Medicare Advantage Payment Basics – Following the Money

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Agenda

Components of Part C Medicare Advantage Revenue

How are MA plans supposed to pay providers, and how does this affect the MA capitation rates?

Medicare Advantage and IPPS

Adjudication adjustments

Recent issues and rate impacts

Caveats, limitations, and qualifications

Presenters

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Components of Part C Medicare Advantage revenue

County specific fee-for service cost-based benchmark

Star rating impact

Pre-ACA benchmark cap

Part C bid process

Other topics

- Risk adjustment
- Payment timing
- EGWP plans
- Sequestration
- COVID-19

County specific benchmark rate

Developed based on the United States Per Capita Cost (USPCC) for Medicare Fee-For-Service (FFS) members

- Phased in from Pre-ACA benchmark rates between 2012 and 2017
- 2022 FFS USPCC = $1,028.38 PMPM

Five-year rolling average geographic adjustment (AGA) applied to each county

- 2022 AGA is based on 2015 through 2019 cost
- Credibility adjustment for counties with less than 1,000 members

Adjustments for FFS costs not applicable to MA plans

- Graduate Medical Expense
- Indirect Medical Expense
- Military Adjustment
- Kidney Acquisition Costs

Quartile adjustments

- Based on prior year FFS cost county rankings
- Changes are phased in over two years

Historical quartile distribution of MA members

There has been a dramatic shift in MA enrollment from high-cost counties to a more even distribution

Quartile	2012	2013	2014	2015	2016	2017	2018	2019	2020
Highest cost (95%)	44%	40%	37%	37%	35%	33%	27%	25%	24%
2nd Highest cost (100%)	22%	23%	23%	23%	22%	22%	24%	27%	27%
3rd Highest cost (107.5%)	15%	17%	20%	20%	22%	23%	24%	23%	24%
Lowest cost (115%)	18%	20%	20%	20%	21%	23%	25%	26%	26%

Star rating impact on revenue

- 2021 Star ratings, released in October 2020, affect 2022 revenue
- Star rating affects both the benchmark and the retained rebate percentage
- Select counties are eligible for double bonus (9% of counties and 26% of MA enrollees)
  - MA penetration > 25% as of December 2009
  - Payment rate at urban legacy floor when 2004 rates established, affiliated with MSA with > 250,000 population
  - **FFS costs < national average FFS costs**

Star rating	Quality bonus	Rebate percentage
5.0	+5%	70%
4.5	+5%	70%
4.0	+5%	65%
3.5	0%	65%
3.0 and lower	0%	50%
New or low enrollment	+3.5%	65%

Star rating distribution

2021 Star rating distribution			
Overall star rating	**2021 Bonus %**	**2021 # of contracts**	**2021 weighted by enrollment**
5 stars	5%	21	9.2%
4.5 stars	5%	64	22.0%
4 stars	5%	110	45.9%
3.5 stars	0%	140	18.8%
3 stars	0%	61	4.1%
2.5 stars	0%	4	0.1%
2 stars	0%	0	0.0%
Total		**400**	

Source: CMS Fact Sheet – 2021 Star Ratings https ://www.cms.gov/files/document/2021starratingsfactsheet-10-13-2020.pdf

Pre-ACA benchmark cap

- Pre-ACA benchmark rates have continued to be updated for annual trend increases
- The final benchmark rate, after adjustments for quartile and quality bonus, is limited to the Pre-ACA benchmark rate
- While the Pre-ACA benchmark cap limits the benchmark in these counties, the star rating still impacts the retained rebate percentage

Star rating	Percent of counties	Percent of MA enrollees
Capped With No Quality Bonus	17%	7%
Capped with 4.0+ Star Quality Bonus	39%	19%

Sample benchmark development – Autauga, AL

- **FFS USPCC = $1,028.38**
- AGA for Autauga, AL = 0.9490
- **AGA Adjusted FFS Cost = $975.97**
- MA Adjustments = -$17.37 (see right)
- **FFS Cost after Adjustments = $958.74**
- Quartile Adjustment = 1.075
- Double Bonus Eligible? = Yes

- **No Quality Bonus Benchmark = $958.74 x 1.075 = $1,030.65**
- **4-Star Bonus Benchmark = $958.74 x 1.175 = $1,126.52**
- Pre-ACA Benchmark = $1,145.66
  - No Impact on Benchmark

MA Adjustments for Autauga, AL

- GME = -$2.89
- MIL = -$1.70
- IME = -$10.26
- KAC = -$2.38

Sample benchmark development – Barbour, AL

- **FFS USPCC = $1,028.38**
- AGA for Barbour, AL = 0.9496
- **AGA Adjusted FFS Cost = $976.57**
- MA Adjustments = -$12.34 (see right)
- **FFS Cost after Adjustments = $963.23**
- Quartile Adjustment = 1.1125 (phasing from 1.15 to 1.075)
- Double Bonus Eligible? = No

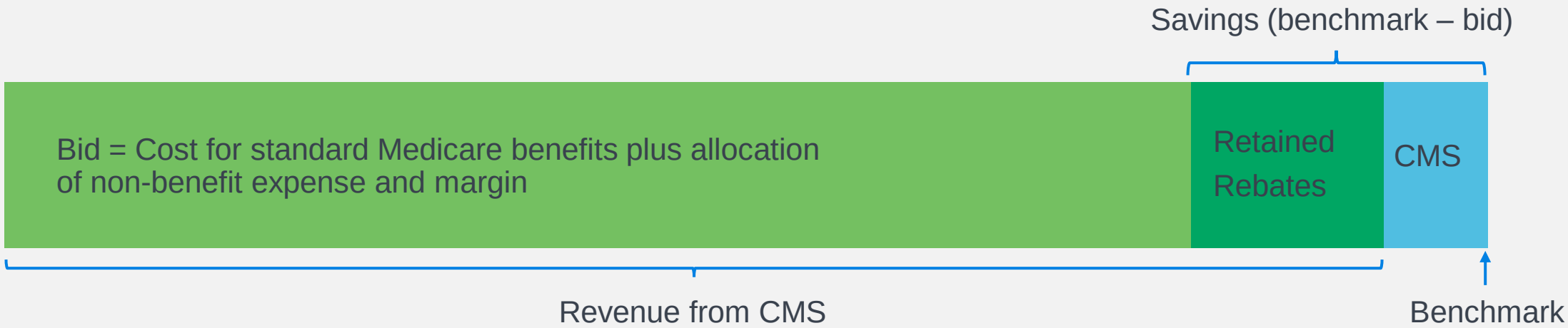
- No Quality Bonus Benchmark
  = $963.23 x 1.1125 = $1,072.71
- 4-Star Bonus Benchmark
  = $958.74 x 1.1625 = $1,120.92
- **Pre-ACA Benchmark = $1,055.00**
  - Impacts both benchmarks: Barbour, AL, benchmark is $1,055.00 for all star ratings

MA Adjustments for Barbour, AL

- GME = -$5.13
- MIL = +$7.61
- IME = -$11.49
- KAC = -3.33

Part C bid process

- The Part C bid amount is the estimated cost for the plan to cover standard Medicare benefits, plus an allocation of non-benefit expense and margin
- The difference between the Part C bid amount and the benchmark is the savings amount
- CMS retains some of the savings amount (35% for a 4.0 star plan)
- The rest of the savings is paid to the plan as “Part C rebate revenue”, which is used to fund supplemental benefits and reduced cost sharing



Other Part C revenue topics

Risk adjustment

- Bid revenue is adjusted to member specific risk scores
- Rebate revenue is not affected by risk score

Payment timing

- Monthly revenue paid to the plan based on the risk score in the Monthly Membership Report files
- True up payment for final risk scores by September following the payment year.

EGWP plans

- No bid process, CMS revenue is EGWP benchmark adjusted for member risk score

Sequestration

- 2% reduction to the bid and rebate revenue (and EGWP benchmarks)

COVID-19

- 2022 FFS cost estimates reflect the impact of deferred care to 2022

How are MA plans supposed to pay providers, and how does this affect the MA capitation rates?

Medicare FFS

Provider payments

Medicare FFS provider payments are made prospectively with a reconciliation process for some types of providers, e.g. acute hospitals, critical access hospitals (CAHs).

Medicare FFS

- Inpatient Prospective Payment System (IPPS)
- Home Health
- Outpatient Prospective Payment System (OPPS)
- Ambulatory Surgery Center (ASC)
- Inpatient Rehabilitation Facility (IRF)
- Long-Term Care Hospitals (LTCH)
- Inpatient Psychiatric Facility (IPF)
- Physician RBRVS
- Anesthesia
- Durable Medical Equipment & Prosthetics (DME-POS)
- Parenteral and Enteral (PEN)
- Clinical Lab
- Ambulance
- Average Sales Price (ASP) drug fee schedule
- CAH, Maryland Waiver, Cancer
- Skilled Nursing Facility (SNF)

Medicare Advantage

Provider payments

In-network

- The contract between the plan and the provider dictates payments
- Many plans contract at a percent of Medicare FFS

Out of network

- Based on Medicare FFS with some nuances

Common trouble areas for MA plans

- Inpatient hospital payment components
- Outpatient facility and professional adjudication adjustments
- MIPS adjustments (professional)
- Sequestration

Medicare Advantage and IPPS

The gory details

Operating Indirect Medical Education (IME) and Graduate Medical Education (GME)

One phase-in; two phase outs

The Balanced Budget Act (BBA) of 1997

- Changed how IME and GME are calculated for each hospital under IPPS
- Phased IME and GME out of the Medicare +Choice rates by 2002
- Phased in direct IME and GME payments from Medicare to hospitals for Medicare + Choice patients

Medicare Improvements for Patients and Providers Act (MIPPA) of 2008

- Phased IME and GME out of the Medicare Advantage county benchmarks by 0.60% per year starting in 2010.
- Phased out by county: As of 2022 only Bronx, NY and Canovanas, PR are not fully phased out. Suffolk, MA completed the phase out in 2021.

Year	IME and GME Payments for Managed Care Patients: phase in
1998	20%
1999	40%
2000	60%
2001	80%
2002	100%

Sources: BBA of 1997, MIPPA of 2008.
2022 Advanced Noticed Part II.

Operating IME and GME

2019 payments to hospitals from Medicare

IME

Hospitals submit a claim to Medicare FFS for the IME for Medicare Advantage patients

- Payment is made when the claim finalizes

GME

Hospitals report bed days for Medicare Advantage patients

- GME payments are made as part of the Medicare Cost Report settlement process

	FY 2019 Payment ($B)
Indirect Medical Education	
Medicare FFS	$4.6
Medicare Advantage	$2.1
Total IME	$6.7
Graduate Medical Education Payments	$4.0
Total Medical Education	$10.7

Sources: Medicare hospital billing guidance from Novitas Solutions. Fiscal year 2019 Medicare Cost Report filings.

Inpatient Prospective Payment System (IPPS)

Medicare Advantage provider payments

For in-network hospitals, the contract between the plan and the hospital dictates payments

For out of network hospitals, payments should match Medicare FFS with the following exceptions:

- *Operating IME* – Exclude
- *Organ acquisition costs* – Pay estimated cost
  - Effective 1/1/2021: do not pay kidney acquisition costs
- *Pass through per diem payments* – Generally exclude
  - Graduate Medical Education (GME): Exclude
  - Organ Acquisition: Exclude, since paying estimated cost
  - Nursing and allied health education costs: Generally exclude
    - Cost based NAH amount: Include
    - Balanced Budget Refinement Act (BBRA) NAH add-on taken from DGME payments: Exclude
  - Bad Debt: Exclude

IPPS payment component summary

Operating payment	Include?	Example
Base operating amount	Yes	$9,923
Proxy Value Based Purchasing (VBP) adjustment	Yes	$7
Readmissions adjustment	Yes	-$78
DSH (after reduction to 25%)	Yes	$326
IME	**No**	$260
Sole Community Hospital Payment (HSP)	Yes	$0
Outlier payment (calc. including IME payment)	Yes	$0
Uncompensated care (per discharge)	Yes	$1,030

Capital payment		
Adjusted capital amount	Yes	$765
DSH	Yes	$46
IME	Yes	$16
Outlier payment	Yes	$0
Adjustments / other		
Low-volume adjustment	Yes	1.000
HAC adjustment	Yes	1.000
Transfer	Yes	1.000
New technology, clotting factor	Yes	$0
Pass through	**No**	$156

IPPS example claim

Medicare Advantage plan payment to an out of network (OON) hospital

Component	Example
Total Medicare FFS payment	$12,451
Operating IME * HAC Adjustment	$260
Pass Through Amount	$156
FFS Total less Operating IME and Pass Through	**$12,034**
Less Member Cost Sharing	$250
Less Sequestration	$0
Net Plan Payment	**$11,784**

Adjudication adjustments

APC grouping – adjudication rules (example)

Adjustment	Description	Approximate impact
Multiple procedures	Second and subsequent services are paid at 50% of the normal rate. Applies to a subset of procedures.	4% decrease
Modifier adjustments	Generally scalar adjustments.	Not available
Composite APCs	Adjustments for certain combinations of services, e.g. multiple radiology services.	<1% decrease
Comprehensive APCs	Case rates for device-intensive procedures and some ED visits.	5% decrease
Conditional Bundling	Pays some services at zero when they are performed in conjunction with significant services, e.g. lab tests.	6% decrease
MUEs	Generally results in claims being resubmitted to fix errors. Maximum procedure limits are most significant.	Highly variable
Outlier	Cost based. Calculated at the service line level with adjustments for the estimated cost of bundled services. Overall impact is small.	1% increase

Sources: Analysis of Medicare 5% Sample data and 2017 OPPS fee schedules using Milliman *Medicare Repricer*
https://www.milliman.com/en/products/Medicare-Repricer

Recent issues and rate impacts

Recent Issues and Rate Impacts

Adjustment	Discussion	MA capitation impact	MA provider Pmt impact
IME, GME, Kidney Acquisition	IME, GME, and kidney acquisition are paid directly by Medicare for Medicare Advantage patients, and therefore excluded from the MA capitation rates. *(Only the Kidney Acquisition component is recent.)*	Approx. 2.5% decrease	Decrease if applied
MIPS adjustment	Scalar adjustments to Medicare FFS physician payment net of cost sharing.	Varies	Varies
Shared savings	Shared savings / CMMI programs affect Medicare FFS expenditures based on ACO performance and payouts	Varies	None
2021 RBRVS CF Increase	3.75% increase to the Resource-Based Relative Value Scale (RBRVS) conversion factor enacted 12/27/2020 as part of the Consolidated Appropriations Act of 2021	None since expires 12/31/2021	2022 increase if congress extends
2021 RVU Changes	Updates to RVUs effective 1/1/2021. Increase to E&M RVUs.	None	Varies

Recent Issues and Rate Impacts (continued)

Adjustment	Discussion	MA capitation impact	MA provider Pmt impact
COVID-19 PHE and DME-POS	CARES Act increased DME-POS schedule for non-rural areas effective 3/6/2020 until the end of COVID-19 PHE. These higher amounts were used in the development of the county benchmarks.	Unclear / increase for non-rural counties	Increase during PHE
Sequestration	CARES Act suspended sequestration through 12/31/2020. Further extended through 3/31/2021 by The Consolidated Appropriations Act, 2021.	2% increase while sequestration is not in effect	
IPPS COVID-19 Add-Ons	IPPS 20% operating DRG weight increase and *New COVID-19 Treatments Add-on Payment* (NCTAP) during the COVID-19 PHE.	None / unclear	Increase during PHE
LTCH Site Neutral Waiver (COVID-19)	Removes the site neutral payment approach for long term care hospitals (LTCH) during the COVID-19 PHE.	None / unclear	Increase during PHE

Questions

Caveats, limitations, and qualifications

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Thank you!