RAND Technical Expert Panel Medicare Advantage (MA) and Part D Contract Star Ratings, February 7, 2022 Meeting

PRESENTATION

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- Liza Assatourians, J.D., America's Health Insurance Plans
- Anne Burns, R.Ph., American Pharmacists Association
- Kim Caldwell, B.S., R.Ph., Texas Star Healthcare Consulting, LLC
- Lindsey Copeland, J.D., Medicare Rights Center
- Darrell J. Gaskin, Ph.D., Johns Hopkins University
- Emma Hoo, B.A., Pacific Business Group on Health
- Deborah Paone, Dr.PH., M.H.S.A., Special Needs Plan (SNP) Alliance
- Ninez Ponce, M.M.P., Ph.D., University of California Los Angeles School of Public Health
- Patrick Romano, M.D., M.P.H., University of California Davis
- Debra Saliba, M.D., M.P.H., A.G.S.F., University of California Los Angeles, RAND, Veterans Affairs Los Angeles HSR&D Center of Innovation
- Jane Sung, J.D., AARP
- Dolores Yanagihara, M.P.H., Integrated Healthcare Association
Welcome to our newest TEP member

Debra Saliba is professor of medicine and the Anna & Harry Borun Endowed Chair in Geriatrics at UCLA and physician policy researcher at RAND. At the Los Angeles VA, Dr. Saliba is associate director for education in the HSR&D Center of Innovation. As a practicing geriatrician and health services researcher, Dr. Saliba's research focuses on creating tools and knowledge that improve quality of care and quality of life of older adults with long-term care needs across the care continuum.
RAND Team Members

• Cheryl Damberg, Project Director
• Maria DeYoreo, Project Co-Director
• Marc Elliott, Principal Senior Statistician
• Rachel Reid, Physician Policy Researcher
• Melony Sorbero, Senior Policy Researcher
• Jessica Phillips, Project Manager
TODAY’S FOCUS

Exploring potential development of a measure to capture the value-based care arrangements Medicare Advantage organizations have with their contracted providers and its possible inclusion in Medicare Advantage Star Ratings
Outline

• Advance Notice

• Measure Concept
  – Overall goals
  – Selected examples of current measurement efforts

• Measure Construction
  – Categorizing value-based arrangements
  – Potential impacts & unintended consequences
  – Measuring provider participation

• Measure Data Collection
  – Data collection and validation approaches
  – Potential challenges

• Additional Examples
Advanced Notice Text: Synopsis

- CMS is interested in Medicare Advantage Organizations’ value-based contracts with providers
  - Considering developing a measure to capture Medicare Advantage Organizations’ value-based arrangements with providers based on outcomes and quality and rewarding value over volume

- CMS is in the early stages of considering such measurement and is interested in feedback on:
  - What types of value-based arrangements Medicare Advantage Organizations have with providers
  - Measure structure
  - Instances where value-based contracts may or may not improve quality in Medicare Advantage
  - Data collection and validation
Measure Construction: Categorizing Value-Based Arrangements

- Health Care Payment Learning and Action Network (HCP-LAN) is a method to categorize payment arrangements
  - Includes all payment arrangements: linked to quality and value and not linked

- Many provider payments may reflect a combination of these categories

- HCP-LAN is the most used, but some entities that currently track APMs and value-based payments use other categorizations
Example: HCP-LAN APM Survey

• LAN collaborated with AHIP, Blue Cross Blue Shield Association, and CMS to measure value-based payments made by health plans, states, and FFS Medicare

• 73 health plans, 5 FFS Medicaid states, and FFS Medicare participated in 2021

• Requested health plans and states to provide retrospective data of actual dollars paid to providers during the previous calendar year

• Included survey questions about future of APM adoption
### HCP-LAN APM Survey: Payment Data Collection

#### LOB Selection

<table>
<thead>
<tr>
<th>Legacy Payments</th>
<th>Commercial</th>
<th>Medicare Advantage</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foundation spending to improve care</td>
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<td></td>
<td></td>
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<tr>
<td>Fee-for-service plus pay-for-performance</td>
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<tr>
<td>Traditional shared savings</td>
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<tr>
<td>Utilization-based shared savings</td>
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<td>Fee-for-service-based shared risk</td>
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<tr>
<td>Procedure-based bundled/episode payments</td>
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<tr>
<td>Condition-specific, population-based payments</td>
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<tr>
<td>Condition-specific bundled/episode payments</td>
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<tr>
<td>Population-based payments that are NOT condition-specific</td>
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<tr>
<td>Full or percent of premium, population-based payments</td>
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<tr>
<td>Integrated finance and delivery programs</td>
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</tr>
</tbody>
</table>

#### Display This Question if LOB selects Medicare Advantage

Q9 Medicare Advantage Line of Business

Please list the total dollars paid through each of the payment models that were in effect in 2020 in your organization’s Medicare Advantage line of business.

Note: To the extent payment to a provider includes multiple APMs, the payers should put the dollars in the dominant APM, meaning the most advanced method. Therefore, there may be some payment models that were in effect but do not have dollars associated as they were not the dominant APM in the arrangement with the provider.

Payment Model Selection = Legacy Payments (Medicare Advantage)

- **Legacy Payments:**

Payment Model Selection = Foundation spending to improve care (Medicare Advantage)

- **Foundation spending to improve care:**

Payment Model Selection = Fee-for-service plus pay-for-performance (Medicare Advantage)

- **Fee-for-service plus pay-for-performance:**

Payment Model Selection = Traditional shared savings (Medicare Advantage)

- **Traditional shared savings:**

Payment Model Selection = Utilization-based shared savings (Medicare Advantage)

- **Utilization-based shared savings:**

Payment Model Selection = Fee-for-service-based shared risk (Medicare Advantage)

- **Fee-for-service-based shared risk:**

Payment Model Selection = Procedure-based bundled/episode payments (Medicare Advantage)

- **Procedure-based bundled/episode payments:**

Payment Model Selection = Condition-specific, population-based payments (Medicare Advantage)

- **Condition-specific, population-based payments:**

Payment Model Selection = Condition-specific bundled/episode payments (Medicare Advantage)

- **Condition-specific bundled/episode payments:**

Payment Model Selection = Population-based payments that are NOT condition-specific (Medicare Advantage)

- **Population-based payments that are NOT condition-specific:**

Payment Model Selection = Full or percent of premium, population-based payments (Medicare Advantage)

- **Full or percent of premium, population-based payments:**

Payment Model Selection = Integrated finance and delivery programs (Medicare Advantage)

- **Integrated finance and delivery programs:**

**Total:**
Example: Washington State Health Care Authority Payment Data Collection Parallels HCP-LAN Survey

<table>
<thead>
<tr>
<th>APM Category</th>
<th>APM Subcategory</th>
<th>Strategy</th>
<th>Medicare</th>
<th>Individual Market (on-exchange; non-public option)</th>
<th>Individual Market (on-exchange; public option)</th>
<th>Individual Market (off-exchange)</th>
<th>Small Group</th>
<th>Large Group</th>
<th>Totals</th>
<th>Category group</th>
<th>FFS vs VBP</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>FFS - No Link to Quality</td>
<td>$</td>
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<td></td>
<td>2A</td>
<td>Pay for Reporting</td>
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<td></td>
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<td>Pay for Reporting</td>
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<td>3</td>
<td>3A</td>
<td>APMS with Upside Gainsharing</td>
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<td></td>
<td>3B</td>
<td>APMS with Upside Gainsharing and Downsides Risk</td>
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<td>APMS with Upside Gainsharing and Downsides Risk</td>
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<td>4</td>
<td>4A</td>
<td>Condition-Specific Population-Based Payment</td>
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<td></td>
<td>4B</td>
<td>Comprehensive Population-Based Payment</td>
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<td></td>
<td>4C</td>
<td>Integrated finance and delivery systems</td>
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<td></td>
<td>4D</td>
<td>Capitated payments no link to quality</td>
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<td>Total Annual Payments</td>
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</table>
### Example: Washington State Health Care Authority
### Additional Data Collection on Incentive Payment Data Collection

<table>
<thead>
<tr>
<th>Sector</th>
<th>Total Payments</th>
<th>Positive Incentives</th>
<th>Negative Incentives</th>
<th>All Incentives</th>
<th>All Incentives Earned / Incurred</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Total Positive Incentives</td>
<td>Total Positive Incentives Earned</td>
<td>Describe*</td>
<td>Total Negative Incentives</td>
</tr>
<tr>
<td>Medicare</td>
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<tr>
<td>Individual Market</td>
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<td>(on-exchange; non public option)</td>
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<td>Individual Market</td>
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<td>-</td>
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<tr>
<td>(on-exchange; public option)</td>
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<td></td>
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<td></td>
<td>All Incentives Earned / Incurred</td>
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<tr>
<td>Small Group</td>
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<td>$</td>
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<tr>
<td>Large Group</td>
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<tr>
<td><strong>Total</strong></td>
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</tbody>
</table>

"For example: "Downside risk arrangement whereby providers make payments to contracted payers from an existing reimbursement structure based on quality reporting and performance."
Potential Impacts & Unintended Consequences

• Is measuring value-based plan-provider payment arrangements likely to increase the quality of care for Medicare Advantage patients?
  – Are there examples of how value-based plan-provider payment arrangements have increased quality in Medicare Advantage?
  – Are there providers or patients where this is more or less likely to be true?
  – Are there specific instances where value-based payment may not increase quality?

• Is measuring value-based plan-provider payment arrangements likely to have any unintended consequences or downsides?
  – Might such a measure affect Medicare Advantage Organization provider networks, particularly for providers for whom value-based payment models may be less attractive or possible (e.g., safety net providers, small independent providers)?
  – Might such a measure differentially affect some Medicare Advantage Organizations more than others (i.e., if smaller or newer Medicare Advantage Organizations lack sufficient market share to engage in value-based arrangements)?
  – Might such a measure affect Medicare Advantage Organization availability in some markets (e.g., if some markets have provider or patient numbers or characteristics that make value-based payment arrangements more challenging).
Measure Construction: Measuring Provider Participation

• How to quantify value-based arrangement participation?
  – Portion of providers participating, of total reimbursements, of Medicare Advantage covered lives?

• Which providers should be included or assessed?
  – Physicians, non-physician providers, facilities, contracted entities (i.e., TINs)?

• How to account for varied categories of value-based contracts?
  – Which categories of payment arrangements should count as value-based arrangements?
Measure Data Collection and Validation

• What collection or reporting mechanisms should be considered?
  – Survey of Medicare Advantage Organizations
  – Submission of structured files or reports (e.g., Excel workbooks)

• How might these data be audited or validated?

• Value-based payment arrangement payments may be made outside of standard claims or reimbursement systems.
  – Might this present challenges for reporting and/or validation?
Measure Data Collection: Potential Challenges

• What challenges might CMS face in collecting these data?
  – What kinds of resources might be needed to provide guidance and technical support?

• What challenges might Medicare Advantage organizations face in submitting these data?
  – At what level is reporting of the data feasible (e.g., contract, parent organization, service area, etc.)?
  – How labor intensive is data preparation likely to be?
  – What might help to streamline data collection and reporting?

• What might be needed to ensure data collected are valid and comparable across years and across Medicare Advantage Organizations?
Additional Examples of Value-Based Payment Arrangement Data Collection from Plans

- Colorado Center for Improving Value in Health Care
- Oregon Health Authority
- Covered California
- Massachusetts Center for Health Information Analysis
- Rhode Island Office of the Health Insurance Commissioner
Each payer submits a detailed payment file that describes all payments and payment types made to each billing provider:

Payments are categorized according to a system modified from the HCP-LAN framework in an approach:
- FFS
- Foundational payments for infrastructure and operations
- Pay-for-reporting
- Pay-for-performance
- APMs with shared savings
- APMs with shared savings and downside risk
- Risk-based payments not linked to quality
- Condition-specific population-based payments
- Comprehensive population-based payment
- Integrated finance and delivery system
- Capitation payments not linked to quality
Each payer submits a detailed payment file that describes all payments and payment types made to each provider entity with which they contract.

Uses a modified HCP-LAN framework including:

- FFS with link to APM
- FFS without link to APM
- Payments based on patient-centered primary care home tier level
- Foundational payments for infrastructure and operations
- Pay-for-reporting
- Pay-for-performance
- APMs with shared savings
- APMS with shared savings and downside risk
- Risk-based payments not linked to quality
- Condition-specific population-based payments
- Comprehensive population-based payment
- Integrated finance and delivery system
- Capitation payments not linked to quality
- Excludes in-kind payments and direct staff support
Covered California: Requires Qualified Health Plans to Report HCP-LAN APM Categories

• Contractor must report on its network payment models using the HCP-LAN APM categories and associated subcategories...Contractor must report the percent of spend within each HCP-LAN APM category and associated subcategory compared to its overall budget in the annual application for certification.

• Contractor must report on its primary care payment models using the HCP-LAN APM categories and associated subcategories ...
  – A combination of payment models across categories may be the most effective to support advanced primary care.
  – Contractor must report in the annual application for certification:
    a) The number and percent of its contracted primary care clinicians paid using each HCP-LAN APM category and associated subcategories;
    b) Total primary care spend, as defined by the Integrated Healthcare Association (IHA), and the percent of spend within each HCP-LAN APM category and associated subcategory; and
    c) A description of the Contractor’s payment model for its five largest physician groups, as defined by the number of providers, and how their primary care clinicians are paid.
Payers classify payment methods based on mutually exclusive payment method allocation hierarchy:

- global payments (full benefits)
- global payments (partial benefits)
- limited budget
- bundled payments
- other, non-FFS based
- FFS

Tracks payments according to:

- claims by type
- non-claims incentive programs
- non-claims capitation, non-claims risk-settlements
- non-claims care management
- non-claims other

Reporting of payments:

- By patient ZIP code
- Physician Group and Physician local practice group
  - with patient costs allocated by member-months associated with a PCP
<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Member months & covered lives in population-based contracts**      | • Overall  
• In RI                                                                                                                                                                                                 |
| **Total dollars allowed for all services**                           | • Total dollars by risk arrangements                                                                                                                                                                          |
| **Total dollars for settlement payments**                            | • Total dollars for settlement payments by risk arrangement                                                                                                                                                  |
| **Total dollars paid under a population-based contract**             |                                                                                                                                                                                                                |
| **Total dollars allowed for all services under bundled payment**     | • Total dollars allowed for all services under bundled payment by risk arrangement  
• Total dollars allowed for all services under bundled payment for lives not attributed to a population-based contract  
• Total dollars allowed for all services under bundled payment by risk arrangement for lives not attributed to a population-based contract |
| **Settlement payments under bundled payments**                       | • Settlement payments under bundled payments for lives not attributed to a population-based contract                                                                                                         |
| **Total dollars paid under additional models:**                      | • Limited capitation  
• Pay for performance  
• Alternative-payment models – other  
• FFS payments                                                                                                                            |
| **Total medical expense**                                            |                                                                                                                                                                                                                |
Advance Notice Text

As we continue to drive value among MA contracts, we are interested in how MA organizations are transforming care and driving quality through value-based contracts with providers.

We are considering developing a measure to capture the value-based care arrangements MA organizations have with providers based on health outcomes and quality of services provided to their patients, including how plans are aligning incentives with their providers so that they are rewarding better value and outcomes rather than the volume of services.

For example, providers may share in financial risk (upside and/or downside) and may receive bonuses or penalties based on meeting performance targets. In other cases, providers may receive non-financial resources to drive improvements in outcomes and cost.

We are interested in feedback on how to potentially structure a measure that focuses on how MA organizations contract with providers and, in particular, what percentage of their providers have value-based contracts and what types of arrangements these contracts entail.

We are also interested in feedback on any circumstances where value-based contracts with providers may not improve quality.

We would also be interested in feedback regarding how this information could be collected and validated. If a measure is developed, it would need to be adopted through rulemaking.

<table>
<thead>
<tr>
<th>Question</th>
<th>Response Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>From health plan’s perspective, what do you think will be the trend in APMs over the next 24 months?</td>
<td>APM activity will increase • APM activity will stay the same • APM activity will decrease • Not sure</td>
</tr>
<tr>
<td>[To those who answered “APM activity will increase”] Which APM subcategory do you think will increase the most in activity over the next 24 months?</td>
<td>Traditional shared-savings, utilization-based shared-savings (3A) • Fee-for-service-based shared risk, procedure-based bundled/episode payments (3B) • Condition-specific population-based payments, condition-specific bundled/episode payments (4A) • Full or percent of premium population-based payments, population-based payments that are not condition-specific (4B) • Integrated finance and delivery system programs (4C) • Not sure</td>
</tr>
<tr>
<td>[To those who answered “APM activity will decrease”] Which APM subcategory do you think will decrease the most in activity over the next 24 months?</td>
<td>Traditional shared-savings, utilization-based shared-savings (3A) • Fee-for-service-based shared risk, procedure-based bundled/episode payments (3B) • Condition-specific population-based payments, condition-specific bundled/episode payments (4A) • Full or percent of premium population-based payments, population-based payments that are not condition-specific (4B) • Integrated finance and delivery system programs (4C) • Not sure</td>
</tr>
<tr>
<td>From health plan’s perspective, what are the top barriers to APM adoption? (Select up to 3)</td>
<td>Provider interest/readiness • Health plan interest/readiness • Purchaser interest/readiness • Government influence • Provider ability to operationalize • Health plan ability to operationalize • Interoperability • Provider willingness to take on financial risk • Market factors • Other (please list)</td>
</tr>
<tr>
<td>From health plan’s perspective, what are the top facilitators to APM adoption? (Select up to 3)</td>
<td>Provider interest/readiness • Health plan interest/readiness • Purchaser interest/readiness • Government influence • Provider ability to operationalize • Health plan ability to operationalize • Interoperability • Provider willingness to take on financial risk • Market factors • Other (please list)</td>
</tr>
<tr>
<td>From health plan's perspective, please indicate to what extent you agree or disagree that APM adoption will result in each of the following outcomes: strongly disagree, disagree, agree, strongly agree, not sure</td>
<td>Better quality care • More affordable care • Improved care coordination • More consolidation among healthcare providers • Higher unit prices for discrete services • Other (please list)</td>
</tr>
<tr>
<td>Question</td>
<td>Response Options</td>
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<tr>
<td>Does your Plan have a strategy to contract with providers using population-based APMs (i.e., HCP-LAN Category 4) over the next year? If yes, please check all responses that apply.</td>
<td>The strategy is/will mostly target small, independent primary care clinicians/practices. • The strategy is/will mostly target independent larger physician group practices. • The strategy is/will target a mix of provider types. • No, my Plan does not have a strategy to contract with providers using population-based APMs. • Other (text)</td>
</tr>
<tr>
<td>Is your Plan leveraging value-based provider arrangements to incent the reduction of health disparities? If yes, please check all responses that apply.</td>
<td>Collect standardized sociodemographic data • Improve the quality and completeness of sociodemographic data • Measure health disparities by stratifying along sociodemographic factors • Improve performance on measures stratified by sociodemographic data • Improve patient consumer experience for targeted populations</td>
</tr>
<tr>
<td>If incentives are included in your value-based provider arrangements to improve health disparities, what specific Social Determinants of Health (SDoH) or delivery strategies are targeted for improvement or enhancement? Check all that apply.</td>
<td>Screening for socioeconomic barriers to health • Multidisciplinary team models (e.g., social worker, community health worker, medical staff, doulas, etc.) • Referrals to community-based organizations to address socioeconomic barriers • Data that tracks whether services were received (e.g., closed loop referrals) • Care coordination for services that address socioeconomic barriers • Food insecurity (e.g., offering resources for access to nutritious food) • Safe transportation (e.g., incentives or partnerships in ride sharing programs) • Housing insecurity (e.g., provider sponsored housing after a hospital discharge) • Economic insecurity (e.g., connections to job placement or training services) • Social isolation and loneliness (e.g., peer connection programs, group meetings, etc.) • Other basic needs (e.g., providing clothing, diapers, or gift cards; helping with utilities or childcare; providing digital devices such as phones to access telehealth and thrive in new digital world, etc.) • Other</td>
</tr>
</tbody>
</table>