Medicare Advantage Toolkit

Module II: Medicare Advantage Plan Reimbursement and Implications for Providers

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About the Authors

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Mr. Reagan is the managing partner and head litigator of the San Francisco office of Hooper, Lundy & Bookman, P.C., the largest full service law practice in the country dedicated solely to the representation of health care providers. He received his B.A. degree in Economics and Communication from Stanford University in 1983. In 1989, he received his J.D. from Loyola Law School, Loyola Marymount University and was admitted to the California Bar that same year.

Throughout his legal career, he has represented long term care facilities, hospitals, physician groups, home health agencies, hospices, medical product suppliers, trade associations, and other health-related entities in California and in numerous other states. His practice is devoted to counseling, litigation and trial and appellate work, before administrative agencies and all courts, with an emphasis on health care issues, including long term care, managed care, health care fraud and elder abuse, licensing and certification, Medicare and Medicaid, false claims, anti-trust, unfair competition, workers' compensation reimbursement, risk management and corporate compliance. He frequently testifies before the California State Legislature on these and other health related matters and assists clients with legislation and regulatory enactments.

Mr. Reagan serves as General Counsel to the California Association of Health Facilities, the largest trade association primarily serving the long-term care profession in California. He serves on the Legal Committee for the American Health Care Association, and was the chair of that group from 2006 through 2009. Mr. Reagan is a board member of the American Board of Medical Quality.

He has also handled several false claims cases to successful conclusions, including *U.S. ex rel. Swan v. Covenant Care, Inc.*, 279 F.Supp.2d 1212, 1217 (E.D. Cal. 2002), in which the Court held that regulatory violations and other "quality of care" concerns cannot give rise to false claims liability as to skilled nursing facilities participating in the Medicare program. Mr. Reagan has had a number of published decisions throughout his career within the California appellate courts and Supreme Court as well as the United States District Courts and the Ninth Circuit Court of Appeals.

Mr. Reagan is also a nationally recognized speaker, instructor and author on health related topics.

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Jim Miles is an attorney with the Denver and Phoenix offices of Miles & Peters, a firm that has a national practice specializing in health law. Mr. Miles has been practicing health law for 18 years. He specializes in the representation of health care providers, emphasizing business planning, commercial transactions, Stark and Anti-Kickback compliance, and joint ventures. His clients include hospitals, physician groups, nursing homes, assisted living facilities, community health centers, ambulatory surgery centers, clinical labs, and all other provider types. His clients also include managed care organizations (MCOs), accountable care organizations (ACOs), and independent practice associations (IPAs).

He serves as outside general counsel to several health care provider trade associations, including Colorado Health Care Association, Arizona Health Care Association, Wyoming Health Care Association, Colorado Community Health Network, and Community Health Association of Mountain and Plains States.

Mr. Miles served as a Vice Chair of the American Health Lawyers Association from 2004 through 2007. He was also selected as one of the top health lawyers in the United States by his peers in two publications, *Super Lawyers* and *Best Lawyers*, for years 2009 through 2014. He also is currently the Vice President of the Executive Council of the Colorado Bar Association's Health Law Section.

Mr. Miles has been actively involved in advising clients regarding health care reform initiatives. He specializes in legal and strategic planning for ACOs, bundled payment initiatives, risk-based contracting, value-based payments, physician integration, managed care contracting, and other related initiatives.

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General Description of MA Plan Reimbursement

MA plan payments are a combination of financial terms (in the form of the "bids," "benchmark" rates, and "rebates") along with a number of adjustments made based on plan quality and the demographics and acuity of the patients that they serve. Generally speaking, the payments made to an MA plan are based upon a comparison of (1) the plan's estimated costs of providing covered services (submitted by the MA Plan in the form of a "bid," which operates to define the plan's "base" rate), versus (2) the maximum amount that CMS will pay for providing those services within the MA plan's service area, known as the "benchmark."

If a plan's "bid" is less than the "benchmark" for the service area, the reimbursement received by the MA plan will equal its "bid" plus a "rebate." Any "rebate" earned by an MA plan must be returned to beneficiaries in the form of either additional benefits, reduced cost-sharing, reduced Part B or Part D premiums, or some combination of the same. Conversely, if the plan's "bid" is equal to or above the benchmark, its payment will be the "benchmark" amount and each beneficiary in that plan will pay an additional premium equal to the amount by which the "bid" exceeds the "benchmark." The bids submitted by MA plans are rarely, if ever, equal to or above the "benchmark." As further discussed below, both the "base" rate and the "rebate" may increase based upon CMS's determination of the MA plan's relative quality.

Calculation of "Benchmark" Rates and "Rebates"

The foundation of an MA plan's reimbursement is based on its "bid" relative to the "benchmark" established for the geographical area in question. The "bid" operates to define the plan's "base" rate. The difference between the "bid" and the "benchmark" determines the maximum amount of a MA plan's "rebate." As a result, the methodology used by CMS to establish the "benchmark" is critical to an MA plan's reimbursement.

Based upon the concern that MA plans were being overpaid, the Affordable Care Act ("ACA") reduced payment to MA plans by reducing the amount of the "benchmark," thereby also reducing the amount of the "rebate." CMS places MA plans into quartiles based upon fee-for-service costs. For example, the 3,140 counties in the nation are divided into quartiles by estimated per capita spending in "original" (*i.e.*, fee-for-service) Medicare. Each one of these quartiles is assigned a percentage reflecting the county's estimated per capita spending on

"original" Medicare. A county within the top quartile – those with the highest per capita spending – is assigned a "benchmark" rate equal to 95% of that county's estimated per capita spending. The second quartile utilizes 100%. The third and fourth quartiles are assigned percentages of 107.5% and 115%, respectively. The per capita spending is then multiplied by the percentage to establish the "benchmark" for that county.

The ACA also changed the mechanism through which the "rebate" is calculated. Under the ACA, the amount of the "rebate" is reduced from 75% to 50% of the difference between the "benchmark" and the MA plan's "bid."

Although the ACA reduced the "benchmark" and the "rebate," the ACA also established a "bonus" payment system exclusively for MA plans that receive the highest quality ratings from CMS. A subsequent "demonstration" program implemented by CMS expanded the "bonus" payments to lower performing plans. Not surprisingly, as MA plans see the "benchmark" and "rebate" reduced, eligibility for "bonus" payments grows in importance. As a result, any skilled nursing center seeking to contract with an MA plan should recognize that it can help or hurt the MA plan's bottom line in several ways. While a skilled nursing center could always impact the MA plan's expenses positively or negatively through provider reimbursement rates and utilization, a skilled nursing center can now affect the MA plan's "bonus" by affecting the MA plan's overall performance.

Impact of Medicare Five-Star Quality Ratings

As described above, MA plans are eligible for "bonus" payments based on their performance on a series of defined metrics. These metrics include a five-part performance measurement system that includes: (1) frequency of screening tests, vaccines, and other preventive check-ups designed to promote wellness, (2) management of chronic conditions, including frequency of testing and treatment to help manage conditions and avoid hospitalizations, (3) plan responsiveness and care, including skilled nursing center satisfaction and quality of communication with physicians, (4) frequency of complaints, timeliness of appeals, and frequency of disenrollment, and (5) quality of customer service. These metrics, along with approximately 40 other factors, yield a rating for each MA plan under Medicare's Five-Star Quality Rating system.

In a typical year, less than 15% of MA plans are rated as 4 or 5 Stars (out of a maximum of 5 Stars). As a result, only about 25% of MA enrollees are served by such plans. Most MA enrollees (approximately 60%) are served by plans scoring between 3 and 3.5 Stars.[1]

Plans that achieve or exceed 4 Stars receive a quality bonus to the "base" rates. For example, plans with ratings between 4 and 4.5 Stars have received bonus payments of 4% in 2012 and 2013, and these payments will increase to 5% in 2014 and beyond. Five Star plans began receiving 5% bonus payments in 2012 and that will remain in place indefinitely. However, 3-Star plans began receiving 3% bonuses in 2012 but these bonuses will end after 2014 when the

[1] Unless otherwise noted, the source for all data in this module is CMS, "Part C and D Performance Data," located at www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html.

CMS "demonstration" ends. Similarly, plans with 3.5 Stars have enjoyed a 3.5% bonus that will likewise terminate after 2014. All bonus payments are tied to the "benchmark" rates established for the particular county. In addition to the "bonus" payments, MA plans that achieve 5 Stars are allowed to market their plans year-round, rather than just during the mid-October through early December MA open enrollment period.

As with plan "base" rates, the "rebate" percentages are likewise tied to the 5-Star system. For example, by 2014, plans with 4.5 to 5 Stars will receive a "rebate" percentage of 70%. MA plans with 3.5 and 4 Stars will receive 65%, and plans with 3 Stars or less will receive 50%. In 2012 and 2013, the "rebate" percentages have been higher as the new system established by the ACA was phased-in.

The ACA also required CMS to double the "bonus" payments for MA plans offered in counties with (1) lower than average Medicare fee-for-service costs, (2) MA program "penetration" greater than a 25%, and (3) a 2004 designated "urban floor" benchmark. In 2012, there were 210 such counties throughout the nation.

In contrast to high-performing plans, MA plans that consistently underperform are tagged with an underperforming "icon" on the CMS website (known as the "Plan Finder"). Ultimately, underperforming plans can be dropped from the MA program.

As a result of the changes made by the ACA, beneficiaries are increasingly enrolling with MA plans with 4 and 5 Stars because, among other things, such MA plans will have more money to spend on additional benefits for enrollees. Moreover, unless the "bonus" payment system is revised, the majority of MA plans will experience further declines in reimbursement when the MA plan quality demonstration program ends in 2015. As a result, plans will be interested increasingly in "partnering" with providers that can assist them with maximizing their Five-Star Quality Rating designation. For example, if a skilled nursing center can help an MA plan reduce hospital readmissions, that assistance – along with many other factors – can lead to a higher rating, higher payments and lower expenses for the MA plan.

Risk Adjustment for MA Plans

As the MA plan payment formula reductions have phased-in, MA plans are paying more attention to their risk adjustment data – data that affects payments and can also lead to program audit issues. An MA plans has to rely greatly on providers and their networks to provide accurate data on patient diagnosis and acuity. It is in the MA plan's best interests to capture data that clearly documents skilled nursing center conditions. It is also in the MA plan's interest to make sure that the medical record is sufficiently adequate to withstand an audit.

The MA plan risk adjustment methodology relies on demographic, health history, and other factors to adjust payments to plans. These factors are identified in a base year, and used to adjust payments to a plan in the following year. In other words, since payments to MA plans are based upon a prospective payment system, CMS attempts to estimate next year's health care expenditures as a function of beneficiary demographic, health, and other factors identified in the current year.

CMS attempts to incorporate health status into payments by using current ICD-9 / ICD-10 codes and by establishing "condition categories" that have a "hierarchy" imposed on them. It has established "hierarchical condition codes" ("HCCs") designed to best predict the following year's Medicare Part A and Part B expenditures. There are approximately 90 HCCs that are incorporated in the current CMS model. Because each new medical problem adds to an individual's total disease burden, multiple but unrelated disease processes should increase predicted costs of care. Accordingly, the CMS model also factors into its system unrelated "disease categories" to increase the beneficiaries' overall "risk score."

The CMS-HCC model is a linear regression model with expenditures predicted by the HCCs and demographic variables. For new enrollees who have not had 12 months of Medicare Part B eligibility in the preceding calendar year, the risk scores are based exclusively on age, sex, Medicaid status, and the original reason for Medicare entitlement. Existing enrollees will have their risk scores updated on an ongoing basis. The scores can be adjusted twice each year in January and July.

MA plans are audited by CMS for the accuracy of their risk adjustment data. These audits are performed using a sampling method, medical record review, and payment error calculation. In addition, beginning July 1, 2014, MA plans will be required to include Health Insurance Prospective Payment System ("HIPPS") codes for all skilled nursing center claims. This requirement is part of the Encounter Data System ("EDS") program implemented by CMS in 2012. Accordingly, the accuracy that the plans utilized in collecting data about the beneficiaries as well as the accuracy of data retained by providers in the plan's network are key to their success in the risk adjustment process and otherwise.

The Minimum Loss Ratio Requirement

As part of the ACA, Congress enacted specific Minimum Loss Ratio ("MLR") governing MA plans. That ratio, established at 85%, requires the plans to demonstrate that not less than 85% of their revenue is devoted toward the payment of health care services. This MLR essentially establishes a "cap" on plan administrative overhead and indirectly establishes a maximum profit margin at 15% of revenues.

If the MA plan cannot demonstrate that it will meet the MLR, its "bid" will not be accepted by CMS and it will not be permitted to participate in the MA program. The establishment of a MLR is designed to ensure that a significant percentage of revenue is actually spent on care. While MA plans have some leeway in allocating costs, the general idea is to ensure that MA plans do not deny necessary care at the expense of beneficiaries. Theoretically, this also helps to keep providers from being taken advantage of by plans.

Performance and Compliance

MA plans are subject to a voluminous and detailed set of requirements, and a corresponding set of performance audit criteria over and above the usual financial audit criteria. CMS has been very clear that MA plans are fully responsible for the shortcomings of their participating

providers. These include their primary contracting partners known as "first tier entities" (*i.e.*, those who agree to share significant portions of financial risk with the plans, such as medical groups, IPAs, or even hospital systems) as well as the providers that contract with the plans or the "first tier" entities on a fee-for-service and/or limited risk basis, referred to as "downstream" entities. Compliance training, monitoring, and auditing expectations have become increasingly strict. As plans are accountable for the conduct of their "downstream" providers, this is yet another area where skilled nursing centers can demonstrate their value to MA plans.

Implications for Skilled Nursing Centers

Skilled nursing centers looking to enter the MA plan marketplace may experience challenges depending on the sizes of their overall organizations. The larger plans (typically operating "regional" plans) may be more interested in contracting with larger rather than smaller provider organizations. This is based on their incentives to cover multiple markets. As a result, except in underserved markets, they may be more likely to have "closed" networks. In contrast, "local" plans do not have the same needs to build networks over larger geographical areas. As a result, these plans may be more open to skilled nursing centers from smaller sized organizations.

For the same reasons, skilled nursing centers associated with smaller organizations may generally have better leverage with "local" plans rather than the larger "regional" plans. Unlike the "regional" plans, the "local" plans have less purchasing power overall to negotiate larger volume arrangements. For more sophisticated skilled nursing centers looking to share financial risk, the "regional" plans are likely better targets to discuss more complicated financial arrangements.

Moreover, while we have seen larger health plans entering the SNP market, we could see a greater number of "local" plans serving "dual-eligible" beneficiaries through SNPs and particularly, D-SNPs. In addition, based on historical performance, "local" plans may have better quality rankings than the larger "regional" plans. As a result, they may have more revenue available and may be agreeable to paying higher rates.

Notwithstanding the above, skilled nursing centers should not avoid marketing to all MA plans operating in their area. In doing so, skilled nursing centers should formulate marketing strategies that focus on any unique service lines that may be of particular interest to the plans. Skilled nursing centers should also focus its marketing on its internal metrics associated with quality indicators, lengths of stay, hospital readmissions, care transitions, and the ability to effectively collaborate with hospitals and physicians on specific episodes of care. Beyond that, skilled nursing centers need to present their vision of how they could best "partner" with the MA plans in order to assist them with better managing care and outcomes.