



Medicare Advantage Toolkit

Module I: A Primer on Medicare Advantage

About the Authors

Mark E. Reagan

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.

Jim Miles

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.

Module I: Medicare Advantage Primer

This document is not intended as legal advice and should not be used as or relied upon as legal advice. It is provided for general information purposes only and may not be substituted for legal advice. Specific legal advice is crucial when preparing for or negotiating an important contract that would have significant financial and legal consequences: **ALWAYS SEEK THE ADVICE OF KNOWLEDGEABLE COUNSEL TO PROVIDE ADVICE THAT IS TAILORED TO THE ACTUAL FACTS AND CIRCUMSTANCES AND TAKES INTO ACCOUNT ALL RELEVANT LAW.**

Description of the MA Program

Medicare Advantage (“MA”) is an alternative way for Medicare beneficiaries to receive covered benefits under original Medicare Parts A, B, and D. Increasingly, the path to provider access to Medicare beneficiaries is through an MA plan. For example, in some areas of the country over 50% of Medicare beneficiaries are enrolled in an MA plan.

Under MA, private health plans are paid a “capitated” (*i.e.*, per person) amount to provide all Medicare-covered benefits (with the exception of hospice) to beneficiaries that enroll in their plan. Medicare beneficiaries who are eligible for Part A or are enrolled in Part B are eligible to enroll in an MA plan if one is available in their area. Some MA plans choose their service area by establishing a “local” MA plan while others agree to serve one or more regions defined by CMS by establishing “regional” MA plans. In 2013, nearly all Medicare beneficiaries have the ability to choose an MA plan and approximately 28% of such beneficiaries were enrolled in such a plan.¹ This ranges from 49% of beneficiaries in Minnesota to less than 1% and 3% of beneficiaries respectively in Alaska and Wyoming.

MA plans use different managed care techniques to influence the medical care used by their enrollees. For example, MA plans that utilize health maintenance organizations (“HMOs”) often require enrollees to receive care from a pre-determined network of providers. Moreover, HMOs may require beneficiaries to see a primary care physician who will coordinate their care and refer them to specialty physicians as necessary. Often, in these types of arrangements, the primary care physician is part of a medical group and/or independent practice association (“IPA”) that contracts with the MA plan for a “sub-capitated” rate and shares risk associated with the financial elements of such care with the MA plan. Other MA plans may operate using a Preferred Provider Organization (“PPO”) model that pays benefits in different percentages for in-network and out-of-network providers, while yet other MA plans operate using a methodology

¹ See Kaiser Family Foundation, “Medicare Advantage 2013 Spotlight: Enrollment Market Update,” (June 2013); Kaiser Family Foundation, “Medicare Advantage Plan Star Ratings and Bonus Payments in 2012: Data Brief,” (November 2011); and Morgan Stanley Research North America, “Managed Care: Expected Impact in Medicare Advantage Star Ratings,” (October 2011). Note: Unless otherwise indicated, all data appearing in Modules I and II are supported by these articles.

such as private fee-for-service (“PFFS”). Generally speaking, these PPO and PFFS alternative formats contain fewer restrictions on the providers from whom the beneficiaries may receive treatment and have less coordination of care than plans utilizing the HMO format.

One of the advantages offered by MA plans is their ability to offer additional benefits or require smaller co-payments or deductibles than original Medicare. While beneficiaries may often times pay for additional benefits through higher monthly premiums, these additional benefits are often financed through the plan through plan savings. The extent of additional benefits and reduced cost-sharing varies often by plan type and geographical location. Increasingly, MA plans are viewed by Medicare beneficiaries as an attractive alternative to more expensive supplemental insurance policies found in the private marketplace.

The “capitated” monthly payment made by CMS to each MA plan is adjusted for various factors including MA plan quality rankings and the demographics/acuity of beneficiaries enrolled in the plan. The same monthly payment is made by CMS regardless of how many or few services a beneficiary actually uses and the MA plan is at financial risk if costs, in the aggregate, exceed a program’s payments. Conversely, the MA plan can retain savings if aggregate costs are less than payments, as long as it spends at least 85% of its revenue on care. *See* Module II for a discussion of the minimum loss ratio requirements.

Beginning in 2006 and continuing through the present, CMS began offering MA “regional” plans. These plans must serve one or more of the requirements designated by CMS. Nationwide, there are 26 MA regions consisting of states or groups of states. Establishing the “benchmark” for such regional plans, CMS utilizes (1) a statutorily determined amount (comparable to the “benchmarks” described above), and (2) a weighted average of plan “bids.” As a result, a portion of the “benchmark” offered to these MA plans is determined based upon competition in the marketplace. Similar to local plans, regional plans with “bids” below the “benchmark” are given a rebate while regional plans with bids above the “benchmark” require an additional beneficiary premium.

Medicare beneficiaries eligible for an MA plan may enroll in any MA plan that serves their area. However, some MA plans are authorized to restrict their enrollment to only those beneficiaries meeting additional criteria. For example, Medicare Special Needs Plans (“SNPs”) are a type of MA plan that exclusively enrolls, or enrolls a disproportionate percentage of, beneficiaries with “special needs.” These individuals include MA-eligible beneficiaries who are either institutionalized, eligible for both Medicare and Medicaid (*i.e.*, “dual eligibles”), or have a severe or disabling chronic condition and would benefit from enrollment in a MA SNP plan.

More specifically, the SNPs authorized by CMS include Medicare beneficiaries who are “dually eligible” for Medicare and Medicaid (“D-SNPs”), beneficiaries requiring a nursing home or institutional level of care (“I-SNPs”), and beneficiaries with chronic or disabling conditions (“C-SNPs”). Some of the D-SNPs are fully integrated dual-eligible (“FIDE”) SNPs, if the state in which they operate agrees to pass and implement legislation or a waiver program allowing for Medicare-Medicaid integration through a single managed care plan. While the FIDE SNPs are a type of SNP plan that allows for a more complete integration of the dual-eligible population, FIDE SNPs are not (1) required to be utilized by a state implementing the Dual-Eligible Demonstration Program. or (2) directly tied to a state’s participation in that program. While

SNPs are offered through a variety of types of MA plans, including HMOs as well as local and regional PPOs, 87% of SNP enrollees were in an HMO plan in 2013.

From the perspective of the skilled nursing profession, Medicare beneficiaries choosing MA plans will largely see two different populations from MA plans. First, in non-SNP MA plans, the beneficiaries referred to post-acute care providers will include Medicare beneficiaries who are less likely to be poor enough to qualify for Medicaid and less likely to have significant chronic health conditions. Generally speaking, this population is much more likely to be transferred home after their post-acute care needs have been met.

Second, the Medicare beneficiaries from SNP plans likely are enrolled already in Medicaid (often through Medicaid managed care) and/or have chronic conditions. It may be more likely that these beneficiaries would “cross-over” after their post-acute stay and remain at a skilled nursing center for a Medicaid stay thereafter. Because of the establishment of “demonstrations involving increased integration of the dual-eligible population,” and because the number of states implementing Medicaid managed care programs, the number of SNP plans, as well as the total number of SNP plan enrollees, have been growing at a rapid pace since their establishment by CMS in 2003.

Differences between Conducting Business with an MA Plan versus “Original” Medicare

In “original” Medicare, facility certification by CMS authorizes the skilled nursing center to receive Medicare reimbursement for Part A inpatient services and those services required to be billed through the consolidated billing rule under Part B. In contrast, payment from an MA plan can be received only by virtue of a contractual relationship between the skilled nursing center and an MA plan. Though the MA program includes a payment methodology for “out-of-network” providers, such instances will be relatively rare for skilled nursing centers as compared to MA beneficiaries receiving emergent or non-emergent hospital services in an acute care hospital.

In order to have a contract with an MA plan, a skilled nursing center must be admitted to the MA plan’s network. This can be a real challenge if the plan’s network is “closed,” which means that no further providers of that type are being offered contracts. Skilled nursing centers facing this situation should seek to determine whether they can demonstrate their value based upon the provision of specialty services or a specific market niche. If unsuccessful in persuading the plan to “open” its network, skilled nursing centers should attempt to evaluate whether the MA plan meets the required network access standards for Medicare beneficiaries. If all else fails, such skilled nursing centers should remain in touch with the plan in order to determine whether at a subsequent time it may be willing to “open” its network. This type of opportunity may also arise if the skilled nursing center is serving a Medicaid beneficiary in their center who also has a Part B benefit administered by an MA plan. In this instance, the MA plan may have a financial incentive to contract with the skilled nursing center in order to potentially gain preferable Part B rates. Otherwise, the MA plan would be required to pay the skilled nursing center the full Part B fee-for-service rate as an “out-of-network” provider.

If the network of an MA plan is “open,” skilled nursing centers will need to become “credentialed.” This occurs through the submission of information by the center to the MA plan. The credentialing information that will need to be provided likely includes, among other things, evidence of licensure and program certification as well as other quality and enforcement data (e.g., hospital readmission rates, Medicare Five-Star Quality Rating, recent state survey reports, etc.). Once “credentialed,” the skilled nursing center may enter into a contract with the MA program. Contracts are complex documents that establish the terms of the business relationship between the skilled nursing center and the plan. Some elements of the contract with an MA plan (as described in this tool kit) are required by CMS statute or regulation. However, many are left entirely up to the parties in that the MA program includes statutory and regulatory provisions that prohibit the government from “interfering” in establishing certain terms of the contract between the MA plan and the provider.

For example, one of the areas in which CMS will not “interfere” is in the area of provider reimbursement. Generally speaking, reimbursement to skilled nursing centers for Part A inpatient services may be calculated on a percentage of the payments made under the RUGs system or calculated using an alternative methodology of specified “levels” or “tiers” that are aligned to the acuity of the individual beneficiary as well as those services required to be supplied by the skilled nursing center. With respect to Part B services, and particularly rehabilitation, MA plans may pay a percentage of the applicable Medicare “fee schedule” or seek to reimburse the skilled nursing center at a particular hourly rate for rehabilitation services otherwise covered by Part B. *See* Module III for a thorough discussion of MA plan rate methods.

In addition, there will be other important requirements involving the “prior authorization” of services to be provided arranged for by the skilled nursing center. This will be the case particularly if the MA plan is an HMO. It is important for skilled nursing centers to understand these “prior authorization” requirements and be prepared to navigate these systems because the contract will condition payment on having an authorization in place from the plan, or the beneficiary’s primary care physician, or another individual or entity. As part of its navigation of these authorizations, it is important for skilled nursing centers to monitor these authorizations to ensure that contact is made with the necessary individual or entity prior to the expiration of such authorization. *See* the discussion of utilization review in Module III for additional information regarding authorization issues.

Finally, unlike “original” Medicare for Part A and Part B reimbursement, which is made by a Medicare Administrative Contractor (“MAC”), all claims made to MA plans by skilled nursing centers will be paid exclusively by the plan. The methodology for payment by an MA plan will be specified in the contract including the number of days in which payment must be made for “clean claims.” “Clean claims” generally refer to claims that do not require any additional information to demonstrate a right to payment.

Often, state statutes and/or regulations will govern payment timeframes for HMOs and PPOs. As plans are often licensed (or at least regulated) by state insurance oversight agencies, the plans will be bound by these requirements. Such statutes and/or regulations do not relieve the skilled nursing centers from having to ensure timely and accurate billing, including the presentation of “clean claims” with the required documentation or data specified by the MA plan. Skilled

nursing centers should become familiar with all of the billing forms and provisions utilized by the MA plan to maximize success in this area. With the possibility of having to process claims to multiple MA plans, it is essential for the skilled nursing centers to monitor its receivables from MA plans along with original Medicare and the applicable Medicaid program.

Once the contract is in place, the skilled nursing center can receive admissions from the MA plan. Unlike “original” Medicare Part A, where the skilled nursing center receives admissions from a “discharge planner” typically employed by an acute care hospital, the skilled nursing center will receive admissions from either the plan, the medical group, or an independent physician association (“IPA”) associated with the plan. When the patient is admitted to the skilled nursing center, the admission may also come with an expected length of stay (“LOS”) or a prior authorization for a defined period of time (e.g., five days), with the expectation that, in cases of longer stays than authorized, the LOS will be reviewed and re-established prior to the termination of the prior authorization. Skilled nursing centers should expect that the LOS for MA plan beneficiaries generally will be shorter than those experienced by Medicare beneficiaries covered under Part A.

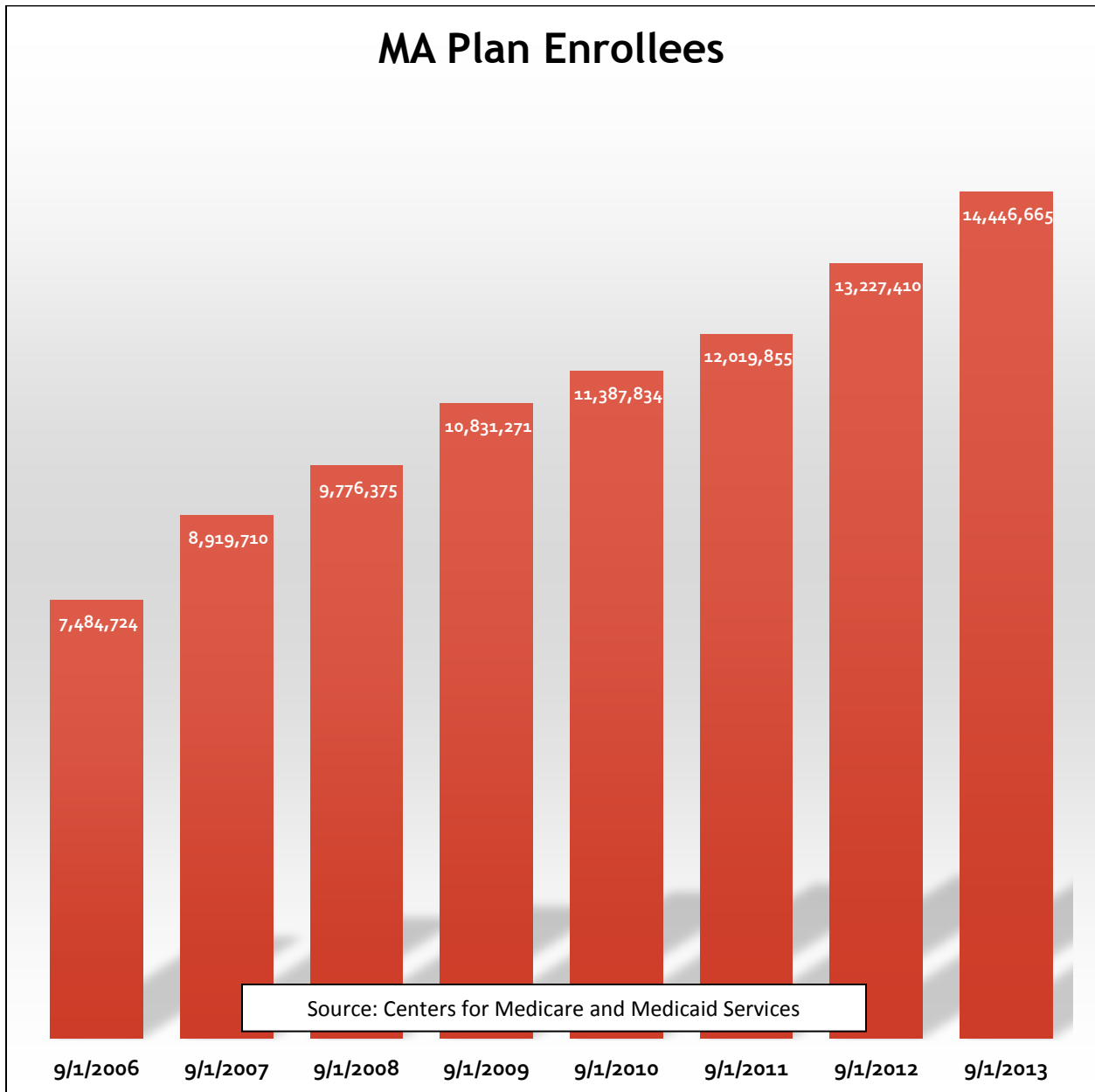
While doing business with an MA plan may produce a lower average LOS than under “original” Medicare Part A, there are nevertheless advantages that skilled nursing centers enjoy in relationships with MA plans that do not exist under Part A. For example, MA plans are not required to apply the three-day hospital stay rule with respect to admissions to a skilled nursing center. This will give greater flexibility to an MA plan in designing post-acute care for its beneficiary without regard to the payment rules established under Part A.

Having a contract with an MA plan does not ensure that any skilled nursing center will receive any specified level of admissions or referrals. MA plans look to skilled nursing centers as “partners” in successful post-acute stays and transitions. A skilled nursing center participating with an MA plan should view that relationship as one in which the MA plan (as well as the beneficiary) are “customers.” As such, the skilled nursing center should make good “customer service” with the MA plan a priority in order to forge a stronger relationship over time and secure additional admissions. This does not mean that a skilled nursing center should cease advocating for its residents and the care and treatment that they require. However, the skilled nursing center has to be sensitive to the needs of the MA plan and its financial pressures, including those resulting from increased acute care hospital re-admissions. Skilled nursing centers that can “partner” with MA plans will have significant advantages in growing business relationships.

MA Plan Enrollment

The current enrollment in MA plans in 2013 exceeds 14 million Medicare beneficiaries. Despite government and private organization projections that MA plan enrollment would decline after passage of the Affordable Care Act in 2010, enrollment has grown approximately 30% since then. The rapid growth associated with MA plans appears to have occurred concurrently with the introduction of Medicare Part D in 2006, and despite a decrease in the number of available plans from almost 50 plans in 2009 to 20 plans in 2013. The Congressional Budget Office projects MA plan enrollment will continue to grow moderately through 2022. Some predict

more than moderate growth due to demographics (the increased number of people having eligibility), and also because many states are adopting privatized Medicaid managed care programs that attract MA plans to new or underdeveloped geographic markets.



Despite the increasing diversity in MA plan types, the majority of enrollees are in HMOs. As with MA plans as a whole, enrollment in MA SNP plans is also increasing. For example, 1.6 million Medicare beneficiaries are currently enrolled in a SNP plan with 82% of all SNP enrollees in a D-SNP plan. Enrollment in C-SNPs and I-SNPs represent a smaller share of SNP plan enrollment, though they are also growing quite rapidly. Nationally, approximately 12% of “dual-eligible” beneficiaries are in D-SNPs in 2013, which is an increase from 10% in 2012.

D-SNP enrollment varies quite a bit across states. For example, in nine states (Alaska, Arizona, Florida, Hawaii, Minnesota, Oregon, Pennsylvania, Tennessee, and Utah), at least 20% of all “dual-eligible” beneficiaries are enrolled in D-SNPs. In contrast, there are 14 states in which no “dual-eligible” beneficiary is enrolled in a D-SNP plan.

As with D-SNP plans, overall MA plan penetration varies substantially by state and within states. For example, 14 states had at least 30% Medicare beneficiary enrollment in MA plans while 6 states had less than 10% of their beneficiaries in an MA plan. Similarly, MA plan penetration often is widely variable across counties with the same state.

There are also significant distinctions between enrollment in MA plans between the metropolitan and non-metropolitan areas. For example, 80% of Medicare beneficiaries eligible to enroll in an MA plan live in metropolitan areas. As such, the overall penetration of MA enrollment is in excess of 30% in metropolitan areas as compared with less than 20% of non-metropolitan areas. Moreover, while two-thirds of Medicare beneficiaries resided in counties in the top one-half of Medicare fee-for-service costs, 45% of MA plan enrollees are also in the top quartile of such costs.

Based upon the above, and in order to determine their best marketing strategy, skilled nursing centers should evaluate the MA market in the areas that they serve.

Market Concentration of MA Plans

There is a high concentration of MA enrollment within a small number of health plans. For example, in 2013, five health plans reflected approximately 63% of all MA plan enrollees. These included United Healthcare (21%), Blue Cross Blue Shield affiliates (17%) (including 4% in Well Point affiliates), Humana (17%), Kaiser Permanente (8%), and Aetna (4%). In addition, another seven health plans accounted for 11% of all enrollment, including Cigna (3%) followed by Coventry, Well Care, Health Net, and Universal American. The remainder of enrollees (approximately 25%) are in plans offered by more local or regionally-focused MA plans.

The top plans have very different distributions of enrollees by type of plan. For example, 94% of Kaiser Permanente’s enrollees are enrolled in HMO plans while United Healthcare’s HMO enrollment is slightly less than 70%. Among plans operated by Blue Cross Blue Shield affiliates, slightly less than 50% are enrolled in HMOs with the remaining one-half in local or regional PPOs. Only slightly more Humana enrollees are within HMOs.

From the perspective of state concentration, United Healthcare has the largest market share in 20 states and is among the top three MA plans in 17 additional states and in the District of Columbia. Humana has the largest enrollment in 12 states and is among the top three in another 17 states. Blue Cross Blue Shield affiliates have the highest enrollment in 7 states and are among the top three firms in another 15 states. Kaiser Permanente’s presence is far more geographically-focused with a heavy concentration in California, Colorado, the District of Columbia, Hawaii, Maryland and Oregon. Kaiser has more enrollees than any other plan in California, the District of Columbia, and Maryland.

As of 2012, the following ten counties had the highest MA plan enrollment by county:

Rank	County / State	MA Plan Enrollees
1.	Los Angeles, CA	489,411
2.	Maricopa, AZ	221,361
3.	Miami-Dade, FL	214,357
4.	Orange, CA	177,972
5.	San Diego, CA	170,638
6.	Allegheny, PA	146,499
7.	Riverside, CA	144,128
8.	Broward, FL	129,662
9.	Harris, TX	127,928
10.	Queens, NY	117,573

Source: Centers for Medicare and Medicaid Services