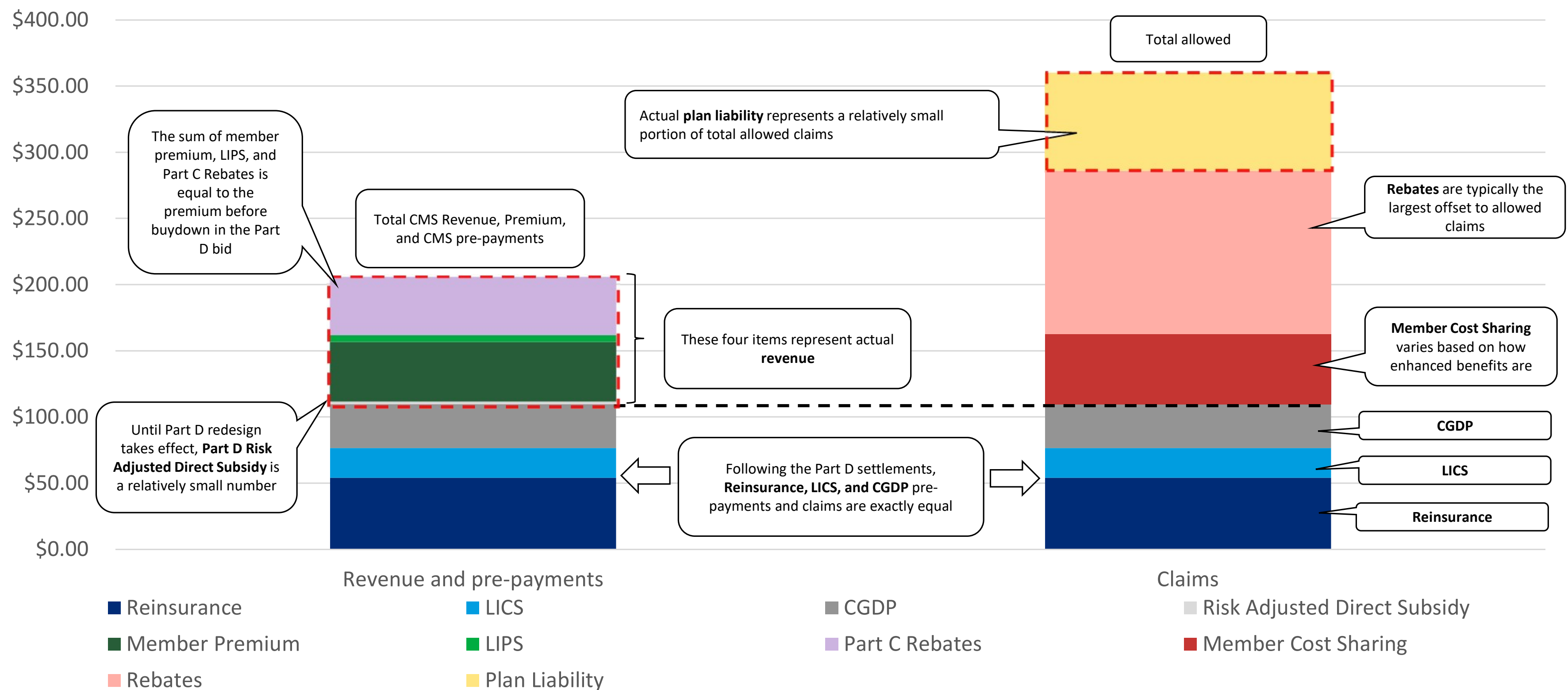
STRUCTURING THE CONTRACT AND FINANCIAL MODELING

THE CONTRACT MUST BE CLEARLY DEFINED AND SHOULD IDEALLY INCLUDE NUMERICAL EXAMPLES GIVEN THE LARGE NUMBER OF PART D CASH FLOWS



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